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National Evaluation of the Residential Substance Abuse Treatment for State Prisoners Program

From Onset to Midpoint

FINAL REPORT

"RSAT at Midpoint"

Prepared by

Douglas S. Lipton, Frank S. Pearson, Harry K. Wexler

National Development and Research Institutes, Inc.
Two World Trade Center
New York N. Y. 10048

Final Report

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EXECUTIVE SUMMARY

What is the Residential Substance Abuse Treatment (RSAT) for State Prisoners Program? The Residential Substance Abuse Treatment formula grant funds were designed by Congress to be used to implement residential substance abuse programs providing individual and group treatment for inmates in residential facilities operated by State and local correctional agencies.

How is the RSAT initiative being implemented? Under the Corrections Program Office of the Office of Justice Programs of the Department of Justice, state and local correctional agencies receive funds to develop (or enhance existing) programs that will: (1) last between 6 and 12 months; (2) be provided in residential treatment facilities set apart from the general correctional population, that is, in a totally separate facility or a dedicated housing unit within a facility exclusively for use by program participants; (3) be directed at the substance abuse problems of the inmate; (4) be intended to develop the inmate's cognitive, behavioral, social, vocational, and other skills so as to solve the substance abuse and related problems; and (5), continue to require urinalysis and/or other proven reliable forms of drug and alcohol testing of individuals assigned to treatment programs during and after release from residential custody.

How is funding allocated for the RSAT Program? The total funding for this five-year effort is $270 million. This sum is divided as follows: 1996 - $27 million; 1997 - $36 million; 1998 - $63 million; 1999 - $72 million; 2000 - $72 million. Each state is allocated a base amount of 0.4 percent of the total funds available for the program, and the remaining funds are allocated to each participating state on the basis of the ratio of the prison population of each State to the total prison population of all participating states.

What is the National Evaluation of the Residential Substance Abuse Treatment (NERSAT)? The National Institute of Justice and the National Development and Research Institutes, Inc. (NDRI) entered a cooperative agreement wherein NDRI would evaluate through the use of surveys the extent to which the goals of the RSAT program were being accomplished and the problems that were encountered by the participating States.

WHAT HAS RSAT ACCOMPLISHED? RSAT Highlights as of December 31, 1998

How many states have generated plans for at least one RSAT program?
Fifty-six—that is, the 50 States, the 5 Territories, and the District of Columbia.

How many states have RSAT programs that have actually begun admitting clients?
47 states have RSAT programs that have actually begun admitting clients.

How many RSAT programs have actually begun admitting clients?
70 RSAT programs are known to have actually begun admitting clients.

What are the main treatment approaches being utilized in the RSAT programs?
The therapeutic community is the most frequently used (24%). The next most frequently used main modality is cognitive behavioral treatment (13%), followed by Twelve-Step programs (05%). The remainder (58%) are mostly programs attempting to combine these treatment modalities, i.e., combining elements of cognitive behavioral and 12-Step programming (14%), therapeutic community with cognitive skill training (21%), therapeutic community with12-Step programming (1%), therapeutic community, cognitive behavioral and 12-Step programming combined together (15%), and there are 6% other.

Are all of the RSAT programs new programs?
More than three out of four (76%) of the programs are new programs; the remaining 24% are existing programs expanded in capacity through the use of RSAT funds.

How many clients have thus far been admitted to RSAT programs during the RSAT initiative?
Over 13,000 clients have thus far been admitted to RSAT programs. Naturally, not all of these are currently in residence in the RSAT programs. Some of these have dropped out, washed out, or successfully completed the programs.

How many clients are currently in RSAT programs?
Approximately 7,700 clients are currently in RSAT programs.

How many RSAT treatment beds or slots have been generated thus far?
Over 9,600 beds/slots have thus far been generated by the RSAT initiative.

How many full time equivalent (FTE) staff are there to provide substance abuse treatment (exclusive of custodial or support services) in the RSAT initiative?
There are over 860 substance abuse treatment staff (FTE) in the RSAT programs.

How many RSAT treatment clients have been graduated thus far?
Over 3,600 clients have successfully completed the RSAT programs.

How many State RSAT Officials responding to the initial NERSAT state survey assert that the RSAT initiative has helped their state increase its substance abuse treatment capacity?
All of them say that RSAT helped their state increase its substance abuse treatment capacity.

Where is the RSAT initiative at the end of 1998?
The RSAT initiative is about at its mid-point. Programs continue to move through preparation, hiring and training stages to actually admitting clients and operating. At the same time, new programs are still coming into the pipeline, that is, proceeding into detailed planning and/or hiring staff.

What are the problems States are encountering in using RSAT funding?
Where significant delays have occurred, the States report having the most difficulty with locating appropriate facilities, constructing facilities, recruiting trained treatment staff, and contracting with treatment providers because of State bidding and proposal processes.

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INTENT OF THIS REPORT

This is the Final Report by the National Development and Research Institutes, Inc. of its national evaluation of the federal Residential Substance Abuse Treatment (RSAT) formula grant. This report presents results of an examination of the RSAT program's progress at about the halfway point of the program's existence. We examine the utilization by the fifty States, the District of Columbia and the five territories of the Residential Substance Abuse Treatment formula grant funds by showing the extent of the work accomplished in the Nation through this point in time. It is also intended to show the work yet to be done: the proposed efforts just getting underway or in the pipeline that will be developing over the final two years of the legislated program.

INTRODUCTION

Intent of the Residential Substance Abuse Treatment Program

The Residential Substance Abuse Treatment formula grant funds were designed by Congress to be used to implement residential substance abuse programs providing individual and group treatment activities for inmates in residential facilities operated by State and local correctional agencies. The law specifies that these programs will:

(1) last between 6 and 12 months;

(2) be provided in residential treatment facilities set apart from the general correctional population, that is, in a totally separate facility or a dedicated housing unit within a facility exclusively for use by program participants;

(3) be directed at the substance abuse problems of the inmate;

(4) be intended to develop the inmate's cognitive, behavioral, social, vocational, and other skills so as to solve the substance abuse and related problems; and

(5) continue to require urinalysis and/or other proven reliable forms of drug and alcohol testing of individuals assigned to treatment programs during and after release from residential custody.

There are three legislative purposes behind the RSAT legislation. By reducing drug relapse through the application of proven treatments the programs are intended to:

(1) reduce drug-connected criminality by those returning to society when they are paroled or discharged from prison,

(2) help reduce overcrowding in prisons by reducing recidivism, and,

(3) help reduce the rate of drug abuse-related infectious disease (such as HIV, TB, and Hepatitis C) among drug abusers, and thereby improve the health of the nation.

The total funding for this five-year effort is $270 million. This sum is divided as follows: 1996 - $27 million; 1997 - $36 million; 1998 - $63 million; 1999 - $72 million; 2000 - $72 million. Each state is allocated a base amount of 0.4 percent of the total funds available for the program, and the remaining funds are allocated to each participating state on the basis of the ratio of the prison population of each State to the total prison population of all participating states.

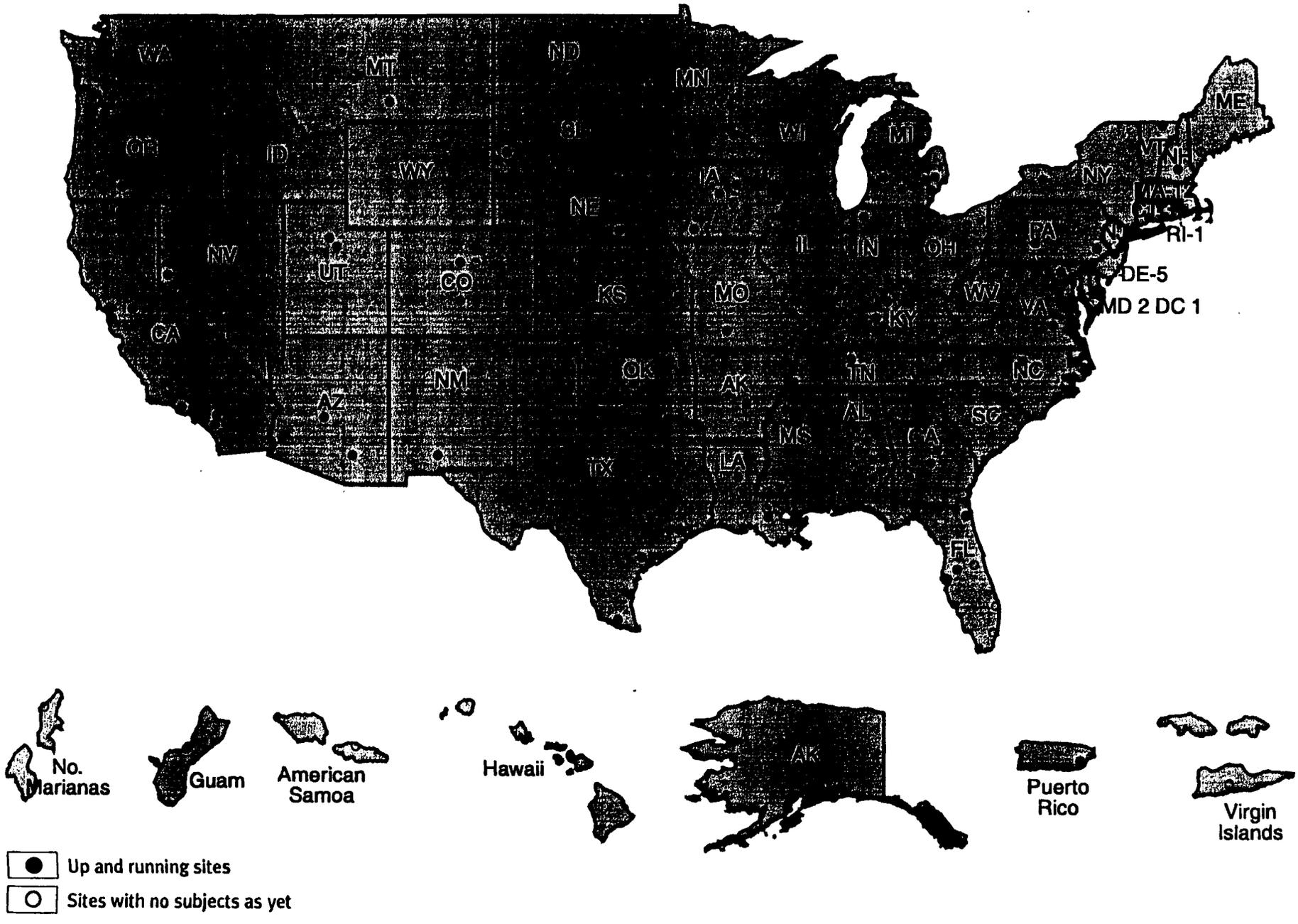
In this report we present information from all the participating [and reporting] states regarding correctional residential substance abuse programs funded by the act as they have reported it in surveys conducted by our organization as part of our Cooperative Agreement with the National Institute of Justice. We examine each State's correctional substance abuse treatment capacity, and how the scope of the State facilities' treatment capacity has been altered by the addition of RSAT funding over the last two and a half years. We present the most current information about each State's correctional substance

abuse treatment programs funded as part of RSAT on a map of the State, including data regarding each program's operational status, its modality of treatment, inmate participants, its staffing, and other relevant factors. Particular attention is given to the accomplishments that occurred as a direct result of RSAT funding such as the addition of residential treatment slots, and, in some cases, the numbers thus far of inmate completions from treatment programs. We present findings derived from three surveys following the section of the report in which the maps are presented.

On the following page is a map of the United States and its territories. It depicts the overall distribution of RSAT-funded program sites at the mid-point of the five-year funding period of the RSAT legislation. Because some of the sites have more than one program, the number of sites and the number of programs do not agree. Where programs are operational, the sites are marked with a red dot. Some of the sites are still in preparation and have no clients as yet; these are indicated by a hollow dot.

In the appendices to the report we present the specific frequencies of the state officials' and the program representatives' responses to the three surveys. For example, whether States are using federal program funds to generate funds from other non-federal sources, and, if so, how much of the federal dollars are matched with state and local expenditures.

RSAT Sites as of December 31, 1998



Background

By the end of 1997, state prisons held more than 1,046,000 prisoners (BJS 1999). Additionally, more than 3.9 million were under community supervision—(BJS 1998). This is the largest number ever held by these authorities. The prison population alone grew more three times between 1980 and 1997. (Gilliard and Beck 1998). Since the federal surveys conducted in 1991 the number of persons convicted of a drug offense[1] in prisons in this country has grown at an annual growth rate of 6.4% (BJS 1997). They comprise about a fifth of the state prison population. Likewise, the number of inmates incarcerated for non-drug offenses has grown at virtually the same rate over that period (6.3%). So, apparently those convicted of drug offenses make up the same proportion of the prison population as in 1991. These facts do not reflect the actual percentage of State prisoners who use drugs — 83% report past drug use and 57% were using drugs in the month before their offense (Gilliard and Beck 1998).

Active drug-using offenders are responsible for a relatively large amount of crime. For example, heroin-using "violent predators," when compared with non-drug using offenders committed: 15 times as many robberies, 20 times as many burglaries, and 10 times as many thefts (Chaiken 1986). Studies in Baltimore (Ball et al. 1983) and New York (Johnson 1986) demonstrate that active drug use accelerates the users' crime rate by a factor of about five, and that crime content is at least as violent as that of non-drug using felons. While the subjects of these early studies were heroin users, findings from crack-crime studies indicate crack-related crime is at least as high or higher than heroin-related crime, and is certainly more violent (Fagan 1990).

Moreover, although data vary across studies, it would appear that drug-using felons also constitute a disproportionate share of parole failures and repeat offenders. Sixty to

[1] Possession 27.%, trafficking, 70.1% other drug offenses 2.8%.

75 percent of untreated parolees with histories of heroin and/or cocaine use are reported to return to heroin and/or cocaine use within three months after release, and become re-involved in criminal activity (Wexler, Lipton & Johnson 1988). The proportion of drug using offenders among those arrested according to the Drug Use Forecasting (DUF) system data since its origin has rarely fallen below 60 percent and has reached as high as 85 percent (NIJ 1998)[2]. The proportion of drug using offenders among those incarcerated is even higher than their proportion among arrestees (USGAO 1991; Prendergast 1992). These men and women are typically users of many different drugs[3]—using them in combination with each other and with alcohol. If they are chronic users of addicting drugs such as heroin and cocaine, their drug use preoccupies their lives. Typically, much time each day is spent in pursuit of the money to purchase these substances, and the remaining hours spent under the influence of these substances. Moreover, most of these persons have avoided treatment while actively addicted in the community, although many have experienced detoxification either in jail or hospital. About a third of the State prisoners say in the BJS survey (BJS 1999) that they have participated in drug or alcohol treatment or other substance abuse programs since entering prison. These programs include residential facilities, professional counseling, detoxification units, self-help/peer counseling groups, educational and awareness programs, and maintenance drug programs. The majority of the programs with which these offenders participate fall into the 'self-help/peer counseling groups' and 'educational and awareness programs' categories.

Surveys of treatment for incarcerated drug abusers prior to the implementation of the RSAT legislation indicated that less than 20% of identified drug-using offenders were being treated by these programs (GAO 1991). In the most recent Bureau of Justice

[2] The ADAM system has replaced the DUF system as of mid-1998. These proportions still hold true.
[3] Marijuana, 12.9%; cocaine/crack 72.1%, heroin/other opiates, 12.8%, stimulants, 9.9%; depressants, 1.2%, hallucinogens, 1.1%. Source: NIJ, 1998.

Statistics Special Report, *Substance Abuse and Treatment, State and Federal Prisoners,* the authors state that 14.6 percent of alcohol- or drug-involved State prisoners report being treated since admission for substance abuse (BJS1999:13). Slightly higher percentages of white alcohol- or drug-involved State prisoners (17%) said they were treated for substance abuse since admission than Blacks (13%) and Hispanics (12%). Treatment[4] is distinguished in the BJS report from participation in "other substance abuse programs"[5] in which almost 32 percent of state prisoners say they participated. Thus, prior to RSAT, more than 85 percent of inmates with substance abuse problems still were not receiving treatment while in prison. BJS reports in their survey that a total of over 360,000 prisoners in 1997 report that they had participated in drug or alcohol treatment or other substance abuse programs since admission. Certainly Federal spending has increased steadily; however, reported levels of inmates in treatment were lower for both state and Federal prisoners than those reported in 1991 (BJS, 1999: 1).

Most inmates in need of treatment, however, still do not seek treatment nor are there enough treatment 'slots' even to begin to accommodate those needing treatment. For example, in a study done about ten years ago, 70% of active street addicts in NYC had never been in treatment nor did they intend to enter treatment for their addiction (Lipton 1989). Peyton (1994) reports almost the identical finding for Delaware's offender population. Unfortunately, most inmates have not been treated in the community and report no interest in being admitted to treatment (Lipton 1989). Thus, criminal justice custody provides a major opportunity to provide drug abuse treatment for this recidivistic and otherwise untreated population. Incarceration provides the venue for active intervention using human change modalities that these offenders would more than likely avoid if they were not in legal custody. Without treatment, a high percentage is

[4] Includes residential facilities, professional counseling, detoxification units, and maintenance drug programs.
[5] Includes self-help/peer counseling groups such as Alcoholics Anonymous or Narcotics Anonymous, as well as drug abuse educational or awareness programs.

likely to relapse to drug use and to re-offend shortly after release from custody. These behaviors are part of a lifestyle that is both highly destructive and resistant to change (Walters 1992).

A Multi-Problem Population

Many of these prisoners have severe substance abuse problems. Indeed, about one-half of the inmates previously used a major drug (e.g., opiates, cocaine) on a regular basis; and 56.5 percent of State offenders reported using drugs during the month prior to the crime for which they were incarcerated. About 52 percent say they were under the influence of alcohol or drugs at the time of the offense for which they were incarcerated (BJS 1999). Some of these inmates are predatory criminals with severe substance abuse problems who are responsible for an extraordinary amount of crime and are involved in a large volume and variety of violent crimes, property offenses and drug deals. For example, 52.5 percent of State prisoners surveyed report being under the influence of alcohol or drugs at the time of the violent offense for which they were imprisoned. Likewise, 53.2 percent of those committed for a property offense, and 52.4 percent of those incarcerated for a drug-related offense such as possession or trafficking report being under the influence of alcohol or drugs at the time of their offense.[6]

Beyond their substance use-related problems, these offenders typically have problems in most areas of their lives. A typical offender has little if any legitimate work experience; has left school prematurely; has few (if any) non-drug or alcohol-related personal relationships; has poor relationship with parents or spouse and other family members; and, often lacks a permanent residence. In addition, he or she is typically immature, irresponsible, and holds anti-social attitudes and values. Consequently, in our belief, treating these factors as well as the substance use problems is necessary to allow them to return to and sustain an acceptable level of social functioning once they have

returned to the free community. Thus, since most of these offenders will return to the community within three years, utilizing treatment methods of sufficient range, length and intensity creates the best chance to reduce relapse and reoffending behaviors.[7] While they are incarcerated, reducing offenders' tendencies to relapse to drugs and criminality is essential for sustaining or improving the quality of community life. Based on prior research into effectiveness of the residential substance abuse treatment, the Federal government initiated the Residential Substance Abuse Treatment for State Prisoners initiative. This legislation provides funding for the States and localities to intervene in the lives of offenders using powerful treatments, therapeutic community treatment and cognitive-behavioral treatment, for producing sustained change[8].

Treatment Approaches Used in RSAT Programming

Therapeutic Community Treatment

Therapeutic community treatment is a modality used by about 60 percent of the RSAT programs.[9] Published findings substantiate the significant accomplishments of correctional-based therapeutic communities with incarcerated drug abusing felons.[10] These programs have produced consistent and positive outcomes with relatively hard-core offender populations when they are combined with continuing treatment in an aftercare setting. The effect size, i.e., the favorable difference in recidivism outcome between experimental and control groups, has been about 22 - 25 percentage points when optimal treatment conditions are met, and between 14 and 17 points when

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[6] All of these percentages are above the levels reported by the prisoner population surveyed in 1991.

[7] Furthermore, we are likely to encounter individuals with psychiatric problems, HIV infection, physical problems, or retardation in about 10 to 15 percent of the cases. Teaching them how to manage these problems also becomes a necessity.

[8] These treatments are described in Lipton, D. S. 1995. *The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision*; Lipton, D. S. 1998. Therapeutic community treatment programming in corrections. *Psychology, Crime & Law*, 4(3), 213-263, and Pearson, F. S., Lipton, D. S., Cleland, C. M. and Yee, D. 1999. The Effects of Behavioral /Cognitive Behavioral Programs on Recidivism. (forthcoming).

[9] TC is the only treatment approach used in 24% of the RSAT programs; plus 37% have TC as part of a blended treatment.

conditions are less than optimal. Drug abuse treatment in prisons has been influenced by the development of therapeutic communities, which often incorporate recovered drug users as staff in a therapeutic environment within the prison but isolated from the general prison population. Optimal treatment appears to include nine to twelve months of intensive TC treatment prior to release followed by about six to twelve months of TC treatment in a community-based facility or program or in a work release center, as well as staffing by a mix of trained recovered ex-addicts — role models — who have been through the TC experience, trained correctional officers, and professionals. This is complemented in this decade with broad-scale research findings that also strongly support the effectiveness of this method of drug abuse treatment (Hubbard, Marsden, Rachel, Cavanaugh, and Ginzburg, 1989; and Gerstein and Harwood 1992).

Therapeutic communities (TCs) for addicted persons in the United States currently admit about 80,000 persons annually (Therapeutic Communities of America 1994). De Leon (1995) has provided a clear portrait of the therapeutic community method: A typical community-based TC is a residence with a few professional staff but primarily recovered addicts serving as staff. Residents are asked to spend about 9 to 18 months in residence, but the drop out rate from community-based TCs is quite high—usually 60-80 percent are gone within the first three months. Prison-based TCs, in contrast, retain more than 50 percent of their treatment population over the full duration of treatment. A core characteristic of most TCs is the use of work as an organizing therapeutic activity, i.e., residents are involved in all aspects of the community's operations including administration, maintenance, and food preparation.

Drug abuse is viewed in a TC as a disorder of the whole person, so the treatment problem to be addressed is the person, not the drug. That is, drug abuse is seen as a

[10] The Stay'n Out Program by Wexler, Lipton and Falkin (1990), the Cornerstone Program by Gary Field (Field 1984, 1989), the Key-Crest programs by Inciardi (1995, 1998), the Amity program in Donovan Prison by Wexler et al. (1995, 1998) and one-year follow-up results from the New Vision at Kyle in Texas by Simpson and Knight (1995)

symptom not the essence of the disorder, and the pattern of drug use is less important than psychological and behavioral disorders. Drug abuse is seen as a symptom of immaturity. Thus, the abuser is seen as unable to postpone gratification, unable to tolerate frustration, and as unable to maintain stable healthy relationships. Beside immaturity, most abusers have conduct or behavior problems as well as low self-esteem. The TC staff and senior residents target these characteristics for behavior change. Recovery is considered to involve the development of a personal identity and global change in lifestyle including the conduct, attitudes, and values consonant with "Right Living," and is a continuing process extending lifelong. Right Living develops from committing oneself to the values of the TC community including both positive *social* values such as the work ethic, social productivity, and communal responsibility, and positive *personal* values such as honesty, self-reliance, and responsibility to oneself and significant others. The goals of treatment are congruent with these values: abstinence from drug use, termination of illicit behaviors, gainful legitimate employment or school matriculation, and maintenance of positive stable social relationships.

TCs are hierarchically organized or stratified. Staff and resident roles are aligned in a clear chain of command. New residents are assigned to work teams with the lowest status, but can move up strata as they evidence increased competency and emotional growth. They thus have an incentive to earn better work positions, associated privileges and living accommodations. The stratified character of the TC facilitates the process of working through authority problems and helps the residents to accept appropriate authority as they move out to assume responsible roles within the society. The distinguishing feature of the TC in contrast with other treatment approaches is the "purposive use of the *community* as the primary method for facilitating social and psychological change in individuals" (De Leon 1995) as it blends confrontation and support to help residents undergo the arduous changes that are necessary. The perception of the *community* is

constantly emphasized. The program uses groups and meetings to provide "positive persuasion" to change behavior, and confrontation by peer groups whenever values or rules are breached. On the other hand, peers also provide supportive feedback such as reinforcement, affirmation, instruction and suggestions for changing behavior and attitudes, and assist the residents during group meetings as they recall painful memories from childhood and adolescence. It should be noted that the TC regimen of today often provides additional services such as family treatment, and educational, vocational, medical, and mental health services, and staffing is augmented by increasing proportions of professionals from the mental health, medical and education fields (De Leon 1994a).

Cognitive Behavioral Treatment for Incarcerated Offenders

Cognitive Behavioral treatment approaches characterize the second largest grouping of RSAT-funded treatment programs. As an approach to addressing the recidivistic behavior of prison inmates, 'cognitive-behavioral' approaches are based on social learning theory. It assumes offenders are shaped by their environment and have failed to acquire certain cognitive skills or have learned inappropriate ways of behaving. Their thinking may be impulsive and egocentric, and their attitudes, values and beliefs may support anti-social behavior. By drawing on a range of well-established cognitive and behavioral techniques, offenders are helped to face up to the consequences of their actions, to understand their motives, and to develop new ways of controlling their behavior (McGuire, 1996). Cognitive-behavioral approaches are frequently used as part of a wider program that includes problem-solving training, social skills training, and pro-social modeling with positive reinforcement of non-criminal behavior or attitudes. Proponents argue that cognitive-behavioral programs offer the best chance of success in reducing recidivism since they address such a broad range of needs and problems.

The clear and comparatively quite consistent finding of the effectiveness of cognitive-behavioral treatment (CBT) with offenders has emerged in several recent meta-

analyses.[11] The majority of the original studies were undertaken in the United States and Canada in the period between the 1970s and 1990s, and most focused on the use of CBT with juveniles and young offenders. Thus, the available research on juvenile and adult offender programs points to a broad consensus as to the types of approach which achieve the greatest impact on offending behavior (expressed in terms of experimental groups achieving lower recidivism rates than comparison groups). Those that combine cognitive-behavioral techniques with the other success factors identified in some of the meta-analysis (targeting, structured approaches, program integrity) appear to offer the best chance of reducing rates of recidivism. Although cognitive skill training findings are more limited with regard to adult offenders, the message with regard to cognitive-behavioral approaches is consistent with that reported in the more numerous studies of young offenders. The reviews by Lipsey (1992), Andrews et al. (1990) and Lipton et al. (1998) also indicate that cognitive-behavioral interventions, particularly cognitive skill training, are consistently associated with substantial reductions in recidivism.

Although some commentators have expressed considerable skepticism about the applicability of the results and conclusions to adult offenders, current researchers (Mair, 1995; Losel, 1993; Mayer et al. (1986) and Lipsey (1992) found no significant relationship between age and treatment effect in their meta-analyses. Since, however, the age range for most studies included ended at 21, this will have effectively excluded many offenders with serious drug and alcohol problems that have developed over time or with long-standing relationship or employment difficulties. Despite this, in one of the largest meta-analyses to have included juvenile and adult offender programs, Andrews et al. (1990) found no significant difference in their effectiveness according to age. The

[11] Andrews, D.A., Zinger, I., Hoge, R.D, Bonta, J., Gendreau, P. & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, 28, 369-404. McGuire, J. & Priestley, P. (1995) . Reviewing 'What Works': Past, present and future. In: McGuire, J. (Ed.) *What Works: Reducing Reoffending*. Chichester: Wiley. Pearson, F. S., Lipton, D. S., Cleland, C. M. and Yee, D. 1999. The Effects of Behavioral / Cognitive Behavioral Programs on Recidivism. (forthcoming).

following section considers the use and impact of cognitive-behavioral interventions with substance abusing offenders.

Substance abusers

The evaluation of CBT programs delivered to *drug abusing offenders* has, in the main, been conducted in the U. S. and Canada. In a review of the literature of drug misuse and the criminal justice system, Hough (1995) points out that these reviews have largely been of programs rather than program components — a general difficulty with the literature concerning rehabilitative work with offenders. Moreover, many studies of different forms of treatment have not evaluated programs located within the criminal justice system and have not examined effectiveness in reducing recidivism. For example, a review carried out by Husband and Platt (1993) of approaches used to address drug and alcohol abuse indicates that cognitive skills approaches which include problem solving training are successful in reducing alcohol intake. The review does not examine whether this type of approach was also effective in reducing further offending, but an evaluation by Platt, Perry and Metzger (1980) on a heroin treatment program which included behavioral therapy and training in interpersonal problem-solving showed promising results with regard to reducing recidivism. Young offenders who attended the program located within a correctional center for youths had significantly lower rates of parole revocation for further offences (both drug and non-drug offences) than a matched control group. One other published study, reported by Johnson and Hunter (1995) examined patterns of parole revocation for groups of drug abusing offenders, some of whom attended a program adapted from the Ross et al. Reasoning & Rehabilitation (R&R) program.[12] Drug offenders were randomly assigned either to regular probation, a

[12] The full list, from Ross et al. (1988), is: structured learning theory (to teach social skills); lateral thinking (to teach creative problem solving); critical thinking (to teach logical, rational thinkin ·i; values education (to teach values, concern for others); assertiveness training (to teach non-aggressive ways to meet ends); negotiation skills training (to teach alternatives to violent behaviors in interpersonal conflict situations); interpersonal cognitive problem solving (to teach thinking skills required to deal with interpersonal problems and conflicts); social perspective training (to recognize and

non-cognitive drug program or the cognitive skills program. After one year, 6 out of 32 (19%) of the cognitive skills program sample had been revoked, compared with 8 of 23 (35%) for the regular probation, and 10 of 33 (30%) of the non-cognitive drug program. With such small numbers, however, these results are not statistically significant.

An approach advocated by McMurran and Hollin (1993) for addressing alcohol abuse is that of a modular program involving: thorough assessment; behavioral social skills training; skills training; relapse prevention; and lifestyle modification. According to this approach, the client acts as a 'personal scientist', monitoring alcohol consumption, setting goals, and modifying his or her expectations from alcohol consumption. Behavioral social skills training has been successful in reducing alcohol consumption in non-offender populations, but again, there is no evidence of its effect on recidivism in offender populations. Furthermore, this approach has apparently not been attempted with illicit drugs users (McMurran, 1996). McMurran's review of the literature published in 1996 also confirmed that there is insufficient research evidence on alcohol, drugs and crime to permit conclusions about precisely what combinations of cognitive, behavioral and skills elements are necessary for successful intervention, measured in terms of both substance intake reduction and in reduced recidivism. This is not surprising, given the complexity of the research task and the relatively few studies in this field of inquiry. In the Correctional Drug Abuse Treatment Effectiveness (CDATE) project, the recently completed meta-analytic study by Lipton et al. (1998), the authors report that CBT produces generally quite favorable recidivism outcomes with offenders. For example, programs using cognitive and social learning methods (44 studies with various types of offenders) yields more than a fourteen-point percentage difference, on the average, in favor of treatment when those treated are compared with those not treated taking into consideration the quality of research. Looking just at cognitive and social

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understand other people's views and feelings); and role-playing and modeling (to demonstrate socially acceptable behaviors).

learning programs treating substance abusers (10 studies), the average difference in favor of treatment is 11 percentage points.

Relapse prevention techniques are, as the label suggests, concerned with longer term coping strategies and with enabling drug abusing offenders to recognize situations as they return to society when there is a high risk of a recurrence of the problem behavior. This set of techniques generally falls within the category of cognitive treatment, has also been adopted by many of the RSAT programs. Some cognitive-behavioral approaches used in relapse prevention include role playing of risky situations, positive self-statements, etc. There is some evidence of their success in alcohol treatment groups: Allsop and Saunders (1989) found that offenders who underwent relapse prevention were less likely to relapse to heavy drinking after six months. However, the published evidence of the success of relapse prevention techniques with drug users is sparse, as is the evidence of their impact on recidivism among substance abusing offenders. CDATE's meta-analytic evidence from six studies with drug abusers is barely supportive with the average difference in favor of relapse prevention being only 3 percentage points (Lipton et al. 1998).

Twelve-Step Program Approach

The third main approach to treatment adopted by the RSAT programs is the 12-Step approach. It is based on the concept of substance abuse as a spiritual and medical disease. Alcoholism and other drug problems are seen as chronic progressive illnesses that must be arrested or they will inevitably lead to insanity or death. The approach educates users to the predictable symptoms and course of substance abuse. The effects of substance abuse are addressed on many levels including the psychological, social and spiritual. This approach began with Alcoholics Anonymous (AA) for persons with alcohol problems and has spread to other drug problems such as Narcotics Anonymous

(NA), Cocaine Anonymous (CA), Marijuana Anonymous (MA) for persons claiming dependence on marijuana, and to a number of behavioral problems such as obesity with Overeaters Anonymous, hypersexuality with Sexaholics Anonymous and Sexual Addicts Anonymous, tobacco addiction with Nicotine Anonymous, etc.).

The 12-Step approach is conceptualized as a fellowship of peers connected by their common addiction and guided by 12 steps which consist of specific graduated practices, beliefs and traditions that progress from dealing with denial to sustaining a healthy, responsible and abstinent lifestyle. The only requirement for admission is a desire to stop substance use. Central to the approach are the concepts of loss of control and denial. Two primary themes are usually emphasized: (1) Spirituality, which is proclaimed as the belief in a "Higher Power" as defined by each participant and represents faith and hope for recovery; and (2) Pragmatism, which is the belief in doing "whatever works" in order to avoid breaking sobriety such as taking the first drink.

The 12-Step approach is usually not in and of itself a primary treatment. It is typically adjunctive to other treatments such as therapeutic community and cognitive behavioral approaches, and functions effectively as an aftercare component. Often it is blended with a variety of treatment components in the belief that combining best practices with a spiritual dimension will promote recovery. For example, the twelve-step approach typically provides the sequence of activities and the guiding principles around which other techniques such as 'problem solving' and 'thought stopping'[13] may be interwoven.

Unfortunately, there are almost no studies of the effectiveness of 12-step approaches with offender populations. The lack of research is partially related to this modality's emphasis on anonymity and its resistance to research. The use of 12-step approach, however, is widespread throughout correctional systems in the United States. This is, in part, because it usually bears no costs to the correctional system that adopts it since it customarily is delivered by volunteers from outside the institution who are themselves

persons recovering from addiction to alcohol or drugs. In the RSAT programs the 12-step approach is used in about 35 percent of the programs either by itself as the only method or in combination with other approaches such as in Idaho where the 12-step approach is combined in a therapeutic community utilizing cognitive skills training.

How these various program approaches are distributed and other vital data regarding the accomplishments to date may be seen in the next section.

[13] Typical program elements in a cognitive behavioral program.

Introduction to the Programs

The following section displays the main data regarding programmatic accomplishments of the RSAT program at the mid-point of its five-year existence. There are maps of the fifty States and the District of Columbia, and the five U.S. territories in alphabetic order displaying the programs that have been created by the RSAT funding. Each individual state map page provides the following data:

(1) Number of adult persons incarcerated

(2) Number of juveniles held in detention or physical custody

(3) Number of females incarcerated

(4) Number of RSAT treatment beds created as of September 1, 1998

(5) Number of persons in RSAT treatment at September 1, 1998

(6) RSAT funds received in 1996, 1997 and 1998

(7) Program Name of each program funded by RSAT funds

(8) Treatment Modality of each program funded by RSAT funds

(9) City or town where each program funded by RSAT funds is located

(10) Institution where each program funded by RSAT funds is located

(11) Number of beds in each program funded by RSAT funds

(12) Gender of inmates in each program funded by RSAT funds

(13) Whether inmates in each program funded by RSAT funds are adults or youth

(14) Name of Contractor providing treatment in each program funded by RSAT

(15) Number of FTE staff in each program funded by RSAT funds

(16) Whether the program is operational or not

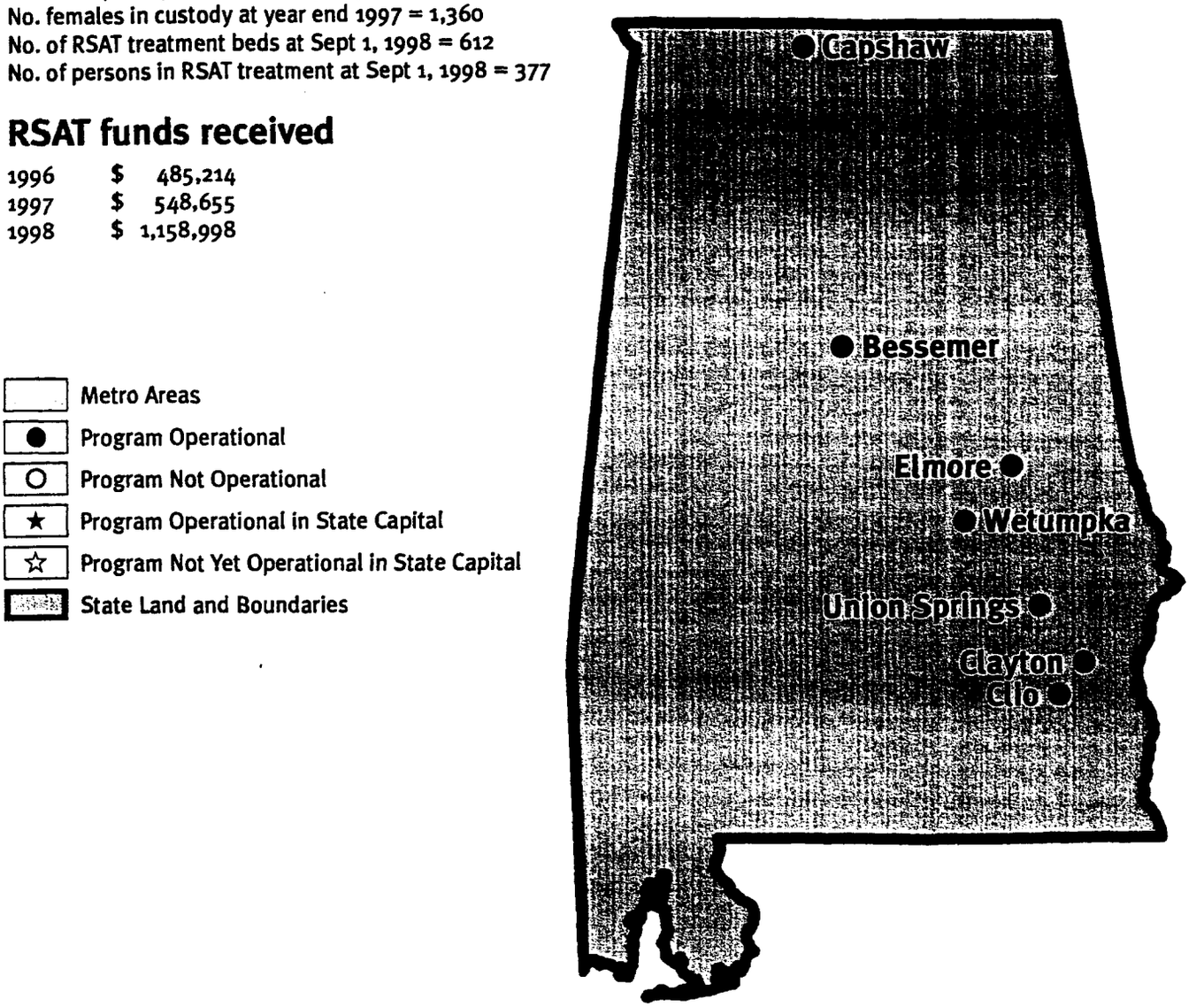
These facts are then restated in narrative form below each map followed by comments by a state official regarding the RSAT accomplishments.

Alabama RSAT Accomplishments

No. adults in custody at year end 1997 = 22,290
No. delinquent youth in custody at year end 1995 = c. 700
No. females in custody at year end 1997 = 1,360
No. of RSAT treatment beds at Sept 1, 1998 = 612
No. of persons in RSAT treatment at Sept 1, 1998 = 377

RSAT funds received

1996	$ 485,214
1997	$ 548,655
1998	$ 1,158,998



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Bullock	12 step + CB + other modalities	Union Springs	Bullock Correctional Facility	40	Male	Adult	None	2	Yes
Limestone CF	"	Capshaw	Limestone Correctional Center	150	Male	Adult	None	2	Yes
Donaldson	"	Bessemer	Donaldson Correctional Facility	192	Male	Adult	None	2	Yes
Tutwiler	"	Wetumpka	Julia Tutwiler Prison for Women	50	Female	Adult	None	2	Yes
Draper	"	Elmore	Draper Correctional Center	30	Male	Adult	None	1	Yes
Ventress	"	Clayton	Ventress Correctional Facility	90	Male	Adult	None	3	Yes
Easterling	"	Clio	Easterling Correctional Facility	60	Male	Adult	None	1	Yes

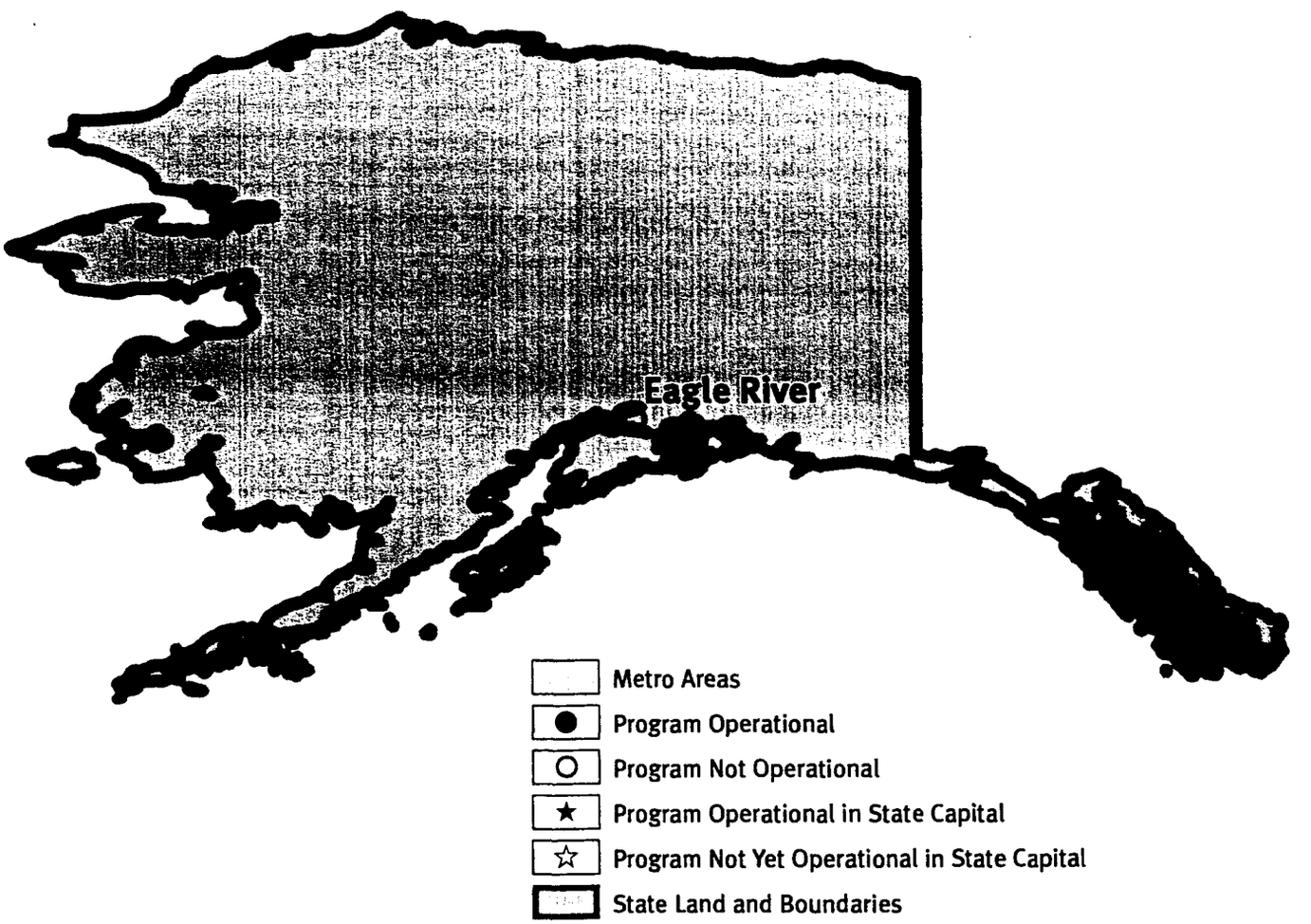
Alabama has one program with one model approach operating at seven sites. All seven sites employ a total of 13 staff (FTE). These staff provide 612 inmates with a program combining 12-step treatment with elements of cognitive behavioral programming. One program site for 40 males at Bullock Correctional Facility in Union Springs; one for 150 males at Limestone Correctional Center in Capshaw; one for 192 males at Donaldson Correctional Facility at Bessemer; one for 50 females at the Julia Tutwiler Prison for Women in Wetumpka; one for 30 males at Draper Correctional Center in Elmore; one for 90 males at Ventress Correctional Facility in Clayton; and one for 60 males at Easterling Correctional Facility in Clio. State official comment regarding the impact of RSAT: "There was no inpatient treatment before RSAT and the curriculum that treats addiction and criminal thinking disorder as dual diagnosed was not used. Beds in separate dorms were started as a direct result of the grant...467 beds of long-term (6 mos.) aftercare, since wardens gave cell blocks for aftercare, has had an obvious impact. A pro-social attitude is apparent."

Alaska RSAT Accomplishments

No. adults in custody at year end 1997 = 4,220
No. delinquent youth in custody at year end 1995 = c. 205
No. females in custody at year end 1997 = 304
No. of RSAT treatment beds at Sept 1, 1998 =
No. of persons in RSAT treatment at Sept 1, 1998 =

RSAT funds received

1996	$ 133,887
1997	$ 154,682
1998	$ 338,428



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Highland Mountain RSAT	Cog. Behav. + 12-step	Eagle River	Highland Mountain Correction Center	64	Male	Adult	None	3	No

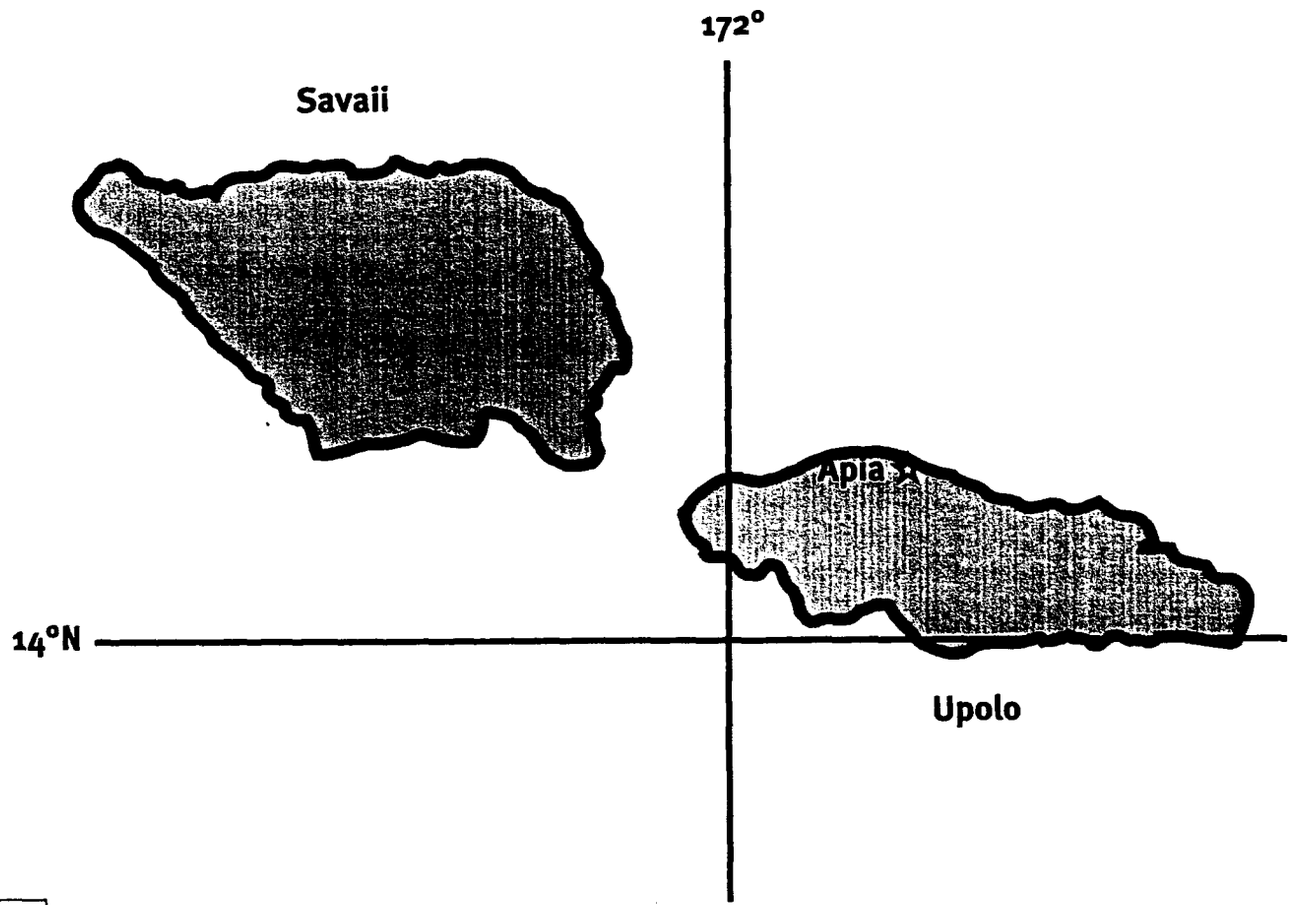
Alaska has one RSAT program at one site with one model approach, but the program is not yet operational. When open it will employ 3 staff to implement a cognitive behavioral program with elements of 12-step treatment for 64 male adults at the Highland Mountain Correctional Center in Eagle River outside of Anchorage. The 64 beds are projected to be operational in the spring of 1999.

American Samoa RSAT Accomplishments

No. adults in custody at year end 1997 = 202
No. delinquent youth in custody at year end 1995 =
No. females in custody at year end 1997 =
No. of RSAT treatment beds at Sept 1, 1998 =
No. of persons in RSAT treatment at Sept 1, 1998 =

RSAT funds received

1996	$ 100,186
1997	$ 111,862
1998	$ 240,417



- Metro Areas
- ● Program Operational
- ○ Program Not Operational
- ★ Program Operational in State Capital
- ☆ Program Not Yet Operational in State Capital
- State Land and Boundaries

Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
RSAT									No

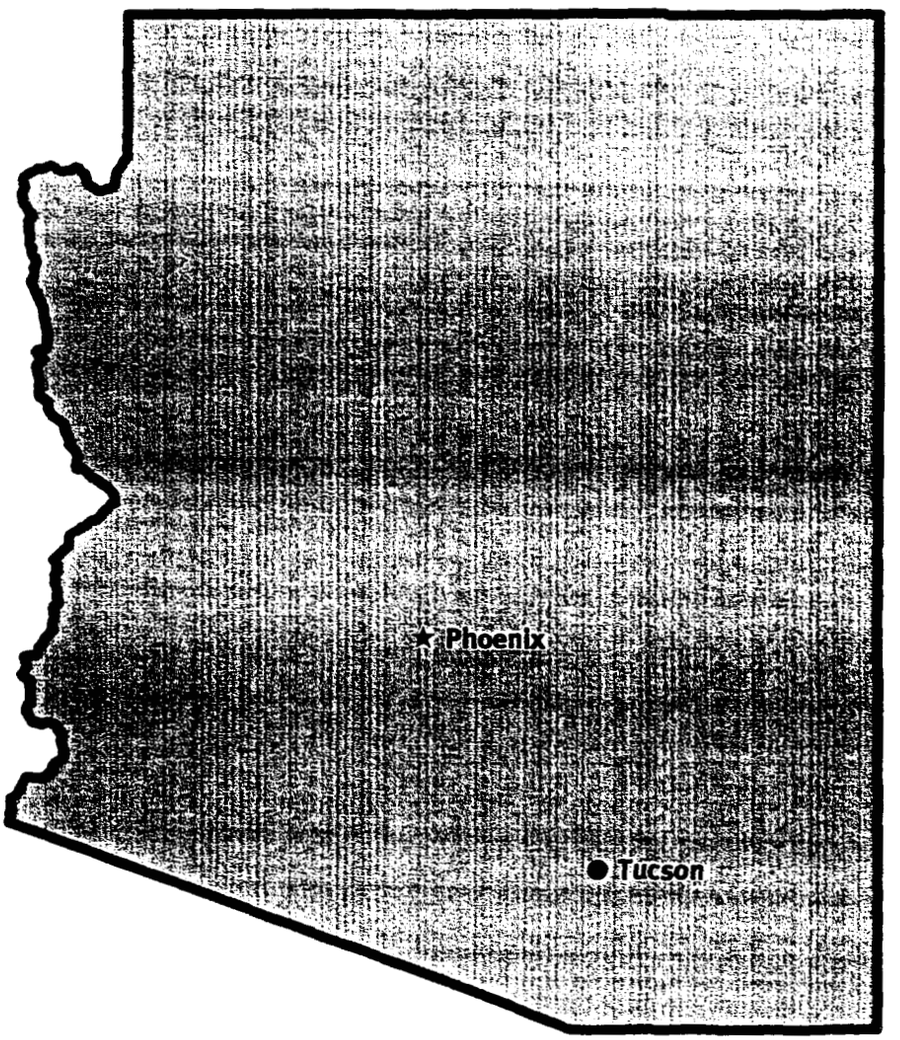
Arizona RSAT Accomplishments

No. adults in custody at year end 1997 = 23,484
No. delinquent youth in custody at year end 1995 = c. 450
No. females in custody at year end 1997 = 1,560
No. of RSAT treatment beds at Sept 1, 1998 = 22
No. of persons in RSAT treatment at Sept 1, 1998 = 22

RSAT funds received

1996	$ 501,066
1997	$ 561,850
1998	$ 1,204,915

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Recovery at Catalina	Cog. Behav.	Tucson	Catalina Mountain School	22	Male	Youth	None	4	Yes
Recovery at Black Canyon	Cog. Behav.	Phoenix	Black Canyon School	24	Female	Youth	None		No
Recovery at Adobe	Cog. Behav.	Phoenix	Adobe Mountain School	48	Male	Youth	None		No

Arizona has one operational RSAT program offering cognitive behavioral treatment at theCatalina Mountain School serving 22 male youths. It employs 4 staff (FTE). The other program, which is not yet operational, will also provide cognitive behavioral treatment, and it will operate at two different facilities. It is planned that in April 1999 they will have 24 slots for female youths at the Black Canyon School and 48 male youth slots at the Adobe Mountain School. State official comment regarding the impact of RSAT: "We added 20 new beds; there were no treatment beds separate from the general population prior to funding. Treatment, counseling and drug testing went from non-existent to functional since July of 1997."

