IMPLEMENTING A CHRONIC DISEASE MODEL FOR TREATMENT OF SUBSTANCE USE DISORDER: BARRIERS TO CARE AND STRATEGIES FOR IMPLEMENTATION

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1 Executive Summary

In the 2019 session, the Oregon Legislative Assembly passed House Bill (HB) 2257, a bill recognizing Substance Use Disorder (SUD) as a chronic illness for which commensurate treatment should be available and provided. To treat addiction as a chronic illness is a significant paradigm shift. The potential impact of this shift on corrections-based addiction treatment cannot be understated. Currently, the Oregon Department of Corrections (DOC) treats SUD as an acute condition related to criminality and recidivism: qualifying adults in custody (AICs) receive addiction treatment that is time-limited, discrete episode of care at the end of their DOC incarceration. The system is organized for earlier intervention or to continue care necessary to manage addiction as a chronic condition. To provide care outside of this historical context would require not just a shift in treatment protocols, but also in organizational culture.

As this report will detail, treating SUD as a chronic disease will require an investment in service delivery that can be individualized, cumulative, and long-lasting[1]. DOC is committed to the adoption of this approach. However, it is not positioned to withstand the weight of this shift without a commensurate allocation of resources. This transformation will require changes to the system[2] which require significant funding to operationalize. It will also depend upon an available continuum of care in all Oregon counties to provide transitioning AICs with the ongoing treatment and support necessary for the management of their chronic conditions. The effort is not DOC's alone. It will take a collective commitment from elected officials, state agencies, counties, and community partners to succeed.

The department aims to stay current with best practices in the treatment of addiction. The department continually strives to incorporate evidence-informed practices into services and care provided to AICs. For example, in the last five years, DOC has worked with contracted alcohol and drug treatment providers to review practices and ensure they align with trauma-informed care guidelines, later adjusting contract language to assist these programs with operational modifications needed to meet this protocol. More recently, DOC has rapidly expanded the reach of medication assisted treatment (MAT) services to serve AICs at seven[3] correctional facilities as they transition into the community and continue care for their Opioid Use Disorders (OUD). As of June 1, 2020, DOC has served 39 AICs through this program. These efforts speak to DOC's commitment to provide responsive and evidence-based care to AICs.

At the direction of the Legislative Assembly per House Bill 2257, this report provides findings on: existing barriers to diagnosis, treatment and continuity of care for AICs; SUD treatment options for AICs; proposals for how the department will initiate and maintain diagnosis, treatment, and continuity of care for AICs; and recommendations for legislation. It provides an in-depth analysis of existing barriers to effective diagnosis and treatment of SUD in the DOC system. Following this analysis are proposed strategies for the integration of a chronic disease approach into DOC's assessment, treatment, and continuing care practices. The report concludes with policy recommendations informed by our comprehensive analysis.

[1] See Dennis & Scott, 2007; McLellan, Lewis, O'Brien & Kleber 2000; Saitz, Larson, LaBelle, Richardson & Samet 2008; Scott, Dennis & Laudet, 2014.

[2] Operational changes, such as: contracts, staffing, allocation of space, program design, release planning, and evaluative measures.

[3] As of June 1, 2020, the following DOC facilities accept patients on MAT: CRCI, CCCF, SCI, OSCI, OSP, DRCI, SRCI.

The report will highlight the following key topics:

- A universal and non-time-limited screening and assessment approach for effective diagnosis of SUD in the corrections setting;
- Individualized approaches to treating SUD and co-occurring disorders in the corrections setting;
- The untapped potential of technology-assisted treatment;
- Culturally responsive and trauma-informed treatment environments;
- Peer-based recovery support services;
- Assertive linkages to continuing care in the community; and
- Unintended consequences of the Alternative Incarceration Program statute.

The following is a brief summary of identified barriers, implementation strategies, and policy recommendations that will be expanded upon in the main section of this report:

BARRIERS, PROPOSED STRATEGIES, and POLICY RECOMMENDATIONS

Screening and Assessment of SUD

Barrier: Screening and designation of treatment need are time-limited.

Strategy: Reorient screening and assessment process to a "no wrong door" approach. Universal screening will continue to be utilized with all AICs at Intake. Screening services will be expanded to be available throughout custody.

Barrier: Current substance dependency screening tool is no longer a good fit for the population DOC serves and is not effectively integrated with clinical practices.

Strategy: Adopt a new screening tool that is empirically-validated for use with corrections populations. Implement a blended screening and assessment approach, which will align with clinical practices to support better diagnosis of SUD.

Barrier: Formal clinical evaluation for diagnosis of SUD is limited and not available to all who score high for substance abuse risk at screening.

Strategy: Create a formalized clinical practice to refer all AICs who score high for substance abuse risk at screening to be evaluated by a qualified mental health provider for possible SUD diagnosis.

Treatment of SUD

Barrier: Addiction is still treated as an acute condition.

Strategy: Implement a chronic disease model across DOC for treatment of SUD, including opiate-use disorders. Treatment will be individualized, holistic, culturally responsive, and available throughout the custody cycle.

Barrier: Need for MAT is increasing. Expansion of services is costly and will require more X-DEA-waivered providers.

Strategy: Expand MAT services across more institutions and increase the duration of MAT treatment to extend throughout custody, in alignment with best practice recommendations. Identify number of additional waivers that will be necessary to meet the need of increased MAT patients.

Barrier: The limited number of treatment beds and select location of programs hinders entry for many.

Strategy: Expand treatment services to be available in as many DOC institutions as possible. Treatment services will be professionally-driven and diversified to include other evidence-informed modalities of care. This would include creation of a women's co-occurring disorder program and implementation of an agency wide peer recovery support-services model.

Barrier: Care for SUD is not integrated across disciplines. The absence of an electronic health records (EHR) system makes integrating care difficult.

Strategy: Treatment of SUD should extend across all levels of care in DOC to be fully integrated. Medical, mental health, and addictions providers will actively collaborate in treatment of SUD, leading to better continuity of care. An EHR system will facilitate seamless sharing of records and enhance collaborative communication.

Continuing Care for SUD

Barrier: Limited institution resources make it difficult to provide assertive linkages to community care for adults releasing from custody.

Strategy: Designate Recovery Care Coordinators for each institution. All SUD-diagnosed AICs will work with these coordinators to develop assertive linkages for the ongoing care of their chronic condition. Support the Institution Release Counselors and Community Corrections staff by developing strong recovery care pathways prior to release.

Barrier: There is disparity of available treatment services across Oregon counties.

Strategy: Partner with Community Corrections and Medicaid-coordinated care organizations to advocate for expansion of services, with a focus on rural and high-poverty counties. Utilize institution Recovery Care Coordinators to enhance relationships with community providers, including linkages to Federally Qualified Health Centers and community-based recovery organizations.

POLICY RECOMMENDATIONS

Increased funding for DOC Addiction and Mental Health Treatment Services

To adequately meet the need of SUD-impacted AICs, in alignment with a chronic-disease approach, it will be necessary to expand treatment services. More staff will be needed to provide these services. Operational costs will increase to support services and guarantee the materials necessary to their provision are available. The creation of peer recovery support services will require investment toward AIC training and oversight. As DOC expands MAT across more institutions and for longer durations in custody, the cost of those services increases.

Increased funding for Community-Based Addiction and Mental Health Treatment

Ongoing care for individuals with SUD who have released from DOC custody can be difficult to come by, particularly in rural Oregon counties. In order to provide the continuation of care for AICs, there needs to be services to link them too. Results of a survey conducted with Community Corrections partners indicated ongoing structural barriers faced by releasing AICs include a lack of available treatment program slots and transitional sober housing beds to meet need. Multiple survey respondents indicated insurance limitations are a barrier to access care for those they supervise. Further investigation of these reported barriers is needed to better understand the root cause of the access issues.

In-depth evaluation is needed of the current Alternative Incarceration Program statute to determine if it is inadvertently creating inequities of access for AICs who are ethnic and/or racial minorities, physically and/or developmentally disabled, and/or severely mentally ill.
The current language of the statute presents a barrier to the restructuring of addiction treatment services in alignment with a chronic disease model. It restrains eligible participants to an acute, end-loaded, episode of care – the current structure of all DOC's addiction treatment programs. It limits the operation of AIPs to minimum custody institutions, which creates access barriers for AICs who are unable to meet that level of custody. This limitation prevents AICs in need of intensive addiction treatment from accessing the clinically appropriate level of care necessary for treatment of their SUD. In order to better understand how these restrictions in access may be impacting DOC's population, the department is interested in conducting a racial equity analysis of AIP eligibility and placement.

