The Costs and Benefits of Recovery Service Programs

December 2011

Carol Robison,
Principal Author

The views expressed are those of the author and should not be attributed to the members of the Correctional Institution Inspection Committee, or any member of the Ohio legislature.

Acknowledgments

This paper would not be possible without the assistance and cooperation of numerous individuals. First and foremost, we are grateful to Dr. Edward Rhine, Deputy Director of the Office of Policy and Offender Reentry, and Mr. Rod Woods, Chief of the Bureau of Recovery Service Programs, at the Ohio Department of Rehabilitation and Correction Operation Support Center. In addition, much appreciation is extended to numerous recovery services program facilitators and coordinators in Ohio's correctional institutions, including the following Recovery Services Supervisors, Mr. Dale Friel, Ms. Kristen Faine, Mr. Mark Cowart. All of these individuals exude remarkable commitment and skills as they provide recovery services programs to hundreds of individuals in Ohio prisons. We further extend appreciation to Dr. Edward Latessa at the University of Cincinnati for his insights into data collection, and to Mr. Jeff Golon, Division Chief, and Mr. Joseph Rogers, Senior Budget Analyst, representing the Legislative Service Commission, for their assistance in assuring that the most current budget data was represented in this report. Through the collective efforts of many highly-skilled people, recovery services programs are poised to continue to make a positive difference in thousands of lives over the coming years.

About CIIC

The Correctional Institution Inspection Committee (CIIC) is a legislative committee of the Ohio General Assembly that maintains a continuing program of inspection of each state correctional institution used for the custody, control, training, and rehabilitation of persons convicted of crime. Per Ohio Revised Code Section 103.73, CIIC has the authority to evaluate and assist in the development of programs to improve the condition or operation of correctional institutions.

Table of Contents

Introduction	4
Key Findings	5
Recommendations	7
Overview of Recovery Service Programs	9
The Cost of Recovery Service Programs	11
DRC Program Observation	17
National Research on Recovery Service Benefits	20
Conclusion	27
Appendix and Endnotes	28

INTRODUCTION

Since the 1990's, state legislatures have considered costs associated with incarceration and costs of recovery services programming offered in the correctional system. The subject has received legislative attention because substance abuse-related crimes have increased dramatically over past decades.[1] Legislators and agency administrators have also sought an understanding of cost savings realized through a reduction in recidivism among offenders who have completed recovery programs.

Substance abuse carries multiple individual and societal costs.[2] Individual costs include pain and suffering for the addicts and their families, domestic instability, and the loss of wages and health.[3] Private losses are difficult to quantify and capture, and while important, are not the focus of this report. Costs that are borne by society may include costs of incarceration and fund transfers associated with welfare payments to abusers' victims, caregivers, and dependents.[4] Costs associated with recovery services for offenders in state prisons is the primary focus of this report.

Overall, several clear conclusions can be drawn. First, recovery service programs have demonstrated tentative success at reducing recidivism. Second, the programs provided in the Ohio corrections system are both "very good," as rated on a number of factors, and they are consistently audited by corrections staff to ensure fidelity to policies and procedures. Last, national research regarding recovery service programs shows that such programs result in significant cost savings to the tune of $7 or more dollars' return for each dollar spent in programming.

The following section outlines the key findings and recommendations stemming from the report. A summary of fiscal data is provided, followed by program observations conducted by CIIC and an analysis of a national literature review. Research results and a few program descriptions are provided to illustrate the national significance and national research on the benefits of recovery service programs.

KEY FINDINGS

After a literature review, including reports published by the Ohio Department of Rehabilitation and Correction (DRC), multiple observations of DRC recovery programs, and interviews with DRC Recovery Services administrators and staff, the CIIC offers the following findings.

1. Recovery Services programs create cost savings because program completers have lower rates of recidivism.

- The DRC completed an evaluation of a core program in recovery services. The study tracked one-year recidivism rates for program *completers* compared to program *non-completers* released in three categories. Data showed that program completers averaged 3.4% less recidivism than non-completers.[5]

2. Partnerships between the DRC and Recovery Services related agencies, such as the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) or community-based programs that can provide continuity of care post-release, lead to a reduction in recidivism.

- *Tapestry* and *OASIS* are two programs produced through the DRC and ODADAS collaboration. The programs, which are examples of Therapeutic Communities, are known for their effectiveness with clients.
- Programs that begin within prisons and extend into post-release programs, such as those found in community correctional centers, have been shown in research at the University of Cincinnati to produce lower incidents of recidivism.

3. The current Recovery Services programs are consistently audited by DRC Operation Support Center staff, who ensure that department-wide policies are followed, and who plan to include program observations in the future.

- DRC Recovery Services staff in the Operation Support Center maintain an ongoing and active schedule of auditing institutional programs, ensuring program fidelity and compliance with DRC policies.

4. CIIC observations of recovery service programs revealed all programs were given an overall 'very good' rating based on program strengths in areas of classroom management, curriculum and instructional materials, and instructional strategies or methods.

- Ratings were based on the following types of observations:

    - Facilitator instructional style was active rather than passive.
    - Facilitators exercised sensitivity and respect to all inmates.
    - Facilitators made efforts to engage every inmate within a group session.
    - Facilitators assumed and cultivated the sincerity of clients in attendance using verbal interviewing strategies.
    - Instructional materials and pedagogy were primarily interactive during sessions.
    - Curriculum included stated goals, which were referenced throughout the sessions.
    - Curriculum design included applications to assist in transferring program principles to life situations.
    - References were made to cross-over service options, so the client might begin to envision and construct a support system as part of his bridge to his future.

5. Numerous states have completed studies that indicate both cost savings generated by Recovery Services programs and innovative thinking regarding alcohol and substance abuse.

- At least 14 states were noted from the literature during the preparation of this report. California began studies in the early 1990's and showed an initial cost-benefit ratio of 7:1. For every $1 spent on recovery service programs, $7 was saved in future costs through reductions in recidivism among program completers. Texas studies showed the 'drug court' option produced cost-benefits up to $9.43:$1.00 and South Dakota studies showed cost-benefits of prison recovery programs at $8.43: $1.00.

RECOMMENDATIONS

In a series of discussions with DRC staff, CIIC found that many of its recommendations were readily agreed-upon by DRC staff and were in fact already in the process of being implemented. Therefore, the following is a list of mutually agreed-upon improvements for Recovery Services. CIIC will conduct a follow-up evaluation of Recovery Services in two years to determine whether DRC accomplished the goals set forth.

1. Given the fiscal benefits to Ohio taxpayers due to the reduction of recidivism, the DRC should work to improve access to Recovery Services programs.

- The DRC should continue to seek federal funding that will supplement state funds.
- Creative measures may need to be taken, such as the encouragement of inmate-led recovery groups, creation of recovery service related housing areas, and recruitment of volunteers.

DRC Action Plan

- Develop and implement Dual Diagnosis Programs in 3 institutions by June 2012.
- Develop and implement Family Programs in 10 institutions by December 2012.
- Increase contact with the Tapestry Alumni and Winners Circle Peer Support Groups in all institutions by June 2012.
- Develop and implement Recovery Units in 10 institutions by December 2012.

2. The DRC should conduct ongoing studies that evaluate the effectiveness of the programs in terms of recidivism.

- To ensure that expected reductions in recidivism (and therefore cost savings) are in fact occurring, an ongoing series of evaluations and studies should be implemented for each Recovery Services program.
- In addition, the DRC should continue to identify current specific program traits that correlate with high ‘effect levels,’ and continue giving consideration to specific program components and attributes that constitute ‘best practices.’ A continued review of successful and innovative programs implemented in other states is recommended as part of that ongoing investigation.

