Recovery Oriented System of Care (ROSC) Framework the Criminal Justice System

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Project Goal

Project Description

Project Implementation Activities

Project Achievements and Evaluation

Project Follow-up

Next Steps
Why transform the criminal justice system?

The criminal justice system and the substance use disorders service system are connected. Nationally, the criminal justice system is the largest referral source for substance use disorder treatment (Robertson, 2008). It is estimated that the rate of substance abuse or dependence among adult offenders on probation or parole supervision is more than four times that of the general population (38.5% vs. 9.0%) (DHS, Office of Applied Studies, 2005). The following system reforms are key reasons there is momentum for transforming the CJ System:

- Health Care Reform: Increased integration of prevention, addiction treatment and recovery, mental health and primary health care
- Sentencing reform
- Medicaid reform
- Advancements in Research (MAT and EBPs)

What will we do differently? Start by addressing the following concerns:

- Denial – we are already doing recovery-focused treatment. Recovery management is a “new” name for work we have been doing for years
- Projection of Blame – we can’t do any of this Recovery management because no one will pay for it
- Fiscal & regulatory barriers
- Integrated care in a categorically segregated service world
- Technology deficits
- Stigma/Hope

What are the Implications for Transformation?

- Manage the growth of the prison population and reduce spending on corrections
- Improve the cost-effectiveness of existing criminal justice system resources
- Reinvest in strategies that can increase public safety
- Grow towards a Public Health approach of a Recovery Oriented System of Care and Wellness for the CJ client, their families and communities
- Partner Together: Utilize an approach for transformation; additive, selective or transformational
Imagine the client in the middle of the web: Upon release from jail or prison the offender maybe required to report to the following people and/or agencies:

- Parole Officer
- Employment Agency
- Children Services
- Food Pantry
- Family Members
- Peers
- Health Department
- Housing Authority and/or Shelter
- Substance Abuse and Mental Health Care Provider
- 12 Step Meetings

So what kind of supports would work?

Let’s look forward to a community that has adopted principles where individuals have the right to choose the recovery services and supports that best meet their needs. The recovery oriented system of care, (ROSC), supports person-centered, self-directed approaches to care that build on the strengths and resilience of individuals, families and communities to take responsibility for their sustained health, wellness and recovery. A ROSC offers a comprehensive menu of prevention, early intervention, treatment and recovery support services that can be readily adjusted to meet an individual’s needs.
ROSC Philosophy: Imagine a future where the client is working with agency and community partners towards a mutual plan for reentry.

“A Preferred Future”!

Diagram:
- Lifespan Booster Sessions
- Peer Recovery Services
- Education & Training
- Science Research and EBP
- Family Members & other Allies
- Continuity of Care Coordination
- Flexibly Financed
- Cultural & Spiritual
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<tr>
<th>Current System</th>
<th>In a Recovery Oriented System of Care</th>
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<td><strong>Who Receives Services</strong></td>
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<td>Capacity and funding exists to serve primarily court and/or corrections referred SA clients who are deeply enmeshed in their addiction. Personal and family resources have often been depleted by the time of acute treatment. This treatment approach serves approximately 10% of the SA population. The pathways to treatment are limited and the appropriate level of care is lacking in many agency programs.</td>
<td>Community and Primary Care based resources would identify individuals with SA early in the addictive cycles and maintain proactive involvement and outreach, even during the pre-contemplative stage of change. An effective broad based approach would reach more than 80% of SA population.</td>
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<td>Traditional approaches to treatment have only limited involvement of family in the treatment paradigm. The definition of family is limited.</td>
<td>Family members would be incorporated in to treatment at almost the same level as the substance abusing individual. Recovery is holistic.</td>
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<td>Screening and assessment tools and processes primarily exist only with the SA professionals, limiting the size of the net identifying those who will qualify for treatment. The sharing of information is inconsistent, wait list exist, and a lack of pre-treatment supports.</td>
<td>Screening and assessment tools, skills and processes would be widespread among a host of organizations, providers and community resources creating a broad net for identifying, encouraging and referring families and individuals to proactively deal with SA concerns.</td>
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<td><strong>Who Gives Services</strong></td>
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<td>Most service falls in to two, somewhat separated camps: 1. licensed and/or certified professionals in acute (residential and IOP) settings; 2. peer support/mutual aid fellowships or groups (AA, NA etc) While enjoying a respectful relationship, these camps have tended to work at a distance from one another.</td>
<td>Peer support and mutual aid would become an integrated part of the treatment process and provide long-term connectivity between levels of care and service professionals. Tailoring services to fit the needs of the individual is important. Recovery is a reality.</td>
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<td>With MH, SA, and physical care, funding has been maintained in distinctively separate management systems, treatment of SA, MH or physical health has been forced to be an ‘either – or’ proposition for providers, required to focus on one or the either at any given time. There are services duplicated, and a lack of treatment that addresses factors associated with criminal behaviors.</td>
<td>SA, MH and physical care funding would not be an impediment, but rather encourage concomitant treatment of all aspects of the individual and family by the same an integrated service team. Proven holistic approaches would be funded. Assessment is the first step in treatment.</td>
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## Comparing Our Current Substance Abuse Treatment System with a Recovery Oriented System of Care

### How and Where Services are Provided

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<th>Traditional, face-to-face groups and individual therapy are the primary mechanisms of service delivery. These are typically done in the provider’s office or residential facility. Services and supports for the CJ client are driven by the professionals. Drug use during treatment can too often result in termination.</th>
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<td>Service location would become much more community based, which could include schools, churches, libraries, work sites, and homes. The delivery mechanism, while still including face-to-face delivery would also include phone and internet based tools. These approaches would be endorsed by governmental bodies, like SAMHSA and funded by 3rd party payers and government.</td>
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### How Long Services are Provided