The conditions of the statute create an equity issue for DOC. Due to the specifications of rigor required for AIP participants, a subset of DOC's population is limited in their access to SUD treatment: AICs with complex physical or developmental disabilities or severe persistent mental health diagnoses. Outside of the existing AIP-structured treatment programs, there are limited alternative addiction treatment pathways in DOC for these individuals. This area should also be examined to determine if pathways for equitable access may be created by a shift in statute language.

2 Forward

The conditions of care are well established for most chronic disorders. Hypertension, diabetes, and asthma require patients to take medication as prescribed, eat healthy, get regular exercise, maintain a healthy weight, manage stress, avoid smoking, track symptoms, and attend regular check-ups. It is common knowledge there is no cure for these illnesses and continuing care will be required for these patients throughout their lives. What is lesser known, is the fact that the relapse rate for these conditions is comparable to the relapse rate for SUDs. In a one-year post-discharge follow-up study, approximately 50 percent of people with SUD relapsed, while approximately 40 percent of people with diabetes and 60 percent of people with asthma or hypertension relapsed.[4]

In the cases of a recurrence of symptoms with diabetes, asthma, or hypertension, the treatment response is to intercede with additional medical care until a remission of symptoms is achieved. The individual patient is not punished for their lack of success in independently managing their condition. These are chronic conditions: there was never an expectation that these patients would be cured after an acute episode of treatment. The treatment approach is not found to be ineffectual because symptoms of the chronic condition returned. In these instances, additional treatment is not denied. Instead, worsening symptoms are met with increased care.

The traditional acute approach to treating SUD has perpetuated the belief that it is somehow distinctly different than other chronic conditions. Historically, treatment has been rendered through a discrete episode of care, after which the treatment recipient is expected to self-manage their way to lifelong abstinence. Criminal justice system-involved persons with SUD have been viewed through an even narrower lens, where desistance from crime and recovery from addiction are expected after an acute

[4] See McLellan et al (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance and outcomes evaluation. *JAMA, 284*(13), 1689-1695.

episode of prison-based treatment. When relapse or recidivation result, treatment is considered to have been a failure.[5] Indeed, addiction is the only chronic condition where a person is punished for exhibiting symptoms of their disease. With other disorders, we offer additional interventions or supports when a patient experiences a recurrence of problems: a diabetic experiencing glycemic relapse is referred to a nutritionist; and an individual experiencing a sharp increase in their HIV viral load is referred to a medical case manager.

This is the significant paradigm shift that corrections faces to stay consistent with medical science. If the Department is to improve the quality of care for SUD, then the agency must invest in the resources necessary to deliver responsive, individualized, longitudinal treatment. It is "recognizing that recovery from drug use and desistance from crime are processes that take considerable time and effort".[6] If DOC would not withhold the same level of care to a diabetic AIC, then DOC should not diverge in approach for the care of addiction.

What follows in this report reflects an in-depth assessment that was conducted over the last seven months to build a greater understanding of the areas of need and opportunities for growth that exist in DOC's addiction treatment services. This assessment comprised of a review of relevant best practice literature, quantitative data collection, and qualitative research that included: stakeholder focus groups, a digital survey, direct treatment service observations, and experiential screening exercises. The collective understanding generated as a result of this work is the foundation of this report.

3 Barriers to Screening and Diagnosis

3.1 Background on Current Screening Methods

The current approach utilized by DOC is in alignment with an acute care model. Screenings for possible substance dependency are administered to all AICs, in the beginning of their sentence. There are two steps to this process: 1) the completion of a drug use and dependency screening – the Texas Christian University Drug Screen (TCU-DS); and 2) the administration of a gender-specific criminogenic risk assessment that include domains specific to substance dependency risk. These gender-specific risk assessment tools are the Levels of Service/Case Management Inventory (LS/CMI) and the Women's Risk Needs Assessment (WRNA). Screenings and assessments are conducted at the DOC Intake Center within the first weeks of arrival.

The TCU-DS is the primary tool used to evaluate for treatment need in DOC. It is administered in an intake orientation class, along with a series of other tests and surveys. AICs are provided extremely limited information as to what the purpose of the TCU-DS is or how to interpret the questions. Focus groups of AICs and interviews with intake orientation staff revealed the TCU-DS is perceived as confusing to administer and complete. AICs acknowledged feeling emotionally fatigued after completing the other battery of tests and paperwork, which are received before the TCU-DS. Staff who facilitate the Orientation class receive limited training on the administration of the tool, leading to inconsistencies in how AICs are instructed to complete it. Due to these circumstances, there exists a significant probability that the TCU-DS results are flawed.

[5] See Turnbull, P. (2020). The relationship between drugs and crime and its implications for recovery and desistance. In D. Best & C. Colman (Eds.), Strengths-based approaches to crime and substance use: From drugs and crimes to desistance and recovery (pp. 8-22). New York, NY: Routledge.

[6] [6] Turnbull, P. (2020), p. 18

The score which results from the TCU-DS is converted into a substance abuse risk score (SUB score) and is a primary qualifier for entry into one of DOC's addiction treatment programs. Many AICs, especially those returning to custody, are aware that the results of this screening tool influence treatment placement and have admitted to manipulating their answers to avoid eligibility.[7] There are no other screening processes currently used to identify risk for substance dependency. There is, however, an additional assessment process utilized at Intake, the Personality Assessment Inventory (PAI). This tool assesses personality and psychopathology to identify mental health conditions for additional evaluation. Within the PAI, there are clinical scales that evaluate for alcohol and drug problems as well as motivation for treatment. At this time, these substance dependency scales are not being utilized to inform SUD treatment placement.

Due to the front-loaded approach DOC uses to manage its substance dependency screening process, SUB scores remain static. Most AICs will never be re-screened for substance dependency using the TCU-DS.[8] This is relevant as this score is a significant factor of consideration in potential placement in one of DOC's addiction treatment programs. AICs with identified alcohol and other drug (AOD) abuse histories are referred to the Treatment Assignment and Screening Committee (TASC) for review of their risk, need, level of motivation, and eligibility factors. The TASC meets weekly and is comprised of stakeholders from Population Management, Behavioral Health Services, and the Correctional Rehabilitation Unit. At the point of review, the SUB score and LS/CMI or WRNA risk/need score(s) are reviewed. In the case where there is discrepancy between a SUB score and risk/need scores, the TASC may request that a Correctional Counselor re-administer the TCU-DS. Given the fact that there is no formalized process of training for the re-administration of this tool, the results are variable. If a revised SUB score is inaccurately calculated, it may lead to placement in an inappropriate level of care. If a re-administration does not occur, it may lead to ineligibility for treatment entry.

It is relevant to briefly mention screening and assessment for gambling disorder (GD). Currently, DOC does not screen or assess for GD at intake. A study by the Oregon Health Authority's (OHA) Problem Gambling Services Division found there is an overrepresentation of problem gambling in DOC as compared to the general population in Oregon.[9] Recommendations from this study will be included in the next section.

3.2 Aligning Screening and Assessment with a Chronic Disease Approach

Barrier: Screening and designation of treatment need are time limited.

Screening for possible SUD should be available throughout the entirety of an AICs sentence. A time-limited, front-loaded screening approach may lead to a skewed diagnostic picture.[10] It fails to account for substance abuse problems that develop or worsen while in custody. It overlooks the possibility of inaccurate reporting due to withdrawal of detoxification from substances upon entry into custody. It

[7] From AIC focus groups - the reasons for this manipulation varied: low motivation for treatment, hopelessness around a recent relapse that led to re-incarceration, no eligibility for AIP or STTL, influence and social pressure from another AIC.

[8] On rare occasions, the Correctional Counselor may opt to conduct a fresh TCU-DS as part of their process of submitting an AIC for treatment eligibility review to the TASC. However, there is not a concrete policy or process for this and most Correctional Counselors have not been trained in administration or scoring of the TCU-DS.

[9] See Moore (2018) Problem Gambling Prevalence in the Oregon Criminal Justice System.