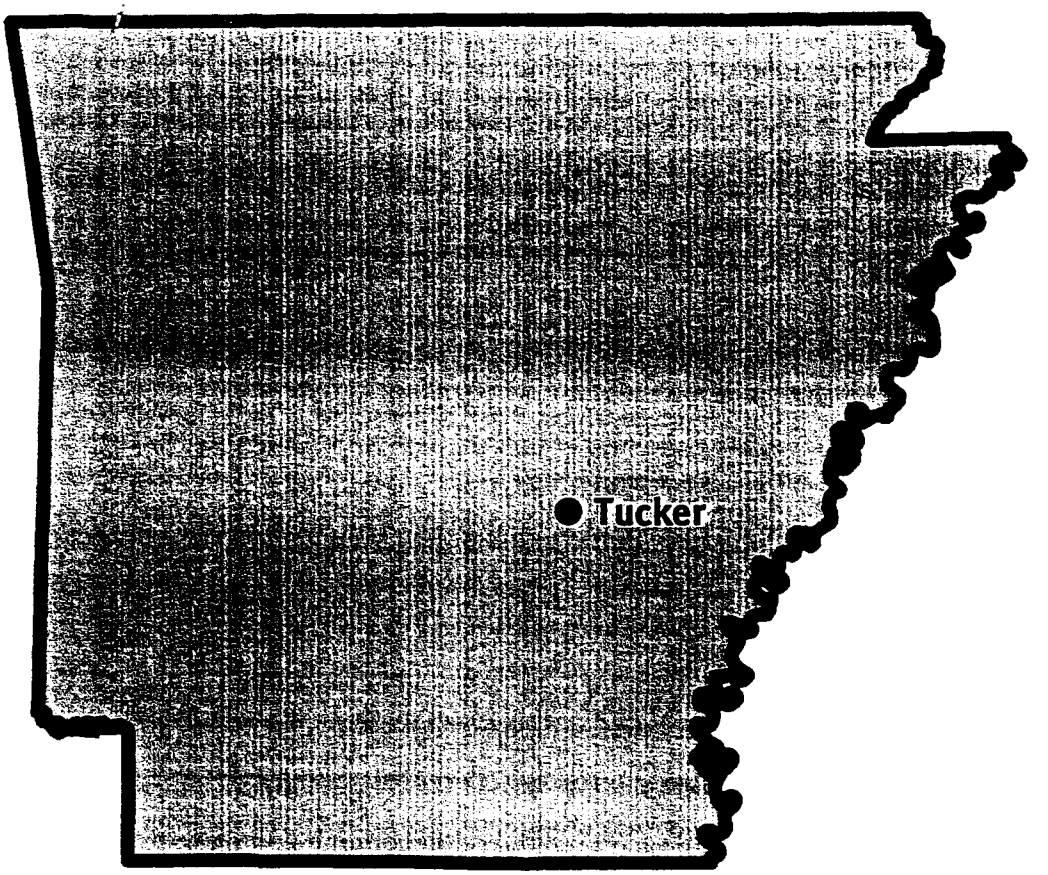
Arkansas RSAT Accomplishments

No. adults in custody at year end 1997 = 10,021
No. delinquent youth in custody at year end 1995 = c. 190
No. females in custody at year end 1997 = 611
No. of RSAT treatment beds at Sept 1, 1998 = 120
No. of persons in RSAT treatment at Sept 1, 1998 = 111

RSAT funds received

1996	$ 268,923
1997	$ 302,994
1998	$ 635,675

- Metro Areas
- ● Program Operational
- ○ Program Not Operational
- ★ Program Operational in State Capital
- ☆ Program Not Yet Operational in State Capital
- State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Comprehensive Substance Abuse Treatment Program TC	TC + 12 step	Tucker	Tucker Unit	120	Male	Adult	None	8	Yes

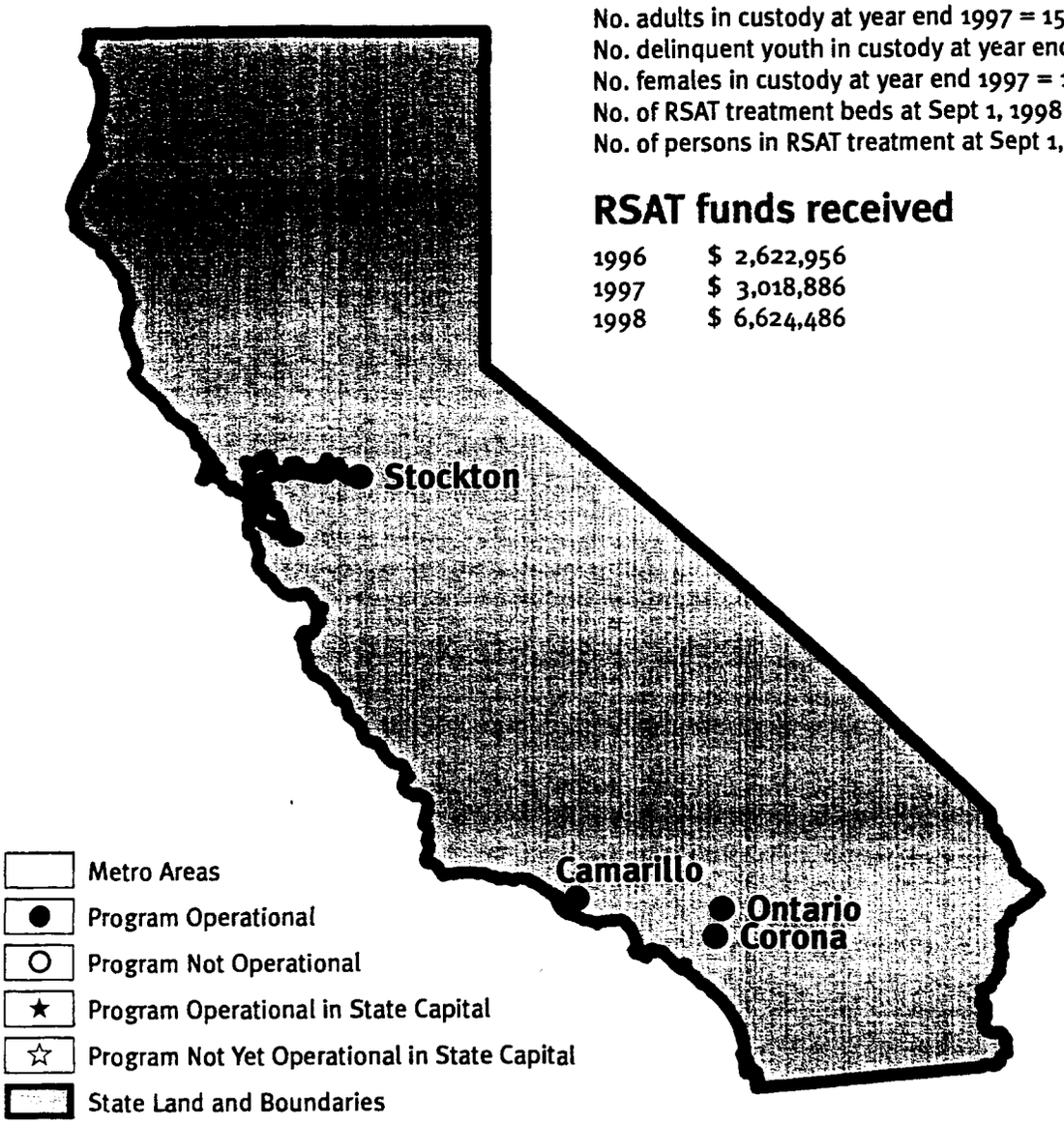
Arkansas has one RSAT program that is operational. It is located at the Tucker Unit. The site employs 8 staff serving 120 male adults providing a combination of therapeutic community treatment with 12-step programming. State official comment regarding the impact of RSAT: "We enhanced services by hiring new professional staff, we purchased a new treatment curriculum, and have 120 additional beds."

California RSAT Accomplishments

No. adults in custody at year end 1997 = 157,547
No. delinquent youth in custody at year end 1995 = c. 9,000
No. females in custody at year end 1997 = 11,076
No. of RSAT treatment beds at Sept 1, 1998 = 975
No. of persons in RSAT treatment at Sept 1, 1998 = 974

RSAT funds received

1996	$ 2,622,956
1997	$ 3,018,886
1998	$ 6,624,486



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Contractor	FTE Staff	Operational
Forever Free	Cog. Behav.	Corona	California Institute for Women	120	Female	Adult	Mental Health Systems	13	Yes
RSAT-CYA	TC	Stockton	Karl Holton Youth Correc. Drug & Alcohol Facility	425	Male	Youth	None	136 for all CYA progs. Only 5 are RSAT funded	Yes
Substance Abuse Treatment Program	12-step	Camarillo	Ventura Youth Corrections Facility	65 F 65 M	Both	Youth	None	*	Yes
Substance Abuse Free Environment	TC	Ontario	Herman G. Stark Youth Correc. Facility	300	Male	Youth	None	*	Yes

California has 4 operational RSAT programs at 4 different sites. Each site is implementing a different program. California's DOC Forever Free program provides cognitive behavioral programming at the California Institute for Women in Corona. It employs 13 staff (FTE) and serves 120 female adults. It is implemented by Mental Health Systems, Inc. The other three programs are under the California Youth Authority. The RSAT-CYA program at the Karl Holton Youth Correctional Drug & Alcohol Facility in Stockton employs 136 staff (FTE) serving 425 male youth. It provides therapeutic community treatment. The Ventura Youth Correctional Facility Substance Abuse Treatment Program in Camarillo provides a 12-step program for 65 male youths and 65 female youths. The Substance Abuse Free Environment at the Herman G. Stark Youth Correctional Facility in Ontario employs 53 staff (FTE) serving 300 male youths and it also provides therapeutic community treatment. State official comment regarding the impact of RSAT: no comment made.

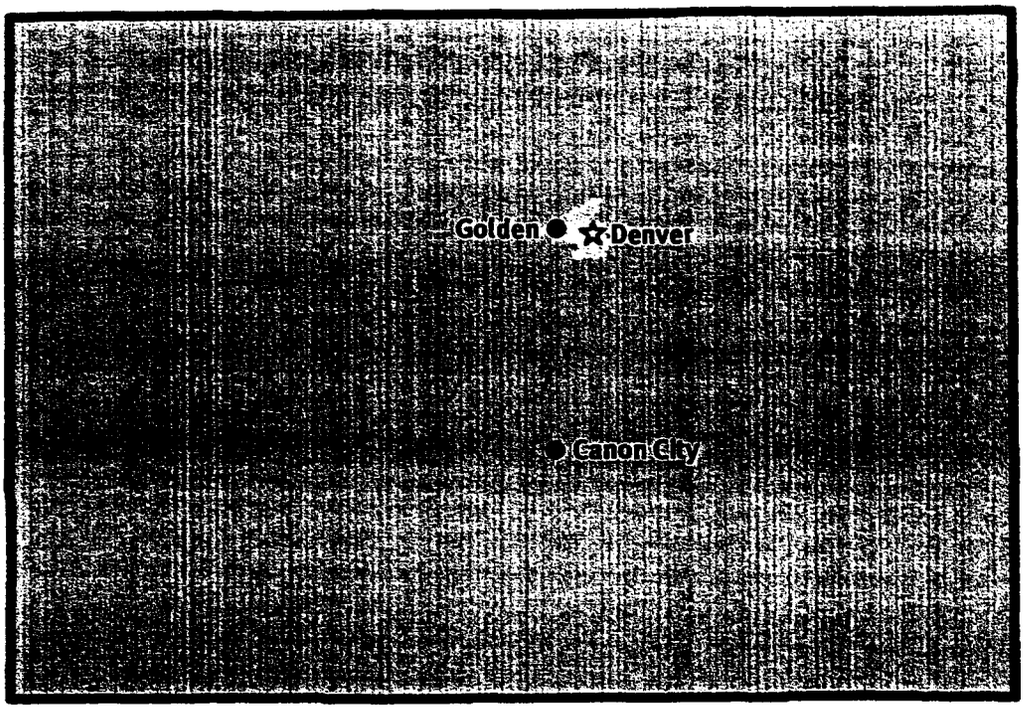
Colorado RSAT Accomplishments

No. adults in custody at year end 1997 = 13,461
No. delinquent youth in custody at year end 1995 = c. 790
No. females in custody at year end 1997 = 949
No. of RSAT treatment beds at Sept 1, 1998 =372
No. of persons in RSAT treatment at Sept 1, 1998 = 221

RSAT funds received

1996	$ 306,044
1997	$ 350,070
1998	$ 773,466

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
DOC RSAT	TC	Canon City	Arrowhead Correction Center	96	Male	Adult	None	19	Yes
L.E.T.T.S.	Cog. Behav	Golden (for men)	Lookout Mountain Youth Services Center	51	Both	Youth	None	2.5	Yes
L.E.T.T.S.	Cog. Behav	Denver (for women)	Mountain View Services Center	10-F	Both	Youth	None	*	yes
ARTS-Enhanced TC	TC	Denver	Community Correction Facility	215	Both	Adult	None	3.6	Half started
DOC Women RSAT	TC	Denver	Denver Women Prison	36	Female	Adult	None	4	No

Colorado has four programs located at five sites. The DOC RSAT providing therapeutic community treatment at the Arrowhead Correctional Center in Canon City employs 19 staff (FTE) serving 96 male adults. The L.E.T.T.S. program operates at two different sites both providing cognitive behavioral treatment. The program employs 2.5 staff (FTE) and serves 51 male youths at the Lookout Mountain Youth Services Center in Golden, and serves 10 female youths at Mountain View Services Center in Denver. The ARTS-Enhanced TC program provides therapeutic community treatment at the Community Correctional Facility in Denver. It has only recently started; it will employ 3.6 staff (FTE) and serve 215 adults when fully operational. The DOC Women RSAT, is not yet operational, but plans to employ 4 staff (FTE) and provide therapeutic community treatment to 36 female adults at the Denver Women Prison. State official comment regarding the impact of RSAT: "We expanded our prison TC from 40 to 96 beds, thereby occupying an entire housing unit, alleviating contamination [and improving] program efficacy. Residents in treatment [are now] more forthcoming with pro-social expectations of each other. [RSAT] permitted the addition of another TC-dedicated prison work site, additional treatment and evaluation components, and we were able to write a gender-specific curriculum for the female population."

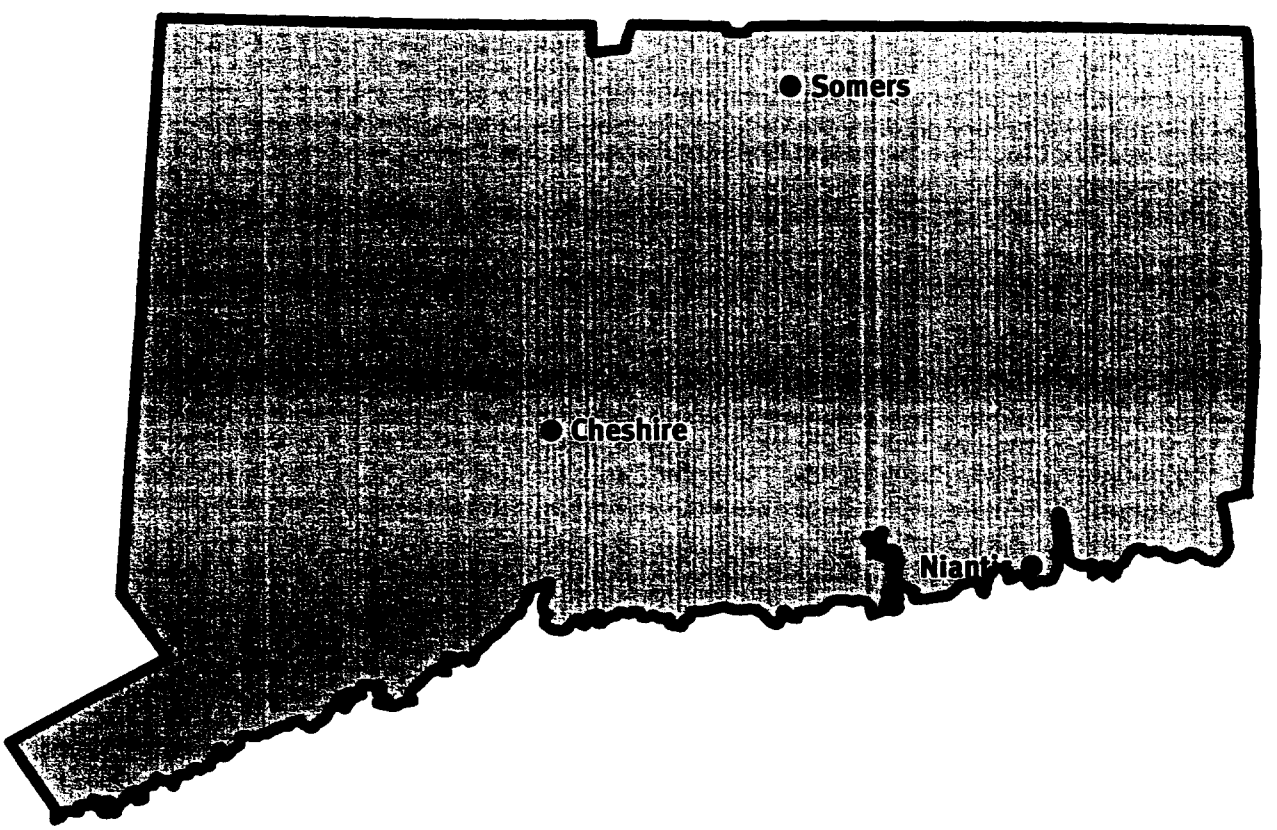
Connecticut RSAT Accomplishments

No. adults in custody at year end 1997 = 18,521
No. delinquent youth in custody at year end 1995 = c. 380
No. females in custody at year end 1997 = 1,550
No. of RSAT treatment beds at Sept 1, 1998 =231
No. of persons in RSAT treatment at Sept 1, 1998 = 191

RSAT funds received

1996	$ 303,393
1997	$ 323,743
1998	$ 677,960

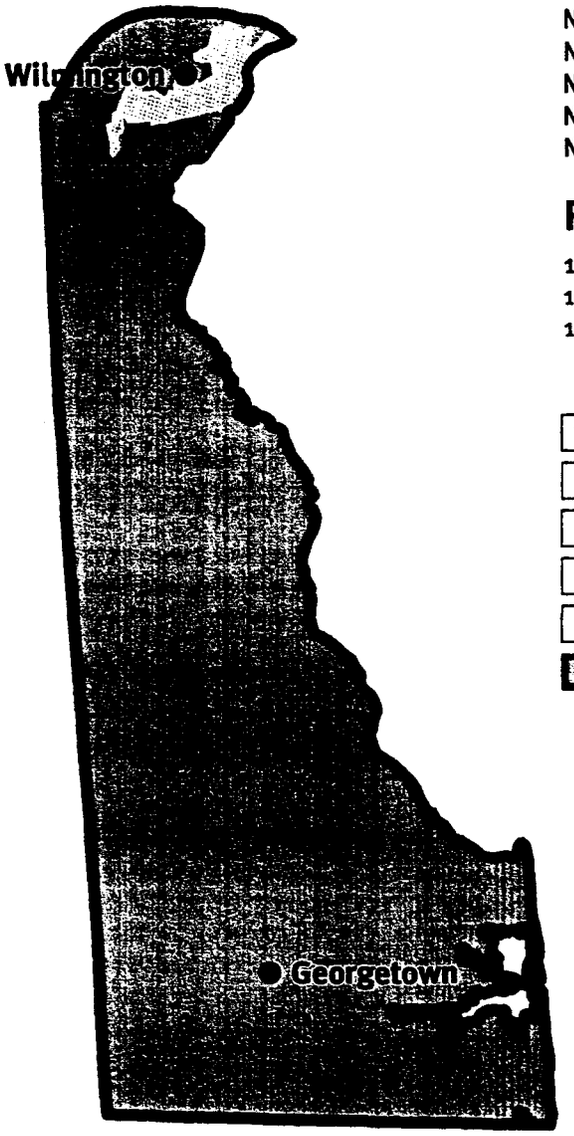
Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Osborne- CI	Modified TC	Somers	Osborne Correc. Facility	60	Male	Adult	None	6	Yes
York-CI	Modified TC	Niantic	York Correc. Institution	99	Female	Adult	None	7	Yes
Manson Youth Institution- H Unit	Modified TC	Cheshire	Manson Youth Institution	72	Male	Youth	None	6	Yes

Connecticut has three operational residential programs, all are modified therapeutic communities. One, employing 6 staff (FTE) at the Osborne Correctional Facility in Somers, is for 60 male adults. One for 99 women inmates is at the York Correctional Facility in Niantic. This TC employs 7 staff (FTE) serving 99 female adults. One TC, serving 72 male youth, 16 to 21, is at the Manson Youth Institution in Cheshire. It employs 6 staff (FTE). State official comment regarding the impact of RSAT: "Prior to RSAT residential programs in other facilities were not possible due to lack of suitable program and office space. [With RSAT funding we] reduced the counselor-to-client ratio and expanded the amount of treatment services available within each program...the program was expanded to include 14 newly contracted halfway house substance abuse treatment beds."

Delaware RSAT Accomplishments



No. adults in custody at year end 1997 = 5,435
No. delinquent youth in custody at year end 1995 = c. 190
No. females in custody at year end 1997 = 383
No. of RSAT treatment beds at Sept 1, 1998 = 638
No. of persons in RSAT treatment at Sept 1, 1998 = 317

RSAT funds received

1996	$ 155,100
1997	$ 173,862
1998	$ 372,531

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries

Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Crest Outreach Center	TC + CB	Wilmington	Plummer Work Release Center	80	Both	Adult	Correctional Medical Services	17	Yes
The Key	TC	Wilmington	Multi-purpose Criminal Justice Facility	160	Male	Adult	Correctional Medical Services (CMS)	9	Yes
Passage Way Treatment Program	TC	Georgetown	Sussex Work Release Center	128	Both	Adult	CMS	12	Yes
New Hope Program	TC	Wilmington	WEBB Correct. Facility	90	Male	Adult	CMS	8	Yes
Key South	TC	Georgetown	Sussex Correc. Institution	180	Male	Adult	CMS	5	Yes

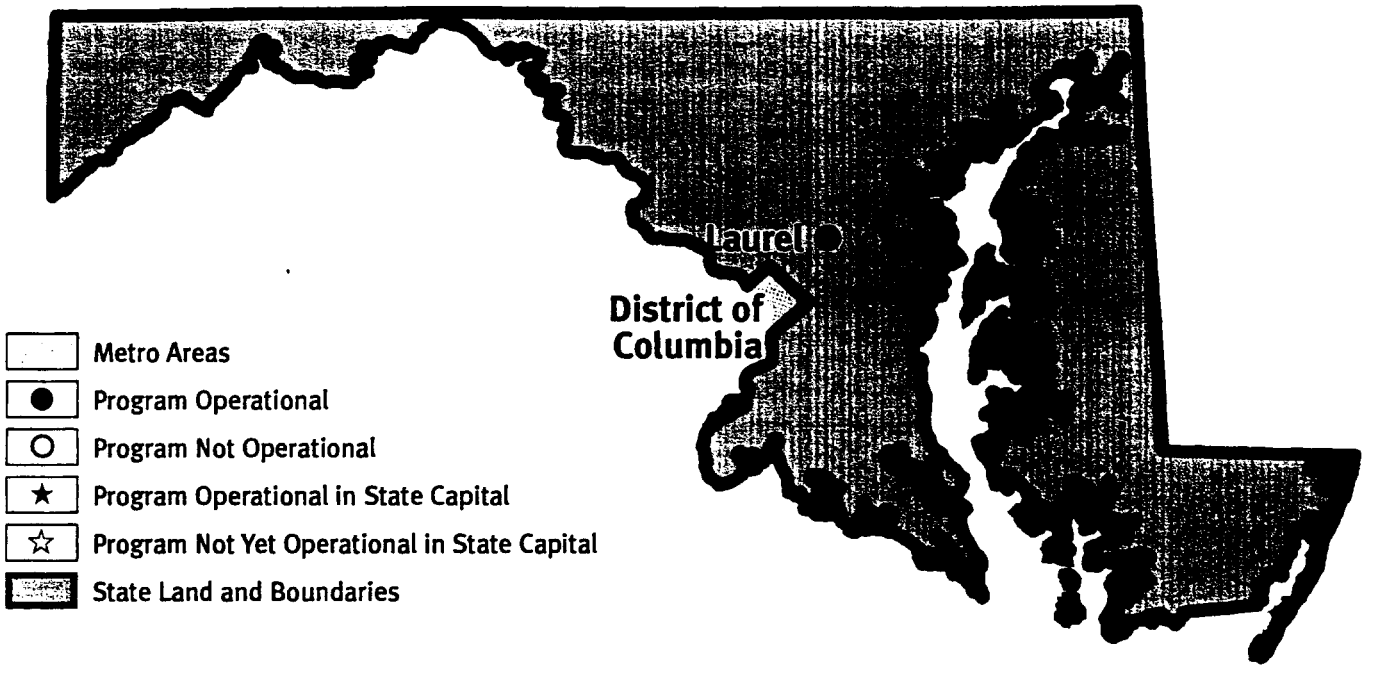
Delaware has five operational RSAT programs located at five sites. The Crest Outreach program providing a combination of therapeutic community treatment and cognitive behavioral programming is located at the Plummer Work Release Center in Wilmington It employs 17 staff (FTE) serving 80 female and male adults. The KEY program providing therapeutic community treatment at the Multi-purpose Criminal Justice Facility in Wilmington employs 9 staff (FTE) and serves 160 male adults. The Passage Way Treatment Program providing therapeutic community treatment at the Sussex Work Release Center in Georgetown employs 12 staff (FTE) for 128 female and male adults. The New Hope Program at the WEBB Correctional Facility in Wilmington provides therapeutic community treatment for 90 male adult inmates, and employs 8 staff (FTE). The Key South program providing therapeutic community treatment is located at Sussex Correctional Institution in Georgetown. It employs 5 staff for 180 male adult inmates. State official comment regarding the impact of RSAT: no comment made.

District of Columbia RSAT Accomplishments

No. adults in custody at year end 1997 = 9,353
No. delinquent youth in custody at year end 1995 = c. 200
No. females in custody at year end 1997 = 1,286
No. of RSAT treatment beds at Sept 1, 1998 = 20
No. of persons in RSAT treatment at Sept 1, 1998 = 17

RSAT funds received

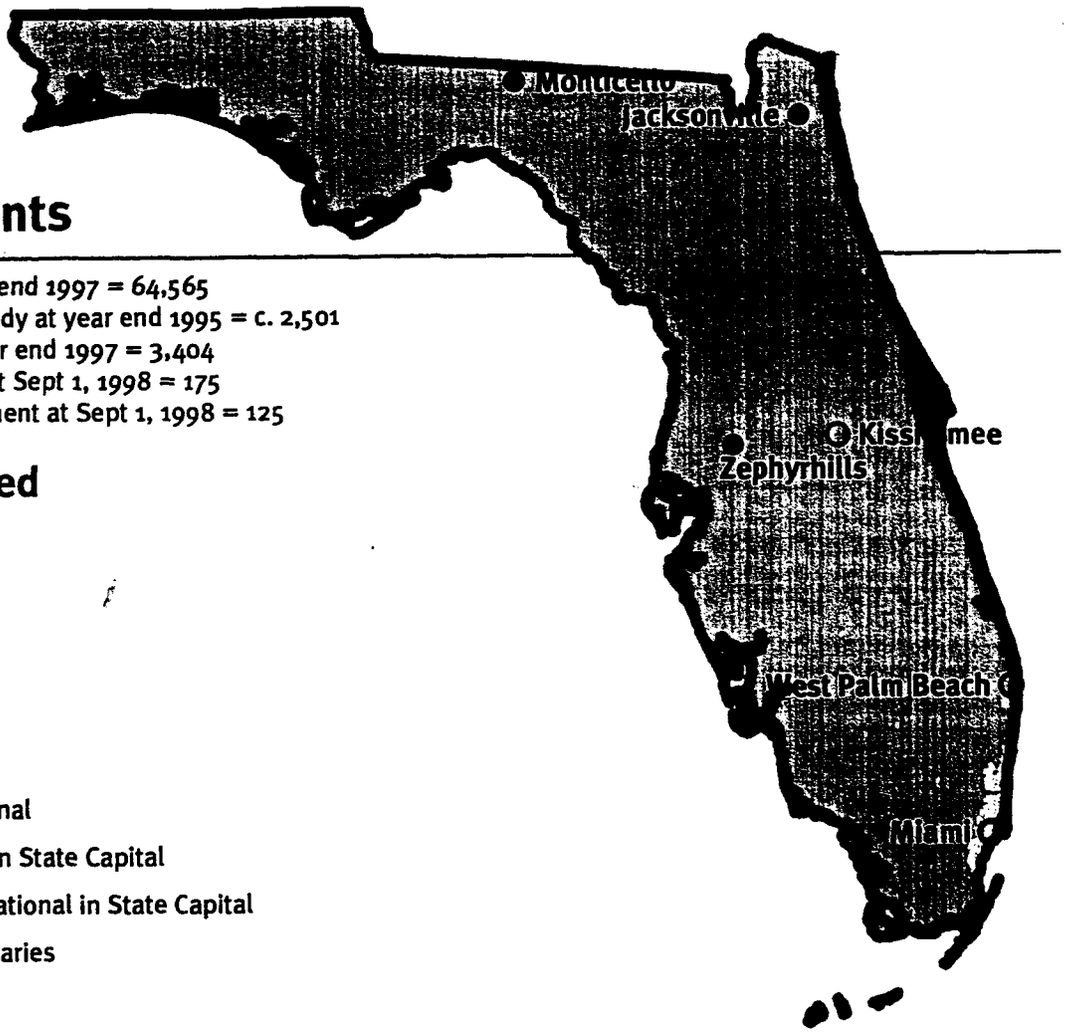
1996	$ 284,967
1997	$ 270,355
1998	$ 542,423



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Substance Abuse Free Enrichment (SAFE)	12 step + CB + TC	Laurel, MD	Oak Hill Youth Center, Laurel, MD	20	Male	Youth	None	10	Yes

DC has one program located at the Oak Hill Youth Center in Laurel, Maryland. It employs 10 staff (FTE) serving 20 male youth providing 12-step programming with elements of cognitive behavioral and therapeutic community treatment. State official comment regarding the impact of RSAT: Prior to funding, no residential substance abuse treatment was available for DC's committed juvenile males; the program has provided 20 beds. Funding has established awareness of the need for residential substance abuse treatment in secure facilities."

Florida RSAT Accomplishments



No. adults in custody at year end 1997 = 64,565
No. delinquent youth in custody at year end 1995 = c. 2,501
No. females in custody at year end 1997 = 3,404
No. of RSAT treatment beds at Sept 1, 1998 = 175
No. of persons in RSAT treatment at Sept 1, 1998 = 125

RSAT funds received

1996	$	1,290,470
1997	$	1,420,879
1998	$	2,938,765

- Metro Areas
- ● Program Operational
- ○ Program Not Operational
- ★ Program Operational in State Capital
- ☆ Program Not Yet Operational in State Capital
- State Land and Boundaries

Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Corrections Dual Diagnosis Project	TC + CB	Zephyrhills	Zephyrhills Correction Institution	80	Male	Adult Dual Diag.	None	12	Yes
Corrections Dual Diagnosis Project	TC + CB	Monticello	Jefferson Correction Institution	60	Female	Adult Dual Diag.	None		Yes
PBCSO- Drug Farm Phase II	Intensive Structured TC	West Palm Beach	Palm Beach County Jail	106	Both	Adult	Drug Abuse Foundation	10.5	No
Metro-West Rehab Unit	Residential Tx	Miami	Metro West Correction Facility	64	Not sure yet	Adult	None	3.5	No
RSAT	Gp, Ind. & Fam. Csig. + CB	Jacksonville	Duvall County Jail	35	Male	Youth	Gateway Community Services	3	yes
Inmate Residential Drug Tx	Cog. Behav. + 12-step	Kissimmee	Osceola County DOC	64	Male	Adult	In the process of getting one	4	No

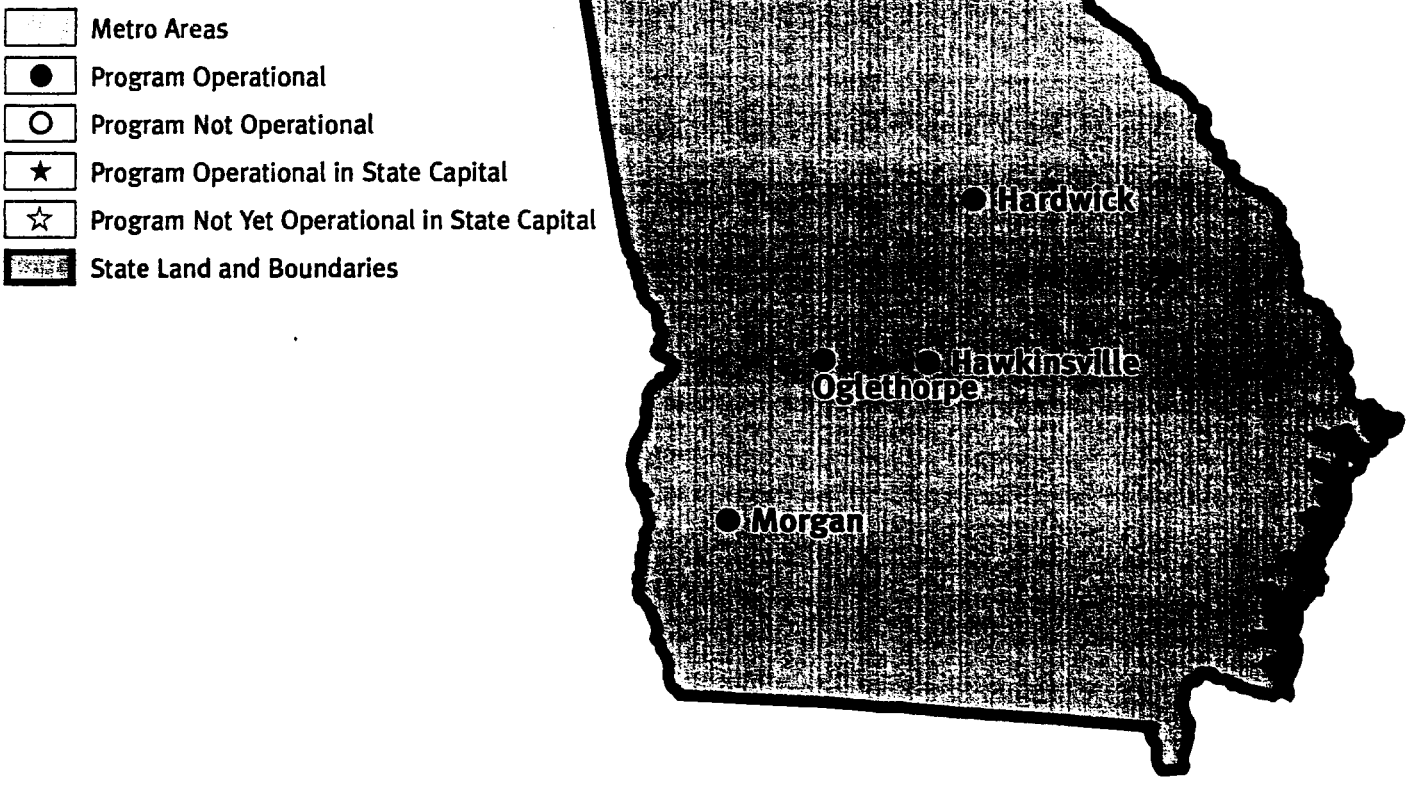
Florida has five programs which when full operational will be at six sites. The Corrections Dual Diagnosis Project employing a total of 12 staff (FTE) is operating at two different sites—at the Zephyrhills Correctional Institution in Zephyrhills, and at the Jefferson Correctional Institution in Monticello. It provides a combination of therapeutic community treatment and cognitive behavioral programming for 80 male adult inmates and 60 female adult inmates, respectively. The RSAT program, located at the Duvall County Jail in Jacksonville, employs 3 staff (FTE) and provides a combination of group, individual and family counseling and cognitive behavioral treatment implemented by Gateway Community Services for 35 male youth. The Inmate Residential Drug Treatment program is not yet operational. It will be located at the Osceola County DOC in Kissimmee and will employ 4 staff (FTE) to provide cognitive behavioral programming with elements of 12-step treatment for 64 male adults. They are in the process of getting a contractor to implement the program. When operational, the PBCSO Drug Farm - Phase II program will be located at the Palm Beach County Jail in West Palm Beach. It will employ 10.5 staff (FTE) for 106 female and male adults and will provide an intensive structured therapeutic community program implemented by the Drug Abuse Foundation. When operational, the Metro-West Rehabilitation Unit program in Metro West Correctional Facility in Miami will employ 3.5 staff (FTE) and provide residential therapeutic community treatment) for 64 adult inmates. State official comment regarding the impact of RSAT: "[There were] zero beds prior, but 120 beds are available now. Treatment for dually-diagnosed inmates would not be available otherwise."

Georgia RSAT Accomplishments

No. adults in custody at year end 1997 = 36,450
No. delinquent youth in custody at year end 1995 = c. 2,200
No. females in custody at year end 1997 = 2,258
No. of RSAT treatment beds at Sept 1, 1998 = 310
No. of persons in RSAT treatment at Sept 1, 1998 = 310

RSAT funds received

1996	$ 754,766
1997	$ 819,727
1998	$1,753,951



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Georgia RSAT Prog.	Cog. Behav.	Hawkinsville	Pulaski State Prison	48	Female	Adult	None	22	Yes
	"	Oglethorpe	Macon State Prison	96	Male	Adult	None		Yes
	"	Morgan	Calhoun State Prison	96	Male	Adult	None		Yes
	"	Hardwick	Scott State Prison	70	Male	Adult	None		Yes

Georgia has seven programs with one model approach operating at four sites. All four sites employing 22 staff (FTE) serving 310 inmates provide a holistic program combining features of cognitive-behavioral programming and modified therapeutic community treatment: one for 48 females at Pulaski State Prison in Hawkinsville; one for 96 adult males at Calhoun State Prison in Morgan; one for 96 adult males at Macon Sate Prison in Oglethorpe, and one for adult males at Baldwin State Prison in Hardwick. State official comment regarding the impact of RSAT: "Prior to RSAT we didn't have a structured intensive residential treatment, a gender specific program for women, nor did we have a requirement for all inmates to develop an individual aftercare plan. [RSAT] allowed the establishment of 7 programs at 4 sites with a total of 310 beds at maximum capacity."

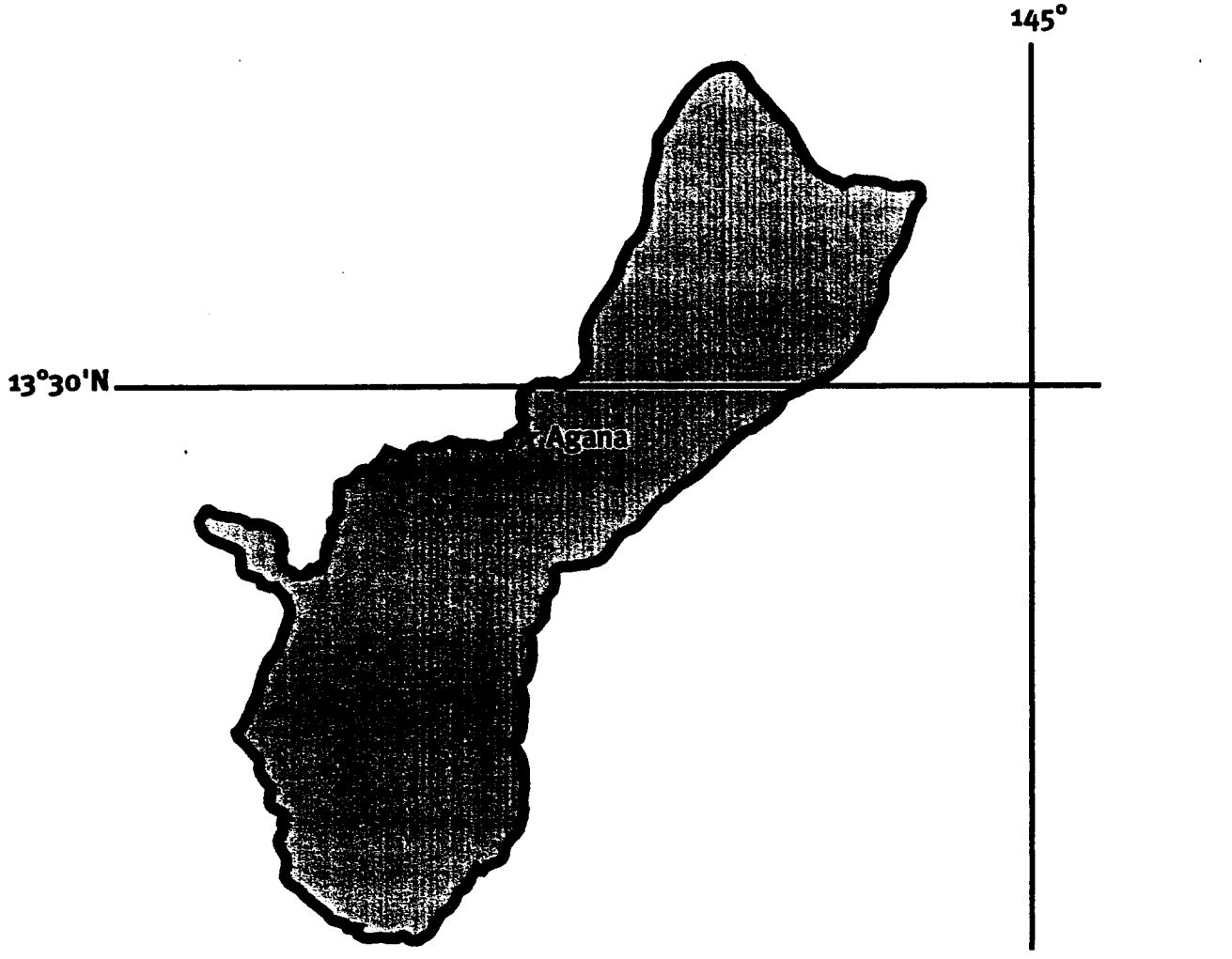
Guam RSAT Accomplishments

No. adults in custody at year end 1997 = 464
No. delinquent youth in custody at year end 1995 = c.
No. females in custody at year end 1997 =
No. of RSAT treatment beds at Sept 1, 1998 =
No. of persons in RSAT treatment Sept 1, 1998 =

RSAT funds received

1996	$ 105,412
1997	$ 117,400
1998	$ 250,978

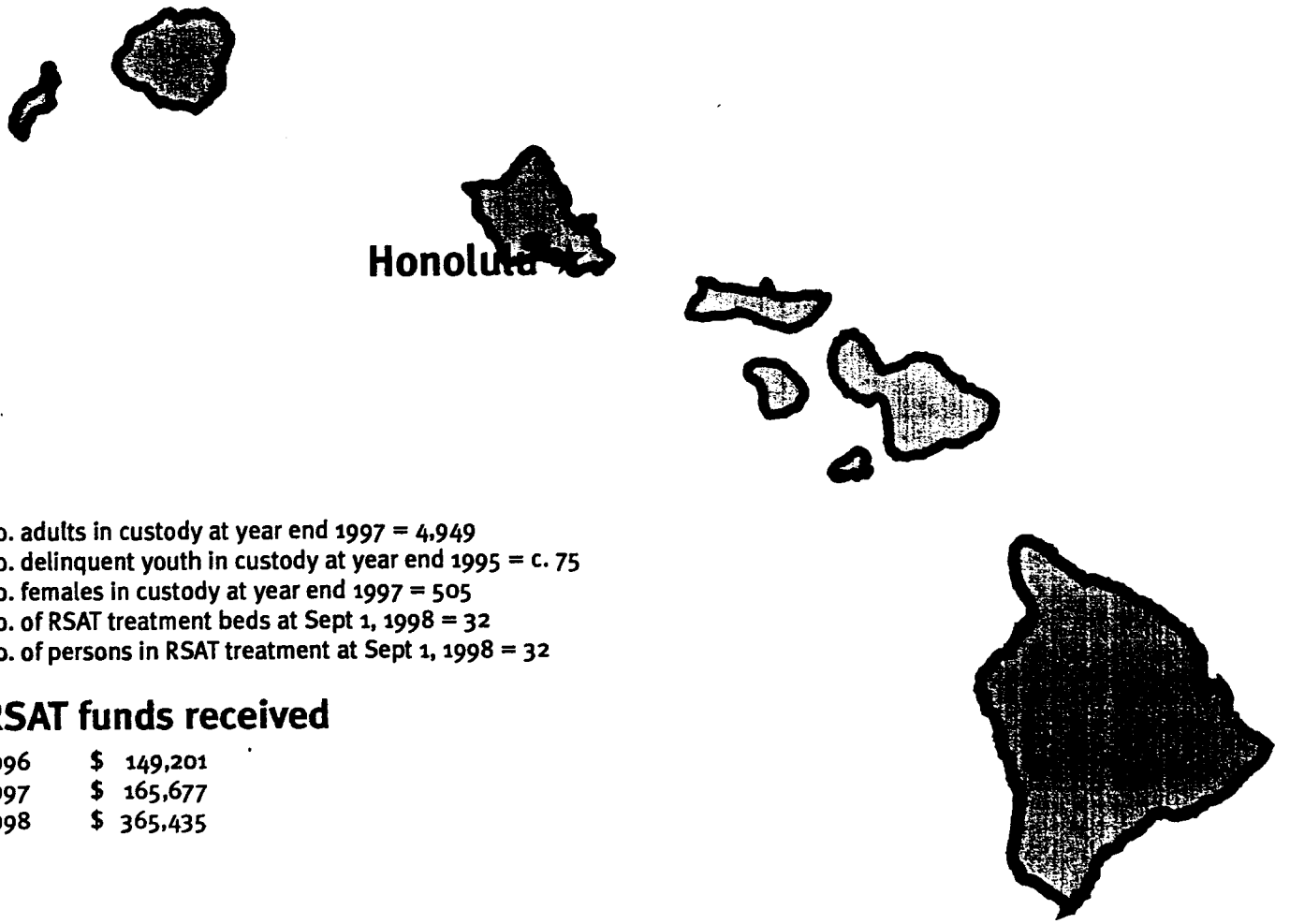
Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
RSAT 96	Cog. Behav. + TC		Constructing new facility	80		Adult		6	No
RSAT 97									
RSAT 98									

Guam is in the process of constructing a new facility that will hold 80 adult inmates, employ 6 staff (FTE) and provide cognitive behavioral programming with elements of therapeutic community treatment. State official comment regarding the impact of RSAT: "Given that the Dept. of Correction has a limited annual budget, funding derived from RSAT program is very significant as it provides a dedicated source of funds with which to provide treatment services. [F]unding support from RSAT insures that materials, supplies and contracted services will be available without interruption or delay...otherwise [it would] offset positive progress in the treatment process."

Hawaii RSAT Accomplishments



No. adults in custody at year end 1997 = 4,949
No. delinquent youth in custody at year end 1995 = c. 75
No. females in custody at year end 1997 = 505
No. of RSAT treatment beds at Sept 1, 1998 = 32
No. of persons in RSAT treatment at Sept 1, 1998 = 32

RSAT funds received

1996	$ 149,201
1997	$ 165,677
1998	$ 365,435

Metro Areas
● Program Operational
○ Program Not Operational
★ Program Operational in State Capital
☆ Program Not Yet Operational in State Capital
State Land and Boundaries

Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Project Bridge	TC + 12- step + CB	Honolulu	Oahu Community Correctional Center	32	Male	Adult	None	3	Yes

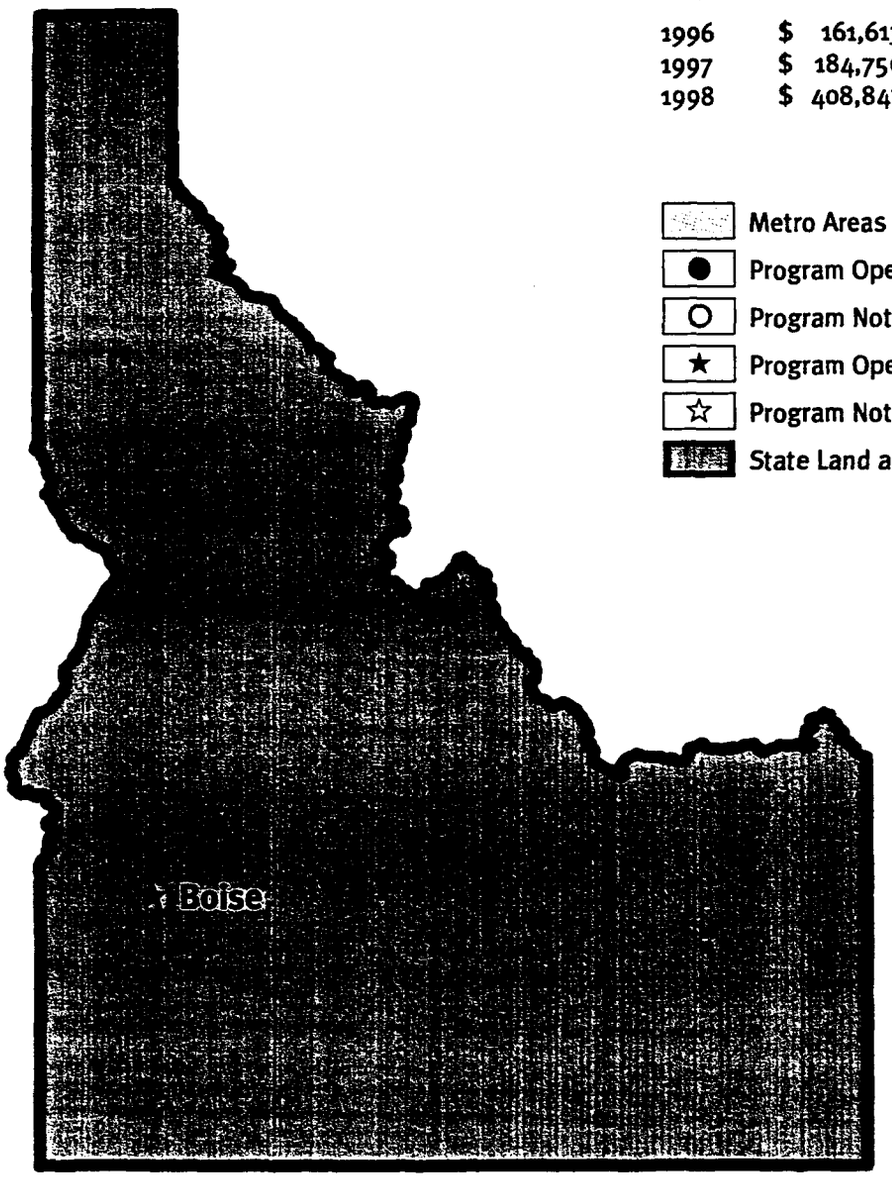
Hawaii has one program, Project Bridge, located at the Oahu Community Correctional Center in Honolulu employing 3 staff (FTE) serving 32 male adults providing a combination of therapeutic community treatment, cognitive behavioral programming and 12-step treatment. State official comment regarding the impact of RSAT: "Due to staffing delay, project hasn't started treatment yet. The anticipated impact is an increase of 32 beds allowing continuous substance abuse treatment to offenders."

Idaho RSAT Accomplishments

No. adults in custody at year end 1997 = 3,946
No. delinquent youth in custody at year end 1995 = c. 105
No. females in custody at year end 1997 = 281
No. of RSAT treatment beds at Sept 1, 1998 = 48
No. of persons in RSAT treatment at Sept 1, 1998 = 39

RSAT funds received

1996	$ 161,613
1997	$ 184,756
1998	$ 408,847



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
SICI-RSAT	CB +TC +12-Step	Boise	South Idaho Correctional Institution	48	Male	Adult	None	3	Yes

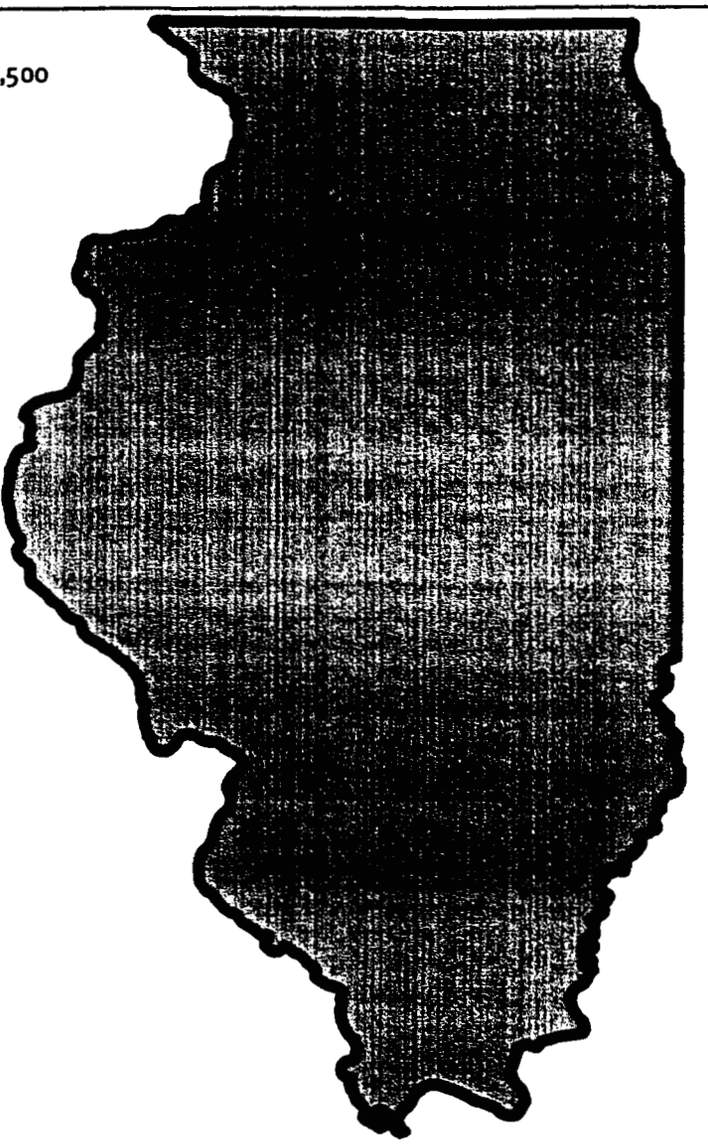
Idaho has one program, SICI-RSAT, located at the South Idaho Correctional Institution in Boise. It employs 3 staff (FTE) for 48 male adult inmates. It provides cognitive behavioral treatment as well as 12-step treatment program elements within a Therapeutic Community structure. State official comment regarding the impact of RSAT: no comment made.

Illinois RSAT Accomplishments

No. adults in custody at year end 1997 = 40,788
No. delinquent youth in custody at year end 1995 = c. 1,500
No. females in custody at year end 1997 = 2,430
No. of RSAT treatment beds at Sept 1, 1998 =
No. of persons in RSAT treatment at Sept 1, 1998 =

RSAT funds received

1996	$ 825,455
1997	$ 892,316
1998	$ 1,924,928



- Metro Areas
- ● Program Operational
- ○ Program Not Operational
- ★ Program Operational in State Capital
- ☆ Program Not Yet Operational in State Capital
- State Land and Boundaries

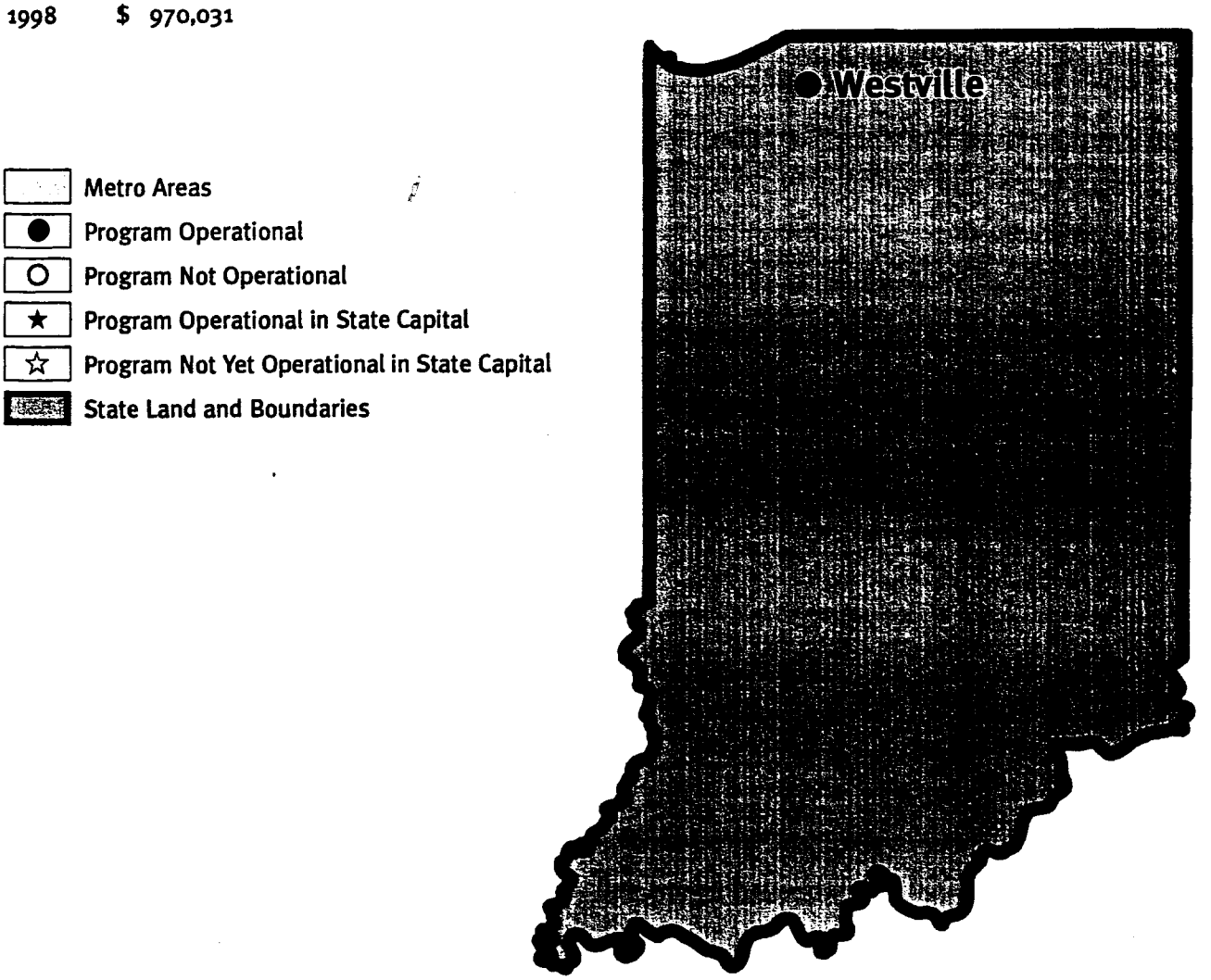
Program survey received—No funds expended as of September 30, 1998.