DRC Action Plan

- Conduct a recidvisim evaluation by December 2012 of inmates who completed the Recovery Services Intensive Outpatient Program during 2009 and 2010.

3. The DRC should continue its internal auditing to ensure successful program delivery and program fidelity. The DRC may develop measurements of program fidelity and track the results of those measurements.

DRC Action Plan

- All DRC Recovery Services programs will receive Ohio Department of Alcohol and Drug Addiction Services certification by August 2012.
- All Recovery Services Reentry approved programs will participate in the Univesity of Cincinnati programs evaluation by June 2013.

4. The DRC should continue to seek additional collaborative and cost-saving partnerships with agencies and local entities to develop an expanded network that may include service providers from the private sector, non-profit organizations, academia, and religious institutions.

DRC Action Plan

- Recovery Services will partner with the Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Mental Health and selected community partners to submit at least 3 Federal Second Chance Act grants by Decemeber 2012.

OVERVIEW OF RECOVERY SERVICE PROGRAMS

The Ohio Department of Rehabilitation and Correction (DRC) is committed to providing a comprehensive continuum of alcohol and other drug (AOD) treatment services. The continuum begins at DRC reception centers where inmates receive an AOD screening. For inmates with AOD problems, the next phase of the AOD treatment continuum is provided at parent institutions. A variety of treatment services are offered based on the institutional mission, physical capacity and staffing. Inmate participation in these programs is voluntary.

Upon completion of a treatment program, the counselor works with the inmate to develop a continuing care plan. This plan will include participation in institutional AOD continuing care activities while incarcerated and community care when released. AOD services for offenders under DRC supervision in the community are coordinated by eight Chemical Dependency Specialists (CDS). The CDS' are responsible for developing treatment resources, making referrals, providing AOD assessments and interim services.

The Bureau of Recovery Services utilizes a cognitive-behavioral approach which is an evidenced-based intervention that has been shown to be effective with criminal justice population. Additional ancillary services include peer support / self-help goups, alcohol and other drug education, smoking cessation and services to those with co-occurring disorders of substance abuse and mental illness.

Substance abuse treatment programs consist of the following:

- Therapeutic Community (TC) – A treatment modality that uses an inmate hierarchy in which treatment stages are used to reflect personal and program growth. The TC treatment regime lasts approximately 12 months. There were 526 inmates that participated in the TC program during fiscal year 2011.
- Intensive Program Prisons (IPP) – A 90-day program focusing on substance abuse treatment/DUI programs designed to provide intensive programming for eligible inmates in accordance with Ohio Revised Code 5120.032. Upon successful completion of this program, the inmate's sentence may be reduced to 90 days and the inmate will then serve a transitional type of detention followed by a release under post-release control sanctions or, in the alternative, will be placed immediately under post-release control sanctions. There were 245 inmates that participated in the IPP during fiscal year 2011.
- AOD Treatment Readiness Program – The AOD Treatment Readiness Program is a 60-hour program delivered daily for a minimum of 15 hours a week. A minimum of ten of the hours must be cognitive behavioral treatment specific. The remaining hours shall consist of ancillary services. This program incorporates the stages of change model to focus on participant motivation and readiness that will enhance treatment engagement and retention.

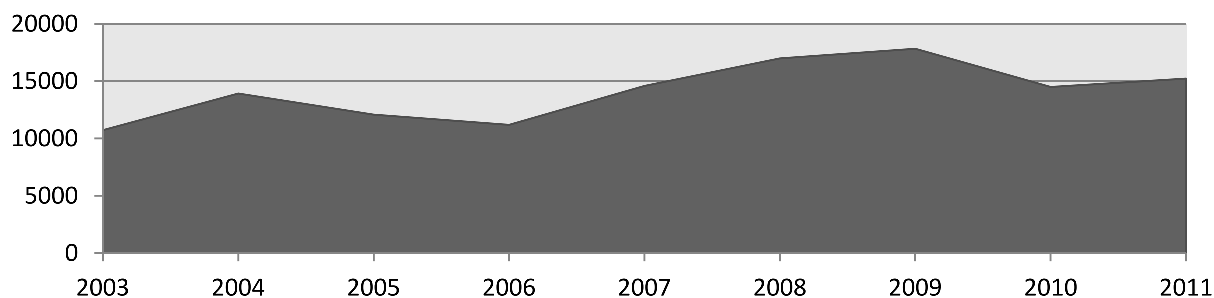
- Intensive Outpatient Program (IOP) – The Intensive Outpatient Program is a 180-hour program that provides treatment services delivered daily for a minimum of 15 hours a week. A minimum of ten of the hours must be cognitive behavioral treatment specific. The remaining hours will consist of ancillary services. This program is offered to Recovery Level 2 and 3 inmates. There were 2,778 inmates that participated in the IOP during fiscal year 2011.
- Continuing Care Services – Recovery services provided following the successful completion of a Recovery Services Treatment Program that consists of two 1-hour professionally facilitated group meetings per week for a total of 8 weeks (16 sessions).

To supplement the provision of Recovery Services programming the Department has partnered/collaborated with the Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Mental Health and two community partners in gaining federal funding for substance abuse treatment in two institutions.

- Succeeding at Home Grant – in partnership with the Columbus Area Mental Health agency a Second Chance Act grant was secured to provide treatment services to inmates with co-occurring disorders of substance abuse and mental health.
- Bridges to Success – The Lucas County Treatment Alternatives for Safer Communities (TASC) secured funding to provide case management and continuing treatment services for inmates with children at Northeast Pre-Release Center returning to Lucas County.

A full list of recovery service programs provided in the DRC as of July 2011 is shown in Table 2 and a detailed breakdown is provided in the Appendix.

Despite a decreasing budget over the past few years, Recovery Services staff have been able to maintain services for a consistent number of inmates. The following chart provides a breakdown by fiscal year of the total number of inmate participants in Alcohol and Other Drug (AOD) programs.[6]



THE COST OF RECOVERY SERVICE PROGRAMS

The following sections provide an overview of public institutions' attempts to address the issue of substance abuse within the community, as well as a detailed discussion of the current costs of recovery service programs within Ohio specifically.

A. ADDRESSING SUBSTANCE ABUSE

The societal costs of substance abuse are ultimately incurred at taxpayer expense and may go beyond costs associated with state incarceration and rehabilitative treatment of convicted substance abusers. In the aftermath of substance abuse and violation of laws, public monies may be spent for police protection, prosecution, courts, community corrections (probation/parole), incarcerations (jail/prison), victim losses, theft losses, outpatient care, inpatient care, emergency room, outpatient mental health, inpatient mental health, loss of legal earnings, and welfare and disability "transfers."[7] In determining the appropriate levels for society of any activity, government is interested in the cost that the activity imposes on the rest of the community. Thus, from the point of view of public policy, it is the social (direct) costs that are primarily considered, not private (indirect) costs.[8]

Motivated by a desire to reduce publicly-funded expenses and realize cost savings in the government domain, the substance abuse problem has merited legislative attention regarding how the prison recidivism rate can be lowered among substance abuse offenders who have completed recovery services programs. In recent years, several states have conducted studies in search of effective ways to favorably address substance abuse among its incarcerated citizens. California's CALDATA study in 1993 has been noted as the first state effort to identify and determine "cost offsets" associated with recovery services programming provided to offenders. Reportedly, in recent years, Washington State has done a number of well-regarded cost offset studies.[9]

Research completed at the University of Cincinnati has indicated that among effective programs producing favorable results, the therapeutic and extended community corrections model has shown itself to make a difference.[10] The extended community corrections model supports the development of life skills, development of familial reconnections, development of employable skills through education, thinking skills, behavior management skills, and the integration of pro-social attitudes. The community corrections model moves the client beyond thoughtful introspection to functional and purposeful actions associated with self-management.