[10] Given the overrepresentations of COD in the justice system, it is appropriate to default to these practice standards for SUD evaluation. For more, see Substance Abuse and Mental Health Services Administration. *Screening and Assessment of Co-occurring Disorders in the Justice System* (2013); American Psychological Association. *The diagnostic and statistical manual of mental disorders* (5th ed.).

misses the opportunity to capture the change in insight and level of motivation that may occur with the passing of time, and it does not allow time for the stabilization of mental health symptoms, which can reveal a clearer picture of an individual's substance dependency.[11]

Implementation strategy: Adopt a "no wrong door" approach to screening and assessing for SUD.
This would allow DOC to create multiple pathways to care. Adopting universal precautions at intake, would allow for all adults entering custody to be screened for substance abuse risk. Any screenings that show elevated risk of substance dependency would be referred to a qualified mental health provider for clinical evaluation and a DSM-V diagnosis of SUD, as indicated. After intake, all institutions would have the capacity to administer the screening tool to any AIC who demonstrated need, if the administering staff has received the requisite training. Demonstrated need might include: a positive urinalysis test for drugs, drug overdose, drug possession, AIC self-disclosure of previously unknown addiction history, or provider concern related to past or current substance abuse. If the results of the screening indicate elevated risk, the AIC would be referred to a qualified mental health provider for evaluation and possible diagnosis of SUD. Moving toward an integrative care model would open an additional channel for identification of need, with medical providers using the screening tool to routinely assess patients for possible substance dependency.

Barrier: Current substance dependency screening tool is no longer a good fit for the population we serve and is not effectively integrated with clinical practices.
DOC is currently using the TCU-DS, second version, which is outdated, as the instrument is now available in a fifth version. While DOC could move forward with implementing this newer version, it not recommended at this time. The instrument has proven complicated to administer and the length of its application in DOC has led to an undesirable outcome where AICs are able to game the results. Best practice literature recommends evaluation for SUD (in alignment with chronic disease models) should be a blended approach: brief screening followed by a more extensive clinical assessment[12]. Due to the length and complexity of the TCU-DS[13], it no longer seems the appropriate tool to utilize if DOC is to adopt a blended approach.

Implementation Strategy: Adopt a new screening tool that is empirically-validated for use with corrections populations. Implement a blended screening and assessment approach, which will align with clinical practices to support better diagnosing of SUD.
Since the development of the TCU-DS many other alcohol and substance abuse screening tools and processes have emerged that are empirically validated, with several demonstrating reliability with corrections populations. Screening tools, like the UNCOPE or the CAGE-AID, both recommended by SAMHSA, would be easily adapted in DOC "no wrong door" approach. Their brevity better aligns with a blended approach to diagnosing SUD. This would allow practical application universally at intake and, later in custody. Staff from multiple disciplines may be trained in these screening tools and allow a more integrated approach to addiction treatment. Incorporating such a screening tool into an EHR system would allow ease of access to screening and screening results by multiple providers in support of integrative care. Adoption of a new screener would require acquisition of the tool, training of staff,

[11] Ibid. "In order to accurately examine CODs and related issues, these individuals need to be provided a period of detoxification. Even for those in jail or prison, residual effects of substance abuse may cloud the symptom picture for several months after incarceration." (pp. 39)
[12] See McLellan, Lewis, O'Brien & Kleber (2000); Prendergast, M., Cartier, J. & Lee, A. B. (2014); Proctor & Hoffman (2016); SAMHSA (2013); Saitz, Larson, LaBelle, Richardson & Samet (2008).
[13] The TCU-DS version 5 is 17 questions with 19 sub-categories.

updating of classification processes, and establishment of new referral processes for clinical assessment. Fortunately, cost of these tools is low, as both SAMHSA recommended instruments are public domain[14].

A universal approach to screening for problem gambling should be adopted. All individuals entering DOC intake would complete the Problem Gambling Severity Index. Those who scored moderate to high for problem gambling would be referred to a Qualified Mental Health Professional (QMHP) for clinical evaluation of a Gambling Disorder (GD). Any individuals diagnosed with a GD would be recommended for problem gambling treatment. These are consistent with the screening and assessment recommendations made to DOC by the OHA Gambling Services Division.

Barrier: Formal clinical evaluation of SUD is limited and not available to all who score high for substance abuse risk at screening.

A limited number of AICs currently receive a formal, clinical evaluation for SUD. As previously mentioned in the report, at Intake, this is attributable to existing workflow of screening practices, as well as clinical discretion. Later in custody cycles, this limitation is due to no existing practice or process to refer AICs for clinical assessment of SUD. Current ODOC staffing capacity will not allow for an expansion of these services. Creating a workflow to accomplish this would require increased clinical staff hours; this is especially notable in the Intake BHS unit, where they conduct the largest volume of mental health evaluations in our system.

Implementation Strategy: Create a formalized clinical practice to refer all adults in custody that score high for substance abuse risk at screening to be evaluated by a qualified mental health provider for possible SUD diagnosis.

The Behavioral Health Services unit will need to create a policy and practice for the clinical evaluation of SUD. In institutions where there are no qualified mental health providers on site, arrangements will need to be made to complete the evaluation. To minimize barriers, telemedicine might be considered as an option. A process will also need to be created that allows for the diagnostic code to be entered into DOC tracking system. Following these steps, the SUD diagnosed AIC will be assigned to a Qualified Mental Health Professional for individualized treatment planning.

Recommendation: Practices for screening and assessment should be trauma-informed and culturally-responsive.

The outcome of screenings and assessments may be influenced by conditions of physical and psychological safety. Given that traumatic experiences are disproportionately represented in the incarcerated population[15], efforts to reduce retraumatization are critical to screening and assessment practices.[16] Staff in the Intake center and BHS units might consider conducting Trauma-Informed Environment Scans[17] to assist with identifying potential barriers to physical and psychological safety in places where they meet with AICs. Screening and assessment policies and practices should reflect the principles of Trauma-Informed Practice.

Culturally-specific screening and assessment services should be the goal for DOC. At this time, the Intake unit and BHS unit are significantly homogenous, with more than 85 percent of staff identified as white.

[14] CAGE-AID and UNCOPE

[15] See SAMHSA Screening and assessment of co-occurring disorders in the justice system (2013).

[16] See SAMHSA Concept of trauma and guidance for a Trauma-Informed Approach (2014).

[17] Harris, M. & Fallot, R. Using Trauma Theory to Design Service Systems. New Directions for Mental Health Services (2001).

The racial and ethnic identities of these staff are often not representative of the AICs they serve. While DOC continues its work to diversify staff at all levels in the agency, it must commit to continue to invest in training and support for the cultivation of cultural awareness and humility among staff[18]. Screening instruments and assessment questions must be culturally-relevant and inclusive. When possible, paperwork should be available to AICs in their language of choice. Screening and assessment policies and practices should be responsive to the racial, ethnic, and cultural needs of the AICs.

4 Barriers to Treatment

4.1 Background on Treatment Approach

Currently, DOC's treatment for SUD and co-occurring disorders (COD) is restricted to an acute episode of care available to qualifying individuals six months prior to their projected release. To qualify for treatment, an individual must meet custody level of the treatment institution, have enough time left on their sentence to complete the program, be found physically and mentally stable enough to withstand the rigors of the program, not be impacted by significant learning disabilities or substantial language barriers, and demonstrate need for SUD treatment by their Automated Criminal Risk Score (ACRS), SUB score ,and LS/CMI or WRNA risk/need scores. Given the challenges inherent in the determination of SUB scoring, the current approach is flawed; it creates the likelihood that treatment access may be restricted for those whose screening at intake was incorrect, incomplete, or inaccurate.

Level of care for treatment placement is largely determined by LS/CMI or WRNA risk scores, jurisdictional records, ACRS, SUB score, and Correctional Counselor recommendation. No American Society of Addiction Medicine (ASAM) assessment is conducted to determine level of care prior to treatment entry. The assignment to one of DOC's treatment programs is made by the TASC, as previously discussed in this report. Assignment to a treatment program does not guarantee placement. DOC does not have enough treatment beds to serve all individuals in need. Once on the waiting list, entry into a program is dependent on a myriad of complex factors, including: bed opening date in relation to place on waiting list, AIP or short-term transitional leave (STTL) window, level of criminogenic risk, level of motivation, institution location, and ability to be transported to treatment institution within timeframe of bed opening.

