

RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

Aftercare Planning and Community Corrections

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TASC, Inc.

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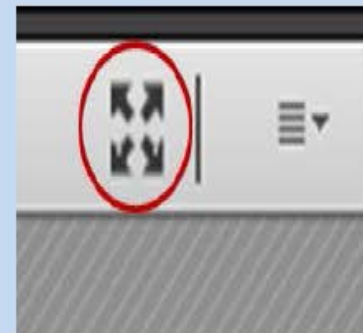
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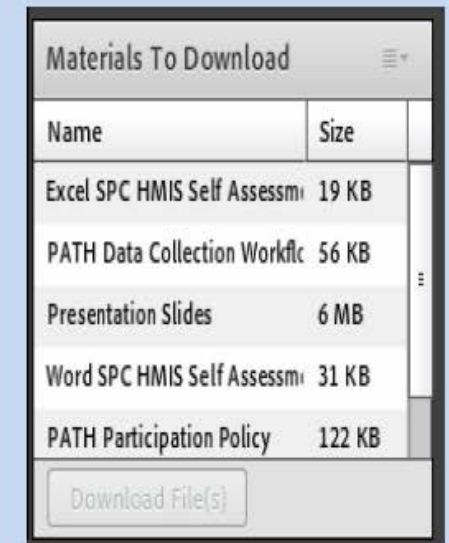
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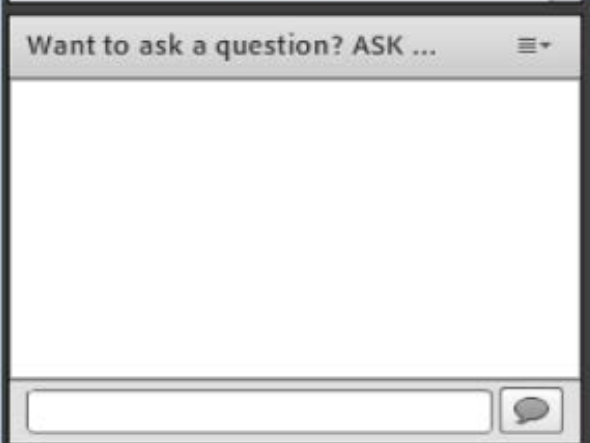
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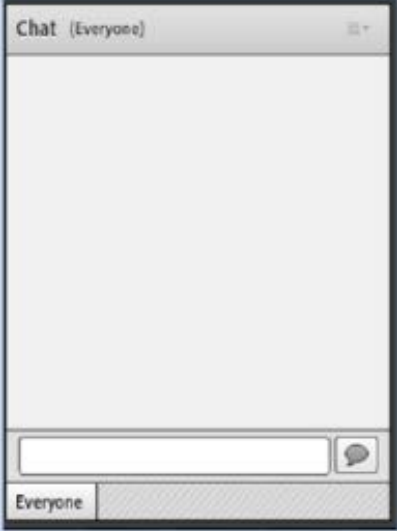
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Nixon Camilien, PhD

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(Treatment Alternatives for Safe Communities)

Learning Objectives:

At the end of this webinar, participants will be able to:

1. Describe the role of the community corrections officer in aftercare planning for RSAT clients.
2. Provide examples of how community corrections can work with community service providers to optimize the recovery of RSAT clients.
3. Integrate best practices strategies in the supervision of RSAT clients in the community.



RSAT Goals and Elements

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Evidence of RSAT effectiveness

- Evidence that treatment programs in custody settings are effective
- Greater reduction in recidivism with **continuing community-based** addiction treatment upon release

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RSAT Program Goals

- The overarching goal is **to break the cycle** of drugs and crime
- Enhance the capacity of states and units of local government to **provide residential substance** abuse treatment in custody.
- Prepare RSAT clients for reintegration **through linkages to community-based** treatment, social services and recovery supports.
- Assist both re-entering clients and community-based providers to **coordinate continuing care** for SUDs and other behavioral health services.
- **Reduce recidivism** by promoting a post-release drug-free lifestyle, structured pro-social activities and expanded networks of recovery support.

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RSAT : Core Elements

- Prison-based treatment programs: **6 to 12 months**;
- Jail-based programs are **3-6 months in duration**.
- Residential treatment is **set apart** from the general correctional population—in separate facilities, dedicated housing units or ‘treatment pods’ in jails.
- Treatment develops **cognitive, behavioral, and vocational skills that** support the client’s recovery from addiction and promote criminal rehabilitation.
- Program participants and graduates undergo periodic, random **drug testing** while they remain in treatment, in custody or under correctional supervision.