The size of the problem has also weighed upon government officials to identify a corrective course of action. Over the past two decades, the overall number of offenders admitted to prison in Ohio has steadily increased and drug offenders have historically outnumbered other offenders. Most notably, between year-end 1982 and mid-year-1998, Ohio's prison population nearly

tripled in size from 17,147 to 49,029, before the rate of admissions slowed.[11] The dramatic increase from admissions was largely driven by a surge in admissions for drug offenses.[12]

As the prison population increased during the past 25 years, so has spending on the criminal justice system. In 1986, the total was just $15 billion, adjusted for inflation.[13] In 2001, state spending on corrections totaled $38 billion. Spending on corrections represents the fastest growing part of most state budgets, eclipsing Medicaid. Approximately 80 percent of money spent on corrections ($30.4 billion) was spent specifically on the aforementioned inmates who committed a crime while under the influence, to raise money to support their habit, or any drug- or alcohol-related offense. [14]

B. FISCAL SUMMARY

Measurable costs begin at reception into the penal system. Various actual costs associated with drug offenders may be tracked, with the primary cost to the state being the cost of prison incarceration. The DRC determined the annual average cost for an inmate in one of its prisons to be $25,345.60 as of July 2011.[15]

In 1995, there were 10,266 offenders who were provided with alcohol and other drug services, with another 1,500-plus on waiting lists.[16] In 1997, a comprehensive strategy for addressing the needs of offenders receiving substance abuse services under the supervision and care of the ODRC was framed and published as the Ohio Plan (Ohio Plan for the Treatment of Alcohol and Other Drug-Impacted Offenders under the Supervision of the Ohio Department of Rehabilitation and Correction). During a period of more than two decades, recovery services has grown from two agency employees to a system of credentialed and certified staff and supervisors who deliver evidence-based recovery service programs.[17]

Funding for Ohio’s recovery services programs is predominantly derived from appropriations to the General Revenue Fund, GRF Line Item 507321, Institutional Recovery Services. Additional funds are supplied from commission revenue generated in Fund 4D4 from telephone systems established for inmate use in the institutions.[18] The 4D4 funds are used for the salaries of supervisors and the costs of contracted services delivered through the Department of Administrative Services, currently in three locations. Contracted services are in place at Grafton Correctional Institution (Therapeutic Community), Belmont Correctional Institution (Therapeutic Community), and at the Franklin Pre-Release Center.[19]

Ohio's Appropriations and Expenditures. The General Revenue Fund line item appropriation pays for a range of alcohol and other drug (AOD) treatment services for inmates under the jurisdiction of the DRC. The amount of the allocation supports payroll-related expenses, purchased personnel services, supplies, and maintenance.

Appropriations and expenditures were reviewed for GRF 507321, Institutional Recovery Services. Fiscal data for the previous four fiscal years, FY 2008 through FY 2011, is shown in the following table.[20] Appropriations for the current FY 2012 and upcoming FY 2013 are also shown.

Final appropriations for GRF 507321 for FY 2010 amounted to $5,025,028, which was a reduction of $2,540,144, or 33.6 percent less than the actual $7,565,172 expenditures for recovery service programs for FY 2009. The GRF appropriations for FY 2011 amounted to $5,899,110, which was 17.4 percent more than the amount appropriated for FY 2010, but still $1,666,065 less than the actual expenditures in FY 2009.

Table 1.
Fiscal Year Appropriations and Expenditures
General Revenue Fund – GRF 507321

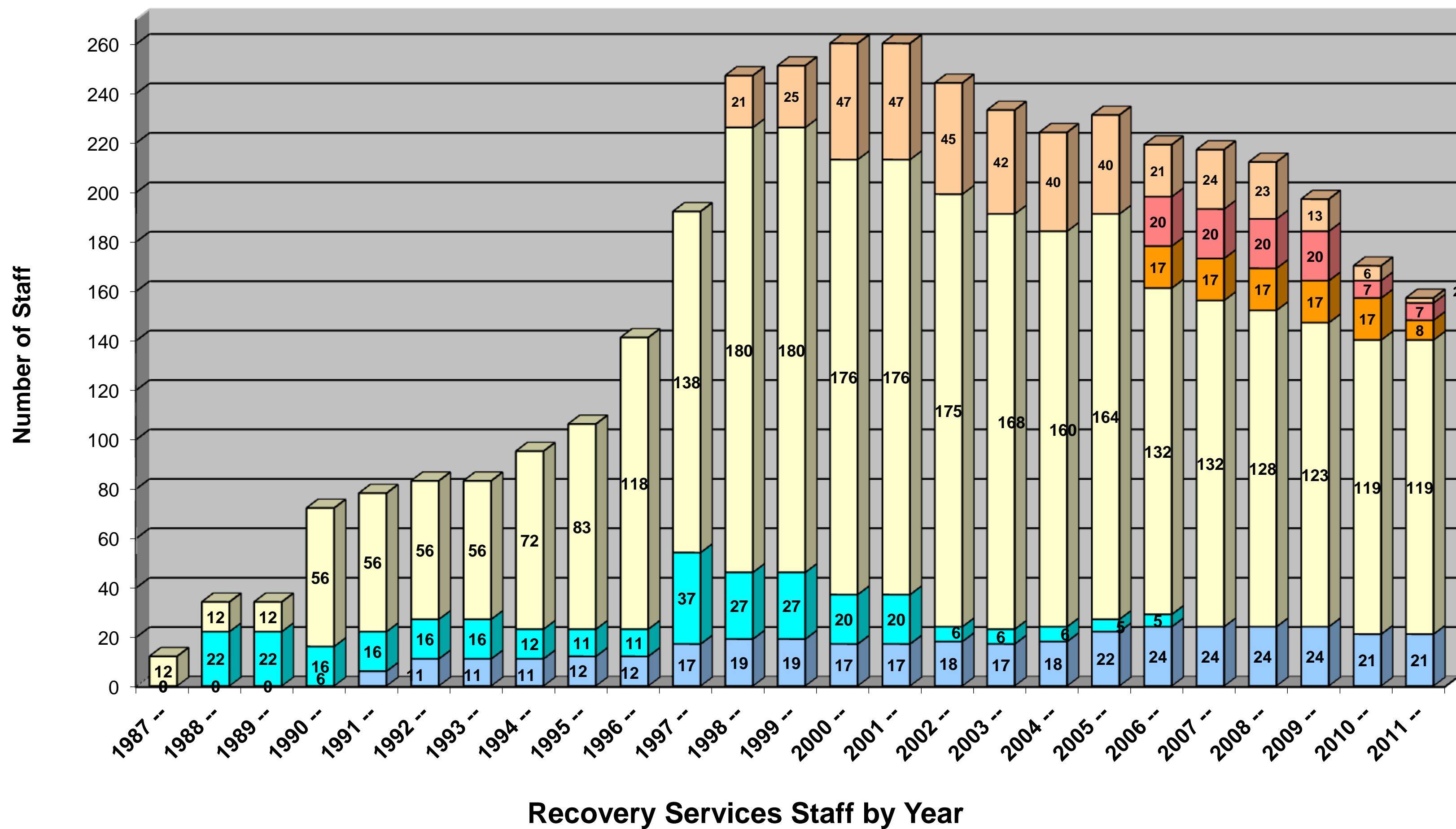
Fiscal Year	GRF Appropriation	Actual Expenditures	Variance
FY 2008	$7,319,028	$ 7,269,155	-$ 49,873
FY 2009	$7,664,520	$ 7,565,172	- $ 99,348
FY 2010	$ 5,025,028	$ 4,865,989	-$ 159,039
FY 2011	$5,899,110	$ 5,732,069	-$ 167,041
FY 2012	$5,786,109		
FY 2013	$5,375,737		