Indiana RSAT Accomplishments

No. adults in custody at year end 1997 = 17,903
No. delinquent youth in custody at year end 1995 = c. 700
No. females in custody at year end 1997 = 1,071
No. of RSAT treatment beds at Sept 1, 1998 = 194
No. of persons in RSAT treatment at Sept 1, 1998 = 194

RSAT funds received

1996	$ 401,000
1997	$ 448,620
1998	$ 970,031



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Correctional Recovery Academy	TC + CB	Westville	Westville Correc. Facility	194	Male	Adult	Correctional Recovery Academy	12	Yes

Indiana has one program, Correctional Recovery Academy, located at the Westville Correctional Institute in Westville employing 12 staff (FTE) serving 194 male adults providing therapeutic community treatment and cognitive behavioral programming. State official comment regarding the impact of RSAT: "A 194-bed TC has been developed at Westville Correctional Facility. This intensive of a treatment program was not available prior to receipt of RSAT funds."

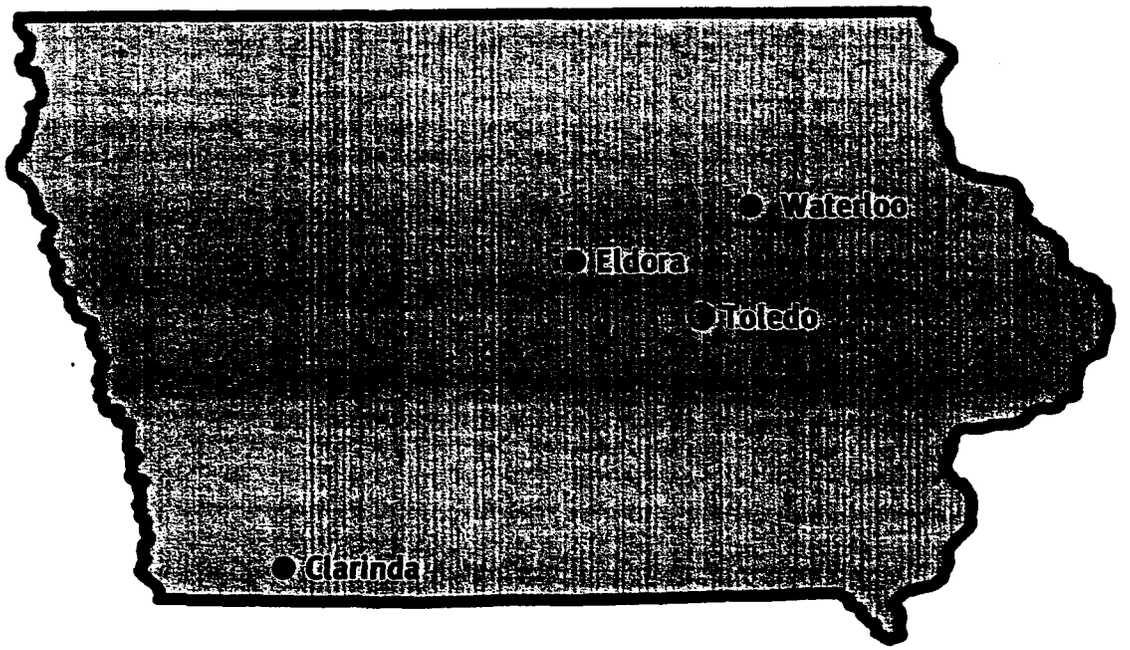
Iowa RSAT Accomplishments

No. adults in custody at year end 1997 = 6,938
No. delinquent youth in custody at year end 1995 = c. 220
No. females in custody at year end 1997 = 528
No. of RSAT treatment beds at Sept 1, 1998 = 116
No. of persons in RSAT treatment at Sept 1, 1998 = 60

RSAT funds received

1996	$ 208,726
1997	$ 236,738
1998	$ 514,497

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
The Other Way Substance Abuse Treatment Program	Cog. Behav.	Clarinda	Clarinda Correc. Facility	80	Male	Adult	None	5	Yes
The Dual Diagnosis Offender Program	*Cognitive* restructuring group	Waterloo	Waterloo Residential Facility	16	Male	Adult Dual Diag.	None	1	Yes
RSAT Note: Same program at two different facilities	Outpatient Intensive Trt with outpatient 12-step (individualized)	Eldora	Iowa Boys State Training School	20	Males	Youth	Addiction Managemt Systems	3	Yes
RSAT	" "	Toledo	Girls Juvenile Hall	20	Female	Youth	" "	2 planned	No

Iowa has three programs operating at four sites. The Other Way Substance Abuse Treatment Program located at the Clarinda Correctional Facility in Clarinda providing cognitive behavioral treatment employs 5 staff (FTE) for 80 male adult inmates. The Dual Diagnosis Offender program located at the Waterloo Residential Facility in Waterloo provides cognitive restructuring group treatment and employs 1 staff person (FTE) for 16 male adult inmates. The last program providing outpatient intensive treatment with individualized outpatient 12-step treatment is located at two different facilities: the Iowa Boys State Training School in Eldora employing 3 staff (FTE) and serving 20 male youths which is operational; the same program located at the Girls Juvenile Hall in is not yet operational. It plans to employ two staff and serve 20 female youths. Both latter programs are implemented by Addiction Management Systems. State official comment regarding the impact of RSAT: "We originally had 2 dedicated substance abuse treatment units (total 160 beds); RSAT added a third unit (80 beds) and [permitted] hiring 6 additional counselors and one clerk."

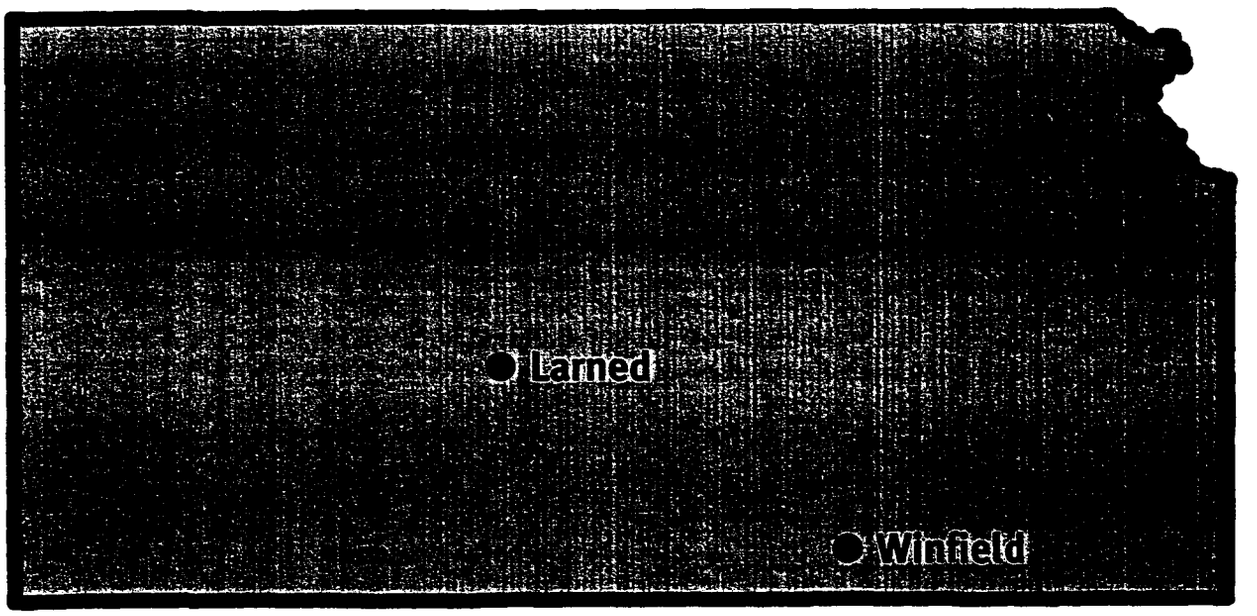
Kansas RSAT Accomplishments

No. adults in custody at year end 1997 = 7,911
No. delinquent youth in custody at year end 1995 = c. 500
No. females in custody at year end 1997 = 476
No. of RSAT treatment beds at Sept 1, 1998 = 140
No. of persons in RSAT treatment at Sept 1, 1998 = 140

RSAT funds received

1996	$ 232,455
1997	$ 262,923
1998	$ 562,668

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Larned Juvenile Correc. Facility	TC + CB	Larned	Larned Juvenile Correc. Facility	20	Male	Youth	None	2	Yes
KS DOC	TC	Winfield	Winfield Correc. Facility	120	Male	Adult	None	11	Yes

Kansas has two operational RSAT programs at two sites. One, the Larned Juvenile Correctional Facility program, is located at the Larned Juvenile Correctional Facility in Larned. It provides a combination of therapeutic community treatment and cognitive behavioral programming for 20 male youths and employs two staff (FTE). The KS DOC program providing therapeutic community treatment is located at the Winfield Correctional Facility in Winfield. It employs 11 staff for 120 male adult inmates. State official comment regarding the impact of RSAT: "Prior to RSAT funding, the Juvenile Correctional Facility of Kansas didn't have intensive inpatient drug/alcohol treatment programming available. Each facility had and continues to have drug and alcohol assessment, pretreatment counseling and referral services. RSAT [has provided funding for its] first inpatient program, and 20 beds have been converted to the RSAT program. [At KS DOC] it has provided intensive inpatient treatment services for primarily a violent offender population. The RSAT staff hired included 2 counselors, 1 clerical and 1 case management specialist."

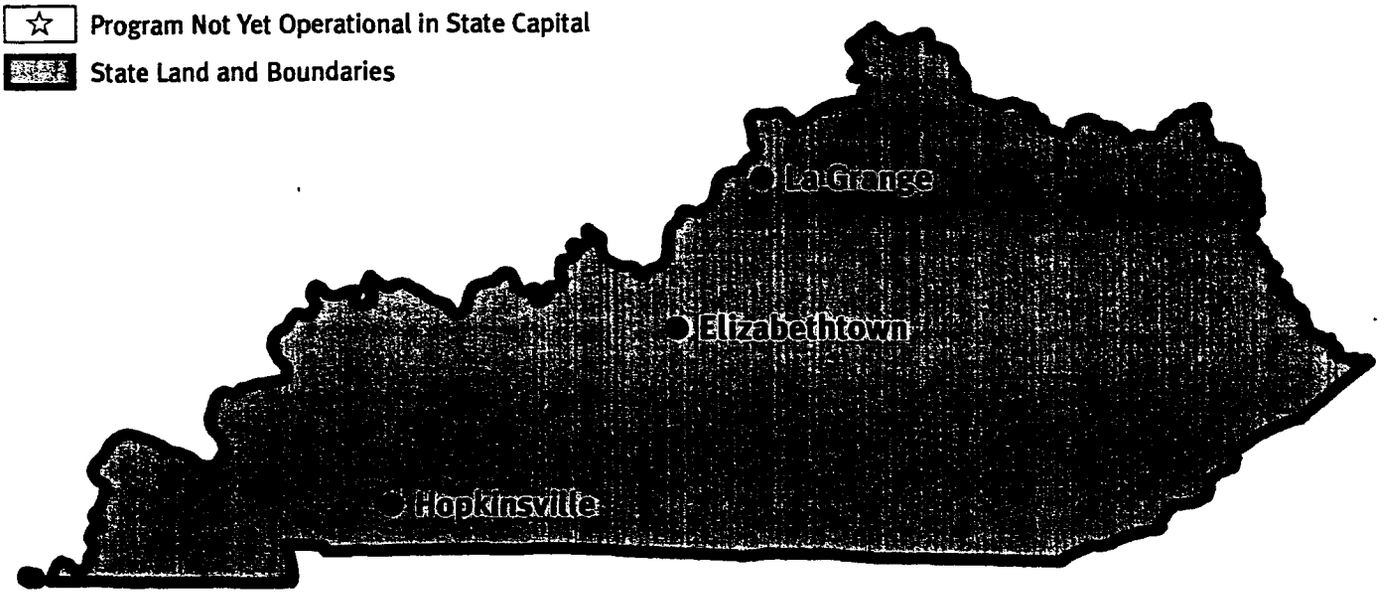
Kentucky RSAT Accomplishments

No. adults in custody at year end 1997 = 14,600
No. delinquent youth in custody at year end 1995 = c. 390
No. females in custody at year end 1997 = 1,052
No. of RSAT treatment beds at Sept 1, 1998 = 149
No. of persons in RSAT treatment at Sept 1, 1998 = 72

RSAT funds received

1996	$ 328,947
1997	$ 368,599
1998	$ 815,960

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Phoenix Recovery Program	Cog. Behav.	Hopkinsville	Christian County Detention Center	31	Both	Adults	None	2	Yes
Bridges Recovery Program	Cog. Behav.	Elizabethstown	Hardin County Detention Center	22	Both	Adult	None	3	Yes
Luther Luckett Correctional Complex	TC + CB	LaGrange	Luther Luckett Correc. Complex	96	Male	Adult	None	3	Yes

Kentucky has three operational RSAT programs at three sites. The Phoenix Recovery Program, located at the Christian County Detention Center in Hopkinsville, provides cognitive behavioral treatment for 31 female and male adults and employs 2 staff (FTE). The Bridges Recovery Program provides cognitive behavioral treatment at the Hardin County Detention Center in Elizabethstown. It employs 3 staff (FTE) for 22 female and male adult inmates. The Luther Luckett Correctional Complex Program, located at the Luther Luckett Correctional Complex in LaGrange employs 3 staff (FTE) providing a combination of therapeutic community treatment and cognitive behavioral programming for 96 male adult inmates. State official comment regarding the impact of RSAT: "Prior to RSAT substance abuse treatment was not available to Class D offenders despite enormous need. The Parole Board has begun to recognize the value of this program and parole its graduates."

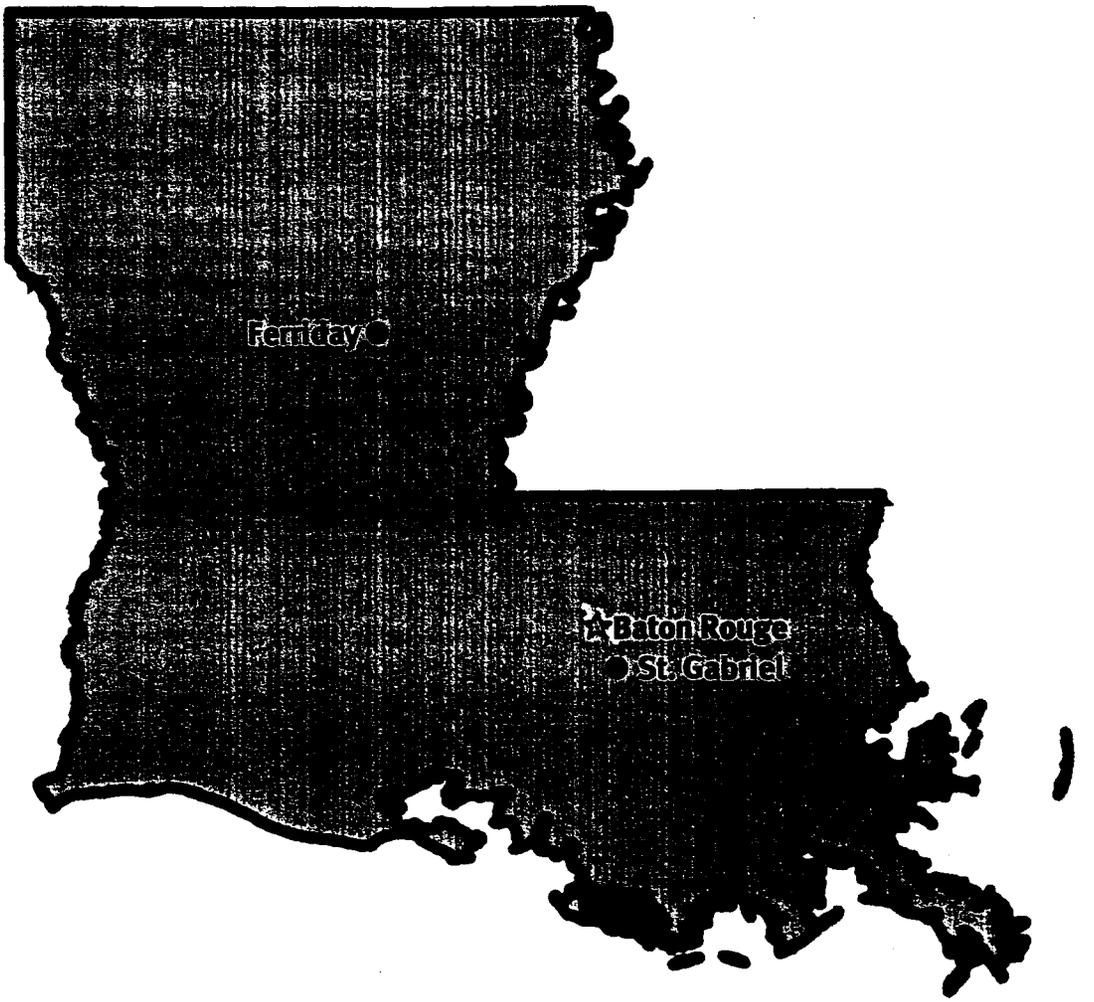
Louisiana RSAT Accomplishments

No. adults in custody at year end 1997 = 29,265
No. delinquent youth in custody at year end 1995 = c. 1,030
No. females in custody at year end 1997 = 1,868
No. of RSAT treatment beds at Sept 1, 1998 = 300
No. of persons in RSAT treatment at Sept 1, 1998 = 189

RSAT funds received

1996	$ 576,634
1997	$ 654,087
1998	$ 1,422,225

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Concordia Parish Facility	12 step + Moral Reconation	Ferriday	Concordia Parish Detention Facility	100	Male	Adult	None	4	Yes
Youth Goal	TC	Baton Rouge	Jetson Corr.Ctr. for Youth	40	Both	Youth	None	6 planned	No
Impact Boot Camp	Moral Reconation + TC + CB	St. Gabriel	Elayn Hunt Correctional Center	200	Both	Adult	None	6	Yes

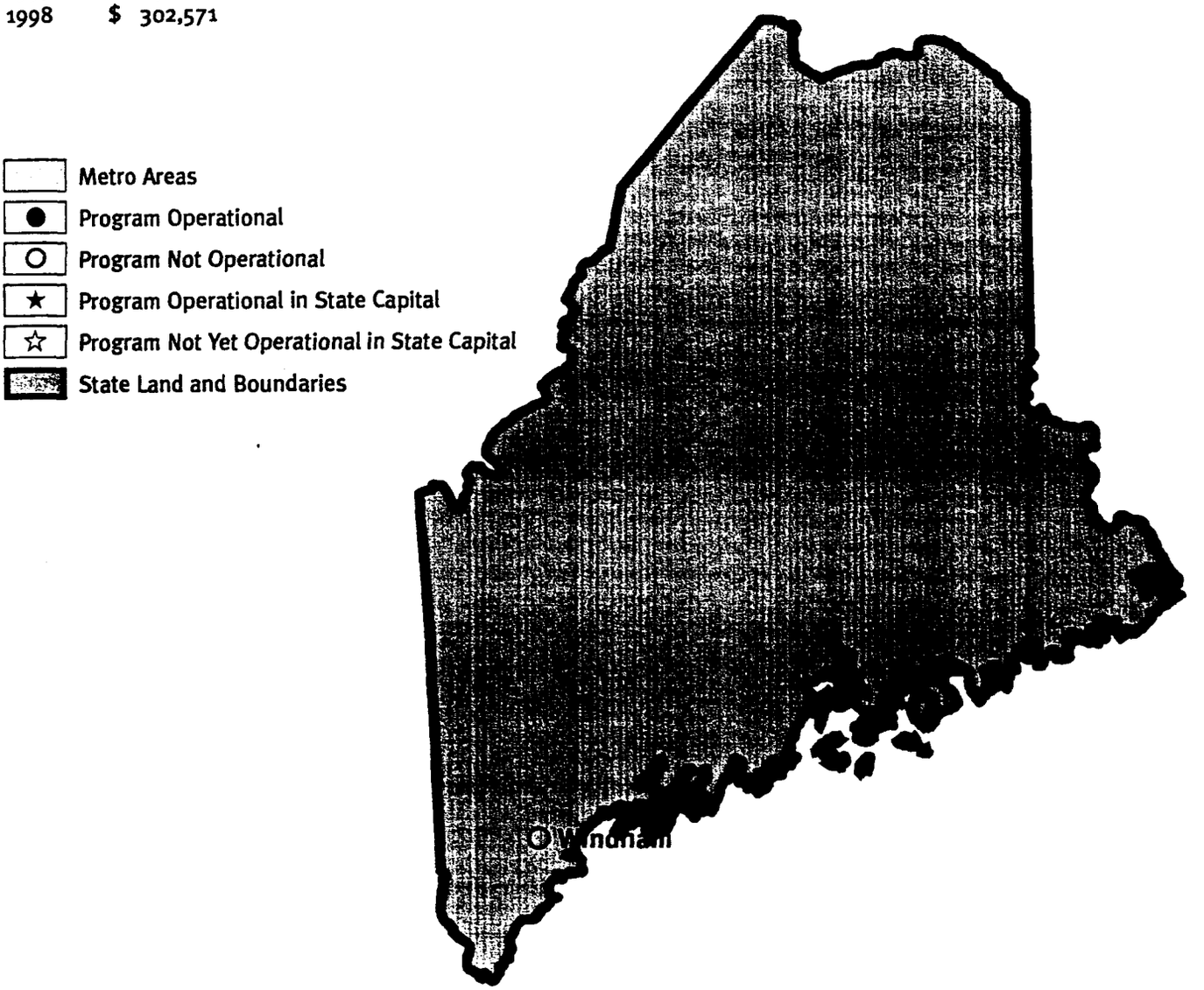
Louisiana has three RSAT programs at three sites, two are operational. One, the Concordia Parish Facility, is located at the Concordia Parish Detention Facility in Somers. It employs 4 staff (FTE) providing 12-step treatment with Moral Reconation Therapy and elements of cognitive behavioral programming for 100 male adult inmates. The Elayn Hunt Correctional Center—Impact Boot Camp, located in St. Gabriel, provides Moral Reconation Therapy combined with TC and cognitive-behavioral treatment for 200 adult male inmates with 6 FTE staff. The Youth Goal Program, a therapeutic community, is to be located at the Jetson Corrrectional Center for Youth, but is not yet operational. State official comment regarding the impact of RSAT: "RSAT provided 100 treatment slots [at Concordia] ... and 200 treatment slots [at Hunt] for program participants. [With RSAT funding] we are providing Moral Reconation Therapy (MRT) as a complement to the AA 12-Step approach [at Concordia] and MRT along with an additional substance abuse therapy component to the IMPACT Shock Incarceration Boot Camp Design [at Hunt]."

Maine RSAT Accomplishments

No. adults in custody at year end 1997 = 1,620
No. delinquent youth in custody at year end 1995 = c. 385
No. females in custody at year end 1997 = 62
No. of RSAT treatment beds at Sept 1, 1998 =
No. of persons in RSAT treatment at Sept 1, 1998 =

RSAT funds received

1996	$ 127,393
1997	$ 140,877
1998	$ 302,571



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Contractor	FTE Staff	Operational
Intensive Residential TC (IRTC)	TC	Windham	Maine Correctional Center	400	Male	Adult	Spectrum Behavioral Services	2	No

Maine has one program, the Intensive Residential TC (IRTC), located at the Maine Correctional Center in Windham. It is just getting underway having an opening date of March 1st. It plans to provide therapeutic community treatment for 40 male adult inmates. State official comment regarding the impact of RSAT: "Intensive residential TC [is the RSAT effect] that we are planning as a collaborative effort between Maine DOC and the Office of Substance Abuse scheduled to be on line 3/1/99."

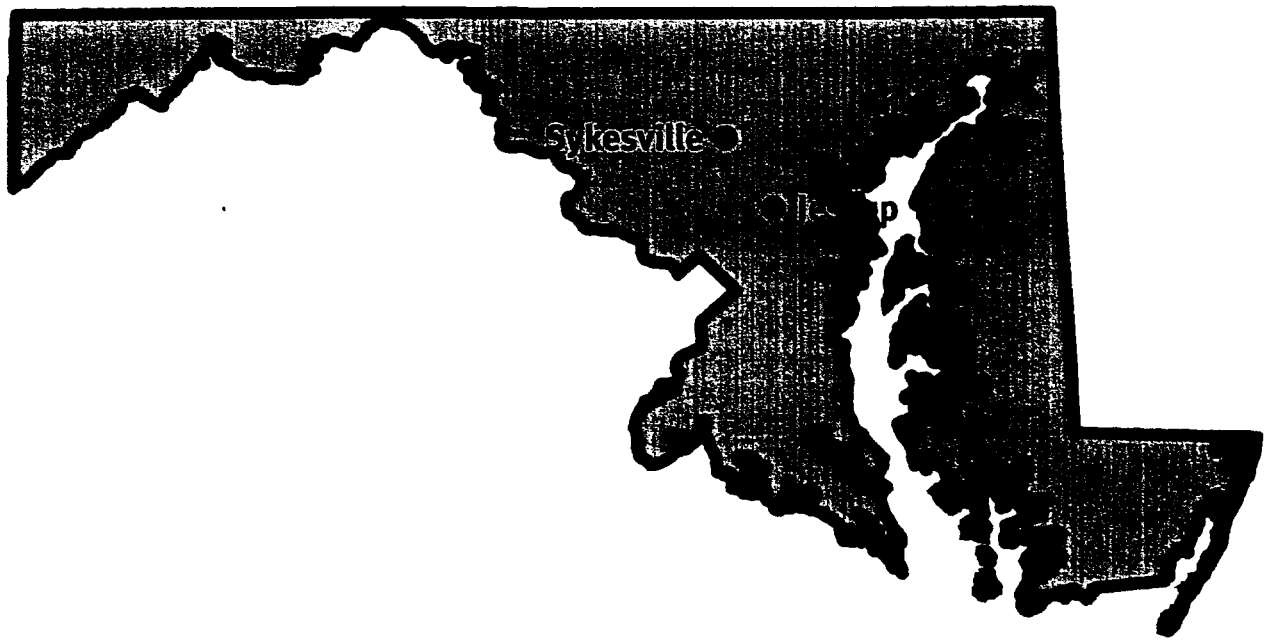
Maryland RSAT Accomplishments

No. adults in custody at year end 1997 = 22,232
No. delinquent youth in custody at year end 1995 = c. 790
No. females in custody at year end 1997 = 1,108
No. of RSAT treatment beds at Sept 1, 1998 = 299
No. of persons in RSAT treatment at Sept 1, 1998 = 82

RSAT funds received

1996	$ 511,326
1997	$ 561,341
1998	$ 1,173,149

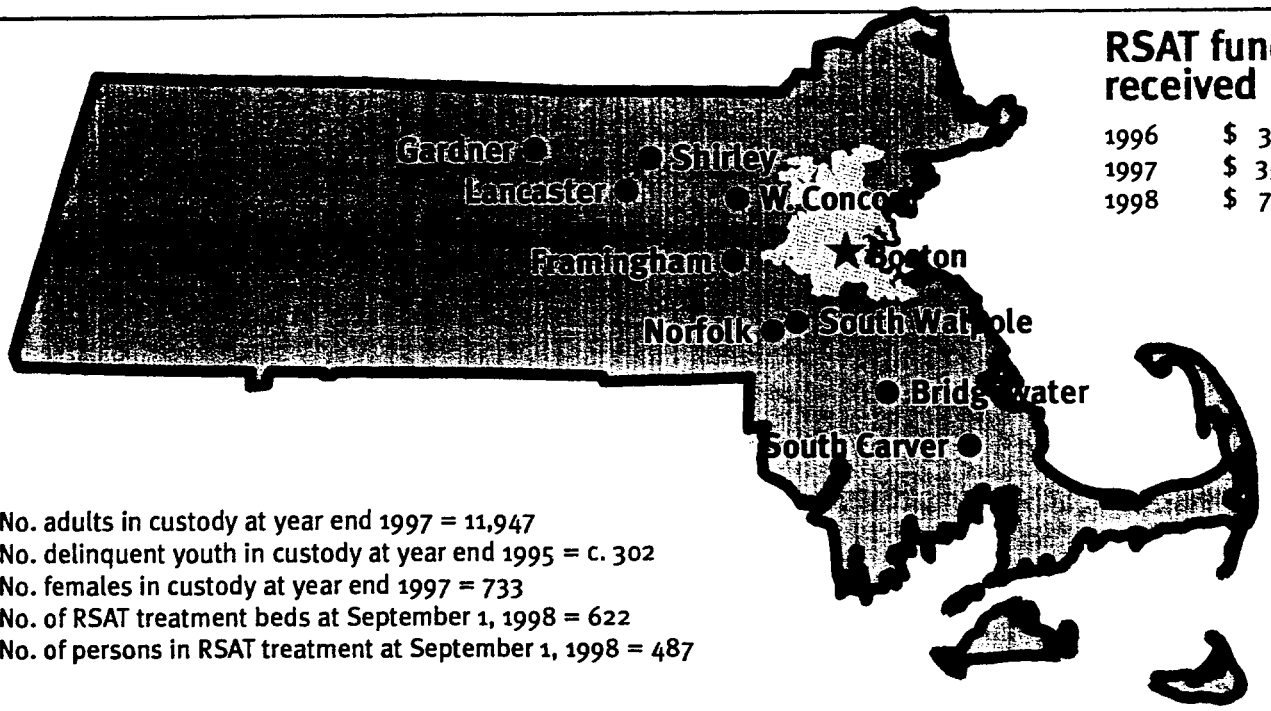
Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
RSAT – Men	Cog. Behav.	Sykesville	Central Laundry Pre-release Facility	275	Male	Adult	None	9	Yes
RSAT-Women	Cog. Behav.	Jessup	Maryland Correc. Institution for Women	24	Female	Adult	None	2	Yes

Maryland has two programs at two sites. The RSAT-men program located at the Central Laundry Pre-Release Facility in Sykesville employing 9 staff (FTE) for 275 male adult inmates providing cognitive behavioral treatment; and the RSAT-Women program providing cognitive behavioral treatment located at the Maryland Correctional Institution for Women in Jessup employing 2 staff (FTE) for 24 female adult inmates. State official comment regarding the impact of RSAT: "RSAT funding allowed implementation of this [entire] program."

Massachusetts RSAT Accomplishments



RSAT funds received

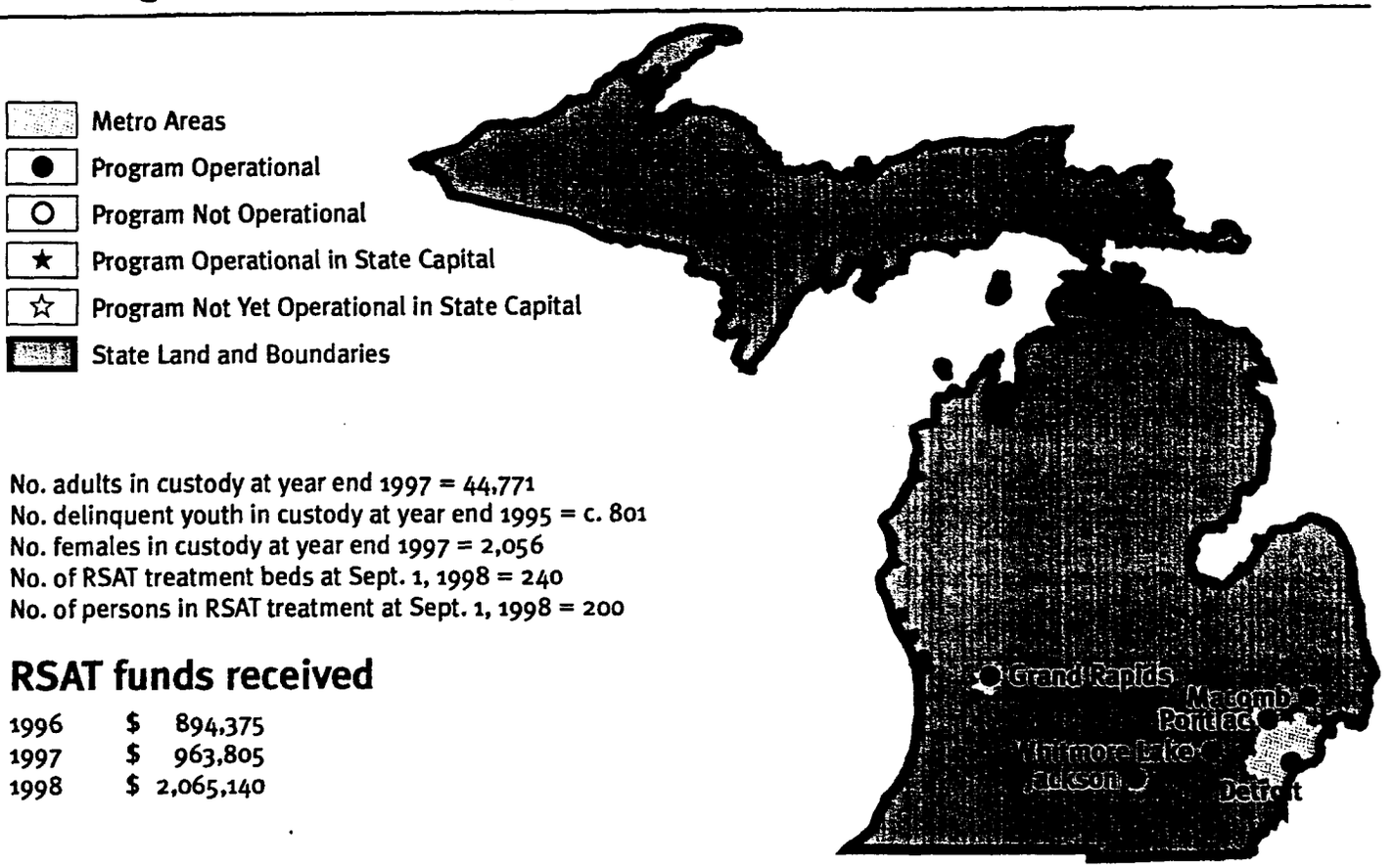
1996	$ 319,725
1997	$ 355,242
1998	$ 734,521

No. adults in custody at year end 1997 = 11,947
No. delinquent youth in custody at year end 1995 = c. 302
No. females in custody at year end 1997 = 733
No. of RSAT treatment beds at September 1, 1998 = 622
No. of persons in RSAT treatment at September 1, 1998 = 487

Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Correctional Recovery Academy	Cog. Behav.	Gardner	North Central Correctional Institution	537	Male	Adult	Correctional Recovery Academy	42.75	Yes
"	"	Lancaster-Men	Lancaster Prerelease Center		Male	Adult	(CRA)		Yes
"	"	Lancaster-Women	"		Female	Adult	CRA		Yes
"	"	Shirley	Massachusetts Correctional Institution-Minimum		Male	Adult	CRA		Yes
"	"	Shirley	Mass. Correctional Institution-Medium		Male	Adult	CRA		Yes
"	"	Norfolk	Mass. Correctional Institution-Lancaster		Male	Adult	CRA		Yes
"	"	South Walpole	Mass Correctional Institution-Cedar Junction		Male	Adult	CRA		Yes
"	"	Framingham	Mass Correctional Institution-Framingham		Female	Adult	CRA		Yes
"	"	South Carver	Mass Correctional Institution-Plymouth		Male	Adult	CRA		Yes
"	"	Bridgewater	Old Colony Correctional Center		Male	Adult	CRA		Yes
"	"	Bridgewater	Southeastern Correctional Center		Male	Adult	CRA		Yes
"	"	W Concord	North Correctional Center		Male	Adult	CRA		Yes
RSAT Prog. At Sheriff's Dept.	Cog. Behav.	Boston	Suffolk County House of Corrections	85	Female	Adult	None	1	Yes

Massachusetts has two RSAT programs all providing cognitive behavioral treatment. The Correctional Recovery Academy program operates at 12 sites employing 42.75 staff (FTE) for 537 inmates. The 12 sites are: North Central Correctional Institution in Gardner; Lancaster Prerelease Center for men in Lancaster; the Lancaster Prerelease Center for female offenders; Massachusetts Correctional Institution-Minimum in Shirley; Massachusetts Correctional Institution - Medium in Shirley; Massachusetts Correctional Institution - Lancaster in Norfolk; Massachusetts Correctional Institution - Cedar Junction in South Walpole; Massachusetts Correctional Institution in Framingham for female offenders; Massachusetts Correctional Institution - Plymouth in South Carver; Old Colony Correctional Center in Bridgewater; Southeastern Correctional Center in Bridgewater; and North Correctional Center in West Concord. The other program, the RSAT Program at the Sheriff's Department, located in Boston's Suffolk County House of Corrections, employs one staff person (FTE) and is for 85 female inmates. It also provides cognitive-behavioral treatment. State official comment regarding the impact of RSAT: "The program has been able to treat more offenders. It had not been able to keep staff on for long due to poor salaries. This has been addressed and the quality of services has improved."

Michigan RSAT Accomplishments



No. adults in custody at year end 1997 = 44,771
No. delinquent youth in custody at year end 1995 = c. 801
No. females in custody at year end 1997 = 2,056
No. of RSAT treatment beds at Sept. 1, 1998 = 240
No. of persons in RSAT treatment at Sept. 1, 1998 = 200

RSAT funds received

1996	$ 894,375
1997	$ 963,805
1998	$ 2,065,140

Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Maxey Training School	Peer-based group bio-psychosocial model based on relapse prevention, cog. Behav. and 12-step techniques.	Whitmore Lake	W. J. Maxey Training School	44	Male	youth	None	3.5	Yes
MDOC RSAT Program	A combination of TC + CB + 12-step and	Detroit		44	Both m & f	Adult	Salvation Army	Varies	Yes
	"	Macomb			"	Adult	Salvation Army	Varies	Yes
	"	Grand Rapids			"	"	Pathfinders	"	Yes
	"	Grand Rapids			"	"	Project Rehab	"	Yes
	"	Detroit			"	"	Metro Matrix	"	Yes
	"	Pontiac			"	"	Community Programs	"	Yes
	"	Detroit			"	"	Christian Guidance	"	Yes
	"	Jackson	Cooper Street Correctional Facility	152.120 more are planned 4/99	Male	Adult	Western Michigan university	9	Yes

Michigan has two programs operating at 9 different sites. One at the W.J. Maxey Training School in Whitmore Lake employing 19 staff (FTE) serving 44 male youth providing a peer-based group bio-psychosocial model based on relapse prevention, cognitive behavioral programming and 12-step techniques. The second program, the MDOC RSAT program, is at 7 sites with a total of 44 beds divided among Salvation Army in Detroit, Salvation Army in Macomb, Pathfinders in Grand Rapids, Project Rehab in Grand Rapids, Metro Matrix in Detroit, Community Programs in Pontiac, and Christian Guidance in Detroit. Staff whose size varies from site to site provides a combination of therapeutic community treatment, cognitive behavioral programming, 12-step treatment, and relapse prevention. The MDOC program is also located at the Cooper Street Correctional Facility in Jackson. It employs 9 staff, serves 152 male adult inmates, with plans to expand that number to 272 in April 1999, it provides the same treatment here as in the other sites. Western Michigan Univ. staff implements the program. State official comment regarding the impact of RSAT: "Two new halls were opened using a relapse prevention model — a total of 32 new beds...44 new beds available [in addition] as a result of RSAT & state-matching funds. We hired 3 therapists to train staff on substance abuse issues and relapse prevention. [We have] treated 97 new clients, so far only 16% [have been] treated unsuccessfully."

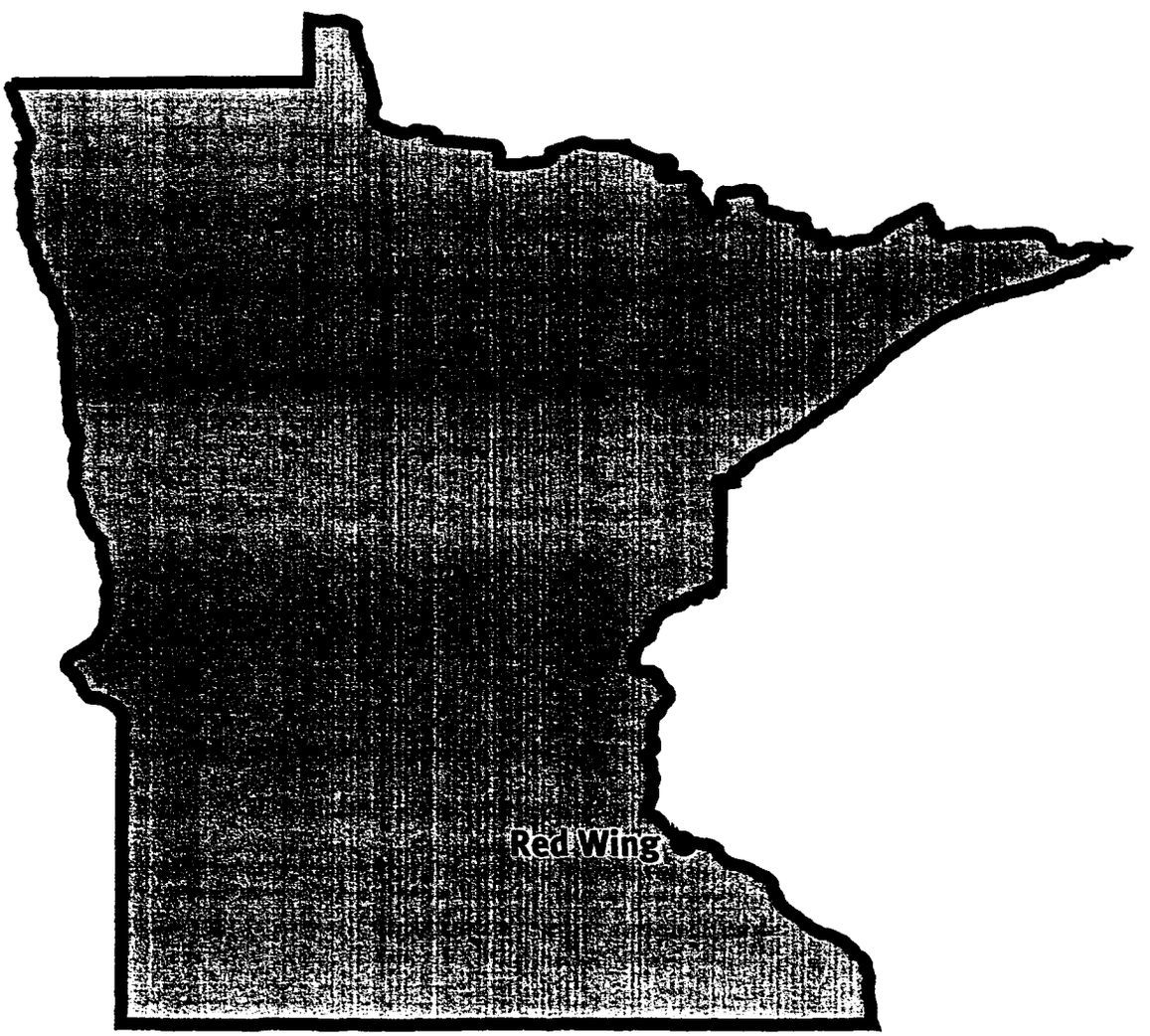
Minnesota RSAT Accomplishments

No. adults in custody at year end 1997 = 5,326
No. delinquent youth in custody at year end 1995 = c. 280
No. females in custody at year end 1997 = 258
No. of RSAT treatment beds at Sept. 1, 1998 = 30
No. of persons in RSAT treatment at Sept. 1, 1998 = 15

RSAT funds received

1996	$ 190,895
1997	$ 213,608
1998	$ 460,733

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Red Wing RSAT Program.	TC+CB+12 step	Red Wing	Minnesota Correc. Facility-Red Wing	30	Male	Youth	None	3	Yes

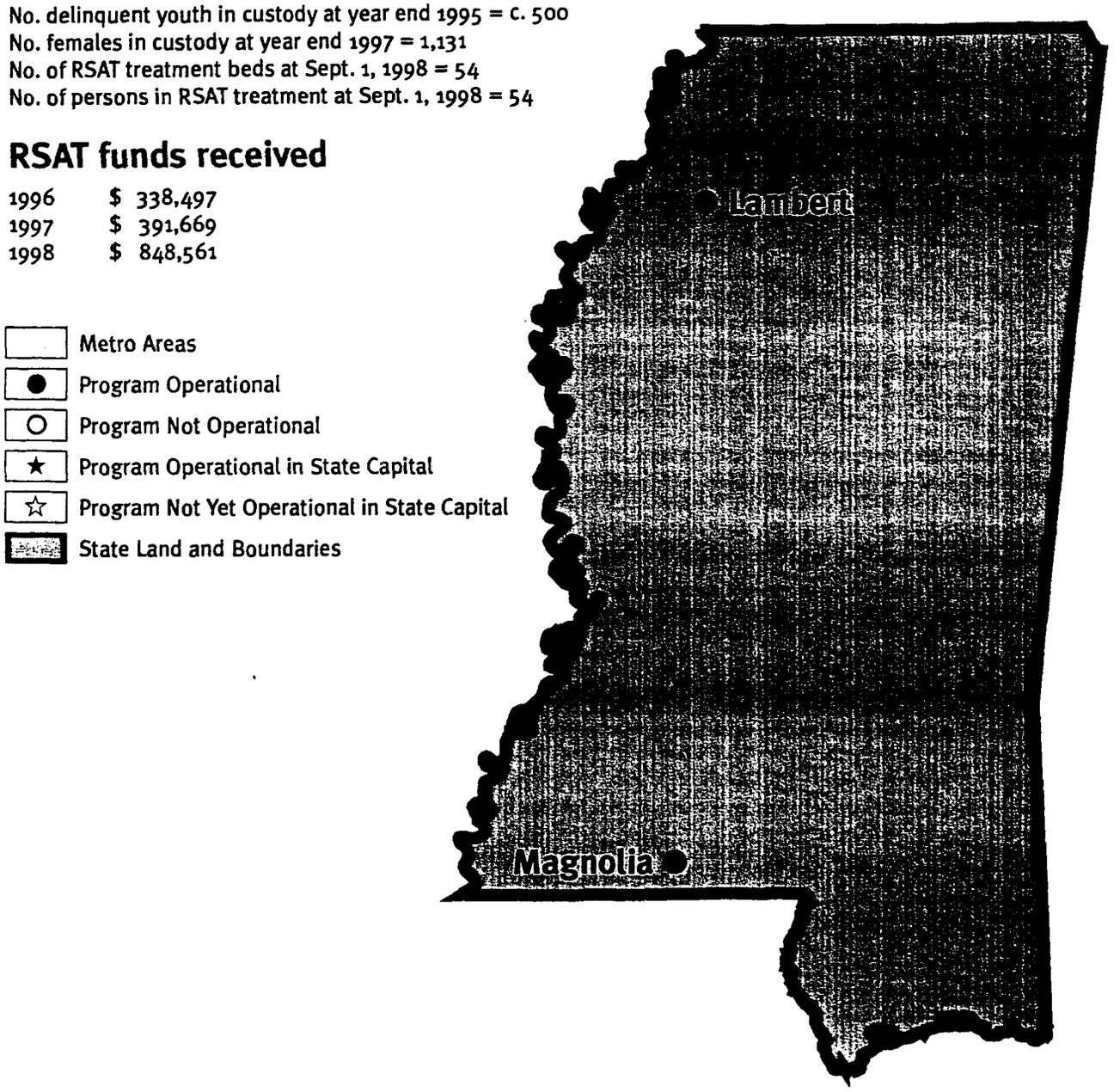
Minnesota has one program, the Red Wing RSAT program, located at the Minnesota Correctional Facility- Red Wing. It employs 3 staff (FTE) serving 30 male youth providing a combination of therapeutic community treatment, cognitive behavioral programming and 12-step treatment. State official comment regarding the impact of RSAT: "This is the first time MCG-Sauk Centre [which was moved to Red Wing] has been able to dedicate a full group of adolescents to a residential chemical dependency program. [We can now] offer specific classes; coordinate AA meetings both on and off grounds, [and do] mandated routine drug screening."

Mississippi RSAT Accomplishments

No. adults in custody at year end 1997 = 15,477
No. delinquent youth in custody at year end 1995 = c. 500
No. females in custody at year end 1997 = 1,131
No. of RSAT treatment beds at Sept. 1, 1998 = 54
No. of persons in RSAT treatment at Sept. 1, 1998 = 54

RSAT funds received

1996	$ 338,497
1997	$ 391,669
1998	$ 848,561



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Pike County Resid. Substance Abuse Pre-release Program	12-step program'g + CB	Magnolia	Pike County Pre-Release Center	34	Male	Adult	None	4	Yes
Quitman County Residential Substance Abuse Pre-release Program	12-step program'g + CB	Lambert	Quitman County Pre-Release Center	20	Male	Adult	None	4	Yes

Mississippi has two programs operating at two sites: one, the Pike County Residential Substance Abuse Pre-Release Program, located at the Pike County Pre-Release Center in Magnolia, employs 4 staff (FTE) serving 34 male adult inmates. It provides 12-step programming with elements of cognitive behavioral treatment. Two, the Quitman County Residential Substance Abuse Pre-Release Program is located at the Quitman County Pre-Release Center in Lambert. It employs 4 staff (FTE) who provide 12-step programming with elements of cognitive behavioral treatment for 20 male adult inmates. State official comment regarding the impact of RSAT: "[As a result of RSAT we have] dedicated two 75-bed pre-release centers for substance abuse treatment of inmates entering the pre-release program. [This] provides an opportunity to provide substance abuse treatment to inmates who [otherwise] because of limited treatment capacity would be released from prison without being treated for their problems."

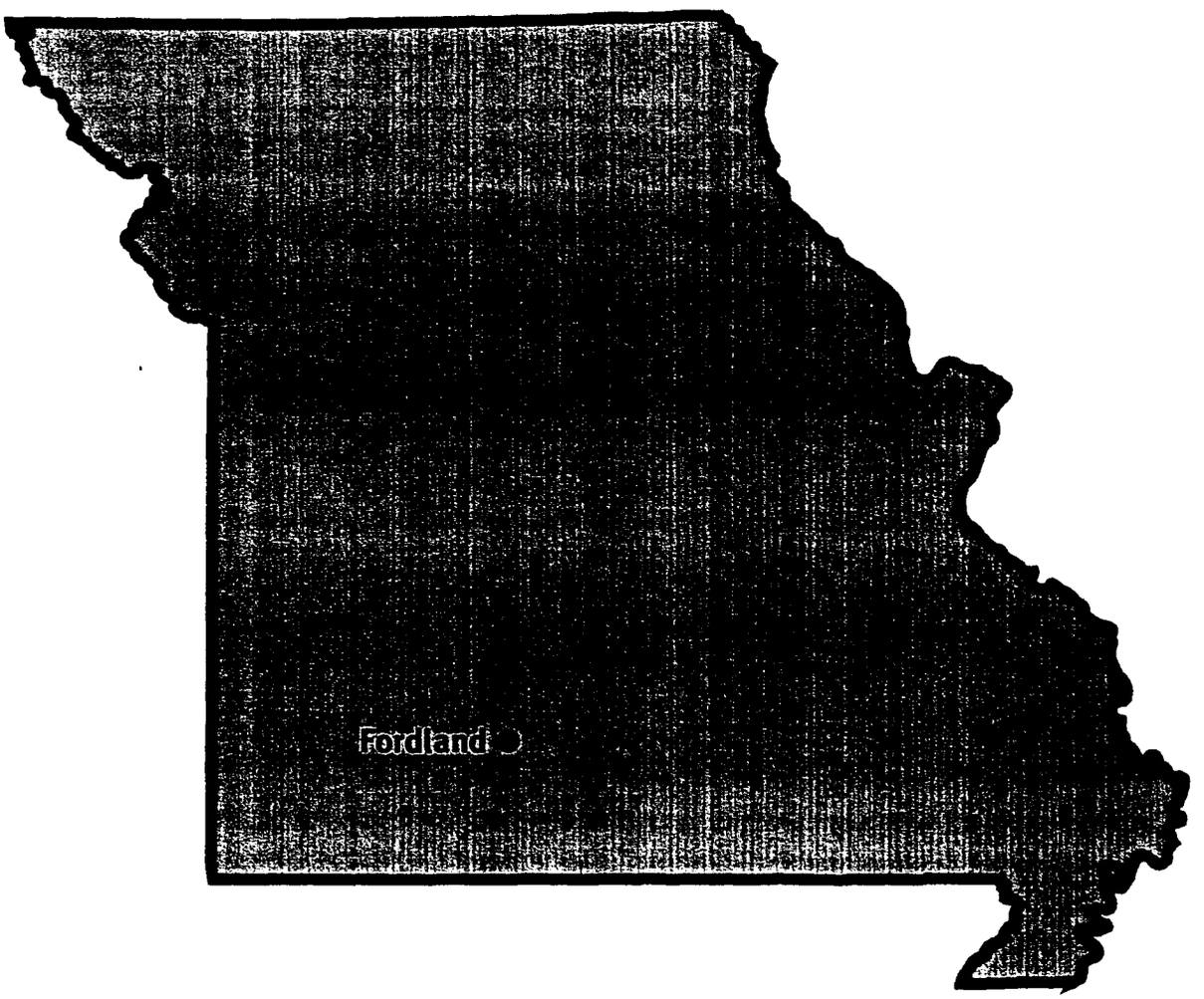
Missouri RSAT Accomplishments

No. adults in custody at year end 1997 = 23,998
No. delinquent youth in custody at year end 1995 = c. 405
No. females in custody at year end 1997 = 1,693
No. of RSAT treatment beds at Sept. 1, 1998 = 652
No. of persons in RSAT treatment at Sept. 1, 1998 = 645

RSAT funds received

1996	$ 463,272
1997	$ 529,231
1998	$ 1,226,245

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Avalon/Ozark Correctional Center	TC ++	Fordland	Ozark Correctional Center	652	Male	Adult	None	29	Yes

Missouri has one operational RSAT program, the Avalon/Ozark Correctional Center program, located at the Ozark Correctional Center in Fordland. It employs approximately 29 staff (FTE) providing therapeutic community treatment with elements of cognitive behavioral programming and 12-step treatment to 652 male adults. State official comment regarding the impact of RSAT: "[RSAT has] allowed operation of program at full capacity, expanding from previous year's 125 beds and avoiding potential 50% reduction due to inadequate state funding. [It] has protected the integrity of the therapeutic community environment and the treatment environment by assuring [that the] entire population would be engaged in TC treatment."

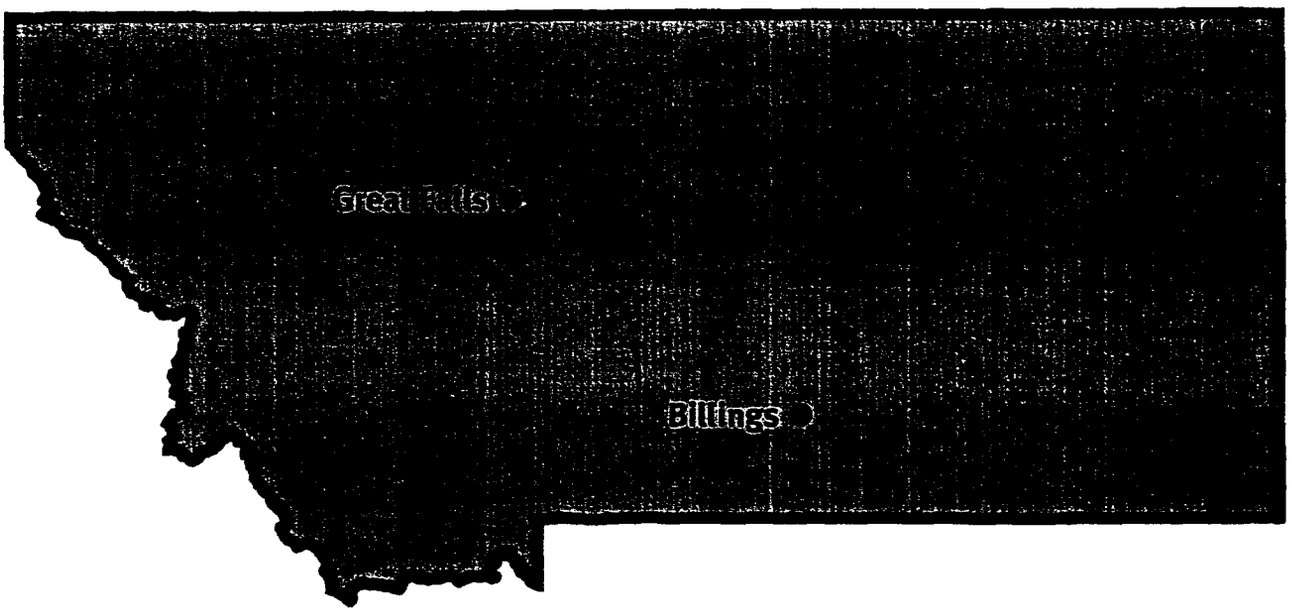
Montana RSAT Accomplishments

No. adults in custody at year end 1997 = 2,242
No. delinquent youth in custody at year end 1995 = c. 100
No. females in custody at year end 1997 = 115
No. of RSAT treatment beds at Sept. 1, 1998 = 24
No. of persons in RSAT treatment at Sept. 1, 1998 = 19

RSAT funds received

1996	$ 133,964
1997	$ 155,415
1998	$ 333,924

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Youth Evaluation/ transition center	CB + motivational enhancement therapy solution focused approach	Great Falls	Youth Evaluation/ Transition Center	12	Male	Youth	None	3	Yes
Billings Transition Center/Community Counseling	CB +12-step programming	Billings	Billings Transition Center	12	Male	Youth	None	3	Yes

Montana has two operational programs at two different sites: one program located at the Youth Evaluation/Transition Center in Great Falls employing 19 staff (FTE) serving 12 male youth providing cognitive-behavioral programming and a motivational enhancement therapy with a solution-focused approach. The other program is at the Billings Transition Center in Billings employing 3 staff (FTE) serving 12 male youth. It provides cognitive-behavioral programming with elements of 12-step treatment. State official comment regarding the impact of RSAT: "[RSAT] has enabled construction of innovative treatment modality for juveniles at the YEP Home in Great Falls; as many as 14 offenders per research period have participated in the program. Preliminary data (pre-post comparisons) [on various psychological] measures have been enhanced as a result of treatment programming."

