Evidence-based practice in offender programming: An examination of the CrimeSolutions.gov registry

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Offender reentry, felony declassification, and the opioids epidemic have led to quick and widespread implementation of substance abuse and mental health treatment programming in justice settings. This tremendous increase in offender treatment programming has outpaced applied research on program quality and treatment efficacy. This study examined whether designated evidence-based practices are actually delivered in funded treatment initiatives. Secondary data was utilized from the National Institute of Justice’s CrimeSolutions.gov, a national evidence-based practice and program registry. A content analysis methodology examined CrimeSolutions.gov program profiles and topical refereed literature through systematic analysis of five offender treatment evidence-based practices (actuarial screening, co-occurring disorders treatment, medication assisted treatment, individual treatment planning, and isolated therapeutic communities). Findings indicate a variable degree of evidence-based practice delivery and orient discussion around how to improve the implementation of evidence-based practices toward enhancing offender substance abuse programming.

*Keywords:* offender programming, evidence-based practice, co-occurring disorders treatment, medication assisted treatment
Evidence-Based Practice in Offender Programming: An Examination of the CrimeSolutions.gov Registry

Overlapping contemporary criminal justice movements (offender reentry, offender declassification, and evidence-based practice) have prompted a tremendous increase in offender treatment programming over the last two decades. Several states have now passed offender declassification bills wherein the supervision of lower level felons have been transferred from state to community corrections agencies. This supervision transfer has been coupled with the widespread implementation of substance abuse and mental health recovery programming. The nation’s ongoing opioids crisis has only further intensified the proliferation of treatment that is, allegedly, aligned with other mainstream criminal justice initiatives like justice mental health and evidence-based practice.

In the mid-1980s, the creation of mandatory minimums and expansion of the War on Drugs by President Ronald Reagan resulted in increased incarceration rates and overcrowding of jails and prisons (Subramanian & Moreno, 2014). However, in subsequent decades budgetary restrictions and a shifting view of substance abuse as a public health problem have contributed to offender declassification, particularly for those incarcerated for drug crimes. Between 2009 and 2013 more than fifty bills from a combined thirty states were passed that changed how drug offenses were classified (Subramanian & Moreno, 2014). New York, Rhode Island, Minnesota, and New Jersey were the first states to pass legislation reforming penalties for drug offenses. Declassification alone has transferred many offenders with drug crimes to jails and county probation, instead of prison, and presents an opportunity to screen for and address the needs of drug involved offenders.
In the last decade, drug abuse has reemerged as America’s leading social problem, one that has now reached unprecedented proportions particularly in regard to overdoses related to opioids (Hawk, Vaca, & D’Onofrio, 2015). Beginning in the 1990s, pharmaceutical companies reassured physicians and medical professionals that prescription opioids were not addictive (“Opioid Overdose Crisis,” 2019). The irresponsibility of pharmaceutical companies is broadly deemed the launching point for the saturation of society with opioids. However, the reality of the opioids crisis is multifaceted as other entities such as Chinese manufacturers and Mexican cartels also took advantage of the growing addiction (United States Drug Enforcement Administration, 2016).

The great influx of offender programming that followed has called attention to the quality of programming, ranging from services delivery fidelity to perhaps the most obvious concern, treatment efficacy (Miller, Miller, & Miller, 2019). The current study addresses the issue of treatment quality through program delivery content analysis of a leading national evidence-based registry, CrimeSolutions.gov. Evidence-based practices (EBPs) and information regarding EBPs are publicly available online to the public. To be evidence-based according to CrimeSolutions.gov, a program or practice must demonstrate causal evidence of effectiveness through the use of high-quality evaluations and a rigorous methodology (Evidence-Based Practice and Program Registries, n.d.). Assessments of nominated programs and practices are conducted and place recommended modalities and practices into categories. The mission and purpose of the registry is to educate practitioners and academics alike regarding which practices and programs are scientifically determined to be effective, promising, and not effective in the criminal justice field (Evidence-Based Practice and Program Registries, n.d.). EBPs are available on a variety of topics including but not limited to corrections and reentry, substance abuse,
courts, juvenile justice, and law enforcement. Toward this end, evidence-based practice has emerged as a guiding orientation for modality selection in treatment services delivery towards predictable positive outcomes. Ostensibly, EBPs are requisite to receive federal funding for offender treatment and related programming (Miller, Miller, & Barnes, 2018). However, it remains unknown if funded programs in practice truly employ evidence-based practices as this question has not been empirically considered.

Accordingly, this study executes a content analysis to ascertain “truth in funding” regarding the use of evidence-based practices in substance abuse programming. The specific purpose of the current study is to determine whether assumed EBPs are indeed delivered in actual substance abuse programming. Prior to describing the analysis plan, the following chapter reviews relevant literature regarding the proliferation of offender drug treatment as a function of the reentry, decategorization, EBP, and now co-occurring treatment movements. Following a methods chapter, findings orient discussion around the use (or non-use) of EBPs in offender substance abuse programming and the general efficacy of the CrimeSolutions.gov program registry in this focused treatment context.

**Literature Review**

This chapter examines the literature regarding current intertwined justice movements, generally, and challenges regarding the ongoing opioids crisis, specifically. Through the standardization and utilization of EBPs, national registries theoretically become public clearinghouses to share programs and practices nominated and found to meet a set of specific criteria. The criteria include having been previously implemented, scientifically evaluated, and successfully replicated. Next, the current literature is reviewed regarding a subset of EBPs for effective offender substance abuse treatment, referred to throughout this study as axioms.
The Opioids Epidemic

While irresponsibility on the behalf of pharmaceutical companies contributed to the saturation of society with opioids in the 1990s, the reality of the epidemic is multifaceted. The ongoing opioids crisis is also attributable to illicitly manufactured fentanyl from China that is 50 to 100 times more potent than morphine and provides what is described as a heroin-like effect ("Opioid Overdose," 2018). According to the National Institutes of Health (NIH), the number of national overdose deaths from 2002 to 2017 involving opioids increased more than fourfold while the number of national deaths involving synthetic opioids, primarily fentanyl, increased 22-fold ("Overdose Death Rates," 2018). More pointed, the CDC reports that 130 fatal overdoses attributable to opioids occur daily in the United States (Scholl, Seth, Kariisa, Wilson, & Baldwin, 2018).

While the increased potency is concerning for substance users, fentanyl also has the potential to be inhaled through the air or absorbed through the skin, posing a unique threat for law enforcement and emergency responders as well (Rothberg & Stith, 2018). In 2016, public announcements made by the Drug Enforcement Administration and U.S. National Institute for Occupational Safety and Health were aimed toward law enforcement and health care employees to inform them about the danger of exposure to fentanyl and similar drugs (Moss et al., 2018).

Most of the illicitly manufactured fentanyl is coming from China and subsequently smuggled into the U.S. from Mexico (Felter, 2019). Mexican cartels are using two primary methods to transport illegal drugs into the United States: 1) new cartel routes and 2) the U.S. Postal Service. Historically, illegal drugs have passed through a chain of criminal organizations before arriving to the U.S., but due to the soaring profits attainable from the fentanyl markets, Mexican cartels have sought to eliminate the middleman. Cartels take the illegal drugs directly to
large cities, namely Los Angeles, Chicago, Atlanta, Phoenix, and Houston in exchange for cash currency (Rothberg & Stith, 2018). However, fentanyl is also entering the U.S. through the mail. This method is preferred as to avoid direct contact or violence with buyers, however it poses a great risk to society because of the ease of absorption or inhalation from contact with the drug (Felter, 2019).

