Collaborative Case Planning

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Disclosure

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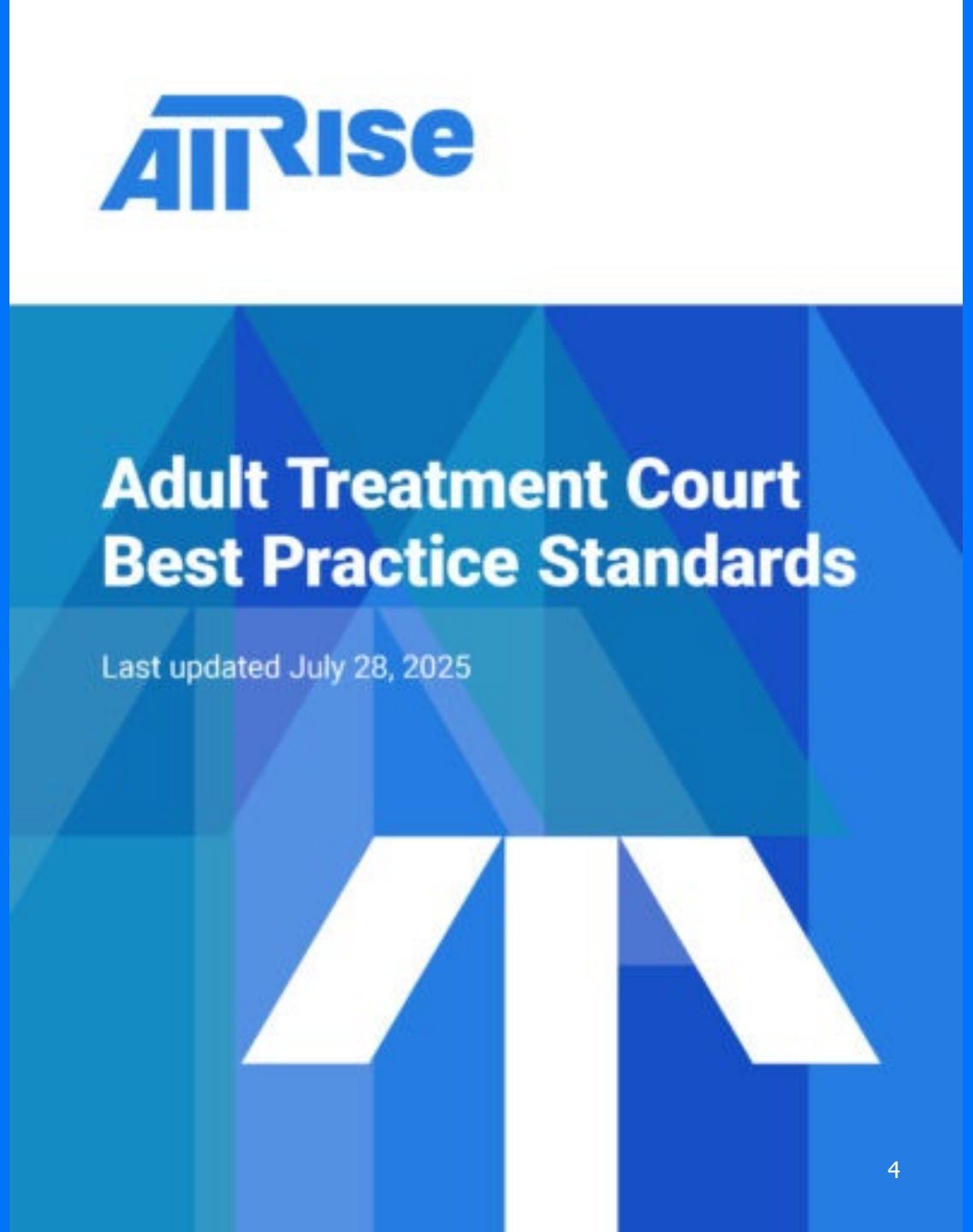
Session Objectives

- Review of how The 10 Key Components & Adult Drug Court Best Practice Standards apply to collaborate case planning
- Develop an understanding of applicable roles & responsibilities of team members' in related to collaborate case planning
- Introduce collaborate case planning strategies from screening & assessment to aftercare planning
- Increase team members' confidence in enhancing current practices related to collaborative case planning

Applying Adult Drug Court Best Practice Standards to Collaborative Case Planning



The Standard: Collaborative, Person-Centered Treatment Planning

Adult Treatment Court Best Practice Standards July 28, 2025 (pp. 45)

- *Participants collaborate* with their treatment providers or clinical case managers in setting treatment plan goals and *choosing* from among the *available treatment options* and provider agencies.
- Team members serve complementary roles in *both supporting participants'* treatment preferences and *ensuring adequate behavioral change* to protect participant welfare and public safety.
- Treatment professionals and defense attorneys emphasize helping participants to select and reach their preferred goals and are *not responsible for enforcing* court orders or sanctioning program infractions.
- Other team members, including the judge, prosecutor, and supervision officers, also work collaboratively with participants to help them achieve their goals while ensuring that they make the necessary *behavioral changes to safeguard their welfare and protect public safety*.