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<th>In the current, acute care model, services have a distinct admission and discharge cycle, in a relatively short period of time, and re-involvement in treatment includes subsequent admissions and discharges. Often, if an individual ‘fails’ treatment once or more they are excluded from access to the limited treatment resources. In many instances, this means increasing criminal involvement resulting in penal action instead of treatment.</th>
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<td>Once identified, the individual and family is considered in the treatment system for the long-term duration with various degrees of involvement over the course of a lifetime. Services are continually available at some level and the consumer’s ‘membership’ in the system never expires and relationships with peers and providers is considered to be more enduring in nature, in spite of periods of continued substance use.</td>
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### Who the Decision Makers Are

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<th>Those deciding what and how services are provided are primarily the service providers themselves, with direction, limitations and oversight by government and other payers. Consumers have a limited role in deciding how, where and what services are provided.</th>
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<td>Consumers would become much more visible and involved in the decision making around the design of the service delivery system. Local boards and committees would be heavily represented by consumers/families who would help decide funding decisions for the delivery system. Local flexibility in the use of funds would be much greater.</td>
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The goal for individuals with substance use disorders is long-term recovery from addiction, getting their lives back on track, improving their health, wellness and quality of life. Systems that support recovery-based care provide individuals receiving care with a variety of services and options tailored to their specific needs to aid them in their process.

**Peer-based recovery support services (P-BRSS) are emerging from:**
Research confirming the limitations of existing treatment models,
Calls to reconnect treatment to the more enduring process of addiction recovery,
A shift from pathology and treatment paradigms to a recovery paradigm, and
A shift from acute care to models of sustained recovery management.

**Four types of social support useful in organizing the community-based peer-to-peer services they provide to recovering people.**
- **Emotional** - Peer mentoring & Peer-led support groups.
- **Informational** - Parenting class, Job readiness training, & Wellness seminar.
- **Instrumental** - Child care, Transportation, Help accessing community health and social services.
- **Affiliational** - Recovery centers, Sports league participation, Alcohol- and drug-free socialization opportunities.

**Peer Leader in stable recovery provides social support by:**
Peer Mentoring or Coaching
Peer Recovery Resource Connecting
Facilitating and Leading Recovery Groups
Building Community
Janet is a 32-year-old female that arrived at the ALI Community Re-Entry Center after serving 8 months for embezzlement. Janet is in good physical condition, and reports no major medical concerns. Janet is being treated for major depression and has a 15-year history of alcohol and drug use. Janet has successfully completed substance abuse treatment programs and a six-week workforce development program during her incarceration. Janet has maintained contact with her children, Jake, age 9 and Jordan, age 11. Janet obtained her high school diploma and three years of college course work. Janet has completed several other training programs and participated in her children’s school activities, which included the PTO. Her best friend and two siblings support Janet. Janet is being released early to the Community Re-Entry Center for assessment and to develop a support plan.

The ALI Community Re-Entry Center is one of eight divisions within CARE CORP. CARE CORP is an Accountable Care Organization that manages all eight divisions that represent the follow services: division of family and children services, probation and parole, IHS (Integrated Healthcare Services), social security, and Education. CARE CORP also has a Leadership Council that meets monthly to guide and direct agency goals. The Leadership Council is made up of representatives from all the local governmental agencies, as well as, persons in recovery, family members and allies. CARE CORP Professionals and stakeholders are committed to providing efficient and cost effective services, starting with the least intrusive to the most comprehensive services based on assessment and client’s choice. Recovery plans are comprehensive, client-centered, strength based with the goal of matching people to the most appropriate resources in their natural environment.

Janet met Pat eight weeks prior to being released to the Re-Entry Center. Pat provides assertive case management and support for clients. Pat is cross-trained in all the divisions at CARE CORP and has an understanding of the local recovery support services outside of the agency. Pat will meet with Janet at the agency, travel to appointments with her to introduce her to new opportunities, supportive environments, and provide assistance through other methods, which may include coaching and role modeling. One of Janet’s priorities is to gain back custody of her two children. Janet and Pat will work to incorporate the custody of her children as a main focus when building the recovery plan. Janet and Pat will meet with Family and Children Services (FSC) to discuss how to begin visitation at the Re-Entry Center and next steps. FSC will work with Janet and Pat to include reunification with her children as part of the larger recovery plan. The facilitation to coordinate safe housing, access to school, public transportation and the Re-Entry Center recovery support services will be a central theme though out the development of the recovery plan. Janet can work with Pat to evaluate what supports she has in place that can be a foundation for the future.

The IHS Division has facilitated Janet’s need for services in the community regarding her addiction to alcohol and drugs, and her major depressions. While Janet was incarcerated she completed two treatment programs, and this information has been shared with IHS prior to her release. Janet met with a treatment specialist two times via e-conference to examine what recovery supports would be in her best interest and support her goal of regaining custody of her children. Janet reports that she has tried on her own to quit and had the short periods of success. Janet is concerned about her cravings when she returns home. The treatment specialist will review the existing electronic health records and consult with collateral sources. The Treatment Specialist and Janet will examine the treatment options. Janet is interested in medication-assisted treatment and requested information regarding the pros and cons. Janet reports she want to live a life free from addiction and to raise her children. She would like to finish her education and support herself and her family.