**The Criminal Justice System Response**

There have been widespread multifaceted government responses to the present drug crisis ranging from not only the most pronounced ongoing political example of the wall, but also awareness and prevention initiatives targeting abuse of opioids, vast increases in border security, and shifts in drug enforcement resources away from marijuana. First, strategies such as medication drives to collect unused medications coupled with communicating the importance of not sharing prescription opioids proved viable yet without general impact. For example, several state and federal medication take back events have been held in the last decade across the U.S., resulting in the collection of over 2,400 tons of medications since 2010, however the problem remains (Hawk et al., 2015). Mandated prescription monitoring systems now are being implemented so that providers can access any patient’s prescription history. For example, a study conducted in Pennsylvania analyzed the prescription of opioids in emergency departments from July 2015 to March 2017 (Suffoletto, Lynch, Pacella, Yealy, & Callaway, 2018). The study found that from pre-state-controlled medication monitoring in August of 2016 to post-state-controlled substance monitoring in September of 2016, opioids prescription rates decreased by 2.2% initially. Furthermore, the overall percentage of opioids prescribed upon discharge decreased by 0.5% monthly until March 2017. The findings suggested that increased awareness
and availability of a patient’s controlled medication history may reduce the likelihood of the misuse of opioids.

In addition to prevention awareness, increased enforcement has also been implemented in response to the opioids epidemic. Shifting drug enforcement objectives are trending toward decriminalization of marijuana to free resources for reallocation to the overwhelming opioids abuse problem. Additionally, the United States has attempted to provide counternarcotic assistance to China including assistance in detecting drug trafficking and informant utilization (Felter, 2019). Most recently in a 2018 meeting with President Donald Trump, Chinese President Xi Jinping committed to placing restrictions on fentanyl and all similar substances. While attempting to directly inhibit the dealer of the deadly opioids is an important step in the right direction, enforcement proves challenging. President Trump has also ordered an increased number of agents at the U.S. Southern border and the building of a wall, to block the flow of fentanyl and other drugs, the main reason for this controversial extreme measure.

In conjunction with prevention awareness and enforcement, drug control policy has been responsive to the opioids epidemic. Although there has been an effort to regulate prescription opioids, the belief in false dichotomies has fueled overreaction causing particularly stark shifts in prescription opioids laws in some states, most notably Florida. False dichotomies are common forms of public misconception regarding criminal justice policy, defined as an erroneous assumption that only one of two often polar opposite solutions exist, also known as an “either or mentality” (Mears, 2010). For example, this belief has fueled the drastic shift from lax to stringent prescription opioids regulation with disregard for solutions that fall in the middle ground. The implementation of Florida House Bill 21 in July of 2018 placed restrictions on how many opioids a physician can prescribe at one time and exemplifies the illogic of “false
dichotomy policy.” A 3-day only supply for acute pain is now standard practice, while a 7-day supply can be provided if medically necessary. During the same time as this regulation of opioids, medical marijuana use in Florida has grown steadily since 2016 (Sexton, 2018). It is unknown to what extent state law redirects use from opioids to cannabis nor the extent that street heroin or fentanyl fills the sudden prescription opioids void (Compton, Jones, & Baldwin, 2016; Cicero, Ellis, & Harney, 2015). However, drastic changes in drug control policy typically entail unintended and collateral consequences.

These changes have prompted quick implementation and widespread infusion of offender programming for the treatment of mental health and substance abuse disorders. This programming is largely guided by the current paradigmatic model increasingly dominating the social and behavioral sciences, evidence-based practice, and is the focal concept in a surging justice system movement. This EBP movement, especially as it pertains to opioids, has prompted a renewed effort to unify academics and criminal justice practitioners through researcher-practitioner partnerships (RPPs) to provide scientifically informed intervention and decision making.

**The Rise of the Evidence-Based Practice (EBP) Paradigm**

A famous 1974 examination of the effectiveness of 231 rehabilitation programs for offenders, the most comprehensive such study at the time, concluded that rehabilitation overall did not have a significant impact on recidivism rates (Martinson, 1974). A subsequent book (Lipton, Martinson, & Wilks, 1975), enlightened the “nothing works” in offender rehabilitation mantra which in turn influenced attitudes toward rehabilitation with implications for punitive sentencing guidelines in the 1970s. In contrast to the “nothing works” literature, Palmer (1978) suggested that the Martinson (1974) research group failed to consider the individuality of
offenders, therefore misjudging the impact potential of intervention, generally. Palmer asserted that widespread treatment effectiveness is not necessarily required for services to prove useful for individual offenders. As noted by Martinson himself and emphasized by Farabee (2002) and then Cullen and Gendreau (2000), there were flaws in the evaluation method used to examine program effectiveness in the Martinson (1974) study. These criticisms were instrumental in helping shift the controversial assertion from “nothing works” to “what works” (Wright, Zhang, & Farabee, 2010). “Nothing works” is largely thought attributable to poor methodology and lack of design rigor-observations that effectively refuted the assertion that offender programming is not effective as evident by the current burgeoning treatment community.

Continuing into the mid-1980s, the creation of mandatory minimums and the War on Drugs by the Reagan administration quickly worsened prison overpopulation. As mentioned above, public misconception dominating the criminal justice field is the belief in false dichotomies—the wrong assumption that two concepts are the only possible answers—which in the 1980s fueled a shift from rehabilitation to incarceration (Mears, 2010). However, beginning in the 1990s in contrast to the “nothing works” motto, a slow shift toward the evidence-based practice (EBP) model was underway. Originating first in medicine and quickly spreading into other fields such as psychology, education, and finally criminal justice, EBPs are programs and practices that demonstrate effectiveness, in this case in offender programming, based on the findings of high-quality scientific research with rigorous methodology (Lynch, Miller, Miller, Heindel, & Wood, 2012; Prendergast, 2011; Mihalic & Elliott, 2015). For example, cognitive behavioral therapy (CBT), frequent drug testing, the use of actuarial risk assessment tools, the treatment of co-occurring mental health and substance abuse disorders, and the use of individual treatment planning (ITP) are identified as effective components for offender programming.
EVIDENCE-BASED PRACTICE IN OFFENDER PROGRAMMING

(Andrews et al., 1990; Friedmann, Taxman, & Henderson, 2007; Godley et al., 2000; De Leon, 2010).

The paradigmatic shift in criminal justice from intuitive and experiential decision making in offender programming, often the underpinnings of “best practices”, to programs and practices based on contemporary scientific research, called EBPs, has and continues to change how the criminal justice system functions. One of the purposes of the EBP movement is to replace the former best practices concept, which refers to the idea of being valid and denotative of positive impact, but not subject to any uniform definition or standardized selection process (Driever, 2002). While these terms are often used interchangeably, there are distinct models defined by different philosophies regarding how effective offender programming should be implemented, with a best practices model driven by decisions based on experience and EBPs rooted in science and an empirical knowledge base. This shift initially created tension between academics and practitioners, however the transition ultimately allows for academics, practitioners, and policy makers alike to have access to research proven to be effective in offender programming through new mutually advantageous funding partnerships (Wright et al., 2010; Lynch et al., 2012).

Although the transition period of acceptance of EBP logic among field practitioners continues, there is growing momentum per the many advantages of use of the new model. First, the widespread acceptance and utilization of EBPs facilitates new research partnerships and enhances the likelihood of receiving federal grant funding (Mihalic & Elliott, 2015; Lynch et al., 2012). Moreover, the continued study and development of EBPs allows for furtherment of the scientific standard of the criminal justice system. Lastly, utilizing evidence-based programming allows for better use of the limited resources available in the criminal justice field by ensuring the programs being implemented are empirically based and found to be effective. For example,
the state of Washington estimated that the implementation of EBPs between the years of 2008 and 2030 would save taxpayers between $1.9 to $2.6 billion as funding is discontinued for programming not evidence rated (Mihalic & Elliott, 2015).

While the implementation of EBPs benefit the criminal justice system, the criteria for a practice or program to be categorized as evidence based is rigorous: a practice or program must have been previously implemented, scientifically evaluated, determined to have positive effects, and then successfully replicated (About CrimeSolutions.gov, n.d.). The shift in criminal justice from a best practices outlook to the EBP model culminates pragmatic in the development of national evidence-based registries as related below (Miller, Tillyer, & Miller, 2012).

