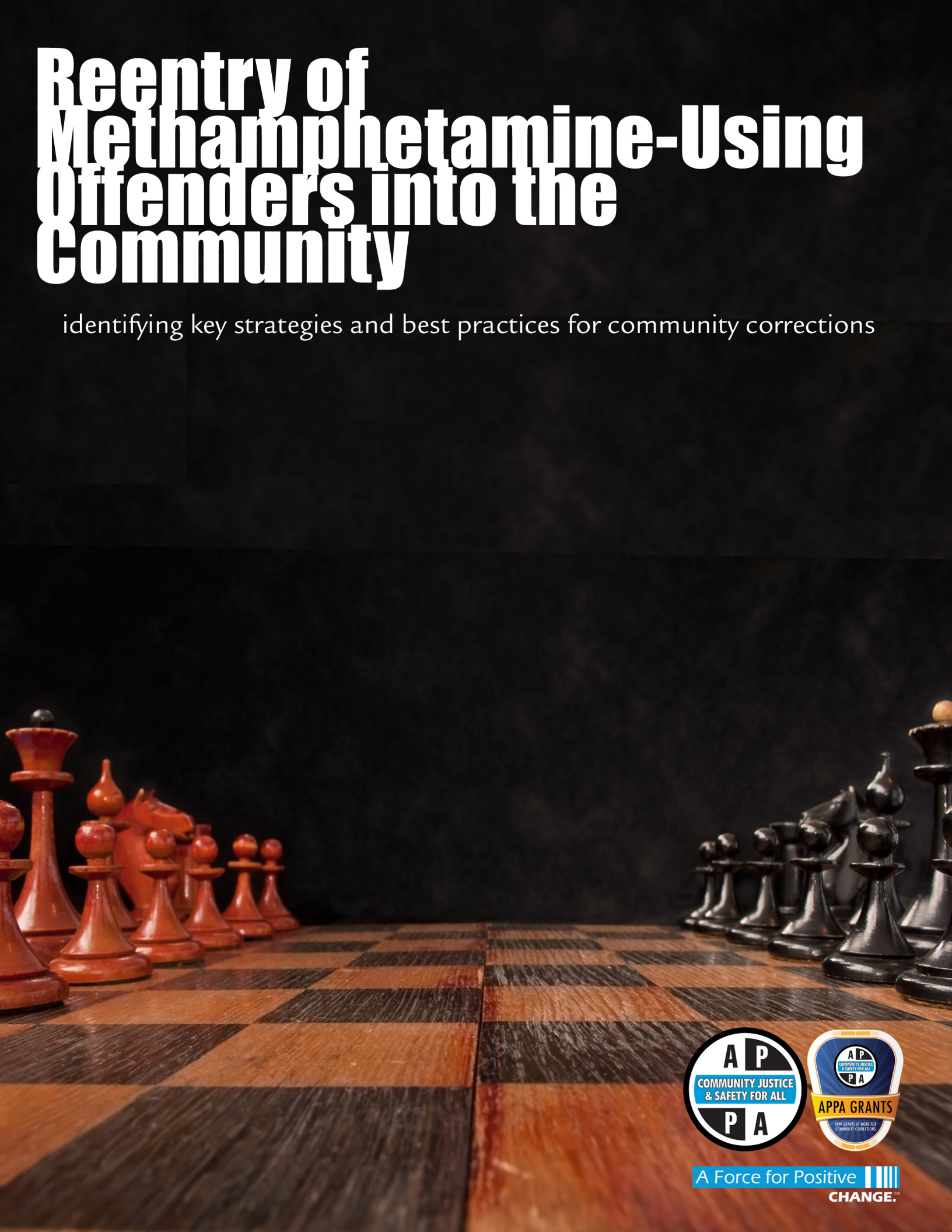
Reentry of Methamphetamine-Using Offenders into the Community

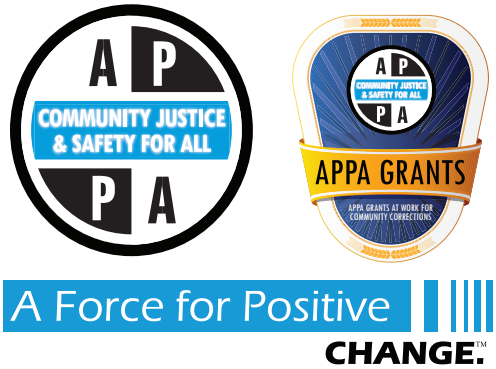
identifying key strategies and best practices for community corrections



A Force for Positive CHANGE.™

Reentry of Methamphetamine-Using Offenders into the Community:

Identifying Key Strategies and Best Practices for Community Corrections



Prepared by the Council of State Governments/American Probation and Parole Association

Authors:
Nathan C. Lowe, M.S.
Matthew DeMichele, Ph.D.

October 2010

This project was supported by Grant No. 2006-RE-CX-K102 from the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the U.S. Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, the Community Capacity Development Office, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. The points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice or other funding agencies.

Table of Contents

Introduction

The community corrections field is being called upon to respond to the realities of the mass incarceration movement over the past three decades. An area of particular concern for the community corrections field is substance abuse. This report discusses issues related to reentry of methamphetamine (MA) users. From 1997 to 2004, MA use increased among both state and federal prison inmates in the month before the convicting offense was committed and at the time of the convicting offense (Mumola & Karberg, 2006). This increase in MA use among offenders has created significant challenges for the corrections field. Specifically, correctional and treatment professionals have worked together in efforts to implement the most effective strategies to treat MA use and abuse among offenders in the community. Some claim that MA-abusing offenders in the community may embody a "special population" of offenders with regard to both treatment and supervision (Stoops, Tindall, Mateyoke-Scrivner, & Leukefeld, 2005, p. 273).

It is imperative for community corrections professionals to be adequately prepared and trained to supervise MA-using offenders in the community. With funding from the Bureau of Justice Assistance (BJA), the Council of State Governments/ American Probation and Parole Association (CSG/APPA) has identified effective supervision and programming strategies to address issues faced by MA-using offenders returning to the community. On-site technical assistance and a focus group of practitioners working with MA-related offenders in the community pointed to the challenges, collaborative efforts, and key strategies for supervising MA-using offenders. The technical assistance sites were: Colorado State Court Administrators Office-Division of Probation Services, Denver, Colorado; and South Dakota Board of Pardons and Parole, Intensive Methamphetamine Treatment (IMT) Program, Sioux Falls, South Dakota; and Maricopa County Adult Probation, Phoenix, Arizona.

The purpose of this report is to highlight the need for a coherent strategy for community corrections professionals to use when supervising MA-using populations in the community. This report offers the community corrections field baseline data to understand some of the obstacles and lessons learned regarding supervision of MA-using offenders. The data were gathered from a focus group and three technical assistance site visits with the underlying intention of identifying key strategies in dealing with MA-using offenders in the community. Policy and practice recommendations are also offered. These recommendations rely on the focus group, site visits, and emerging body of research literature on effective community supervision and successful substance abuse strategies.

An Overview of MA use and Criminal Populations

During the 1960s, MA pharmaceutical products were widely available and often abused. In 1971, MA was placed into Schedule II of the Controlled Substances Act[1], ending the legal availability of injectable MA and resulting in significant reductions in MA use medically. Through the 1980s, as the medical use of MA decreased significantly, the manufacturing and use of MA was manufactured, trafficked and used on the black-market. Today, despite increased enforcement efforts, MA availability continues through clandestine and more mobile lab production throughout the United States and importation of MA from Mexico (Hunt, Kuck, & Truitt, 2006). Although MA continues to be a prominent drug of choice in many Western and Midwestern states (Hunt et al., 2006), some researchers (Listwan, Shaffer, & Hartman, 2009) suggest the entire nation is currently facing a potential methamphetamine epidemic. Nationally, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), an estimate of more than 10 million people age 12 or older have reported using MA at some point in their life (SAMSHA, 2006). Research suggests a significant increase in MA use in rural areas (MacMaster, Tripp, & Argo, 2008; Stoops et al., 2007).

Whether on probation or during reentry on parole, judicial and correctional workgroups are faced with serious dilemmas in managing and supervising MA-using offenders in the community. One such dilemma relates to the goals of sentencing this population. For substance abusing populations, sentencing goals are often conflicted with holding offenders accountable for their actions, while simultaneously ensuring appropriate treatment services for these offenders. The solution is for all parties (i.e., judges, attorneys, probation and parole officers, and treatment staff) to reach a consensus on the expectations for offenders. To do this, there must be collaboration and a clear line of communication. Over the last decade, several programs that are based on the principle of effective collaboration and communication among criminal justice professionals in the community have been implemented around the nation. Two of the more prominent community supervision models—California's treatment-in-lieu-of-incarceration initiative (Proposition 36) and Hawaii's swift and certain sanctions program (HOPE)—are examples of potentially successful models for supervising MA-abusing offenders in the community.

In 2000, the Substance Abuse and Crime Prevention Act of 2000, better known as Proposition 36, was passed and implemented into law. This law allowed adults convicted of non-violent drug possession offenses the option of participating in drug treatment in the community in lieu of incarceration or probation without treatment. More than 54,000 individuals are referred to the program each year, and more than half report MA as their primary drug (Urada, Longshore, & Hawken, 2007). The statewide evaluation of Proposition 36 showed a cost-saving benefit in that $2.50 was saved for every $1.00 invested in the program (Hawken, Longshore, Urada, & Anglin, 2007). This evaluation also found that many substance abusers were not receiving appropriate levels of treatment (Hawken, Anglin, & Conner, 2007), particularly with regard to the underutilization of residential treatment for MA users. When given residential treatment, however, participants who reported MA as their primary drug had significantly better treatment outcomes and significantly lower recidivism as compared to similar participants who were placed into outpatient care (Hawken, Aglin, & Conner, 2007). While the treatment outcomes of MA users did improve, the evaluation also found that about one-fourth of Proposition 36 offenders never appear for treatment and, for those who do appear, only about one-third complete it (Urada et al., 2007).