The RSAT Model

Screening/Assessment

Program intake/ Treatment planning

Program participation (3-6 mos=jail and 6-12 prison)

Pre-release phase (1-3 mos)

Step-down aftercare

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RAST Aftercare

- Aftercare services are defined as the treatment and support provided **after release from prison/jail** (Pelisser et al., 2007) .
- BJA specifies that “aftercare services must involve the coordination between the correction treatment program and other social service and rehabilitation programs, such as education and job training, parole supervision, halfway houses, self-help, and peer group programs” (BJA, 2008; 2014).
- In 2008, Section 102 (a) of the Second Chance Act amended the RSAT program funding legislation to provide aftercare, including case management and other support
- In 2013, BJA removed the 10% cap on treatment services for individuals released from facilities



Community Corrections

The role of Community Corrections

Considerations for the differences between probation and parole.

Probationers

- Spent little or no time in a correctional facility (jail)
- RSAT requires three to six months while in jail
- Less time away mean the same anti-social peers or influences are present upon return to the community.
- Supervision agency is the Court

Parolees

- Usually spent significant time away in prison and away from the community.
- Generally more seasoned offenders with greater risks for public safety.
- RSAT requires six to twelve months for completion.
- Extended removal from society can mean that they will require more reintegration back into a community
- Report directly to the prison system

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Selecting and Orientation of RSAT officers

- Community corrections officers have traditionally seen themselves primarily in a risk containment framework (Clear and Dammer 2003)
- The objectives of RSAT aftercare requires that community corrections officers fully **embrace their dual roles of supervision and rehabilitation**
- The rehabilitative approach is only possible if officers fully embrace the fundamental premise that **addiction is a disease** that can be treated with evidence-based interventions

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Selecting officers for RSAT aftercare

- That is why a **specialized caseload** is recommended for RSAT clients
- Like facility officers, probation or parole officers should be given opportunity to **volunteer for RSAT caseload**
- **Committed to treatment** goals of RSAT programming .
- Must be familiar with the **values and philosophy of the program** and model the attitudes of the program
- Agency should **certify and reward officers** who volunteer for RSAT

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Orientation and Training of RSAT Officers

- Case Management
- The Science of Addiction
- Criminogenic Risk-Need-Responsivity (RNR)
- Motivational Interviewing (MI)
- Cognitive Behavioral Therapy (CBT)
- Joint Training with Community Service Providers



Reentry Planning

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Key Roles of Community Corrections Officers in RSAT Aftercare.

- Contribute to the development of an aftercare and case management plan for the individual (**collaborative case planning**);
- Identify and expand the network of aftercare services beyond the primary aftercare treatment program such as housing, vocational and educational services (**Community partnerships**);
- Perform **case management** to guide and encourage compliance with aftercare treatment plans;
 - Use **graduated sanctions and rewards** weighing the costs to the individual's recovery and public safety.

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Reentry Planning: Pre-release assessment

The community corrections officer participates in the **pre-release assessment** of RSAT clients to determine progress in treatment, motivation to change, prospective support in the community and other ancillary needs.

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Reentry Planning: Addressing Practical Needs

- Housing
- Employment
- Health care
- Transportation
- Family reunification

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Reentry Planning: Addressing Criminogenic Risks

Levels of supervision and structured pro-social activities for:

- Clients stepping down to transitional living facilities and halfway houses;
- Clients released to the community under correctional supervision;
- Clients completing their sentences to be released without supervision.

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Reentry Planning: Addressing Criminogenic Risks

- Anti-social cognition
- Anti-social companions
- Anti-social personality/temperament
- Family and/or marital
- Substance abuse
- Employment
- School
- Leisure and/or recreation

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Reentry Planning: Clinical Needs

- Treatment and recovery support services;
- Linkage or referral to medication-assisted treatment (**MAT**) providers;
- Continuing care for **co-occurring** mental health disorders (COD);
- Care for chronic health conditions such as HIV/AIDS or chronic pain;
- Linkages to overdose prevention/risk reduction resources upon re-entry.