**National Registries and CrimeSolutions.gov**

The utilization and widespread implementation of EBPs became conventional and prompted the creation of national registries which consisted of nominated programs and practices found to meet the specific set of criteria for EBPs described above. Well-known national registries including the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), the Office of Juvenile Justice and Delinquency Prevention’s (OJJDP) Model Programs Guide (MPG), and the National Institute of Justice’s (NIJ) CrimeSolutions.gov. These agencies emphasize the importance of EBPs in funding decisions, especially for offender programming. Therefore, practitioners are able to partner with academics to select, implement, and test EBPs in daily criminal justice operations (Lynch et al., 2012). Ergo, further enriching national registries such as CrimeSolutions.gov with quality research programs and practices based on evidence instead of occupational culture or personal experiences.
Established in 2011, the NIJ’s CrimeSolutions.gov is the foremost used crime and justice registry to inform practitioners, academics, and policy makers about the effectiveness of programs and practices in criminal justice. The registry provides information on a wide variety of topics, including reentry, courts, and law enforcement. In order for a program to be placed in CrimeSolutions, it must be nominated and undergo a rigorous multi-step screening and approval process. First, preliminary program identification, including nomination or discovery through relevant searches of journals and databases is conducted. Second, initial program screening is used to determine if the program meets the criteria of CrimeSolutions.gov. These criteria include aims to reduce crime or delinquency, prevent or respond to victimization, improve criminal justice processes, or target an at-risk or offender population. Third, a literature search to review all relevant information to contextualize the research and program is conducted. Fourth, initial evidence screening ensures that the study took place after 1980, the study outcomes relate to crime or victimization, the program was evaluated with at least one randomized field experiment or quasi-experimental research design, and that it was published in a peer-reviewed publication (About CrimeSolutions.gov, n.d.).

Next in the CrimeSolutions.gov screening process, literature review specifies up to three of the most rigorous studies that are reviewed for strength of research, breadth of documentation, type of procedure utilized, sample size, and year published. Next, expert review takes place where two or more evaluators rate the study taking into consideration the quality of the conceptual framework, program outcomes, and fidelity. To follow, study classification places programs into one of five classes as determined by the expert review ratings. Class 1 is very rigorous, well-designed, and show positive effects, whereas class 5 has significant limitations, a lack of information, or is not able to establish a causal relationship. Lastly, program evidence
rating follows in which programs in the national registry are labeled “Effective,” “Promising,” or “No Effects” (About CrimeSolutions.gov, n.d.). “Effective” is defined as a study that has been replicated, found positive effects, and suited for future replication. “Promising” is defined as a study that has shown positive effects once but must be replicated. “No effects” is defined as a method not rigorous enough to determine an effect or the methodology was rigorous, but no effects were found.

CrimeSolutions.gov is a registry open to the public and the NIJ intends for it to aid academics and practitioners alike. For example, researchers can remain informed about current research, criminal justice practitioners can improve effectiveness of their programs, and policymakers can make informed funding decisions. Between the years of 2009 and 2015, the NIJ provided over $10 million in funding for twenty-nine RPPs and CrimeSolutions.gov has as of January 22nd, 2019, 568 programs in which 97 programs are rated effective and 330 programs are rated promising (Pesta, Blomberg, Ramos, & Ranson, 2018). Registries such as CrimeSolutions.gov facilitate relationships between academics and practitioners, while also furthering the field of criminal justice in its entirety. Registries allow for the dissemination of research to the public and the ability for practitioners and academics to join forces to implement EBP’s into the everyday operations of the criminal justice system.

**EBP’s in Offender Programming**

This chapter next examines the current empirical literature to identify EBPs indicative of effective substance abuse treatment for offenders. The foremost evidenced practices of effective and fundable programming, collectively, constitute “axioms” for substance abuse treatment delivered by the criminal justice system. These include: the employment of actuarial screening, treating co-occurring mental health and substance abuse disorders, the use of medication assisted
treatment (MAT), the utilization of individual treatment planning (ITP), and the employment of therapeutic communities (TCs) isolated from the general population.

A leading axiom of offender treatment, and thus an EBP, is actuarial screening. Actuarial screening, often referred to as an “intake assessment,” is defined as a tool used to assess and identify needs of an offender population based on criminogenic risk (Taxman, Thanner, & Weisburd, 2008). Beginning in the 1920s and 1930s, researchers began identifying criminogenic risk factors with the primary focus first on parole and community release (Glaser, 1998; Taxman et al., 2008). With the first generational actuarial screening tool, personal experience and professional judgement was utilized to determine needs and the risk of reoffending was typically based on the administrative data available for a person, often referred to as static factors, such as criminal record, age, and arrest record, however disregarding any behavioral factors (Taxman, Cropsey, Young, & Wexler, 2007; Andrews, Bonta, & Wormith, 2006). However, as actuarial screening improved, many different measures, called dynamic factors, are now considered including attitudes, mental health, substance abuse, and criminal peers, which include factors pertaining to psychological and social information about the offender (Taxman et al., 2007; Taxman et al., 2008). This is important, because the dynamic factors are targeted for treatment and subject to change. The improvement of actuarial screening tools since their creation ensures that offenders are more likely to have their needs met, receive the services most beneficial to their own unique circumstance, and reduce the likelihood of recidivism.

More specifically, a model referred to as risk-need-responsivity (RNR) drives suggested types of program placements based on criminogenic risk (Taxman et al., 2007). The RNR concept was primarily developed by Lee Sechrest and Ted Palmer from treatment classification literature (Taxman et al., 2008). The primary goal of this concept was to match offenders with
appropriate services based on their individualized needs. Examples of developed actuarial screening tools utilizing the RNR model include but are not limited to Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) and Correctional Assessment and Intervention System (CAIS) (Taxman et al., 2007; Andrews et al., 2006). As there are a limited amount of resources and programming options offered, offenders with the highest need and likelihood to benefit from the treatment should be receiving the service.

Before beginning any type of treatment, it is essential that offenders be assessed for risks and needs to ensure fit in the program as discussed above with the RNR model. For example, a study was conducted that included 97 correctional programs and over 13,000 offenders. An actuarial screening tools was used to measure various factors, such as demographic information, substance use, and mental health needs, and it was found that offenders who scored the highest on the screening tools were more likely to reap the greatest benefits from the program than offenders that scored low (Taxman et al., 2007). Therefore, actuarial screening is important in determining which offenders will be the best fit in a program. However, rehabilitation as a response to crime is criticized by the public as being too lenient and is typically costly. For that reason, matching offender needs to specific programming allows for an increased confidence that offenders are more likely to benefit from the treatment. Screening therefore proves advantageous to both the program, offender, and the public. In addition, findings such as the ones described above have resulted in advocacy for increased service referral matching as actuarial assessments are better predictors of offender risks and needs than clinical judgement (Taxman et al., 2007).

Actuarial risk assessment tools specific to substance abuse problems have been implemented in correctional settings much more frequently with the high rates of substance use disorders among offenders. Specifically, tools such as the Arrestee Drug Abuse Monitoring
System (ADAM), Simple Screening Instrument for Alcohol and Other Drug Abuse (SSI-AOD), and Addiction Severity Index (ASI) are utilized to determine if there is a presence of substance abuse or dependency (Taxman et al., 2007). Moreover, the development of advanced screening tools listed above allows for analysis of the severity of the substance use disorder. The use of actuarial screening tools to identify programming specific to an offender based on their risks and needs is key to effective treatment in correctional settings.

Another leading axiomatic offender treatment EBP is the treatment of co-occurring disorders (CODs), defined as concurrent mental health and substance abuse disorders (Chandler, Peters, Field, & Juliano-Bult, 2004). Historically, CODs among individuals have been treated separately, with the majority not receiving any integrated care (Osher, 2013). This treatment model is problematic, because treatment of one disorder and not the other or treatment of each disorder alone has been shown to have little to no positive effect (Havassy, Shopshire, & Quigley, 2000). Unfortunately, integrated treatment of CODs is uncommon among offenders prior to becoming justice-involved. It is very likely that jail may be the first time offenders receive any type of screening or treatment for CODs (Osher, 2013).