Hawaii's Operation Probation with Enforcement (HOPE) demonstrates to probationers that there are consequences to their behaviors through a joint effort by the judiciary and probation; offenders receive a consistent message about personal accountability and responsibility. HOPE is unique in its perspective on drug use among probationers as they advocate for a behavioral triage approach. This approach entails randomly assigning probationers either to HOPE or traditional supervision services. Offenders placed in the HOPE group are brought in for an initial warning hearing administered by a judge. The message

1 Drugs and drug products that came under the jurisdiction of the Controlled Substances Act are categorized into five categories. Schedule II drugs are those with high abuse potential, but some medical utility, and require medical use justification and a prescription (i.e., methadone, Ritalin). There are generally no refills and no telephone prescriptions for Schedule II drugs. All amphetamines are Schedule II drugs. Their current medical use is restricted to the treatment of narcolepsy and minimal brain disorder in children in the form of dextro-amphetamine (Merck, 2004). See here for complete details of the Controlled Substances Act: www.justice.gov/dea/pubs/csa.html.

is given that any detected drug use will result in some period of incarceration. A three-month follow-up found that there was a significant reduction in positive urinalysis for the HOPE group, with a baseline of 53% testing positive for drugs decreasing to 9% testing positive (Hawken & Kleiman, 2009). The underlying philosophy of the HOPE program is that since many probationers will use drugs, substance abuse may not be their central criminogenic need, and given the scarcity of treatment resources, only those offenders who consistently test positive on drug screens will be mandated to treatment. Interestingly, less than 10% of the HOPE probationers had two positive tests and about 2% of them had four or more positive tests.

Both Proposition 36 and HOPE illustrate the innovativeness of the criminal justice system in recent years in responding to drug abusing offenders, particularly those who are MA users. These initiatives point out ways in which policy makers, judges, correctional personnel, and treatment staff can collaborate to disrupt the criminogenic patterns of many drug-using probationers, while also decreasing recidivism and costs.

MA Treatment and Offender Populations

Substance abuse increases the obstacles facing returning offenders to communities. Offenders with substance abuse problems have an uphill battle to find employment, meet familial and childcare responsibilities, and actively participate in treatment. Unfortunately, the treatment services offered to criminal justice populations are inadequate to address the substance abuse problems facing individuals under community supervision (Belenko & Peugh, 2005). According to SAMHSA (2009), from 1992 to 2007, admissions to treatment referred by the criminal justice system increased significantly for primary MA abuse (from 37% to 57%), which was the largest increase among all primary substances abused. Such an increase over a 15-year period signifies not only the heightened prevalence of MA abuse among offenders in the criminal justice system, but also the important role that treatment providers have assumed in dealing with this population.

The National Institute on Drug Abuse (NIDA) is the nation's leading agency for researching the effects of drug abuse and the strategies most likely to foster pro-social behavior change. In 2007, NIDA published a guide identifying 13 research-based principles that criminal justice practitioners and policymakers should consider with regard to substance-abusing criminal populations. The first principle is the platform from which the other principles are to be understood by viewing drug addiction as a brain disease, one that shapes behaviors among individuals. Drug use changes the cognitive, behavioral, and physiological make-up of people, which could last for months or years even after an individual stops using drugs. For MA, this principle definitely applies to users. For example, Nordahl and his associates (2003) argue that prolonged use of MA leads to neural damage resulting in reduced cognitive functioning among users, affecting memory, motor skills, and abstract reasoning (see Ornstein et al., 2000; Simon et al., 2000). In general, this principle is fundamental to the NIDA approach because substance abuse does not become viewed as merely a personal issue. Rather, as neurological features are affected by long-term use, it becomes perceived as a public health concern for society.

The second principle emphasizes the importance of drug addiction being addressed with structured treatment modalities for extended periods of time in which abusers may need to undergo multiple episodes. Relapse is quite common, if not expected to a certain degree, which community corrections professionals must understand, particularly among offenders with serious drug use habits. This fact necessitates the need for offenders with substance abuse problems to be monitored closely, in addition to those dynamic risk factors that may precipitate drug use (NIDA, 2007). For MA-using offenders, although there is still not a general consensus among researchers and clinicians on the best way to treat this population, particularly in a community setting, several models have shown to be effective for this population. These models include contingency management, cognitive-behavioral therapy, and drug court and other diversion models.

Contingency management (CM) is based on empirical research that supports the position that drug use is a type of behavior that produces spontaneous effects within an individual (Bigelow & Silverman, 1999; Higgins, 1997; Higgins, Heil, & Plebani-Lussier, 2004), and if so, drug use will decrease when alternative non-drug reinforcements become prominently available to the

individual (Carroll, Lac, & Nygaard, 1989; Higgins, Bickel, & Hughes, 1994; Nader & Woolverton, 1991). In other words, this treatment model uses rewards to emphasize desired behavior (e.g., abstinence), while withholding the reinforcement or punishment of undesired behavior (e.g., relapse) within individuals. Research has shown that contingency management is effective in deterring substance abuse problems in general (Lussier et al., 2006; Roll et al., 2006). Only one study to date has been conducted on the effectiveness of contingency management on substance-abusing criminal offenders, with the majority of offenders in the study indicating MA as their primary drug (Prendergast, Hall, Roll, & Warda, 2007). Prendergast and his associates did not find any overwhelming support for the low-value vouchers awarded as part of the treatment protocol in being effective in altering the attitudes, drug use behaviors, and other outcomes among participants. Rather, Prendergast and his colleagues concluded that the judge who presided over the legal cases of the participants had a greater influence than the contingencies, which seems to validate the necessity for open collaboration between agents of the criminal justice system while working with MA-abusing offenders in the community.

Cognitive-behavioral therapy (CBT) has become a treatment model used within correctional settings to address criminal thinking and behaviors, including substance abuse. As Farabee and Hawken (2009) note, "CBT is based on the theory that self-destructive thinking styles are learned and, therefore, can be unlearned or restructured" (p. 164). The popularity of CBT has been validated through research that has shown its effectiveness in promoting reasoning and rehabilitation among offenders in order to change their criminal thinking patterns and behaviors (see Pearson, Lipton, Cleland, & Yee, 2002). As CBT relates to the treatment of MA-abusing offenders, the matrix model (Rawson et al., 1995; also, for a general overview, see http://www.drugabuse.gov/BTDP/Effective/Rawson.html) has proven to be effective. The matrix model is a community-based program that utilizes a balance of group and individual counseling, family education, routine urine testing, participation in 12-step programs, and weekly homework to develop and strengthen healthy behaviors and healthy thoughts among offenders. To this extent, then, it rests on five general principles and goals: (1) stop drug use; (2) learn issues critical to addiction and relapse; (3) receive education for family members affected by addiction and recovery; (4) become familiar with self-help programs; and (5) receive weekly monitoring by urine toxicology and breathalyzer alcohol testing (Rawson, Gonzales, & Brethen, 2002). In general, research has found the matrix model to be more effective in retaining MA-dependent treatment participants than other standard treatments. For example, in the largest trial of a treatment for MA-dependent patients (Rawson et al., 2004), matrix model participants were 38% more likely to stay in treatment, 27% more likely to complete treatment, produced more drug-free urine samples, and achieved longer periods of abstinence as compared to participants undergoing standard treatment.

NIDA's (2007) third principle identifies the need for treatment to continue adjusting the cognitive and behavioral patterns related to drug abuse among offenders. Since behavior changes do not come easily for most people, NIDA (2007) suggests a longer duration of comprehensive treatment services (i.e., a minimum of 90 days) to address severe drug problems and co-occurring disorders among offenders. This long-term strategy encourages substance-abusing offenders to recognize the need to change their drug-related cognitive and behavioral patterns. Furthermore, offenders who successfully complete long-term treatment are less likely to continue engagement in criminal activities and drug abuse. Long-term treatment is particularly important for MA-using offenders in the community, since they may face more barriers to successful completion of treatment as compared to offenders who undergo treatment in an impatient setting. Some researchers (Semple, Zians, Strathdee, & Patterson, 2008) have argued for non-cognitive skills training and building new social networks as effective strategies for successful reentry among MA-using felony offenders. Social networks include people with whom offenders build positive relationships, while non-cognitive skills training includes developing characteristics like high self-esteem and pro-social coping skills. Both strategies help offenders develop ways to resist the negative influences of pro-criminal others.

The fourth principle recognizes the importance of substance abuse assessment. Although assessment is the fourth principle mentioned, it should be seen as one of the first actions that an officer completes to develop effective case management plans (NIDA, 2007). Before an officer can supervise offender treatment and behavior change, there must be an understanding of the individual characteristics of each offender. Assessments provide community corrections with a tool to identify past behaviors

that may be related to drug abuse patterns as well as uncover potential dynamic risk factors (i.e., predictors) that may precipitate relapse. Community corrections research is routinely finding that officers should interrupt these dynamic or criminogenic factors to prevent relapse before it happens. In fact, recent research on MA use and crime has found several significant predictors of criminal activity among MA users. In a study examining 349 MA users over a two-year period, participants who were males, had less education, had less months of treatment participation, had higher pre-treatment levels of MA use, and who were involved in community-based treatment were more likely to report engagement in crime as compared to their counterparts (Brecht, Greenwell, von Mayrhauser, & Anglin, 2006).

The fifth and sixth principles dovetail with the fourth principle. With the fifth principle, NIDA (2007) recognizes the need to tailor services to fit the individual needs of each offender to improve treatment outcomes. Since each offender presents unique characteristics regarding his or her level of readiness to change, level of drug addiction, and supervision needs, among other issues, individualized treatment is needed for offenders. Additionally, in order to provide a realistic strategy for drug abuse recovery, NIDA identifies that there is a high likelihood for drug use relapse among substance-abusing offenders. While the community corrections field cannot simply turn a blind eye to such infractions, officers can incorporate what are believed to be more effective strategies to respond to such violations than punishment. This relates to the sixth principle, which suggests that drug use during treatment should be carefully monitored by community corrections officers.