Looking forward to FY 2012, the final GRF appropriation is $5,786,109 for institutional recovery services. This appropriation is $54,040 or 0.9% increase over the FY 2011 actual expenditures of $5,732,069. The final appropriation for FY 2013 is $5,375,737, which is $410,372, or 7.1%, less than the FY 2012 allocation.[21]

With these appropriations, DRC staff indicated in Spring 2011 that it would be unlikely that the current level of institutional recovery services could be maintained in the next biennium (FY 2012 – FY 2013). There were no specific plans indicated at that time, except that there would be a mix of cuts in personnel and program services.[22]

Staffing for Recovery Services through GRF 507321. In the spring of 2011, as the Main Operating Budget was under development, DRC staff estimated that planned allocations would support approximately 65 full time employees (FTEs) in both FY 2012 and FY 2013.[23]

The following chart displays the historical increase and decrease in staff over a recent eight-year period.[24]


Recovery Services Staffing Pattern 1987 - 2011
Number of Staff
Recovery Services Staff by Year
ODADAS
Grant
Institution
APA
Private
Contract

Continuum of Services and Costs per Inmate. The DRC provides substance abuse programming ranging from *residential treatment programs* that focus on education to *self-help groups*. In FY 2002, the DRC provided nearly 14,000 inmate participants with various forms of substance abuse recovery programming in the institutions.[25] In FY 2010, there were 14,495 inmates who received a range of recovery services programming.[26] The breakdown of programs is shown in the following table:[27]

Table 2.
Recovery Services Provided to ODRC Inmates – FY 2010

PROGRAM	**PARTICIPANTS**	**PERCENT of Recovery Population**[28]
Self-Help Groups	6,059	41.8
AOD Education	4,079	28.1
Intensive Outpatient	2,052	14.2
Therapeutic Community	529	3.6
Outpatient	501	3.5
Tobacco Cessation – Voluntary	380	2.6
Residential Unit	360	2.5
Substance Abuse and Mentally Ill (SAMI)	275	1.9
Intensive Program Prison	260	1.8
TOTAL	14,495	100%

Curriculum Materials and Costs. Some recovery program groups use curriculum materials that may be teacher-made and/or purchased from a specialty publisher. The *Intensive Outpatient Program (IOP)*, for example, uses a published recovery program curriculum published by The Change Companies with a 2004 copyright. One noted instructional feature of the materials is *Interactive Journaling®,* which engages the inmate in reflective and constructive thinking and *writing* regarding his past and future.

The Recovery Services staff reportedly has maintained a consistent cost for the Change Company curriculum materials over the four-year period from FY 2007 to FY 2010. The approximate annual cost per inmate in a three-month program with the materials has been $20.25 and the monthly cost for a six-month program has been $24.36.[29]

The total cost to acquire the Change Company curriculum in FY 2011 was reported at $97,196.40, amounting to an approximate cost of $30.61 per inmate.[30] At that cost, approximately 3,175 inmates are presumed able to participate in the program. In FY 2010, there were approximately 2,042 inmates who participated in the Intensive Outpatient Program (IOP) through the prisons and would have potentially used the curriculum materials. As of January

2011, there were reportedly 662 inmates participating in the Intensive Outpatient Program (IOP).[31]

Assessments - No Costs. Alcohol and drug screening and assessments are completed for all inmates as part of the mental health screening process.[32] Further, the Bureau of Recovery Services utilizes the Texas Christian University Drug Screen II (TCU) upon intake to determine the Recovery Services Level (RSL), which guides program recommendations for inmates. The TCU is a public domain screening tool; therefore, there is no purchase cost incurred.[33] Assessments of inmate needs cannot be avoided because it is through structured and specific assessments of 'criminogenic needs' that programming may be individualized to each inmate. The literature indicates that inmates benefit more from programming that targets their specific needs than from completing every available recovery program.[34] Assessments and subsequent selective programming should constitute one way to manage costs.

Drug Testing – No Costs to Recovery Services. Initial testing for drugs is conducted on every inmate at intake. The reported cost to conduct the initial drug screening or test per inmate is not part of the costs associated with the recovery services programs. After inmates are transferred to their parent institutions and recovery programming has begun, subsequent drug tests are conducted periodically. The costs for follow-up drug tests are likewise not incurred as part of the recovery services budget.[35]

Variances in Costs and Program Effectiveness Associated with Location or Program Site. Programs provided in various locations carry different costs. The DRC has historically recognized the need and value of effective recovery services within prisons and within alternative locations, such as community-based sites.

From that perspective, the collaborative model of engaging offenders in community-based recovery programs after incarceration in a state prison or in lieu of a prison sentence may create cost savings when program completers do not enter or return to prison. Embracing a "cross-over" model has become a viable option in the delivery of recovery services to clients. Research conducted at the University of Cincinnati also found that a favorable solution lies in directing offenders toward programs that are extended into the community sites after prison incarceration.[36]

DRC PROGRAM OBSERVATIONS

Program 'effectiveness' has been identified as a program's ability to make a positive difference toward attaining specified goals, for example, the reduction in recidivism. A variety of program traits may be noted in conducting evaluations of programs. The process of gathering data involves collecting evidence. Effective evidence-based programs are those that produce evidence of success, shown as measurements of data, in targeted areas. Recovery programs in current use through the DRC are those that are deemed evidence-based and effective. Efforts toward program improvements are continuous.

Program observations offer opportunities to collect anecdotal notes on the traits of programs in real time; and structured reviews of client files offer opportunities to collect data regarding record-keeping. CIIC staff collected data from guided observations of recovery programs and a standardized file review. CIIC research conducted this research between February and April 2011. Client files were found to be complete, well-organized, and consistently maintained. CIIC observations of recovery service programs revealed all programs were given an overall 'very good' rating based on the following synopsis of program strengths in areas of classroom management, curriculum and instructional materials, and instructional strategies or methods:[37]

- Facilitator instructional style was active rather than passive.
- Facilitators exercised sensitivity and respect to all inmates.
- Facilitators made efforts to engage every inmate within a group session.
- Facilitators assumed and cultivated the sincerity of clients in attendance through verbal interviewing strategies.
- Instructional materials and pedagogy were primarily interactive during sessions.
- Curriculum included stated goals, which were referenced throughout the sessions.
- Curriculum design included applications to assist in transferring program principles to life situations.
- References were made to cross-over service options, so the client might begin to envision and construct a support system as part of his bridge to his future.

The instructional climate within a classroom is directly linked to a facilitator's instructional style and skills, strategies employed, attitude toward students, knowledge and passion for the subject, and even personality. CIIC staff observed the instructional climate within numerous recovery service program groups and class sessions. In addition to the pervasive program strengths previously mentioned, many details of individual groups and sessions were noted over the approximate three month observation period. Attention was focused on the impact these details made on the instructional climate within the groups. The Appendix provides an additional summary of program observations and reflections on these noteworthy details for contemplation.