While the integration of treatment for CODs is difficult and uncommon, dually diagnosed offenders are more likely to have committed a violent offense, return to jail or prison, and struggle with substance abuse problems (Ditton, 1999). These offenders typically display patterns of unpredictability, impulsivity, and erratic behavior (Chandler et al., 2004). Moreover, individuals with CODs do not necessarily possess equal amounts of mental health and substance abuse challenges. While one offender may experience mainly substance abuse problems with a small mental health problem, another offender may experience both extreme mental health and substance abuse problems. Therefore, working with offenders diagnosed with CODs poses a
unique challenge. One model designed to deal with CODs is the integrated dual disorder treatment (IDDT). This model ensures that individuals with CODs receive treatment for both mental health and substance use disorders at the same time from the same team of providers (Osher, 2013).

In the last decade, the severity and high prevalence of CODs, especially in correctional populations, has become apparent. One study found that 17% of jail inmates have a mental illness and further goes on to predict that over 72% of those individuals have co-occurring mental health and substance abuse disorders (Blandford & Osher, 2012). In a study conducted with 216 individuals with CODs, the IDDT model was found to result in more positive outcomes than separate mental health and substance use treatment (Mangrum, Spence, & Lopez, 2006). Additionally, this integrated model has shown to reduce the likelihood of arrest and other legal involvement. Furthermore, treating CODs concurrently has been found to result in positive health benefits for the offender and increased public safety (Osher, 2008). Similarly, a three-year study conducted in Illinois studied offenders with severe CODs and paired each individual with a case manager to facilitate access to appropriate treatment services (Godley et al., 2000). The study found that offenders had significantly less legal problems and symptoms six months into treatment and they reported overall improvement in life. Therefore, the findings of these studies suggest that integrated treatment may be effective in treating CODs reflected in decreased justice involvement and increased overall health.

Medication assisted treatment (MAT) is another primary axiomatic offender treatment EBP. MAT is defined as a treatment for substance use disorders, primarily addiction to opioids, using medication. Historically, substance abuse disorders were viewed as a choice rather than a disease and prescribing medication to help with symptoms of withdrawal was seen as further
enabling drug use for abusers (Miller, Griffin, & Gardner, 2015). Consequently, many believed abstinence was the only acceptable method to treat substance abuse (Musto, 1999). The first methadone clinic was established at the Rockefeller Institute in 1964 (Miller et al., 2015). Following in 1974, the Controlled Substances Act was modified to include procedural guidelines for methadone clinics (Medication-assisted treatment, 2005). Although methadone clinics were legalized by the modifications, many states strictly prohibited their operation. Although a negative stigma is still attached to MAT for some, the shifting views of drug use as a public health problem and proven effectiveness of MAT programming has popularized the substance abuse treatment.

As MAT has become commonplace in substance abuse treatment, there are three primary medications that are used including methadone, buprenorphine, and naltrexone. Methadone is a synthetic opioid that reduces the craving for opioids (Miller et al., 2015). The medication is known to make the brain think it is still receiving opioids, but there is no subsequent high nor withdrawal effects (Medication and counseling treatment, 2015). Buprenorphine is known to trigger the same parts in the brain as morphine without withdrawal symptoms and reduces cravings (Miller et al., 2015). Naltrexone is different from the previous medications in that it blocks the effects of opioids and is usually administered as an injection. If an individual were to use opioids while taking naltrexone, the medication prevents the euphoric effects (Medication and counseling treatment, 2015).

Implementing the use of MAT in correctional institutions to relieve symptoms of withdrawal is important, because at the time of a study conducted in 2006 it was predicted that about 50% of all prisoners meet the criteria for drug dependence as set forth by the DSM-IV (McKenzie, Nunn, Zaller, Bazazi, & Rich, 2009). A study of a correctional facility in Rhode
Island that functions both as a jail and prison found that when an inmate begins a methadone treatment program before they are released from prison or jail, there is a decreased risk of recidivism and substance use (McKenzie et al., 2009). In another study conducted with inmates released from Rikers Island jail, buprenorphine was prescribed for opioid dependence. In the short term, buprenorphine was not effective and many struggled to maintain abstinence from opioids (Lee et al., 2012). However, in the long-term, buprenorphine treatment was shown to limit ongoing opioids use. Furthermore, a five-site study examining the effectiveness of the injectable form of extended-release naltrexone, Vivitrol, for justice-involved adults found that sustaining this treatment was effective (Lee et al., 2015). In addition, retention rates in the study were about 77% after six months and continued use resulted in a significant decrease in opioids use.

In addition to the reduced risk of recidivism and substance use post-release, the impact of MAT on individuals addicted to opioids was found to result in lower expenditures overall (Mohlman, Tanzman, Finison, Pinette, & Jones, 2016). This study examined Medicaid beneficiaries who received MAT versus non-MAT treatment. Those who received MAT had higher treatment costs overall, however had slightly lower annual expenditures than the non-MAT group. However, removing the cost of MAT from the annual expenditures resulted in significantly lower annual health care costs than the non-MAT group. Therefore, these findings suggest that MAT is potentially associated with the pursuance of additional preventative health services. Accordingly, this axiom is essential in any drug treatment program, especially for offenders.

Individual treatment planning (ITP) is another primary axiom in offender substance abuse treatment. ITP can be defined as a treatment plan that varies based on the offender, more
specifically being tailored to the particular needs of the individual and including services for things such as substance abuse and mental health disorders, job skills, or anger management issues (Andrews et al., 1990). Most importantly, ITP focuses on aspects beyond criminal behavior and involves the integration of other components to improve an offender’s overall well-being including medically, with their family, and educationally. ITP is fluid and able to be changed upon the appearance of additional issues or hardships and is largely related to the RNR model discussed previously (Taxman et al., 2007). The use of an individual case plan for each offender ascertains the matching of a treatment plan to the specific needs of the offender, however, ITP is time consuming and rarely incorporated into correctional settings.

In the 1970s, the disbelief in effective rehabilitation in correctional institutions and the stark shift from rehabilitation to punitive sentencing contributed to the downfall of ITP. However, by the 1990s, support for rehabilitation and evidence-based practice was on the incline (Lynch et al., 2012). Andrews et al. (1990) challenged the claims of widespread ineffectiveness of rehabilitation suggested by Martinson (1974) reasoning that every treatment technique does not work the same with every individual and treatment services are most beneficial when they are individually designed for each offender. Researchers found that matching client’s needs, learning styles, and modes of treatment resulted in a significantly greater effect when using appropriate correctional services, defined as the targeting of criminogenic needs and specific responsivity, in comparison to unspecified correctional services, defined as neither an entirely matched nor poorly targeted service, but containing some individualized aspects and some poorly matched aspects of treatment (Andrews et al., 1990). In addition, both appropriate and unspecified correctional service had greater effects than inappropriate correctional services, defined as poorly matched services, and non-service criminal sanctions, defined as non-treatment
interventions. These findings were found to be the same among juvenile and adult populations. Therefore, the results of the study draw attention to the potential benefits of ITP in offender programming.

With the increasing empirical support found for ITP and EBPs, although still limited, the integration of ITP in offender programming has become more common. For example, in a study conducted with a sample of justice-involved substance abusers housed in a Virginia therapeutic community, inmate functioning and ITP effectiveness were measured using the Texas Christian University (TCU) Criminal Justice Client Evaluation of Self and Treatment (CJ CEST) instrument. The study found that programs were delivered more efficiently and effectively with the implementation of ITP (Roberts, Contois, Willis, Worthington, & Knight, 2007). More specifically, offenders categorized in the highest risk category showed a 55% improvement in progress assessments and 80% of the sample showed at least some type of improvement in the progress assessment. The study concluded that by targeting and tailoring services to each offender, treatment plans can be much more specialized to meet specific needs and post-release services can be identified.