The seventh principle recognizes the importance of treatment to target the factors associated with criminal behavior, namely "criminal thinking" (NIDA, 2007). This technique is a composite of attitudes, beliefs, and values that support criminal lifestyles and allow offenders to neutralize and rationalize negative psychological costs of criminality. Or, to put it simply, criminal thinking is a strategy used by offenders to allow them to think that criminal behavior is appropriate for various reasons. Often offenders lack what is referred to as an internal locus of control. Instead, they externalize the causes of their anti-social behavior. This sort of thinking pattern provides offenders with psychological techniques to encourage placing blame on others for their actions, perceiving laws as unjust and inappropriate, or neutralizing their criminal and risky behaviors. Drug-abusing offenders often employ such techniques to rationalize their actions. Community corrections officers should use communication techniques that counter offenders' neutralization of responsibility and work to break down their criminal thinking.

NIDA's (2007) eighth principle recognizes the importance of multi-agency coordination by advising treatment providers and correctional officers to keep one another informed of the progress. Communication is one of the most essential elements to effective community supervision of offenders, specifically drug-using offenders. Indeed, community corrections officers should develop good relationships with treatment providers to foster clear and open lines of communication. As Stojkovic and his colleagues (2008) argue, effective communication among community corrections partners minimizes the risk of any ambiguity from occurring about the agencies' goals with an offender, which can keep workers on task and motivated by a distinct direction. Treatment providers need to realize that community corrections officers are interested in both the recovery progress for offenders and the inevitable consequences for offenders who fail to seriously engage in treatment. Among MA-using offenders in the community, research has shown that offenders who successfully complete treatment are more likely to successfully meet the terms of their supervision, which includes both desistance from crime and reduction in MA use (Brecht et al., 2006).

Essential to reentry is providing a smooth transition from prison to the community. One contributing factor to this transition is NIDA's (2007) ninth principle, which suggests, if applicable, offenders should continue to receive treatment for substance abuse once they are released into the community. While in prison, offenders who have substance abuse problems commonly participate in a therapeutic community (TC). The underlying philosophy of the TC model is that substance abuse is part of a larger problem pertaining to the "disorder of the whole person" (Farabee & Hawken, 2009, p. 162). Thus, TCs emphasize personal responsibility in which offenders initiate change within one another, rather than relying on a counselor or therapist to effect any change in substance-abusing behaviors. Research has shown that when followed by aftercare in the community, TCs have a positive effect on reducing criminal recidivism and drug relapse among offenders (Hiller, Knight, & Simpson, 1999; Knight, Simpson, Chatham, & Camacho, 1997; Simpson, Wexler, & Inciardi, 1999).

The tenth principle encourages community corrections officers to work to identify rewards and sanctions to respond to pro-social and antisocial behaviors among offenders, respectively. For instance, the HOPE program provides some preliminary data suggesting the level of punishment that drug-using offenders, particularly MA-using offenders, receive is not what is most effective at fostering behavior change. Rather, applying minimal sanctions in a swift and certain fashion is more powerful at shaping behavior (see Hawken & Kleiman, 2009). Reentry strategies should integrate such operant conditioning principles to match perceived rewards with pro-social behavior and perceived sanctions with rule infractions among offenders.

NIDA's (2007) eleventh principle claims offenders with co-occurring mental health and drug abuse problems often require an integrated approach in effectively dealing with problems. Co-occurrence between drug abuse problems and severe mental illness is quite common. In fact, about 50% of persons with severe mental health problems suffer from a diagnosable drug abuse disorder at some point during their lives (Regier et al., 1990). The association between mental health problems and MA use has not been well documented in the literature. To this date, there have not been any epidemiological data on the prevalence of mental health problems and MA use (Pasic & Ries, 2009). Of the existing research, however, studies have found evidence for co-occurrence among MA users with regard to depression, bipolar disorder, schizophrenia, anxiety, suicidal tendencies, and other psychotic problems (Cho & Melega, 2002; Gray, Fatovich, McCoubrie, & Daly, 2007; Kalechstein et al., 2000; Pasic, Russo, Ries, & Roy-Byrne, 2007; Simon et al., 2000; Zweben et al., 2004).

The treatment of persons with co-occurring mental health and drug abuse problems can be a challenging task. Unfortunately, with regard to comorbidity among MA addicts, there has not been any published research to date on effective treatment modalities (Pasic & Ries, 2009). Among offender populations with co-occurring mental health and drug abuse problems, however, recent research by Skeem and her colleagues (Skeem, Emke-Francis, & Louden, 2006; Skeem & Louden, 2006) found that offenders with co-occurring mental health and drug abuse problems performed better in the community when these problems were treated directly by correctional staff. Examples included altering interaction practices (e.g., more reliance on motivational interviewing) between the offender and supervising officer, assessing both mental health and substance abuse problems, and ensuring that those with mental health problems receive needed medications.

Similarly, NIDA's (2007) twelfth principle suggests that drug-abusing offenders should be offered alternative medications that are found to assist with treatment of certain addictions. For MA specifically, although currently there are not any medications approved by the Federal Drug Administration for the treatment of MA dependence (Pasic & Ries, 2009), recent research has shown some preliminary evidence for three medications having a positive effect on reducing MA use. One medication, bupropion, is an antidepressant that has been commonly used to treat nicotine dependence (Vocci & Appel, 2007). In a multisite outpatient trial funded by NIDA, bupropion was found to have reduced MA use among users who had administered the drug intravenously (Newton et al., 2005). Gamma-vinyl-GABA, also known as vigabatrin, is a second medication that has been found to reduce MA use among individuals. In a preliminary open-label clinical trial that included both MA and cocaine abusers, vigabatrin was found to have a positive effect on decreased use among 18 of 30 participants (Brodie, Figueroa, Laska, & Dewey, 2004). A third and final medication, modafinil, has been found to improve the cognitive functioning in MA-dependent users. The study was also a NIDA-funded multisite trial in which the researchers found evidence for improvement of concentration and daytime alertness among the subjects (see Vocci, Elkashef, & Appel, 2009). Such improvement would allow subjects to participate in CBT and other forms of psychotherapy.

NIDA's (2007) thirteenth and final principle recognizes the need to develop strategies for drug-abusing offenders who are living or reentering the community to effectively prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis. Infectious diseases are a concern for criminal justice populations due to their risky lifestyles and the tight living conditions offenders experience while incarcerated, which tend to contribute to the spread of infectious diseases. The risks of contracting any of these diseases are heightened for drug abusing populations, especially when drugs are administered intravenously. Also, drug-addicted offenders are likely to engage in riskier forms of sexual activity, whether due to lower inhibitions from intoxication or as a mechanism to earn money for drugs. The reality is that there are greater probabilities

for offenders to become infected or infect others; therefore, in response, it is suggested that "probation and parole officers who monitor offenders with serious medical conditions should link them with appropriate healthcare services, encourage compliance with medical treatments, and re-establish their eligibility for public health services (e.g., Medicaid, county health departments) before release from prison or jail" (NIDA, 2007, p. 5).

The association between MA use and HIV risk behaviors, especially among homosexual, bisexual, and heterosexual self-identified men who have sex with men (MSM), has substantial support in the literature (see Cartier, Greenwell, & Prendergast, 2008). While this literature focuses primarily on those MSM subsamples of the population in urban settings, the link between MA use and HIV risk should cause considerable concern to social and health policy makers, since the use of MA is spreading to other areas of the country and to a more diverse population (National Drug Intelligence Center, 2007). MA use is a problem that is becoming increasingly both rural and heterosexual in scope (MacMaster et al., 2008). Molitor and his associates have examined the association between MA use and high-risk sexual activity. In one study (Molitor, Truax, Ruiz, & Sun, 1998), they reported that MA use was the most significant predictor of lower levels of condom use and higher levels of sex with drug-injecting partners. In a later study involving a sample of 1,392 out-of-treatment injection drug users, Molitor and his associates (1999) found that MA-using heterosexual males and females had more sexual partners, participated in more acts of anal and vaginal intercourse, and reported trading sex for money and drugs. Additionally, MA use was correlated with using shared needles or syringes, which were not always disinfected with bleach. The researchers concluded that MA may contribute to HIV transmission among heterosexuals.

Methods

The intentions for this research are to provide baseline data to contribute to developing effective reentry strategies for MA offenders. To accomplish this goal, information was collected from a focus group. To compliment information gathered through these focus groups, three technical assistance site visits of MA reentry programs were completed. The details of each of these efforts are discussed below.

Focus Group

A focus group was held over two days in April 2007 to define principle guidelines for technical assistance in working with MA-abusing offenders. The focus group was composed of participants selected by APPA and BJA staff. Participants were chosen to reflect both community corrections and substance abuse treatment perspectives, including localities that have developed specialized programming for MA-abusing offenders. Of special benefit to the focus group was participation by a former MA-abusing offender. The focus group was asked to describe the challenges that MA-abusing offenders face in both community corrections and substance abuse treatment, including any special reentry issues or needs. The focus group identified patterns and themes related to MA reentry challenges. Five key areas were identified:

- Strategies used by community corrections professionals to assist returning MA-abusing offenders;
- Strategies used by substance abuse treatment professionals to assist with returning MA-abusing offenders;
- Importance of developing effective community collaboration and public safety strategies and resources for community corrections staff working with MA-abusing offenders;
- Unique issues related to MA-abusing offenders; and
- Guidelines for community corrections officers working with MA-abusing offenders.

Technical Assistance Sites

A major component of this project is the provision of technical assistance to three sites for the purpose of enhancing their programming strategies in working with MA-using offenders in the reentry process. A technical assistance application form was developed to select three agencies from a pool of candidates. The application form was designed to help community corrections agencies assess their supervision and programming strategies for addressing the needs of MA-using offenders returning to the community. The application was distributed electronically in August 2007 by using APPA's membership database, other listservs (i.e., DiscussMeth), focus group members, and other individuals and groups believed to have specific interested in returning MA-using offenders to the community. Based on the returned applications (n = 36), three sites were selected for technical assistance site visits: (1) Colorado State Court Administrator's Office, Division of Probation Services, Denver, Colorado; (2) South Dakota Board of Pardons and Parole, Intensive MA Treatment (IMT) Program, Sioux Falls, South Dakota; and (3) Maricopa County Adult Probation, Phoenix, Arizona. Each of these locations is described below.