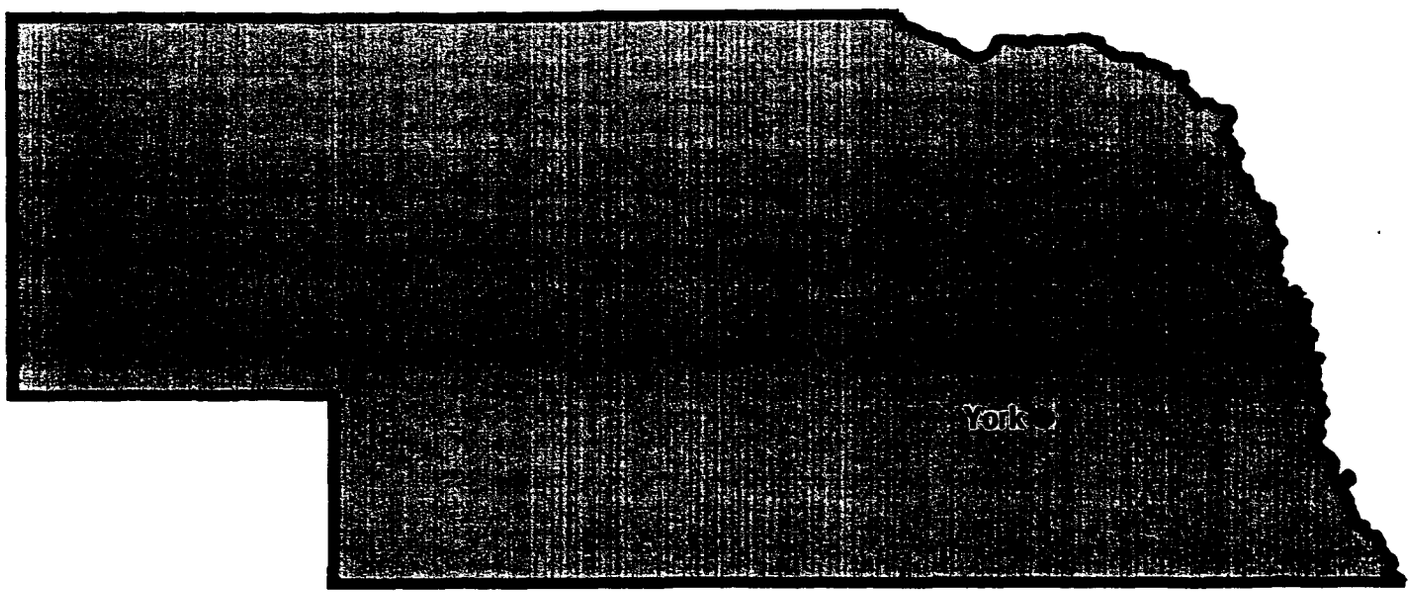
Nebraska RSAT Accomplishments

No. adults in custody at year end 1997 = 3,402
No. delinquent youth in custody at year end 1995 = c. 299
No. females in custody at year end 1997 = 225
No. of RSAT treatment beds at Sept. 1, 1998 = 19
No. of persons in RSAT treatment at Sept. 1, 1998 = 19

RSAT funds received

1996	$ 153,178
1997	$ 177,120
1998	$ 380,713

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
NCCW- Substance Abuse Unit	CB + 12-step using Hazelden: "A Design for Living"	York	Nebraska Correctional Center for Women	19	Women	Adult	None	3	Yes

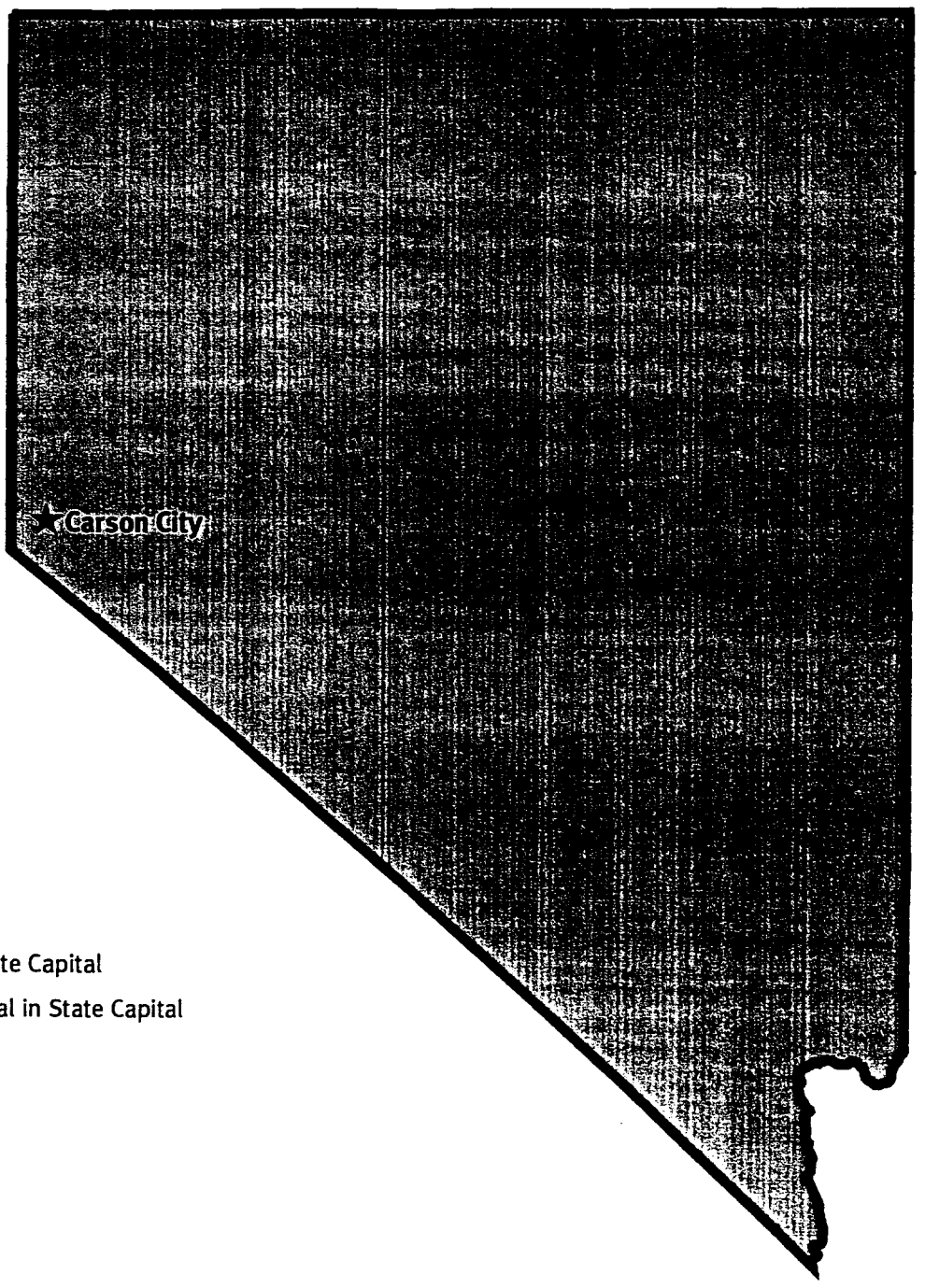
Nebraska has one operational program at the Nebraska Correctional Center for Women in York employing 3 staff (FTE) serving 19 female adults. It provides cognitive behavioral programming and 12-step treatment using Hazelden's "A Design for Living". State official comment regarding the impact of RSAT: "none"

Nevada RSAT Accomplishments

No. adults in custody at year end 1997 = 9,024
No. delinquent youth in custody at year end 1995 = c. 302
No. females in custody at year end 1997 = 695
No. of RSAT treatment beds at Sept. 1, 1998 = 85
No. of persons in RSAT treatment at Sept. 1, 1998 = 85

RSAT funds received

1996	$ 243,215
1997	$ 275,181
1998	$ 597,189



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Wings	TC	Carson City	Warm Springs Correc. Ctr.	85	Male	Adult	Vitality Center	5	Yes

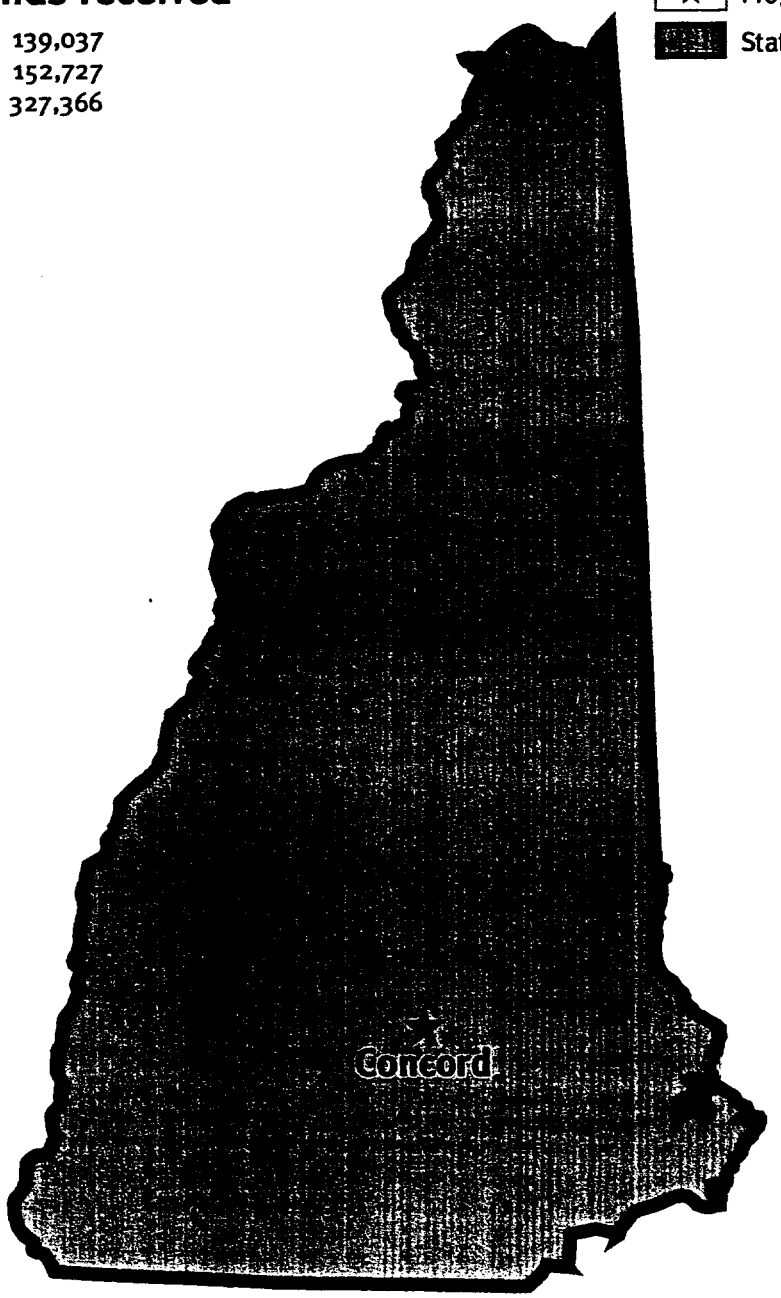
Nevada's program, Wings, located at the Warm Springs Correctional Center in Carson City employs 5 staff (FTE) providing therapeutic community treatment to 85 male adult inmates. The TC is implemented by the Vitality Center. State official comment regarding the impact of RSAT: "none"

New Hampshire RSAT Accomplishments

No. adults in custody at year end 1997 = 2,164
No. delinquent youth in custody at year end 1995 = c. 100
No. females in custody at year end 1997 = 109
No. of RSAT treatment beds at Sept. 1, 1998 = 48
No. of persons in RSAT treatment at Sept. 1, 1998 = 48

RSAT funds received

1996	$ 139,037
1997	$ 152,727
1998	$ 327,366



- Metro Areas
- ● Program Operational
- ○ Program Not Operational
- ★ Program Operational in State Capital
- ☆ Program Not Yet Operational in State Capital
- State Land and Boundaries

Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Summit House/NHSP	TC approach with CB, utilizing 12-step philosophy	Concord	New Hampshire State Prison	48	Male	Adult	None	4	Yes

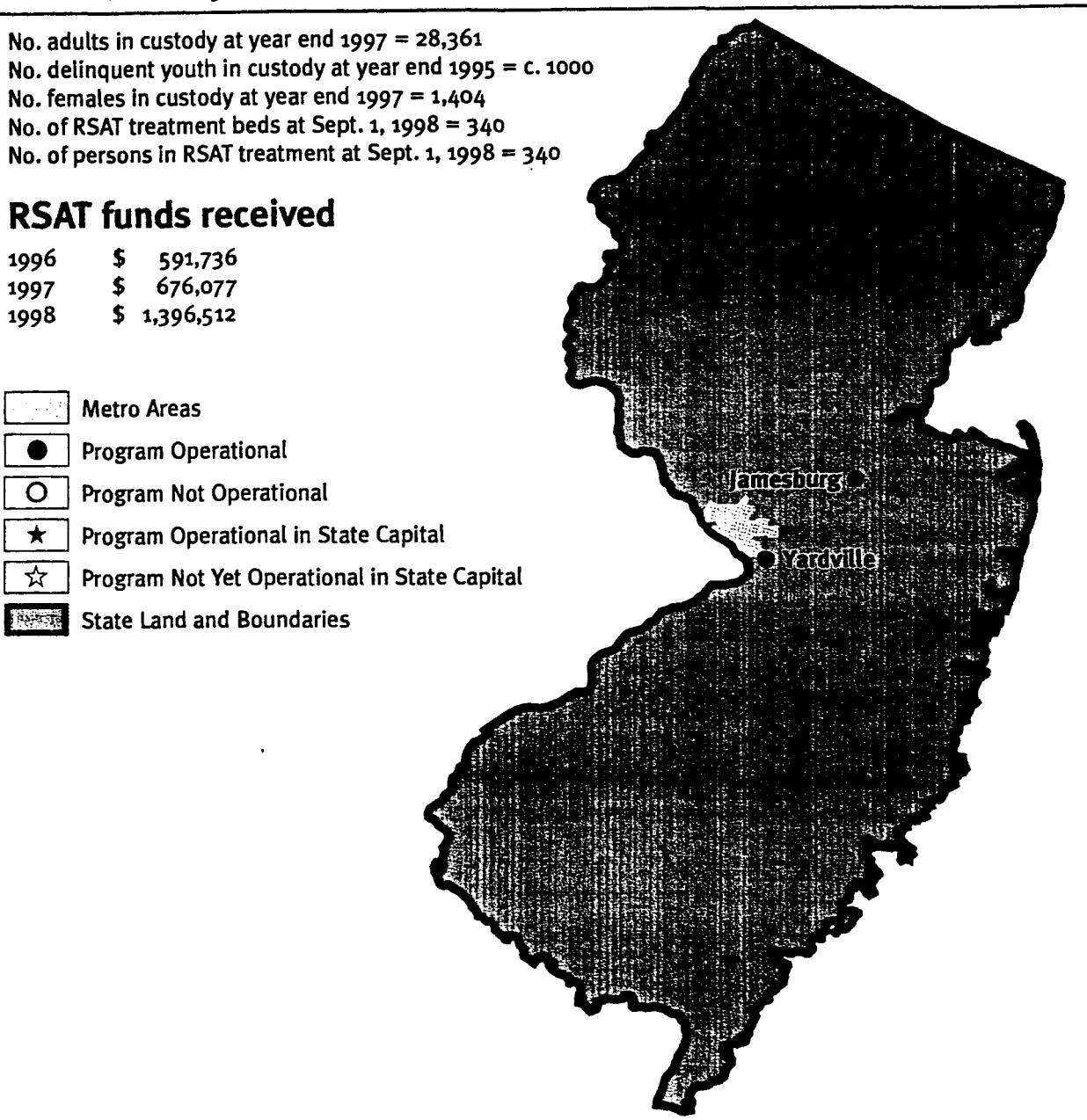
New Hampshire has one operational program, the Summit House/NHSP program, located at the New Hampshire State Prison in Concord. It employs 4 staff (FTE) providing a modified therapeutic community approach with cognitive behavioral components, utilizing a 12-step philosophy. It serves 48 male adult inmates. State official comment regarding the impact of RSAT: "[RSAT] enabled us to increase our capacity from 20 to 48 with the addition of 3 counselors. It allowed us to use some of the non-RSAT counselors to help in minimum security and halfway houses for offender transition to the community."

New Jersey RSAT Accomplishments

No. adults in custody at year end 1997 = 28,361
No. delinquent youth in custody at year end 1995 = c. 1000
No. females in custody at year end 1997 = 1,404
No. of RSAT treatment beds at Sept. 1, 1998 = 340
No. of persons in RSAT treatment at Sept. 1, 1998 = 340

RSAT funds received

1996	$ 591,736
1997	$ 676,077
1998	$ 1,396,512



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Contractor	FTE Staff	Operational
No Return Program	TC	Yardville	Garden State Correctional Facility	100	Male	Adult	Correctional Medical Services	8	Yes
First Step Program	TC	Yardville	Garden State Correctional Facility	188	Male	Adult	Correctional Medical Services	10	Yes
Alpha Meta	TC + CB	Jamesburg	New Jersey Training School for Boys	52	Male	Youth	none	4	Yes

New Jersey has three programs at two different sites. The No Return Program and the First Step Program are both located at the Garden State Correctional Facility in Yardville. Both programs are implemented by Correctional Medical Services. The No Return Program employs 8 staff (FTE) serving 100 male adult inmates, and the First Step Program employs 10 staff (FTE) serving 188 male adult inmates, both programs provide therapeutic community treatment. The third program, the Alpha Meta program at the New Jersey Training School for Boys in Jamesburg employs 4 staff (FTE) who provide therapeutic community treatment with elements of cognitive behavioral programming for 173 male youths (ages 13 – 18), 52 of whom are RSAT-funded. State official comment regarding the impact of RSAT: "Prior to RSAT, NJ DOC had 435 inpatient drug treatment beds. With RSAT our capacity has increased by 43%, and a 52-bed unit was identified for the specific purpose of developing a residential substance abuse treatment program. Treatment delivery appears more professional and stable. The DOC has been able, with the addition of RSAT funds, to adopt treatment model standardization. [With RSAT funding] substance abuse treatment is now offered to adolescent inmates at the NJ Training School for Boys with experienced counselors and within a proven treatment milieu."

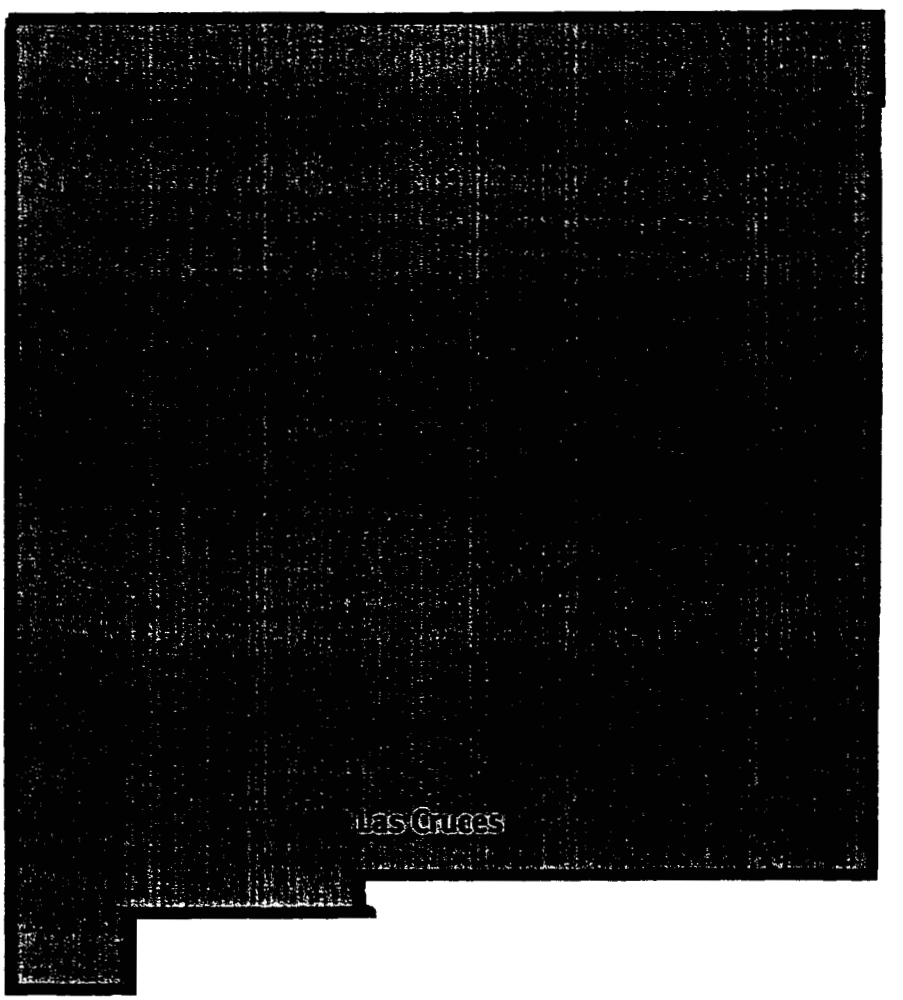
New Mexico RSAT Accomplishments

No. adults in custody at year end 1997 = 4,688
No. delinquent youth in custody at year end 1995 = c. 530
No. females in custody at year end 1997 = 374
No. of RSAT treatment beds at Sept. 1, 1998 = 45
No. of persons in RSAT treatment at Sept. 1, 1998 = 34

RSAT funds received

1996	$ 178,541
1997	$ 203,183
1998	$ 433,350

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
W.A.R. Paul Oliver Unit (POU) Therapeutic Community	TC + CB + 12-step programming	Las Cruces	Southern NM Correct'al Facility	45	Male	Adult	None	4	Yes

New Mexico has one operational program, the W.A.R. (We are Recovering) POU (Paul Oliver Unit) Therapeutic Community program, located at the Southern New Mexico Correctional Facility in Las Cruces. It employs 4 staff (FTE) providing therapeutic community with elements of cognitive behavioral programming and 12-step treatment to 45 male adult inmates. State official comment regarding the impact of RSAT: "[RSAT has enabled a] dramatic increase [in treatment capacity]. We opened a new TC at our Minimum Restrict Facility with the capacity for 45-50 inmates, hired dedicated treatment staff who provide intensive programming 6 hours a day for each TC member (it used to be 1.5 hours/day). [It enabled the] acquisition of treatment resources and the ability to implement program-directed urinalysis testing."

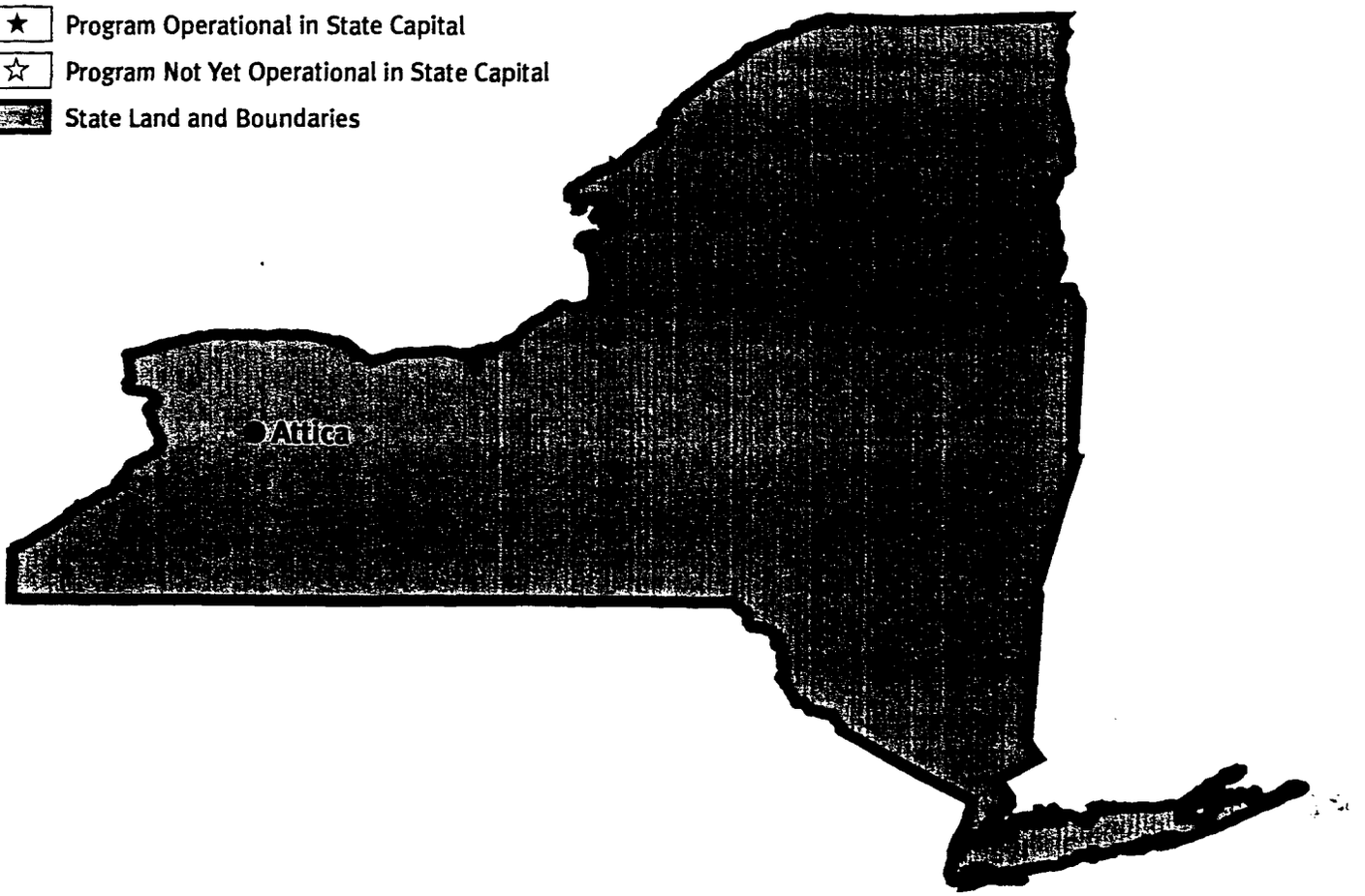
New York RSAT Accomplishments

No. adults in custody at year end 1997 = 70,026
No. delinquent youth in custody at year end 1995 = c. 2,300
No. females in custody at year end 1997 = 3,584
No. of RSAT treatment beds at Sept. 1, 1998 = 205
No. of persons in RSAT treatment at Sept. 1, 1998 = 205

RSAT funds received

1996	$ 1,416,014
1997	$ 1,510,245
1998	$ 3,139,838

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
RSAT	TC	Attica	Wyoming Correctional Facility	205	Male	Adult	None	9	Yes

New York has one operational RSAT program located in Attica at the Wyoming Correctional Facility. The 9 FTE staff provide therapeutic community treatment for 205 male adult inmates. State official comment regarding the impact of RSAT: "Plans are underway for the development of programs at several other sites which in total will serve more than 1,000 inmates."

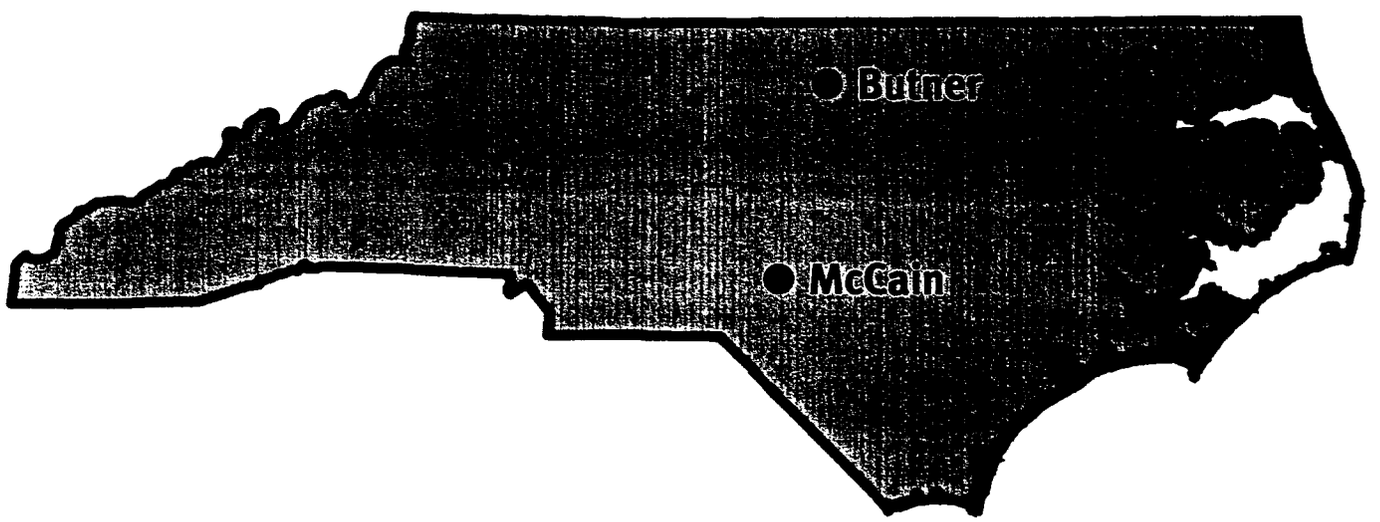
North Carolina RSAT Accomplishments

No. adults in custody at year end 1997 = 31,638
No. delinquent youth in custody at year end 1995 = c. 950
No. females in custody at year end 1997 = 1,864
No. of RSAT treatment beds at Sept. 1, 1998 = 125
No. of persons in RSAT treatment at Sept. 1, 1998 = 125

RSAT funds received

1996	$ 614,639
1997	$ 735,492
1998	$ 1,589,191

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
The SARGE Program	12-step treatment (Hazelden-Juvenile)	McCain	Sandhills Correctional Center	92	Male	Youth	None	9	Yes
The SARGE Program	12-step treatment (Hazelden-Juvenile)	Butner	Dylan Training School	33	Male	Youth	None	7	Yes

North Carolina has one program at two different sites. Both sites serve male youths. The SARGE Program located at the Sandhills Correctional Center is in McCain, NC. It employs 9 staff (FTE) who provide 92 male youth offenders with 12-step treatment (Hazelden- Juvenile). The SARGE program at the Dylan Training School in Butner employs 7 staff (FTE) who provide 33 male youth offenders with 12-step treatment (Hazelden- Juvenile). Both sites are at capacity. [Information obtained mid-April 1999.]

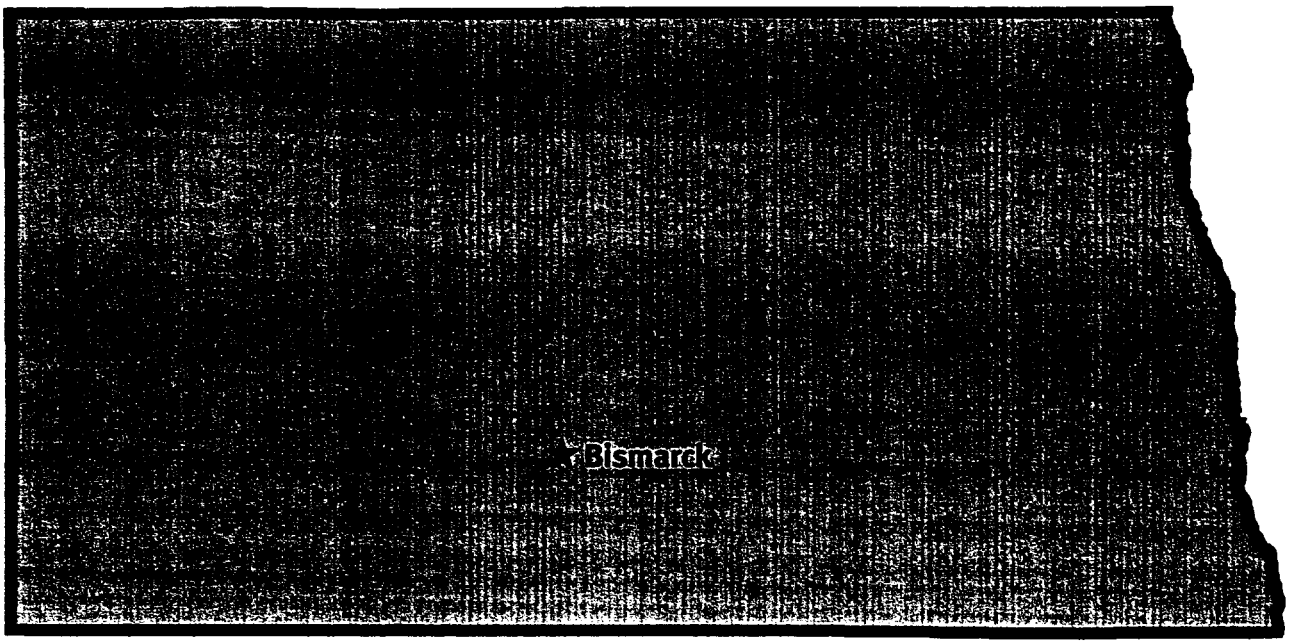
North Dakota RSAT Accomplishments

No. adults in custody at year end 1997 = 797
No. delinquent youth in custody at year end 1995 = c. 75
No. females in custody at year end 1997 = 62
No. of RSAT treatment beds at Sept. 1, 1998 = 60
No. of persons in RSAT treatment at Sept. 1, 1998 = 60

RSAT funds received

1996	$ 111,080
1997	$ 124,017
1998	$ 268,343

Metro Areas
● Program Operational
○ Program Not Operational
★ Program Operational in State Capital
☆ Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Long Term RSAT for State Prisoners	12-step treatment including CB, medicine wheel, non-religious-based self support programs, education programs and life skills	Bismarck	North Dakota State Penitentiary	60	Male	Adult	None	14	Yes

North Dakota has one operational program, the Long Term RSAT for State Prisoners program, located at the North Dakota State Penitentiary in Bismarck. It employs 14 staff (FTE) providing 12-step treatment including cognitive behavioral, medicine wheel, non- religious-based self-support programs, education programs and life skills treatment. It provides treatment for 60 male adult inmates. State official comment regarding the impact of RSAT: "[RSAT] made continuation of long-term treatment possible. Although the number of beds remained at 60, it would have gone to zero without the RSDAT funding."

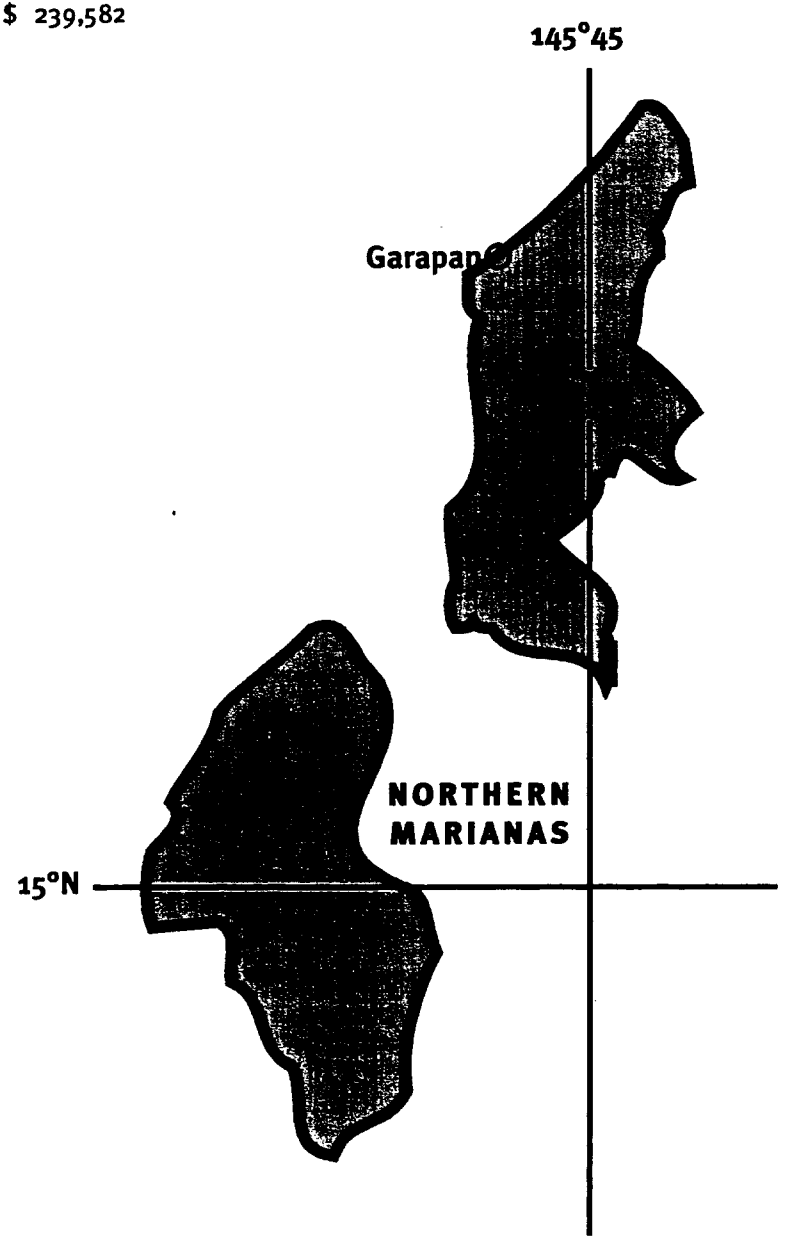
Northern Mariana Islands RSAT Accomplishments

No. adults in custody at year end 1997 = 63
No. delinquent youth in custody at year end 1995 =
No. females in custody at year end 1997 =
No. of RSAT treatment beds at Sept. 1, 1998 =
No. of persons in RSAT treatment at Sept. 1, 1998 =

RSAT funds received

1996	$ 100,590
1997	$ 112,289
1998	$ 239,582

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
RSAT									No

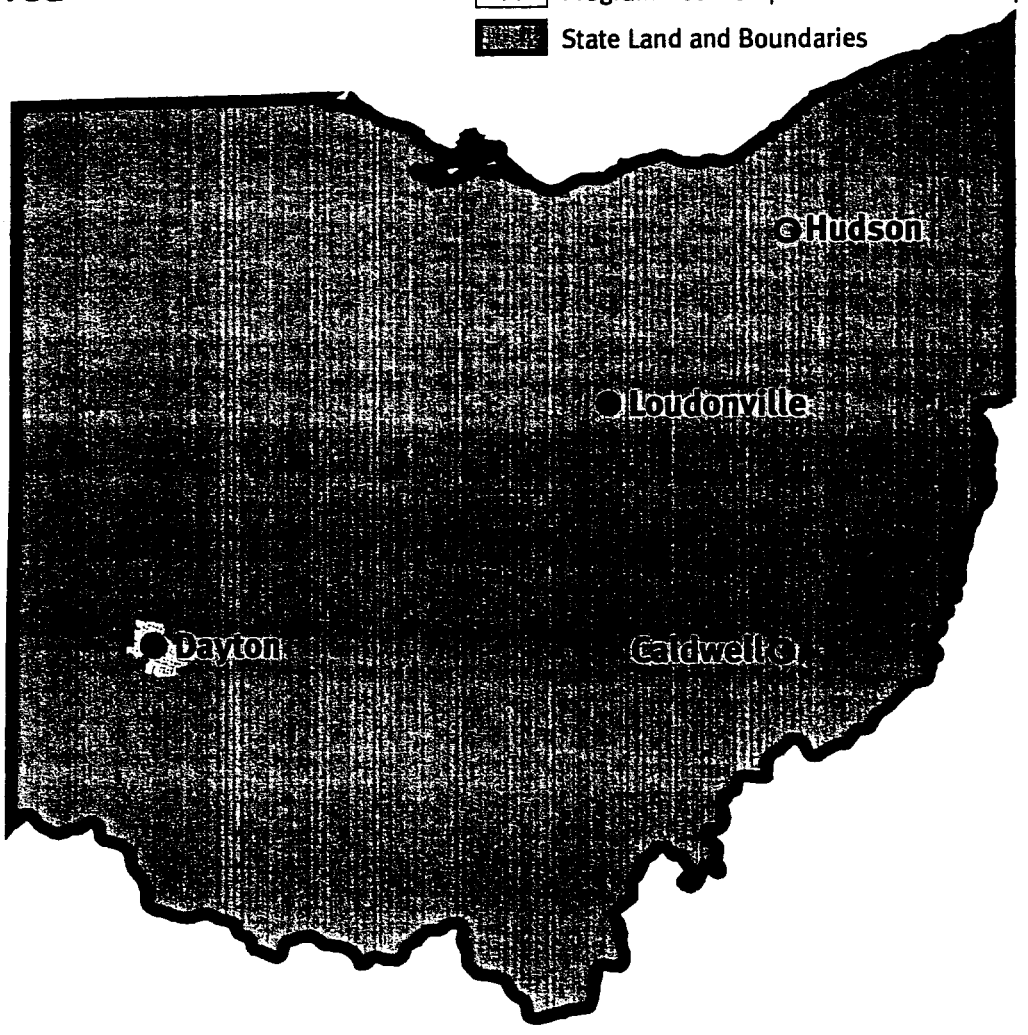
Northern Mariana Islands (Tinian and Saipan) plan to implement one program. At this time the facility is in the process of being constructed.

Ohio RSAT Accomplishments

No. adults in custody at year end 1997 = 48,002
No. delinquent youth in custody at year end 1995 = c.1700
No. females in custody at year end 1997 = 2,843
No. of RSAT treatment beds at Sept. 1, 1998 = 350
No. of persons in RSAT treatment at Sept. 1, 1998 = 350

RSAT funds received

1996	$ 928,595
1997	$ 1,033,645
1998	$ 2,209,736



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Monday TC	TC + elements of CB	Dayton	Monday Community Correctional Institution	30	Male	Adult	None	3	Yes
Noble Correctional TC	TC + elements of CB	Caldwell	Noble Correctional Institution	120	Male	Adult	None	2	No
Youth Development Ctr. TC	TC + elements of CB	Hudson	Youth Development Center	40	Male	Youth	None	9 planned	No
Mohican Youth Center	12-step + CB	Loudonville	Mohican Youth Ctr.	320	Male	Youth	None	10	Yes

Ohio has four programs, two are operational. The Monday TC program, located at the Monday Community Correctional Institution in Dayton employs 3 staff (FTE) and provides therapeutic community treatment with elements of cognitive behavioral for 30 male adult inmates; the second operational program, located at the Mohican Youth Center in Loudonville, employs 10 staff (FTE) and provides 12-step treatment with elements of cognitive behavioral programming for 320 male youth, ages 16-21. The two which are not yet operational are the Noble Correctional TC, located at the Noble Correctional Institution in Caldwell, which will provide therapeutic community treatment with elements of cognitive behavioral with plans to employ 2 staff (FTE) and serve 120 male adult inmates; and the Youth Development Center TC at the Youth Development Center in Hudson plans to employ 9 staff (FTE) serve 40 male youth and provide therapeutic community treatment with elements of cognitive behavioral programming. State official comment regarding the impact of RSAT: "none"

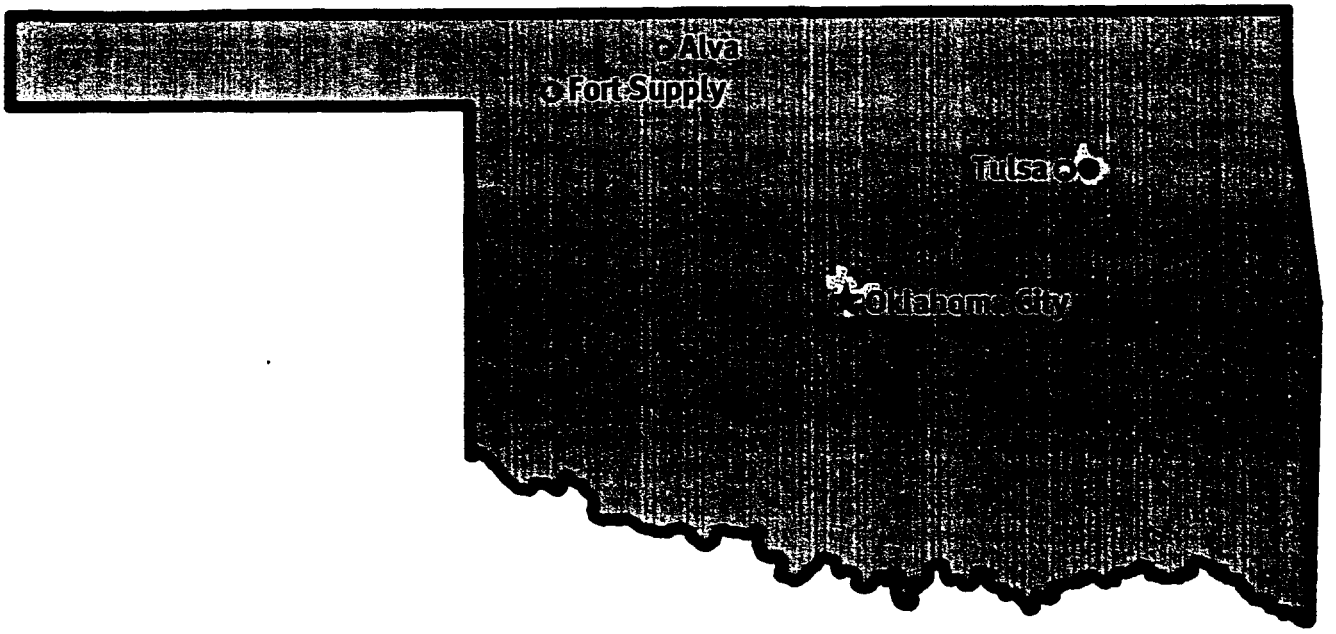
Oklahoma RSAT Accomplishments

No. adults in custody at year end 1997 = 20,542
No. delinquent youth in custody at year end 1995 = c.226
No. females in custody at year end 1997 = 2,053
No. of RSAT treatment beds at Sept. 1, 1998 = 20
No. of persons in RSAT treatment at Sept. 1, 1998 = 20

RSAT funds received

1996	$ 437,621
1997	$ 500,582
1998	$ 1,069,461

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
OJA, Male Tulsa Boys Home	TC + CB + 12-step	Tulsa	The Raider Institution	10	Male	Youth	none	9	Yes
OJA, Female Program	TC + CB + 12-step + Mental Health Counseling	Oklahoma City	Southwest Oklahoma Juvenile Treatment Center	10	Female	Youth	Drug Recovery Inc.	7	Yes
DOC, Tulsa Female		Tulsa	Dr. Eddie W. Warrior Correctional Center		Female	Adult	None		No
DOC, BTCC		Alva	Charles E. "Bill" Johnson Correctional Center		Male	Adult	None		No
DOC, William Key		Fort Supply	William S. Key Correctional Center		Male	Adult	None		No

Oklahoma has five programs at five different sites, but only two are operational thus far. One, the Office of Juvenile (OJA) Male Tulsa Boys Home program in Tulsa, employs 9 staff (FTE) providing a combination of therapeutic community treatment, cognitive behavioral programming, and 12-step treatment for 10 male youth; and the OJA, Female Program, located at the Southwest Oklahoma Juvenile Treatment Center in Oklahoma City, employs 7 staff (FTE) providing a combination of therapeutic community treatment, cognitive behavioral programming, 12-step treatment and Mental Health counseling implemented by the Drug Recovery Inc. for 10 female youth. The three which are not yet operational are the: DOC, Tulsa Female located at the Dr. Eddie W. Warrior Correctional Center in Tulsa; the DOC, BTCC located at the Charles E. "Bill" Johnson Correctional Center in Alva; and the DOC, William Key located at the William S. Key Correctional Center in Fort Supply. State official comment regarding the impact of RSAT: "[RSAT] funds allowed the office of Juvenile Affairs (OJA) to address issues specific to substance abuse. OJA has been able to increase bed space and reduce the number of female juvenile offenders on waiting lists for treatment. Before, OJA had to house juvenile offenders in 1 blanket treatment program. Now we can intensify and focus on substance abuse and behavior management."

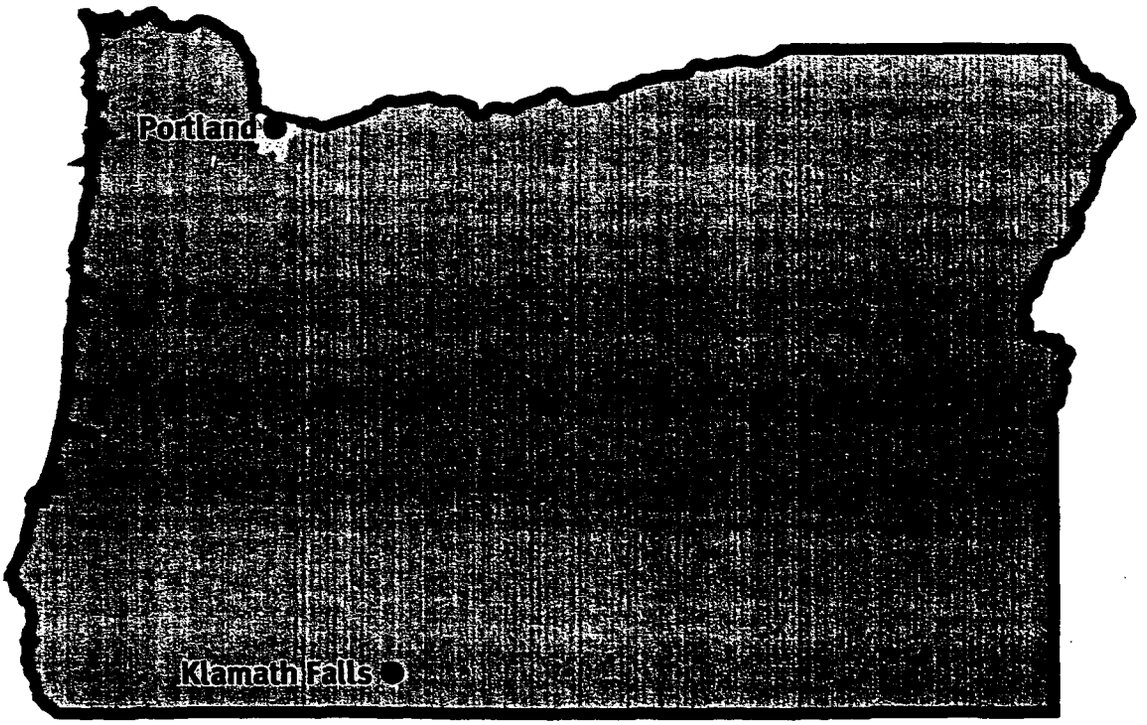
Oregon RSAT Accomplishments

No. adults in custody at year end 1997 = 7,999
No. delinquent youth in custody at year end 1995 = c. 620
No. females in custody at year end 1997 = 450
No. of RSAT treatment beds at Dec. 31, 1998 = 244
No. of persons in RSAT treatment at Dec. 31, 1998 = 235

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries

RSAT funds received

1996	$ 243,561
1997	$ 285,361
1998	$ 567,218



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Turning Point - Men's Unit	TC	Portland	Columbia River Correct. Institution (CRCI)	50	Male	Adult	ASAP Treatment Services of Portland	39 in total serve all 4 at CRCI	Yes
Turning Point - Women's Unit	TC	Portland	CRCI	50	Female	"	"		Yes
Bridgepoint	TC	Portland	CRCI	60	Male Dual Diag.	"	"		Yes
In Focus Women	TC	Portland	CRCI	60	Female Dual Diag.	"	Tualatin Valley Hlth. Svcs		Yes
Klamath Residential Sanction Treatment & Transitional Housing	CB	Klamath Falls	Klamath Residential	24, but only 14 are RSAT	70% f 30% m	Adult	Klamath Community Corrections	2.5	Yes

Oregon has five operational programs operating with RSAT funding at two sites. Four programs (Turning Point – Men's with 50 beds, Turning Point – Women's with 50 beds, Bridgepoint with 60 beds for male MICA adults, and In Focus with 60 beds for female MICA adults) are all located in the Columbia River Correctional Institution in Portland. Each is a modified Therapeutic Community. The four programs employ 39 staff (FTE). The fifth facility, Klamath Treatment employs 2.5 FTE personnel who provide cognitive skill training and tribal-sensitive treatment to 14 adults in a residential institution in Klamath Falls. State official comment regarding the impact of RSAT: "RSAT funding has allowed us to go up to 130 capacity at CRCI and we have added beds for dual diagnosed inmates. [In Klamath] we will close significant gaps in our nearly complete continuum of offender sanctions and treatment interventions."

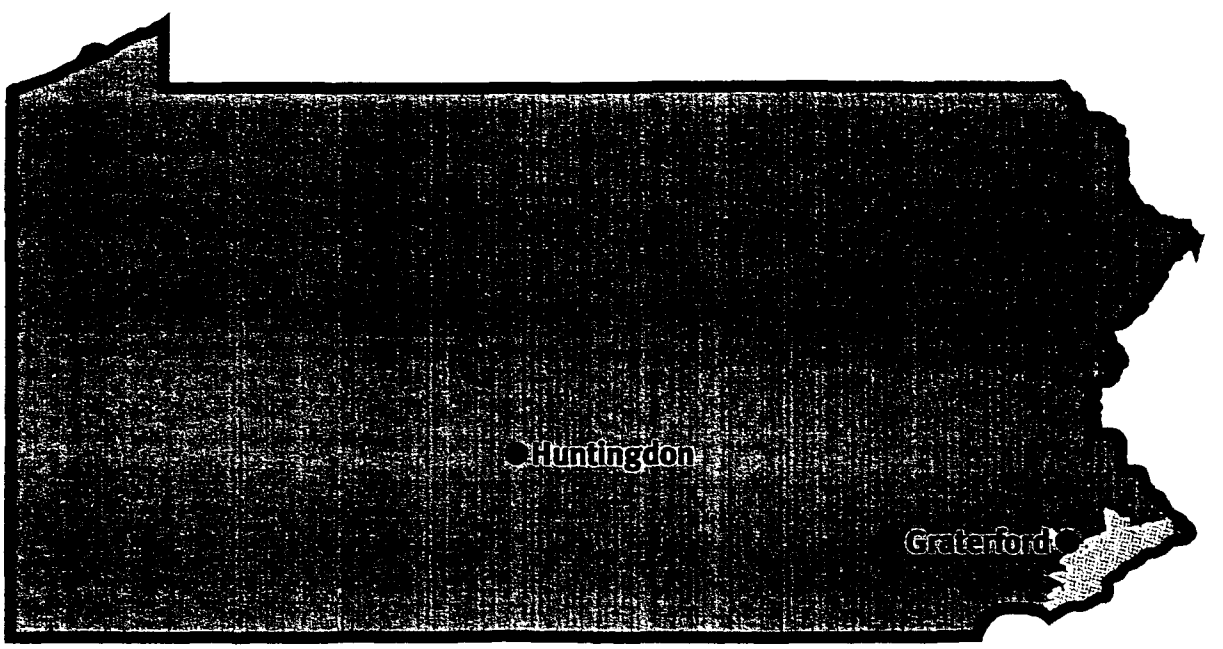
Pennsylvania RSAT Accomplishments

No. adults in custody at year end 1997 = 34,964
No. delinquent youth in custody at year end 1995 = c. 700
No. females in custody at year end 1997 = 1,414
No. of RSAT treatment beds at Sept. 1, 1998 = 120
No. of persons in RSAT treatment at Sept. 1, 1998 = 115

RSAT funds received

1996	$ 672,781
1997	$ 802,033
1998	$ 1,686,078

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
RSAT SCI Graterford	TC + CB + 12-step	Graterford	State Correctional Institution at Graterford	60	Male	Adult	Gateway Rehabilitation Center	2	Yes
RSAT SCI Huntingdon	TC	Huntingdon	State Correctional Institution at Huntingdon	60	Male	Adult	None	3	Yes

Pennsylvania has two operational programs at two sites. One is at the State Correctional Institution at Graterford in Graterford. It employs 2 staff (FTE) providing a combination of therapeutic community, cognitive behavioral programming and 12-step treatment implemented by the Gateway Rehabilitation Center for 60 male adult inmates. The second is at the State Correctional Institution at Huntingdon employing 3 staff (FTE) who provide therapeutic community treatment for 60 male adult inmates. State official comment regarding the impact of RSAT: "A total of 100 new treatment slots [have been] created as a result of RSAT funding. This funding will provide a direct treatment program for technical parole violators."