Once entered in treatment, program staff conduct an ASAM assessment. This assessment is utilized to guide individualized treatment and continue care planning within that prescribed program. Since the program placement, which is fixed in dosage and length, has been pre-determined, the results of the ASAM assessment do not lead to changes in level of care. For example, if the AIC was placed in an intensive outpatient program, but their ASAM assessment shows a residential level of care is needed, they will not be reassigned programs. While this is not in alignment with best practice protocols for level of care determination[19], DOC is not positioned to provide this level of responsive treatment assignment due to structural restrictions that exist as part of a consequence of program locations, bed space, and time limitations.

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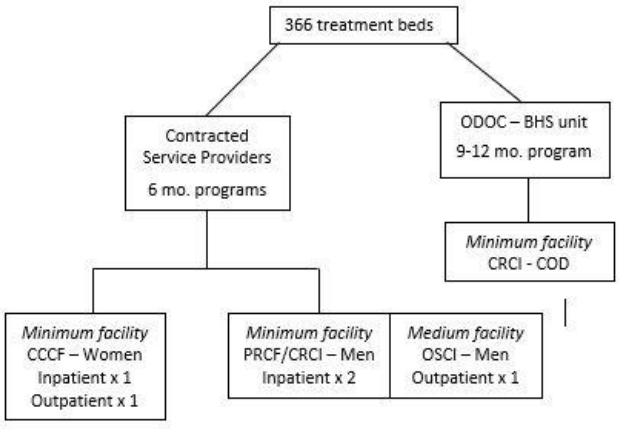
[18] Curry-Stevens, A., Reyes, M.-E. & Coalition of Communities of Color (2014). Protocol for culturally responsive organizations. Portland, OR: Center to Advance Racial Equity, Portland State University.

[19] The goal is for treatment that is outcome-driven where the priority is "person-centered, individualized treatment, responsive to specific needs and progress" as opposed to program-driven, where the diagnosis drives the level of care and placements are fixed lengths of stay. See M*ee-Lee, D., Shulman, G., Fishman, M., Gastfriend, D. & Miller, M. (2013)*

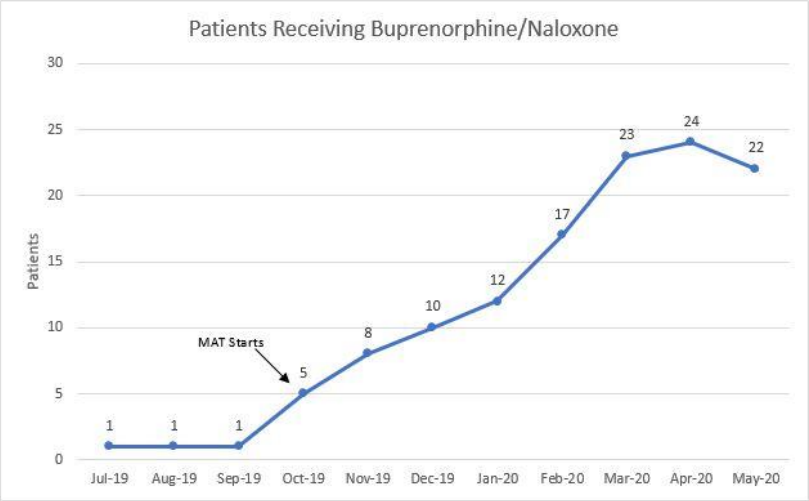
Figure 1 – ODOC Intensive Treatment Programs



Current placement is limited to DOC's six addiction treatment programs, for a total of 366[20] treatment beds. Treatment duration is set at a range of six to 12 months[21]. All existing programs are housed in minimum custody facilities, except for the men's outpatient treatment program at Oregon State Correctional Institution, which is a medium custody facility. Of the six programs, five are provided by contracted service providers (CSP). These include two men's intensive inpatient programs, located at Powder River Correctional Facility (PRCF) and Columbia River Correctional Institution (CRCI), and two women's programs (one intensive inpatient and one intensive outpatient) at Coffee Creek Correctional Facility (CCCF). Four out of six operate as modified therapeutic communities; all utilize gender-responsive curricula. Starting in the summer of 2020, DOC will officially open its men's COD program at CRCI. The program will be staffed by Qualified Mental Health Associates (QMHAs) and QMHPs from the Behavioral Health Services unit.

The department recently concluded a pilot study that implemented a peer recovery support model to assist SUD-impacted individuals with recovery-oriented release planning at three institutions; approximately 15 AICs were trained and certified as peer recovery coaches. After the conclusion of the study, the program ended due to limitations in funding. Currently, DOC is using peer supports in two institutions: a) As part of the Reducing Overdose After Release from Incarceration (ROAR) study, in partnership with Oregon Health & Science University, at CCCF[22]; and b) In the program design of our contracted outpatient men's treatment program at OSCI known as Freedom & Recovery.[23] Through ROAR, enrolled women engage in initiation of medication assisted treatment and peer support, with a focus on community-based care for release. The program aims to serve 100 women by the conclusion of the study. The Freedom & Recovery Program trains and certifies recovery mentors to support men enrolled in the treatment program, as well as provide mentoring to men in general population that are seeking recovery pathways. This program has been hugely successful and is a model to look to when considering wider implementation of peer recovery support services.

[20] 316 of these beds are currently online. The remaining 50 come online, progressively, with the COD program opening.
[21] The SUD treatment programs are 6 months in duration. The COD program is 9 to 12 months with length of stay based on individual acuity and treatment need. 5 of the 6 treatment programs accept AIP candidates.
[22] https://news.ohsu.edu/2019/09/11/reducing-the-risk-of-post-incarceration-opioid-overdose-in-women
[23] Freedom & Recovery is provided by a Contracted Service Provider and is also DOC's only culturally-specific addiction treatment program.



Since its launch in the summer of 2019, DOC's MAT program has expanded significantly. We are now able to serve AICs at seven institutions across the state. Medical release nurse coordinators work closely with community partners like CODA and Bridgeway to establish continuing care for these patients.

Another current treatment approach is for Gambling Disorder. This treatment is provided in three DOC institutions by OHA-contracted treatment providers. This 12-week curriculum, Gambling Reduction and Recovery for Incarcerated Persons (GRIP), is currently offered to SUD-treatment enrolled AICs that score moderate to high on the Problem Gambling Severity Index (PGSI). From 2016 to 2018, these groups served a total of 165 AICs.[24]

4.2 Aligning Treatment with a Chronic Disease Approach

Barrier: Addiction is being treated as an acute condition.

Implementation Strategy: Implement a chronic disease model across DOC for treatment of SUD. Treatment will be individualized, holistic, culturally responsive, and available throughout the custody cycle.

Implementation of a chronic disease model for SUD treatment requires a redesign of the current DOC treatment system. It will need to ensure every AIC is screened and evaluated for SUD, with opportunities for this to occur throughout the custody cycle. While this expanded screening process is likely to increase the number of individuals identified with SUD in custody, the chronic care model affords DOC the opportunity to approach treatment in a way that ultimately reduces a strain on resources. This would be accomplished by directing all SUD-diagnosed AICs through an individualized treatment planning process. Individualizing care is not only the road to best practice for treating addiction as a chronic illness; it is also an opportunity to use distributive principles to better manage population flow through services.

Instead of funneling all SUD-impacted individuals through one available resource, thoughtful treatment planning that begins earlier in the incarceration cycle will allow for care tailored to an AIC's strengths and needs. Individualized care is collaborative and patient-centered. It allows for targeted interventions that may address compounding issues of SUD [25], including medical comorbidities. For example, an AIC that has significant chronic pain issues due to a debilitating health condition is likely to benefit from a care approach that targets chronic disease self-management and distress tolerance skills before focusing on substance-dependency issues. An additional benefit of this model, is that it creates time for the

[24] See WHO *Guidelines for psychosocially assisted pharmacological treatment of Opioid Dependence* (2009); SAMHSA TIP 63 (2018); SAMHSA *Medications for Opioid Use Disorder: TIP series, no. 63 (2018).*

[25] Addressing comorbidities through solution-focused, individualized counseling is a SAMSHA TIP. See SAMHSA (2012).

development of therapeutic alliance between the SUD-impacted individual and clinician, creating earlier opportunities to reduce resistance to treatment; thereby increasing the impact of later interventions. This recommendation of clinician-client centered treatment planning is in alignment with the contextual model recommended in the Criminal Justice Commission's (CJC) 2019 report and findings for Senate Bill 1041.[26]

Barrier: Care for SUD is not integrated across disciplines. The absence of an EHR system makes integrating care difficult.