A more recent twenty-one site study also assessed the effectiveness of ITP when utilized with community reentry drug-involved offenders called case plan integration, defined as an individualized treatment plan that seeks to address the needs unique and specific to each individual (Welsh et al., 2015). In order to implement case plan integration, a team ranging from six to ten members was formed between the correctional agency and a community treatment partner who had experience working with correctional populations. The study found that case integration planning had the strongest and most significant effect on the treatment sample. The study findings therefore suggest that ITP can be an effective treatment intervention for substance
abuse offenders. Most aspects of the criminal justice are not one size fits all, therefore implementing programming that is individualized proves to be essential to best serving offender populations, especially those with substance abuse and mental health disorders.

Lastly, the utilization of therapeutic communities (TCs) isolated from the general population is the final evidence-based offender substance abuse treatment axiom. TCs are long-term, group-based residential living facilities typically utilized for the treatment of mental illness and substance abuse and often follow a treatment perspective that is defined by the goal of changing negative thinking, behavior, and feelings (De Leon, 2010). The first TC was founded in 1958 in California with rapid implementation of TCs in over 65 countries following in the 1960s (Bunt, Muehlbach, & Moed, 2008). The first TCs functioned as an alternative to medicated treatment, however the shifting public opinion and recognition of substance abuse as a medical disorder in recent years has shifted TCs to allow medicated treatment (De Leon, 2010). As a result, TCs have embraced multifaceted programming to include medication assisted treatment, individual and group therapy, and behavioral interventions (Smith, 2012).

Substance abuse treatment in a correctional setting is particularly difficult, as drugs are easily accessible in jail and prison hindering any treatment progress. However, TCs isolated from the general population have been found to be especially effective in treating mental health and substance abuse disorders in correctional settings. In a study examining the release of over 300 clients from a Delaware prison-based TC, about 55% were drug free after six months post release in comparison to only 35% of offenders drug free that were not a part of a TC while in prison (Hooper, Lockwood, & Inciardi, 1993). 83% of offenders who only utilized a work release TC, but no prison-based TC were drug free after six months post release. 91% of the offenders who partook in both the prison-based TC and the work release TC were drug free six months post
release. The results of this study draw attention to the large percentage of inmates who abstained from drug use post release that were a part of TCs while either incarcerated or during work release.

Moreover, a follow-up study of offenders five years post-release from Delaware TCs found that participants had a significantly lower likelihood of drug use and additional arrests (Inciardi, Martin, & Butzin, 2004). More specifically, data collected 60 months post-release from TCs indicates that those who participated in TCs were much more likely to remain drug and arrest free in comparison to those that did not participate in a TC. Among offenders who partook in TCs, 52% were rearrested and 71% had used substances since release five years prior. While these statistics may seem high, it is important to note that offenders in TCs were likely the most difficult substance abusers to treat as they are heavily involved in drugs, potentially have co-occurring mental health and substance abuse disorders, and are criminally involved. However, examining the contrary exemplifies that 30% of graduates successfully abstained from substance abuse and additional arrests. The study’s data suggests that the implementation of TCs has the potential to reduce substance abuse and rearrests post release. While TCs have been scientifically found effective, they are also a fiscally responsible treatment option. Based on a large meta-analysis of data pertaining to therapeutic communities in North America, De Leon (2010) concluded that therapeutic communities are cost effective, as well as effective in treating substance abusers.

**Methods**

**Research Questions**

Having considered the current literature for a subset of EBPs, this chapter presents an overview of the research strategy employed to examine the research questions posed regarding
Evidence rated offender substance abuse treatment programming. More specifically, a content analysis plan will be used to examine evidence-based offender treatment in funded services delivery initiatives. For each program analyzed, the following research questions were asked:

1. Does the program employ actuarial screening and, if so, for both mental health and substance abuse disorders?
2. Does the program treat both mental health and substance abuse disorders?
3. Do recovery plans include medication assisted treatment when indicated?
4. Does treatment include an ITP?
5. For incarcerated settings programs, are isolated therapeutic communities utilized?

**Content Analysis Methodology**

In order to empirically examine these questions, this study employed a content analysis methodology. After briefly examining previously implemented content analysis applications to crime and justice phenomena, the sampling logic and data will be discussed. Lastly, the analytic plan to examine if EBPs are actually present in officially rated programming is described.

Content analysis is a well-established method of inquiry across the social sciences (Berelson, 1952; Holsti, 1968; Wimmer & Dominick, 1994; Hopkins & King, 2010) and has been particularly utilized in criminology and criminal justice research. Applied to a wide range of phenomena and topics, content analysis within the discipline has, for the most part, emphasized either citation or thematic influence as indicated by citation counts, the quality of publication outlets cited, and the now largely outdated page space measurement. Citation-focused content analyses have been heavily employed around concepts of influence and significance portrayal in numerous ranking studies specifying leading topics, departments, and individual scholars in a multitude of ranking categories (Humphries, 1981; Baro & Eigenberg,
Content analysis has also been more directly applied to assess and dissect justice phenomena for various applied reasons. One example is a content analysis of women’s sexual assault resources aimed at examining how institutions of higher education address the distribution of resources for a justice issue that disproportionately affects women (Hayes-Smith & Hayes-Smith, 2009). The analysis found that although many institutions of higher education had sexual assault resources and literature publicly available, very few colleges had women’s resource centers. This content analysis was assessing campus resources and dissecting the justice phenomena of sexual assault on college campuses, particularly impacting women.

In addition, another example of a content analysis attempted to examine mental health among elderly adults in the criminal justice system (Maschi, Sutfin, & O’Connell, 2012). The study was conducted through an in-depth and systematic examination of thirty-one published empirical articles. The results of the content analysis suggest that mental illness must and can be addressed at all stages throughout the criminal justice system, from initial arrest, to imprisonment, and community sanctions. More importantly, this content analysis was used to assess and dissect the justice phenomena of mental health, the elderly, and the criminal justice system. The findings of this research can be applied to draw attention to the detection of mental health, distress, and age-related mental decline within the criminal justice system.

This study, similarly, identifies and systematically examines the contemporaneous justice phenomena of offender treatment through scrutiny of official US NIJ CrimeSolutions.gov data. The current study’s purpose is to determine whether assumed EBPs are indeed present in practice and thus indicative of “truth in funding.” EBPs have emerged as guiding orientations for the
selection of treatment services with predictable positive outcomes, therefore truth in funding informs treatment effectiveness.

Content analysis here will answer important research questions informing to what extent the NIJ’s national evidence-based practices registry, CrimeSolutions.gov, demonstrates implementation of actual evidence-based practices in funded treatment initiatives. Our analysis examined this national database, rather than another registry, because offender treatment programming data specific to substance abuse is available on CrimeSolutions.gov. Since the inclusion of EBPs are requisite to receive federal funding for offender treatment programming, analysis of whether EBPs are indeed present in practice is pivotal in the production and distribution of scholarly knowledge. Additionally, to study the relationship between offender treatment programming and the inclusion of EBPs, we needed to select a specific treatment area for analysis. Due to changes in the last decade such as offender declassification and the nations’ current unprecedented opioids crisis, offender substance abuse treatment programming was examined.