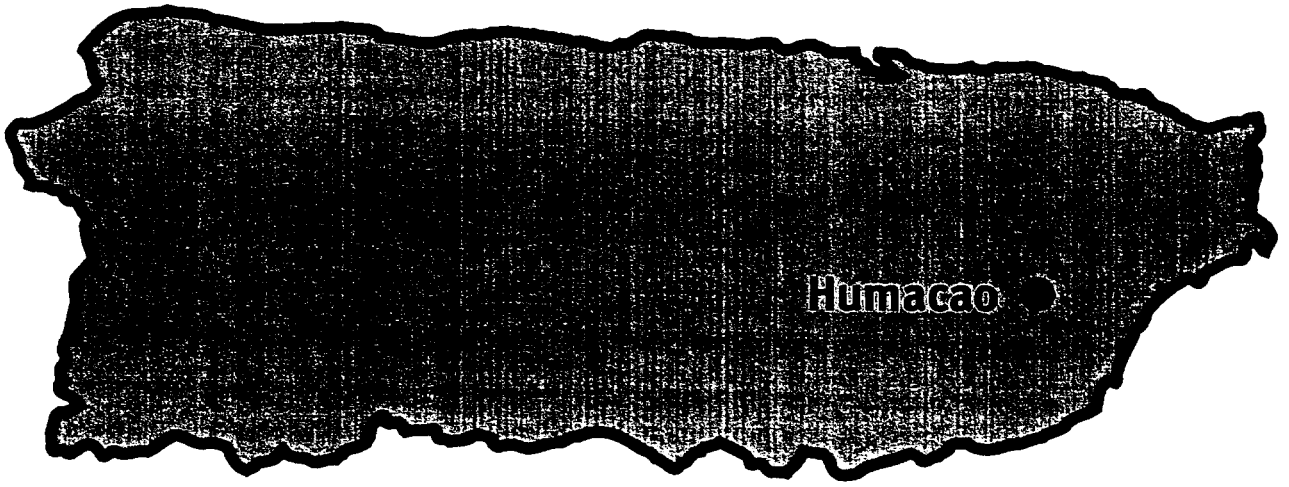
Puerto Rico RSAT Accomplishments

No. adults in custody at year end 1997 = 14,716
No. delinquent youth in custody at year end 1995 = c.
No. females in custody at year end 1997 =
No. of RSAT treatment beds at Sept. 1, 1998 = 100
No. of persons in RSAT treatment at Sept. 1, 1998 = 98

RSAT funds received

1996	$ 265,753
1997	$ 287,316
1998	$ 603,826

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Proyecto Hombre	CB	Humacao	Correctional Facility	100	Male	Adult	None	9 (est)	Yes

Puerto Rico has one operational RSAT program, the Proyecto Hombre program, located at the Correctional Facility in Humacao. It employs 9 staff (FTE) providing cognitive behavioral treatment for 100 male adult inmates. Official comment regarding the impact of RSAT: "RSAT paved the way to more treatment programs for inmates, and also provided better facilities. Before RSAT (there were) no beds, now 100 beds."

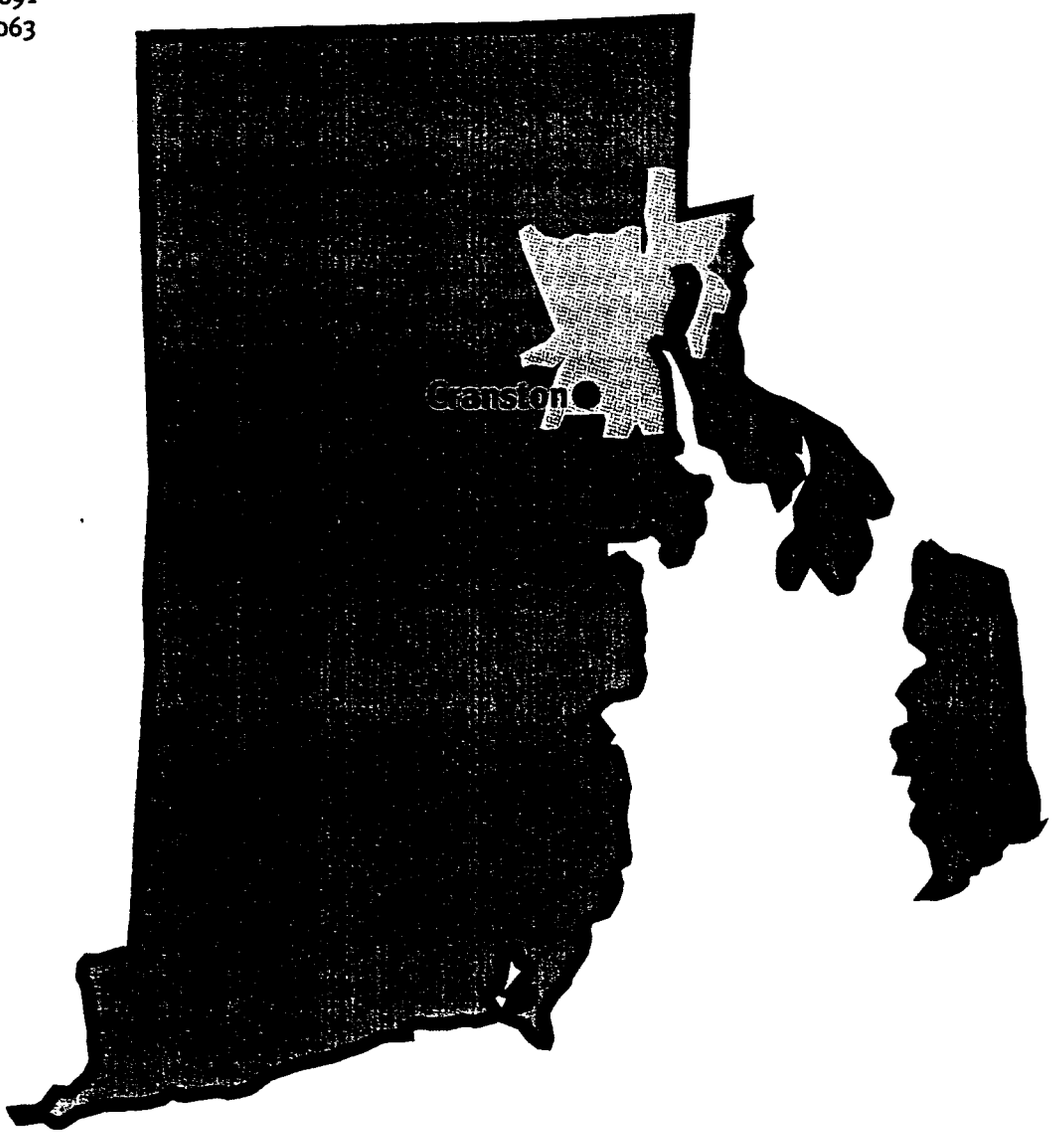
Rhode Island RSAT Accomplishments

No. adults in custody at year end 1997 = 3,371
No. delinquent youth in custody at year end 1995 = c. 149
No. females in custody at year end 1997 = 213
No. of RSAT treatment beds at Sept. 1, 1998 = 52
No. of persons in RSAT treatment at March 31, 1998 = 51

RSAT funds received

1996	$ 135,559
1997	$ 150,691
1998	$ 321,063

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Pre-Release Correctional Recovery Academy	CB + Modified TC also utilizing the "Men's Work" series by Hazelden	Cranston	Minimum Security	52	Male	Adult	Spectrum Health Systems Inc.	5	Yes

Rhode Island has one operational RSAT- funded program, the Pre-Release Correctional Recovery Academy program, located at the Minimum Security I in Cranston. It employs 5 staff (FTE) providing cognitive behavioral programming with a modified therapeutic community approach serving 52 male adult inmates. It also utilizes the "Men's Work" series published by Hazelden.

The program is implemented by Spectrum Health Systems Inc. State official comment regarding the impact of RSAT: " Prior to RSAT there was no residential substance abuse program. [So far we have gotten] good urinalysis results and institutional infractions have been reduced."

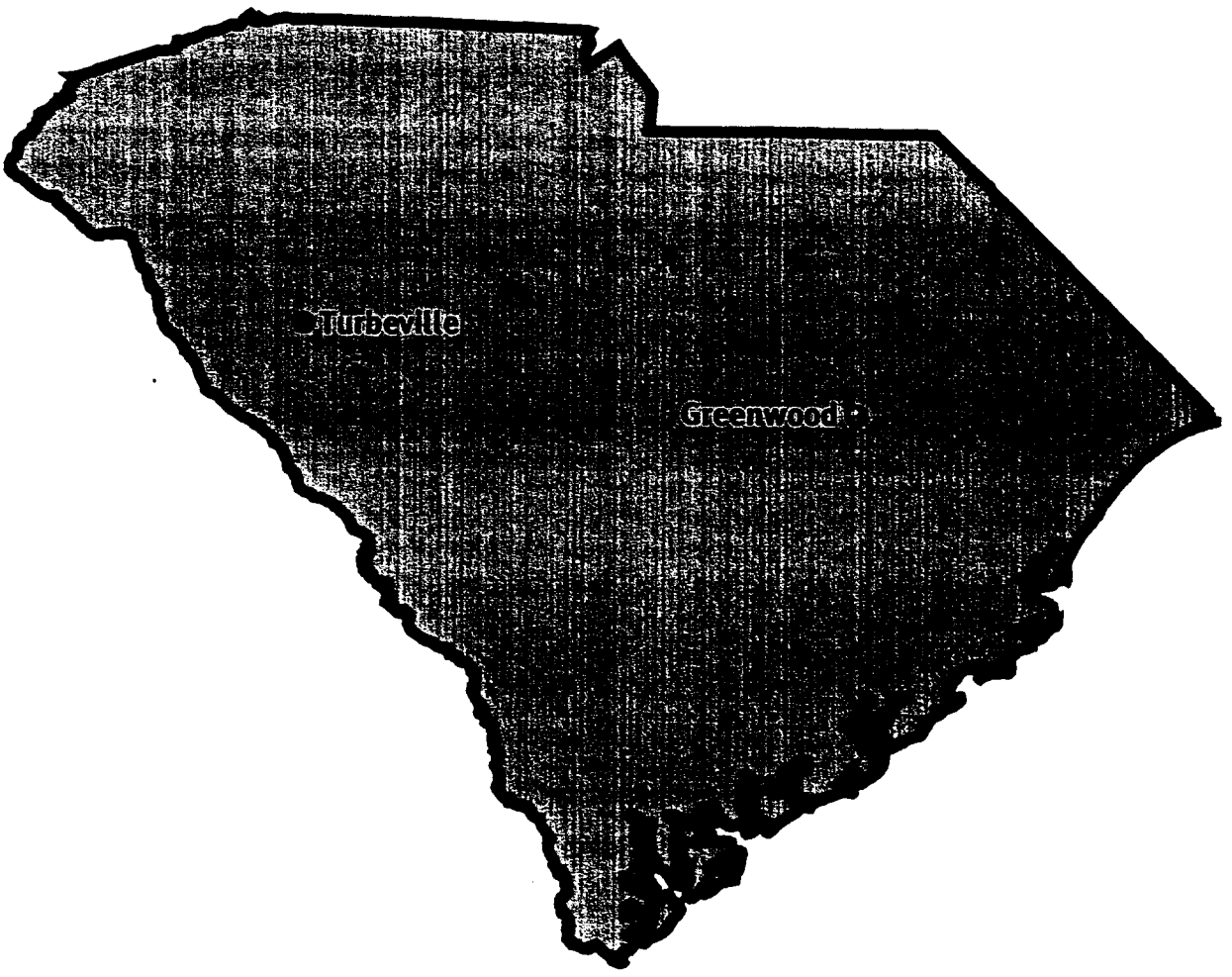
South Carolina RSAT Accomplishments

No. adults in custody at year end 1997 = 21,173
No. delinquent youth in custody at year end 1995 = c. 1,000
No. females in custody at year end 1997 = 1,302
No. of RSAT treatment beds at Sept. 1, 1998 = 136
No. of persons in RSAT treatment at Sept. 1, 1998 = 136

RSAT funds received

1996	$ 473,667
1997	$ 534,789
1998	$ 1,114,960

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Turbeville ATU (Addictions Treatment Unit)	Modified TC using CB	Turbeville	Turbeville Correctional Institution	136	Male	Youth	None	16	Yes
Leath ATU	TC + CB	Greenwood	Leath Correctional Institution - Women		Female	Adult	None		No

South Carolina has two programs, but only one is operational. The Turbeville ATU program which is operational is located at the Turbeville Correctional Institution in Turbeville employing 16 staff (FTE) providing a modified therapeutic community using cognitive behavioral programming elements for 136 male youth. The Leath Addictions Treatment Unit is not yet operational.

Planned is a unit for female inmates at Leath Correctional Institution – Women in Greenwood. State official comment regarding the impact of RSAT: "[RSAT has given us] 136 more treatment beds for young offenders, more emphasis on cognitive restructuring, criminal thinking and behavior-driven, performance-driven structure for inmates."

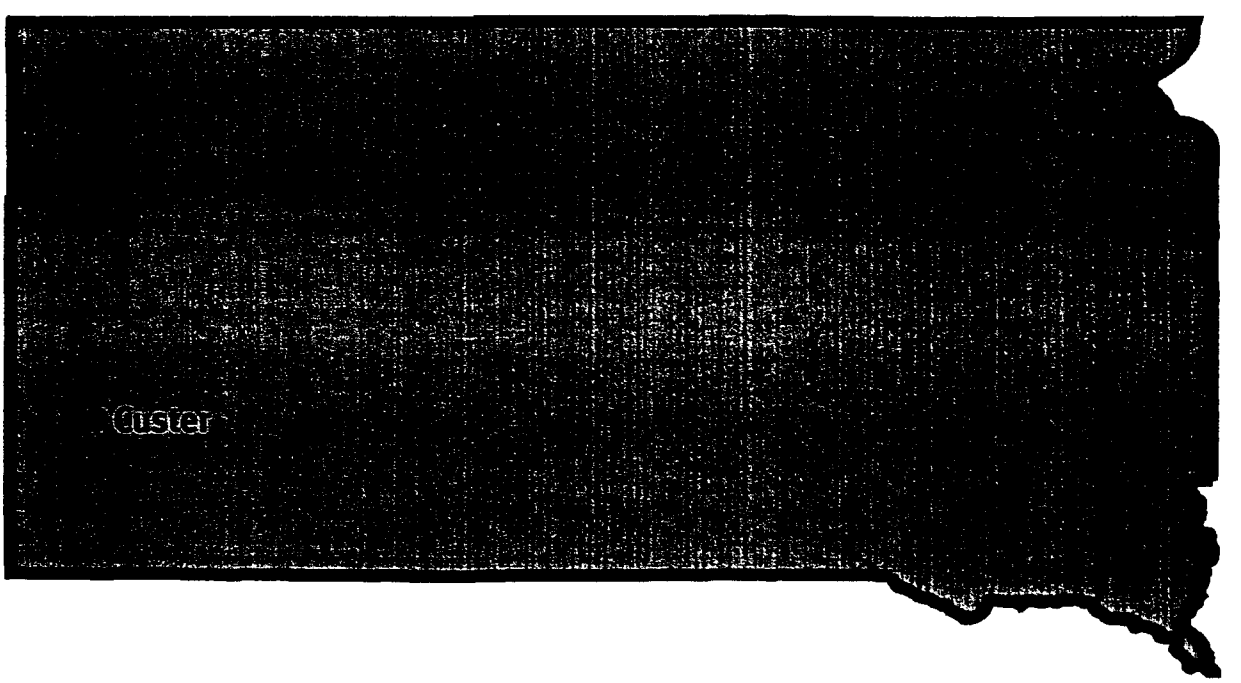
South Dakota RSAT Accomplishments

No. adults in custody at year end 1997 = 2,239
No. delinquent youth in custody at year end 1995 = c. 160
No. females in custody at year end 1997 = 169
No. of RSAT treatment beds at Sept. 1, 1998 = 24
No. of persons in RSAT treatment at Sept. 1, 1998 = 24

RSAT funds received

1996	$ 133,561
1997	$ 152,707
1998	$ 328,368

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Lamont Youth Development Center	TC + elements with CB	Custer	Custer Youth Correctional Center	24	Female	Youth	None	2	Yes

South Dakota has one operational program, the Lamont Youth Development Center program, for female adolescents. It is located at the Custer Youth Correctional Center in Custer, and employs 2 staff providing therapeutic community treatment with elements of cognitive behavioral programming. State official comment regarding the impact of RSAT: "[RSAT] created 24 residential chemical dependency treatment slots with a 20 hour/week program, [allowing us] to conduct assessments on all juvenile females entering the juvenile correctional system, [and to do] drug testing upon entry and during treatment."

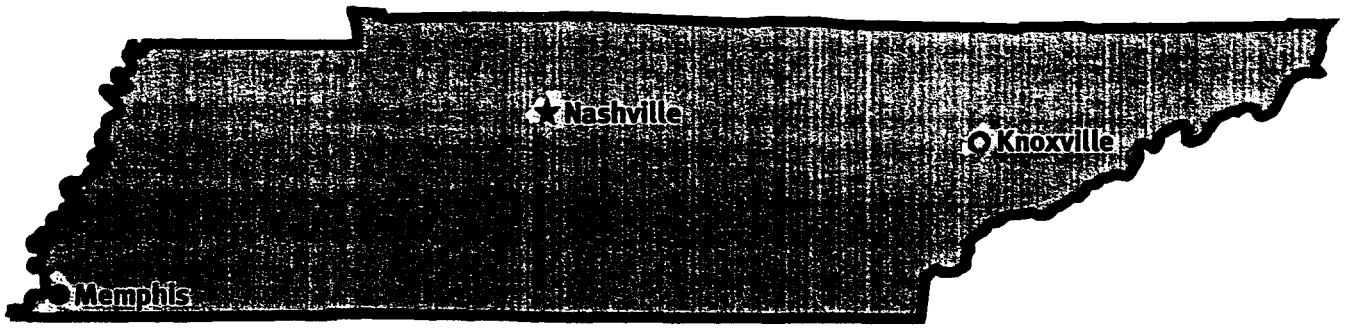
Tennessee RSAT Accomplishments

No. adults in custody at year end 1997 = 16,659
No. delinquent youth in custody at year end 1995 = c. 750
No. females in custody at year end 1997 = 798
No. of RSAT treatment beds at Sept. 1, 1998 = 228
No. of persons in RSAT treatment at Sept. 1, 1998 = 228

RSAT funds received

1996	$ 386,282
1997	$ 429,317
1998	$ 898,151

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries

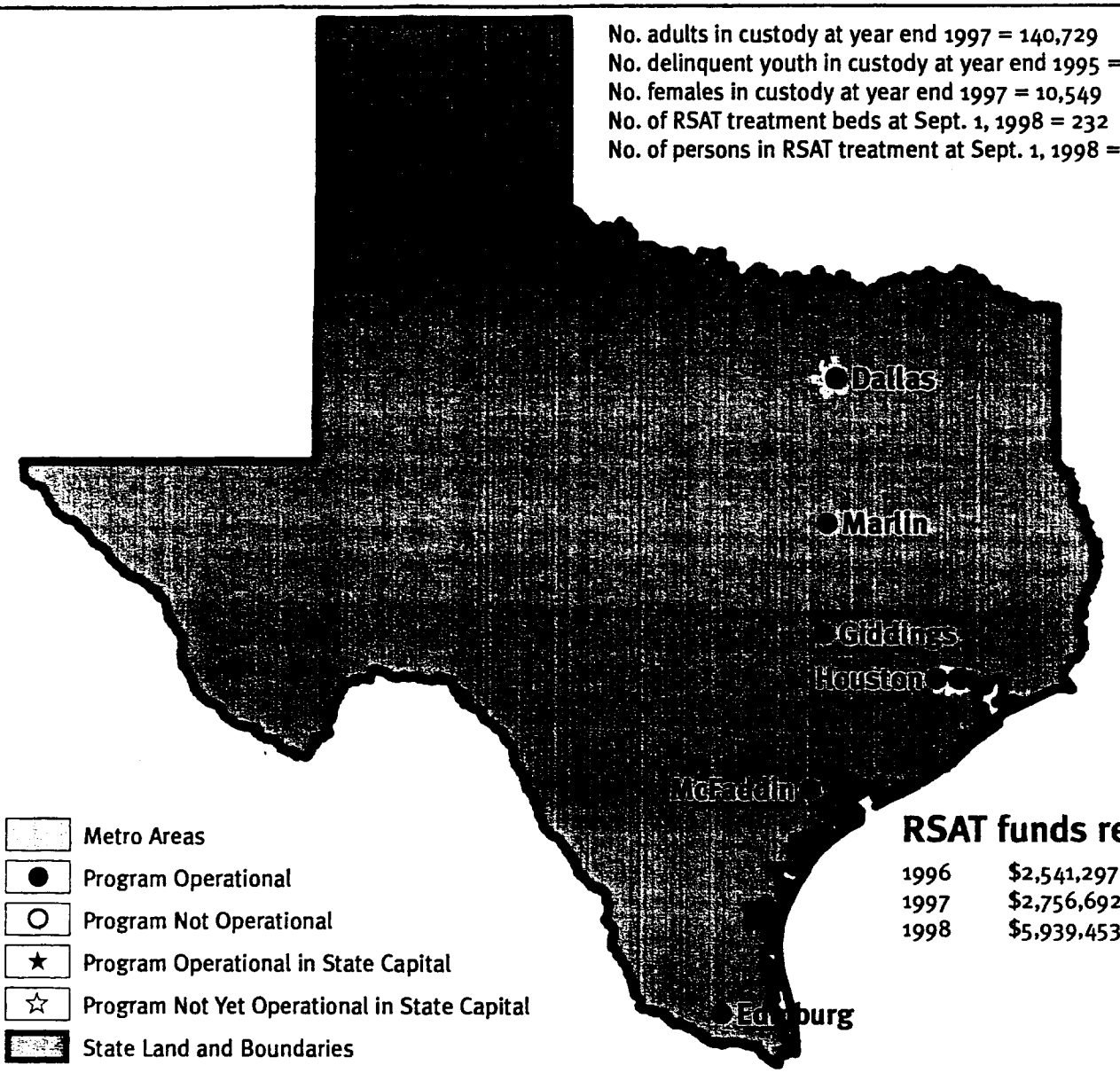


Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Women of Distinction Treatment Program	TC	Nashville	Tennessee Prison for Women	128	Female	Adult	Correctional Counseling Inc.	5	Yes
In Roads	TC	Nashville	Davidson County Community Corrections	467 beds in total 7 programs	Male	Adult	None	Varies	Yes
Shelby County RSAT	TC	Memphis	Shelby County Community Corrections		Male	Adult	None	Varies	Yes
Washington County RSAT		Knoxville	Washington County Community Corrections		Male	Adult	Frontier Mental Health		No
DOC 4 prison RSAT programs					Male	Adult	None		No

Tennessee has 8 different programs, only three are operational. One, the Women of Distinction Treatment Program located at the Tennessee Prison for Women in Nashville employs 5 staff (FTE) providing therapeutic community treatment with elements of cognitive behavioral programming for 128 female adult inmates. Both the In Roads program located at the Davidson County Community Corrections facility in Nashville and the Shelby County RSAT located at the Shelby County Community Corrections facility in Memphis provide therapeutic community treatment for male adults. The programs which are not yet operational are the Washington County RSAT program and four Tennessee DOC prison RSAT programs whose sites have not yet been designated. At the end of implementation all 7 programs will be serving a total of 467 male adults. State official comment regarding the impact of RSAT: " Prior to RSAT funding dedicated housing units where professional-level individual, group and family counseling were provided didn't exist. A cognitive-behavior component was lacking, and treatment efforts were not integrated in a "whole personality" approach. RSAT allowed for implementation of a multi-faceted professionally conducted intensive approach to therapy encompassing the inmates "whole personality" and work toward changing underlying processes leading to criminal activity and substance abuse. Therapeutic intervention for this population prior to RSAT consisted of self-help AA/NA. There were no professionally based integrated and intensive treatment services available for the inmate population. RSAT funding has created a dedicated housing unit for an intensive TC at Tennessee Prison for Women with a maximum of 128 inmates to be served annually."

Texas RSAT Accomplishments

No. adults in custody at year end 1997 = 140,729
No. delinquent youth in custody at year end 1995 = c. 1,900
No. females in custody at year end 1997 = 10,549
No. of RSAT treatment beds at Sept. 1, 1998 = 232
No. of persons in RSAT treatment at Sept. 1, 1998 = 202



RSAT funds received

1996	$2,541,297
1997	$2,756,692
1998	$5,939,453

Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Texas Youth Commission Chemical Dependency Treatment Program	TC	Giddings, McFaddin, Marlin, Edinburg	Giddings Facility; McFaddin Ranch; Marlin Facility; Evans Facility	64	Both	Youth	None	49	Yes
Harris County- RSAT for Harris Co. Juveniles	Cognitive Behavioral	Houston	Harris County - Juvenile Probation Department	12	Both	Youth	None	6	Yes
New Choices	Cognitive Behavioral	Houston	Harris County - Sheriff's Department	140	Both	Adult	None	6	Yes
Dallas County- Resident Drug Treatment Center	TC	Dallas	Dallas County - Juvenile Department	16	Both	Youth	None	4	Yes

Texas has four operational programs at seven different sites. (1) The Texas Youth Commission Chemical Dependency Treatment Program is located at four sites: the Giddings Facility in Giddings, the McFaddin Ranch in McFaddin, the Marlin Facility in Marlin, and the Evans Facility in Edinburg. These sites employ a total of 49 staff (FTE) providing therapeutic community treatment for 64 male and female youth inmates. (2) The Harris County New Choices program is located at the Harris County Sheriff's Department in Houston. It employs 6 staff (FTE) providing cognitive behavioral treatment for 140 male and female adult inmates. (3) The Harris County- RSAT for Harris County Juveniles program is located at the Harris County Juvenile Probation Department in Houston. It employs 6 staff (FTE) for 12 male and female youth inmates who receive cognitive behavioral treatment. (4) The Dallas County Resident Drug Treatment Center program is located at the Dallas County Juvenile Department in Dallas. It employs 4 staff (FTE) providing therapeutic community treatment for 16 male and female youth inmates.

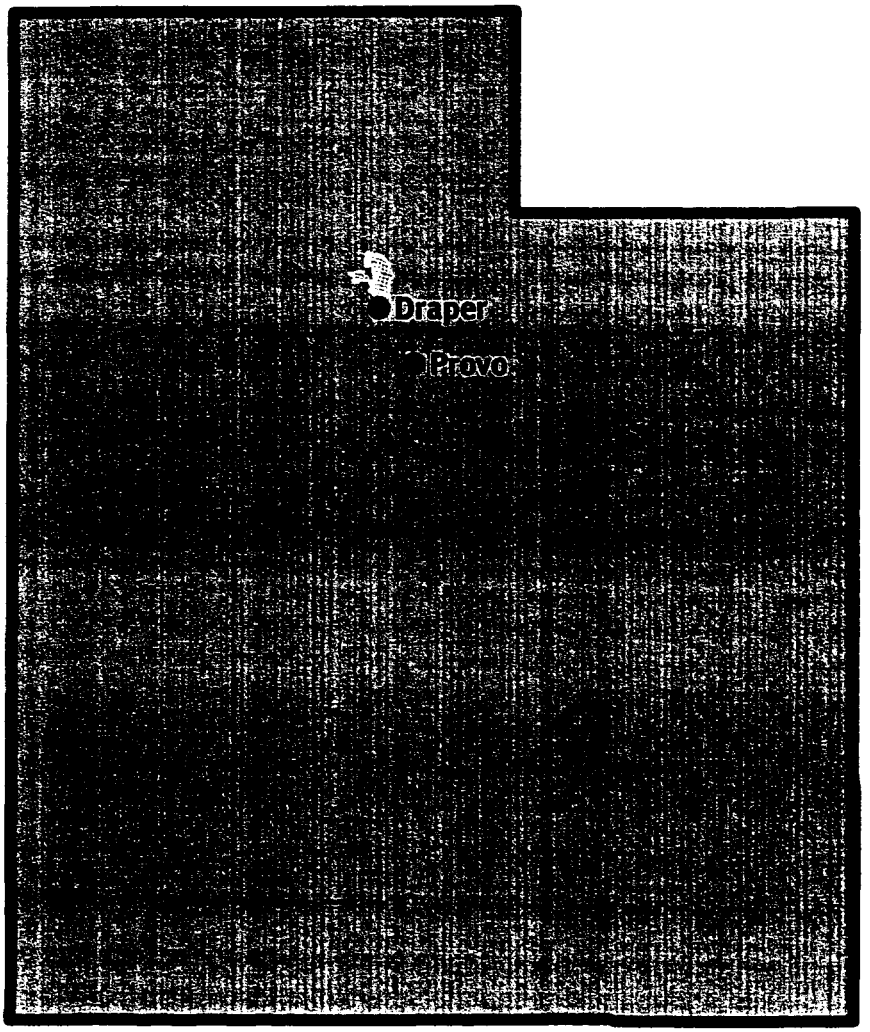
Utah RSAT Accomplishments

No. adults in custody at year end 1997 = 4,284
No. delinquent youth in custody at year end 1995 = c. 401
No. females in custody at year end 1997 = 212
No. of RSAT treatment beds at Sept. 1, 1998 = 176
No. of persons in RSAT treatment at Sept. 1, 1998 = 157

RSAT funds received

1996	$162,228
1997	$185,163
1998	$410,893

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
Con-Quest	TC (using recommended program by the Federal Bureau Prisons "Drug Abuse Treatment Handbook"	Draper	Utah State Prison	144	Male	Adults	None	6	Yes
On Unit Treatment (O.U.T.)	CB with elements of 12-step	Provo	Utah County Security Center	32	Male	Adult	None	3.5	Yes

Utah has two operational programs at two different sites. One, the Con-Quest program, located at the Utah State Prison in Draper employing 6 staff (FTE) serving 144 male adult inmates providing therapeutic community treatment with elements of cognitive behavioral programming (using the recommended program by the Federal Bureau Prisons entitled Drug Abuse Treatment Handbook). The second, On Unit Treatment (O.U.T.) located at the Utah County Security Center in Provo, employs 3.5 staff (FTE) providing cognitive behavioral programming with elements of 12-step treatment for 32 male adult inmates.

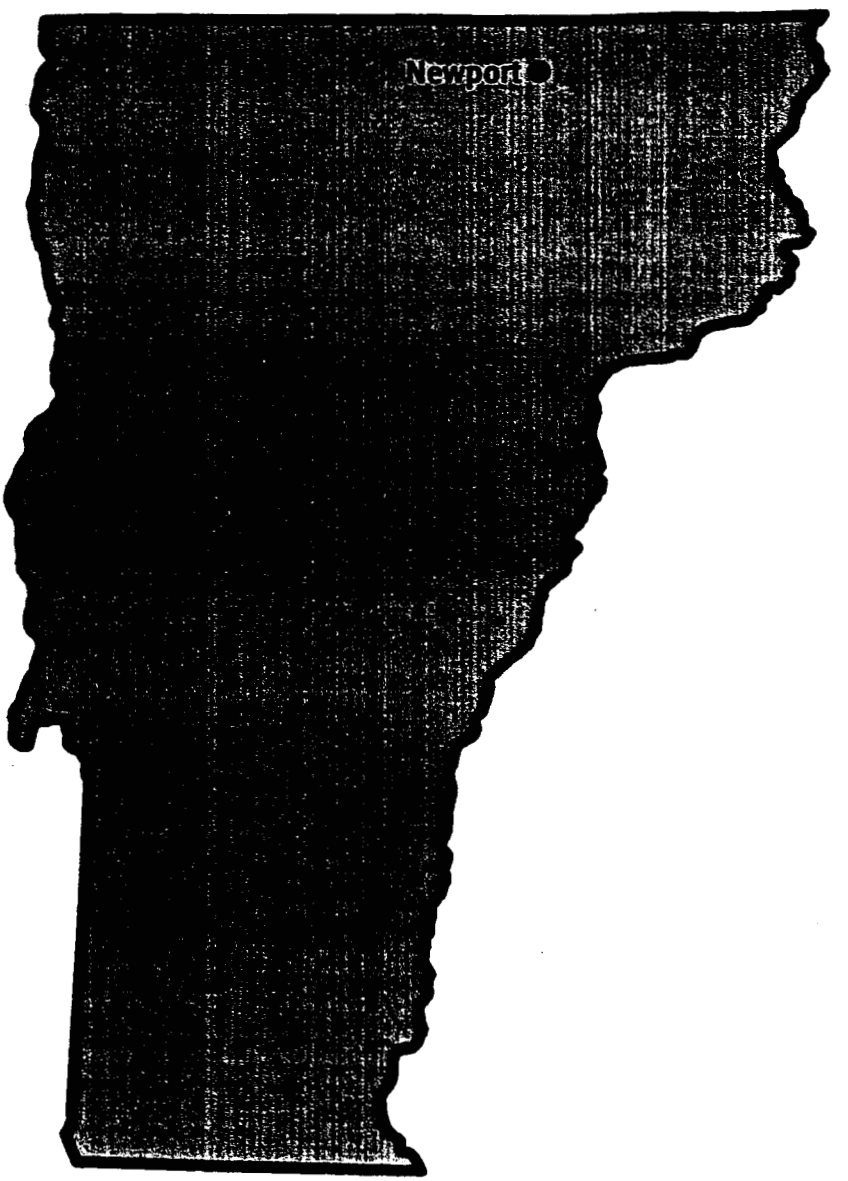
Vermont RSAT Accomplishments

No. adults in custody at year end 1997 = 1,270
No. delinquent youth in custody at year end 1995 = c. 25
No. females in custody at year end 1997 = 53
No. of RSAT treatment beds at Sept. 1, 1998 = 60
No. of persons in RSAT treatment at Sept. 1, 1998 = 44

RSAT funds received

1996	$114,481
1997	$128,110
1998	$274,938

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Pathways	TC + CB	Newport	Northern State Correctional Facility	60	Male	Adult	None	2	Yes

Vermont has one operational program, Pathways, located at the Northern State Correctional Facility in Newport. It employs 2 staff (FTE) and provides therapeutic community treatment utilizing cognitive behavioral programming for 60 male adult inmates.

Virgin Islands RSAT Accomplishments

No. adults in custody at year end 1997 = 417
No. delinquent youth in custody at year end 1995 = c.
No. females in custody at year end 1997 =
No. of RSAT treatment beds planned = 12
No. of persons in RSAT treatment at Sept. 1, 1998 =

RSAT funds received

1996	$103,856
1997	$115,751
1998	$252,397

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries

Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
RSAT		St. Croix	Golden Grove Adult Correctional Center	12	Male	Adult	Planned	0	No

Virgin Islands plans to implement a modified therapeutic community treatment program for 12 male adult inmates at the Golden Grove Adult Correctional Center on St. Croix, VI.

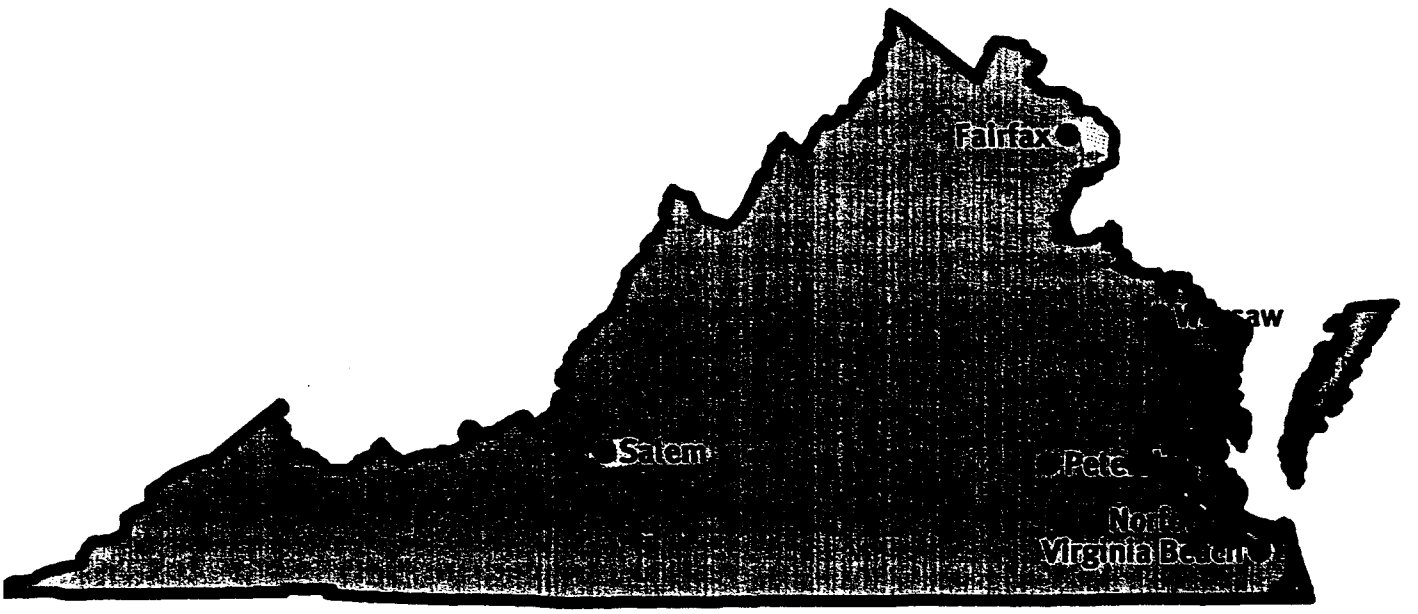
Virginia RSAT Accomplishments

No. adults in custody at year end 1997 = 28,385
No. delinquent youth in custody at year end 1995 = c. 1,000
No. females in custody at year end 1997 = 1,710
No. of RSAT treatment beds at Sept. 1, 1998 = 116
No. of persons in RSAT treatment at Sept. 1, 1998 = 89

RSAT funds received

1996	$624,093
1997	$697,946
1998	$1,434,372

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con-tractor	FTE Staff	Opera-tional
True Freedom	Integrated Dual-Diagnosis Model + CB + 12-step	Fairfax	Adult Detention Center	8	male	adult	None	3	yes
The Fork in the Road	TC + CB + 12-step	Petersburg	Riverside Regional Jail	20- M 10- F	Both	Adult	None	3	yes
Blue Ridge Community Services; Phases	TC	Salem	Roanoke County/ Salem Jail Facility	30	Both	Adult	None	3	Yes
Changing Times	Equal amounts of CB and 12-step within a TC	Warsaw	Northern Neck Regional Jail	10	Male	Adult	None	3	Yes
Jail Treatment Services	TC	Virginia Beach	Virginia Beach Correctional Jail	14	Female	Adult	None	2	Yes
Bridges to Freedom	TC	Norfolk	Norfolk City Jail	24	Female	Adult	None	3	Yes

Virginia has six operational programs at six different sites. Virginia awarded one RSAT grant to the Department of Mental Health Mental Retardation and Substance Abuse. The Department, in turn, subgranted to six local Community Service Boards for services to inmates in regional jails. The six programs are: 1) The True Freedom program, a dual diagnosis program, located at the Adult Detention Center in Fairfax employing 3 staff (FTE) utilizing an integrated dual-diagnosis model with elements of cognitive behavioral programming and 12-step treatment for 8 male adult inmates. 2) The Fork in the Road program, located at the Riverside Regional Jail in Petersburg employs 3 staff (FTE) providing therapeutic community treatment with elements of cognitive behavioral and 12-step treatment for 20 male and 10 female adult inmates. 3) The Blue Ridge Community Services Phases program, located at the Roanoke County/Salem Jail Facility in Salem employs 3 staff (FTE) providing therapeutic community treatment for 30 female and male adult inmates. 4) The Changing Times program, located at the Northern Neck Regional Jail in Warsaw, employs 3 staff (FTE) providing equal amounts of cognitive behavioral and 12-step treatment within a therapeutic community) for 10 male adult inmates. 5) The Jail Treatment services program located at the Virginia Beach Correctional Jail employs 2 staff (FTE) providing therapeutic community treatment for 14 female adult inmates. 5) The Bridges to Freedom program, located at the Norfolk City Jail in Norfolk, employs 3 staff (FTE) providing therapeutic community treatment for 24 female adult inmates.

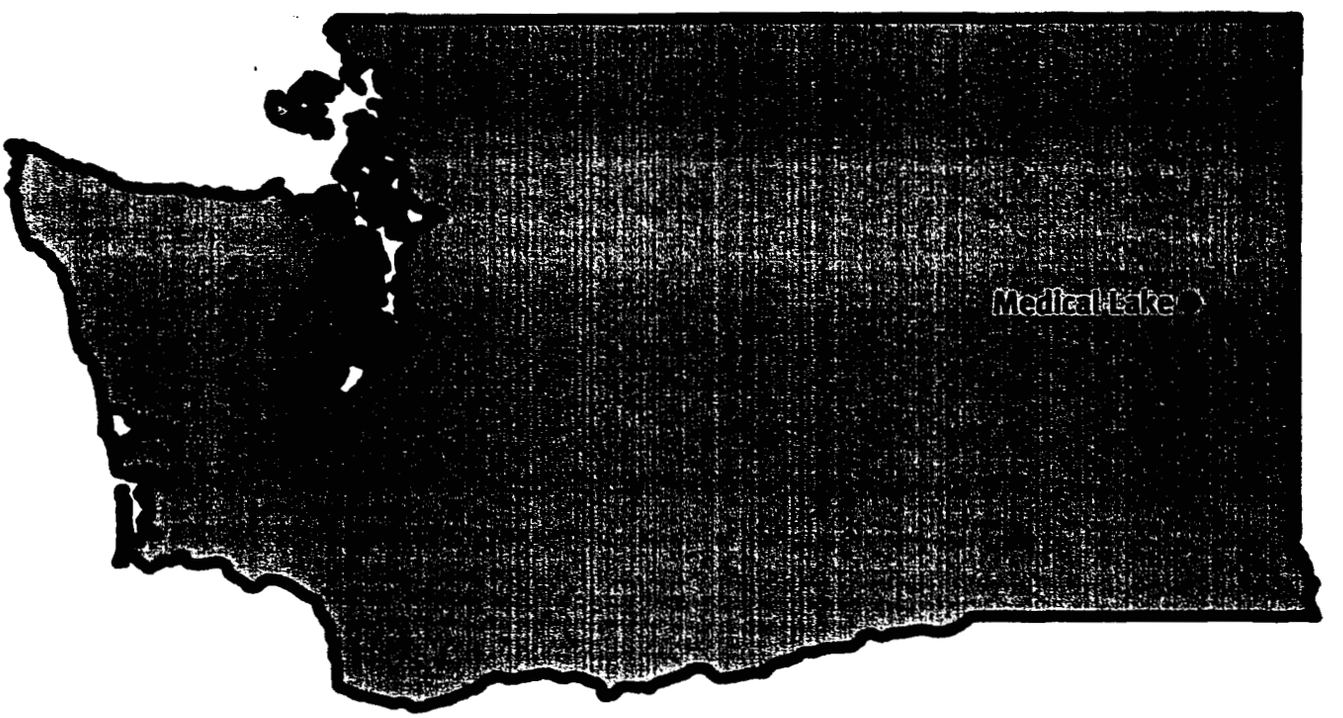
Washington RSAT Accomplishments

No. adults in custody at year end 1997 = 13,214
No. delinquent youth in custody at year end 1995 = c. 1,900
No. females in custody at year end 1997 = 924
No. of RSAT treatment beds at Sept. 1, 1998 = 72
No. of persons in RSAT treatment at Sept. 1, 1998 = 50

RSAT funds received

1996	$318,437
1997	$356,525
1998	$768,958

Metro Areas
● Program Operational
○ Program Not Operational
★ Program Operational in State Capital
☆ Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Pine Lodge Pre-Release RSAT for Women	TC + CB	Medical Lake	Pine Lodge Pre-Release	72	Female	Adult	None	6.25	Yes

Washington has one operational program, the Pine Lodge Pre-Release RSAT for Women, located at the Pine Lodge Pre-Release facility. It employs 6.25 staff (FTE) who provide therapeutic community treatment with elements of cognitive behavioral programming for 72 female adult inmates.

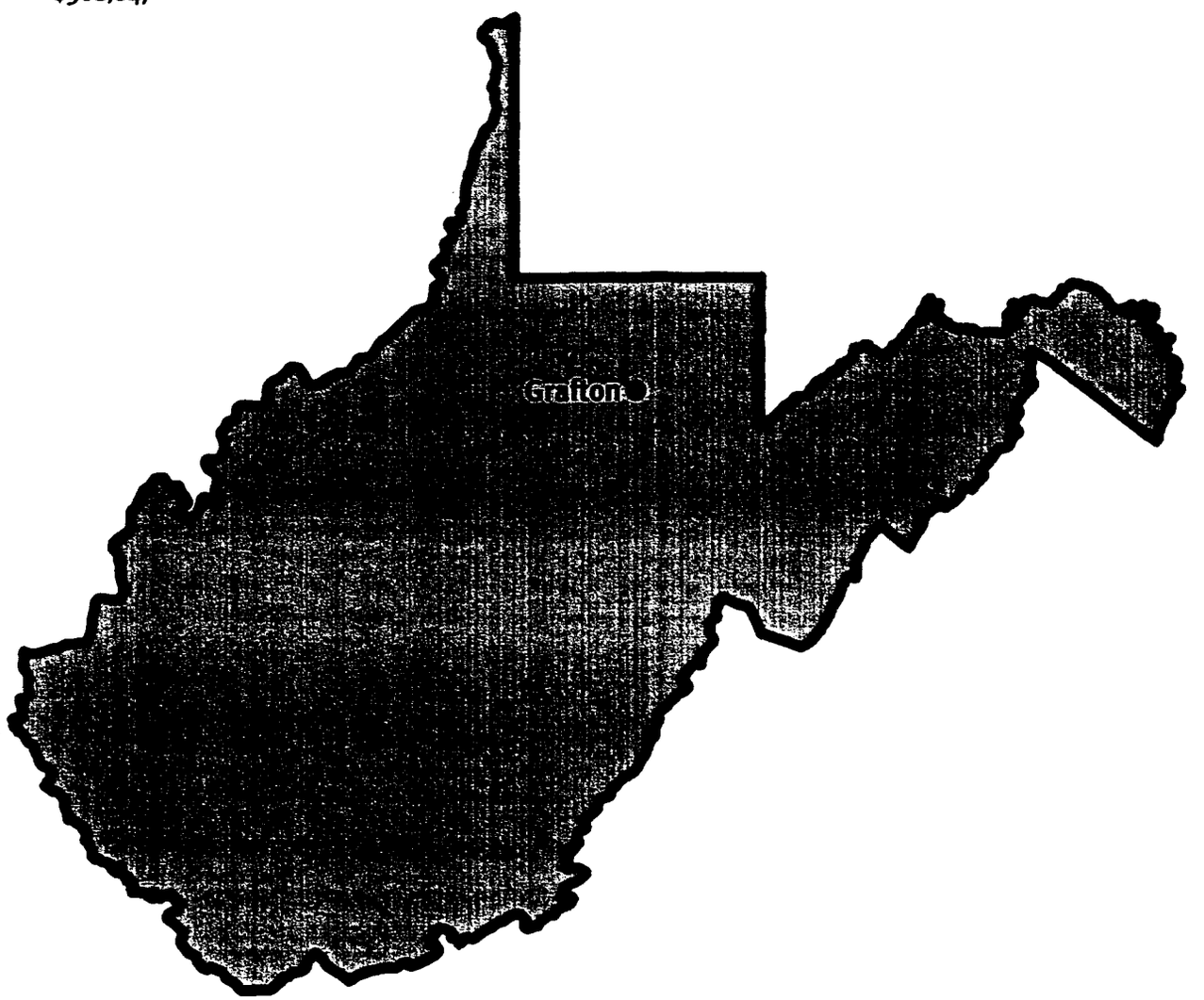
West Virginia RSAT Accomplishments

No. adults in custody at year end 1997 = 3,172
No. delinquent youth in custody at year end 1995 = c. 110
No. females in custody at year end 1997 = 190
No. of RSAT treatment beds at Sept. 1, 1998 = 48
No. of persons in RSAT treatment at Sept. 1, 1998 = 48

RSAT funds received

1996	$146,204
1997	$165,534
1998	$362,847

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
Pruntytown Long-term Residential Program	12-step	Grafton	Pruntytown Corrections Center	48	Male	Adult	None	6	Yes

West Virginia has one operational program, the Pruntytown Long-term Residential Program at the Pruntytown Corrections Center in Grafton. It employs 6 staff (FTE) providing 12-step treatment for 48 male adults.

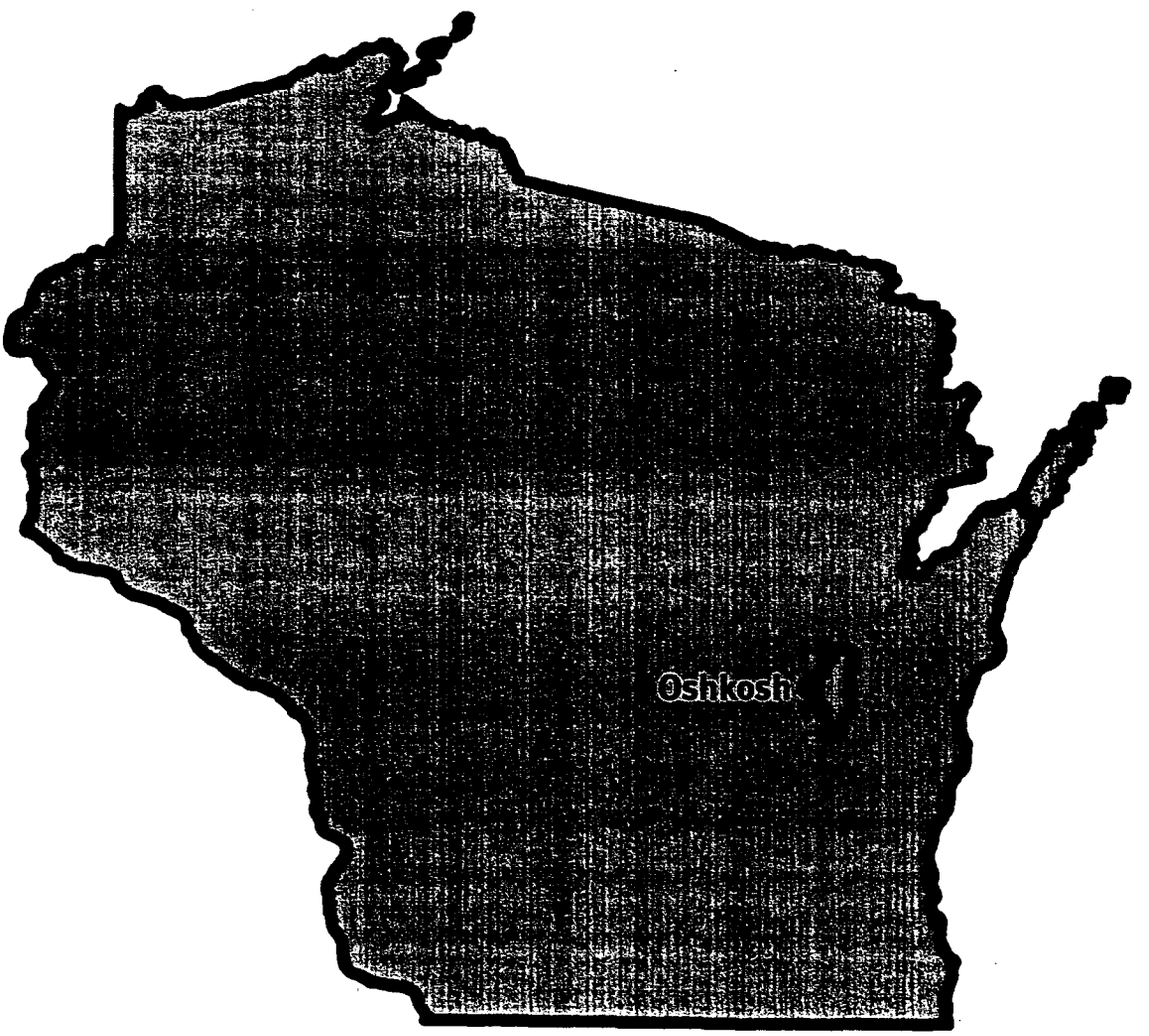
Wisconsin RSAT Accomplishments

No. adults in custody at year end 1997 = 14,682
No. delinquent youth in custody at year end 1995 = c. 1,100
No. females in custody at year end 1997 = 761
No. of RSAT treatment beds at Sept. 1, 1998 = 25
No. of persons in RSAT treatment at Sept. 1, 1998 = 25

RSAT funds received

1996	$303,643
1997	$357,461
1998	$820,426

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
RSAT Program- Dual Diagnosis	TC + CB + Mental Health Counseling	Oshkosh	Oshkosh Correctional Institution	25	Male	Adult DD	None	6.5	Yes

Wisconsin has one operational program, the RSAT-Dual Diagnosis program, located at the Oshkosh Correctional Institution in Oshkosh. It employs 6.5 staff (FTE) providing a combination of therapeutic community treatment, cognitive behavioral programming, and mental health counseling for 25 dually diagnosed male adult inmates.

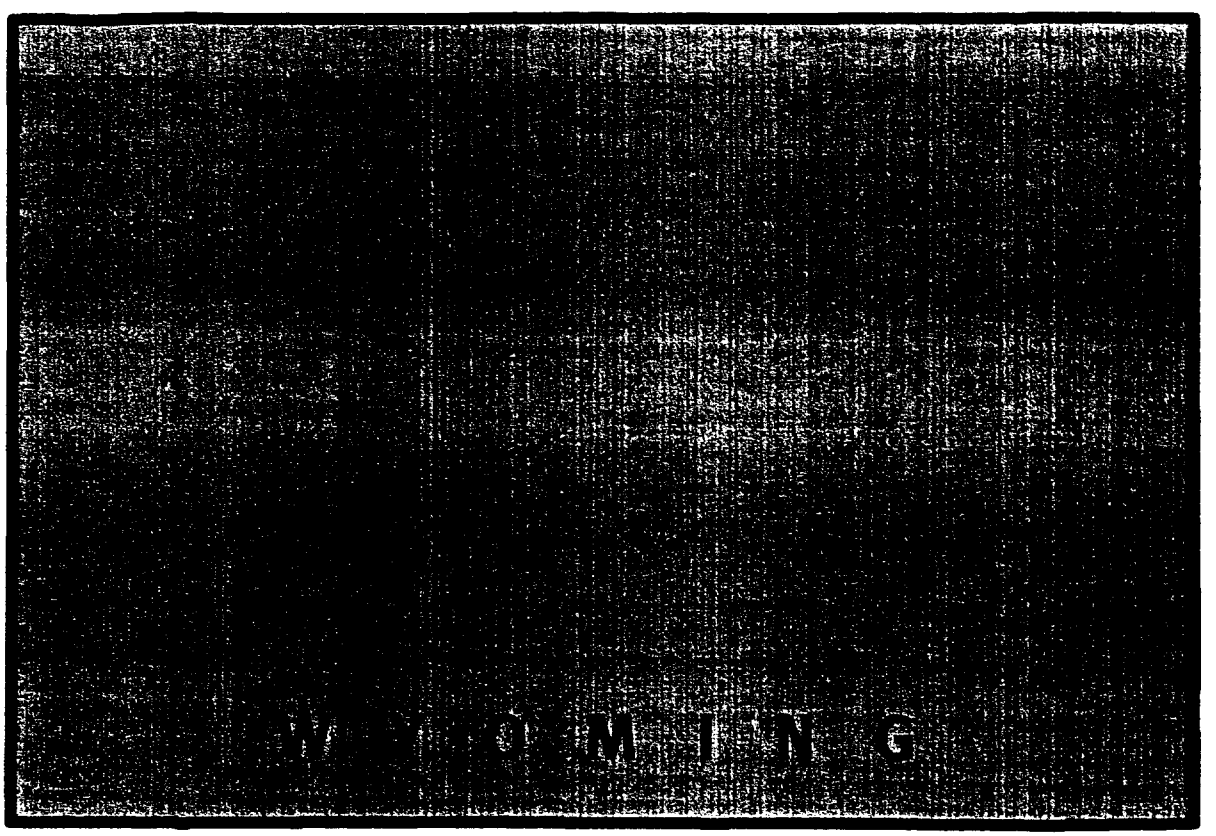
Wyoming RSAT Accomplishments

No. adults in custody at year end 1997 = 1,566
No. delinquent youth in custody at year end 1995 = c. 151
No. females in custody at year end 1997 = 131
No. of RSAT treatment beds at Sept. 1, 1998 =
No. of persons in RSAT treatment at Sept. 1, 1998 =

RSAT funds received

1996	N/A (State did not apply in FY 1996)
1997	$140,673
1998	$298,773

Metro Areas
Program Operational
Program Not Operational
Program Operational in State Capital
Program Not Yet Operational in State Capital
State Land and Boundaries



Program Name	Treatment Modality	City	Institution	No. beds	Gender	Adult/ youth	Con- tractor	FTE Staff	Opera- tional
None									

No funds expended.