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Reentry Planning: the Case Plan

Any case plan should account for the following factors:

- Substance use treatment (Residential or Outpatient depending on level of care indicated, MAT)
- HIV/AIDS education
- Overdose prevention strategies
- Parenting classes
- Mental Health services, if indicated
- Social support services
- Assistance with entitlements including public insurance if eligible
- Vocational and educational training
- Housing assistance/placement

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Reentry Planning The Recovery to Home

- Arrangements are made for transfer of client records.
- RSAT and case management staff confer with receiving facility.
- Client release plans designate additional community/recovery supports in place.
- Plans included for employment, training, education or other structured activities.
- Plan includes where clients intend to live once they leave transitional housing.
- Clinical care for SUD and other behavioral health services are in place.
- Clients are enrolling in benefits or programs that subsidize clinical care.
- Transportation to work and to appointments is considered.

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Reentry Planning: the Relapse Prevention Plan

- Frequent monitoring and screening of the individual by corrections and aftercare staff
- Access to the overdose antidote Naloxone
- Access to medication-assisted treatment
- Collaboration with family members and support network when available



Leveraging Existing Community Resources/Community Partnerships

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Community Partnerships: Explore Capacity and Expectations

- Community corrections officers can cultivate relationships between community services providers and correctional services.
- An obvious priority is **aftercare for substance abuse program**
- Establish partnerships with providers who will accept individuals on community supervision

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Community Partnerships: Capacity and Expectations (suite)

- Identify treatment providers in community who will cater to criminal justice population and target their needs (criminal thinking, antisocial attitudes & SUDs)
- Once providers have been identified, face-to-face meetings help to clarify the expectations of community corrections and the capacity of providers to meet them.
- The results of the conversation and terms of agreement should be clearly spelled out in a memorandum of understanding (MOU).

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Community Partnerships: Treatment Capacity Resource Map

- Create a **treatment capacity resource map** with up to date bed availability to facilitate quick intake

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Community Partnerships: Incentives

- To incentivize providers to participate in an aftercare referral network, officers should **assist individuals with obtaining insurance benefits** as early as possible including during the pre-release period
- Corrections agencies that may have access to a budget to fund treatment services should consider expanding services that Medicaid or private insurance may not cover such as residential or case management services.
- Other possible incentives are recommending that exemplary treatment partners be included in **criminal justice advisory boards** or providing letters of support to treatment partners when seeking public or private funding or recognition.
- Beyond treatment resources, community corrections officers may seek to engage other community partners such as healthcare providers, workforce development boards, faith-based organizations.

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Community Partnerships: Joint Training

- Joint-training sessions provide opportunities to learn from each other
- Counselors can benefit from training **in security guidelines** and learning about inmate attitude and behaviors
- Officers learn about components of substance abuse treatment
- Avoid us vs. them mentalities

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Community Partnerships: Potential Joint-training sessions topics

Potential Joint-training sessions topics

- Overview of treatment and community supervision paradigms (language and jargon of both systems, mission, philosophies)
- Clarification of system and personnel roles
- Establishing communication and managing system conflicts
- Understanding the RSAT inmate: trauma and gender responsive issues
- Confidentiality and sharing of information
- Sanctions and Rewards
- Medication-assisted treatment
- Case conferences



Peer Support

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Peer Support

- Peers are sometimes referred to as mentors, navigators, educators or people with lived experience
- Can help the RSAT graduate navigate some of the challenges of reentry, such as those that continue after discharge from community corrections.
- It is important that community corrections agencies create a protocol to encourage collaboration between community corrections officers and peer recovery coaches.
- Community corrections department must budget for training and remuneration of peer support officers.
- Peers are even more relevant for those who are discharged from RSAT directly to community without supervision.



Case Management

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Case Management

- Case management provides a **standardized framework** for community corrections officers to integrate both public safety concerns and offender rehabilitation in their work.
- For offenders with SUDs, the engagement of community corrections officer **facilitates linkages** between treatment and criminal justice to maximize offender accountability, access to treatment, continuum of care and progress in RSAT aftercare programming.
- **Focus on risk reduction** by addressing criminogenic needs such as antisocial peers and criminal thinking errors