**Institutional Review Board**

A Determination of Human Subjects Research Form was submitted to the University of North Florida Institutional Review Board in order to determine if IRB approval and oversight was required. The IRB determined that the project does not meet the federal definition of human subjects research, because data was not collected through the intervention or interaction with living individuals and the data does not contain identifiable private information as it was obtained from a public use database. Therefore, a Waiver of IRB Review was issued (See Appendix A).
Sampling Logic

We began by initiating a search on CrimeSolutions.gov in November 2018 using the search terms “Alcohol and Drug Therapy/Treatment.” CrimeSolutions.gov was chosen as the registry to obtain the data for the current study, because it contains programs and practices pertaining to offender substance abuse treatment. Due to existing dual diagnosis literature and the proven inability to effectively treat substance abuse or mental health disorders independently of one another, it was assumed that mental health disorders would also be addressed in the substance abuse programming. Results from the initial search were filtered by the following search criteria of topic, delivery setting, age, and randomized control trial. As mentioned previously, the treatment area of analysis selected was substance abuse, therefore the by topic search criteria selected was “drugs and substance abuse.” Next, the selected delivery setting criteria included all possible settings as predetermined by CrimeSolutions.gov, including campus, correctional, courts, high crime neighborhoods/hot spots, home, inpatient/outpatient, other community settings, reservation, residential, school, and workplace. All delivery settings were selected because the current research desires to analyze substance abuse treatment programming for offenders or justice involved individuals in general, not specifically regarding a limited selection of delivery settings.

To follow, the age search criteria selected was “Adults 18+.” The chief reason in selecting an adult sample is the prevalence of offender treatment programming for primarily adults. Although the sampling logic opted for “Adults 18+,” due to how programs and practices are input into CrimeSolutions.gov, juvenile programs were also included in the sample. As long as the juvenile programs aligned with the main premise of the study, substance abuse programming for offenders or justice-involved individuals, the programs were not eliminated
from the sample to create unnecessary attrition. However, both the juvenile and adult programs will be analyzed separately as each population has distinctly different treatment needs and approaches to treatment implementation. Lastly, “randomized control trial only” (RCT) was the last search criteria selected. RCT only was selected, because research in which participants are randomly assigned to a treatment or control group leads to the highest level of confidence that observed effects are the result of the program and not other variables (Wright et al., 2010). In addition, failing to include an RCT has the potentiality to result in insignificant methodological rigor and thus the ensuing inability of the raters to assign an effective or promising program rating.

Data

Forty-one total programs remained after implementing the discussed search criteria. Upon closer examination of the CrimeSolutions.gov program descriptions, sample attrition was revealed (See Appendix B). Specifically, eight programs were eliminated from the sample due to the program goal focusing on victimization of alcohol and other drug offenders (AOD), programming designed to carry out prevention interventions with non-justice involved individuals, and parenting preventative interventions. The current research aims to analyze offender substance abuse treatment programming, therefore eliminating the programs incompatible with the desired research question. An additional two programs were eliminated from the sample due to programming designed for concurrent treatment of adult and juvenile clients. These programs were eliminated as each population possesses unique intervention needs and placing them together may undermine treatment objectives (Blandford & Osher, 2012). An additional program was eliminated from the sample as the corresponding published academic article was inaccessible for analysis.
The thirty programs that remain by design fall into a two-pronged typology of juvenile and adult sample populations. Seven of the programs in the sample are of the juvenile typology and twenty-three programs were adult only samples. The sample dichotomized into juvenile and adult programs as defined by the age of participants as well as the adult versus juvenile program distinctions as made by researchers in the program profiles. Each of the previously mentioned typologies contain programs that are categorized within one of three evidence rating categories including, effective, promising, and no effects. In the juvenile sample, two programs are rated effective, one program is rated promising, and four programs are rated no effects. In the adult sample, five programs are rated effective, ten programs are rated promising, and eight programs are rated no effects.

Analytic Plan

Table 1: EBP Scoring Chart

<table>
<thead>
<tr>
<th>Program</th>
<th>Evidence rating</th>
<th>Age Range</th>
<th>Actuarial Screening</th>
<th>Screen SA&amp;MH</th>
<th>Treat SA&amp;MH</th>
<th>MAT</th>
<th>ITP Component</th>
<th>TC Utilized</th>
<th>Isolated TC</th>
</tr>
</thead>
</table>

All CrimeSolutions.gov program profiles in the sample were scored and analyzed using the above data chart (see Table 1). Each program was scored using the five research questions previously discussed, using yes (y), no (n), unspecified (u), and not applicable (n/a) to respond to each research question (See Appendix C). “Does the program employ actuarial screening?” was answered by first examining the program profile from CrimeSolutions.gov for an indication of screening criteria or a screening instrument utilized within the program. As a follow-up to the first research question in the event of an affirmative response, “Does the program screen for both mental health and substance abuse disorders?,” examined if the program profile included a description of screening criteria or screening instruments to screen for both mental health and
substance abuse disorders. Next, “Does the program treat both co-occurring mental health and substance abuse disorders?” examined if treatment was provided for both disorders as indicated by the program profile methodology and program components, for example, the use of both cognitive behavioral therapy and medication assisted treatment.

The next research question examined “Do recovery plans include medication assisted treatment where warranted?” as indicated by the program profile for severe drug or alcohol use and dependence. In the case of marijuana or minimal alcohol use, for example, medication assisted treatment would be not warranted. “Does treatment include an ITP?” was the next research question and examined if individualized treatment planning was provided for the client, such as through the utilization of individual case planning or individual counseling. Lastly, “For incarcerated settings programs, are therapeutic communities utilized?” inspected the program profiles to first determine if the program utilized a residential component. In the case of an affirmative response, “If so, are therapeutic communities isolated from the general population?” followed to further evaluate if the program utilized an isolated therapeutic community, defined as a specialized housing area for only individuals in the TC. After scoring all of the offender treatment programs based on the five posed research questions using the CrimeSolutions.gov program profiles, further analysis of the thirty programs was conducted using the corresponding published academic literature (See Appendix D). Further analysis using the extant literature was conducted for programs that contained “unspecified” scores for any of the five research questions. The same research questions, definitions, and processes were utilized when examining the academic literature for only the data unspecified in the original CrimeSolutions.gov program profiles. The next chapter explains the findings of the current research in an effort to examine whether EBPs are present in practice and ascertain truth in funding.
Findings

Juvenile Programs

The data in the present study shows that the use of EBPs in practice is less frequent than expected. Note that all data pertaining to the five primary axioms for the juvenile programs were present in the program profiles obtained from CrimeSolutions.gov, therefore no data was sought out for the juvenile sample in the published academic literature.

The seven programs comprised of juveniles all employed actuarial screening. However, only two of the seven (28.6%) programs screened for both substance abuse and mental health disorders. Of the two programs, only one of the programs treated both substance abuse and mental health, while the second program treated substance abuse disorders only. The remaining five of seven (71.4%) juvenile programs only screened for substance abuse, failing to screen for mental health disorders. Of the five programs that only screened for substance abuse, four programs only treated substance abuse disorders and the fifth program treated both substance abuse and mental health disorders.

The inclusion of MAT in recovery plans was determined to be warranted in three of seven (42.9%) juvenile programs, however was not utilized in any of the recovery plans or programs. Programs treating populations with severe drug or alcohol use and dependence, more specifically alcohol and opioids, were categorized in this way because a need for conventionally used MAT was apparent, yet no actual MAT was documented as a part of the current programming. The remaining four (57.1%) programs did not warrant the use of MAT.

We also found that an ITP was utilized in six of the seven (85.7%) programs. Of the seven juvenile programs, two (28.6%) utilized programs with incarcerated settings. However, neither utilized TCs or isolated TCs specifically. One program utilized a purely correctional
setting, while the second program utilized an incarcerated setting that transitioned offenders to parole throughout the course of the program. Of the two programs that utilized incarcerated settings, each employed actuarial screening, included an ITP, and treated both substance abuse and mental health disorders.

Four of the seven (57.1%) juvenile programs in the sample were rated no effects. Three of these programs only screened for substance abuse disorders, while failing to screen for mental health disorders. The same three programs also only treated substance abuse disorders, failing to treat co-occurring mental health and substance abuse disorders. One of the seven (14.3%) programs is rated promising. Most notably, this program utilizes an incarcerated setting however does not utilize an isolated TC nor MAT in its recovery plan. Interestingly, the two (28.6%) juvenile programs that were rated effective did not screen for or treat both substance abuse and mental health and instead screened and treated only for substance abuse disorders. In addition, both juvenile programs rated effective were appropriate for the inclusion of MAT in their recovery plans, but neither utilized MAT.