Research Methods

The research methods utilized in the National Evaluation of Residential Substance Abuse Treatment programs (NERSAT) were modified several times during the course of the project in efforts to be responsive to the expressed needs, issues and guidance raised by the National Institute of Justice (NIJ) and the Corrections Program Office (CPO). Because of these changes and complexities, the NERSAT project underwent changes over its two-year period (see Appendix 1 for a summary of the changes). The methods and research objectives of NERSAT became the following:

1. A survey to ascertain the RSAT program(s) and program director(s) in each of the 50 States plus five Territories plus the District of Columbia (we refer to these as *states* for brevity) and to collect basic information on the aggregate impact of the RSAT-funded programs in each State (or Territory), referred to as the *Initial State Survey*.
2. A survey to describe the separate RSAT programs as they "came on line" and to assess whether a few of the programs might serve as model programs which could undergo subsequent intensive evaluation), referred to as the *Program Survey*.
3. A survey to collect more detailed information on the aggregate impact of the RSAT funded programs in each state and to obtain more up-to-date information on the RSAT program(s) in each state), referred to as the *Final State Survey*.

Our method was **not** that of drawing a *sample* of the RSAT programs to survey or a sample of the state RSAT officials. Rather, we attempted a *census* of all the existing RSAT-funded programs and all of the state RSAT officials.

NERSAT began its study with two different levels of units for which we needed to establish *universe* lists. The **State Level** consisted of the 50 States plus 5 Territories

plus the District of Columbia.[14] The Corrections Program Office provided us with the name, address, and telephone number of the state official serving as the RSAT contact person in each state. The **Program Level** consisted of the actual RSAT *programs*, with many states having more than one program.

No clear specified universe of RSAT programs existed when the National Evaluation of RSAT began. There were two reasons for this as we planned our surveys:

1. Since some states did not have detailed plans for the programs and had not yet decided on program directors, there was neither a complete official list of the RSAT *programs* nor a list of designated program directors.
2. As NERSAT was carrying out its survey work, the set of RSAT programs continued to grow, and continues to grow even at the mid-point of the RSAT initiative. As part of the natural developmental process of the RSAT initiative, states planned new programs, hired and trained staff for these programs, and brought programs on line to operational status, all while NERSAT was conducting its research. Nevertheless, our goal was to identify all of the RSAT programs that initiated operation during the national evaluation project period and to collect information about those programs.

We field tested the Initial State Survey and the Program Survey in September and October of 1997. We made final revisions to them in November. In December 1997, we began mailing the final versions of the Initial State Surveys to state RSAT officials and the Program Surveys to RSAT program directors. For the state survey we were able to use a list of state RSAT officials from the Corrections Program Office. (However, as is often the case in field research, the administrative reality turned out to be more complex: some officials were misidentified and several officials had moved or changed jobs.) The Initial State Surveys which were returned to us included the state official's list of the RSAT programs in the state, their program directors and their telephone numb rs, so these were our first and most important source for us to build a complete

[14] We refer to this level as *states* for brevity.

list of RSAT *programs*. The researchers conducting "local partnership evaluations" on RSAT programs were the next most important source for RSAT program contacts. In some instances these researchers provided us with contact information for program directors which we were unable to obtain from state RSAT officials.

Table 1 shows the NERSAT final coverage of program- and state-level universes.

NERSAT Survey Coverage

TABLE 1

	N of cases	
Program-level		
Universe List of Planned Programs		
Programs known (by Aug. 1998) to be planned RSAT programs	**83 programs planned** •	
a. Survey filled out	76	92%
b. Survey not filled out:	7	8%
b1 Program not operational at time of program survey	6	
b2 Other reason or no reason given	1	
Total a & b:	83	100%
Universe List of Potentially Operational Programs		
Programs except those known to be not operational at that time	**77 programs**	
a. Survey filled out	70	91%
c. Survey not filled out:	7	9%
Total a & c:	77	100%

State-level (includes D.C. and five Territories)	**56 "states"**	
Initial Survey was filled out	43	77%
Final Survey was filled out	46	82%
d. Either Initial Survey or Final was filled out	54	96%
e. Neither Survey was filled out:	2	4%
Total d & e:	56	100%

• This was the number known to be planned while conducting the program survey.
Based on information after the surveys, there are now over 100 programs operational or planned.

An important point that helps to understand this table is that the NERSAT study was in operation for two years and all during that time new RSAT programs were being generated. Thus, throughout the project including writing the Final Report, new RSAT programs were being planned, some programs concluded their planning and were hiring and training staff, some programs admitted their first clients, and some programs revised their program protocols after several months' of program operation. The NIJ staff encouraged us to do process evaluation research to study how the RSAT initiative was developing. Because of the reality of studying RSAT programs ranging from some that were fully operational to some that were at the planning stage, we found in some cases that we were attempting to collect information about RSAT programs (either directly from persons designated as the program director or indirectly from the state RSAT official) *that were not yet operational.* In these cases we were unable to obtain survey information. That is, the program director could not provide information about program clients because no clients had entered the program yet and could provide no information about staff because no treatment staff had been hired. In some cases not even information on the treatment program model was available because the bidding process for the treatment contractor had not yet concluded.

In response to the first mailing of surveys approximately one-quarter of the respondents returned the program survey to us, and about one-third of the state surveys were returned. When surveys were not returned within a few weeks, we followed up with faxes and with telephone calls (including leaving messages with secretaries and on voicemail or answering machines). Three systematic attempts (reasonably separated in time) were made to have a survey completed and returned. If respondents reported that the survey had not been received by them or had been lost, we sent replacement copies and, if necessary, followed up with reminder contacts afterward.

The following describes when the data were collected and what time periods the data reflect:

1. We began the *Initial State Survey* to ascertain the RSAT program(s) and program director(s) and to collect basic information on the aggregate impact of the RSAT-funded programs in each state in November 1997. We continued to receive these surveys through *March 1999*. In the survey the financial items[15] have Fiscal Year time points of reference (e.g., FY 1997); descriptive and assessment items have *relative* time points of reference (e.g., "as of the date you are completing this survey").
2. In November 1997 we began the *Program Survey* to describe the separate RSAT programs as they "came on line," and to assess whether a few of the programs might serve as model programs which could undergo subsequent intensive evaluation. We continued to collect these surveys also through *March 1999*. Items have *relative* time points of reference (e.g., "as of the date you are completing this survey").[16]
3. The *Final State Survey* to obtain more up-to-date information on the RSAT program(s) in each state, and to collect more detailed information on the aggregate impact of the RSAT-funded programs in each state was begun in October 1998. We continued to collect these surveys through March 1999. Items have absolute time points of reference (e.g., "as of August 31, 1998").

Census Completion

The material presented on the next page summarizes the universe lists for each of the surveys, and presents the degree of coverage of each survey.

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[15] We also reviewed the financial award information provided us by the Corrections Program Office.

[16] It would not have made sense to use a fixed time point of reference at the time we began to conduct the surveys (e.g., as of November 1997), since most of the RSAT programs were not operational at that date. The relative time point of reference allowed us to collect information from the RSAT programs as they became operational.

As mentioned, we needed to contact RSAT state officials in part to ask them for lists of the planned RSAT *programs* in their state, and to obtain the names, addresses and phone numbers of the program directors and/or contact persons. In cases where we received no state surveys and hence no names of contact persons to get information about the programs, we contacted researchers known to be planning "local partnership evaluations" on RSAT programs in those states and asked them to obtain contact information on RSAT program directors. These combined efforts produced the universe list of planned programs, which continued to grow throughout the NERSAT project. By August 1998, our universe list consisted of 83 RSAT programs, some operational and some planned. Information from contact persons, however, allowed us to eliminate six of these programs which were known to be not yet operational at the time of the survey. Thus, our practical universe list, was the remaining 77 programs, and each of them received the NERSAT Program Survey. For these 77 programs, 70 program officials (i.e., 91%) did return the NERSAT Program Survey. (Note that some or all of the seven that did not complete and return the survey may not have been operational, but we have no way of knowing that.)[17]

At Level 1, the level of the 56 *states*, 43 (i.e., 77%) filled out the Initial State Survey and 46 (82%) filled out the Final State Survey. (Note: because some filled out the Initial survey but not the Final, and others filled out the Final Survey but not the Initial survey, there were only two *states* (American Samoa and North Carolina) from which we received no state level survey information at all.[18] In some cases the State RSAT official indicated that the survey was not returned because they did not yet have an RSAT program to report on (e.g., the program required construction to house the treatment unit and the construction was not yet complete). In other instances, the state official did

[17] It should be noted that in one state, the responsible state official adopted a variant to the term "program" saying that the state was employing one program model at multiple sites, and that even though there were distinct staffs and kinds of clients at each site, refused to give us data from each site but only provided aggregate data for the entire state.
[18] We finally did receive some information regarding North Carolina's two programs in April 1999.

send the survey back to us but with many blank answers or responses of "information not available."[12] The explanations they provided included: delays in locating appropriate facilities; awaiting completion of residential facility construction; slow release of funds by the state; a time-consuming proposal and bidding process required for securing treatment providers; and/or that the state needed to pass specific legislation regarding the programming.

In a formal sense, the representativeness of *samples* is not an issue here because we were not drawing *samples* from the state-level or the program-level universes. Rather, we were attempting to conduct a complete *census* of both the states and the operational RSAT programs. We know that the census was incomplete, however, in that we did not receive completed surveys from all of the states, and we did not receive completed surveys from all of the RSAT programs that we thought might already be operational. Because there is no definitive universe list of programs, we began by including all planned programs. Thus, we have a concern as to what *biases* may have been introduced because of the absence of those states and programs that did not complete and return the surveys. In our assessment only two characteristics clearly distinguish the cases from which we were not able to obtain surveys. (1) The states from which we did not receive completed state surveys tended to be states housing programs which *did not become operational at all* through the NERSAT project period (April 1997 through March 1999). (2) The programs from which we did not receive completed program surveys tended to be either programs *that became operational after the summer of 1998* or *programs that did not become operational at all* through the NERSAT project period.[19] We do not discern any other systematic factors. In this sense, our survey results may be most "representative" of the RSAT programs (and the states housing those programs) which were on the average (1) more successful in "getting up and

running" and (2) older (referring strictly to the length of time the programs had been in operation).

Analysis of the National Survey Information

As background information, the following table shows the development of the *awards* of RSAT funds to the States from Fiscal Year 1996 through Fiscal Year 1998. For the 56 "states" the mean award was $441,348 in FY96 (median $294,180). By FY98 the mean was $1,060,246 (median $656,818). It is important to note that the states did not have to spend a year's award by the end of the fiscal year; the amount could be carried over for spending into subsequent years. This made sense since some programs needed many months to develop programs, hire and train staff, and begin admitting clients to build toward full capacity.

Table 2
Summary Statistics on RSAT Awards to the States Over Time.*

	FY 1996	FY 1997	FY 1998
Mean	441,348	495,473	1,060,246
Median	294,180	313,369	656,818
Std. Deviation	506,974	561,837	1,212,103
Sum	24,715,511	27,746,496	59,373,800
Valid N	56	56	56

*Entries are dollar amounts. Details are provided in Appendix 2, Table 1.

Forty-six states returned the NERSAT Final State Survey to us. Of course, not all of the states were able to answer all of the questions asked. For example, many states did not yet have RSAT programs operational in FY96. To mention another example, the information for FY 1998 was incomplete in some states, for example, because some of that recent data had not yet been made available to the RSAT state officials.

[19] Through March of 1999 data continued to trickle in from the few states that had not responded, and from late-starting programs. We made phone calls on a continuing basis to try to close gaps in data and to clarify apparent discrepancies that only emerged when all data files had been merged.

Based on the state survey data, Table 3 summarizes RSAT and non-RSAT funding for RSAT programs.[20] Some of the state officials were unable to report the information on state sources of funding of the programs for Fiscal Year 1998 because state data had not yet been made available. Note also that it is problematic to compare these amounts (which refer to budgeted funds per fiscal year) with the amounts awarded per fiscal year noted in the previous table. Some States did not necessarily begin drawing down funds from their awarded amount, for example, when they did not yet have a program underway, they were still in the planning stage, new facility construction had not been completed, a contractor had not yet been selected, the bidding process was delayed, or some other major factor.

Table 3

Sources of Budgets for the RSAT Programs.

Cases are States	RSAT '96	Other '96	RSAT '97	Other '97	RSAT '98	Other '98
Mean	380,984	135,240	340,371	137,312	656,571	171,466
% of funds	74%	26%	71%	29%	79%	21%
Median	248,005	99,042	236,738	75,555	371,779	93,941
% of funds	71%	29%	76%	24%	80%	20%
Valid N	18	18	33	33	36	36

*Mean and median entries are dollar amounts. Details are provided in Appendix 2, Table 2.

In each fiscal year the percentage of funding for the RSAT programs coming from non-RSAT funding sources ranged from 20% to 29%. Taking into account the complexities in reporting these financial data, these numbers are in line with the language and intent of the RSAT initiative: "The Federal share of a grant-funded project may not exceed 75 percent of the total costs of the project."

The Final State survey included the question "In your RSAT program(s) what did you purchase with the RSAT funds during each fiscal year?" The responses, aggregated over the FY96 through FY98 period, show that salaries and benefits (e.g., health plans, pension contributions) of the treatment delivery staff in the RSAT programs formed the

[20] A more refined breakdown shows that state funding was by far the largest source of non-RSAT funding for these

largest component. The mean dollar amount (averaged over the 45 states that responded to these questions) was $201,252. The mean dollar amounts for treatment staff training was $9,671 and that for drug testing was $7,228. The "other" category had a mean of $129,895 — reflecting the fact that many states subcontracted their substance abuse treatment services to outside contractors and the accounting systems in those states list those service delivery contracts in the "other" category.

Table 4

Types of Expenditures in RSAT Programs, Aggregating FY96 – FY98.

State Survey	Treatment Staff Salary	Treatment Staff Training	Drug Tests	Supplies	Other
Mean	201,252	9,671	7,228	24,418	129,895
Median	89,294	0	0	8,608	50,000
Std. Deviation	291,873	25,964	24,127	37,944	181,549
Valid N	45	45	45	45	45

Details are provided in Appendix 2, Table 3.

The study intended to assess the impact of the RSAT initiative by analyzing the answers to questions on the numbers of substance abuse treatment slots and staff over time and comparing any trends in residential treatment (directly affected by the RSAT initiative) with nonresidential treatment (not directly affected by RSAT). Unfortunately, the states' estimates are simply not comparable from state to state. Different states used very different assumptions in generating estimates. Furthermore, it appears that within some states different estimation methods were used in estimating *residential* treatment from those used to estimate *nonresidential* treatment. In short, the statistics in the following tables should be considered very rough estimates that have a wide error margin. The correctional residential substance abuse treatment slots appear to have trended upward over time, from a mean of 330 to a mean of 400 per state. However, note that the non-residential mean was 842 in FY95 but reached 910 in FY98.

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programs.

Table 5

Correctional Residential Substance Abuse Treatment Slots Over Time

	State	'95 slots	'96 slots	'97 slots	'98 slots
Residential	Mean	330	347	391	400
RSAT- and non-RSAT funded	Valid N	32	34	38	37
Non-Residential	Mean	842	879	832	910
Non-RSAT funded	Valid N	27	29	32	28

Details are provided in Appendix 2, Tables 4 and 5.

The correctional residential substance abuse treatment staff increased over time, from a mean of 17 prior to RSAT to a mean of 26 per state halfway through the RSAT initiative. Prior to RSAT the non-residential mean was 16 (in FY95), but rose to 22 in FY 98. Readers are advised they should consider this information to be "food for thought" rather than established facts.

Table 6

Correctional Residential Substance Abuse Treatment Staff Over Time.

	State	'95 slots	'96 slots	'97 slots	'98 slots
Residential	Mean	17	23	28	26
RSAT- and non-RSAT funded	Valid N	26	31	34	35
Non-Residential	Mean	16	19	23	22
Non-RSAT funded	Valid N	25	28	29	28

Details are provided in Appendix 2, Tables 6 and 7.

On the average, the states reporting spent 40% of their annual budget within the first year. One reason for this seemingly low rate of expenditure is that before programs become fully operational, the costs are much lower. It is obviously prudent management to hold off expenditures until they are needed. Also, some states started one program, then some time later started another program while still others were in the planning stage. The data reflect the normal developmental process of expenditures for phasing in new programs.

In some instances, however, problems occurred which *delayed* program implementation. Where the respondents to the state survey perceived a delay, they

supplied possible reasons for the delays. These are displayed in Table 7 below that shows a list of eleven reasons for delays in spending RSAT funds. Respondents rated these on a scale from 1 (not a problem) up to 5 (a severe problem). The reasons most frequently identified as more severe problems (severity ratings of 4 and 5) were difficulties in recruiting substance abuse treatment staff (38% of the states cited this), locating or constructing appropriate facilities (cited by 29% and 20%, respectively), state regulations (28%), and delays required by state bidding or competitive proposal processes (21%). We note that difficulty in getting training for substance abuse treatment staff was also rated as a moderate problem (severity ratings of 2 or 3) by 62% of the states.

Table 7

The Importance of Various Reasons Why There May Have Been a Delay in Spending RSAT Funds.

	Severity of Problem (Collapsed)				
Implementation Problems for RSAT Programs	No problem	Moderate	Severe	Total %	Valid N
Hard to recruit treatment staff	14%	48%	38%	100%	42
Locating appropriate facilities	48%	24%	29%	100%	42
State regulations	44%	28%	28%	100%	43
Treatment providers in bidding or proposal process	43%	36%	21%	100%	42
Constructing facility	63%	17%	20%	100%	41
Funds not released at state level	47%	35%	19%	100%	43
Federal requirements	58%	28%	14%	100%	43
Security considerations for program eligibility	57%	29%	14%	100%	42
Hard to get training for treatment staff	26%	62%	12%	100%	42
Screening for program placement	46%	44%	10%	100%	41
Degree of inter-agency cooperation	67%	26%	7%	100%	42

Details are provided in Appendix 2, Tables 9 and 10.

Table 8 shows summary information on RSAT treatment slots and current client caseloads. The second and third columns provide our estimates based on pooled information from the NERSAT Initial State and Program surveys. In the third and fourth columns the numbers are based on the most recent information available from state officials, provided in the Final State Survey and even from efforts to get this information after the Final State Survey deadline[21].

[21] Usually by "last ditch" telephone calls made while writing this final report on the NERSAT project.

Table 8

RSAT Treatment Slots and Current Client Caseloads.

State	Clients currently in Program	Beds	Clients, revised* state totals	Beds, revised* state totals
Valid N	80	91	50	51
Mean	76	98	154	189
Median	48	60	94	120
Std. Deviation	100	109	179	206
Sum	6,054	8,896	7,690	9,649

Details are provided in Appendix 2, Table 11.

The total number of clients currently in the RSAT programs was almost 7,700 as we ended project NERSAT. The reported capacity of the programs totaled over 9,600 beds. The smaller number of clients relative to the number of treatment slots available (a 68% occupancy rate at the time of our program survey) is a function of our Program Survey having been conducted just as many of the programs had become operational. Programs need time to develop and to reach their full complement of clients. By the end of the NERSAT operation, about an eighty-percent occupancy rate had been achieved, but programs were still coming on line and being planned. New York, for example, is planning to add 1,000 RSAT beds during year four of the RSAT initiative.

Based on information reported to us in the Final State Survey (supplemented with information from the earlier Program survey), as of August 31, 1998 over 13,000 clients had been admitted to the RSAT programs. We consider this to be an underestimate because we had to fill in information for some states (those which did not complete the Final State Survey) with much earlier admissions numbers that we had obtained from the Program Survey. The total of the RSAT treatment staff reported as of August 31, 1998 was 574. (See Appendix 2, Table 12 for details.)

The main treatment approach used in the programs (as reported in the Program Survey, inferred from program descriptions, brochures issued by contractors and from

conversations with program directors) is summarized below in Table 9. Three main treatment categories were identified: Therapeutic Communities (TCs), (n=23), Cognitive Behavioral (n=13), and 12-Step (N=5). Fifty-two percent, however, constitute a combination of TC and/or Cognitive Behavioral and/or 12-Step models.

Table 9
Program Director's Description of Main Treatment Approach in RSAT Program

Main Treatment Approach	Count	Percent
Therapeutic Community (TC)	23	24
Cognitive-Behavioral (CB)	13	13
12-Step	5	5
TC + CB	20	21
TC + 12-Step	1	1
CB + 12-Step	14	14
TC + CB + 12-Step	15	16
Other	6	6
Total	97	100

52% constitute combinations of two or three main treatment approaches. Details are provided in Appendix 2, Table 13.

Our Program Survey asked the program operators to identify the treatment modality that best described their treatment approach and then asked them to rate the importance of 54 treatment components. The program surveys may be found in Appendix 3. Data were analyzed for the 65 programs for which treatment information was provided in the Program Surveys we received.

The component ratings were reduced to categories of *not important*[22] and *at least some importance*. Table 10 shows the percentages of programs that rated treatment components as at least somewhat important. The 24 items included in Table 10 were endorsed by at least 50% of the programs.

[22] Missing data were combined with *none important* responses because blanks were interpreted as not treatment relevant.

Table 10. Percentage of Programs that Rated Treatment Components As At Least Somewhat Important.

Treatment Component Reported	Percentage N = 65
Substance Abuse Education	97
Relapse Prevention	94
Peer Encounter Group	91
Anger Management	91
Problem Solving Skills	91
Positive Peer Pressure	88
Social Skills Training	88
AA Type Meetings	85
Scheduled Group Therapy	83
One on One Counseling	82
Continuos Therapy	81
Cognitive Therapy	79
Life Skills Training	75
Emotional Growth Training	75
Individualized Treatment Plans	75
Education	74
Assertiveness Training	72
Upward Mobility	68
Self Help Therapy	60
Self Instructional Training	60
Rational Emotive Therapy	57
Case Management	54
Readiness for Vocation	51
Relaxation Training	51

Over 90% of the programs considered substance abuse education, relapse prevention, peer encounter groups, training of problem solving skills and anger management training to be important program components. Over 80% of the programs identified positive peer pressure, social skills training, AA type meetings, scheduled group therapy, one-on-one counseling, and continuous therapy as important components for treatment. Thirteen other treatment components were identified by between 50% and 79% of the programs.

Many of the treatment components that were reported by most of the programs included interventions that have traditionally been considered unique to either the TC, Cognitive behavioral or 12-Step models. For example, Peer Encounter Groups which originated as a TC element is used by almost all programs as is the Cognitive Skills component of Problem Solving Skills and 12-Step AA Type Meetings. The results

suggest a shift away from "pure" treatment models toward a merging of models and adoption of treatment components that program operators consider "best practices."

Several treatment components that are generally considered to be important elements of good prison treatment were reported by less then 50% of the respondents, for example, relatively few programs identified Vocational Skills Training (34%) and Family Therapy (34%) as part of their program. As another example, Work Release (23%) and Half Way Houses (20%) were incorporated in few programs. We support the recommendation in the RSAT legislation that treatment following release or the maintenance of "continuity of care" is an important element of good treatment and strongly linked to reductions in recidivism. The low level of these "continuity of care" components in the program descriptions, however, probably reflects the absence of federal funding specifically set aside for this purpose.[23]

A considerable amount of overlap among the TC, Cognitive Behavioral (CB) and Other treatment categories in terms of 54 treatment components was seen. For example, regardless of major modality almost all programs utilize problem-solving skills training and relapse prevention techniques. Peer encounter groups, normally considered a TC component, appear to be used in RSAT programs of all types. The differences among the treatment modalities were neither large nor consistent.

The treatment component results challenge some of the assumptions that underlie the RSAT effort and provide new challenges to researchers. RSAT was founded on the premise that certain treatment modalities 'work" based on evaluations of relatively pure expressions of the TC and CB models. The emerging tendency toward mixing treatment components generates a need for process evaluation studies that examine the implementation process when modalities are combined. As well, there is a need for

[23] It should be noted that 86% of the programs surveyed stated they did have some aftercare or community supervision component.

outcome evaluations that assess the incremental efficacy of *individual treatment components* in terms of recidivism reduction, and the outcomes produced when various treatment component combinations are implemented.

Substance abuse treatment programs generally include several treatment components intended to function together to rehabilitate the clients. The Program Survey revealed that 55% of the programs responding to the survey did not have at least one of their treatment components operational. Similarly, 53% of the program directors considered their program to be in the "shakedown phase" rather than stabilized. These findings are to be expected both because, as all experienced program development personnel realize, it takes more than six months (sometimes more than twelve months) to make needed adjustments in programs that have newly come "on line." Also, the intent of the Program Survey was to reach the programs early in their operational phase, so the "shakedown phase" is heavily represented in these data.

As Table 11 shows, relatively few of the programs rely on a uniform treatment modality that is delivered to all of their clients. Most programs use some degree of individualization in the delivery of treatment, and 26% of the program directors rate their program as an individualized treatment program.

Table 11

Rating of the Degree to which the Program is Uniform or Individualized.

		Frequency	Percent	Valid Percent
	1 Uniform: all get the same treatment	3	4	4
	2 *	13	16	18
	3 *	20	24	28
	4 *	17	20	24
	5 individualized treatment programming	19	23	26
	Total	72	87	100
Missing		11	13	
Total		83	100	

Details are provided in Appendix 2, Table 14.

Responses to the Program Survey by the program directors show that these RSAT programs do rely in part on negative sanctions (penalties or punishments) to respond to substance abuse by a client who is in the program. Most use systems of graduated sanctions of one type or another, but many of them cite a "zero tolerance policy," i.e., just one incident of substance abuse in the program results in the client being ejected from the program. (See Appendix 2, Table 15 for more information on this point.)

As expected, the overwhelming majority (86%) of the programs reported having a community supervision phase as part of their programming plan. Some of the remainder had not yet developed plans for a community supervision phase.

Importantly, but not surprisingly, all of the RSAT state officials replying to the initial NERSAT State Survey stated that the RSAT funds had helped them increase the substance abuse treatment capacity. Examples of their comments are provided in Appendix 2, Table 16.

Other features of the RSAT programs are available from the Program Survey, such as the prison context and the age and gender of the clients. Although many are located in minimum security (29%) and medium security (35%) correctional facilities, an appreciable percentage are located in maximum security facilities (16%). About three-quarters of the programs (72%) are for adults, the remainder for juveniles. (See Appendix 2, Tables 17 and 18.) Most of the RSAT programs are for males. Distribution by gender is shown in Table 12 below.

Table 12

Gender of RSAT Program Clients

Programs		Frequency	Percent	Valid Percent
	Men	54	67	70
	Program with Male & Female Units	14	17	18
	Women	9	11	12
	Total	77	95	100
Missing		4	5	
Total		81	100	

Source: NERSAT Program Survey, Updated with Post-Survey Information

RSAT States and Territories with Limited Information

Some States and Territories either provided information too limited for inclusion in the main body of the report or did not respond to NDRI information collection efforts. The information received from 11 States and Territories is too limited because none had accepted inmates into their treatment programs for a variety of reasons at the time of our surveys. The main reasons for this delayed program implementation are due to difficulties in obtaining program space, unanticipated additional time needed for construction, delays in State approval processes and difficulties encountered in contracting with agencies and service providers needed to operate the program. It should be noted that neither survey forms nor phone responses were received from North Carolina[24] or American Samoa during the course of the project.

Specific reasons for delays are provided below:

Alaska: Delays in locating appropriate facilities and awaiting completion of residential facility construction. (9/28/98)

American Samoa: Never responded after multiple contact attempts.

Guam: Delays in locating appropriate facilities that meet the federal requirements concerning program placement in an isolated unit and awaiting completion of residential facility construction. (10/8/98)

Illinois: Delayed because of slow release of funds by the State and a time consuming proposal bidding process required for securing treatment providers. (9/30/98)[25]

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[24] See footnote 18.

[25] In May 1999 we received the following communication: "The juvenile TC program at the Illinois Department of Corrections' facility in St. Charles, Illinois is finally becoming operational. The therapeutic program is being contracted with Interventions, Inc. Although it has been a very long time in 'development,' the good news is that we will be able to get in on the ground floor in terms of working with the institution and the substance abuse treatment provider prior to the beginning of program operation."

Maine: Delayed due to engagement in a protracted planning and development process. (12/7/98)

Northern Marianas Islands: Treatment facility is under construction. (11/9/98)

North Carolina: Only a telephone response in April, 1999 after multiple contact attempts. No survey instruments were ever returned.

Nevada: Delayed because State was required to pass special legislation and build a facility. (10/2/98)

New York: Delays in release of funds primarily due to meeting federal and state level regulations. (12/7/98)

Virgin Islands: Construction delays as well as development of drug testing policy. (1/26/98)

Wyoming: Treatment program is still being developed. (10/2/98) Program information received in mid-April, 1999.

DISCUSSION

From an overall perspective the RSAT initiative has generated and continues to generate new substance abuse treatment programming opportunities throughout the country for prison and jail inmates. Many new residential treatment slots have been created in correctional systems that had little or no residential treatment for substance abusing prisoners prior to the RSAT initiative. In a few states, such as in Delaware and Massachusetts, RSAT funds were used to expand or modify an existing successful program. In this discussion we will present issues that need to be considered as RSAT programming continues through years four and five, as well as for the future. Among the issues to be discussed are first, the delays States and programs have experienced thus far and are likely to continue to experience in getting their program operations up and running. A second issue focuses on gender, that is, RSAT programming for women

offenders. A third issue concerns RSAT treatment programming for youthful offenders, both boys and girls. Fourth, we will discuss RSAT treatment programming in short-term facilities such as county jails. Fifth, we discuss the issue of providing aftercare and continuity of treatment for individuals being released from RSAT programs back to their communities. The last issue we will discuss below concerns the efficacy and/or possible pitfalls of combining treatment approaches.

A. Delays

Notwithstanding the noteworthy accomplishments of the States' RSAT effort toward fulfilling the legislative intent, a number of problems have occurred in various sites. The most commonly experienced problems (that normally should be anticipated in a program of this magnitude) are caused by delays — delays in processing the funds through State fiscal processes, delays in staffing, in construction, delays in starting, and so forth. Delays have direct implications for the number of persons who may or may not ever be helped by RSAT programs, but the reasons for delays also have important implications for service provision generally.

The three main categories of reasons for delays were:

(1) Staffing. Programs found it extremely difficult to recruit for and staff programs in a timely way.

a) There are too few counselors trained in Therapeutic Community and Cognitive-Behavioral methods — methods suggested in the RSAT legislation.

b) There are also too few persons who are trained in Therapeutic Community and Cognitive-Behavioral methods that are willing to work in correctional settings located in out-of-the-way rural settings. Eighty-six percent of the programs reported moderate to severe difficulties in hiring staff for their programs. Only fourteen percent found this not to be a problem.

c) The number of sources for the training of staff personnel in these modalities is inadequate. About three out of four of the programs encountered moderate to severe difficulties in getting staff trained to provide treatment in their modalities of choice.

This problem has implications for quality programming. When a responsible state official perceives pressure to initiate programming in the face of a shortage of trained personnel, persons trained in related skill areas or with parallel experiences are often hired. For example, in the absence of available trained and experienced therapeutic community staff, some TC programs may recruit staff from other kinds of treatment traditions such as group counselors and social workers who have different sets of experiences and treatment philosophies. The establishment of a TC and the maintenance of treatment integrity may be compromised or called into question in the light of such staffing. Should the empirical outcomes of these programs fall below expectations, that is if higher than expected proportions recidivate than the research results from other studies would suggest, funding for this and other treatments may be inappropriately cut.

(2) Physical plant delays. States found it difficult to find an appropriate location for their programs in a timely way.

a) Survey results indicate that more than half the programs (53%) were confronted with moderate to severe delays due to the difficulty in locating facilities to put the residential program, and that 37 percent of the programs reported delays because of the need to construct or to physically modify an existing structure to house the program or programs.

b) These delays were exaggerated occasionally by protracted state bidding processes necessary for outside contractors to be hired to do the construction or modifications.

There were no specifications in the RSAT legislation relating to how the residential treatment should be physically designed or housed. Still, the necessity of providing an isolated habitat for the programming in the light of existing overcrowding problems

generated pressure to construct new facilities or, in cases of older institutions, to modify existing facilities. In some cases states were engaged in the process of generalized construction or planning for new construction at the time of the RSAT enactment. Thus, in their cases little time was required to be spent initiating architectural work and hiring contractors. In other locations, particularly in outlying states such as Alaska and in most of the Territories, these processes were seriously protracted.

(3) Finding Treatment Providers. Fifty-seven percent of the programs reported they experienced moderate to severe delays due to the state procedures and/or regulations that govern bringing in outside contractors to do treatment in the States' institutions. In a number of cases, a state sought to contract with an outside vendor to provide treatment services only to find that state regulations made it exceedingly difficult or outright prohibited them from contracting with service providers who employed recovered ex-addict ex-offenders. Evidence regarding the effectiveness of the therapeutic community approach shows that a TC staff should consist of a mixture of persons emergent from TCs — recovered graduates from the self-help tradition — and other conventional professionals (e.g., counseling, educational, medical, mental health) grounded in the basic concepts of the TC perspective and community approach (Lipton 1999).

Program-trained former addict-inmates who have graduated from treatment programs and have demonstrated good work histories for at least three years in the community, can be of extraordinary value as counselor/role models in a prison-based TC treatment program. The employment of ex-addict-offenders has clearly been of benefit to the participants in prison-based programs and has helped the drug treatment system function more effectively. The ex-addict ex-offenders (all of who are TC graduates themselves) demonstrate by their presence the realistic possibility of achieving successful rehabilitation. In addition, they speak the language of the street drug users, they generate their trust easier than professional clinicians, and they can empathize with the feelings and concerns of the drug-abusing patient. Thus, the para-

professional ex-addict-offender in a treatment role, having "been there", is especially able to relate to the special problems of the recently addicted offender, serves as a pro-social role-model of successful rehabilitation, and allows the recovered staff members to "pay back" for past behaviors. In prisons where therapeutic community programs for treating drug offenders are in place, such as at the Stay 'N Out Program in New York (for both men and women) and at the Amity Donovan Program in California, ex-addict-offenders serve as powerful role models to the offenders they treat (Wexler & Williams 1986; Graham & Wexler, 1997).

Research studies evaluating the effectiveness of prison-based TCs demonstrate, both statistically and clinically, that the ex-addict offenders working as clinicians are as or more effective than academically-trained clinical staff alone or up-graded correction officer/counselors alone in rehabilitating the drug offenders (Wexler, 1995). In comparisons of effectiveness made with milieu therapy programs run by correctional treatment staff and with supportive counseling programs run by trained clinicians, the results indicate that graduates of programs with ex-addict-offender clinicians are less likely to fail during the post-release period than graduates of programs that do not include recovered persons. Optimal results seem to occur with the combination of ex-addict-offenders, themselves graduates of TCs, and especially trained volunteer correction officers who choose to work in a prison-based TC. (Lipton 1999).

B. Gender

Although the number of men in prison far exceeds the number of incarcerated women, the women's rate of incarceration is growing at a faster rate. Between 1985 and 1995, the number of male inmates in prisons and jails doubled from 691,800 to 1,437,600 while the female inmate population tripled from 40,500 to 113,100 (Morash, et al., 1998). At the mid-point in the RSAT effort, there are 21 RSAT programs across the country that serve youthful or adult female clients either

exclusively or in a combined population of offenders.[26] Table 13 shows that 70% of the RSAT programs were male, 18% included both male units and female units and 12% were designed solely for women. Three states each have initiated only female programs — Nebraska, South Dakota (for girls) and Washington. We view the proportions of RSAT programs for female offenders as relatively high compared to programming for inmates generally, but more programming tailored for women's needs should be undertaken.

Reviews of female inmates by Prendergast and colleagues (1995), and Wellisch and her colleagues at UCLA (Wellisch, et al., 1996) reveal that the needs of female inmates who are substance abusers are often different than those of men and need to be especially addressed. It should be noted that there is a disproportionately positive impact when women are effectively treated in correction settings because untreated women are major vectors for many societal problems. For example, prostitutes are major carriers of the HIV virus and most female inmates have children who are at risk for a life of drugs and crime if their mothers persist in active drug use and criminality. The needs of female offenders are different from men due to their high rates of physical and sexual victimization, extensive involvement with children, greater likelihood of mental illness, poorer vocational skills, and higher level of pre-incarceration unemployment.

Snell (1994) reports that 43% of women versus 12% of men said they were physically or sexually victimized prior to prison. Women sentenced for a violent offense were twice as likely to have committed the offense against someone close to them. Approximately two-thirds of female inmates had children under 18. Studies of correctional resources for women (Ryan, 1994; Owen, 1998) have noted limited medical services, vocational and educational programs, few parenting classes, and little information on women's health issues.

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[26] Now in operation or about to get underway.

Thus, programs specifically designed for women offenders (not warmed-over men's programs) are necessary to deal with the range of services needed by woman offenders. It has been suggested that drug treatment for women offenders should address childhood physical abuse and sexual victimization (Nelson-Zlupko et al., 1995); witnessing domestic violence as children (Reed, 1985); growing up in drug-using families (Burton, 1992); having caretaker responsibility for siblings or other relatives as children (Bepko & Krestan, 1985); the absence of parenting skills and adolescent parenthood (Morash et al. 1998); and experiencing a range of violence as adults (Sterk & Ellifson, 1990). There are three main approaches to drug treatment for women offenders currently in practice: those that primarily address drug use as a way to prevent relapse and recidivism; those approaches that address drug use and criminality as separate issues; and approaches that address a range of traumas that are viewed as having triggered, complicated and protracted both drug use and criminality (Welle, 1998). The RSAT programs that serve women inmates should focus on the special needs of women inmates, provide these needed services, and undertake careful evaluations of effectiveness.

C. Age

About 70 percent of the RSAT programs, now in operation or about to get underway[27], are for adult offenders, the remainder for juvenile offenders. Of the latter, twenty-four states (25%) have opted to initiate programs under this legislation for both adults and juveniles; and five states — Arizona, Minnesota, Montana, North Carolina, South Dakota —have initiated only juvenile RSAT programs. Of the 24 programs for juveniles, now in operation or about to get underway, seventeen are for male youths and seven are for female youths.

[27] Through March of 1999 we acquired data on 97 programs. These data are based on that total.

We believe, in general, that this is a sound trend, i.e., that youths have been included, and of both genders; however, six of these programs are therapeutic communities or are TCs combined with CBT (six) or are TCs combined with other programmatic elements (nine). The research demonstrating the effectiveness of prison-based therapeutic community treatment approach has been with adults. There is still a paucity of evidence to support its utility in reducing recidivism with incarcerated juveniles. Cognitive-behavioral treatment, on the other hand, has demonstrated positive outcomes with delinquent youth, but only for males (Pearson et al., 1999; Yee et al., forthcoming). Hence, we have in this RSAT effort an important opportunity to add to the knowledge base about 'what works' with youthful offenders by evaluating the substantial proportion of the prison-based programs where youths of either gender are being treated. Unfortunately there is, at this stage, an insufficient evaluation research base to give us much confidence that the choices of methods applied to youthful clients will produce desired outcomes. However, it is fortunate that some of the RSAT "partnership" evaluations will add to the knowledge base about recidivism outcomes with these treatment populations where there has been only limited research.

D. Treatment in County Jails

A small proportion of the RSAT programs, 17 out of 97, now in operation or about to get underway, have been initiated in county jails and other local short-term correctional facilities. The great bulk of the RSAT programs have been started in State institutions.[28] Over the years county jails typically received short shrift in Federal programs where states and counties were both targeted for funding. For this reason, and in consequence of county jails being low on the priority listings of state funding and county revenue disbursements, most jails did not have adequate drug treatment services prior to the

[28] Virginia is a notable exception because all their six RSAT programs were placed in county jail facilities; Texas and Florida each have three programs in county facilities and Kentucky has two in county detention centers.

RSAT enactment. One important question, now at the mid-point of RSAT, is whether the RSAT legislation has had an impact on the needs of local and county jails for substance abuse programming.

Of course, it must be noted that the RSAT Formula Grant Program guide stipulates that States must implement residential programs with a planned time in treatment of between 6 and 12 months. This places a difficult burden on most local and county jail facilities because the length of stay is typically much shorter than six months. In a 1996 survey of county jails[29], the BJS reported that over half of all sentenced offenders were incarcerated for about a month and that only 32 percent were incarcerated for over 3 months.

Jails, to be sure, differ enormously in their ability to provide a variety of services depending on a number of factors. In the same 1996 Bureau of Justice Statistics national survey drug treatment programs were more likely to be reported in large jails, in jails with a continuum of adjunctive support services (e.g., screening, urinalysis, training, collection of assessment data), in jails with an orientation toward development of inmate and staff (e.g., employee assistance) programs, and in jails with an orientation toward innovative approaches to inmate management (e.g., direct supervision). Only 19 percent of all jails surveyed reported a drug treatment program supported by paid staff, and even for jails where there were drug treatment programs, only 13 percent of the inmates were involved in treatment.[30]

Many of these programs did not appear to provide an adequate level of drug treatment services, that is, only 30 programs (2%) provided more than 10 hours per week of treatment activities; programs averaged only three paid staff members; and few (12%) drug treatment programs isolated participants from the general inmate population. A

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[29] U.S. Department of Justice, Bureau of Justice Statistics. 1995. *Jails and Jail Inmates: Census of Jails and Annual Survey of Jails* Washington, DC. And U.S. Department of Justice, Bureau of Justice Statistics. 1997. *Prisoners in 1996.* Washington, DC.

serious concern is the absence of reentry/transition planning and case management services which were available in only eight percent of jails surveyed.

Preliminary findings from model demonstration drug treatment programs in jails indicate that even relatively short-term interventions (6 to 8 weeks) can provide inmates with important coping skills to manage high-risk situations and can increase the fund of knowledge regarding the recovery process, health-related consequences of drug abuse, and relapse prevention principles (Peters & May 1992). These results indicate that treatment of incarcerated inmates is a useful means to develop skills crucial to recovery and hence contribute to reducing drug use and rearrest.

Cognitive skills training seems the most ideally suited to the time available for sentenced jail inmates. The foreshortened time still will permit a 20 or 30 session cognitive skills program. The absence of in-jail drug treatment services represents a neglected opportunity to assist offenders in initiating programming to help prevent relapse to drug use. The costs of developing and operating an in-jail comprehensive drug treatment program (for 7 hours a week per inmate for an average of 65 inmates) runs about average cost of $97,000 per year — this translates to $4 per day beyond the ordinary cost of incarceration on a per inmate basis. However, there is a manifest need for jails to hire in-house staff to provide cognitive skills training, and at least minimal treatment interventions such as drug education and group counseling for offenders with only minor drug abuse problems.

It must be noted that the absence of follow-up treatment is a serious gap. For in- jail programs links to community-based programs for continuity of treatment are still critical elements. Without parole leverage to coerce continuing treatment, and without placing offenders in follow-up care in the community, it appears likely that in-jail programs can only have limited effectiveness. Thus, there is a clear need for jails to foster linkages and develop contracts with drug tre tment providers.

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[30]The absence of drug treatment services is particularly striking in smaller jails, e.g. with fewer than 200 beds.

E. Aftercare and Continuity of Treatment

As noted earlier the provision of continuing treatment in the community following release from the institution is an unfunded mandate (p. 38 *infra*). Under § 507 of the Omnibus Crime Control and Safe Streets Act, States are required to give preference to sub-grant applicants who will provide aftercare services to program participants, but that grant funds may only be used for the residential treatment component.

As Wexler (1997) has stated, the establishment of continuity of care in the community is an essential component of any program. Successful prison-based substance abuse treatment programs must establish linkages between the prison programs and sustaining continuity of care through post-release residence in community programs. Research demonstrates that parolees who receive continuing care support have lower drug relapse and recidivism rates (Belenko 1997, Simpson & Knight 1998). Establishing a link between prison and community treatment programs allows the community programs to continue the work started in prison. Groups that utilize the twelve-step approach in prison often can help connect inmates graduating from correctional drug programs with recovery groups that use the twelve-step approach in the community. Most correctional-based TCs include 12-Step programming in discharge planning for inmates if they cannot access a community-based TC to maintain continuity of treatment. At the mid-point of the RSAT effort, according to our survey results, 86% of the programs created or expanded under this legislation have specified either how their graduates may continue their treatment following release to the community or their intention to establish an appropriate mechanism to do so. Survey results show an acute awareness of the importance of this aspect of treatment. Nonetheless, at this midway point few programs have yet developed the funding from internal state sources or other sources, nor developed sufficient linkages to assure that this phase of the treatment process is in place as their graduates emerge.

F. Combining Treatment Approaches

We have some concern regarding the combining of the three treatment approaches. Some clinicians believe that initially there are bound to be some incompatibility between staffs trained in these very different programmatic traditions. TC staffs and 12-step staffs in particular each have a devotion to different beliefs and practices, and there are 17 programs in which TC and 12-Step approaches are combined. There are two views regarding the combining of these approaches — one optimistic and one pessimistic. On the optimistic side, both the TC and 12-Step approaches use elements of social learning theory, and they both conceptually employ staged change, with recognition of increased personal and social responsibility as time passes in the therapeutic process. Those who are pessimistic about combining diverse program elements assert that the fundamental human change models with which they operate differ, so the guidelines for assessing progress differ, and the reward systems for passage through phases differ. Moreover, the focus in "Anonymous" programs is the individual, while the focus in a TC is on the community of residents.

The key difference is at the core of the 12-step approach. Twelve-step approaches such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have from their inception insisted that their solution is a spiritual one. In that sense AA and NA are radically different from professional therapy, and apparent similarities are more superficial than real. Those treatment professionals who are uncomfortable with the implications of this concept typically have chosen to ignore it, to reduce it to a number of familiar psychological processes, or to redefine it as meaningless. Spirituality, however, is repeatedly identified in AA literature as the hard cornerstone of true recovery. Its core is "trust in God and reliance on conscience, informed by sponsorship and activated through The Twelve Steps ... the formula for maintaining sobriety is to depend on God and be useful to others" (Verdon, 1998: 1). As a spiritual quest for recovery, participation

in AA does not diminish over time unlike participation in therapies in which people participate less frequently as time passes and their condition improves. Rather, a person participating in AA as one going to church is not asked to cut down on attendance or set as a goal "complete independence" from the church, nor would anyone suggest that an increasing sense of closeness to a "higher power" should warrant cutting down on prayer or meditation. Yet the fact remains that many professionals seem to believe that continuing active involvement in the AA or NA fellowship indicates insufficient recovery, and conversely that deciding to move on from AA is a sign of improving mental health.

Nevertheless, AA (and NA) has for years worked adjunctively with TCs. Being adjunctive is quite different from being merged. Our primary concern lie with combining therapies, and merging staffs who hold potentially conflicting traditions. In consequence of these disparities, we express some wariness that the very power that recovered persons possess to bring about change may be centrifugal. That is, that the conflict generated among zealous staffs from different traditions or friction generated among treatment concepts may be destructive to good clinical practice. In any case, the form and substance that the differing programmatic traditions take as the staff compromise and negotiate to create merged programming should be examined during process evaluations. Successful or not, it is bound to be informative. Initial verbal reports regarding this process is that merged programming has created difficulties for program managers to handle during the shakedown period.

While there is a constant danger that valuable and successfully tested treatment elements of each of the merged approaches might be lost in the blending process, there is a counter belief that characterizes a more optimistic set of clinicians. The optimistic view follows from the pragmatic experience of many clinicians that have witnessed the gradual blending of program elements across strict modality lines. This l as been characterized as a consequence of a shift by practitioners from a 'purist' orientation toward traditional

modality features to an 'eclectic' orientation favoring adoption of 'best practices.' In other words, there is less commitment to the distinctions in practices that emerged as these modalities developed, and more attention to applying techniques 'that work' (in the judgment of these clinicians) regardless of which modality the techniques came from. The practical realities of the merged forms of treatment are hard to classify, and it will probably be necessary for new nomenclatures to emerge. Most central to the continuation of the residential treatment effort, we believe, is that these new forms of treatment should not be applied without systematic outcome research being undertaken simultaneously. There is legitimate cause for concern because of the contention that new combination treatments could be less effective, that their components could be 'watered down' to facilitate acceptance, or that they are comprised of and trying to operate with incompatible components.

CONCLUSION AND SUMMARY

The Residential Substance Abuse Treatment for State Prisoners Formula Grant Program (abbreviated RSAT) legislation created an opportunity for states to apply for funds to establish residential substance abuse programs beginning in 1996. In conjunction with this legislation, Congress has authorized spending $270 million for the first five years of the program, the largest sum ever for the development and enhancement of substance abuse treatment programs in state and local correctional facilities. Thus, the RSAT Formula Grant Program is the largest program ever funded to implement treatment programs for offenders in the nation's history.

Largely because of research showing that prison-based therapeutic community programs can significantly reduce recidivism and drug relapse, the RSAT legislation encourages the development of this residential treatment model, but does not preclude the

implementation of other viable treatment approaches or combinations of approaches. States have initiated several kinds of prison treatment programming with the use of the RSAT monies other than TCs including cognitive skills training, behavioral programming, and even 12-step programming. In about 20 percent of the new correctional treatment programs started with RSAT funding, experimental modality combinations are being implemented. Examples include a cognitive skills-based therapeutic community, and 12-step-based cognitive skills program.

The accomplishments at the mid-point of the five-year life of the RSAT program are:

1. Fifty-six jurisdictions—that is, the 50 States, the 5 Territories, and the District of Columbia have generated plans for at least one RSAT program.

2. By the end of March 1999, forty-seven states have actually begun admitting clients to RSAT programs.

3. By the end of March 1999, seventy-eight RSAT programs are known to have actually begun admitting clients.[31]

4. About a quarter (24%) of the RSAT programs are using the therapeutic community as their primary treatment approach. About 13 percent are using cognitive skills training and other cognitive behavioral approaches as their main modality, and 5 percent are using the Twelve-Step approach as their primary treatment. Of the remaining programs fifty-two percent are using some combination of these treatment approaches, e.g., cognitive behavioral treatment with 12-Step programming, therapeutic community with cognitive skill training, etc., or some other treatment approach (6%).

[31] This includes telephone contacts made subsequent to the three NERSAT surveys.

5. More than three-quarters of the programs (76%) are new programs; the remaining quarter consists of existing programs expanded in capacity through the use of RSAT funds.

6. Over 13,000 clients had been admitted to RSAT programs by the end of August, 1998. Not all are currently in residence—some have voluntarily left, some have been administratively discharged, and some have successfully completed the programs.

7. At the end of August 1998 over 7,700 clients were currently in RSAT programs.

8. Over 9,600 beds/slots were generated by the RSAT initiative by August 1998.

9. About 570 substance abuse treatment staff (FTE) have been added to staff the RSAT programs by the end of August 1998.

10. All of the State RSAT Officials responding to the NERSAT state survey assert that the RSAT initiative has helped their state increase its substance abuse treatment capacity.

11. At the time of the NERSAT surveys, the RSAT initiative was about at its mid-point. Programs continue to move through preparation, hiring and training stages to actually admitting clients and operating. Yet, new programs are still coming into the pipeline, that is, proceeding into detailed planning and/or hiring staff.

12. Where significant delays have occurred, the States report having the most difficulty with locating appropriate facilities, constructing facilities, recruiting trained

treatment staff, and contracting with treatment providers because of State bidding and proposal processes.

13. About half of the programs combine what have traditionally been distinct treatment approaches. Where programs are combining treatment approaches, such as therapeutic community treatment with 12-step treatment for example, we have three concerns: (1) the new combination treatments may be less effective in reducing recidivism; (2) that their components may be watered down to facilitate acceptance, and (3) that they are comprised of incompatible components. Only careful process and outcome research can reveal the differential impact of these changes in traditional treatment approaches.

Being national in scope, RSAT's potential effect on communities is as wide as possible. It has mobilized a tremendous amount of resources to provide substance abuse treatment for several thousand inmates. It holds the promise of breaking the cycle of dependency and slowing the revolving door of criminal justice. Moreover, it goes to the heart of the President's intention to break the cycle of drug abuse and crime — a primary concern of present-day national, state and local criminal justice policy.

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Appendix 1 Research Methods in Context

Appendix 1: The Research Methods in Context

The research methods adopted in the National Evaluation of Residential Substance Abuse Treatment programs (NERSAT) reflect the fact that this project was funded by the National Institute of Justice (NIJ) as a Cooperative Agreement. This meant that we had an obligation to alter our research project in response to NIJ's expressed needs. NIJ in turn was confronted with a growing number of RSAT programs, each developing in different ways and at different rates. NIJ also had to plan for and develop a growing number of "local partnership evaluation projects" (i.e., in which some RSAT programs had their own separate, NIJ-funded evaluation research project to conduct a process evaluation on that particular program). Because of these changes and complexities, the NERSAT project underwent changes over its two-year period.

Our proposal that was accepted and funded by NIJ had three evaluation research objectives: (1) to conduct a process evaluation, (2) to provide evaluability assistance and assessment, and (3) to carry out preliminary work on an outcome evaluation.

1. The process evaluation was to consist of a small survey of the RSAT programs to collect and report on a variety of descriptive information on the offenders participating in the programs; the treatment staff; the modalities of treatment used; and on the administrative context of the States' programs.
2. The evaluability tasks were to include both providing *technical assistance* to the States to help them enhance the evaluability of their programs and *assessment* of the final levels of evaluability they were able to achieve. The technical assistance was to be provided via mail, telephone, fax, e-mail and face-to-face in a national Technical Assistance Workshop. NERSAT was to

advise programs on the content and form of the instruments and common data elements to be used to measure program operations (including expenditure reports and status reports on the progress and termination of participants) and ultimately to measure program outcomes (including rates of abstinence and recidivism).

3. It was understood that no rigorous outcome evaluation of the RSAT initiative could be completed in this two-year developmental period, but NERSAT had proposed to perform two elements of necessary preliminary work on an outcome evaluation: collect baseline data for a rigorous impact evaluation, and establish standards and selection criteria (agreed-upon with NIJ) to identify three programs that show promise as model programs and that are good candidates for the subsequent long-term outcome evaluation.

From the beginning of this project (April 1997) and throughout the two years of the project NERSAT staff frequently engaged in discussions about the nature and form of this project with NIJ's Program Manager and other appropriate NIJ staff. As a result of these various discussions with NIJ, NERSAT wrote drafts of the Survey of RSAT State Officials and of the Survey of RSAT Programs and circulated the drafts to NIJ and to the local partnership evaluations. As a result of several discussions with NIJ and others, decisions were made to include successively more and more items (mainly in the Program Survey which in its final version solicited up to 700 responses spread throughout 119 items) requiring more writing and rewriting.

On another major task, after a few months NIJ told us that our planned Evaluability Technical Assistance Workshop was to be "put on hold," pending further discussions with NIJ about content and timing. Later, NIJ decided that the technical

assistance needs of RSAT programs would be better met in other ways, so we were no longer to conduct a Technical Assistance Workshop after all. Concerning the NERSAT project task of developing written *Standards of Evaluability* for the RSAT programs, NIJ did approve our them and approved our distribution of copies of the *Standards of Evaluability* to all of the RSAT programs. (See Appendix 4.)

We field tested the Program Surveys and the (initial) State Surveys in September and October of 1997, made final revisions to them in November and in December 1997 we began mailing the final versions of the Program Surveys to RSAT program directors and the State Surveys to RSAT officials. At about the same time, as a result of out discussions with NIJ in fall of 1997, we agreed that NERSAT would continue conducting the surveys of RSAT state officials and RSAT program directors, that NERSAT staff would serve as presenters at The National Workshop on Assessing the Effectiveness of Corrections Programs in February 1998, and that NERSAT would begin systematic assessment of RSAT programs for later selection of site visits to the six most promising programs.

Further discussions with NIJ on April 3, 1998 let us know that it was doubtful that NERSAT's initial two-year national process evaluation could be followed by NERSAT conducting outcome evaluation research on three model programs. We agreed to replace the task of choosing six evaluable programs which showed promise for a subsequent outcome evaluation and conducting site visits to them with a task of identifying at least six *innovative* RSAT programs for possible site visits, regardless of whether they would receive subsequent outcome evaluation from any research organization.

However, on May 1st NIJ let us know that they now thought that NERSAT project resources should be allocated to a Follow-Up State Survey of state RSAT officials

to obtain specific information from them not covered in the initial state survey. To meet NIJ's needs, NERSAT was to consider site visits to be a low priority task, to be undertaken later in the year only if project resources permitted. Thus, it became inappropriate to select six good or innovative programs for site visits and conduct those visits since work on the Follow-Up Survey was deemed the highest priority. Consequently, we revised the Follow-Up State Survey several times in response to feedback from NIJ and CPO. In mid-September 1998 we began the process of telephoning the officials about the State Follow-up and mailing the surveys to them.

We continued to make contacts with potential survey respondents through 1998 in hope of collecting RSAT programs which had not been operational when we first contacted them, but later did become operational. In December 1999 we analyzed the State and Program Survey data and wrote an Interim Report on the NERSAT project.