In an effort to assure program fidelity and policy compliance, the Bureau of Recovery Services conducts scheduled internal audits of each of the institutional recovery service operations. Through *Site Evaluation Visits (Onsite Visits)*, the central office recovery services program administrators document findings associated with recovery programs and issue an evaluation. A CIIC review of the evaluation documents applicable to the internal audits revealed consistency in terminology and criteria from which ratings were derived. The DRC audit process, gleaned from data that is provided in the report, includes the following steps:

- Verification that the Recovery Services Program Manual is up to date and available.
- Staff schedules are current and available.
- Program schedules are accessible and programs are described.
- Earned credit documentation is reviewed for orderliness and compliance with departmental policy.
- Evidence is noted of coordinated efforts or cross-over services among recovery services, the Deputy Warden of Special Services, medical, and mental health.
- Data relevant to the Intensive Out Patient (IOP) Cognitive Behavioral Therapy (CBT) Programs is captured in a database and is checked for compliance.
- Cumulative DUI Inmate screenings are recorded.
- Group Observation is conducted: Cognitive behavioral therapy program is monitored and rated using a numerical scale ranging from (1) Unacceptable to (5) Excellent. Anecdotal explanations for numerical ratings are provided for each rated category. Ratings are given in the following categories: Staff Rating, Client Participation, and CBT Exercise(s) Used during the Observed Visit.
- Record Check is completed by the administrators from the DRC Operations Support Center (central office). The record check includes a rating for the integration of services, and an evaluation of active charts and discharged charts.

Further, the DRC offered evidence of the agency's overall knowledge, ongoing work toward achieving program effectiveness, and efforts to reduce recidivism through the publication, *What Works? General Principles, Characteristics, and Examples of Effective Programs,* reported in January 2010. Based on decades of DRC experience, literature reviews, and primary research, the DRC framed a set of principles and characteristics of effective programs. Each of the following program principles and characteristics could be interpreted as various parts or degrees of an overall recovery program 'action plan' and provides evidence of DRC commitment to recovery programming that works. The following table displays the seven principles and characteristics of effective programs, as shown in the report.

Table 3. **Principles and Characteristics of Effective Programs**[38]
1. Programs should adhere to the "risk principle." 2. Programs should target the criminogenic needs of offenders who are assessed as having a need in a particular area. 3. Take steps to ensure that the program is implemented well and that the program integrity is preserved. 4. Treatment programming should use cognitive-behavioral and social learning strategies. 5. Address offender responsivity (i.e., the skills needed for program success). 6. Program structure and activities should reach out into the offender's real-world social network, when possible. 7. Aftercare services, continuity of care in the community, and relapse prevention are very important for offenders reentering the community after imprisonment.

The identification of these principles and characteristics indicates a knowledge of "what works" that has been effectively applied in the Ohio correctional system and consistently verified through the internal auditing process.

Numerous states have attempted to capture the behavioral and fiscal benefits of recovery service programs. In Ohio, the DRC recently completed an evaluation for a three-year period during 2006 – 2009 of the Intensive Outpatient Program (IOP), a core program in recovery services. The study tracked one-year recidivism rates for program *completers* compared to program *non-completers* released in three categories. Data showed that program completers averaged 3.4% less recidivism than non-completers.[39] In a fiscal sense, these numbers indicate the number of offenders that taxpayers are not paying to house in a state facility.

The DRC study also compared the recidivism rate between program participants (both completers and non-completers) versus the DRC total recidivism rate. That contrast was smaller at a difference of less than one percent; however, it is noted that individuals who enter a recovery program are known to have a greater likelihood of recidivism. The Department has indicated a continuation of studies to examine group results over longer periods of time and to analyze individual program results to evaluate which programs are producing better results.[40]

To make a comparison, the below table provides a concise breakdown of individual states' research efforts regarding recovery services programs. Following the table is a more extensive discussion of additional state initiatives and follow-up studies, including efforts in this area in Ohio.

Table 4.
Summary of State-by-State Research Efforts and Actions to Reduce Costs to Agencies Associated with Substance Abuse[41]

State and Study	Actions Taken and/or Conclusions Indicating an Economic Benefit of Substance Abuse Treatment
California: CALDATA [Study in 1993 used a representative sample of 2,000 from the public Substance Abuse (SA) treatment system from a population of 150,000]	• Reductions/savings = $1.4 billion/year • Treatment cost = $209 million • Cost offset = 7 to 1 • Average discharged client received $10,000/year in benefits, sustained up to 2 years after treatment • Avoided crime comprised 90% of benefits
California: 2007	• Replication of the CALDATA study showed average treatment costs of $1,583 associated with a monetary benefit to society of $11,487 or7:1 ratio (benefits:costs). • Benefits were derived from reduced costs of crime and

	increased employment earnings.
California: 2008	• Diversion program results showed cost savings of 2:1 ($2 was saved for every $1 invested) • Program subsequently reduced incarceration costs
Washington: 1997-2007	• 12 separate studies spanning 1997 through 2007 on substance abuse treatments – summaries include costs and cost-savings associated with treatments. Targeted areas include costs associated with Medicaid and Medical/Health Care. Fiscal highlights of four of the completed Washington studies: o 1997: Indigent clients receiving treatment had Medicaid expenses $4,500 less than similar untreated clients; with savings consistent over five years. o 1997: Average Medicaid clients receiving treatments at a cost of $1,779 showed a benefit (savings) of $692 or $0.38 on each dollar per client. o 2003: Half of clients in treatment group received treatment, half did not. Clients receiving treatment reduced monthly medical costs by $311/month, reduced arrests by 16%, reduced convictions by 15%, and reduced felony convictions by 34%. o 2007: Using a population of Medicaid clients presenting in hospital ERs: some received treatment and some did not. Clients receiving treatment posted a monthly reduction in total medical costs ranging from $157 to $202, and reduction in inpatient hospital costs of $115 to $178. The full reduction in costs produced by the treatment group was offset (lowered) due to an increase of $35 per client for ER visits.
Virginia: 2006	Study revealed that the adverse effects of substance abuse generated a cost to State and local governments of approximately $613 million. To mitigate these effects, State and localities spent $102 million on substance abuse services.
Utah: 2005 Drug Court	Cost-benefit return for the drug court model was approximately $4.29 return for every $1 invested in the program. The cost-benefit figure takes into account a reduction in recidivism and reduction in costs to victims due to lowered recidivism.
Texas: 2002 Drug Court	Study of a 40-month post-treatment period showed a benefit to cost ratio of $9.43 saved for each $1 spent on clients participating in a diversion drug court program.

South Dakota: 2005	Studies that assessed five areas, including criminal justice-*prisons*, showed a benefit to cost ratio of $8.43 saved for each $1 spent on clients receiving treatment.
Oregon: 1996	Two-year study (1991-1992) revealed benefit to cost ratio of $5.60 saved for each $1 spent on client treatment.
Oklahoma: 2004 Drug Court	Two-year study (2001-2003) projected four-year savings of using drug court instead of prison for 1,666 offenders with an estimated 4-year cost savings of $46,646,178, or $11,661,545 per year.
New York: 2000 Drug Court	Report showed annual incarceration costs of $29,000 - $47,000, an average annual cost of $18,400 for residential drug treatment, and $5,100 for an outpatient program.
Michigan: 2008	Estimates show benefit to cost ratio in a range of $4.00 to $7.00 saved for each $1.00 spent on client addiction treatment. Additional estimates show some outpatient programs may produce a benefit to cost ratio of 12:1.
Maine: 2005	Study showed total costs associated with substance abuse treatment to be $25.2 million and costs associated with (substance abuse) crime to be $214.4 million. The benefit to cost ratio amounts to $8.50 saved for each $1.00 spent on client treatment.
Louisiana: 2003	Study concluded for each $1.00 spent on substance treatment programs, there will be a reduction of expenditures on criminal justice, medical care, and public assistance of approximately $3.83. The benefit to cost ratio is $3.83 saved for each $1.00 spent on treatment.
Kentucky: 2006	Fiscal year 2006 showed a benefit to cost ratio of $4.98 saved for every $1.00 spent on treatment.