Implementation Strategy: Treatment of SUD should extend across all levels of care in DOC to be fully integrated. Medical, mental health, and addictions providers will actively collaborate in treatment of SUD, leading to better continuity of care. An EHR system will facilitate seamless sharing of records and enhance collaborative communication.

Integrative approaches create a seamless continuum of care for patients. When medical, mental health, and addictions treatment providers are on the same page, interventions are more impactful. This collaboration and integration are especially critical when medical comorbidities[27] are present[28]. Since the current care model is not integrative, new processes and procedures will need to be established to support the transition. Care integration requires a commitment of time from providers to ensure collaborative communication is consistent and outcome-driven.[29] DOC Medical Services already has established protocols for the ongoing care of chronic illnesses like HIV/AIDS and diabetes that may prove a useful guide in this transition. For example, an AIC with hepatitis is seen as part of a special needs review at a predetermined period for an evaluation of their progress in care. For further oversight, the AIC will also meet with a Chronic Disease Specialist once a year for higher level review of their care. This is a process that could be useful for the management of SUD as a chronic illness. In particular, the department would benefit from hiring an Addiction Medicine Physician to assist with oversight of this substantial expansion of complex care for SUD.

Implementation of an EHR system is critical to facilitate the collaborative communication and information sharing necessary to integrative care. It supports effective decision-making by keeping all providers up to date on the patient's care and needs.[30] DOC is currently in the early planning phases of implementing an EHR. Systemwide implementation will be necessary for the success of an integrative care model.

Barrier: The limited number of treatment beds and location of programs hinders entry for many.

There are not enough treatment beds to meet the needs of individuals with SUD in DOC. The number of available beds for men has decreased by 133 over the last five years. While the opening of the COD program at CRCI is a gain for an underserved segment of our population, it comes with the removal of 50 men's outpatient treatment beds from the system. While CCCF has not lost treatment beds, the need for SUD treatment continues to outpace the availability of slots. Additionally, an availability of only end-of-sentence program beds is out of alignment with a chronic disease approach to treating SUDs.

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[26] Oregon Criminal Justice Commission. (2019). *Analysis of Oregon's publicly funded substance abuse treatment system*, pp. 41-42.

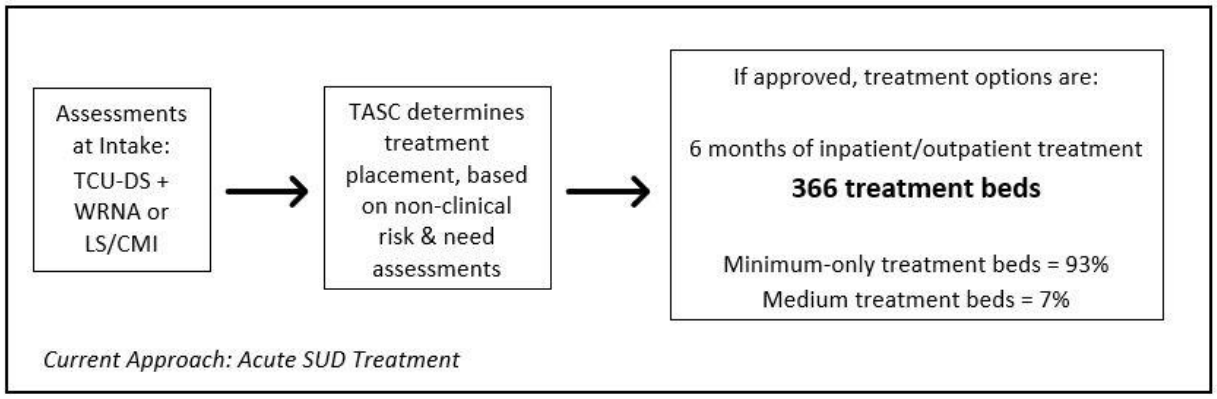
[27] Comorbid medical conditions and co-occurring mental health diagnoses are a common factor with the adults in our custody.

[28] See Weisner, et al. (2001). Integrating primary medical care with addiction treatment: a randomized controlled trial.

[29] See SAMSHA-HRSA (2013). *Innovations in Addictions Treatment.*

[30] Ibid.

The location of treatment programs presents a barrier to effective treatment of SUD. Rather than appropriate level of care placements being made based on identified service need, many are determined based on population management factors. For example: the only intensive inpatient programs for men are in minimum custody facilities. If an AIC with higher risk or need is recommended for intensive inpatient treatment, but he is unable to attain minimum custody classification, he will be denied entry into the most appropriate level of care for him. The likely treatment alternative would be placement in a lower level of care in the men's outpatient program. The reverse is true for a minimum custody-eligible AIC – if he is recommended for an outpatient level of care, he will be placed in an intensive inpatient program due to his lower custody level.



A similar problem exists for female AICs because the only existing treatment programs are in the minimum custody facility at CCCF. In order to qualify for treatment, a woman must attain minimum custody classification. If she cannot achieve this, then she will receive no SUD treatment. An additional complicating factor is that intensive mental health services are only available in the medium facility (CCCM). Given women (especially women of color) are disproportionately represented with trauma, addiction, and mental health comorbidities, limiting their pathway to access care presents an equity and ethics issue. [31] There is currently no COD treatment program for women in DOC.

Implementation Strategy: Expand treatment services to be available in as many ODOC institutions as possible. Treatment services will be holistic, professionally-driven and diversified to include other evidence-informed modalities of care.

In order to effectively serve more SUD-impacted AICs in alignment with a chronic disease approach, DOC will need to diversify its treatment offerings. This should include the creation of a COD treatment program for women in CCCF, so that this underserved population can access the intensive treatment support that it needs. It should retain the existing menu of intensive pre-release treatment programs, however, determinations for eligibility entry should be broadened to include professionally-driven clinical recommendations for level of care. Recommended additional modalities for inclusion are: Computer-assisted treatment, brief-duration treatment groups, gambling disorder treatment groups, expanded mutual aid group offerings and the development of statewide Peer-Based Recovery Services across as many institutions as possible.

[31] See Najavits, et al (1997) *The link between substance abuse and posttraumatic stress disorder in women*; Myers, et al (2014) *Associations between childhood adversity, adult stressful events, and past-year drug use disorders.*

As the Multi-modal SUD Treatment diagram illustrates, once an individual is diagnosed with a SUD, they would work with a QMHP to develop an individualized treatment plan. That plan may initially involve only working with a QMHP on individualized treatment counseling, which is what the return arrow on the diagram indicates – that the work with that clinician is ongoing. More likely, however, they will be connected to at least one, if not more, SUD treatment modalities. These modalities are listed in the

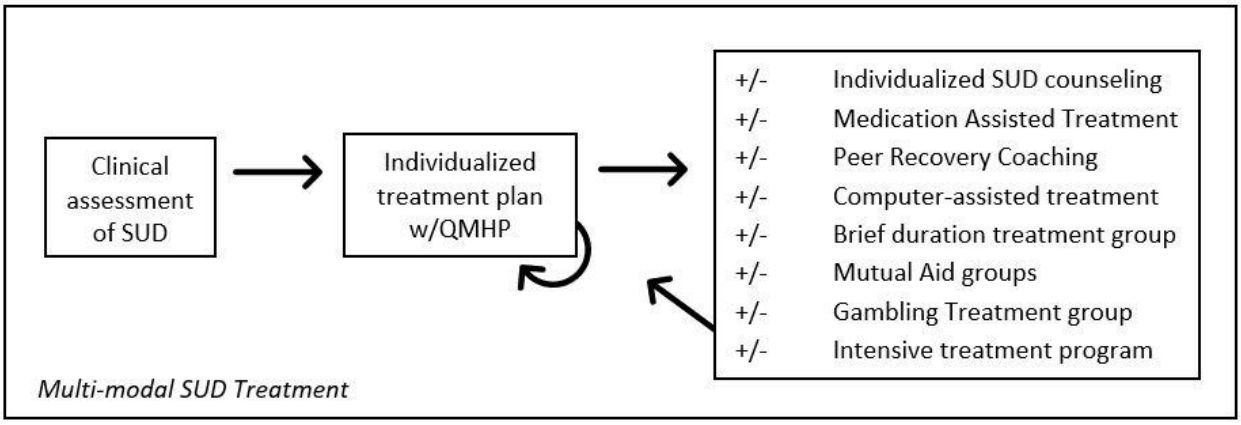


diagram with minus and plus signs next to them to indicate that each intervention could be added or eliminated from an individualized treatment plan. In keeping with best practices, every SUD-impacted individual would need to have an ongoing review of their treatment plan – to evaluate progress and determine if additional interventions are needed or changes to the plan are necessary. This is indicated by the arrow drawing out from the intervention box back to the QMHP. Centralizing work with BHS clinicians streamlines treatment planning and ensures that services are professionally-driven.