Appendix 2 Detailed Tables of Findings

Table 1. RSAT Money Awarded to Each State

State	FY 1996	FY 1997	FY 1998
Alabama	485,214	548,655	1,158,998
Alaska	133,887	154,682	338,428
American Samoa	100,186	111,862	240,417
Arizona	501,066	561,850	1,204,915
Arkansas	268,923	302,994	635,675
California	2,622,956	3,018,886	6,624,486
Colorado	306,044	350,070	773,466
Connecticut	303,393	323,743	677,960
Delaware	155,100	173,862	372,531
District of Columbia	284,967	270,355	542,423
Florida	1,290,470	1,420,879	2,938,765
Georgia	754,766	819,727	1,753,951
Guam	105,412	117,400	250,978
Hawaii	149,201	165,677	365,435
Idaho	161,613	184,753	408,847
Illinois	825,455	892,316	1,924,928
Indiana	401,000	448,620	970,031
Iowa	208,726	236,738	514,497
Kansas	232,455	262,923	562,668
Kentucky	328,947	368,599	815,960
Louisiana	576,634	654,087	1,422,225
Maine	127,393	140,877	302,571
Maryland	511,326	561,341	1,173,149
Massachusetts	319,725	355,242	734,521
Michigan	894,375	963,805	2,065,140
Minnesota	190,895	213,608	460,733
Mississippi	338,497	391,669	848,561
Missouri	463,272	529,231	1,226,245
Montana	133,964	155,415	333,294
Nebraska	153,178	177,120	380,713
Nevada	243,215	275,181	597,189
New Hampshire	139,037	152,727	327,366
New Jersey	591,736	676,077	1,396,512
New Mexico	178,541	203,183	433,350
New York	1,416,014	1,510,245	3,139,838
North Carolina	614,639	735,492	1,587,191
North Dakota	111,080	124,017	268,343
Nothern Mariana Islands	100,590	112,289	239,582
Ohio	928,595	1,033,645	2,209,736
Oklahoma	437,621	500,582	1,069,461
Oregon	243,561	285,361	567,218
Pennsylvania	672,781	802,033	1,686,078
Puerto Rico	265,753	287,316	603,826
Rhode Island	135,559	150,691	321,063
South Carolina	473,667	534,789	1,114,960
South Dakota	133,561	152,707	328,368
Tennessee	386,282	429,317	898,151
Texas	2,541,297	2,756,692	5,939,453
Utah	162,228	185,163	410,893
Vermont	114,481	128,110	274,938

Virgin Islands	103,856	115,751	252,397
Virginia	624,093	697,946	1,434,372
Washington	318,437	356,525	768,958
West Virginia	146,204	165,534	362,847
Wisconsin	303,643	357,461	820,426
Wyoming	0*	140,673	298,773

Table 1. Notes.

This table is based on information provided by the Office of Justice Programs/Corrections Program Office. The zero entry for Fiscal Year 1996 for Wyoming reflects the fact that it did not apply in FY '96.

Table 1 Summary Statistics.

State	FY 1996	FY 1997	FY 1998
Valid N	56	56	56
Mean	441,348	495,473	1,060,246
Median	294,180	313,369	656,818
Std. Deviation	506,974	561,837	1,212,103
Sum	24,715,511	27,746,496	59,373,800

Table 2 Sources of Budgets for the RSAT Programs.

State	RSAT '96	Other '96	RSAT '97	Other '97	RSAT '98	Other '98
Alabama			459,983	153,358	521,222	225,736
Alaska						
Arizona					171,435	57,146
Arkansas	84,850	21,210	291,821	72,650	49,950	0
California						
Colorado			656,114	0	773,466	140,178
Connecticut						
Delaware	147,348	42,000	166,107	94,000	353,905	118,000
Florida					1,274,428	379,762
Georgia			751,766	250,589		
Guam	105,412	0	117,400	0	250,978	0
Hawaii			46,904	15,634		
Idaho			23,762	17,246	200,077	80,633
Illinois						
Indiana	401,000	133,667	448,620	149,540	970,031	323,344
Iowa	208,726	81,423	236,738	78,913	514,497	141,498
Kansas					127,231	44,697
Kentucky					328,947	82,237
Louisiana	576,634	322,850	654,087	264,815	1,422,225	508,609
Maine	123,333	41,465				
Maryland	511,326	161,920	561,341	187,273	1,173,149	0
Massachusetts			77,772	25,925	161,582	53,861
Minnesota			78,989	0	183,704	0
Mississippi			338,487	112,945		
Nebraska	153,178	51,059	177,120	59,040	380,711	126,904
Nevada	230,257	58,432	262,000	87,333	582,189	194,003
New Hampshire			8,603	14,206	136,618	44,555
New Jersey			400,000	133,334	400,000	133,334
New Mexico			178,541	59,630	203,183	67,863
New York	1,416,014	472,005	1,510,245	503,415	3,139,838	1,046,316
North Dakota	111,080	109,500	124,017	1,095,000	268,343	1,095,000
Ohio	928,595	309,531	1,033,645	344,549	2,209,736	0
Oklahoma	437,621	165,156	500,582	70,156	1,069,461	0
Oregon					243,561	81,187
Pennsylvania						
Puerto Rico	265,753	88,584	287,316	95,772	603,826	201,275
South Carolina			5,942	2,292	569,629	189,363
Tennessee	386,282	128,761	429,317	143,106	898,151	299,384
Texas					1,885,819	0
Utah			48,071	16,024	175,877	58,626
Vermont			114,481	38,160	128,110	42,703
Virginia	624,093	198,031	697,946	265,050	1,434,372	159,375
Washington			227,144	75,555	315,617	105,644
West Virginia	146,204	48,734	165,534	55,178	362,847	120,949
Wisconsin			151,841	50,607	151,841	50,607
Wyoming						

Table 2. Notes.

This table is based on a survey question worded "What part of your budget for your state's RSAT program(s) came from the following source in each fiscal year [State FY '96? State FY '97? State FY '98]?" Spaces were provided so the respondent could list any funds from the state, local government, other federal sources, not-for-profit sources or private sources. In this table "Other" is an aggregation of those listed non-RSAT funds.

Of these 46 states, only states with nonmissing information for both RSAT and non-RSAT funds in each fiscal year are listed.

Table 2. Summary Statistics.

State	RSAT '96	Other '96	RSAT '97	Other '97	RSAT '98	Other '98
Valid N	18	18	33	33	36	36
Mean	380,984	135,240	340,371	137,312	656,571	171,466
Median	248,005	99,042	236,738	75,555	371,779	93,941
Std. Deviation	344,649	123,566	326,878	205,218	679,405	249,487
Sum	6,857,706	2,434,328	11,232,236	4,531,295	23,636,556	6,172,789

Table 3. Types of Expenditures in RSAT Programs, Aggregating FY96 – FY98.

State	Tx Staff Salary	Tx Staff Training	Drug Tests	Supplies	Other
Alabama	840,846	16,393	148,800	167,956	186,274
Alaska	0	0	0	0	0
Arizona	88,656	0	2,468	0	14,383
Arkansas	297,426	1,481	15,000	111,787	0
California	623,070	53,829	13,034	6,461	301,280
Colorado	42,553	4,418	0	8,559	392,069
Connecticut	NR	NR	NR	NR	NR
Delaware	648,905	0	17,514	0	0
Florida	180,298	3,024	0	81,990	528,959
Georgia	0	0	0	66,079	439,090
Guam	0	0	0	0	2,993
Hawaii	0	0	1,365	766	29,869
Idaho	0	0	282	10,222	213,332
Illinois	0	0	0	0	0
Indiana	0	0	0	0	534,666
Iowa	802,858	0	0	20,553	131,242
Kansas	113,496	991	0	12,744	0
Kentucky	235,500	50,000	0	35,000	6,000
Louisiana	399,470	158,671	6,912	45,008	239,594
Maine	100,367	0	0	0	64,444
Maryland	179,518	0	0	8,608	74,754
Massachusetts	233,240	17,772	0	14,000	54,124
Minnesota	188,899	11,882	0	27,350	34,562
Mississippi	205,431	22,215	0	14,560	0
Nebraska	406,308	0	0	65,067	239,635
Nevada	11,835	0	0	0	10,481
New Hampshire	132,093	41	0	3,063	10,064
New Jersey	0	0	0	0	800,000
New Mexico	89,294	1,185	1,900	9,735	6,007
New York	0	0	0	0	0
North Dakota	51,566	10,231	0	19,919	148,881
Ohio	765,000	37,000	0	53,000	0
Oklahoma	0	0	0	0	50,000
Oregon	0	0	0	0	325,200
Pennsylvania	0	0	0	0	0
Puerto Rico	0	1,469	17,750	125,620	42,287
South Carolina	472,854	0	0	24,775	51,832
Tennessee	0	10,000	0	10,000	173,702
Texas	1,308,141	15,890	58,384	81,877	307,907
Utah	179,655	4,864	5,733	31,896	0
Vermont	0	0	0	0	242,591
Virginia	0	0	0	0	0
Washington	343,357	0	0	6,112	59,509
West Virginia	0	0	0	0	0
Wisconsin	115,712	13,850	36,109	36,109	129,562
Wyoming	0	0	0	0	0

Table 3. Notes.

This table is based on a survey question worded: "In your RSAT program(s) what did you purchase with the RSAT funds during each fiscal year?" Spaces were provided to list entries in eight specific categories, plus four spaces the respondent could use to write in other categories of expenditures.

Of the 56 "states," 46 returned Final State Surveys containing usable information. Of these 46 states, Alaska, Illinois and New York did not have programs operating at the time of the survey. In this table entries of "$0" are included in the calculations of the summary statistics.

The large numbers in the "Other" category for many of the states generally reflect lump-sum contracts with treatment providers to provide the substance abuse treatment for the program. Colorado, Florida, Georgia, Iowa, Idaho, New Jersey, Oregon, Tennessee, Vermont reported contractual expenditures in this way.

Table 3: Summary Statistics.

State	Tx Staff Salary	Tx Staff Training	Drug Tests	Supplies	Other
Valid N	45	45	45	45	45
Mean	201,252	9,671	7,228	24,418	129,895
Median	89,294	0	0	8,608	50,000
Std. Deviation	291,873	25,964	24,127	37,944	181,549
Sum	9,056,347	435,206	325,251	1,098,817	5,845,294

Table 4. Correctional Residential Substance Abuse Treatment Slots Over Time.

State	'95 slots	'96 slots	'97 slots	'98 slots
Alabama	NR	0	675	847
Alaska	0	0	0	0
Arizona	NR	NR	NR	68
Arkansas	209	242	266	370
California	1,450	1,450	1,378	NR
Colorado	130	130	210	219
Connecticut	336	336	304	304
Delaware	385	NR	699	NR
Florida	1,845	2,393	2,331	2,132
Georgia	0	234	0	310
Guam	0	0	0	0
Hawaii	56	56	98	178
Idaho	0	0	48	48
Illinois	NR	NR	2,262	2,262
Indiana	75	75	75	269
Iowa	700	507	507	710
Kansas	NR	NR	48	140
Kentucky	NR	NR	NR	395
Louisiana	275	275	340	340
Maine	NR	NR	NR	NR
Maryland	98	166	214	513
Massachusetts	1,003	997	819	882
Minnesota	147	155	402	455
Mississippi	396	446	496	546
Nebraska	90	109	109	190
Nevada	0	0	0	0
New Hampshire	192	288	288	288
New Jersey	329	329	623	1,011
New Mexico	46	56	103	181
New York	NR	NR	NR	NR
North Dakota	60	60	60	60
Ohio	2,000	2,500	1,000*	NR
Oklahoma	NR	15	15	NR
Oregon	381	348	362	NR
Pennsylvania	NR	NR	352	519
Puerto Rico	0	0	0	0
South Carolina	332	332	332	556
Tennessee	NR	NR	NR	NR
Texas	0	0	0	400
Utah	36	131	153	180
Vermont	0	0	0	60
Virginia	NR	NR	NR	82
Washington	0	0	72	72
West Virginia	NR	NR	NR	24
Wisconsin	NR	180	205	205
Wyoming	NR	NR	NR	NR

Table 4 Notes.

This table is based on a survey question worded: "In your state's *correctional* substance abuse treatment (excluding costs focused on drug testing, drug abuse education, and self-help programs such as AA) how many [separate residential] treatment slots did you have in each fiscal year? Number of slots for inmates in separate residential units focused on substance abuse treatment:"

Of the 56 "states," 46 returned Final State Surveys containing usable information. All 46 are listed here although some could not respond (NR) to this item.

Florida's entries are not complete for the state because information was not available for a state-level service provider. Georgia's 234 slots in FY '96 were in an experimental program, thus they did not continue into FY '97.New York listed treatment slots for the four periods as '95=10,000, '96=10,000, '97=11,000, '98=NA, citing the Director of Substance Abuse as the source, and indicating that these estimates refer to residential and nonresidential combined. Ohio did not cite the source of these estimates and did not comment on them.

Entries of "0" are included in the calculations of the summary statistics.

Table 4: Summary Statistics.

State	'95 slots	'96 slots	'97 slots	'98 slots
Valid N	32	34	38	37
Mean	330	347	391	400
Median	114	143	212	269
Std. Deviation	524	610	551	508
Sum	10,571	11,810	14,846	14,816

Table 5. Correctional Non-Residential Substance Abuse Treatment Slots Over Time.

State	'95 slots	'96 slots	'97 slots	'98 slots
Alabama	NR	0	0	555
Alaska	209	209	209	209
Arizona	NR	NR	NR	NR
Arkansas	225	235	170	170
California	NR	NR	NR	NR
Colorado	839	887	791	724
Connecticut	542	783	786	674
Delaware	175	NR	513	NR
Florida	3,196	2,526	2,336	2,801
Georgia	NR	NR	NR	NR
Guam	NR	NR	NR	NR
Hawaii	96	120	120	305
Idaho	0	0	0	0
Illinois	NR	NR	650	650
Indiana	2,100	2,580	2,900	2,300
Iowa	922	922	922	922
Kansas	212	212	232	240
Kentucky	NR	NR	NR	NR
Louisiana	2,500	2,500	2,500	2,500
Maine	NR	NR	NR	NR
Maryland	NR	NR	NR	NR
Massachusetts	40	55	55	55
Minnesota	45	45	0	0
Mississippi	NR	NR	NR	NR
Nebraska	180	195	225	420
Nevada	38	40	44	44
New Hampshire	NR	NR	NR	NR
New Jersey	0	0	0	0
New Mexico	280	300	320	360
New York	NR	NR	NR	NR
North Dakota	4	30	30	40
Ohio	8,000	8,000	1,500	NR
Oklahoma	NR	13	20	NR
Oregon	450	550	580	NR
Pennsylvania	NR	NR	6,125	6,430
Puerto Rico	0	0	0	0
South Carolina	0	0	0	60
Tennessee	NR	NR	NR	NR
Texas	0	0	0	0
Utah	176	152	236	671
Vermont	0	0	0	0
Virginia	NR	NR	NR	NR
Washington	2,500	2,500	2,500	2,500
West Virginia	NR	NR	NR	NR
Wisconsin	NR	2,641	2,857	2,857
Wyoming	NR	NR	NR	NR

Table 5. Notes.

This table is based on a survey question worded: "In your state's *correctional* substance abuse treatment (excluding costs focused on drug testing, drug abuse education, and self-help programs such as AA) how many [other types of] treatment slots did you have in each fiscal year? Number of slots for substance abuse treatment other than in separate residential units focused on substance abuse:"

Of the 56 "states," 46 returned Final State Surveys containing usable information. All 46 are listed here although some could not respond (NR) to this item.

Florida's entries are not complete for the state because information was not available for a state-level service provider. Indiana noted that the lower number in FY '98 was "due to staff vacancies / frozen positions." Massachusetts' entries in this table were labeled "per month" (This was not so for their entries which appear in Table 4.) New York listed treatment slots for the four periods as '95=10,000, '96=10,000, '97=11,000, '98=NA, citing the Director of Substance Abuse as the source, and indicating that these estimates refer to residential and nonresidential combined.

Entries of "0" are included in the calculations of the summary statistics.

Table 5: Summary Statistics.

State	'95 slots	'96 slots	'97 slots	'98 slots
Valid N	27	29	32	28
Mean	842	879	832	910
Median	180	195	229	333
Std. Deviation	1,691	1,658	1,339	1,434
Sum	22,729	25,495	26,621	25,487

Table 6. Correctional Residential Substance Abuse Treatment Staff Over Time.

State	'95 staff	'96 staff	'97 staff	'98 staff
Alabama	NR	61	73	76
Alaska	0	0	0	0
Arizona	NR	NR	NR	21
Arkansas	NR	9	17	20
California	NR	125	136	NR
Colorado	27	27	33	32
Connecticut	37	32	31	27
Delaware	NR	NR	NR	NR
Florida	36	36	34	88
Georgia	NR	NR	NR	NR
Guam	12	12	12	0
Hawaii	9	9	13	15
Idaho	0	0	3	3
Illinois	NR	NR	78	78
Indiana	6	6	6	17
Iowa	NR	38	39	41
Kansas	NR	NR	5	13
Kentucky	NR	NR	NR	20
Louisiana	16	16	11	11
Maine	NR	NR	NR	NR
Maryland	8	11	13	20
Massachusetts	48	56	61	63
Minnesota	19	19	44	46
Mississippi	24	24	36	38
Nebraska	10	13	13	19
Nevada	0	0	0	0
New Hampshire	8	8	15	15
New Jersey	19	19	36	59
New Mexico	2	3	7	10
New York	NR	NR	NR	NR
North Dakota	3	7	7	7
Ohio	40	65	85	NR
Oklahoma	NR	22	22	NR
Oregon	70	54	64	NR
Pennsylvania	NR	NR	27	32
Puerto Rico	0	6	0	0
South Carolina	38	38	38	61
Tennessee	NR	NR	NR	NR
Texas	0	0	0	59
Utah	0	3	3	7
Vermont	NR	NR	NR	2
Virginia	NR	NR	NR	17
Washington	0	0	6	6
West Virginia	NR	NR	NR	3
Wisconsin	NR	NR	NR	NR
Wyoming	NR	NR	NR	NR

Table 6. Notes.

This table is based on a survey question worded: "In your state's *correctional* substance abuse treatment (excluding costs focused on drug testing, drug abuse education, and self-help programs such as AA) how many substance abuse treatment staff (in Full Time Equivalents, FTE) did you have? Number of treatment staff for residential component:"

Of the 56 "states," 46 returned Final State Surveys containing usable information. All 46 are listed here although some could not respond (NR) to this item.

Georgia's reported entries for treatment staff are excluded since they only reported state staff, apparently excluding a large number of "contracted staff." Iowa's entry of 922 was explicitly identified as an estimate. New York listed treatment slots for the four periods as '95=250, '96=250, '97=270, '98=NA, indicating that these estimates refer to residential and nonresidential combined.

Entries of "0" are included in the calculations of the summary statistics.

Table 6: Summary Statistics.

State	'95 staff	'96 staff	'97 staff	'98 staff
Valid N	26	31	34	35
Mean	17	23	28	26
Median	10	13	16	19
Std. Deviation	18	27	31	25
Sum	432	718	967	925

Table 7. Correctional NonResidential Substance Abuse Treatment Staff Over Time.

State	'95 staff	'96 staff	'97 staff	'98 staff
Alabama	NR	0	0	0
Alaska	17	17	18	18
Arizona	NR	NR	NR	17
Arkansas	NR	14	9	10
California	NR	NR	NR	NR
Colorado	53	55	56	67
Connecticut	79	85	77	72
Delaware	NR	NR	NR	NR
Florida	NR	NR	NR	NR
Georgia	NR	NR	NR	NR
Guam	1	1	1	1
Hawaii	NR	NR	NR	NR
Idaho	5	5	5	5
Illinois	NR	NR	16	16
Indiana	58	63	69	64
Iowa	NR	22	25	30
Kansas	29	29	31	33
Kentucky	NR	NR	NR	NR
Louisiana	11	11	11	11
Maine	NR	NR	NR	NR
Maryland	0	12	11	17
Massachusetts	2	3	3	3
Minnesota	5	6	NR	NR
Mississippi	NR	NR	NR	NR
Nebraska	7	8	9	15
Nevada	7	7	7	7
New Hampshire	NR	NR	NR	NR
New Jersey	0	0	0	0
New Mexico	5	5	6	8
New York	NR	NR	NR	NR
North Dakota	4	6	8	8
Ohio	60	85	105	NR
Oklahoma	0	0	0	0
Oregon	5	23	25	NR
Pennsylvania	NR	NR	115	127
Puerto Rico	0	0	0	0
South Carolina	0	0	0	4
Tennessee	NR	NR	NR	NR
Texas	0	0	0	0
Utah	8	9	10	6
Vermont	18	18	18	18
Virginia	NR	NR	NR	NR
Washington	17	47	47	48
West Virginia	NR	NR	NR	NR
Wisconsin	NR	NR	NR	NR
Wyoming	NR	NR	NR	NR

Table 7. Notes.

This table is based on a survey question worded: "In your state's *correctional* substance abuse treatment (excluding costs focused on drug testing, drug abuse education, and self-help programs such as AA) how many substance abuse treatment staff (in Full Time Equivalents, FTE) did you have? Number of treatment staff for residential component:"

Of the 56 "states," 46 retumed Final State Surveys containing usable information. All 46 are listed here although some could not respond (NR) to this item.

Georgia's and Hawaii's reported entries for nonresidential treatment staff are excluded since they only reported state staff, apparently excluding a large number of "contracted staff." New York listed treatment slots for the four periods as '95=250, '96=250, '97=270, '98=NA, indicating that these estimates refer to residential and nonresidential combined.

Entries of "0" are included in the calculations of the summary statistics.

Table 7: Summary Statistics.

State	'95 staff	'96 staff	'97 staff	'98 staff
Valid N	25	28	29	28
Mean	16	19	23	22
Median	5	8	10	11
Std. Deviation	22	25	32	29
Sum	390	530	680	604

Table 8. Percentages of RSAT Funds Spent Over Time During the First Year Since the RSAT Award.

State	First 3 Months	First 6 Months	First Year
Alaska	0	0	0
Alabama	4	10	95
Arkansas	0	9	75
Arizona	0	1	46
California	20	40	70
Colorado	10	40	80
Connecticut	0	0	30
Delaware	1	2	100
Florida	0	0	13
Georgia	0	0	0
Guam	0	0	3
Hawaii	16	31	NR
Iowa	0	3	42
Idaho	0	15	100
Illinois	0	0	0
Indiana	0	0	0
Kansas	0	0	21
Kentucky	20	45	90
Louisiana	0	30	75
Massachusetts	20	50	100
Maryland	0	0	0
Maine	NR	NR	NR
Minnesota	7	28	60
Mississippi	3	17	51
North Dakota	0	34	77
Nebraska	0	11	59
New Hampshire	1	6	72
New Jersey	0	10	70
New Mexico	0	3	30
Nevada	0	1	5
New York	0	0	0
Ohio	0	0	0
Oklahoma	1	1	50
Oregon	0	0	0
Pennsylvania	NR	NR	NR
Puerto Rico	NR	NR	NR
South Carolina	0	0	51
Tennessee	NR	NR	57
Texas	0	0	0
Utah	0	0	29
Virginia	0	0	0
Vermont	0	0	2
Washington	0	17	65
Wisconsin	0	0	20
West Virginia	0	11	16
Wyoming	NR	NR	NR

Table 8. Notes.

This table is based on responses to three survey questions: "Some states were not able to begin spending the RSAT funds right away (for a variety of reasons). In the first three months after the RSAT award, what percentage of your projected annual RSAT budget was actually spent? ...In the first six months?... In the first year?"

Of the 56 "states," 46 returned Final State Surveys containing usable information. All 46 are listed here although some could not respond (NR) to this item.

Some states reported spending zero percent of RSAT funds in the first year even though they had made expenditures for RSAT programs in that first year because they used other funding sources (generally state funds) in the first year to cover program development costs. They drew down from the RSAT funds after that first year. Georgia and Maryland added comments to this effect on their surveys.

Note that Alaska, Guam, Illinois, Nevada, New York, and Wyoming did not have a program operational at the time of the survey.

Table 8: Summary Statistics.

State	First 3 Months	First 6 Months	First Year
Valid N	41	41	41
Mean	2	10	40
Median	0	1	42
Std. Deviation	6	15	35

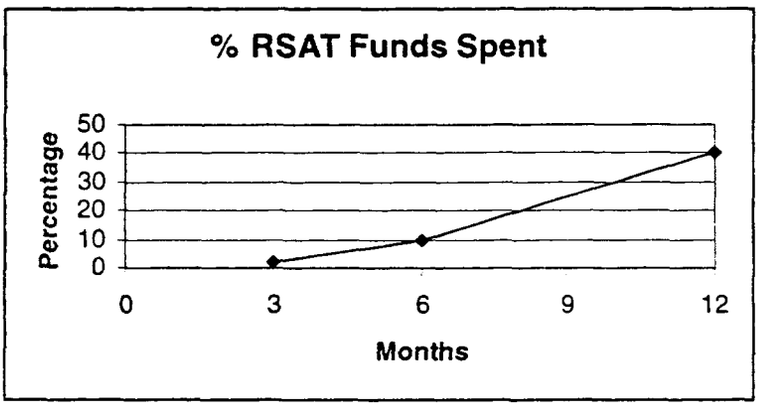

Table 9. Rating the Importance of Various Reasons Why There May Have Been a Delay in Spending RSAT Funds (1=not a problem to 5=severe problem).

State	Funds not released at state level	Treatment providers in bidding or proposal process	Constructing facility	Federal requirements	State regulations	Hard to recruit treatment staff	Hard to get training for treatment staff	Locating appropriate facilities	Screening for program placement	Security considerations for program eligibility	Degree of inter-agency cooperation
Alaska	1	2	5	1	1	1	2	5	2	1	1
Alabama	2	2	1	1	1	3	3	1	1	1	1
Arkansas	1	1	1	1	1	4	1	2	2	2	2
Arizona	1	1	1	1	5	5	5	1	1	1	1
California	3	1	1	3	3	4	2	1	1	1	2
Colorado	2	4	1	1	4	4	4	1	2	1	2
Connecticut	1	4	1	1	1	3	2	3	1	1	1
Delaware	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Florida	1	1	1	3	3	4	1	4	3	3	3
Georgia	1	5	1	1	1	3	1	3	1	1	1
Guam	1	1	5	5	1	3	3	5	1	1	1
Hawaii	1	2	1	3	4	4	3	4	3	3	3
Iowa	1	1	1	1	3	5	2	1	1	1	1
Idaho	5	2	3	1	1	1	2	1	3	1	2
Illinois	4	5	1	1	2	3	2	1	1	1	1
Indiana	2	4	1	1	4	4	2	3	1	1	3
Kansas	5	3	1	1	4	1	3	4	2	2	4
Kentucky	2	3	1	2	2	3	2	3	4	3	5
Louisiana	3	1	1	3	3	3	3	1	1	1	1
Massachusetts	2	1	1	1	1	3	2	1	2	1	1
Maryland	2	2	3	1	1	5	2	2	4	4	3
Maine	2	4	3	2	2	4	3	5	3	4	1
Minnesota	4	1	1	2	2	2	2	2	1	1	1
Mississippi	1	1	4	4	4	5	4	4	5	4	3
North Dakota	4	1	1	1	4	4	3	1	1	1	1
Nebraska	1	1	3	1	1	3	1	1	1	1	1
New Hampshire	4	1	1	1	4	3	3	1	1	1	1
New Jersey	3	4	1	4	1	1	1	1	2	1	1
New Mexico	2	3	1	3	4	5	4	3	2	4	2
Nevada	2	4	5	3	2	1	1	4	3	2	4
New York	4	NR	NR	4	4	NR	NR	NR	NR	NR	NR
Ohio	1	2	4	1	1	3	2	4	1	4	1

State	Funds not released at state level	Treatment providers in bidding or proposal process	Constructing facility	Federal requirements	State regulations	Hard to recruit treatment staff	Hard to get training for treatment staff	Locating appropriate facilities	Screening for program placement	Security considerations for program eligibility	Degree of inter-agency cooperation
Oklahoma	1	2	1	1	5	2	2	1	1	3	2
Oregon	1	2	1	1	1	1	1	1	1	1	1
Pennsylvania	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Puerto Rico	1	1	5	3	3	5	1	1	2	2	1
South Carolina	1	3	1	1	1	2	1	1	1	2	1
Tennessee	2	5	2	5	5	2	2	5	2	2	1
Texas	2	3	2	4	3	3	2	3	3	3	1
Utah	1	1	3	3	1	3	1	3	1	1	1
Virginia	1	2	9	2	2	2	3	1	9	2	1
Vermont	3	3	5	1	1	4	2	4	2	1	1
Washington	1	1	1	1	1	4	1	1	5	1	1
Wisconsin	1	1	4	1	1	3	4	4	2	1	1
West Virginia	5	1	1	1	1	3	2	1	2	4	1
Wyoming	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

Table 9. Notes.

This table is based on responses to a series of questions with the following introduction: "The following is a list of some reasons why there may have been some delay in spending any part of the RSAT money. Rate each statement on a scale from one to five, where 5 means severe impediment and 1 means no problem at all, to indicate how much each of the following was an impediment to using RSAT funds to expand drug treatment in your state."

Of the 56 "states," 46 returned Final State Surveys containing usable information. All 46 are listed here although some did not respond (NR) to this item.

Table 9: Summary Statistics.

State	Funds not released at state level	Treatment providers in bidding or proposal process	Constructing facility	Federal requirements	State regulations	Hard to recruit treatment staff	Hard to get training for treatment staff	Locating appropriate facilities	Screening for program placement	Security considerations for program eligibility	Degree of inter-agency cooperation
N	43	42	41	43	43	42	42	42	41	42	42
Mean	2.1	2.2	2.0	1.9	2.3	3.1	2.2	2.4	1.9	1.8	1.6
Median	2	2	1	1	2	3	2	2	2	1	1
Std. Deviation	1.3	1.3	1.5	1.3	1.4	1.2	1.0	1.5	1.1	1.1	1.0

Table 10. Rating the Importance of Various Reasons Why There May Have Been a Delay in Spending RSAT Funds (Ratings collapsed).

	Severity of Problem (Collapsed)				
Potential Problems for RSAT Programs	1	2 or 3	4 or 5	Total %	Valid N
Funds not released at state level	47%	35%	19%	100%	43
Treatment providers in bidding or proposal process	43%	36%	21%	100%	42
Constructing facility	63%	17%	20%	100%	41
Federal requirements	58%	28%	14%	100%	43
State regulations	44%	28%	28%	100%	43
Hard to recruit treatment staff	14%	48%	38%	100%	42
Hard to get training for treatment staff	26%	62%	12%	100%	42
Locating appropriate facilities	48%	24%	29%	100%	42
Screening for program placement	46%	44%	10%	100%	41
Security considerations for program eligibility	57%	29%	14%	100%	42
Degree of inter-agency cooperation	67%	26%	7%	100%	42

Table 11. RSAT Treatment Slots and Current Client Caseloads.

State	PROGID#	Program ID	Clients currently in Program	Beds	In NERSAT universe of programs?	Clients, state total	Beds, state total
Alabama	21	ALCrimeBill	35	40	Yes		
Alabama	22		74	150	No		
Alabama	23		84	192	No		
Alabama	24		41	50	No		
Alabama	25		26	30	No		
Alabama	26		66	90	No		
Alabama	27		51	60	No	377	612
Alaska	11	AKHiland	0	64	Yes	0	64
American Samoa	41	ASRSAT	NR	NR	Yes	NR	NR
Arizona	51	AZRecovery	22	22	Yes	22	22
Arkansas	31	ARRSAT	111	120	Yes	111	120
California	61	CAForever	120	120	Yes		
California	62	CAHolton	NR	425	Yes		
California	63	CAStark	NR	300	Yes		
California	64	CAVentura	NR	130	Yes	974	975 *
Colorado	71	CODOC	90	96	Yes		
Colorado	72	COLETTS	24	61	Yes		
Colorado	74		107	215	No	221	372
Connecticut	81	CTManson	72	72	Yes		
Connecticut	82	CTOsborn	38	60	Yes		
Connecticut	83	CTYork	81	99	Yes	191	231
Delaware	101	DECrest	5	80	Yes		
Delaware	102	DEKey	NR	160	Yes		
Delaware	103	DEKeySouth	79	180	Yes		
Delaware	104	DENewHope	90	90	Yes		
Delaware	105	DEPassage	109	128	Yes	317	638 *
Dist. of Columbia	91	DCSafe	15	20	Yes	17	20
Florida	111	FLDual	104	140	Yes		
Florida	115		21	35	No	125	175
Georgia	121	GARSAT	310	310	Yes	310	310
Guam	131	GURSAT	NR	80	Yes	NR	80
Hawaii	141	HIBridge	32	32	Yes	32	32
Idaho	161	IDSICI	39	48	Yes	39	48
Illinois	171	ILRSAT	NR	NR	Yes	NR	NR
Indiana	181	INCRA	194	194	Yes	194	194
Iowa	151	IAOthrWay	60	80	Yes	60	116 *
Kansas	191	KSLarned	20	20	Yes		
Kansas	192		120	120	No	140	140
Kentucky	201	KYClassD	31	31	Yes		
Kentucky	202		16	22	No		
Kentucky	203		25	96	No	72	149
Louisiana	211	LAConcordia	40	100	Yes		
Louisiana	212	LAIntensive	149	200	Yes	189	300
Maine	241	MEIntTC	NR	40	Yes	0	40
Maryland	231	MDRSAT	70	275	Yes		
Maryland	232		12	24	No	82	299
Massachusetts	221	MACRA	487	537	Yes		
Massachusetts	222	MARSAT	NR	NR	Yes	487	622 *
Michigan	251	MIMaxey	44	44	Yes		

Michigan	252	MIMDOC	47	44	Yes	200	240 *
Minnesota	261	MNSauk	15	30	Yes	15	30
Mississippi	291	MSPreRel	41	34	Yes		
Mississippi	292		55	20	No	54	54
Missouri	271	MOOzark	645	652	Yes	645	652
Montana	301	MTBillings	NR	12	Yes		
Montana	302	MTYouth	NR	12	Yes	19	24 *
Nebraska	331	NERSAT	19	19	Yes	19	19
Nevada	371	NVWings	83	85	Yes	85	85
New Hampshire	341	NHSummit	48	48	Yes	48	48
New Jersey	351	NJ1stStep	188	188	Yes		
New Jersey	352	NJAlpha	52	52	Yes		
New Jersey	353		100	100	No	340	340
New Mexico	361	NMWARPOU	34	45	Yes	34	45
New York	381	NYRSAT	205	205	Yes	205	205
North Carolina	311	NCRSAT	NR	NR	Yes	125	125 *
North Dakota	321	NDRSAT	60	60	Yes	60	60
Northern Marianas	281	MPRSAT	NR	NR	Yes	NR	NR
Ohio	391	OHMohican	320	320	Yes		
Ohio	392	OHMonday	30	30	Yes		
Ohio	393	OHNCI	0	120	Yes		
Ohio	394	OHYDC	NR	40	Yes	350	510
Oklahoma	401	OKFemale	10	10	Yes		
Oklahoma	402	OKTulsa	10	10	Yes	20	20
Oregon	411	ORKlamath	NR	12	Yes	235	244 *
Pennsylvania	421	PARecAcad	60	60	Yes		
Pennsylvania	422		55	60	No	115	120
Puerto Rico	431	PRRSAT	23	100	Yes	98	100 *
Rhode Island	441	RICRA	NR	52	Yes	51	52 *
South Carolina	451	SCTorbeville	136	136	Yes	136	136
South Dakota	461	SDLamont	24	21	Yes	24	24
Tennessee	471	TNWomen	81	128	Yes	228	228 *
Texas	481	TXChoices	122	140	Yes		
Texas	482	TXHarris	12	12	Yes		
Texas	483	TxYouth	64	64	No		
Texas	484	TXDallas	13	16	No		
Texas		TXRSAT	NR	NR	Yes		
Texas		TXRSAT5	NR	NR	Yes	211	232
Utah	491	UTConQuest	135	144	Yes		
Utah	492	UTOUT	22	32	Yes	157	176
Vermont	521	VTMarPath	44	60	Yes	44	60
Virgin Islands	511	VIRSAT	NR	NR	Yes	NR	NR
Virginia	501	VABlueRidge	16	30	Yes		
Virginia	502	VAChgTimes	10	10	Yes		
Virginia	503	VAFork	16	30	Yes		
Virginia	504	VATrueF	8	12	Yes		
Virginia	505	VAWomen	14	14	Yes	89	116 *
Washington	531	WAPineLodge	50	72	Yes	50	72
West Virginia	551	WVPrunty	48	48	Yes	48	48
Wisconsin	541	WIMICA	25	25	Yes	25	25
Wyoming	561	WYRSAT	NR	NR	Yes	NR	NR

Table 11. Notes.

This table is based on responses to the following survey questions: Please specify the status of all RSAT programs in your state (as of August 31, 1998):
Number of clients currently in the program (as of 8/31/98):
Number of beds or slots available in the program:

In this table information from the 46 states which returned Final State Surveys has been supplemented, when possible, by information collected on these questions from the NERSAT Program Survey and by subsequent telephone calls. An entry of *NR means the information was not reported to NERSAT. Only the 83 programs known to be planned by August 1998 (i.e., the universe of programs covered by NERSAT) were assigned NERSAT Program IDs (i.e., short labels). Information available only from the NERSAT Program Survey (i.e., not from the State Survey) do not have a Program ID number (PROGID#). States marked with an asterisk provided more recent information after the "Final Survey" was concluded; thus the state totals may be larger than sum of the information from the earlier State and Program Survey returns.

In responding to the NERSAT Program Survey Alabama aggregated the information over all of the programs in the state. In the NERSAT Final State Survey they were able to report information broken out by particular programs, as requested. In any subsequent tables from the Program Survey the entry for Alabama refers to information aggregated for all programs in the state.

Table 11: Summary Statistics.

State	Clients currently in Program	Beds	Clients, revised* state totals	Beds, revised* state totals
Valid N	80	91	50	51
Mean	76	98	154	189
Median	48	60	94	120
Std. Deviation	100	109	179	206
Sum	6,054	8,896	7,690	9,649

Table 12. Program Admissions and Treatment Staff.

State	Program ID	Clients Admitted	Treatment Staff
Alaska	AKHiland	0	3
Alabama	ALCrimeBill	46	2
Arkansas	ARRSAT	262	8
American Samoa	ASRSAT	NR	NR
Arizona	AZRecovery	38	4
California	CAForever	492	13
California	CAHolton	NR	136
California	CAStark	NR	NR
California	CAVentura	NR	NR
Colorado	CODOC	277	19
Colorado	COLETTS	50	2.5
Connecticut	CTManson	137	6
Connecticut	CTOsborn	38	6
Connecticut	CTYork	118	7
Dist. of Columbia	DCSafe	17	3
Delaware	DECrest	154	17
Delaware	DEKey	155	9
Delaware	DEKeySouth	116	5
Delaware	DENewHope	269	8
Delaware	DEPassage	598	12
Florida	FLDual	174	12
Georgia	GARSAT	310	22
Guam	GURSAT	NR	6
Hawaii	HIBridge	37	3
Iowa	IAOthrWay	281	5
Idaho	IDSICI	143	3
Illinois	ILRSAT	NR	NR
Indiana	INCRA	202	12
Kansas	KSLarned	83	2
Kentucky	KYClassD	31	2
Louisiana	LAConcordia	124	4
Louisiana	LAIntensive	253	6
Massachusetts	MACRA	3782	42.75
Massachusetts	MARSAT	NR	NR
Maryland	MDRSAT	124	9
Maine	MEIntTC	NR	NR
Michigan	MIMaxey	56	NR
Michigan	MIMDOC	221	NR
Minnesota	MNSauk	17	3
Missouri	MOOzark	1122	NR
N. Marianas	MPRSAT	NR	NR
Mississippi	MSPreRel	90	4
Montana	MTBillings	50	NR
Montana	MTYouth	10	NR
North Carolina	NCRSAT	NR	NR
North Dakota	NDRSAT	60	14
Nebraska	NERSAT	33	3
New Hampshire	NHSummit	288	4
New Jersey	NJ1stStep	342	10

New Jersey	NJAlpha	143	4
New Mexico	NMWARPOU	72	4
Nevada	NVWings	90	5
New York	NYRSAT	126	9
Ohio	OHMohican	320	10
Ohio	OHMonday	30	3
Ohio	OHNCI	0	2
Ohio	OHYDC	NR	9
Oklahoma	OKFemale	10	7
Oklahoma	OKTulsa	10	9
Oregon	ORKlamath	NR	2.5
Pennsylvania	PARecAcad	60	2
Puerto Rico	PRRSAT	24	9
Rhode Island	RICRA	105	NR
South Carolina	SCTorbeville	267	16
South Dakota	SDLamont	57	NR
Tennessee	TNWomen	159	5
Texas	TXChoices	122	6
Texas	TXHarris	12	NR
Texas	TXRSAT	NR	NR
Texas	TXRSAT5	NR	NR
Utah	UTConQuest	335	6
Utah	UTOUT	146	3.5
Virginia	VABlueRidge	33	3
Virginia	VAChgTimes	10	3
Virginia	VAFork	25	3
Virginia	VATrueF	23	3
Virginia	VAWomen	50	2
Virgin Islands	VIRSAT	NR	NR
Vermont	VTMarPath	64	2
Washington	WAPineLodge	160	6.25
Wisconsin	WIMICA	50	6.5
West Virginia	WVPrunty	9	6
Wyoming	WYRSAT	NR	NR

Table 12. Notes.

This table is based on responses to the following survey questions: Please specify the status of all RSAT programs in your state (as of August 31, 1998):

Number of clients ever admitted from when the program started drawing RSAT funds through 8/31/98:

Number of substance abuse treatment staff (as Full Time Equivalent, FTE).

In this table information from the 46 states which returned Final State Surveys has been supplemented, when possible, by information collected on these questions from the NERSAT Program Survey. An entry of NR means the information was not reported to NERSAT. Of the 83 programs known to be planned by August 1998 (i.e., the universe of programs covered by NERSAT) information was only available on admissions in 67 programs and on treatment staff in 63 programs.

Table 12: Summary Statistics.

	Clients Admitted	Treatment Staff
N	67	63
Mean	195.7	9.1
Median	90	6
Std. Deviation	476.8	17.4
Sum	13,112	574

Table 13. Main Treatment Approach

		Frequency	Percent	Valid Percent
Valid	Therapeutic Community	33	40	46
	Cognitive-Behavioral	16	19	23
	12-Step	8	10	11
	Other	14	17	20
	Total	71	86	100
Missing		12	14	
Total		83	100	

Table 13. Notes.

This table is based on responses to the following survey question:

Most programs use more than one treatment component, and we ask you to identify multiple components in subsequent sections. However, in the section immediately below, we ask you to judge what is the main treatment approach in your RSAT program and place a check to the right of your choice in the section below. Please choose only one approach in the following list."

Table 14. Rating of the Degree to which the Program is Uniform or Individualized.

		Frequency	Percent	Valid Percent
Valid	1 Uniform: all get the same treatment	3	4	4
	2 *	13	16	18
	3 *	20	24	28
	4 *	17	20	24
	5 individualized treatment programming	19	23	26
	Total	72	87	100
Missing		11	13	
Total		83	100	

Table 14. Notes.

This table is based on responses to the following survey question:
"Is the program more oriented toward uniformity of treatment programming or individualization of treatment programming?
Circle one number on the scale below.

Every person receives the same treatment components				Every person receives an individualized treatment plan
1	2	3	4	5"

Table 15. Typical Response to Substance Use.

		Frequency	Percent	Valid Percent
Valid	One system of graduated sanctions	32	39	47
	2 or more systems of sanctions	7	8	10
	No overall policy	9	11	13
	Other	20	24	29
	Total	68	82	100
Missing		15	18	
Total		83	100	

Table 15. Notes.

This table is based on responses to the following survey question:
"If participants *are* monitored for drug or alcohol use, choose one of the following as the typical way in which your program would respond to in-program drug or alcohol use:

There is one system of graduated sanctions which applies to all participants.
There are two or more different systems of graduated sanctions.
There is no overall policy to deal with drug use, each infraction is handled on a *case-by-case basis.*
Other [please specify."

Table 16. Examples of State Officials Comments on Impact of RSAT Funds on Capacity.

Program ID	Comments:
AZRecovery	Added 20 new beds; no tx beds separate from general population prior to funding
CODOC	Expanded prison TC from 40 to 96 beds, thereby occupying an entire housing unit, alleviating contamination of program efficacy.
COLETTS	Increased slots for males from 16 to 35 and for females (at Teen Quest) from 0 to 10
DCSafe	Prior to funding, no residential substance abuse tx was available for DC's committed juvenile males; the program provided 20 beds.
FLDual	0 beds prior; 120 beds available now
GARSAT	Allowed the establishment of 7 programs (4 sites) w/ a total of 310 beds, maximum capacity
IAOthrWay	Originally had 2 dedicated SA Tx units (total 160 beds); RSAT added 3rd unit (80 beds) and hiring of 6 add'l counselors and 1 clerk
INCRA	194 bed TC has been developed at Westville Correctional Facility
KYClassD	Prior, substance abuse treatment was not available to Class D offenders despite enormous need.
LAConcordia	Provided 100 treatment slots for program participants
LAIntensive	Provided treatment slots for 200 program participants
MACRA	The program has been able to treat more offenders and keep staff longer due to better wages.
MDRSAT	RSAT funding allowed implementation of this program.
MIMaxey	Two new halls were opened using a relapse prevention model. A total of 32 new beds.
MIMDOC	44 new beds available as a result of RSAT & state-match funding.
MNSauk	This is 1st time MCF-Sauk Centre has been able to dedicate a full group of adolescents to a residential chemical dependency program.
MSPreRel	Dedicated two 75 bed pre-release centers for SA Tx of inmated entering the pre-release program.
NDRSAT	Made continuation of long-term tx possible; Although # of beds remained at 60, it would have gone to zero w/out the RSAT funding.
NHSummit	Enabled us to increase our capacity from 20 to 48 with the addition of 3 counselors
NJ1stStep	Prior to RSAT, NJ DOC had 435 inpatient drug tx beds; With RSAT, capacity increased by 43%.
NJAlpha	A 52 bed unit was identified for the specific purpose of developing a residential SA tx program.
NMWARPOU	Dramatic increase. We opened a new TC at our Minimum Restrict Facility with the capacity for 45-50 inmates.
PARecAcad	A total of 100 new treatment slots will be created as a result of the RSAT funding.
RIRSAT	Prior to RSAT, there was no residential S.A. treatment program.
SCTorbeville	FFY96 funds increased treatment beds by 136 and FFY 97 funds will add an additional 136 beds.
SDLamont	Created 24 residential chemical dependency treatment slots
UTConQuest	Prior to RSAT we had a Byrne grant for a 36 bed program. RSAT funding increased capacity for treatment from 36 to 180 beds.
VTMarPath	Funding created the program known as Pathways at the Northern State Correctional Facility
WIMICA	New 25 bed residential program. Currently (12/97) 12 program participants.

Table 17. Security Level of the RSAT Program.

		Frequency	Percent	Valid Percent
Valid	Maximum	13	16	18
	Medium	27	33	37
	Minimum	19	23	26
	Other	14	17	19
	Total	73	88	100
Missing		10	12	
Total		83	100	

Table 17. Notes.

This table is based on responses to the following survey question: "What is the security level of your facility: (Check one)."

Table 18. Age of RSAT Program Clients

Programs		Frequency	Percent	Valid Percent
	Youth	22	27	28
	Adults	56	69	72
	Total	78	96	100
Missing		3	4	
Total		81	100	

Source: NERSAT Program Survey, Updated with Post-Survey Information

Appendix 3 Survey Instruments

Appendix 3A Initial State Survey

Residential Substance Abuse Treatment for State Prisoners: Report of the State Agency Administering the RSAT Program(s)

1. State _____

2. State Agency responsible for RSAT funds _____

3. Person actually responsible for completing this form:

_____ Phone: (_____)_____

4. Date form completed: ____/____/____
Mo / Day / Yr

NOTE: The person responsible for completing this form may need to ask others for information, such as the staff of the local RSAT program(s).

5. Project Grant Number: _____

6. Current Fiscal Year of RSAT Funding: ____/____/____ to ____/____/____
Mo / Day / Yr Mo / Day / Yr

7. RSAT Award Start Date: ____/____/____
Mo / Day / Yr

8. RSAT Award End Date: ____/____/____
Mo / Day / Yr

9. How does your office maintain oversight of the RSAT program(s)?

_____

_____

_____

10. In your state are corrections and parole a unified system or are they under separate agencies?

A unified system / Under separate agencies (circle one)

11. If separate, what agencies?

_____

12. Some states have one RSAT program, others have several. Please list the different RSAT programs in your state, with contact information:

Program 1:_____

Contact Person_____ Phone:(____)_____

email:_____

↑ Please provide information regarding Program 1 on pages 4 to 7 of this report. →

Program 2:_____

Contact Person_____ Phone:(____)_____

email:_____

↑ Please provide information regarding Program 2 on pages 8 to 11 of this report. →

Program 3:_____

Contact Person_____ Phone:(____)_____

email:_____

↑ Please provide information regarding Program 3 on pages 12 to 15 of this report. →

Program 4:_____

Contact Person_____ Phone:(____)_____

email:_____

↑ Please provide information regarding Program 4 on pages 16 to 19 of this report. →

Program 5:_____

Contact Person_____ Phone:(____)_____

email:_____

↑ Please provide information regarding Program 5 on pages 20 to 23 of this report. →

The items in this section refer to the program you listed as Program 1.

13. What was the amount and source of funding for your program for the following situations (if applicable):

	Annual Budget	Source of Funds
Prior to RSAT		
RSAT current		
Non-RSAT current		

14. Since RSAT funding began, has there been a change in the size of this program (i.e., capacity, slots, beds) enabled by RSAT funding?

YES / NO (circle one)

15. If "Yes," please describe the change and summarize any evidence that the change in size was the result of RSAT funding.

_____

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_____

16. Since RSAT funding began, has there been a change in the nature or quality of your program (e.g., treatment counseling, drug testing, etc.) enabled by RSAT funding?

YES / NO (circle one)

17. If "Yes," please describe the change and summarize any evidence that the change in nature or quality was the result of RSAT funding.

_____

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_____

18. In what month and year did this RSAT program begin to draw RSAT funds?

____/____
Mo / Yr

19. How much RSAT funding have you received each fiscal year up to the present?

1996 $_____ Months covered _____

1997 $_____ Months covered _____

20. Please summarize the main objectives of your RSAT expenditures? [For example, "to begin a new, small-scale therapeutic community" OR "to add treatment counselors to an existing program," etc.]

_____

_____

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Please attach a budget expenditure report for RSAT for each year of RSAT funding.

21. If your RSAT program also receives funds from a source other than RSAT (or other resources which supplement RSAT program costs) please indicate the source and the estimated amount or value of the resources in this past Fiscal Year:

Source (check all that apply)	✔	**Estimated amount or value of resources**
CSAT		
Other SAMHSA		
CPO		
NIJ		
BJA		
NIC		
OJJDP		
NIDA		
NIAAA		
Byrne Law Enforcement Assistance Program		
Other federal source [specify _____ _____]		
State source(s) [specify_____ _____]		
Local source(s) [specify_____ _____]		
Other sources (e.g. private foundations) [specify _____]		

22. Were RSAT program funds leveraged (i.e., used to attract funds from other sources)? If so, please specify in what way.

_____

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23. What was the average daily number of clients in this RSAT program during...

Fiscal Year 1996 [if applicable] _____

Fiscal Year 1997 _____

24. What is your estimate of per capita RSAT costs (average cost per client)?

Fiscal Year 96 [if applicable] $_____ Circle one: Per day or Per Year

Fiscal Year 97 $ _____ Circle one: Per day or Per Year

25. How is that per capita cost estimate computed?

_____

_____

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_____

_____

_____

The items in this section refer to the program you listed as Program 2.

26. What was the amount and source of funding for your program for the following situations (if applicable):

	Annual Budget	Source of Funds
Prior to RSAT		
RSAT current		
Non-RSAT current		

27. Since RSAT funding began, has there been a change in the size of this program (i.e., capacity, slots, beds) enabled by RSAT funding?

YES / NO (circle one)

28. If "Yes," please describe the change and summarize any evidence that the change in size was the result of RSAT funding.

_____

_____

_____

_____

29. Since RSAT funding began, has there been a change in the nature or quality of your program (e.g., treatment counseling, drug testing, etc.) enabled by RSAT funding?

YES / NO (circle one)

30. If "Yes," please describe the change and summarize any evidence that the change in nature or quality was the result of RSAT funding.

_____

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_____

31. In what month and year did this RSAT program begin to draw RSAT funds?

____/____
Mo / Yr

32. How much RSAT funding have you received each fiscal year up to the present?

1996 $_____ Months covered _____

1997 $_____ Months covered _____

33. Please summarize the main objectives of your RSAT expenditures? [For example, "to begin a new, small-scale therapeutic community" OR "to add treatment counselors to an existing program," etc.]

_____

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Please attach a budget expenditure report for RSAT for each year of RSAT funding.

34. If your RSAT program also receives funds from a source other than RSAT (or other resources which supplement RSAT program costs) please indicate the source and the estimated amount or value of the resources in this past Fiscal Year:

Source (check all that apply)	✔	Estimated amount or value of resources
CSAT		
Other SAMHSA		
CPO		
NIJ		
BJA		
NIC		
OJJDP		
NIDA		
NIAAA		
Byrne Law Enforcement Assistance Program		
Other federal source [specify _____ _____]		
State source(s) [specify_____ _____]		
Local source(s) [specify_____ _____]		
Other sources (e.g. private foundations) [specify _____]		

35. Were RSAT program funds leveraged (i.e., used to attract funds from other sources)? If so, please specify in what way.

_____

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36. What was the average daily number of clients in this RSAT program during...

Fiscal Year 1996 [if applicable] _____

Fiscal Year 1997 _____

37. What is your estimate of per capita RSAT costs (average cost per client)?

Fiscal Year 96 [if applicable] $_____ Circle one: Per day or Per Year

Fiscal Year 97 $ _____ Circle one: Per day or Per Year

38. How is that per capita cost estimate computed?

_____

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_____

The items in this section refer to the program you listed as Program 3.

39. What was the amount and source of funding for your program for the following situations (if applicable):

	Annual Budget	Source of Funds
Prior to RSAT		
RSAT current		
Non-RSAT current		

40. Since RSAT funding began, has there been a change in the size of this program (i.e., capacity, slots, beds) enabled by RSAT funding?

YES / NO (circle one)

41. If "Yes," please describe the change and summarize any evidence that the change in size was the result of RSAT funding.

_____

_____

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42. Since RSAT funding began, has there been a change in the nature or quality of your program (e.g., treatment counseling, drug testing, etc.) enabled by RSAT funding?

YES / NO (circle one)

43. If "Yes," please describe the change and summarize any evidence that the change in nature or quality was the result of RSAT funding.

_____

_____

_____

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_____

44. In what month and year did this RSAT program begin to draw RSAT funds?

____/____
Mo / Yr

45. How much RSAT funding have you received each fiscal year up to the present?

1996 $_____ Months covered _____

1997 $_____ Months covered _____

46. Please summarize the main objectives of your RSAT expenditures? [For example, "to begin a new, small-scale therapeutic community" OR "to add treatment counselors to an existing program," etc.]

_____

_____

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Please attach a budget expenditure report for RSAT for each year of RSAT funding.

47. If your RSAT program also receives funds from a source other than RSAT (or other resources which supplement RSAT program costs) please indicate the source and the estimated amount or value of the resources in this past Fiscal Year:

Source (check all that apply)	✔	**Estimated amount or value of resources**
CSAT		
Other SAMHSA		
CPO		
NIJ		
BJA		
NIC		
OJJDP		
NIDA		
NIAAA		
Byrne Law Enforcement Assistance Program		
Other federal source [specify _____ _____]		
State source(s) [specify_____ _____]		
Local source(s) [specify_____ _____]		
Other sources (e.g. private foundations) [specify _____]		

48. Were RSAT program funds leveraged (i.e., used to attract funds from other sources)? If so, please specify in what way.

_____

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_____

49. What was the average daily number of clients in this RSAT program during...

Fiscal Year 1996 [if applicable] _____

Fiscal Year 1997 _____

50. What is your estimate of per capita RSAT costs (average cost per client)?

Fiscal Year 96 [if applicable] $_____ Circle one: Per day or Per Year

Fiscal Year 97 $ _____ Circle one: Per day or Per Year

51. How is that per capita cost estimate computed?

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_____

The items in this section refer to the program you listed as Program 4.

52. What was the amount and source of funding for your program for the following situations (if applicable):

	Annual Budget	Source of Funds
Prior to RSAT		
RSAT current		
Non-RSAT current		

53. Since RSAT funding began, has there been a change in the size of this program (i.e., capacity, slots, beds) enabled by RSAT funding?

YES / NO (circle one)

54. If "Yes," please describe the change and summarize any evidence that the change in size was the result of RSAT funding.

_____

_____

_____

_____

55. Since RSAT funding began, has there been a change in the nature or quality of your program (e.g., treatment counseling, drug testing, etc.) enabled by RSAT funding?

YES / NO (circle one)

56. If "Yes," please describe the change and summarize any evidence that the change in nature or quality was the result of RSAT funding.

_____

_____

_____

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_____

57. In what month and year did this RSAT program begin to draw RSAT funds?

____/____
Mo / Yr

58. How much RSAT funding have you received each fiscal year up to the present?

1996 $_____ Months covered _____

1997 $_____ Months covered _____

59. Please summarize the main objectives of your RSAT expenditures? [For example, "to begin a new, small-scale therapeutic community" OR "to add treatment counselors to an existing program," etc.]