CALIFORNIA

California Follow-Up. Following the first years in the early 1990s of implementation of the research in California, the National Institute on Drug Abuse (NIDA) published that researchers from the University of Chicago's *National Opinion Research Center* found during 1991 and 1992 that the use of crack cocaine, cocaine powder, and amphetamines declined by almost one-half after treatment. Heroin use reportedly dropped by one-fifth, and alcohol use reportedly fell by nearly one-third. The NIDA report on the California study concluded that it would take years to evaluate long-range taxpayer savings attributable to treatment, but all forms of drug abuse treatment showed some returns immediately after treatment. The NIDA report indicated that only one key study finding was not fiscally promising: Patients typically lost income while they were undergoing drug abuse treatment, and their financial condition did not improve immediately after treatment. The reason cited was that clients typically worked in the year

before treatment, lost or quit their jobs to undergo therapy, and then started working again at a lower pay after treatment.[42]

On January 25, 2011, the Public Information Officer (PIO) for the State of California relayed to CIIC staff that the current ratio of benefits to costs, as seen as cost savings, in California has evolved from the early 1990's ratio of 7:1 to approximately 4:1. For each $1.00 spent on programming, approximately $4.00 is reportedly saved in costs associated with the substance abuse offender and otherwise incurred by the state at taxpayer expense.[43]

California - Recovery Treatment Outcomes - ReducingMedicaid Costs. As reported in 2002, while monitoring treatment clients in California as part of the California Treatment Outcome Project (CalTOP), it was discovered that the average cost of a hospital night for a substance abuse client nine months *before treatment* was $1,380 and the average cost of a hospital night for a substance abuse client nine months *after treatment* was $1,008, which is a nightly savings of $372. *Before treatment*, the average cost of an emergency room visit was $631, and *after treatment*, the average cost was $408. It was determined, therefore, that the state's system for substance abuse treatment produced cost offsets in areas associated with health care.[44]

ILLINOIS

Two innovative drug treatment programs were developed and continue in Illinois. The *Sheridan National Drug and Reentry Program*, located at the Sheridan Correctional Center, which re-opened on January 2, 2004, specifically targets medium-security, male, drug-involved offenders. Second, the *Meth Prison and Reentry Program* at Southwestern Illinois Correctional Center serves as a 200-bed location for delivery of centralized and specialized services.[45] The Sheridan program uses a holistic approach to equip offenders to return to drug-free, crime-free lives upon release. The following characteristics comprise some of the defining traits of the Sheridan program:

- The Sheridan Correctional Center consists of 75 buildings, comprised of 600,000 square feet, with 13 housing units and a 90-bed health care unit. The facility sits on 270 acres with 80 acres insider the perimeter fence. The Center has an operational capacity of 1,710 inmates and a population as of May 31, 2011 of 1,653 inmates, which reflects bed space capacity as outlined in a *July1, 2011 Quarterly Report to the Legislature*. The average cost per inmate at Sheridan Correctional Center is published at $43,607.
- Treatment interventions and access to other services are coordinated from the outset of incarceration.
- Clinical 'best practices' gleaned from other state programs are implemented into the Sheridan program.
- The program uses a modified 'therapeutic community' model.

- Staff collaborates with other organizations to integrate job preparation programming, clinical reentry management services, and community reintegration, including continuing care provided by community-based substance abuse treatment providers.
- Eligibility structure is somewhat unique in the nation because it takes a medium-security general population, and because it takes offenders with three lengths of sentences (6-9 months, 9-12 months, and 12-24 months), whereas most facilities take a smaller minimum-security population with a more specific sentence period.[46]

The *Meth Prison and Reentry Program* at Southwestern Illinois Correctional Center (SWICC) has been reported by the Illinois Department of Corrections (IDOC) as an innovative drug treatment and community reentry program providing a 200-bed unit to combat Meth addiction and reduce crime by focusing on the very specific challenges facing people addicted to Meth. The Meth program is reportedly being supported through $1.9 million state funding, and $4.78 million federal funding. Three partnerships are reportedly integral to the structure of the program. Partnerships exist with CiviGenics, reportedly the nation's largest correctional treatment company, Safer Foundation, which reportedly focuses on community-based job preparation and placement, and Treatment Alternatives for Safe Communities (TASC), to oversee the clinical case management needed to oversee the reentry of participants. [47]

The Illinois Department of Corrections Annual Report for Fiscal Year 2009 reported both drug treatment programs have continued and offer numerous client programs, including parenting skills and vocational training in the construction trades and horticulture.[48]

OHIO

Ohio's Research Toward Identification of Best Practices. The Ohio Department of Rehabilitation and Correction has engaged in its own research in search of facts and discoveries relevant to the goal of providing programs that are evidence-based and shown to have a high effective level while maintaining program fidelity. The agency's efforts to analyze programs and seek best practices is shown in their research and findings published in at least two recent publications. One report, *What Works? General Principles, Characteristics, and Examples of Effective Programs,* was completed by the Office of Policy and Offender Reentry in January 2010. *What Works* was prepared for the purpose of identifying and describing the major characteristics of effective offender programming as found in the research literature.[49] In a separate report, *Best Practices Tool-Kit: Community Corrections and Evidence-Based Practices*, which was completed for the Ohio Institute on Correctional Best Practices in February 2009, the importance of evidence-based practices and programs provided within "community corrections" was established. The report reinforces academic findings that programs extending into the community environment during reentry produced greater favorable results compared to programs without a community connection. Favorable results are defined as reduced rates of recidivism among the clients in the programs.

Research conducted at the University of Cincinnati has shown that the most lasting results occur when an inmate begins an evidence-based treatment program within prison and extends the treatment beyond prison into his life in the community after release. Part of the rationale for pairing the community correction component with evidence-based programs in prison is that once an inmate is released from the drug-vacuum environment within the prison, the inmate faces the drug-contaminated environment on the streets and may not be able to withstand temptations and pressures associated with a return to drug use. The community correction component serves as a support system that continues the work started within the prison's recovery services programs, and it assists the inmate's efforts to remain drug-free.[50]

SOUTH DAKOTA

South Dakota Reduces Recidivism and Costs by Supplementing Treatment. As reported by the National Conference of State Legislatures (NCSL), South Dakota provides a recent example of state support for supplementing recovery treatments. The South Dakota Attorney General Larry Long was concerned about the continual re-arrest of the same people for driving under the influence (DUI) and found that 60 percent of felonies involved controlled substances or DUIs. In February 2005 the South Dakota Legislature established the "24/7 Sobriety Program," under the aegis of the Attorney General's office. The program supplements recovery programming and reduces jail incarceration costs by monitoring DUI offenders, using a range of monitoring systems, particularly a bracelet that tests offenders remotely every half hour.[51]

In 2007, the South Dakota legislature appropriated $345,000 to take the program statewide. Funding was used for staffing, breath analysis machines, tubes, electronic ankle monitoring bracelets, and urinalysis testing tools. Participants paid for their own testing with fees ranging from $2 per day for urinalysis, to $40 for a 7-10 day patch or $140 a month for electronic ankle monitoring. Reportedly, *the state has not had problems with affordability because the costs are less than offenders would otherwise spend on alcohol and drugs*, according to the Attorney General. However, failing a test or not showing up can result in fines or incarceration. At the time of the NCSL report, the state of *South Dakota estimated that it had saved over $30 million by keeping people out of jail.*[52]

TEXAS

Texas Follow-up. Instead of building new prisons, Texas decided to take $241 million of the prison budget and spend it on *increased drug and alcohol treatment programs* and efforts to divert people away from prison and into alternative settings. The state expanded its capacity for treatment to include more room for incarcerated prisoners, as well as those on probation and parole. Additionally, the state expanded its ***drug courts*** – *special courts where judges with expertise in addiction decide whether to send a person arrested for a non-violent substance-abuse related crime to alternative treatment or to prison*. Texas state officials reportedly gave an estimate that the expansion of treatment and diversion programs would eliminate an expected

2012 prison-bed shortfall, and in the 2009-2010 biennium, would save the state over $430 million in incarceration costs.[53] The annual cost per Texas inmate is reportedly more than $16,000,[54] not including initial construction costs.