Additional background on several of these treatment modalities is provided below.

4.3 Peer Recovery Support Services

DOC sees the introduction of Peer Recovery Supports as one of the most critical steps to laying the foundation for the shift to a chronic disease approach to treating SUD. It expands pathways to recovery to include care that is non-hierarchical, empowerment-based, culturally-responsive, and reciprocal. One of the greatest assets of Peer Coaching is that it is reciprocal: the coach gains as much from the helping relationship as the mentee receiving it. In a closed system, like corrections, the impact reverberates even further. There is a "positive contagion of hope"[32] that is created when transformative change is role-modeled for others.

Peer Coaches can assist mentees with:

- Setting recovery goals
- Identifying institutional resources to assist with behavioral goals
- Helping to learn about and integrate into recovery culture
- Coping with difficult emotions
- Practicing social skills and problem solving for difficult situations
- Exploring education and employment pathways
- Assisting with recovery action planning
- Offering instrumental support with release and transition processes

[32] See Best et al (2020), pp. 88.

Incorporated into a continuum of care for SUD, Peer Coaches may be utilized to intercede at multiple points on a person's recovery pathway: pre-treatment to strengthen motivation for change; between treatment interventions to maintain engagement with recovery skills; or post-treatment to support transition processes and relapse prevention planning. Peer Coaching is a treatment modality that may be added to an AICs individualized treatment plan. With a goal of implementing Peer Support Services across 11 institutions, approximately 110 AICs would need to be identified and trained. Each institution would have a supervising Qualified Mental Health Associate (QMHA) that would provide the operational support and ongoing skill-based supervision for these Peer Coaches. In addition to carrying a caseload of mentees, these Peer Coaches would co-facilitate Brief-Duration Treatment Groups with their supervising QMHA.

A strength of this proposed model is the high level of oversight that the supervising QMHAs would provide to the Peer Coaches. This helps to address a general concern of peer programs in a correctional environment: that the potential for exploitation or manipulation exists between the AIC Coach and the AIC Mentee. Having a dedicated staff that is present, on-site, with the Peers is a key part of this. Additionally, the supervising QMHA would conduct regular observations of Peer Coach and Mentee meetings and would conduct regular, intensive individual and group supervision.

Evidence for the positive impact of the integration of Peer Recovery Supports in the SUD care continuum is strong. Empirically-validated research demonstrates that Peer Mentoring reduces substance use, improves relationships between patients and their treatment providers, increases treatment retention, decreases criminal justice system involvement, reduces relapse rates and increases social functioning.[33] The capacity of ODOC's treatment system would be substantially expanded with the addition of a strong Peer Recovery Support network: more SUD-impacted individuals could be served the care continuum would be lengthened.

4.4 Brief Duration Groups

Research shows that when brief-duration addiction interventions are introduced in treatment systems of care, they reduce risk, increase retention, and enhance motivation. These groups assist SUD-impacted individuals with setting behavioral goals and building up the skills necessary to achieve them. Engagement in group-based, recovery-oriented learning builds community and cultivates opportunities to feel hopeful about making life changes.[34] Adopting these interventions into DOC's system of care for SUD treatment would further expand the available recovery care pathways available to AICs. Possible groups that ODOC might offer, include: Chronic Disease Self-Management, Cognitive Behavior Therapy (CBT) or Dialectical Behavior Therapy (DBT) -based coping skill, psychoeducational groups focused on social skills development and problem-solving skills, Gambling Education and Reduction, and risk-reduction education. Treatment dosage might range anywhere from 14-days, to 45-days, to 60-days maximum. Integrative care providers would be able to refer to one or more groups based on the unique needs of the AIC and their individualized treatment goals. These groups may also be used to add-on additional treatment support when an AIC experiences a relapse or is struggling with behavioral problems in the institution. These groups could be co-facilitated by Peer Recovery Coaches, QMHAs, or member of the integrative care team.

[33] See SAMHSA (2009) *What are peer recovery support services?*; Ashford et al (2019) *Building recovery ready communities*

[34] See SAMHSA Brief Interventions and Brief Therapies for Substance Abuse - Treatment Improvement Protocol Series, No. 34; Hunter (2014) *Defining Recovery-Oriented Systems of Care*

4.5 Gambling Treatment Groups

As recommended in the OHA Problem Gambling Services report, all AICs diagnosed with a Gambling Disorder would be placed on a treatment pathway. The need for treatment is significant across our institutions, with notable severity in our female population: the study found that 61.2-70.4% of women were at high risk for serious problems associated with their gambling, as compared to 21.6-28.8% of men.[35] Treatment groups should expand to as many ODOC facilities as possible, with a priority focus on expanding services to CCCM first. Implementation cost would be low since the GRIP program would be provided by OHA-funded-contractors.

4.6 Medication Assisted Treatment

DOC has implemented Medication Assisted Treatment (MAT) across 7 institutions. The need for this treatment modality continues to grow. With this need comes increased cost, both in medication and the increased need for licensed and waivered providers. An expansion of available treatment counseling supports for MAT-engaged AICs would be beneficial. While connecting individuals with OUD to MAT services is a critical component of care, best practice standards recommend that it not be a singularity, and that individualized counseling and treatment are still made available.[36]

4.7 Computer-assisted Treatment

The utilization of computer-assisted treatment extends the reach of chronic care for SUD and COD. These services have the potential to bring individualized treatment to more people at a wider number of institutions. For example, medium custody facilities which are underrepresented with addictions programming could now deliver impactful SUD treatment to a population previously untargeted for care. Computer-assisted treatment increases flexibility in care due to being user-driven; access can occur at more periods in the day/week than in-person services might be available, which frees up clinician time. The treatment intervention itself is strengthened by its standardization, removing concerns about fidelity practices. A notable strength of computer-assisted addiction treatment serves is its cumulative effect on skill-development. Treatment planning could target the remediation of cognitive impairment early on in an AICs continuum of care, setting the conditions for stronger impacts of addiction treatment services to follow.

A variety of software exists that could be incorporated into the corrections-setting: cognitive-behavioral therapy programs like CBT4CBT[37], cognitive enhancement programs like PSSCogRehab[38], or cognitive remediation programs like COGPACK[39]. All have applications with SUD-impacted or COD-impacted populations. Randomized control trials of the computer-assisted cognitive-behavioral addiction therapy, CBT4CBT, show promising results. This intervention demonstrates measurable improvement in areas of cognitive impairment related to treatment response, specifically: inhibition, cognitive flexibility, memory, learning and attention[40]. Outcome measurements show reduction in substance use and longer

[35] See Moore (2018). Problem gambling prevalence in the Oregon Criminal Justice System, pp. 13.
[36] See SAMHSA (2018) *Medications for Opioid Use Disorder: TIP series, no. 63.* It should be noted that counseling should never be an "arbitrarily required as a condition for receiving OUD medication." (pp. 216)
[37] See https://cbt4cbt.com/
[38] See http://www.psychological-software.com/psscogrehab---english.html
[39] See http://www.cogpack.com/USA/frames.htm
[40] Carroll, K. M., Kiluk, B. D., Nich, C., Babuscio, T. A., Brewer, J. A., Potenza, M. N., Ball, S. A…(2011). Cognitive function and treatment response in a randomized clinical trial of computer-based training in Cognitive-Behavioral Therapy. *Substance Use & Misuse*, *46*(1), 23-34.

periods of abstinence[41]. Topics covered in the program include: understanding and changing patterns of substance abuse, coping with craving, refusing offers of alcohol and drugs, problem solving, decision-making, identifying and changing thoughts about substance use.

Recommendation: Treatment services should be trauma-informed and culturally-responsive.
BHS treatment staff should be provided ongoing training and supervision toward the cultivation of their Trauma-Informed Care (TIC) skills. Clinical interactions should be attuned to prevent retraumatization, with special attention paid to the stigmatizing experiences that individuals with SUDs often face, most especially communities of color.[42] Treatment curricula should be evaluated for alignment with the principles of TIC and for cultural responsivity factors. Individualized treatment planning should be trauma-responsive and culturally-relevant. Whenever possible, AICs should be allowed the choice to work with staff of shared racial, ethnic or cultural identity. Given recent data which showed that African Americans were 77% less likely than their White counterparts to get the access that they need to MAT, DOC should pay close attention to the presence of such racial disparities in institutional access to MAT for OUD[43].