**Adult Programs**

When examining the data from the adult program sample, note that all data pertaining to the five primary axioms were not present in the program profiles obtained from CrimeSolutions.gov, therefore some data was sought out for the adult sample in the published academic literature. Specifically, four of twenty-three (17.4%) programs required further examination of the published literature to find information pertaining to the axioms not addressed in the program profiles. The axiom with data most likely to be missing from the program profile was the inclusion of MAT. Three of the six (50%) missing fields were for MAT,
with all three fields indicating that MAT was not included in recovery plans when looking to the published literature.

Not surprisingly, seeing as though all were funded initiatives, all reviewed programs included some form of actuarial screening. However, thirteen of the twenty-three (56.5%) programs did not screen for both substance abuse and mental health disorders, screening only for substance abuse disorders. Additionally, eleven of these thirteen programs that screened only for substance abuse disorders also treated only substance abuse disorders. Ten of the twenty-three (43.4%) programs did screen for both substance abuse and mental health disorders. Of these ten programs, five treated both substance abuse and mental health disorders, four treated substance abuse only, and one program treated neither disorder. The use of MAT in recovery plans was warranted in seventeen of the twenty-three (73.9%) programs, however was only utilized in eleven (64.7%) recovery plans. The inclusion of an ITP in the treatment program was present in nineteen of twenty-three (82.6%) adult programs.

Only six of the twenty-three (26.1%) adult programs utilized an incarcerated setting. However, only one of six (16.7%) programs utilized a TC that was also isolated from the general population. The remaining five programs took place within incarcerated settings, but no TC was utilized. Four of these programs took place in correctional settings that transition to community settings over the course of the program, whereas one program had a purely correctional setting. Of the six programs that utilized incarcerated settings, five (83.3%) programs only screened and treated for substance abuse disorders. The remaining program (16.7%) that utilized an incarcerated setting and a TC screened and treated for both mental health and substance abuse disorders. Additionally, five of the six (83.3%) incarcerated settings programs utilized an ITP in
treatment, while only two of the five (40%) programs determined to be warranted to include MAT included the treatment in the recovery plan.

Eight of the twenty-three (34.8%) adult programs were rated no effects. Six of the eight (75%) adult programs rated no effects only treated substance abuse or neither substance abuse or mental health disorders. Additionally, six of eight (75%) no effects programs were warranted to include MAT in recovery plans, however only two of six (33.3%) programs did utilize MAT. Two of the six (33.3%) incarcerated settings programs rated no effects.

Ten of the twenty-three (43.5%) adult programs were rated as promising. Eight of the ten (80%) promising programs only treated for substance abuse, failing to treat for mental health disorders as well. Seven of the ten (70%) programs rated promising were warranted to include MAT, however only five of the seven (71.4%) programs included MAT in the recovery plans. Nine of ten (90%) promising programs utilized an ITP in treatment. Additionally, four of the six (66.7%) incarcerated settings programs rated promising.

Five of the twenty-three (21.7%) adult programs were rated as effective. Four of the five (80%) programs rated effective screened for both mental health and substance abuse disorders, however only two of those four (50%) programs also treated for both substance abuse and mental health disorders. The remaining two programs (50%) only treated for substance abuse disorders. Four of the programs rated effective were warranted to use MAT in their recovery plans and all four utilized the practice. Four of the five (80%) programs included an ITP in the treatment plan. Interestingly, none of the programs rated effective utilized programming in incarcerated settings.

**Conclusion**

This study examined the extent to which assumed EBPs are indeed present in practice, specifically examining substance abuse treatment for justice involved populations using five
primary treatment axioms: the employment of actuarial screening, treating co-occurring mental health and substance abuse disorders, the use of medication assisted treatment, the utilization of individual treatment planning, and the employment of therapeutic communities isolated from the general population. Results from the content analysis indicates that about 29% of the juvenile programs included screening for both substance abuse and mental health disorders, however only one program from the entire juvenile sample treated both substance abuse and mental health. The inclusion of MAT in recovery plans was possible in about half of the juvenile programs, however was not utilized in any of the treatment plans. ITP was utilized in 86% of the juvenile programs. Results from the adult sample indicates that over half of the programs did not screen for both substance abuse and mental health disorders. Additionally, about 74% of program populations indicated the potential for MAT, however was utilized in only 65% of the adult programs. 26% of adult programs were carried out with incarcerated populations, however only one program utilized an isolated TC.

Juvenile Programs

There are several implications that arise from the juvenile sample findings. Of the seven programs in the juvenile sample, only two programs screen for both substance abuse and mental health disorders, drawing attention to the inadequate extent of screening. More than half of the juvenile programs only screen for substance abuse. This finding is indicative of more screening needed in general within treatment programs. Although the existing literature has found that co-occurring mental health and substance abuse disorders cannot be treated independently of one another, a significant proportion of the programs fail to screen for both. Of the scant few that do, virtually none (actually only one) treats both substance abuse and mental health disorder. This finding calls attention to effectively implementing treatment for co-occurring needs where
indicated. Despite the previous assertion of the importance of treating co-occurring disorders, appropriate screening must first be effectively implemented before treatment begins. In addition, the fact that only one juvenile program screened and treated for both mental health and substance abuse suggests that we should not assume that the identification of need is in any way a response to it.

**Adult Programs**

In addition to the juvenile sample, there are several implications that arise from the adult findings. Despite the solidification of dual diagnosis in practice, both mental health and substance abuse disorder screening was applied less than 50% of the time. This finding illuminates the lack of implementation of evidence-based practice regarding dual diagnosis as indicated by the academic literature. Co-occurring disorders are unable to be treated individually, therefore treating only one and not the other is doing a disservice to the program and the individual receiving treatment. Moreover, of the programs that did screen for both mental health and substance use disorders, half treated only one or neither. Co-occurring treatment must be delivered where indicated and we must not assume that screening for a problem is equivalent to responding to it. Lastly of the six programs that utilized therapeutic communities, virtually none (again, only one) screened and treated for both substance abuse and mental health disorders. Therapeutic communities are designed to be intensive programs meant to address primarily mental illness, substance abuse, and personality disorders. In analyzing the data, even programs with therapeutic communities are failing to screen for both co-occurring mental health and substance abuse disorders. This analysis draws attention to the deficit in screening and treating co-occurring disorders in offender substance abuse programming and the failure to implement essential EBPs into treatment plans. The inclusion of an ITP in the treatment program was only
present in 83% adult programs, meaning that, for the other 17%, there is neither optimal connectivity between individual needs assessment and actual services delivered nor, more fundamentally, any individual counseling.

**CrimeSolutions.gov**

CrimeSolutions.gov is supposed to be a reference tool and entity in and of itself, however to even discern the evidence-based nature as indicated by the five treatment axioms reviewed here required an additional literature review for about 17% of the adult programs in the sample. Additional literature was required to make an accurate assessment if programs were based on EBPs or not. For example, 14% of the required data was missing in three programs. Therefore, important data required to determine if the program was evidence-based was missing and further review of the academic literature was required. A fourth program was missing 43% of the information regarding the use of EBPs from the program profile and required a justifiable dig for the missing information. Discovered in this study is a discrepancy between the information availability in CrimeSolutions.gov and a deeper literature review. As indicated by the five treatment axioms reviewed in this study, indication of EBP use or omission had to be found in the outside literature.