WASHINGTON

Washington State Studies Programs for Drug-Involved Offenders. Using a set of research methods called 'meta-analysis,' the Washington review revealed that evidence-based programs designed for drug-involved offenders show varying percentages of reductions in recidivism rates. The rates were determined by comparing rates of recidivism of program participants with a treatment-as-usual group. The results from the analysis of programs is provided in the following table, taken from the publication by the Washington State Institute for Public Policy.[55]

Table 5.
Estimated Percentage of Change in Recidivism Rates for Programs for Drug-Involved Offenders

Programs for Drug-Involved Offenders	Estimated Percentage Change in Recidivism Rate	Number of Studies on Which the Estimate is Based
Adult drug courts	-10.7%	56
In-prison therapeutic community - community aftercare	-6.9%	6
In-prison therapeutic community - NO community aftercare	-5.3%	7
Cognitive-behavioral drug treatment in prison	-6.8%	8
Drug treatment in the community	-12.4%	5
Drug treatment in jail	-6.0%	9

Clearly, a review of the research described in the literature will produce much evidence that state legislatures across the United States have directed their focused attention to the area of government that deals with substance abuse among its citizens and subsequent recovery services programs, particularly programs that begin in state prisons. The objective of legislative attention uniformly has been to provide high quality programs that reduce recidivism and generate the maximum cost benefit to state budgets.

CONCLUSION

The role of recovery services programming in the state correctional system is a vital one to the transformation of lives and to fiscal efficiency and responsibility. There is much research on the subject, and collective results show that when inmates engage in evidence-based and effective programming, they are more likely to not recidivate. Recidivism is not only a negative factor in the human experience; recidivism also creates a significant drain on state budgets.

This report has been developed to enlighten the reader regarding the value in funding effective recovery services, to offer information regarding past and current recovery programming, and to illustrate that Ohio is certainly not the only state in search of answers in its quest to meet the challenges associated with rehabilitating substance abusers who enter the penal system. Research for this report revealed that many states have been conducting in-depth studies for decades and some states have developed interesting and innovative ideas and programs in search of solutions.

The Bureau of Recovery Services under the DRC has evolved from its small beginnings to an arm within the agency comprised of certified and credentialed professionals who are observably passionate in fulfilling the responsibilities of their positions in service to individuals and to the state. The Bureau of Recovery Services has demonstrated commitment to maintaining and improving effectiveness and quality in its programs. The Bureau has engaged in its own internal studies to better understand program effective levels, so that they may make educated and confident decisions regarding program development, expansion, adaptation, or reduction. Early studies have shown initial favorable results.

The Bureau of Recovery Services has also engaged in cooperative efforts to maximize the benefit from each dollar spent in this area of operations. Through partnering with other agencies, local community-based service providers, nonprofit entities, academia, and religious institutions, the recovery services organization is invested in collaboration. The depth and breadth of knowledge and skills that may be brought to the recovery mission is multiplied and amplified as a result of the richness of this network. As collaboration continues, it would be anticipated that services may become increasingly more seamless and monies spent may be spent in the most efficient manner.

APPENDIX

A. RECOVERY SERVICE PROGRAMS IN THE DRC[56]

ALCOHOL AND OTHER DRUG (AOD) SERVICES PROFILE –																
INST.	Long-term AOD Programs available and program length and capacity						Out Patient Programs Available					Self-Help and Fellowship Services Available				Mandatory AOD Prog.
	T.C.'s	Res.	IOP	IPP	Program Length	Program Capacity	Outpatient	AOD Ed.	Tobacco Cessation	SAMI	Other Groups	Self Help	A.A.	N.A	Other Fellowship	
ACI			1		3 mo.	45 sp.										
BECI			1	1	3 mo. 3 mo.	36 bd. 60 sp.										
CCI		1			3 mo.	45 bd.										
CMC																
CRC			1		3 mo.	45 sp.										
DCI/MEPRC			1		3 mo.	60 sp.										
FPRC				1	3 mo.	30 bd.										
GCI			1		3 mo.	30 sp.										
HCF			1		14 wk.	15 sp.										
LAECI*			1		3 mo.	30 sp.										
LEC I			1		3 mo.	30 sp.										
LOCI		1		1	3 mo. 3 mo.	24 bd. 60 bd.										
LORCI			1		4 wk.	45 sp.										
MACI			1	1	13 wk. 3 mo.	30 sp. 24 bd.										
MANCI			1		3 mo.	30 sp.										
MCI			1		14 wk.	45 sp.										
NCI			1		3 mo.	60 sp.										
NCCI			1		3 mo.	45 sp.										
NCCTF*			1		13 wk.	30 sp.										
NEPRC			1		3 mo.	30 sp.										
OCF																
ORW	1		1		15 mo. 3 mo.	110 bd. 60 sp.										
OSP			1		3 mo.	30 sp.										
PCI	1	1	1	1	12 mo. 3 mo. 3 mo. 3 mo.	145 bd. 40 bd. 60 sp. 30 bd.										
RICI			1		3 mo.	45 sp.										
RCI			1		3 mo.	45 bd.										
SCI			1		3 mo.	30 sp.										
SOCF			1		16 wk.	45 sp.										
TOCI			1		3 mo.	30 sp.										
TCI			1		3 mo.	45 sp.										
WCI		1			3 mo.	48 bd.										
TOTAL	2	4	25	5		975 sp. 637 bd.	7	30	29	6	6	9	31	31	23	3

B. CIIC PROGRAM OBSERVATIONS

Over a period of nearly three months, the Correctional Institution Inspection Committee observed numerous details associated with instructional climate within recovery service program groups and class sessions. A summary of observations and reflections are provided.

Table 6.
CIIC Observations and Reflections Regarding DRC Recovery Services Programs

Observation	Reflection
1. Facilitators were observed to be more actively than inactively engaged with the clients in group sessions. In groups where the facilitator was more actively engaged, the inmates were more actively engaged.	1. The degree to which facilitators make the principles of the program 'come alive' influences the degree to which the inmate clients engage with the content or meat of the program, which influences the degree to which the inmate may understand and accept the full meaning of the program's fundamental principles and applications.
2. Instructional pedagogy is primarily oral and written. There is also some role play opportunity within the curriculum.	2. Oral and written forms of pedagogy are traditional and can be effective, especially if the knowledge, personality, speaking, and group management skills of the facilitator prompt energetic and dynamic interaction and communication within the group. Role play adds a different dimension to the exchange of thoughts among the participants, and in some situations, role play may help inmates visualize a new model of thinking and behavior in their own life scenarios.
3. The strategy of 'think aloud' was very prevalent.	3. The presence of the 'think-aloud' strategy is seen as an important pedagogical strategy in the delivery of the program content. It is through the revelation of a person's mental processing with a set of data, information, or variable, in a situation, that others are able to perceive, reflect, and enhance their own cognitive activity on the same subject. Through 'think aloud' students learn from one another. 'Think aloud' strategies make instruction cognitively 'rich.'
4. The instructional materials purchased from The Change Company are perceived as a functional and useful tool from which to deliver the program.	4. A review of the workbooks and discussions with inmates and facilitators revealed an overall appreciation for the materials. * Session formats were identified as good because the format prompted the client to go beyond reading and contemplation to engage in the writing process (guided journaling), forcing another level of thinking as the client forms their thoughts into written text. * In addition, the materials were credited for guiding the client's thoughts in a sequence conducive to deeper understanding of important concepts like cause and