Colorado

A request for technical assistance was submitted by the State Court Administrator's Office, Division of Probation Services indicating a need for technical assistance to "develop more appropriate supervision plans for offenders and be able to effectively increase community safety and reduce recidivism." The application noted that substance abuse treatment services and MA-specific services were lacking in rural and mountain areas throughout the state. A series of telephone conversations were conducted between key respondents within the Colorado Division of Probation Services and APPA staff members to describe the Colorado system, the context within which probation services were organized within the system, and the nature of the technical assistance request. In addition to these telephone conversations, copies of policies and procedures were provided to APPA staff members. Based on the correspondence and the provided information, it was decided that site visits would be conducted in three districts across the state. The purpose of the site visits would be to identify strengths and areas for enhancement of community supervision of offenders with MA and other substance use disorders.

Colorado is divided into 22 Judicial Districts, ranging from single municipality districts (e.g., District 2), to large, multi-county districts encompassing vast land masses and population bases that meet federal definitions for frontier areas (e.g., District 15). Each Judicial District is headed by a Chief District Judge and a Chief Probation Officer. The probation office provides investigation and assessment, as well as supervision of adult and juvenile offenders. Within each probation office, the Investigations Officers and/or Regular Supervision Officers are responsible for administering the Standardized Offender Assessment (SOA) and making treatment referrals. The majority of SOA administration lies with investigating officers when a jurisdiction has a formal investigation unit.

In 1991, the Interagency Advisory Committee on Adult and Juvenile Correctional Treatment (IACAJCT) was established to provide a multi-state agency response to the provision of effective treatment of substance-using adult and juvenile offenders. The IACAJCT is comprised of the following five state agencies: Department of Human Services, Department of Corrections, Department of Public Safety, State Board of Parole, and State Court Administrator's Office. In recent years, one of the key tasks of the IACAJCT has been to find alternatives to incarceration for non-violent drug offenders. Most notably, in response to legislation (i.e., SB 03-318) that aims to decrease the felony class level and resulting penalties associated with the possession and use of smaller amounts of illicit substances, the IACAJCT issued a report documenting a cost-savings in excess of $2.2 million for state.

The Colorado state legislature subsequently appropriated $2.2 million to the Judicial Department to be allocated to local judicial districts for the purposes of providing enhanced substance abuse treatment services to offenders. Districts were required to establish a Drug Offender Treatment Board to identify issues specific to their jurisdiction and propose targets for treatment expansion and/or enhancement. Overall, the goals for the districts were to reduce recidivism rates and the prevalence of substance abuse among offenders. Ten districts identified MA use to be a significant local problem with eight of these districts proposing to utilize funding to establish or enhance MA specific treatment options. Additionally, 10 districts proposed to utilize funding to enhance treatment services for Drug Court offenders. The site visits for this project were conducted within the first year of funding allocation of SB 03-318; therefore, each district was at varying stages of program implementation associated with these new funds.

In June 2008, site visits were conducted in Districts 7, 14, and 18. Each site visit was approximately four-to-five hours in duration and consisted of a facilitated group discussion with a cross-section of key informants from within the districts, including the District Chief Probation Officer, one-to-four probation officers, representatives from local substance abuse and/or mental health treatment agencies, local law enforcement officers, local judges, and other members of the community. In total, the site visit team met with approximately 35 individuals. While a standard agenda had been established prior to the site visits, the activities, sequence, and focal points of discussion varied based upon the presence of particular participants and the nature of the local community. Field notes were made to identify common themes, explore program and systems issues influencing local community supervision and treatment practices, and areas for program enhancement. relative strengths, weaknesses and challenges facing probation supervision of methamphetamine users throughout the state.

South Dakota

In recent years, the state of South Dakota has experienced a significant increase in the number of female offenders testing positive for MA and the assessments identifying MA abuse. As a response, the Department of Corrections and Department of Human Services designed a program targeting MA-abusing female inmates—the Intensive MA Treatment (IMT) Program. This four-phase program is designed to deliver 15 months of treatment services for a maximum of 40 female inmates. The phases include: three months in the main prison, three months in a therapeutic community (i.e., an isolated cell block on the prison grounds), three months in a halfway house, and six months on community-based aftercare. The IMT program presents a unique organizational and operating structure encompassing the South Dakota Department of Corrections, the Division of Pardons and Paroles, Halfway Houses, and the Division of Alcohol and Drug Abuse.

APPA staff members held a series of telephone interviews and a one-day, on-site action planning meeting with IMT staff members. The telephone interviews were designed for the purpose of identifying potential gaps in the program's current system of operation, specifically in the processing of IMT program participants through its multi-phase structure. The interviewees consisted of individuals from the three halfway houses accepting IMT clients, parole agents with IMT clients on their caseloads, staff members from the Division of Alcohol and Drug Abuse, and the correctional case manager for IMT program within the Department of Corrections.

The on-site technical assistance meeting was held in October 2008 in Oacoma, South Dakota. Those persons in attendance at the technical assistance meeting were from various agencies involved with the IMT program, as well as the individuals interviewed prior to the technical assistance site visit. Based upon the results of the telephone interviews and document review, three elements were deemed essential to include on the proposed agenda. The first was to inform the group of the strengths and areas of needed improvement identified through the course of the telephone interviews and the documents that were reviewed by APPA staff members. The second element was to provide information pertaining to the process and outcome evaluation being conducted on the IMT program by Mountain Plains Evaluation, which is based in Salem, South Dakota. During the telephone interviews, a number of respondents indicated that while they were aware an evaluation of the IMT program was being conducted, they were not aware of any outcomes or findings pertaining to that evaluation. The third element was to facilitate a discussion on action planning to address the needed programmatic improvements identified through the telephone interviews and documents review.

Arizona

Since 2005, the Maricopa County Office of Adult Probation, in conjunction with the Maricopa County Drug Court, has operated a unique program for offenders with MA use disorders. This 32-week program utilizes a probation officer specialty caseload model wherein all of the offenders supervised by a designated probation officer are individuals under the jurisdiction of the Court, who receive mandated outpatient and residential, where appropriate, treatment from a designated community-based treatment provider. The program is designed for participants to move through three phases, with each phase having differential rates of court supervision, treatment participation, drug testing, and other critical lifestyle indicators. In addition to court appearances and probation office meetings, participants are exposed to a random schedule of drug testing, mandated treatment participation, and required support group participation. To successfully complete the program, an offender must be working full-time, living in a stable residence, demonstrating at least 20 weeks of sobriety, and having attended approximately 300 hours of individual and group counseling.

Maricopa County contracts with three treatment providers in the community, with only one of these providers (i.e., Community Bridges, Inc.) contracted to provide treatment services to the participants of the MA Drug Court. Community Bridges, Inc. (see http://communitybridgesaz.org/) provides a continuum of substance abuse and mental health services throughout the state with their major concentration of services in Maricopa County. Community Bridges operates two detoxification treatment centers, residential treatment services for pregnant women, and homeless outreach services. A Community Bridges employee serves as a drug court liaison, attending all drug court staffing and proceedings, thereby facilitating communication between the treatment team and the drug court team.

The clinical treatment component of the MA Drug Court is comprised of four distinguishing features. First, the treatment program follows the Matrix Model (Rawson et al., 1995) as described above. Clients referred by the MA Drug Court are exposed to a highly structured cognitive behavioral treatment model that utilizes a balance of group and individual counseling, family education, and weekly homework to develop and strengthen healthy behaviors and healthy thoughts. A second aspect of the Community Bridges program is the use of paraprofessionals (i.e., persons in recovery) as members of the clinical treatment team. Two full-time employed Peer Support Specialists compliment the one full-time treatment professional in providing an array of case management services. A third aspect is the use of on-site urinalysis drug testing and contingency management techniques to reinforce and reward the progress of participants. Finally, the program includes a family component. While this component is also noted in the Matrix Model, it bears special mention, as Community Bridges improved this component by adopting aspects of and receiving training on the Community Reinforcement and Family Training (CRAFT) model (see Meyers & Smith, 1997).

Multiple methodological techniques were employed to gather information about the program and in an effort to develop "best practices" for community corrections agencies in dealing with MA-abusing offenders during the reentry process from prison or jail. Data were gathered at this site during the period of May-September 2009. Direct observations were conducted by APPA staff members of MA Drug Court proceedings and of a women's support group meeting. In addition, interviews were conducted with the MA Drug Court supervisor, the probation officer assigned to the MA Drug Court offender caseload, and the Community Bridges program supervisor. A focus group was also conducted with the substance abuse therapist, two peer support staff members employed with Community Bridges, and the Director of Outreach and Peer Support Services. Finally, agency documents and records, including a client drug court handbook and annual reports, were reviewed for the site.

Results

A key objective of this project is to research and identify effective supervision and programming strategies for community corrections agencies assisting the return of MA-using offenders to the community. The focus group brought together community corrections and substance abuse treatment professionals to identify best practices for correctional agencies dealing with MA offenders in the community. The three technical assistance site visits provided an understanding of MA-related issues facing community corrections agencies.

Findings from the Focus Group

The focus group identified patterns and themes of the challenges to managing MA-using offenders in the community. The group established a common understanding of the MA-using offender's experiences while in the community, and it allowed for the group to begin exploring both common conceptions and misconceptions about this population. The identified themes are: treatment, sentencing and sanctions, supervision, collaboration, and public safety concerns. Table 1 provides a summary of the findings from the focus group, and further details are provided on next page.