**Actual EBPs in Treatment Programming**

A systematic analysis was conducted of programs within CrimeSolutions.gov using the following five evidenced thematic practices of effective offender programming: employment of actuarial screening, treatment of co-occurring substance abuse and mental health disorders, the use of mediation assisted treatment, utilization of individual treatment planning, and the use of therapeutic communities isolated from the general prison and jail populations. After review of all
of the data collected, the evidence allows for an assessment of the purpose of the current research. *Are assumed EBPs indeed delivered in actual offender substance abuse programming?*

The first research question analyzed if (a) the programs employed actuarial screening and (b) if so, was actuarial screening employed for both mental health and substance abuse disorders? Overall most programs employed some form of actuarial screening initially, however this is not surprising because it is funded research. Therefore, the data points to yes, actuarial screening was employed generally across programs. However, actuarial screening was not employed for both mental health and substance abuse disorders generally. The programs were more likely to screen for substance abuse disorders only. The second research question analyzed if the programs treated for both mental health and substance abuse disorders. The data suggests that programs do not treat for both mental health and substance abuse disorders, with most programs treating substance abuse only.

The third research question examined if recovery plans included medication assisted treatment when indicated. The data suggests that MAT where indicated was not utilized regularly, but instead categorized by infrequent and irregular use. The fourth research questions analyzed if treatment included an ITP. Overall, programming did include ITP. The fifth research question asked (a) for residential programs, are therapeutic communities utilized and (b) if so, are therapeutic communities isolated from the general population? The programs did not widely utilize correctional populations nor therapeutic communities for that matter. Therefore, therapeutic communities isolated from the general population was even more scarce. However, due to the small sample of programs utilizing correctional populations, the generalizability of this specific finding is uncertain.
In general, the study suggests that EBPs are not delivered in actual substance abuse programming to the extent that is suggested by the registry. Instead, there is much to be desired regarding the implementation of EBPs within the evidence rated programs and practices. In the case of general actuarial screening and ITP, the data suggests that these two EBPs are delivered regularly. However, the remaining EBPs, namely actuarial screening of both mental health and substance abuse disorders, treatment of both mental health and substance abuse disorders, MAT, and therapeutic communities isolated from the general population, fall short of actual delivery. While there are programs that implement these EBPs in program delivery, the application is irregular. Shockingly, there is a large discrepancy between what the registry is presumed to represent and what is actually delivered in evidence-rated programming.

Limitations, Future Directions, and Implications

Although findings from the content analysis indicate general shortcomings in the public-use database in terms of EBP implementation, axioms beyond the five selected are underexplored in this study. A stronger conclusion may be made by examining the extent of EBPs present in practice for additional evidence-based axioms found to be effective in substance abuse treatment for justice involved populations. Future analysis may also utilize a larger sample size to increase generalizability. Making the search terms in CrimeSolutions.gov less specific and restrictive will allow for the collection of a larger sample than utilized in the current study. Moreover, conducting the same methodology with a sample of program profiles not related to offender drug treatment may strengthen conclusions regarding the widespread representation of shortcomings of EBP implementation across CrimeSolutions.gov in general.

Perhaps more importantly and beyond the implications for drug treatment reviewed here are the extent that these problems are representative of CrimeSolutions.gov of which we suspect
is the case. There needs to be changes to the continuity of inclusion of EBPs in practice for programs accepted to CrimeSolutions.gov and stricter review processes overall. To be fair, the NIJ has made substantial improvements to CrimeSolutions.gov nomination and review process in just the last couple of years. For example, the nomination and review process are now more akin to a journal review process. While these improvements have moved into a format less likely to neglect the EBPs, the system that it was allegedly designed to promote, the current study unfortunately suggests that there are still criteria that remain to be transformed. In examining the challenges and shortcomings presented by CrimeSolutions.gov, offender treatment programming can be more meaningfully redesigned toward implementing EBPs to ascertain truth in funding, treatment effectiveness, and fiscal accountability.
References


United States, Drug Enforcement Administration, Strategic Intelligence. (2016). *Counterfeit prescription pills containing fentanyl: A global threat* (pp. 1-10).


Appendix A

Waiver of IRB Review

Office of Research and Sponsored Programs
1 UNF Drive
Jacksonville, FL 32224-2665
904-620-2455  FAX 904-620-2457
Equal Opportunity/Equal Access/Affirmative Action Institution

MEMORANDUM

DATE: March 25, 2019

TO: Ms. McKenzie Jossie

VIA: Dr. Mitchell Miller,
Criminology and Criminal Justice

FROM: Dr. Jennifer Wesely, Chairperson
UNF Institutional Review Board

RE: Review conducted on behalf of the UNF Institutional Review Board
“Evidence-Based Practice in Offender Programming: An Examination of the CrimeSolutions.gov Registry”

This is to advise you that your project, “Evidence-Based Practice in Offender Programming: An Examination of the CrimeSolutions.gov Registry,” was reviewed on behalf of the UNF Institutional Review Board and was declared “not research involving human subjects” based on the definitions provided in the U.S. Department of Health and Human Services Code of Federal Regulations found at 45 CFR 46.102. As such, this project qualifies for a Waiver of IRB Review.

Please note, this waiver does not absolve the Principal Investigator from complying with other federal, state, or local laws or institutional policies and procedures that may be applicable in the conduct of this project.

This waiver applies to your project in the form and content as submitted to the IRB for review. Any variations or modifications to this project involving the participation of human subjects must be approved by the IRB prior to implementing such changes. Please maintain a copy of this waiver for your records.

Thank you for submitting your project to the IRB for consideration. Should you have any questions or if we can be of further assistance, please contact the Research Integrity office at 904-620-2455, or IRB@unf.edu.

IRB Form Version 01.03.2019
Appendix B

CrimeSolutions.gov Programs Omitted from Sample

1. Opportunity to Succeed (OPTS)
2. Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
3. Spit Tobacco Intervention for Athletes
4. Teams-Games-Tournaments (TGT) Alcohol Prevention
5. Brief Alcohol Screening and Intervention of College Students (BASICS)
6. Adults in the Making (AIM)
7. Nurse-Family Partnerships
8. Brief Strategic Family Therapy
9. Strengthening Families Program: For Parents and Youth 10-14
10. Adolescent Community Reinforcement Approach
11. Families Facing the Future
## Appendix C

### CrimeSolutions.gov Program Profile Scoring Sheet

<table>
<thead>
<tr>
<th>Program</th>
<th>Evidence rating</th>
<th>Age Range</th>
<th>Actuarial Screening</th>
<th>Screen SA&amp;MH</th>
<th>Treat SA&amp;MH</th>
<th>MATc</th>
<th>ITP Componentd</th>
<th>TC Utilizedf</th>
<th>Isolated TC</th>
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<td>No Effects</td>
<td>14-18</td>
<td>y</td>
<td>n</td>
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## Appendix D

### Published Literature Scoring Sheet

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Vita

McKenzie L. Jossie

Education

Ph.D., Criminology, Law, and Society Expected 2023
University of Florida

M.S., Criminal Justice April 2019
University of North Florida

B.S., Psychology and Spanish May 2017
Criminal Justice (Certificate)
University of Wisconsin-Madison

Professional Experience

Graduate Teaching Assistant August 2018-Present
Department of Criminology and Criminal Justice
University of North Florida

Distance Learning Coach August 2017-May 2018
Department of Criminology and Criminal Justice
University of North Florida

Legal Studies Teaching Assistant/Peer Mentor January 2017-May 2017
Criminal Justice Program
University of Wisconsin-Madison

Peer to Peer Student Debriefe August 2016-March 2017
University of Wisconsin Police Department

Probation and Parole Intern May 2016-August 2016
WI Department of Corrections, Division of Community Corrections
Publications


Extracurricular Experience

Vice President September 2018-Present
Alpha Phi Sigma-Pi Omega (National Criminal Justice Honor Society)
University of North Florida

Criminology and Criminal Justice Club January 2018-Present
University of North Florida

Honors and Awards

*Student Government Travel Grant* March 2019
University of North Florida

*Herfurth-Kubly Award for Initiative and Efficiency* nominee January 2017
University of Wisconsin-Madison

*Dean’s List* Fall 2016, Spring 2017
University of Wisconsin-Madison

*Honored Student Award* April 2015
University of Wisconsin-Madison

Professional Memberships

Alpha Phi Sigma (National Criminal Justice Honor Society)
Academy of Criminal Justice Sciences
Southern Criminal Justice Association