Reasons to Collaborate:

- Treatment and Supervision share goals for the participants
  - Recovery
  - Reducing recidivism
- Creates treatment and case plans that support mutual goals without overwhelming the participant
- Avoids conflicting or competing goals
- Fills in gaps in information
- Collaborative prioritization for addressing risks *(criminogenic)*, needs *(clinical)*, & responsivity *(barriers)*
- Increases team's knowledge of the participant and progress, increasing support, incentives and accountability


THIS IS THE WAY TO DO IT!
NO, THIS IS HOW TO DO IT!

Back to Basics:

Applying the 10 Key Components to Collaborative Case Planning

#1: Drug courts integrate alcohol and other treatment services with justice system processing.

- Requires a multifaceted, collaborative "team" approach for **integrating the delivery of services**
- Promotes mission of **promoting recovery** while **ensuring accountability**
- Underscores the need for **collaborative goal setting** and program monitoring
- Ensures **ongoing communication** of timely and accurate information about each participant's performance in the program

#2: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

- Maintains focus on the primary purpose of the program: the **participant's recovery**
- Supports due process, ethical, and strengths-based treatment, and confidentiality
- Promotes **individual accountability** and **community safety**
- Bridges the traditional gap between case processing, protecting the public, treatment mandates (HIPAA, 42CFR), and **respect for individual rights.**

#3: Eligible participants are identified early and promptly placed in the drug court program.

- Ensures the coordination of this process by "tracking" and facilitating the prompt **sharing among the team of all relevant information** arising from the initial referral, eligibility screening, and assessment process
- Promotes **cross-system** training, communication, and information sharing.

#4: Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

- Assist team in **identifying and monitoring** each participant's **unique needs** for support and rehabilitation services
- Coordinates services and supports for to participants and family
- **Ensures linkage and coordination** among the treatment court team and service providers
- Ensures **ongoing** assessment and communication of the participant's progress; and **coordination & oversight of referrals** to appropriate ancillary service providers

#5: Abstinence is monitored by frequent alcohol and other drug testing.

- Ensures that forensic drug test results are promptly and accurately recorded and disseminated to the drug court team
- Promotes health outcomes by using clinical testing to explore ambivalence, motivation, and substance use behaviors

#6: A coordinated strategy governs drug court responses to participants' compliance.

- Assists team in tracking and ISSA for each participant to help ensure a graduated response to participant behavior
- Promotes an individualized response to participant behavior by **based on their unique criminogenic risks, clinical needs, and responsivity considerations**

#7: Ongoing judicial interaction with each participant is essential.

- Ensures the drug court judge has essential information and critical insight **to promote effective interactions** from the bench

#8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

- Ensures relevant information is accurately, promptly, and systematically documented **to effectively monitor, engage, and advocate** for participants
- Establishes processes for ongoing monitoring and evaluation of the program outcomes

#9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.

- Facilitates interdisciplinary education within the drug court team
- Integrates interdisciplinary training into drug court meetings by periodically enlisting an ancillary service provider or justice system professional to address the team and, if appropriate, participate in the staffing process

#10: Forging partnerships among drug courts, public agencies, and community-based organizations increases the availability of treatment services, enhances drug court effectiveness, and generates local support.

- Sustains **ongoing contact** with key line staff of the partnering agencies and organizations
- Ensures **consistent and direct contact** with other community-based services & supports
- Increases team members' **understanding of existing services & supports**; and helps to **identify service gaps**/community needs
- fosters **collaboration** between the court and the community

Components of Case Management

Screening & Assessment

Communication

Participant
Family
Team
Service Providers

Treatment & Service Planning

Monitoring & Evaluation

Advocacy

Selecting Screening & Assessment Tools

- Reliable = Predicts risk consistently from person to person
- Valid = Has been tested multiple times in defined population and it is accurate *(for CJ population)
- Standardized = Has proscribed instructions for use that, if followed, have the same result with different users
- Ease of use = Instructions easy to follow, not too long to be practical
- Cost = Within acceptable price range according to resources available, some good free tools