At this time, staff in the treatment programs and BHS unit are significantly homogenous, with more than 85% of staff identified as white. The racial and ethnic identities of these staff are often not representative of the AICs that they serve. While the department continues its work to diversify staff at all levels in the agency, it must also commit to transformative learning and support for the cultivation of cultural awareness and racial equity.[44] As part of this work, the Health Services and Behavioral Health Services units should consider conducting an equity assessment to inform meaningful change around diversity and inclusion.

5 Barriers to Continuing Care

5.1 Background on Continuing Care Approach

For an AIC enrolled in one of ODOC's intensive addiction treatment programs, their release planning is currently a collaboration between the Institution Release Counselor, the assigned Parole/Probation Officer (PO), and treatment program staff. There is no exact task delineation, as processes can vary by County. In most cases, the PO is the gatekeeper for housing. They will approve or not approve private addresses provided by an AIC. If a private residence is not an option or cannot be approved, the PO may recommend a sober-living transitional home, like an Oxford House. In some counties, there are no sober-living homes or transition centers. In these cases, it is not unusual to see an AIC be approved to release to a homeless shelter.

Addiction treatment aftercare is similarly organized. Treatment programs will recommend what type and dosage of aftercare is appropriate for the AIC, but the PO typically makes the determination as to what amount of treatment an AIC will need to complete to comply with conditions of their supervision. Often, attendance at mutual aid meetings and attending 30-60 days of outpatient treatment is required.

[41] See Olmstead, T. A., Ostrow, C. D., & Carroll, K. M. (2010). Cost-effectiveness of computer-assisted training in cognitive-behavioral therapy as an adjunct to standard care for addiction. *Drug and alcohol dependence*, *110*(3), 200-207.
[42] See Substance Abuse and Mental Health Services Administration. (2013).
[43] See American Medical Association article, Nov. 2019: https://www.ama-assn.org/delivering-care/opioids/black-patients-less-likely-get-treatment-opioid-use-disorder
[44] See Curry-Stevens, A., Reyes, M.-E. & Coalition of Communities of Color (2014).

Not every county has available treatment services to attend. Insurance may also be a barrier to aftercare treatment entry. Some providers will not accept the Oregon Health Plan (OHP). ODOC assists AICs with applying for OHP prior to release, but sometimes the system is back-logged and they can't obtain their card and policy number until several weeks after release.

For AICs with substance dependency that do not enter an intensive treatment program, there is limited ODOC coordination of care, unless they are enrolled in MAT services at the time of their release. (These AICs receive extensive release planning care coordination facilitated by ODOC Medical staff.) The Institutional Release Counselor and PO will collaborate on transition plans for these non-treatment-enrolled AICs. If services are available, the PO will coordinate SUD treatment upon release. Housing options are limited to approved addresses and transition centers. Generally, sober-living transition homes are not open to take candidates that didn't complete addiction treatment prior to release from prison. Homeless shelters are also an option utilized for this group of AICs.

ODOC has incomplete information on what the process is for accessing Peer Recovery Mentors prior to release as part of the continuum of care for SUD. Peer Mentoring services are often provided by community-based non-profit agencies and AIC access is limited to the counties where such services are available. A few of the CSP Treatment programs have established partnerships with such agencies and are able to connect their treatment participants with a peer prior to release. This tends to be limited to the Portland metro area and the I-5 corridor. An additional exception is for women that are enrolled in the ROAR program pilot. The MAT-initiated participants of the program are connected with a peer mentor prior to release.

5.2 Aligning Continuing Care with a Chronic Disease Approach

Barrier: Limited resources make it difficult to provide assertive linkages to community care.

There is current disparity in the continuing care process for SUD-impacted individuals. Individuals enrolled in one of the treatment programs get support with accessing a community care continuum, while the unenrolled receive the same level of transition planning support as a non-substance-dependent AIC. General population coordination of addiction treatment aftercare is very limited. DOC does not have the resources to provide a higher-level of continuing care for the full substance dependent population. It would take an increase in staff to facilitate a higher-level of care coordination.

Continuing care planning with Oregon's 34 independently-run counties[45] is a challenge. This challenge is attributable to the lack of consistent, available resources to transition AICs into for long-term recovery management. Due to resource scarcity, strong collaboration between DOC and community corrections will be more important than ever if a chronic disease approach to addiction treatment is to be implemented. Results from a survey distributed to Community Corrections Directors and supervisors across the state of Oregon[46] indicated a desire for increased collaboration with and support from DOC is desired across counties – with over 43 percent of respondents indicated it as a high priority. This speaks to the value of this partnership to ensure success in the implementation of a chronic disease addiction treatment model in Oregon.

[45] 2 of the 36 Oregon counties are under the authority of the Oregon Department of Corrections.

[46] A 5-question Survey Monkey was distributed to 94 Community Corrections Directors and Supervisors in late April of 2020 via interagency email. A total of 32 individuals responded to the survey. These responses were analyzed and contributed to the continuing care barriers and recommendations provided in this report.

Strategy: Designate Recovery Care Coordinators for each institution. These staff will work with SUD-diagnosed AICs to develop individualized recovery care pathways prior to release, partnering with institution release counselors and Community Corrections staff to establish assertive linkages to continuing care.

In keeping with the best practices for chronic disease management, continuing care planning for release should be individualized and intensive. It should go beyond treatment referrals and aftercare recommendations to actively establish linkages for holistic, ongoing care in the community before an AIC releases back to the community. Supporting SUD recovery requires the consideration of medical and mental health comorbidities, stable housing, and economic mobility.[47] These are not typically areas that receive much focus (beyond a 30-day picture) as part of addiction treatment release planning. However, research shows that these factors are all high predictors for relapse if destabilized.[48]

Chronic Disease Care Management is now being used as a model to inform the design for assertive continuing care of SUD. It is a medicalized approach to manage chronic conditions that creates integrative linkages between providers and systems to reduce barriers to care.[49] Serving in a centralizing role on the team is the Care Manager (or Care Coordinator), who collaborates directly with the patient to reduce barriers to care and establish linkages for follow-up. Drawing from this model, DOC could integrate Recovery Care Coordinators into the release planning process for SUD-impacted individuals that have not entered an intensive treatment program. Filling these roles would be qualified medical and mental health providers with backgrounds in addiction treatment and care coordination. Designated Care Coordinators would be identified for each institution to reduce barriers to communication among the many stakeholders involved in release planning. The coordinator would work collaboratively with the SUD-impacted AIC to develop an individualized recovery care plan. This plan would serve as the roadmap for the establishment of community care continuity. For example, Care Coordinators would get initial appointments scheduled for the AIC for their follow-up care for MAT, mental health, and other required care. Instead of leaving prison with referrals for ongoing care, an AIC would leave with program intakes already completed, and scheduled appointments. When linkages to ongoing care are strong, there is increased success in recovery maintenance after release. This proactive approach to establish continued care for releasing AICs would be done in collaboration with community corrections and could help alleviate the initial workload for Parole Officers (PO) who will be supervising the AICs in the community.

A secondary component of the Care Coordinator's duties would be to engage in ongoing follow up care for up to 90 days[50] after the AIC releases from DOC. Using the empirically-validated Recovery Management Checkup (RMC) protocol, the Coordinator would engage in regular check-ups by telephone with the AIC to assess early evidence of problems. Instead of relying on the patient to notice symptoms and ask for help, the RMC is pro-active, using assessment instruments designed to capture ambivalence about recovery and potential relapse risk. When relapse occurs, the coordinator makes connections to quickly get the participant re-engaged with services, including possible treatment readmission. This would be done in close collaboration with the supervising PO.

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[47] See McLellan, et al (2014) *Can Substance Use Disorders be Managed Using the Chronic Care Model?; Saitz, et al (2008).*

[48] See Scott, et al (2005) *Utilizing Recovery Management Checkups to shorten the cycle of relapse, treatment reentry and recovery.*

[49] Saitz, et al (2008).

[50] RMCs were designed for long-term engagement and retention, with most implementations lasting 2 to 4 years. However, research evaluations have measured positive outcomes in RMCs as short as 90 days.