Table 1: Summary of Findings from the Focus Group

Thematic Category	Summary
Treatment	• Community corrections and treatment personnel should undergo cross-training to minimize miscommunication and enhance collaboration among one another. • Community corrections and treatment personnel should learn to recognize offenders' "triggers" for drug use in order to identify any potential signs of relapse or return to use. • Community corrections personnel should utilize Medicaid-eligible treatment services whenever possible to assist with treatment compliance. • Substance abuse treatment should be comprehensive in dealing with multiple issues of offenders, including past sexual abuse trauma, life skills, and family issues.
Sentencing and Sanctions	• Judges, supervising officers, and treatment personnel should intervene in criminal behavior through timely sanctions to promote pro-social cognitive and behavioral change among MA-using offenders.
Supervision	• A waiver of confidentiality should be included in an offender's conditions of supervision in order to facilitate communication between treatment, community corrections, and judicial staff members. • All MA-using offenders should be considered "high risk." • Encourage positive behavior through negative drug screens. • Supervising officers should consider, in greater proportion, a more treatment-oriented response to moments of relapse for MA-using offenders.
Collaboration	• Supervising officers and treatment professionals should collaborate to develop realistic and timely behavior expectations and terms of conditions for MA-using offenders to avoid competing expectations during the recovery phase of treatment. • Community corrections agencies should also collaborate with other programs, services, and organizations at the local and state levels.
Public Safety Concerns	• Supervising officers should be properly trained to: recognize clues to the manufacturing of MA upon conducting home visits; appropriately manage MA-using offenders if they become aggressive; and utilize proper self-care techniques in response to any traumatic event.

Treatment

With regard to the treatment of MA-using offenders in the community, the focus group was guided by the underlying philosophy that, in accordance with NIDA (2007), "treatment offers the best alternative for interrupting the drug abuse/criminal justice cycle for offenders with drug abuse problems" (p. 13). In keeping this philosophy in mind, the group identified numerous issues regarding the treatment of MA-using offenders. One issue that was identified by the group was the miscommunication and cross-training that often occurs between community corrections and treatment personnel. For example, community corrections staff may not recognize that anti-depressants or other drugs may be prescribed to an offender during treatment. The group decided that a potential way to resolve, or at least mediate, this issue would be to develop a common understanding of the differing roles

and limitations of both treatment and community corrections personnel. This could be done via training that involved both groups of personnel. Not only would such an understanding among both groups lead to more reasonable expectations and timelines for all parties, but it would also help ease an offender's recovery process.

Secondly, during treatment, since MA-using offenders should be able to identify their "triggers" for drug use, community corrections and treatment professionals should be able to identify them. This is mainly due to the fact of staff members being able to identify any potential signs of relapse or return to use. Both community corrections and treatment personnel should work to recognize, expect, and prepare to prevent potential relapses and provide intervention or sanctions if necessary to offenders. Uncovering these dynamic risk factors or criminogenic needs is crucial for individualizing supervision conditions and minimizing relapse incidents among any substance abusing offender. Although many agencies currently use needs assessments to uncover these time-varying traits that foster patterns of anti-social behaviors, relapse may happen with even the most low-risk offenders. The group concluded that assessments may not be the only way for staff members to identify an offender's "triggers;" therefore, they must be cognizant of each offender's overall behaviors in order to detect any warning signs. Community corrections professionals may complete these tasks by establishing initial frequent contact with a MA-using offender vis-à-vis telephone, email, or face-to-face. Ultimately, a MA-using offender should be encouraged by community corrections, treatment, and the courts to engage in long-term recovery during the treatment process.

Third, focus group members also expressed a concern about Medicaid eligibility for MA-using offenders with regard to receiving treatment services in the community. Members agreed that community corrections personnel should utilize Medicaid-eligible treatment services whenever possible to assist with treatment compliance; thus, removing the barrier of private or uninsured payment costs. The group recognized that some states have requested and secured Title 19 Medicaid Eligibility waivers for an offender's MA treatment. Knowing this, the group recommended that community corrections agencies check with their state's Medicaid office to determine each offender's eligibility status with Title 19. This option is yet another way to enhance an offender's treatment success rate.

Finally, the focus group determined that substance abuse treatment alone may not adequately address all of an offender's treatment issues. For example, if a MA-using offender has engaged in high-risk sexual activity in his life, treatment should also include addressing any past sexual trauma, sexually transmitted diseases, personal safety, and emotional issues that an offender may have experienced in his or her life. Additionally, due to the cognitive impact of MA use, basic living skills may have to be learned or re-learned by an offender. As one focus group member explained, many MA addicts are initially like stroke victims and they will require the additional assistance and patience of others to accomplish basic skills and expectations. Some of these skills include budgeting, personal hygiene, housekeeping, and accessibility to public transportation. Lastly, a MA-using offender with children may need parenting skills training or reunification strategies and goals as part of his or her treatment plan. Community corrections professionals may need to initially arrange more frequent visits and add supplemental conditions of supervision with this offender population in order to address this potential issue.

Sentencing and Sanctions

The focus group also identified issues and strategies relating to the sentencing of MA-using offenders in the community and the sanctions that are typically applied to them. Ideally, there should be two goals of sentencing: intervening in criminal behavior through sanctions and promoting pro-social cognitive and behavioral change. Intervention requires that community corrections professionals reliably detect the problematic behaviors of offenders. The group agreed that sentencing should be appropriately given based on the risks and needs of offenders. Similarly, sanctions and incentives should be applied in a timely manner that promoted behavior change. If jail time is necessary, use the shortest time possible to get an offender's attention and refocus him or her on progressing in treatment. The group members reported that drug addiction is the most common issue judges see in their courtrooms and the one they have the least amount of knowledge. Judges, community corrections staff, and treatment professionals would undoubtedly benefit from some type of cross-training on drug addiction and criminal populations, particularly relating to MA.

Supervision

The focus group identified several issues pertaining to the supervision of MA-using offenders in the community. One, with respect to Title 42 of the Code of Federal Regulations, the group suggested that a waiver of confidentiality be included in an offender's conditions of supervision in order to facilitate communication between treatment, community corrections, and judicial staff members. Two, the group suggested that it may be best to consider all MA-using offenders as "high risk" for the purposes of supervision in the community. Anecdotally, substance use and engagement in domestic violence disputes are two of the top reasons for the reincarceration of MA-using offenders; therefore, supervision plans for this population should include potential ways to address issues relating to drug use and interpersonal violence. Three, the group encouraged the use of negative drug tests as a sign of progress in the style of contingency management techniques where offenders are rewarded for positive behavior, in addition to receiving sanctions for behaviors in which violate their conditions of supervision. According to the group, many jurisdictions across the U.S. do not stress the use of drug test results in this way; yet, such a practice should be adopted, because drug tests results should not be used to only "collect" evidence to prosecute an offender. Finally, with regard to supervision, the group recommended that community corrections professionals consider, in greater proportion, a more treatment-oriented response to moments of relapse for MA-using offenders, rather than a response that is simply based on punitive retribution in the form of reincarceration. In other words, offenders could undergo a new substance abuse assessment to reevaluate their risks and needs or more intensive treatment services.

Collaboration

The focus group fundamentally agreed that effective collaboration between agencies and programs is a crucial element for any MA-using offender to have success during the reentry process from jail or prison into the community. Most notably, community corrections and treatment professionals should collaborate to develop realistic and timely behavior expectations and terms of conditions for the offender to avoid competing expectations during the recovery phase of the treatment process. Effectively supporting a MA-using offender's treatment and recovery may require some community corrections agencies to clarify their mission in order to change the behaviors of offenders, rather than to simply violate offenders, especially during the initial treatment phase. As the focus group concluded, such refinement may allow community corrections to become an agent of change by serving as an adjunct to treatment during the initial recovery phase, as opposed to playing an unsupportive role in the process.

The focus group also noted the benefits of community corrections agencies collaborating with other programs, services, and organizations. For example, legal aid services may be sought after for MA-using offenders to provide assistance with issues like bankruptcy and obtaining parental rights. Or, if offenders experience problems with housing, public or faith-based organizations may be able to assist with this issue. Yet, another example would be if offenders needed to participate in educational or vocational services or programs. Community corrections agencies should be willing to assist offenders in this process, as well as work with staff members involved with offenders in those programs.

Public Safety Concerns

Finally, the focus group recognized another challenge to many communities: the threat to public safety caused by the manufacturing of MA. As the group acknowledged, first responders and community corrections professionals may be at risk to unexpectedly encountering MA labs while supervising offenders in the community. As Fuller (2005) has documented, officers involved in lab seizures have experienced harmful effects, such as sustaining chemical burns and developing respiratory problems from being exposed to the chemicals that are used to manufacture MA. Knowing this, the group stressed the need for all community corrections line staff to receive MA lab recognition and awareness training to become adequately prepared to recognize and respond to potential MA hazards. The training components the group identified were: recognition of clues to the manufacturing of MA upon conducting home visits; appropriately managing a MA-using offender if he or she becomes aggressive; and proper self-care techniques in response to any trauma that an officer may experience. It is recommended that staff receive training to increase awareness about the risks of MA labs and to learn about appropriate protective equipment to wear when entering a suspected MA lab.

Findings from the Technical Assistance Sites

A key objective of the technical assistance provided to each of the sites was to identify effective practices involved in working with MA-using offenders returning to the community. Since the approaches at each of the sites were different, each one presented unique issues when working with this population of offenders. The findings for each of three sites are summarized in Table 2.

Table 2: Summary of Findings from the Technical Assistance Sites

Site Location	Summary of Best Practices
Colorado	• Establish local interagency committees comprised of agency representatives and county government officials in order to create and maintain localized memoranda of understanding among the various agencies. • Utilize on-site urine screens and formalize programs of motivational incentives. • Promote offender participation in mutual aid and self-help recovery groups, particularly in rural communities. • Establish sources of transportation for offenders.
South Dakota	• As part of the pre-release process for offenders: o Institutional staff members should notify supervising officers in the community 45 days prior to the release date. o Supervising officers should be assigned to cases upon receiving notification of the release date. o Supervising officers should be trained on the early notification process and their roles, responsibilities, and limitations. • Implement more effective lines of communication among supervising officers in the community, institutional staff members, and treatment personnel about the IMT program. • Centralize the governance of the IMT program to one agency, namely the Division of Alcohol and Drug Abuse.
Arizona	• Develop strong partnerships between agencies in the community. • Encourage better treatment participation among offenders through the use of intermediate rewards and sanctions. • Utilize progress reports of offenders to maintain communication between the drug court and the supervising officer. • Provide better access to support services for offenders. • Include offenders' families, where appropriate, in the treatment process. • Encourage treatment staff to be flexible in scheduling treatment sessions in an effort to avoid conflicts with offenders' other requirements. • Provide better accessibility of offenders in the community to treatment staff.