_____

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Please attach a budget expenditure report for RSAT for each year of RSAT funding.

60. If your RSAT program also receives funds from a source other than RSAT (or other resources which supplement RSAT program costs) please indicate the source and the estimated amount or value of the resources in this past Fiscal Year:

Source (check all that apply)	✔	**Estimated amount or value of resources**
CSAT		
Other SAMHSA		
CPO		
NIJ		
BJA		
NIC		
OJJDP		
NIDA		
NIAAA		
Byrne Law Enforcement Assistance Program		
Other federal source [specify _____ _____]		
State source(s) [specify_____ _____]		
Local source(s) [specify_____ _____]		
Other sources (e.g. private foundations) [specify _____]		

61. Were RSAT program funds leveraged (i.e., used to attract funds from other sources)? If so, please specify in what way.

_____

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_____

62. What was the average daily number of clients in this RSAT program during...

Fiscal Year 1996 [if applicable] _____

Fiscal Year 1997 _____

63. What is your estimate of per capita RSAT costs (average cost per client)?

Fiscal Year 96 [if applicable] $_____ Circle one: Per day or Per Year

Fiscal Year 97 $ _____ Circle one: Per day or Per Year

64. How is that per capita cost estimate computed?

_____

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_____

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_____

The items in this section refer to the program you listed as Program 5.

65. What was the amount and source of funding for your program for the following situations (if applicable):

	Annual Budget	Source of Funds
Prior to RSAT		
RSAT current		
Non-RSAT current		

66. Since RSAT funding began, has there been a change in the size of this program (i.e., capacity, slots, beds) enabled by RSAT funding?

YES / NO (circle one)

67. If "Yes," please describe the change and summarize any evidence that the change in size was the result of RSAT funding.

_____

_____

_____

_____

68. Since RSAT funding began, has there been a change in the nature or quality of your program (e.g., treatment counseling, drug testing, etc.) enabled by RSAT funding?

YES / NO (circle one)

69. If "Yes," please describe the change and summarize any evidence that the change in nature or quality was the result of RSAT funding.

_____

_____

_____

_____

_____

70. In what month and year did this RSAT program begin to draw RSAT funds?

____/____
Mo / Yr

71. How much RSAT funding have you received each fiscal year up to the present?

1996 $_____ Months covered _____

1997 $_____ Months covered _____

72. Please summarize the main objectives of your RSAT expenditures? [For example, "to begin a new, small-scale therapeutic community" OR "to add treatment counselors to an existing program," etc.]

_____

_____

_____

_____

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Please attach a budget expenditure report for RSAT for each year of RSAT funding.

73. If your RSAT program also receives funds from a source other than RSAT (or other resources which supplement RSAT program costs) please indicate the source and the estimated amount or value of the resources in this past Fiscal Year:

Source (check all that apply)	✔	**Estimated amount or value of resources**
CSAT		
Other SAMHSA		
CPO		
NIJ		
BJA		
NIC		
OJJDP		
NIDA		
NIAAA		
Byrne Law Enforcement Assistance Program		
Other federal source [specify _____ _____]		
State source(s) [specify_____ _____]		
Local source(s) [specify_____ _____]		
Other sources (e.g. private foundations) [specify _____]		

74. Were RSAT program funds leveraged (i.e., used to attract funds from other sources)? If so, please specify in what way.

_____

_____

_____

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_____

75. What was the average daily number of clients in this RSAT program during...

Fiscal Year 1996 [if applicable] _____

Fiscal Year 1997 _____

76. What is your estimate of per capita RSAT costs (average cost per client)?

Fiscal Year 96 [if applicable] $_____ Circle one: Per day or Per Year

Fiscal Year 97 $ _____ Circle one: Per day or Per Year

77. How is that per capita cost estimate computed?

_____

_____

_____

_____

_____

_____

Thank you for your time and effort in providing this information!

Appendix 3B Program Survey

CHECKLIST OF DOCUMENTS TO BE SENT TO NERSAT WITH THIS REPORT

Some of the questions in this report can be more completely answered by sending program documents you may have. If they are available, please attach the following documents to help answer the questions.

- ☐ Please send a sample copy of each type of summary program report or Management Information System (MIS) report that is regularly produced about the RSAT program. (See Q.27 in this report form.)

- ☐ If information on types of exits from the RSAT program can be provided in detailed time periods (e.g., months or quarters) please attach that detailed "cohort history" information. (See Q.34 in this report form.)

- ☐ Please send us your RSAT staff training curriculum. (See Q.41 in this report form.)

- ☐ Please send us an organizational chart including the numbers of staff in each position in the RSAT program. (See Q.48 in this report form.)

- ☐ Please send a copy of the research design or protocol. (See Q.76 in this report form.)

- ☐ Please send program handbooks, brochures, staff manual, inmate handbook, and any other basic program documentation. (See Q.80 in this report form.)

- ☐ Please attach a current schedule for participants in your program, showing what they do each day of the week, including Saturday and Sunday. If the schedules vary depending on the participant's month or stage in the program, please attach all and explain. (See Q.97 in this report form.)

Residential Substance Abuse Treatment for State Prisoners: Program-level Report

1. Program Name _____

2. State _____

3. Person completing this form:

   _____ Phone: (_____)_____

   email: _____

   Comment: _____

4. Date form completed: ____/____/____
   Mo / Day / Yr

5. Project Grant Number: _____

6. Current Fiscal Year of RSAT Funding: ____/____/____ to ____/____/____
   Mo / Day / Yr Mo / Day / Yr

7. RSAT Project Start Date: ____/____/____ (Date you started drawing RSAT funds)
   Mo / Day / Yr

8. RSAT Project End Date: ____/____/____
   Mo / Day / Yr

9. Have inmates/clients actually begun the RSAT program?

   YES / NO (circle one)

10. If "Yes", when did the first inmates/clients begin the RSAT program?

    ____/____/____
    Mo / Day / Yr

11. If "No", when is the expected start date? ____/____/____
Mo / Day / Yr

12. If inmates/clients have not yet begun the RSAT program, please explain:

_____

_____

_____

_____

The person responsible for completing this form will probably need to ask others for information, such as the person in charge of treatment services for your local RSAT program, a researcher responsible for evaluating the program, etc.

Program Goals and Performance Measures

Please use current thinking, not just language from the proposal.

13. Program goal (priority 1) (For example, "Reduce recidivism.")

_____

Program goal (priority 2) (For example, "Reduce drug use.")

_____

Program goal (priority 3) [If applicable]

_____

Program goal (priority 4) [If applicable]

_____

14. What measures, instruments, or records will be used (if any) to assess the degree of achievement of each of the program goals?

Specific goal-achievement measure(s) for goal priority #1 (e.g., lower rearrest rate)

_____

_____

_____

Specific goal-achievement measure(s) for goal priority #2 (e.g., clean urine tests)

_____

_____

_____

Specific goal-achievement measure(s) for goal priority #3 [If applicable]

_____

_____

_____

Specific goal-achievement measure(s) for goal priority #4 [If applicable]

_____

_____

_____

15. Concerning a potential comparison group, is there an identified set of offenders about as large or larger than that in the RSAT program who are similar in demographics, criminal history, substance abuse history, and employment history but who are not admitted to the RSAT program?

YES / NO (circle one) [If "NO," skip to #18]

16. Can you obtain detailed information on the type(s) and amounts of treatment programming that persons in the control/comparison group receive?

YES / NO (circle one)

17. Are you confident that your program could obtain copies of urinalysis reports and arrest records for those who are in the comparison group and of drop outs of the RSAT program, as well as for your RSAT program graduates?

YES / NO (circle one)

18. Does the RSAT program have (or have access to) its own PC or Macintosh™ computer?

YES / NO (circle one) [If "NO," skip to #26]

19. If "Yes," do you or does your unit produce regular reports (such as program status reports or reports about clients' progress) about the RSAT program?

    YES / NO (circle one)

20. Does that computer have a modem?

    YES / NO (circle one)

21. If "Yes," what speed?

    a. Slower than 14,400 bps

    b. 14,400 bps

    c. 28,800 or faster bps

22. Do you have access to the Internet?

    YES / NO (circle one)

23. Do you have an email address (or Web page address)?

    YES / NO (circle one)

24. If "Yes," please provide that address: _____

25. Whose email address is it? _____

26. Does some other unit produce regular reports (such as program status reports or reports about clients' progress) for the RSAT program?

    YES / NO (circle one)

27. If "Yes," what reporting is provided and what unit or organization does this for the RSAT program?

    _____

    _____

[Please send a sample copy of each type of summary program report or Management Information System (MIS) report that is regularly produced about the RSAT program.]

Characteristics of the Participants

28. Total number of admissions to the RSAT program within each Fiscal Year?

	Total number of admissions	**Months on which based**
Fiscal Year 1996		
Fiscal Year 1997		

29. If the program targets a specific group of offenders (e.g. sex offenders, MICA) please indicate here and specify:

_____

_____

30. The actual (or, if unknown, the estimated) number of admissions to the RSAT program within the last full (completed) Fiscal Year which have the following participant characteristics. **If you are estimating a number for any of the following characteristics, please indicate with an asterisk (e.g. 25*).**

ETHNIC BACKGROUND	**MALE**	**FEMALE**
Caucasian (Not of Hispanic Origin)		
African American (Not of Hispanic Origin)		
Asian		
Hispanic		
Native American		
Other		

Characteristic	Number
AGE GROUPS	
Under 15	
15 - 18	
19 - 20	
21 - 25	
26 - 30	
31 - 35	
36 - 40	
41 - 50	
51 - 60	
61 and older	
MEDICAL STATUS	
Pregnant (anytime in program)	
HIV Positive	
Active AIDS	
PARTICIPATION IN OTHER PROGRAMS **(during current incarceration)**	
Work release program	
Vocational training program	
GED	
AA	
Other (specify)_____	

Characteristic	Number
LABOR FORCE STATUS (during the year before current incarceration)	
Full time employed (35 hours +)	
Part time employed	
Seasonally employed	
Illicit employment	
Unemployed	
In prison	
Other (Specify_____)	
MARITAL STATUS	
Married (legal or common law)	
Single (never married)	
Divorced/separated	
Widowed	
EDUCATION	
Less than high school education	
HS graduate or GED (but not beyond)	
Education beyond high school	

Characteristic	Number
LIVING STATUS (during the year before current incarceration) Choose the one most appropriate.	
With spouse	
With spouse and children	
Alone	
With parents	
With other relatives	
With friends	
Institutionalized	
In residential substance abuse treatment	
Homeless	
SPECIAL POPULATIONS	
Juveniles	
Dual Diagnosed	

31. What numbers of RSAT clients have used each of the following substances at some time during the last year they were not incarcerated? **If you are estimating a number for any of the following characteristics, please indicate with an asterisk (e.g. 25*).**

Substance	Number
Heroin	
Non-crack cocaine	
Crack	
Amphetamines	
Barbiturates /Tranquilizers	
Marijuana / hashish	
LSD	
PCP	
Inhalants	
Over the counter drugs	
Alcohol	
Polydrug	
Other	

A given individual *should* be counted in more than one cell if he/she used more than one substance.

32. For the same Fiscal Year, indicate the number of RSAT clients whose primary drug problem or "drug of choice" is listed below. If you are estimating a number for any of the following characteristics, please indicate with an asterisk (e.g. 25*).

Substance	Number
Heroin	
Non-crack cocaine	
Crack	
Amphetamines	
Barbiturates /Tranquilizers	
Marijuana / hashish	
LSD	
PCP	
Inhalants	
Over the counter drugs	
Alcohol	
Polydrug	
Other	

A given individual should be counted only in one cell, the one that is probably his or her most commonly abused substance.

33. What is the number of admitted individuals who have exited the residential RSAT program in each of the following ways?

Number of completers (successful exits)	
Number exited due to failure or misconduct	
Number who voluntarily exited before completion	
Number of other administrative exits (e.g., old charges, early parole, medical problems, etc.).	
Number still in the program	

34. The information provided in the table above is current as of what date?

_____

If the same information can also be provided in more detailed time periods (e.g., months or quarters) please attach that detailed "cohort history" information.

35. What is the *planned* time in the program (for a typical participant) from start to successful completion of the residential treatment phase? Call this "**T**."

T = _____ Circle one: Days / Weeks / Months (e.g. 9 Months)

36. Counting only those clients admitted more than T [above] days / weeks / months ago, what is the number of admitted individuals who have exited the residential RSAT program in each of the following ways?

Number admitted more than T days/weeks/ months ago. (e.g. if T is 9 months, only those clients admitted more than 9 months ago.)	
Number of completers (successful exits)	
Number exited due to failure or misconduct	
Number who voluntarily exited before completion	
Number of other administrative exits (e.g., old charges, etc.)	
Number still in the program	

Staff Characteristics

37. Indicate the number of RSAT staff having the following characteristics. **If you are estimating a number for any of the following characteristics, please indicate with an asterisk (e.g. 25*).**

ETHNIC BACKGROUND	MALE	FEMALE
Caucasian (Not of Hispanic Origin)		
African American (Not of Hispanic Origin)		
Asian		
Hispanic		
Native American		
Other		

Characteristic	Number
AGE GROUPS	
24 and under	
25 through 34	
35 through 44	
45 and older	
YEARS OF EXPERIENCE Providing Treatment	
Less than one	
One to two	
Three to five	
More than five	

Characteristic	Number
TIME IN CURRENT PROGRAM	
Less than 6 months	
Six months to one year	
One to two years	
Three or more years	
OTHER CHARACTERISTICS	
Have had custodial / security experience	
Are recovered / ex-addict / ex-alcoholic / recovering (role models)	

38. What number of hours is considered a normal, full time workload per week? (For example, in some organizations 40 hours per week is the normal full-time workload.)

_____hours per week

39. Using the table immediately below as an example, in the empty table on the next page please indicate how much time people in each staff role devote to responsibilities concerned with the RSAT program.

Staff function or position	Hours per week	Number of staff with that job and workload	E=Employee C=Contract V=Volunteer O=Other	Part RSAT Funded	Security (S) Treatment (T) Admin.(A) Other (O)
Program Director	40	1	E	50%	½ A, ½ T
Sr. Counselor(s)	20	2	C	100%	T
Counselor(s)	12	3	C	100%	T
Tutor(s)	7	1	V	Travel	T
Officer(s)	40	5	E	None	S

Please include entries for all relevant staff roles that are needed to keep your RSAT program running properly, including manager/supervisors; clinical staff; medical staff; security staff; clerical staff, and any other relevant roles.

Staff function or position	Hours per week	Number of staff with that job and workload	E=Employee C=Contract V=Volunteer O=Other	Part RSAT Funded	Security (S) Treatment (T) Admin.(A) Other (O)

40. Indicate the number (rather than the percentage) of clinical staff employed by your program, and their highest educational degree or qualification. (List each clinician only once if a clinician works for more than one program.)

	Full Time	Part Time	Contractual
CAC (Chemical Abuse Counselor or similar)			
MD or DO (Medical Doctor or Doctor of Osteopathy)			
PA or NP (Physician's Assistant or Nurse Practitioner)			
RN / LPN (Registered Nurse / Licensed Practical Nurse)			
Ph.D.			
Master's degree			
MSW (Masters of Social Work)			
CSW (Certified Social Worker)			
Bachelor's degree			
Associate of Arts or technical school degree			
HS diploma (or less)			

41. Please describe your staff training procedures and staff training schedules, including pre-service and in-service training:

_____

_____

_____

_____

_____

[Please send us your RSAT staff training curriculum.]

42. For what <u>percentage</u> of clients do you have case conferences to assess progress?

_____%

43. Occasionally staff are shared (e.g., half in RSAT and half in another program). Is staffing shared with other programs? (If so, what linkage or coordination exists?)

YES / NO (circle one)

_____

_____

44. Indicate the <u>number</u> of full- and part-time clinical staff who are recovering alcoholics and/or ex-drug abusers:

	Full Time	**Part Time**
Recovering Substance Abusers		

45. How many volunteers are used? In what capacity?

_____

_____

46. What are the volunteers' typical hours of work?

_____

_____

47. What is the average number of clients assigned to each staff level?

	Counselor	**Supervisor (including subordinates' clients)**
Average case load		

48. Do you have case management services? If yes, what is the average number of cases assigned to each case manager:

Do you have a Case Management system? (Circle one)	YES / NO
If "Yes," average number of cases:	

[Please send us an organizational chart including the numbers of staff in each position in the RSAT program.]

49. How many staff members left their positions (for whatever reasons) during:

Fiscal Year 1996 [if applicable]: _____

Fiscal Year 1997: _____

Assessment and Orientation Phase

50. What percentage of the RSAT residential program clients are:

a. ordered into the program (e.g., by judges)?_____%

b. volunteers? _____%

51. What recruitment methods are used?

a. brochures inviting inmates to apply YES / NO (circle one)

b. nomination by intake center YES / NO (circle one)

c. other (specify) _____

_____

_____

52. If there are **inclusionary** criteria (rules specifying the only types of inmates who may be admitted to the RSAT program), list the requirements here. (Examples: 9 months time left to serve; must have substance use problem.)

1st Requirement _____

2nd Requirement _____

3rd Requirement _____

4th Requirement _____

5th Requirement _____

6th Requirement _____

53. If there are **exclusionary** criteria (rules specifying the types of inmates who will not be admitted to the RSAT program), list the requirements here. (Examples: violence, arson, or sex offenses in criminal history, mental illness.)

1st Requirement _____

2nd Requirement _____

3rd Requirement _____

4th Requirement _____

5th Requirement _____

6th Requirement _____

54. After inclusionary and exclusionary criteria for your RSAT program are met, are all candidates... [choose one]

a. equally acceptable and taken in on a "first come, first served" basis?

b. not necessarily equally acceptable, so further assessments of suitability for the RSAT program are made?

55. If "b", what further assessments are made?

_____

_____

56. Clients begin the RSAT program: (Circle one)
    a. When enough individuals are available to form a cohort or cycle or unit.
    b. Separately as individuals whenever the next single bed becomes available.
    c. Other (Specify: _____)

57. Is there a waiting list? YES / NO (circle one) [If "NO," skip to #60]

58. If there is a waiting list, what is the approximate ratio of acceptable applicants waiting to new persons who could be admitted to the program at this time? Circle one:
    a. About 1 applicant waiting for each 1 new slot to open
    b. About 3 applicants waiting for each 2 new slots to open
    c. About 2 applicants waiting for each 1 new slots to open
    d. About 3 applicants waiting for each 1 new slots to open
    e. More than 3 applicants waiting for each 1 new slot to open

59. If there is a waiting list, will the authorities approve and abide by a lottery system for admission to the experimental group? [For example, if there are two candidates for each available bed, can selection be done using a fair, random procedure to decide which one gets admitted?]

YES / NO (circle one)

60. Since RSAT funding began, have any changes been made in selection/recruitment criteria during the course of the program? (For example, original exclusionary criteria have been relaxed.)

YES / NO (circle one)

61. If yes, please explain: (e.g. because of overcrowding in the broader institution some inmates without drug histories were admitted.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

62. For what percentage of clients do you use the following diagnostic instrument(s) at intake, for each use of the assessment information listed in the top row of the matrix? (Indicate a percentage only for those instruments and uses applicable to your program.)

INSTRUMENTS	Program Assign-ment (%)	Risk Assess-ment (%)	Needs Assess-ment (%)	Measure change over time (%)	DSM-IV diag-nosis (%)	Other use (specify below) (%)	**Not used** (✔)
ASI (Addiction Severity Index)							
MAST (Michigan Alcoholism Screen Test)							
Wisconsin Uniform Substance Abuse Battery							
Drug Offender Profile Index							
16 PF							
MMPI							
PEI							
Raven's Matrices							
Your own bio/psychosocial [please send us a copy]							
Other (Specify) [please send us a copy] _____							

63. Specify here if "Other use" is applicable:

_____

_____

_____

64. Does each of your clients have a treatment plan? (Check all that apply):

Treatment Plans	Yes	No
Completed at intake		
Updated during treatment		

65. Does each client participate in formulating the treatment plan? (e.g. contingency contracts, joint goal setting, etc.)

YES / NO (circle one)

66. Comments: _____

_____

67. Who participates in **updating** the treatment plans? (Check all that apply):

Primary counselor	
Case manager	
Clinical supervisor	
Probation / Parole agent	
Client	
Other (Specify)	

Residential Treatment Programming Phase

Responsibility for the treatment program

68. To what government entity or entities does the RSAT program report? If more than one, circle all that apply. [If contracted out, to whom does the contractor report?]
    a. Department of Corrections
    b. County sheriff
    c. District Attorney
    d. Drug Court
    e. Department/Division of Rehabilitation
    f. Division of Substance Abuse
    g. Juvenile Corrections/Office of Delinquency
    h. Other (Specify) _____

69. What governmental organizations are responsible for oversight and/or for running the residential program? If more than one, describe how responsibility and information are shared.

_____

_____

_____

70. List all agencies employing personnel who work on the RSAT program, and the number of staff each agency employs:

AGENCY	NUMBER OF STAFF

71. Is the program able to produce:

    a. aggregate status reports on the progress of participants? YES / NO (circle one)

    b. reports on the termination/transfer of participants? YES / NO (circle one)

    c. up-to-date expenditure reports? YES / NO (circle one)

---

72. Is an evaluation research study of your RSAT program planned (or already underway)?

    YES / NO (circle one)

73. If yes, by what organization? _____

74. Name and phone number of person in charge of the evaluation research:

    _____ Phone (____)_____

75. What is the start date of this evaluation? ____/____/____
    Mo / Day / Yr

76. Are you currently following a research design or protocol established by your state or local evaluator or some other organization?

    YES / NO (circle one)

    [If yes, please send a copy of the research design or protocol.]

Setting of the treatment program

77. What is the security level of your facility: (Check one)

Maximum	
Medium	
Minimum	
Other (specify): _____	

78. Do the RSAT program participants regularly talk with other inmates who are not in the RSAT program in any of the following areas?

Check one:

	Occasionally	Frequently	Comments
Sleeping area			
Meal facilities (mess hall, cafeteria)			
Recreational facilities			
Educational facilities			
Vocational or work facilities			

79. Where is the RSAT program located?

⇒ Housing unit name or identifier _____

⇒ Institution or correctional facility _____

⇒ County _____

⇒ State _____

80. How many beds do you have in your program?

_____

[Please send program handbooks, brochures, staff manual, inmate handbook, and any other basic program documentation.]

81. Most programs use more than one treatment component, and we ask you to identify multiple components in subsequent sections. However, in the section immediately below, we ask you to judge what is the main treatment approach in your RSAT program and place a check to the right of your choice in the section below. Please choose only one approach in the following list.

Treatment approach	**Most important**
Therapeutic Community	
Cognitive-Behavioral	
12-Step (AA, NA, CA model)	
Boot Camp	
Token Economy	
Mental Health Counseling	
Other Residential Substance Abuse Treatment [Please specify] _____ _____ _____ _____	

Treatment components used

82. If the RSAT program uses any of the following treatment components, please rate each component in terms of its **importance** to the success of your program, using one of the following response options.

5 = extremely important (vital) for our program
4 = very important for our program
3 = moderately important for our program
2 = somewhat important for our program
1 = slightly important for our program
Blank = not used in our program or not applicable

Then enter the duration of that component (in weeks) for the typical client participating in your RSAT program and the number of sessions it is used for the typical participant.

For example,

Treatment component	Duration	Sessions	Importance
Remedial Education	25 weeks	50	2

If a component is generally provided throughout each day, enter "continuous" in the Sessions box. If a treatment component is not used at all, leave the boxes blank.

Treatment component	Duration	Sessions	Importance
Peer encounter groups: Under the supervision of a trained staff person as group leader/facilitator, clients discuss specific problem behavior patterns and how they should be changed.			
Behavior modification: use of "pure" behaviorist techniques, e.g., positive reinforcement (only if using a technical, behaviorist procedure), extinction, satiation, fading, backward chaining, negative reinforcement, etc.*			

* This item was adapted from McGuire (1996) *Cognitive-Behavioural Approaches: An Introductory Course on Theory and Research*. Department of Clinical Psychology, University of Liverpool, Liverpool L69 3BX, United Kingdom.

Treatment component	Duration	Sessions	Importance
Behavior therapy: use of behaviorist approaches in a wider, more general sense, e.g., systematic desensitization, flooding, covert sensitization, thought stopping, response prevention, exposure training, etc.			
Social skills training: Training to remedy social interaction problems (e.g., relative social isolation, inappropriate behavior, poor communication) using a variety of training techniques such as instruction, modeling the appropriate behaviors, *imaginal* rehearsal, behavioral rehearsal, feedback, and coaching.*			
Self-instructional training: Training clients to make statements to themselves (usually just in thought rather than aloud) telling themselves how to behave appropriately in specific situations and providing self-reinforcement for appropriate behavior.*			
Problem solving skills training: developing skills in how to handle crises and upsetting incidents in life without resorting to criminality or substance abuse, e.g., by thinking before acting or reacting, by finding alternative ways of dealing with problems than the first ones that spring to mind, by weighing the consequences of possible actions, and so forth.) Examples include D'Zurilla & Goldfried's "Interpersonal Cognitive Problem Solving" and Ross et al.'s "Reasoning and Rehabilitation."*			
Relaxation training: Exercises for helping individuals reduce levels of emotional arousal; the most common method is progressive muscular relaxation.*			

* This item was adapted from McGuire (1996) *Cognitive-Behavioural Approaches: An Introductory Course on Theory and Research*. Department of Clinical Psychology, University of Liverpool, Liverpool L69 3BX, United Kingdom.

Treatment component	Duration	Sessions	Importance
Rational-Emotive therapy: Pointed questioning of clients to find distorted and irrational beliefs, which lead them into inappropriate behaviors, and to erode these distorted cognitions and their behavioral effects.*			
Cognitive therapy (including Thinking Errors therapy). Theorizing that much problem behavior results from the individual's fallacious thought process, these programs point out these thinking errors and specify straight-thinking alternatives. The cognitive errors may be culled from interviews and/or from the client's *dysfunctional thoughts diary*). Examples of such cognitive errors are: over-generalization, all-or-nothing thinking, and catastrophizing.*			
Upward mobility: Clients who demonstrate behavioral improvement and responsibility are given more privileges and higher status in the program.			
Assertiveness training: Overcoming problems in communication and social interaction (e.g., anxiety) through training in communicating with others in a straightforward (but polite) way and using positive responses in social situations.			
Anger management or aggression management: Use of a variety of programming techniques (e.g., self instructional training, stress inoculation training) so that offenders learn to recognize the situations likely to trigger an angry outburst and the signs that they are starting to feel angry, and learn how to avoid the situation or behave in ways to minimize their anger.			

* This item was adapted from McGuire (1996) *Cognitive-Behavioural Approaches: An Introductory Course on Theory and Research*. Department of Clinical Psychology, University of Liverpool, Liverpool L69 3BX, United Kingdom.

Treatment component	Duration	Sessions	Importance
Positive peer pressure: Clients are expected to use mutual help and support, positive persuasion and (when necessary) negative sanctions and confrontation to change the behavior and attitudes of clients not advancing properly in the program.			
Boot camp incarceration: military style drill and discipline, including an initial shock or stress period before treatment			
Continuous therapy: Clients are expected to provide therapeutic help and support to one another not just during counseling sessions but also during routine daily activities, when needed.			
Mentoring or big brother: matching the client/participant with a non-criminal, non-substance abusing "role model" to take part in regular activities with that role model so that the client may adopt non-criminal/non-substance abusing values.			
Education (academic or remedial focus, e.g., GED courses, remedial reading)			
Vocational skills training (e.g. a course in welding, a course in auto repair)			
Readiness for vocation (e.g. learning how to meet employers' expectations for obedience, how to search for jobs, etc.)			
Power is shared with clients: Clients have significant input into program planning and decisions.			
Life skills training (teach specific skills in dealing with mundane problems of independent living such as finding a place to live, doing laundry, handling a checking account, etc.)			

Treatment component	Duration	Sessions	Importance
Relapse prevention model (emphasizes preparing the offender to deal with cravings, peer pressure, etc. to prevent relapse to substance use)			
Token economy. This is a reinforcement system in which offenders/inmates who perform specific behaviors satisfactorily (such as, cleaning their living area, helping other inmates, etc.) are rewarded with tokens which can later be exchanged for privileges (more time to watch television) or desired goods (snacks from the canteen).			
Contingency contracting. In this system the offender signs a contract with the person supervising him or her in which punishment and rewards are contingent upon specific behaviors. It thus includes punishments for certain specified behaviors (e.g., a stricter curfew for a positive urine test) and rewards for certain other specific named behaviors (e.g., good time credits for satisfactory work performance).			
Emotional growth training: teaching clients how to identify feelings, express feelings appropriately, and manage feelings constructively through the interpersonal and social demands of communal life.			
Biofeedback training. Training the offender/client to identify internal physical cues and alter responses thus controlling stress, anger, etc.			
Group unity: The program works to forge the clients (together with treatment staff) into a unified group with positive personal relationships and a sense of belonging to bring about positive changes in their personalities and methods of coping with problems.			
Transcendental meditation			

Treatment component	Duration	Sessions	Importance
Relaxation methods. Stress reduction methods such as the "Quieting Response," yoga techniques, etc.			
Hypnosis			
Moral or ethical training (didactic training to attempt to have the offenders internalize a religious, moral, or normative system such as Born Again Christians or moral reconation)			
Wilderness or experiential challenge programs (programs that confront groups of clients/participants with difficulties designed to teach them self confidence and that working together with everyone in the group cooperatively is a more rewarding approach than trying to compete with or exploit others.			
Advocacy by the program staff to obtain services/benefits for the offender (e.g. unemployment benefits) which may make it easier to avoid criminality and/or drug abuse relapse.			
Art or recreation programs as therapy			
Methadone maintenance			
Medical treatment with prescription drugs, hormones, etc.			
Staged recovery process model (specified treatment depends on the offender's stage in the recovery process; also termed a "treatment matching" model)			
Substance abuse education (educates substance abusers about the harmful health effects of using that substance)			

Treatment component	Duration	Sessions	Importance
Other drug/alcohol treatment (specify _____ _____			
AA-type meetings and activities.			
Self-help therapy using a manual or diary so that the individual is more likely to identify problems leading to criminality and/or substance abuse and more likely to find personal solutions not entailing crime or substance abuse.			
One-on-one counseling by trained staff holding academic degrees and/or credentials in the professions of counseling offenders and/or substance abusers.			
Individually administered psychotherapy by psychotherapists with academic degrees and internships in psychiatry or clinical psychology.			
Scheduled group therapy or group counseling (e.g., Guided Group Interaction, Positive Peer Culture)			
Family therapy: includes treatment of family members as well as the client in the belief that their reactions to the offender can help him/her avoid crime and substance abuse.			
Work release (the inmate is released from a residential correctional facility to work outside during the day, then returns to the correctional facility for sleep and normal residential activities.			
Halfway house: a residential correctional facility designed to house small groups of "inmates" in a normal house (not a lockup) guided by a house leader and counselor. This is intended to ease the transition to normal life on parole and after discharge.			

Treatment component	Duration	Sessions	Importance
Case management (emphasis on procuring and monitoring service from various agencies to insure delivery of treatment to the clients in the program)			
Casework (extends beyond case management and includes active integration of the care provided, counseling - from a social work perspective, and involvement with the client's family)			
Meeting with the victim. This is intended to have the client/participant learn the gravity of his/her crime by listening to the person who suffered the consequences of the crime, to learn how to see things from the victims point of view, and to develop remorse and motivation to avoid new crimes and substance abuse.			
Individualized treatment plans that are based on differential needs (or diagnoses) of the individuals. Client-to-treatment matching. Treatment should be tailor-made matching clients with particular needs to specific types of treatments			
Other definite types of correctional response or treatment that would not fit within any of the above categories without distortion. Please specify below			

83. Please provide any comments or explanations of the above treatments here:

_____

_____

_____

_____

84. Is the program organized into distinct phases? YES / NO (circle one)

If yes, please specify the phases of the program:

_____

_____

_____

85. Is the program more oriented toward uniformity of treatment programming or individualization of treatment programming?

Circle one number on the scale below.

Every person receives the same treatment components				Every person receives an individualized treatment plan
1	2	3	4	5

86. Comment:_____

_____

_____

87. If there is some emphasis on individualization, in what ways are treatment plans individualized? (For example, special sessions for sex offenders or mentally ill offenders; increased time devoted to anger management if client's history or psychological scale score warrant it; literacy training offered of client reads below a fourth grade level.)

_____

_____

_____

88. Is there any important component of the program that you have not yet been able to put into operation or put into operation successfully?

YES / NO (circle one)

89. If so, which component? What were the obstacles?

_____

_____

_____

_____

_____

90. Has the program stabilized or is it still in the "shakedown" phase?

Stabilized / In shakedown phase (circle one)

91. Explain: _____

_____

_____

_____

_____

92. Has the program changed in any important way since it began operations?

YES / NO (circle one)

93. Explain:_____

_____

_____

_____

94. Are quality control checks made regarding treatment delivery?

YES / NO (circle one)

If yes....

95. Who checks? _____

96. With what frequency? _____

97. How do they check (e.g. site visits, check records)?

_____

_____

_____

_____

[Please attach a current schedule for participants in your program, showing what they do each day of the week, including Saturday and Sunday. If the schedules vary depending on the participant's month or stage in the program, please attach all and explain.]

Monitoring participants (drug testing, etc.)

98. If drug testing is used while participants are in the residential RSAT program, please indicate in the table below:

⇒ what types of drugs are tested for (check all that apply)

⇒ what method of sample collection is used (e.g. urine samples, hair samples, breathalyzer, other)

⇒ method of testing (e.g., EMIT™, TD™, RIA, thin-layer chromatography)

⇒ average number of tests per month per person in the RSAT program

Substance (check all that apply)		**Method of Sample Collection (e.g., urine)**	**Method of Testing (e.g. EMIT, thin layer chromatography)**	**Average # of tests per person per month**
Marijuana				
Cocaine				
Opiates				
Phencyclidine (PCP)				
Benzodiazepines				
Methaqualone				
Propoxyphene				
Barbiturates				
Amphetamines				
Alcohol				
Other (specify): _____				

99. For inmates in the RSAT program indicate in the table below whether samples are collected for the following drugs:

⇒ at random days and times (i.e. it can occur any day at almost any waking hour.)

⇒ at regularly scheduled days and times (e.g. only on Tuesdays and Saturdays between 1:00 and 3:00 p.m.)

(check one)

Substance	Random	Regular schedule	Not tested
Marijuana			
Cocaine			
Opiates			
Phencyclidine (PCP)			
Benzodiazepines			
Methaqualone			
Propoxyphene			
Barbiturates			
Amphetamines			
Alcohol			
Other (specify): _____			

100. What percentage of inmates are tested each *week*?

_____%

101. On what basis are they included for testing?

a. All RSAT participants

b. For cause

c. Random

d. Other _____

102. What percentage of inmates are tested each *month*?

_____%

103. On what basis are they included for testing?

a. All RSAT participants

b. For cause

c. Random

d. Other _____

104. If participants *are* monitored for drug or alcohol use, choose one of the following as the typical way in which your program would respond to in-program drug or alcohol use:

_____**There is one system of graduated sanctions which applies to <u>all</u> participants.**

(For example, a first positive test for substance use, e.g., a dirty urine, carries a penalty of 10 hours of extra work duty, a second positive test carries a penalty of being set back to a lower level in the program, a third positive test carries a penalty of ejection from the RSAT program).

If yes, please specify the complete system of graduated negative sanctions that is used in this RSAT program or send us a copy of the institutional policy outlining drug policy and sanctions.

OR...

_____**There are two or more different systems of graduated sanctions.**

(For example, one set of negative sanctions for newcomers to the program and a different set of sanctions for those who have been in the program longer.)

If yes, please specify the different systems of graduated negative sanctions that are used in this RSAT program.

OR...

_____**There is no <u>overall</u> policy to deal with drug use, each infraction is handled on a *case-by-case basis*.**

OR...

_____Other [please specify] _____

_____

_____

105. Comments / specifications for previous question:

_____

_____

_____

106. Are incentives or rewards given to participants who do not get a positive test for substance use during a fixed length of time? (For example, one month with no dirty urine earns increased access to recreational facilities.)

YES / NO (circle one)

107. If yes, what are they?

_____

_____

_____

Community Supervision Phase

Setting of the treatment program

108. Is the residential phase of your RSAT program followed by a post-release, community supervision phase?

YES / NO (circle one) If "NO," skip the rest of this section.

109. Comment?_____

_____

110. Does the RSAT program have its <u>own</u> community supervision/aftercare program?

YES / NO (circle one)

111. If "NO," do you have a regular relationship with another community supervision/aftercare provider in the community?

YES / NO (circle one)

112. Who provides community supervision/aftercare? (Check all that apply)

Parole	
Community-based treatment program under contract	
DOC halfway house or work release facility	
No organization yet identified / no arrangement made yet	
Other (Specify) _____	
None / No plans to provide community supervision	

113. Who is in charge of the community supervision phase of the RSAT program?

Name:_____Phone:_(_____)_____

email: _____

Name:_____Phone:_(_____)_____

email: _____

114. Is community supervision/aftercare provided at the following? (Check all that apply)

Work release facility	
Halfway house/pre-release facility	
Group home	
Therapeutic community	
Transitional Living house ("a sober residence" e.g., Oxford House)	
RSAT clients reside in their own private homes although they may be required to report periodically to other locations, such as a parole office.	
Other (Specify) _____ _____	

115. If responsibility for the program is shared between the residential and community supervision phases, what information about participants is passed from the residential program to the community supervision program? Please explain:

_____

_____

_____

116. Is there an evaluation research study of the community supervision/aftercare phase of the RSAT program?

YES / NO (circle one)

117. If "Yes," who is in charge of that evaluation research?

_____Phone (_____)_____

Technical Assistance

118. Has your RSAT program received any technical assistance? YES / NO

If you have requested technical assistance with any feature of your RSAT program, please complete the following matrix for each instance it was requested.

What technical assistance did you request for the RSAT program?	Were you told it would be provided? If so, what organization is to provide the TA?	Has the technical assistance been provided to your program? If so, please describe the extent to which it has been helpful or not.

119. If you need technical assistance and have not yet requested it (or if you were told it would be provided but never received it), please describe the problem.

_____

_____

_____

_____

_____

Thank you for your time and effort in providing this information!

Appendix 3C Final State Survey

Follow-Up Survey

The Residential Substance Abuse Treatment (RSAT) initiative was in part a response to the gap that existed between the number of offenders who were assessed to need residential substance abuse treatment and the residential substance abuse treatment slots available. The Corrections Program Office (CPO) and the National Institute of Justice (NIJ) wanted this Follow-Up Survey to focus more closely on how the RSAT initiative is helping to bridge the substance abuse treatment gap.

1. State (or Territory) _____

2. State agency responsible for RSAT funds _____

3. Person actually responsible for completing this form:

_____ Phone: (_____)_____

4. Date form completed: ____/____/____
   Mo / Day / Yr

NOTE: The person responsible for completing this form may need to ask others for information.

5. What month and day START your state's Fiscal Year (State FY)? ___/___
   Mo / Day

6. What month and day END your state's Fiscal Year (State FY)? ___/___
   Mo / Day

Please use those dates of your state's Fiscal Year to answer the following questions.

7. How much RSAT money did your state receive in

State FY'96	State FY'97	State FY'98
$_____	$_____	$_____

8. When did your state first begin to draw down money from the RSAT award? ___/___/___
   Mo /Day/ Yr

9. What part of your budget for your state's RSAT program(s) came from the following sources in each fiscal year?

	State FY'96	State FY'97	State FY'98
RSAT funds?	$	$	$
Other federal funds?	$	$	$
State funds?	$	$	$
Local funds?	$	$	$
Not-for-profit funds?	$	$	$
Private funds?	$	$	$

10. What part of your state's correctional substance abuse treatment budget (excluding costs focused on drug testing, drug abuse education, and self-help programs such as AA) came from the following sources in each fiscal year?

	State FY'96	State FY'97	State FY'98
RSAT funds?	$	$	$
Other federal funds?	$	$	$
State funds?	$	$	$
Local funds?	$	$	$
Not-for-profit funds?	$	$	$
Private funds?	$	$	$

11. In your RSAT program(s) what did you purchase with the RSAT funds during each fiscal year?

	State FY'96	State FY'97	State FY'98
Salaries and benefits for treatment staff	$	$	$
Salaries and benefits for correctional officers	$	$	$
Training for treatment staff	$	$	$
Training for correctional officers	$	$	$
Drug test contracts	$	$	$
Drug test kits (If not included in the above)	$	$	$
Other materials and supplies	$	$	$
Facility alterations or renovations	$	$	$
If there were other major expenses to implement and operate the RSAT program please list them:			
Other:	$	$	$
Other:	$	$	$
Other:	$	$	$
Other:	$	$	$

Other comments:

12. In your state's *correctional* substance abuse *treatment* (excluding costs focused on drug testing, drug abuse education, and self-help programs such as AA) how many treatment slots (distinguishing separate residential vs. other types) did you have in each fiscal year?

	At the close of State FY'95	At the close of State FY'96	At the close of State FY'97	At the close of State FY'98
Number of slots for inmates in separate residential units focused on substance abuse treatment				
Number of slots for substance abuse treatment other than in separate residential units focused on substance abuse				

13. What is your source of information?

14. In your state's *correctional* substance abuse *treatment* (excluding costs focused on drug testing, drug abuse education, and self-help programs such as AA) how many substance abuse treatment staff (in Full Time Equivalents, FTE) did you have?

	At the close of State FY'96	At the close of State FY'96	At the close of State FY'97	At the close of State FY'98
Number of treatment staff for residential component				
Number of treatment staff for nonresidential component				

15. Does your state correctional system do a formal diagnostic assessment of drug treatment needs **when the offender is first admitted** to the correctional system? YES / NO

15.1. If YES, what diagnostic instrument is used?

16. Do you do diagnostic assessments **at some other time** during incarceration? YES / NO
If NO, please skip to question 18.

16.1. If YES, when during the period of incarceration?

16.2. If YES, what diagnostic instrument is used?

17. Based on these formal assessments (questions 15 and 16), what were the numbers of offenders needing residential treatment:

17.1. at the close of State FY '95? _____
17.2. at the close of State FY '96? _____
17.3. at the close of State FY '97? _____
17.4. at the close of State FY '98? _____

Please skip to question 19.

18. If no formal assessments are done, what are your *estimates* of the numbers of offenders needing residential treatment:

18.1. at the close of State FY '95? _____
18.2. at the close of State FY '96? _____
18.3. at the close of State FY '97? _____
18.4. at the close of State FY '98? _____

18.5. On what information do you base these estimates?

19. Some states were not able to begin spending the RSAT funds right away (for a variety of reasons). In the first **three months** after the RSAT award, what percentage of your projected annual RSAT budget was actually spent? _____%

20. In the first **six months** after the RSAT award, what percentage of your projected annual RSAT budget was actually spent? _____%

21. In the first **year** after the RSAT award, what percentage of your projected annual RSAT budget was actually spent? _____%

22. The following is a list of some reasons why there may have been some delay in spending any part of the RSAT money. Rate each statement on a scale from one to five, where 5 means severe impediment and 1 means no problem at all, to indicate how much each of the following was an impediment to using RSAT funds to expand drug treatment in your state.

	Severe impediment				**Not a problem**
A. Funds not officially released at the state level	**5**	**4**	**3**	**2**	**1**
B. Treatment providers have to undergo a time consuming proposal/bidding process	**5**	**4**	**3**	**2**	**1**
C. Awaiting completion of construction of a residential facility	**5**	**4**	**3**	**2**	**1**
D. Federal requirements	**5**	**4**	**3**	**2**	**1**
E. State-level regulations	**5**	**4**	**3**	**2**	**1**
F. Difficulty recruiting treatment staff	**5**	**4**	**3**	**2**	**1**
G. Difficulty securing training for treatment staff	**5**	**4**	**3**	**2**	**1**
H. Locating appropriate facilities	**5**	**4**	**3**	**2**	**1**
I. Screening mechanisms for program placement	**5**	**4**	**3**	**2**	**1**
J. Security considerations for program eligibility	**5**	**4**	**3**	**2**	**1**
K. Degree of inter-agency cooperation	**5**	**4**	**3**	**2**	**1**

Other comments on this:

23. Please specify the status of all RSAT programs in your state (as of August 31, 1998):

1. RSAT Program 1:
   1.1. Program Name_____ Phone # ( ) -
   1.2. Number of clients ever admitted from when the program started drawing RSAT funds through 8/31/98: _____
   1.3. Number of clients currently in the program (as of 8/31/98): _____
   1.4. Number of beds or slots available in the program: _____
   1.5. Number of substance abuse treatment staff (as Full Time Equivalent, FTE)_____
2. RSAT Program 2:
   2.1. Program Name_____ Phone # ( ) -
   2.2. Number of clients ever admitted from when the program started drawing RSAT funds through 8/31/98: _____
   2.3. Number of clients currently in the program (as of 8/31/98): _____
   2.4. Number of beds or slots available in the program: _____
   2.5. Number of substance abuse treatment staff (as Full Time Equivalent, FTE)_____
3. RSAT Program 3:
   3.1. Program Name_____ Phone # ( ) -
   3.2. Number of clients ever admitted from when the program started drawing RSAT funds through 8/31/98: _____
   3.3. Number of clients currently in the program (as of 8/31/98): _____
   3.4. Number of beds or slots available in the program: _____
   3.5. Number of substance abuse treatment staff (as Full Time Equivalent, FTE)_____
4. RSAT Program 4:
   4.1. Program Name_____ Phone # ( ) -
   4.2. Number of clients ever admitted from when the program started drawing RSAT funds through 8/31/98: _____
   4.3. Number of clients currently in the program (as of 8/31/98): _____
   4.4. Number of beds or slots available in the program: _____
   4.5. Number of substance abuse treatment staff (as Full Time Equivalent, FTE)_____
5. RSAT Program 5:
   5.1. Program Name_____ Phone # ( ) -
   5.2. Number of clients ever admitted from when the program started drawing RSAT funds through 8/31/98: _____
   5.3. Number of clients currently in the program (as of 8/31/98): _____
   5.4. Number of beds or slots available in the program: _____
   5.5. Number of substance abuse treatment staff (as Full Time Equivalent, FTE)_____

24. Please send us a copy of your state's Department of Corrections *Annual Report* for the two most recent years.

Thank you for providing this information to help assess the RSAT program initiative!
Please return this survey to:

Dr. Douglas S. Lipton
NDRI
2 World Trade Center, 16th Floor (212) 845-4547 Phone
New York, NY 10048 (212) 845-4698 Fax

Appendix 4 Standards of Evaluability

Standards of evaluability

Purpose

These "standards of evaluability" are intended:

- to serve as guidelines which may help to improve the quality of some of the RSAT programs, at least in certain areas.
- to serve as guidelines or indicators suggesting how ready programs are to undergo a rigorous outcome evaluation.
- to serve as indicators to help NERSAT in choosing six RSAT programs for site visits (which may lead to nominating one to three of them as potential model RSAT programs.

These "standards of evaluability" are **not** requirements to which all RSAT programs must conform. For example, some RSAT programs may be considered worthwhile and "promising" even though they are not yet at a stage where they could undergo a rigorous outcome evaluation.

Treatment Program Model

1. The program uses an established treatment program model and fits the criteria specified for that model or uses an innovative model which seems credible.

2. If the program uses an established treatment program model, there is documentation of that model and how closely the model is being duplicated at the RSAT site.

3. If the program does not use an established treatment program model but rather a new treatment approach, there is documentation of the rationale for why this innovative approach is expected to be successful. (Examples of such documentation include evaluation research of its use in other fields and theoretical documents.)

4. The context of the program should be adequately described, including the physical setting, the administrative context (e.g., organizational charts and special regulations or constraints which may apply), stability or instability of funding sources, and any other factors or events external to the program which are likely to substantially affect the nature or operations of the program.

5. A primary part of the RSAT program treatment model must deal with how to substantially decrease (ideally, to eliminate) rates of substance abuse among RSAT program participants when they are later released into community supervision, as well as while in confinement.

6. State level policy makers view the RSAT program as an integrated part of a comprehensive substance abuse treatment strategy in the state's correctional system.

7. An important component of the program treatment model is programming to develop the treatment group's cognitive, behavioral, social, or vocational skills (or related skills) to decrease recidivism.

8. An important component of the treatment model is programming to develop the treatment group's cognitive, behavioral, social, or vocational skills (or related skills) to decrease substance abuse relapse.

9. The program model includes systematic assessment of the treatment needs of the offenders admitted to the program.

10. The program model takes into account individual client differences in treatment services which may be needed. (A common approach is for programs to develop and use individual treatment plans for offenders admitted to the program.)

11. The program has clearly defined goals and measurable objectives.

12. The program model takes into consideration not just the residential phase of the RSAT program, but also the subsequent period of supervision in the community, for example, by having detailed plans for the aftercare period.

Implementation of the Program Model

13. There should be sufficient documentation describing the program's objectives, structure, operations, resources, and changes over time. The documentation should include organization charts, descriptions of the duties and responsibilities of each position, job posting notices, documented standard operating procedures, schedules, training manuals, etc. (Since most programs do change over time,

14. There should be records which document the program *as actually observed* in operation. This may include such things as records of the dates and times of treatment contacts with participants, supervisor's records of monitoring actual counseling sessions, staff logs, and so on, as appropriate.

15. The program *actually in operation* corresponds to the stated treatment program model, or....

16. The program *actually in operation* is believed to be an <u>improved version</u> of the initially stated treatment program model (which should lead to rewriting the initially stated program model).

17. At least fifty percent of the persons admitted to the residential phase of the RSAT program become successful terminations ("graduates") within the time frame planned for the residential phase.

18. Program participants recorded as having successfully terminated the residential phase of the RSAT program must have been residents of the program for at least 6 months but not more than 12 months.

Program Maintenance

19. The program checks to ensure that the quality of the programming actually is maintained (or improved) over time. This may be done through such means as inspections, supervisory reviews, audits, and/or site visits by outside observers.

Client Characteristics

20. The caseload is large enough so the program could be of practical benefit as a model for other jurisdictions; generally, at least thirty persons admitted to the program in a year.

21. The program focuses its treatment components on offenders known to need the specific components (e.g., lengthy substance abuse treatment targeting clients who had used drugs with some regularity while excluding persons who had used drugs rarely or never).

22. The program concentrates on inmates who have just enough time left in their term of confinement so that they can be released from confinement soon after successfully completing the residential RSAT program.

23. The program delivers treatment to a special population that may not have received adequate programming in the past, for example, a program for women or for HIV positive persons. (This standard points out that such a program may receive special consideration as a model program.)

Staff Characteristics

24. The staff have received relevant and adequate pre-service training in the program model. Documentation of the staff training (e.g., training schedules) should be made available.

25. The staff have received (and continue to receive as necessary) adequate on-the-job (in service) training (work experience) in the program model. Documentation of the staff training (e.g., training schedules) should be made available.

26. The program contains satisfactory features *reflecting cultural sensitivity, sensitivity to gender differences* and/or use of *role models* with program clients for whom such issues may arise. One such feature would be an adequate degree of match of staff background characteristics to client background characteristics in order to facilitate the rehabilitative process. (For example, a program targeting young African-Americans might not be so effective if there were hardly any African-American successes in the program social system to serve as potential role models. Such a program is more likely to be effective if members of the treatment staff and/or volunteer staff are African-American. Similarly, a program targeting females is more likely to be effective if members of the treatment staff and/or volunteer staff are female.

Administrative Context

27. The RSAT clients have adequate separation from the general population in the correctional facility to avoid excessive interference with the program from offender peers not in the program.

28. The residential RSAT program and community-based substance abuse treatment programs work together to place the clients in appropriate community substance abuse treatment when the clients leave the correctional facility at the end of their sentence or when released on parole.

29. The residential RSAT program works together with other agencies (such as parole, halfway houses, mental health agencies, etc.) or other appropriate aftercare systems so that treatment continues in the community and so that treatment supervision is maintained after the RSAT clients are released from confinement.

Control/Comparison group adequacy

30. Programs should have access to data likely to be related to relevant outcomes (such as recidivism, substance abuse, etc.) covering periods before and after the current incarceration on a set of inmates not receiving RSAT program treatment so that set of inmates could constitute a comparison group as similar as possible to the RSAT program participants in all important respects.

31. For every two beds in the RSAT program there are at least three applicants who completely satisfy the admission criteria for the RSAT program. This identifies the "waiting list approach" to building a comparison group: For every two persons admitted, at least one more equally qualified applicant will not be admitted due to lack of space and can thus serve as part of a comparison group.

32. If a "waiting list approach" to building a comparison group is used, the reasons for choosing one waiting applicant rather than another waiting applicant should be clearly identified. Some programs might choose strictly on a first come, first served basis, choosing from the pool of those conditionally accepted for the program the person who had been waiting for admission the longest time. Other programs might review again those on the waiting list of persons conditionally accepted for the program and choose the person considered most likely to succeed, regardless of time on the waiting list. (The latter approach is far less satisfactory in terms of evaluability.) Whatever, the procedure, the selection criteria should be fully specified.

33. If there are far more acceptable candidates for admission to the RSAT program than there are available beds, the authorities will approve and abide by a lottery system for admission to the experimental group. [For example, if there are two candidates for each available bed, can selection be done using a fair, random procedure?]

34. There is adequate evidence of the type(s) and amounts of treatment programming that persons in the control/comparison group receive.

35. There is adequate evidence that the *difference* in the treatment programming experienced by persons in the experimental group in contrast to persons in the control/comparison group is identical to the *treatment model* adopted by the RSAT program.

36. Pretest information will be available to show the degree to which persons in the control/comparison group were similar to those in the experimental group in terms of criminal history, substance abuse history and positive adjustment variables (education, employment) before they experienced a difference in treatment programming.

37. If there were dissimilarities between persons in the control/comparison group and those in the experimental group in terms of criminal history, substance abuse history and positive adjustment variables (education, employment) before they experienced a difference in treatment programming, the differences seem (1) to be small and (2) to indicate that there are more high-risk, high-need cases in the experimental group. As one example, it is desirable that the individuals entering the RSAT program and the individuals in the comparison group should be tested for *motivation* to participate in treatment (for example, using the *Circumstances, Motivation, Readiness (CMR) scale* mentioned below) to assess whether both groups were about equally motivated to try to resist temptations to return to substance abuse and crime, and this scale should be administered before the groups experience the differences in programmatic treatment.

Ability to Meet Outcome Evaluation Research Needs

38. The RSAT program has access to a computerized DRS (data reporting system) or MIS (management information system) which provides data useful for program management.

39. The RSAT program DRS / MIS contains client risk assessment information.

40. The RSAT program DRS / MIS contains client needs assessment information.

41. The RSAT program DRS / MIS contains information on each client's status/progress in the program.

42. The RSAT program DRS / MIS contains other psychological scales and/or diagnostic instruments routinely administered.

43. The program can provide evidence that rearrest data on clients released from RSAT and from the comparison group into community supervision can be obtained (e.g., from a state police record keeping system).

44. The program can provide evidence that substance abuse relapse data on clients released from RSAT and from the comparison group into community supervision can be obtained (e.g., from a parole urinalysis record keeping system).

45. The program can provide evidence that parole infraction data on clients released from RSAT and from the comparison group into community supervision can be obtained.

46. The program can provide evidence that employment status data on clients released from RSAT and from the comparison group into community supervision can be obtained.

47. The program can provide evidence that it can and will protect the rights of human subjects in research, if evaluation research on the program takes place.

48. The program model can list all of the categories of persons who might be substantially affected by a research evaluation (including, but not necessarily limited to, offenders who enter the program and the staff who operate the program).

49. Any potential conflicts of interest which might exist in conducting an outcome evaluation should be clearly identified.

50. Any known problems in the *validity* of measures, scales or observations should be clearly identified. This would include known bias in any particular instrument, scale, or method of observation.

51. Any known problems in the *reliability* of measures, scales or observations should be clearly identified. This would include low inter-rater agreement, low test-retest consistency, etc.

52. Any differences in the time periods of monitoring or observing the outcome behavior of experimental and comparison group should be clearly identified. For example, if the experimental group participants tend to be institutionalized longer than those in the comparison group and thus experimental group subjects are not at risk for recidivism in the community for as long as the comparison group persons are, this should be made clear.

Common Data Elements

One of the tasks given to the National Evaluation of Residential Substance Abuse Treatment (NERSAT) project has been to encourage the use of common data elements by the RSAT programs. The purpose of this emphasis is that it will be more meaningful to compare and contrast the different kinds of RSAT programs if they use the same data collection instruments.

53. Because of the usefulness of common data elements in comparing and contrasting RSAT programs overall and in comparing and contrasting RSAT programs which are considered to be especially promising, programs will be considered more evaluable in terms of the national evaluation if they have for each RSAT program participant and for each of the offenders who can form a comparison group:

    a) a completed *Addiction Severity Index (ASI),*
    b) a completed *Circumstances, Motivation, Readiness (CMR) scale* (18-items, predictive of client readiness for drug abuse treatment), and
    c) a completed criminal history form, compatible with the FBI *Uniform Crime Reports for the United States* crime types (Part II as well as Part I offenses), which includes multiple charges (if present) and which includes charges prior to the charge which eventuated in the prison sentence (if any).