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Case Management Models

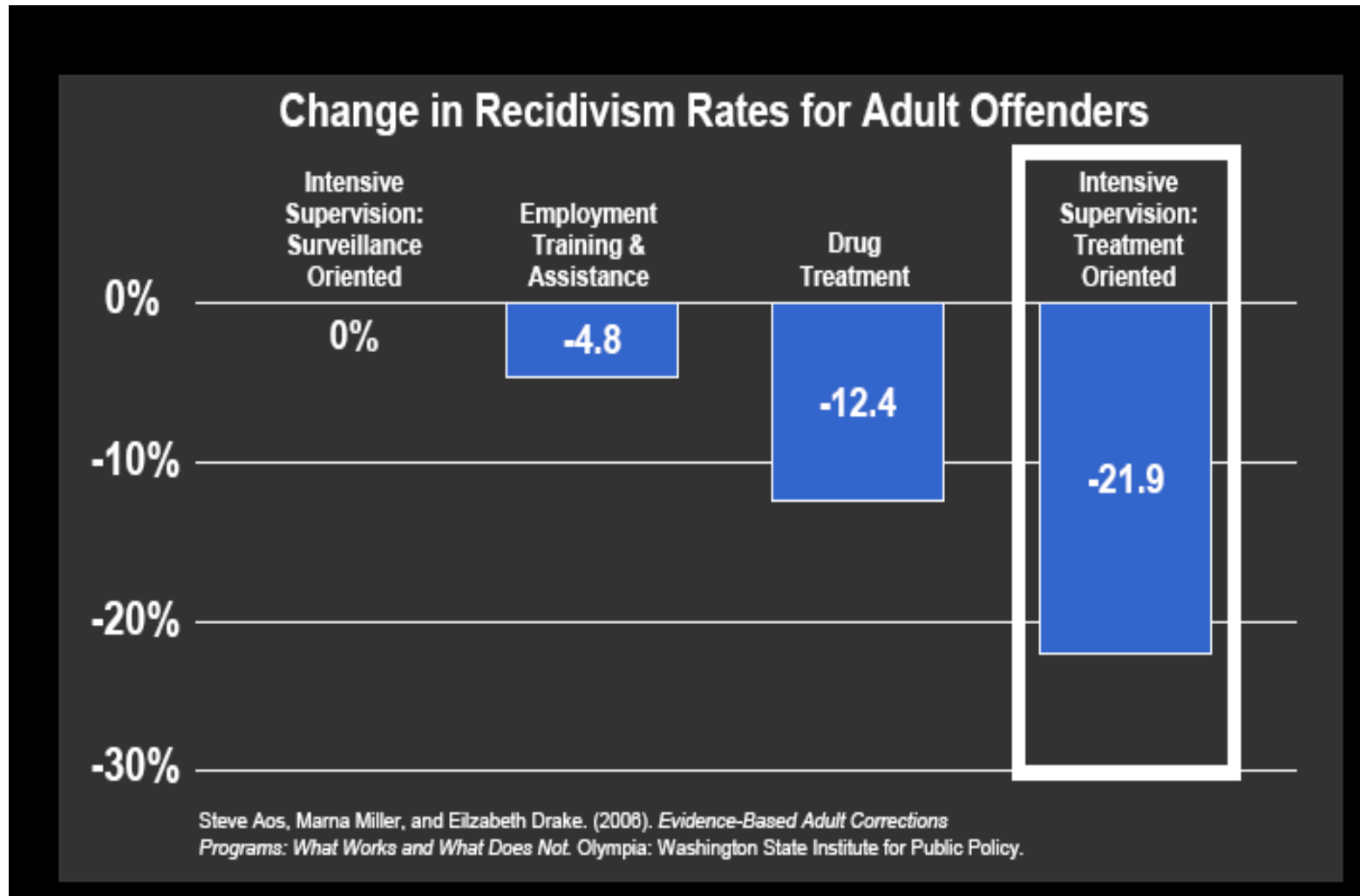
- **Case management in custody:** may be a responsibility between RSAT staff and correctional case manager, or in some cases, with designated re-entry case managers
- **Transitional case management:** reach into custody settings and extend into the community post-release.
- **Community case management:** almost exclusively available to people receiving community-based care, except for certain agencies that offer limited in-reach to individual clients nearing release.

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Case Management

- The RSAT aftercare caseload consists primarily of individuals who are at high risk for recidivism.
- They require higher **intensity supervision and interaction** to remain compliant, particularly within the first few weeks of release.
- It is the professional responsibility of the community correction officer to **create cooperative relationships** with the offender through their **engagement** in the process;
- Drug testing may be used to determine clinical service needs, set a standard of accountability, and provide baseline information on the nature of the clients' drug use.