Colorado

The Colorado site visit revealed a lack of interagency cooperation at the local level, despite the work of the IACAJCT at the state level. In district 14, the relationships among the treatment providers and judicial district appeared strained, and in district 18, the agency contracted with a Denver-based treatment provider due to the limited cooperation from the established mental health and substance abuse providers in the local community. Contrasting these strained relationships, district 7 demonstrated local collaboration that the state should replicate in other communities. Probation officers, in general, expressed varying levels of satisfaction with the quality of services and responsiveness provided to them by their corresponding local treatment providers. Further, there did not appear to be any formal linkages between the judicial district offices and local social services programs, especially child welfare services, which are organized at the county level. In an effort to resolve the breakdown of interagency cooperation at the local level, APPA staff recommended state agencies (namely, the Division of Probation Services and the state Department of Human Services, Division of Behavioral Health) promote the establishment of local interagency committees. These committees should mirror the state committee to include representation of county government officials in order to establish and maintain localized memoranda of understanding (MOU) among the various agencies. MOUs should specify minimal standards of treatment and common referral and reporting requirements.

A second observation was in regard to making greater utilization of on-site psychological assessments and motivational incentives to MA-using offenders in an effort to promote abstinence during the reentry process into the community. The utilization of on-site urinalysis equipment provides immediate results to offenders, instead of the delayed response when using an externwal lab. Immediate response, whether positive or negative, creates a context for the probation officer to highlight positive behavior changes (e.g., abstinence) or address a relapse or recurring use among offenders. Research has shown the positive results of using a progressive program of rewards and sanctions for substance-using offenders in the community, particularly among programs based on CM (Lussier et al., 2006; Roll et al., 2006). It is recommended that the Division of Probation Services consider requirements for judicial districts to utilize on-site urinalysis and formalized programs of motivational incentives as components of a comprehensive program for substance abusing clients.

Another observation was the lack of mutual aid and support groups available for the treatment of MA-using offenders. Such groups entail individuals serving dual roles as both participants and providers in the common goal of helping one another overcome a particular issue; in this case, substance abuse. Although they should not be considered as substitutes for intensive outpatient treatment services, mutual aid and other recovery oriented support communities can provide an invaluable adjunct to treatment. It is recommended that the Division of Probation Services actively promote participation in mutual aid groups for probationers with known substance use disorders. At a minimum, making information available to probationers of the location and meeting times of mutual support groups, along with information on the growing number of online recovery support communities, should be afforded to offenders. Further, it is recommended that the Division of Probation Services, in conjunction with the Division of Behavioral Health, stimulate and encourage the establishment of mutual aid and self-help recovery groups in rural communities. Establishing partnerships with local non-profit organizations and existing treatment and social service agencies to serve as host facilities for such groups, providing small start-up funding packages for initial supplies and program material, and identifying and encouraging successful probationers to become engaged as self-help sponsors are some of the activities that could be undertaken to establish adjuncts to formal treatment options in rural communities.

Finally, a key impediment to substance abuse treatment for MA-using offenders identified across all three districts was a lack of transportation. One way to address this issue is to budget for transportation options for offenders, such as the use of certain technologies. Technologies would assist offenders in reporting to their supervising officers in a timely manner and in maintaining contact with their assigned treatment staff members. In many states, "flex funds" have been utilized, which provide supervising officers or case managers with the financial means to address the transportation barriers of their clients by paying for car repairs, providing gas vouchers to attend treatment, or paying a friend or family member to drive a client to treatment.

South Dakota

A serious problem for the IMT program was the process of pre-release planning. The IMT is administered in the Department of Corrections, which means the institutional case manager is the person responsible for scheduling inmates according to a conditional discharge assessment. The case manager also develops offender case plans and collects and communicates programmatic information including phase transition dates, parole dates, program completion dates, treatment information, drug screen information, and mental and physical health information. IMT clients can be released to the community as either an inmate (i.e., still under institutional supervision) or as a parolee (i.e., under conditional supervision in the community). For IMT clients with fixed parole dates, getting release plans to the parole agents was not an issue; however, for IMT clients with discretionary parole dates, which includes about half of the IMT participants, the process became a bit more bogged down.

To address this issue, it is recommended that the Department of Corrections Institutional Case Manager begin immediately to notify the Division of Pardons and Paroles supervisor 45 days prior to the release of an IMT client to a halfway house in the community. This notification process will ensure the Division of Pardons and Paroles staff receiving a copy of the exit file sent to the halfway house approximately two weeks prior to the inmates release to the halfway house. Additionally, the Division of Pardons and Paroles supervisor would assign a parole agent to an IMT client immediately upon receiving notification of the offender's release. The agent would begin working with the IMT client to develop a solid release plan for implementation once the IMT client is released from the halfway house or once the IMT client is officially makes parole altogether. The parole agent would not incur supervision responsibilities until the IMT client is released from inmate status to parole status. Lastly, parole agents would undergo training to learn the new early notification process and their roles, responsibilities, and limitations in working with IMT clients.

The second issue was the confusion across community corrections personnel of the criteria used to enroll clients in the IMT program. Respondents in the telephone interviews indicated they uncertainty of the eligibility criteria and thought clients were accepted into the program that were addicted to stimulants in general, but not limited to MA. Nevertheless, this issue may be easily resolved by implementing more effective communication among correctional professionals and entities. It is recommended that the Division of Alcohol and Drug Abuse regularly update information pertaining to the IMT program to include more specific language about eligibility criteria and other programmatic features.

The third concern was related to the decentralized nature of administering the IMT program. Each person involved with the program found that he or she struggled with knowing who to contact for specific questions (e.g., funding issues, supervision issues, etc.). The South Dakota Legislature did not include a source of funding for employing one person to oversee the management of the program. The program, in result, faced the challenge of developing chains of command to field questions or issues that arise based upon the underlying issue. To resolve this issue, it is recommended that the Division of Alcohol and Drug Abuse take the lead in developing an informational sheet listing name, agency, contact information, and issues that person should be contacted for and distributing that list to all individuals working with IMT clients.

Arizona

One of the unique aspects of the Maricopa County MA Drug Court was the strength and the quality of the relationship and communication among all agencies involved, including the drug court, probation department, and community treatment provider. The structure of this program facilitates effective collaboration among the agencies. The identification and physical placement of the community-based drug court liaison within the court facility, along with the use of a single probation officer to manage the caseload of those offenders participating in the MA Drug Court were important components of the program.

The issue of court supervision was identified as an area of concern for participants in this program, especially for newly enrolled offenders, since they expressed reservations about sharing sensitive information with their corresponding therapists or peer support specialists in fear of such information being shared with the court. Staff members noted that clients who were further along in their

treatment often helped the newer clients overcome this reluctance by simply informing them that such information would not be shared with the court or any legal authority. The therapist addressed this issue directly and noted that information sharing with the probation officer will generally center around program phase changes, collateral contact information needed on clients who have been absent from treatment, or in circumstances wherein a client divulges information determined to place their legal status in jeopardy.

The use of monthly status reports strengthen and reinforce the collaborative effort and communication within the Maricopa County MA Drug Court program. These reports complimented the parallel status reports that were completed by the supervising officer, and they provided an integrated and comprehensive assessment of each offender's progress. The monthly reports summarized session attendance, test results, and progression within treatment, along with significant changes in the offender's employment and housing status.

In an effort to enhance the MA Drug Court program, APPA staff members developed a list of recommendations. For example, there were cases in which clients lost dental services and residential treatment due to the loss of administrative transfer request funding. Undoubtedly, such services are essential to treatment progress among clients. A second recommendation related to the lack of immediate rewards and sanctions used in response to the behaviors of clients in the program. CM techniques and on-site urinalysis could easily be implemented into group counseling sessions. Otherwise, the treatment progress of clients may be compromised without these therapeutic interventions. Third, there seemed to be absence of the clients' families engaged in their treatment plan. In fact, the treatment staff members consistently identified this as being a barrier to successful treatment outcomes. Fourth, participants were sometimes hindered by other mundane tasks that were expected of them while engaged in the drug court program, such as scheduling of treatment to balance it with other court demands (e.g., employment). In order to mediate these issues, treatment staff expressed a desire to offer early morning treatment sessions or whatever worked for clients. Lastly, treatment staff expressed concern for being limited to accessibility to clients in the community. At the time, client outreach was limited to telephone calls. Treatment staff, however, wanted to be able to conduct home visits with clients, as an example.

Conclusion: Lessons Learned and Policy Recommedations

More effective responses to crime will address the economic stability, mental health condition, and level of substance abuse among offenders. If long periods of incarceration are not found to be effective at increasing public safety, then the focus must turn to developing effective strategies for successful reentry of offenders, particularly substance abuse offenders. Western (2008) recently outlined a plan in a report titled, *From Prison to Work: A Proposal for a National Prisoner Reentry Program*. Within this plan, he details strategies to combine transitional employment, housing, and a variety of treatment services, including substance abuse treatment, in order to reduce the social and economic costs that have been traditionally associated with punishment in the United States. Western points out that the criminal justice system is facing two central public policy challenges. First, the sheer size of returning populations from prisons and jails that has grown to nearly 700,000 annually from around 150,000 since the late 1970s is a great challenge. The second public policy challenge relates to the costs associated with punishment practices. Consider that, in 1982, total correctional spending was around $20 billion; now it is closer to $70 billion.