Research evaluations have identified positive outcomes within 90 days of RMC engagement. Naturally, the benefits of the model increase the longer is it utilized. Outcome studies have shown that the protocol[51]:

- Reduced time to substance abuse treatment readmissions;
- Contributed to enhanced treatment participation and attendance;
- Reduced instances of substance use; and
- Increased abstinence .

Barrier: There is great disparity of available treatment services across Oregon counties.
The results of the survey of DOC's community corrections partners, showed a unified commitment with DOC in regard to implementing a chronic disease approach to SUD treatment. Ninety-three percent of respondents indicated their communities were in support of MAT services and 87 percent indicated community support for the peer recovery mentor model. This alignment toward a chronic disease treatment approach is encouraging. It indicates barriers to continuing care for SUD in the community are not about philosophical disagreement with approaches to addiction treatment. Instead, the survey revealed more study needs to be done on potential system integration issues and root causes for barriers as identified by the community corrections survey respondents. The primary structural barriers to re-entry identified include a lack of available treatment program slots and a lack of enough transitional, sober housing beds to meet need. Multiple survey respondents indicated insurance limitations are also a barrier to access of care for individuals they supervise. Further investigation is needed of these reported barriers, to understand the root cause of the access issues.

Reported areas for further exploration and analysis are:

- Difficulty accessing inpatient treatment programs and co-occurring treatment programs, particularly in rural counties;
- Lack of safe, sober transitional housing (primarily outside of the Willamette Valley);
- Challenge in accessing inpatient treatment beds for individuals without insurance or those with OHP; and
- Limited Medicare coverage for treatment, especially inpatient level of care (identified as a problem on the rise, due to the aging of DOC's corrections population).

Given longitudinal care is necessary to the successful management of SUD, it is concerning that community-based treatment resources continue to be difficult to access, especially in Oregon's rural counties. Without an appropriate continuum of care in the community, advances made in prison-based treatment will be lost.

Strategy: Partner with Community Corrections and Medicaid Coordinated Care Organizations to advocate for expansion of services, with a focus on rural and high-poverty counties. Utilize institution Recovery Care Coordinators to develop stronger relationships with community providers, including linkages to Federally Qualified Health Centers and community-based recovery organizations.
Partnering to address the substantial gaps in care in our Oregon communities must be a priority for ODOC. Systemic failures in state insurance processes must be reviewed. As this report details, if there is to be an effort toward assertive continuing care for SUD-impacted AICs, there must be available services to connect them with. If we, as a state, are committed to this paradigm shift, we must not divest from

[51] Scott, Dennis & Foss (2005); Dennis & Scott (2012); Dennis, Scott & Laudet (2014)

the resources necessary to support transitioning individuals with the long-term management of their chronic condition.

6 Summary of Policy Recommendations

1. **Increased funding for DOC addiction and mental health treatment services**
    a. Additional staffing across all stages of care: screening, assessment, treatment, transition, ad continued care
        1. Qualified mental health providers for clinical assessment and diagnosing, individualized treatment planning, expanded COD treatment programs
        2. QMHAs for Recovery Care Coordination, COD treatment, brief-duration treatment groups, Peer Recovery Support Services program coordination and Peer Coach supervision
        3. Addictions Medicine Specialist, MD
    b. Operational costs to support additional staff and services
        1. Computers, phone lines, supplies
        2. Training
        3. Institution supervision and AIC management
        4. PRAS Points for Peer Recovery Coaches
    c. Materials costs to build up new programs and services:
        1. Software and hardware for computer-assisted treatment
        2. Curricula for brief-duration SUD treatment groups
        3. Training and support materials for Peer Recovery Coaches

In order to reduce barriers to treatment access for AICs with SUD in DOC, there will need to be an expansion of services. As detailed in this report, this expansion would extend the reach of treatment beyond the current approach of acute, group-based care at the end of AIC sentences. In alignment with a chronic disease approach, this expansion of services will be individualized, holistic, multi-modal, culturally-responsive, and incorporative of peer-based recovery coaching. This service expansion will require an increase in staffing across all stages of care. With additional staff, programs, and AICs to serve, there will be increased operational costs.

2. **Increased funding for community-based addiction and mental health treatment**:
    a. Expansion of community-based SUD and COD treatment programs/services for individuals transitioning from DOC custody, with a focus on economically-disadvantaged counties and rural counties:
        1. More access to inpatient treatment beds
        2. Growth of outpatient treatment services
        3. Continued expansion of access to MAT

    b. Continued support and expansion of peer-based recovery support services, with a focus on growing these services in rural counties
    c. Expanded investment in recovery-based transitional homes and beds, with a focus on economically-disadvantaged and rural counties

Preparing AICs with SUD for a supportive transition into community care continues to be a challenging task for DOC treatment programs and institution staff. The extensiveness of planning for ongoing recovery management supports is often dependent on how resource-rich or resource-deprived the area is. In the direst of cases, there are no services to refer to – counties with no inpatient treatment programs or no transitional housing beyond a homeless shelter. As this report details, if there is to be an effort toward assertive continued care for SUD-impacted AICs, there must be available services to connect them with. If Oregon is committed to this paradigm shift, we must not divest from the resources necessary to support transitioning individuals with the long-term management of their chronic condition.

3. In-depth evaluation is needed of the current AIP statute to determine if it is inadvertently creating inequities of access for AICs who are ethnic or racial minorities, physically or developmentally disabled, or severely mentally ill.

The conditions of this statute present a barrier to the restructuring of addiction treatment services in alignment with a chronic disease model. The statute restrains eligible participants to an acute, end-loaded, episode of care –the current structure of all DOC's addiction treatment programs. Whether an AIC is AIP-eligible, STTL-eligible, or day-for-day, they enter the same treatment program with the rigorous 14-hour day structure dictated by statute.[52] Operation of AIPs is limited to minimum custody institutions, which creates access barriers for AICs that are unable to meet that level of custody. This limitation prevents AICs in need of intensive addiction treatment from accessing the clinically appropriate level of care. In order to better understand how these restrictions in access may be impacting the AIC population, DOC is interested in conducting a racial equity analysis of AIP eligibility and placement.

The statutory language creates an additional equity issue for the department. Due to the specifications of rigor required for AIP participants, a subset of the population is limited in access to SUD treatment to include AICs with complex physical or developmental disabilities, or severe persistent mental health diagnoses. Without AIP eligibility, there are limited alternative addiction treatment pathways in DOC for these individuals.[53]

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[52] The single exception to this rule is DOC's one men's outpatient treatment program at OSCI, which does not accept AIP participants.

[53] 2020 marks the opening of a men's COD treatment program in DOC that will be able to serve some of these individuals previously ineligible for other programs. However, there is no women's equivalent of COD treatment currently. There is no current SUD treatment pathway for developmentally disabled AICs.

Acronyms

AIC	Adults in Custody
AIP	Alternative Incarceration Program
AOD	Alcohol and other drugs
ASAM	American Society of Addiction Medicine
BHS	Behavioral Health Services
CADC	Certified Alcohol and Drug Counselor
CCCF	Coffee Creek Correctional Facility - Minimum
CCCM	Coffee Creek Correctional Facility – Medium
CJC	(Oregon) Criminal Justice Commission
COD	Co-Occurring Disorder
CRCI	Columbia River Correctional Institution
CRM	Certified Recovery Mentor
CSP	Contracted Service Provider
DSM	Diagnostic and Statistical Manual of Mental Disorders
FQHC	Federally Qualified Health Centers
GRIP	Gambling Reduction and Recovery for Incarcerated Persons
GNC	Gender Non-conforming
GP	General Population
LS/CMI	Level of Service/Case Management Inventory
MAT	Medication Assisted Treatment
ODOC	Oregon Department of Corrections
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OSCI	Oregon State Correctional Institution
PGSI	Problem Gambling Severity Index
PO	Parole/Probation Officer
PRAS	Performance Recognition and Award System
PRC	Peer Recovery Coach
PRCF	Powder River Correctional Facility
PRSS	Peer Recovery Support Services

QMHA	Qualified Mental Health Associate
QMHP	Qualified Mental Health Professional
RMC	Recovery Management Check-up
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Use Disorder
TCU-DS	Texas Christian University Drug Screen
TIC	Trauma Informed Care
TIP	Treatment Improvement Protocol
WRNA	Women's Risk Need Assessment

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