	effect, action and reaction, proactive thinking versus reactive thinking. * Materials were noted for the way concepts are linked to each other, helping the client build a cognitive web of concepts and knowledge.
5. While the majority of inmates participated, some very enthusiastically, a small percentage of inmates were observed to be reticent and essentially nonverbal.	5. It is unknown if the facilitator implements a specific action plan for reluctant or withdrawn inmates such that their lack of participation is noted and follow up is provided to assure the reasons for the inmate's disengagement are known, and furthermore, are addressed specifically, timely, and appropriately. * It was noted that referrals to mental health are not uncommon and there is communication between the mental health providers and the recovery program supervisor.
6. One drawback identified by a staff was the short-term effect on the inmate, with an indication that once the program is finished, some inmates slide backward and do not sustain the new thinking habits and behavioral applications of the lessons from the program.	6. After-care journals were identified by one staff as a partial solution to post-program slippage. * In addition, the ancillary programs found in the 12-step meetings were cited as assisting some inmates in retaining the newly learned lessons and benefits from the recovery program experience. * The recognition that recovery is not linear, but that it spirals, might serve as a platform from which to conceptualize and develop 'extension' programs that utilize highly selected and trained inmates to serve as extension program tutors, so that inmates may continue to stay connected to the core principles of the program they completed. Perhaps these extension groups could function like a book club or small study group, focusing their attention on quality and applicable literature that would support their acceptance of personal responsibility. Selective and preapproved books by known authors in the self-help field may be considered. ***(It must be noted that the DRC recovery programs do currently engage inmate mentors. These inmates are program graduates who have reached a high level of mastery and possess excellent mentoring skills to work with inmates in current classes.)*** * Consider supplying inmates with lists of books and other materials, like audio media, if permitted, which may be available to them through their public libraries, so that prior to and after release, they have something to reference, in addition to the actual personal assistance they should be receiving during their transitional period

	within the community.

ENDNOTES

[1] FBI, The Uniform Crime Reports (UCR). Bureau of Justice Statistics. Retrieved August 30, 2011 from http://bjs.ojp.usdoj.gov/content/glance/drug.cfm.
[2] International Guidelines for Estimating the Costs of Substance Abuse – 2001 edition. p13. Retrieved August 2011 from http://www.pierrekopp.com/downloads/International%20guide.
[3] Estimating Costs Associated with Alcohol Abuse: Towards a Patterns Approach (1), International Center for Alcohol Policies, ICAP Reports 7, August 1999.
[4] Ibid. Footnote 2. (pp. 14-15).
[5] VanDine, Steve. (February 25, 2011.) Ohio Department of Rehabilitation and Correction.
[6] DRC Recovery Service Annual Reports, 2003 – 2011. All reports are accessed through the DRC website: drc.ohio.gov.
[7] Harwood, Henrick, (2008). *An inventory of cost offset studies for state substance agencies.* PPT, completed for the California CALDATA study.
[8] Ibid.
[9] Ibid.
[10] LaTessa, Dr. Edward. (personal communication, December 2010). University of Cincinnati.
[11] Vigne, Nancy, & Thomson, Gillian. (2003). *A portrait of prisoner reentry in Ohio.* Urban Institute, Justice Policy Center. Washington DC. Retrieved 2011 from www.urban.org.
[12] Ibid.
[13] Department of Justice, State Prison Expenditures, Retrieved 2011 from http:www.ojp.usdoj.gov/bjs/pub/pdf/spe01.pdf, as accessed October 20, 2006.
[14] *Behind Bars: Substance Abuse and America's Prison Population*, (1998). National Center on Addiction and Substance Abuse at Columbia University, 154. Retrieved from http://www.casacolumbia.org/articlefiles/379-Behind%20Bars.pdf.
[15]Ohio Department of Rehabilitation and Correction Fact Sheet, (July 2011). Retrieved July 2011 from http://www.drc.state.oh.us/web/Reports/FactSheet/July%202011.pdf.
[16] Wilkinson, Reginald (ODRC), & Fleming, Luceille (ODADAS). (1997). Ohio Plan for the Treatment of Alcohol and Other Drug-Impacted Offenders under the Supervision of the Ohio Department of Rehabilitation and Correction
[17] Bureau of Recovery Services staff. (personal communication, 2011). Department of Rehabilitation and Correction
[18] Division Chief. (personal communication, February 10, 2011). Legislative Service Commission.
[19] Ibid. Footnote 17.
[20] *Budget in Detail*. (December 13, 2007, September 22, 2009, and August 15, 2011). Legislative Service Commission
[21] Ibid.
[22] Ibid.
[23] Rogers, Joseph. (2011). LSC Redbook. Legislative Service Commission.
[24] Chart provided by the DRC Bureau of Recovery Services. Personal communication, October 12, 2011.
[25] La Vigne, Nancy G., & Thomson, Gillian, L. (2003). *A portrait of prisoner reentry in Ohio.* Urban Institute, Justice Policy Center, Washington DC. Retrieved April 2011 from http://www.urban.org.
[26] *Bureau of Recovery Services Annual Report, Fiscal Year 2010.* Ohio Department of Rehabilitation and Correction.
[27] Bureau of Recovery Services staff. (personal communication, 2011). Department of Rehabilitation and Correction.
[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] Ibid. Footnote 23.
[33] Ibid.

---

[34]Andrews, Donald. (2000). *Principles of effective correctional programs*. Compendium 2000 - Effective Correctional Programming, Part One Contributing to Effective Correctional Programs, Correctional Services of Canada, Ontario.
[35] Ibid. Footnote 27.
[36] Ibid. Footnote 10.
[37] CIIC anecdotal observations and structured group observation forms. (2011).
[38] Rhine, Edward, E. & VanDine, Steven, & Bickle, Gayle. (2010). *What Works? General Principles, Characteristics, and Examples of Effective Programs,* Ohio Department of Rehabilitation and Correction.
[39] VanDine, Steve. (electronic communication, February 25, 2011.) Ohio Department of Rehabilitation and Correction.
[40]Ibid.
[41] Ibid. Footnote 7.
[42] Swan, Neil. National Institute on Drug Abuse (NIDA), Vol. 10, No. 2, March/April 1995.
[43] Chief Information Officer, (personal communication, January 25, 2011). State of California.
[44] *The California treatment outcome project (CalTOP) final report.* (2003). UCLA Integrated Substance Abuse Programs. The California Department of Alcohol and Drug Programs. Retrieved March 2011 from http://www.uclaisap.org/caltop/FinalReport.html.
[45]Illinois Department of Corrections, Retrieved March 2011 from http://www.idoc.state.il.us/subsections/facilities/information.asp?instchoice.
[46] Ibid.
[47] *IDOC Annual Report to the Legislature*, Fiscal Year 2007, Illinois Department of Corrections
[48] *IDOC Annual Report to the Legislature*, Fiscal Year 2009, Illinois Department of Corrections
[49] Ibid. Endnote 38.
[50] Ibid. Footnote 10.
[51] Gever, Matthew. (2008). *State finds alternatives to jail produce significant savings.* National Conference of State Legislatures, Health Notes, Vol. 29, No. 521. Retrieved March 2011 from http://www.ncsl.org/default.aspx?tabid=14221.
[52] Ibid.
[53]Texas Performance Review, The Challenge of Change in Texas Government, retrieved March 2011 from http://www.window.state.tx.us/tpr/tpr4/vol1/v12rec4.html.
[54] Ibid.
[55] Aos, Steve, & Miller, Marna, & Drake, Elizabeth. (2006). *Evidence-based adult corrections programs: what works and what does not.* Washington State Institute for Public Policy, Olympia.
[56] Ohio Department of Rehabilitation and Correction (July 2011). Bureau of Recovery Services Annual Report. P.6.