Integrating Treatment and Supervision Reduces Risk



National Reentry Resource Center, 2012



Graduated Sanctions and Rewards

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Graduated Sanctions and Rewards

- Have realistic goals for the client and include possible **rewards or sanctions** to support these goals.
- Case plan should **anticipate consequences** for relapse
- Consider **other mitigating factors** such as compliance with treatment and day reporting appointments before the severity of sanctions is determined

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Graduated Sanctions

- Provide a swift, fair, consistent and certain consequence for technical violations without resorting to revocation.
- Increase in severity with continued problem behavior.
- An increase or decrease in treatment dosage should never be considered as a sanction for problem behavior.

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Rewards

- Serve as positive social recognition and affirmation of positive behavior.
- Non monetary, social recognition of progress
- Research indicates that supervision is most effective when positive recognition is given at a rate of 4 to 1 for every negative sanction.



The HIPAA question

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Sharing and Receipt of Information

Difficulties to share and receive information due to the Health Insurance Portability and Accountability Act (**HIPAA**) and Title 42: Public Health, Part 2—Confidentiality of Substance Abuse Patient Records (**42 CFR Part 2**)

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Sharing and Receipt of Information: Components of a Privacy Framework

1. A **privacy policy** to articulate the entity's position **to protect medical, mental health, and substance abuse diagnosis and treatment information**—or PHI; adhere to legal requirements; and specify the rules and procedures for such compliance.
2. Individual **consent authorizations and/or court orders** authorizing the sharing of PHI between corrections and community treatment providers.
3. Contractual agreements between correctional entities and outside organizations that perform a specified set of functions or provide services to or on behalf of the entity.

Questions?

Type your questions in the Q&A box on your screen

Speaker Contact Info:

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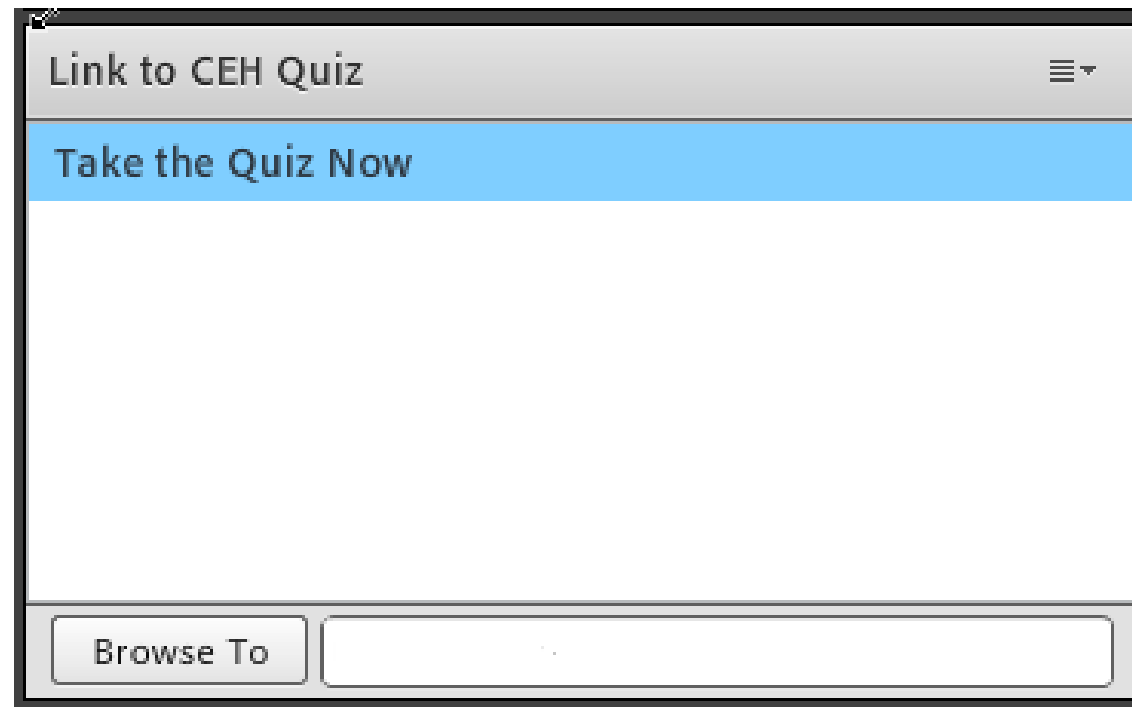
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<http://www.rsat-tta.com/Home>

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