Three obstacles face offenders who are returning to the community from prison or jail, regardless of their status: adequate employment, stable housing conditions, and accessibility to social services, including substance abuse treatment. Western (2008) provides a review of the research literature on employment programs aimed at improving workforce participation and reducing recidivism. The limited research evidence to date suggests some ambiguity regarding identifying effective programs and strategies, but there are a couple of noteworthy points. Interventions that are less intensive (i.e., training and subsidies) and directed toward young males are unsuccessful at improving workforce rates or reducing recidivism. In contrast, interventions that are more intense and aimed toward older offenders tend to have better success. Finally, regardless of the specific intervention or the age group targeted, results are improved when the interventions begin as soon as an offender is released from a correctional institution.

It is important for the community corrections field to understand the bulk of returning offenders will have limited work experience. Western (2008) points out the importance of thinking about what it means for offenders to have limited work experience as more than the lack of technical skills and knowledge related to specific industries or labor sectors. In addition, we must consider the severe neglect of what psychologists refer to as non-cognitive skills that are acquired through socialization processes (see Carneiro & Heckman, 2004; Heckman, Stixrud, & Urzua, 2006). For example, according to Western (2008), holding regular employment requires a person to acquire "the rudimentary life skills of reliability, motivation, and sociability with supervisors and coworkers" (p. 14). Essentially, then, non-cognitive skills target those learned skills that one learns over their lifetime of showing up for work, showing up on time, and showing up prepared to conduct themselves appropriately for the work environment.

The foundation of Western's (2008) proposal is one year of subsidized community service employment for all returning offenders without employment. The idea here is that offenders will have the ability, especially older offenders who may be more motivated to succeed, to learn both the technical and non-cognitive skills related to employment. He identifies four elements of this reentry proposal: transitional housing and substance abuse treatment must be provided to offenders who are in need of those

services; revocations for technical violations must be minimized and handled alternatively in community settings; prison programs must prepare offenders for employment; and federal welfare and education assistance should be accessible to felons. The point to this reentry proposal is not so much that education or employment alone will improve community supervision effectiveness. Rather, this plan recognizes the serious absence of basic life skills within offender populations. It challenges policy makers to consider ways to improve reentry processes. Western (2008, p. 16) simply states that "sobriety and the habits of regular work offer the best chance of improving employment among released prisoners," and increased employment will potentially reduce the likelihood that offenders will turn to crime for financial stability.

In addition, Western's (2008) proposal suggests offenders be employed full-time within one week of release from prison or jail, which would typically be low- or minimum-wage positions. Officers must ensure these positions provide ample supervision of offenders. Coupling this employment strategy with transitional housing would support offenders who experience periods of homelessness or unstable living conditions, thereby improving their stability. Also, access to social services, including substance abuse treatment, is a mandatory element for any successful reentry plan. Central to Western's proposal is the need for offenders to learn new word-related skills and habits, and that homelessness and substance abuse are major impediments to developing such skills and habits. Finally, offenders in transitional employment will need additional financial subsidies to meet their needs. This may sound as though Western is proposing that we go "soft" on crime, but actually, his approach encourages us to become "smart" on crime. In fact, he notes that by providing transitional employment, housing, and substance abuse treatment, jurisdictions can save money without threatening public safety.

MA-using offenders are not unique in that they need assistance with employment, housing, and treatment during the reentry process; if anything, their needs may be greater than other offender populations. In considering Western's (2008) plan, three "lessons learned" can be taken from this project to be used in the development and implementation of policy pertaining to MA-using offenders returning to the community for community corrections. First, the development of strategies for effective collaboration among all partner agencies in supervising and managing MA-using offenders in the community appeared to be a central theme reflected across the focus group and the three technical sites. Effective collaboration begins with the development of a comprehensive plan involving all partner agencies. This allows for a clear line of communication between the agencies beginning at when offenders are first incarcerated to when they are released with the intent that offenders receive the best services available in the community. Also, the consideration of this proposal stresses the need for agencies to collaborate on locating and providing employment, housing, and treatment services to MA-using offenders.

Secondly, treatment must be a primary objective in supervising MA-using offenders in the community. The findings of this project are indicative of how easy the treatment of MA-using offenders may fall to the wayside during the reentry process. Not only does this population present unique needs with regard to treatment (e.g., issues pertaining to past high-risk sexual activity), but they also require agencies to develop comprehensive and often complex treatment approaches, which also must consider comorbidity issues and appropriate medications for offenders. A treatment approach that incorporates both CM and CBT, preferably the matrix model, techniques appears to be a viable method in treating MA-using offenders in the community. Although it is important for judges to be involved in these cases, they do not have to be involved in order for offenders to be successful in treatment.

Finally, supervising officers must be properly trained in managing MA-using offenders in the community. Whether it is due to officers knowing how to apply graduated sanctions to MA-using offenders or how to approach an offender's house that may also be used as a MA lab, supervising officers need proper training in order to be most effective in supervising MA-using offenders in the community. If possible, it may be best for agencies to form a special unit of officers that only manages this population. It is also important for officers to understand the effects of MA use and the "warning signs" that an offender has relapsed or is in the process of relapsing. All of these components are essential for community corrections agencies to be successful in effectively supervising MA-using offenders in the community.

Throughout this project, the underlying objective has been to develop effective strategies for community corrections agencies at the state and local levels in dealing with MA-using offenders. In conjunction with Western's (2008) proposal, which again emphasizes the need to provide offenders with adequate employment, housing, and social services during reentry, the three "lessons learned" described above are intended to provide jurisdictions with such strategies. Only with multi-agency collaboration, treatment as a primary objective, or the proper training of supervising officers can community corrections agencies adequately deal with MA-using offenders. Otherwise, jurisdictions will risk falling short and, therefore, continuing the cyclical process of the criminal justice system that has existed for the past three decades. The fact remains that the current state of the criminal justice system cannot afford such an alternative, both fiscally and legally. New approaches, such as the one discussed in this report, are needed in order for the system, in general, to feasibly produce positive changes in the future.

References

Belenko, S., & Peugh, J. (2005). Estimating drug treatment needs among state prison inmates. Drug and Alcohol Dependence, 77, 269-281.

Bigelow, G. E., & Silverman, K. (1999). Theoretical and empirical foundations of contingency management treatments for drug abuse. In S. T. Higgins and K. Silverman (Eds)., Motivating behavior change among illicit-drug abusers: Research on contingency management interventions (pp. 15-31). Washington, DC: American Psychological Association.

Bozza, J. A. (2007). Benevolent behavior modification: Understanding the nature and limitations of problem-solving courts. *Widener Law Journal, 17*, 97-143.

Brecht, M.-L., Greenwell, L., von Mayrhauser, C., & Anglin, M. D. (2006). Two-year outcomes of treatment for methamphetamine use. *Journal of Psychoactive Drugs, 3*, 415-426.

Brodie, J. D., Figueroa, E., & Laska, E. M., & Dewey, S. L. (2004). Safety and efficacy of Y-vinyl GABA (GVG) for the treatment of methamphetamine and/or cocaine addiction. *Synapsis, 55*(2), 122-125.

Carneiro, P., & Heckman, J. J. (2004). Human capital policy. In B. M. Friedman (Ed.), *Inequality in America: What role for human capital* (pp. 77-240). Cambridge, MA: MIT Press.

Carroll, M. E., Lac, S. T., & Nygaard, S. L. (1989). A concurrently available non-drug reinforce prevents the acquisition or decreases the maintenance of cocaine-reinforced behavior. *Psychopharmacology (Berl), 97*, 23-29.

Cartier, J. J., Greenwell, L., & Prendergast, M. L. (2008). The persistence of HIV risk behaviors among methamphetamine-using offenders. *Journal of Psychoactive Drugs, 40*(4), 437-446.

Cho, A. K., & Melega, W. P. (2002). Patterns of methamphetamine abuse and their consequences. *Journal of Addictive Diseases, 21*, 21-34.

Farabee, D., & Hawken, A. (2009). Methamphetamine and crime. In J. M. Roll, R. A. Rawson, W. Ling, & S. Shoptaw (Eds.), *Methamphetamine addiction: From basic science to treatment* (pp. 157-171). New York: The Guilford Press.

Fuller, K. (2005). A dangerous business. *Occupational Health & Safety, 74*(9), 188-190.

Gray, S. D., Fatovich, D. M., McCoubrie, D. L., & Daly, F. F. (2007). Amphetamine-related presentations to an inner-city tertiary emergency department: A prospective evaluation. *The Medical Journal of Australia, 186*(7), 336-339.

Hawken, A., Anglin, M. D., & Conner, B. T. (2007) Treatment differences. In *Evaluation of the Substance Abuse and Crime Prevention Act: Final report* (pp. 81-93). Sacramento, CA: California Department of Alcohol and Drug Programs.

Hawken, A., & Kleiman, M. (2009). *Managing drug involved probationers with swift and certain sanctions: Evaluating Hawaii's HOPE* (NCJ No. 229023). Retrieved April 21, 2010 from www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf.

Hawken, A., Longshore, D., Urada, D., & Anglin, M. D. (2007). SACPA benefit-cost analysis. In *Evaluation of the Substance Abuse and Crime Prevention Act: Final report* (pp. 94-125). Sacramento, CA: California Department of Alcohol and Drug Programs.

Heckman, J. J., Stixrud, J., & Urzua, S. (2006). The effects of cognitive and noncognitive abilities on labor market outcomes and social behavior. *Journal of Labor Economics, 24*, 411-482.

Higgins, S. T. (1997). The influence of alternative reinforcers on cocaine use and abuse: A brief review. *Pharmacology, Biochemistry, and Behavior, 57*, 419-427.

Higgins, S. T., Bickel, W. K., & Hughes, J. R. (1994). Influence of an alternative reinforcer on human cocaine self-administration. *Life Sciences, 55*, 179-187.

Higgins, S. T., Heil, S. H., & Plebani-Lussier, J. (2004). Clinical implications of reinforcement as a determinate of substance use disorders. *Annual Review of Pyschology, 55*, 431-461.

Hiller, M. L., Knight, K., & Simpson, D. D. (1999). Prison-based substance abuse treatment, residential aftercare and recidivism. *Addiction, 94*, 833-842.

Hunt, D., Kuck, S., & Truitt, L. (2006). *MA use: Lessons learned* (DOJ 99-C-008). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Kalechstein, A. D., Newton, T. F., Longshore, D., Anglin, M. D., van Gorp, W. G., & Gawin, F. H. (2000). Psychiatric Comorbidity of methamphetamine dependence in a forensic sample. *The Journal of Neuropsychiatry & Clinical Neurosciences, 12*(4), 480-484.

Knight, K., Simpson, D. D., Chatnam, L. R., & Camacho, L. M. (1997). An assessment of prison-based drug treatment: Texas' in-prison therapeutic community program. *Journal of Offender Rehabilitation, 24*(3/4), 75-100.

Listwan, S. J., Shaffer, D. K., & Hartman, J. L. (2009). Combating methamphetamine use in the community: The efficacy of the drug court model. *Crime & Delinquency, 55*(4), 627-644.

Lussier, J. P., Heil, S. H., Mongeon, J. A., Badger, G. J., & Higgins, S. T. (2006). A meta-analysis of voucher-based reinforcement therapy for substance use disorders. *Addiction, 101*, 192-203.

MacMaster, S. A., Tripp, K., & Argo, S. (2008). Perceptions of HIV risk behaviors and service needs among methamphetamine users in rural Appalachian Tennessee. *Journal of Ethnicity in Substance Abuse, 7*, 115-130.

Merck (2004), *The Merck Manual of Diagnosis and Therapy, 17th Edition, Internet Edition* M. Beers and R. Berkow (Eds.), Section 15, Chapter 195, "Amphetamine Dependency," Medical Services USMEDSA, USHH.

Meyers, R. J., & Smith, J. E. (1997). Getting off the fence: Procedures to engage treatment-resistant drinkers. *Journal of Substance Abuse Treatment, 14*(5), 467-472.

Molitor, F., Ruiz, J. D., Flynn, N., Mikanda, J. N., Sun, R. K., & Anderson, R. (1999). Methamphetamine use and sexual injection risk behaviors among out-of-treatment injection drug users. *American Journal of Drug and Alcohol Abuse, 25*(3), 475-493.

Molitor, F., Truax, S., Ruiz, J., & Sun, R. (1998). Association of methamphetamine use during sex with risky sexual behaviors and HIV infection among non-injection drug users. *Western Journal of Medicine, 168*, 93-97.

Mumola, C. J., & Karberg, J. C. (2006). *Drug use and dependence, state and federal prisoners, 2004* (NCJ 213530). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Nader, M. A., & Woolverton, W. L. (1991). Effects of increasing the magnitude of an alternative reinforcer on drug choice on a discrete-trials choice procedure. *Psychopharmacology (Berl), 105*, 169-174.

National Drug Intelligence Center (NDIC). (2007). *National methamphetamine threat Assessment 2008.* Retrieved January 13, 2010, from www.usdoj.gov/ndic/pubs26/26594/index.htm.

National Institute on Drug Abuse (NIDA) (2007). *Principles of drug abuse treatment for criminal justice populations: A research-based guide* (NIH Publication No. 06-5316). Washington, DC: U.S. Department of Human and Health Services, National Institutes of Health, NIDA.

Newton, T. F., Roache, J. D., De La Garza, R., II, Fong, T., Wallace, C. L., Shou-Hua, L., ...Kahn, R. (2005). Bupropion reduces methamphetamine-induced subjective effects and cue-induced craving. *Neuropsychopharmacology, 31*(7), 1537-1544.

Nordahl, T. E., Salo, R., & Leamon, M. (2003). Neuropsychological effects of chronic methamphetamine use on neurotransmitters and cognition: A review. *The Journal of Neuropsychiatry and Clinical Neurosciences, 15*, 317-325.

Ornstein, T. J., Iddon, J. L., Baldaccino, A. M., Sahakian, B. J., London, M., Everitt, B. J., & Robbins, T. W. (2000). Profiles of cognitive dysfunction in chronic amphetamine and heroin abusers. *Neuropsychopharmacology, 23*(2), 113-126.

Pasic, J., & Ries, R. (2009). Treatment of methamphetamine addiction that co-occurs with serious mental illness. In J. M. Roll, R. A. Rawson, W. Ling, & Shoptaw, S. (Eds.), *Methamphetamine addiction: From basic science to treatment* (pp. 230-245). New York: The Guilford Press.

Pasic, J., Russo, J. E., Ries, R. K., & Roy-Byrne, P. P. (2007). Methamphetamine users in the psychiatric emergency services: A case-controlled study. *American Journal of Drug & Alcohol Abuse, 33*(5), 675-686.

Pearson, F. S., Lipton, D. S., Cleland, C. M., & Yee, D. S. (2002). The effects of behavioral/cognitive-behavioral programs on recidivism. *Crime & Delinquency, 48*(3), 476-496.

Prendergast, M. L., Hall, E. A., Roll, J., & Warda, U. (2008). Use of vouchers to reinforce abstinence and positive behaviors among clients in a drug court treatment program. *Journal of Substance Abuse Treatment, 35*, 125-136.

Rawson, R. A., Gonzales, R., & Brethen, P. (2002). Treatment of methamphetamine use disorders: An update. *Journal of Substance Abuse Treatment, 23*, 145-150.

Rawson, R. A., Marinelli-Casey, P., Anglin, M. D., Dickow, A., Frazier, Y., Gallagher, C., ...Methamphetamine Treatment Project Corporate Authors. (2004). A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence. *Addiction, 99*, 708-717.

Rawson, R., Shoptaw, S., Obert, J. L., McCann, M., Hasson, A., Marinelli-Casey, P., ...Ling, W. (1995). An intensive outpatient approach for cocaine abuse: the matrix model. *Journal of Substance Abuse Treatment, 12*(2), 117-127.

Reiger, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. *Journal of the American Medical Association, 264*(19), 2511-2518.

Roll, J. M., Petry, N. M., Stitzer, M. L., Brecht, M. L., Peirce, J. M., McCann, M. J., ...Kellogg, L. L. S. (2006). Contingency management for the treatment of methamphetamine use disorders. *American Journal of Psychiatry, 163*, 1993-1999.

Semple, S. J., Zians, J., Strathdee, S. A., & Patterson, T. L. (2008). Methamphetamine-using felons: Psychosocial and behavioral characteristics. *The American Journal on Addictions, 17*, 28-35.

Simon, S. L., Domier, C., Carnell, J., Brethen, P. B., Rawson, R., & Ling, W. (2000). Cognitive impairment in individuals currently using methamphetamine. *The American Journal of Addictions, 9*(3), 222-231.

Simpson, D. D., Wexler, H. K., & Inciardi, J. A. (1999). Drug treatment outcomes for correctional settings, Parts 1 and 2. *The Prison Journal, 79*(3/4/), 291-445.

Skeem, J. L., Emke-Francis, P., & Louden, J. E. (2006). Probation, mental health, and mandated treatment: A national survey. *Criminal Justice and Behavior, 33*(2), 158-184.

Skeem, J. L., & Louden, J. E. (2006). Toward evidence-based practice for probationers and parolees mandated to mental health treatment. *Psychiatric Services, 57*(3), 333-342.

Stojkovic, S., Kalinich, D., & Klofas, J. (2008). *Criminal justice organizations: Administration and management* (4th ed.). Belmont, CA: Thomson Higher Education.

Stoops, W. W., Tindall, M. S., Havens, J. R., Oser, C. B., Webster, J. M., Mateyoke-Scrivner, A., ...Leukefeld, C. G. (2007). Kentucky rural stimulant use: A comparison of methamphetamine and other stimulant users. *Journal of Psychoactive Drugs, 4*, 407-417.

Stoops, W. W., Tindall, M. S., Mateyoke-Scrivner, A., & Leukefeld, C. (2005). Methamphetamine use in nonurban drug court clients. *International Journal of Offender Therapy and Comparative Criminology, 49*(3), 260-276.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2006). *Results from the 2005 National Survey on Drug Use and Health: National Findings* (NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, Office of Applied Studies.

SAMHSA. (2009, August 13). *The TEDS report: Substance abuse treatment admissions referred by the criminal justice system*. Rockville, MD: U.S. Department of Health and Human Services, SAMHSA, Office of Applied Studies.

Truitt, L., Rhodes, W. M., Hoffmann, N. G., Seeherman, A. M., Jalbert, S. K., Kane, M., ...Finn, P. (2003). *Evaluating treatment drug courts in Kansas City, Missouri and Pensacola, Florida: Final reports for phase I and phase II* (NCJ Publication No. 198477). Cambridge, MA: Abt Associates, Inc.

Urada, D., Longshore, D., & Hawken, A. (2007). Re-offending. In *Evaluation of the Substance Abuse and Crime Prevention Act: Final report* (pp. 57-67). Sacramento, CA: California Department of Alcohol and Drug Programs.

Vocci, F. J., & Appel, N. M. (2007). Approaches to the development of medications for the treatment of methamphetamine dependence. *Addiction, 102*(1), 96-106.

Vocci, F. J., Elkashef, A., & Appel, N. M. (2009). Pharmacological treatment of methamphetamine addiction. In J. M. Roll, R. A. Rawson, W. Ling, & Shoptaw, S. (Eds.), *Methamphetamine addiction: From basic science to treatment* (pp. 202-229). New York: The Guilford Press.

Western, B. (2008, December). *From prison to work: A proposal for a national prisoner reentry program*. Washington, DC: The Brookings Institution, the Hamilton Project.

Zweben, J. E., Cohen, J. B., Christian, D., Galloway, G. P., Salinardi, M., Parent, D., & Iguchi, M. (2004). Psychiatric symptoms in methamphetamine users. *American Journal on Addictions, 13*(2), 181-190.