Traditional Assessment Tools of the Trade

CRIMINAL JUSTICE

- COMPAS (Correctional Offender Management Profiling for Alternative Sanctions)
- Ohio Risk Assessment System (ORAS)
- Level of Service Inventory – Revised (LSI-R)
  - Level of Service / Case Management Inventory (LS/CMI)

MH / SUD TREATMENT

- Addiction Severity Index (ASI)
- ASAM Continuum
- Structured Clinical Interview for DSM-5 Disorders—Clinician Version (SCID-5-CV)
- Global Appraisal Of Individual Needs (GAIN)

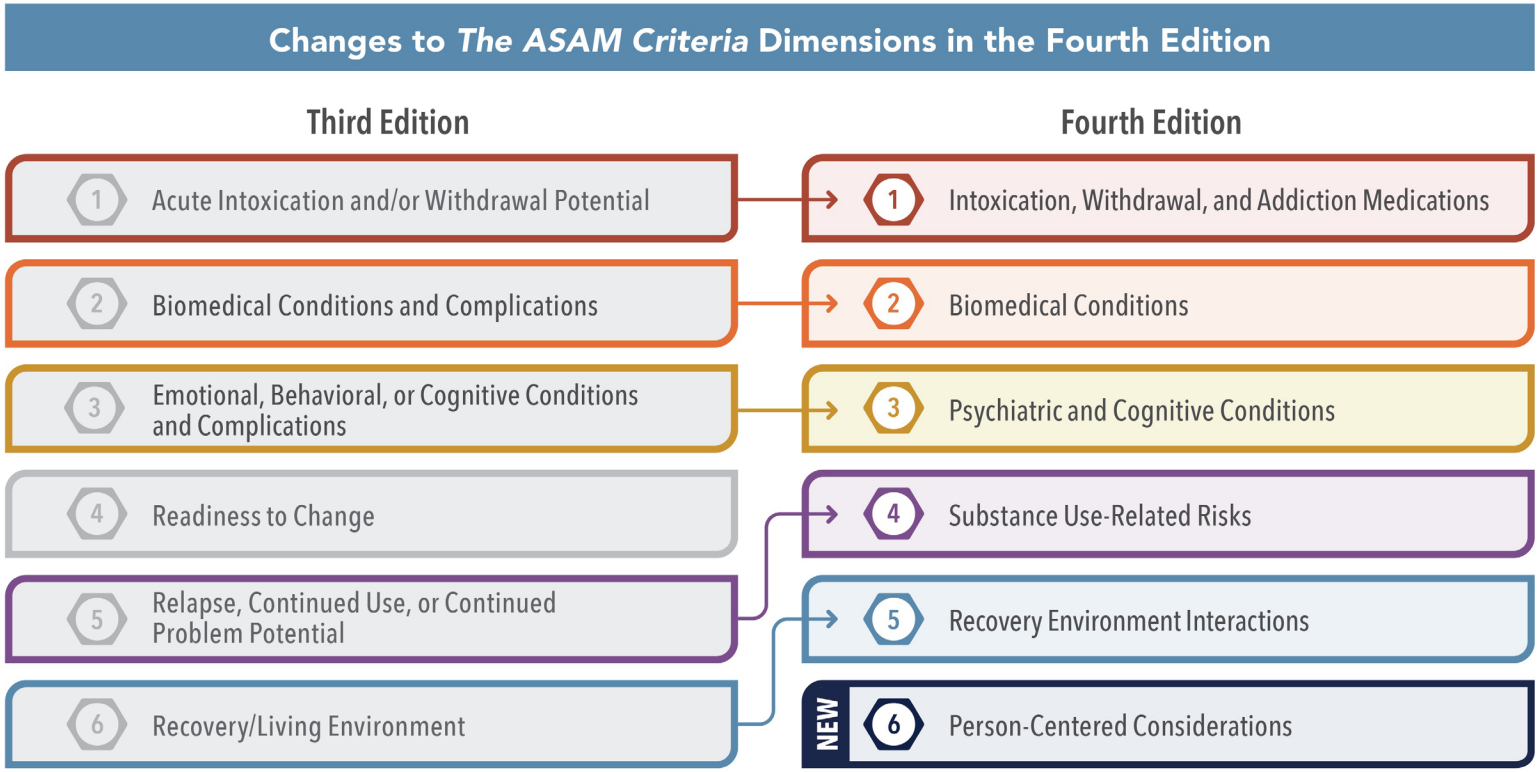
The Central 8

Criminal History	Education / Employment	Family / Marital Relationships	Leisure / Recreation Activities
Substance Use	Antisocial Peers	Antisocial Thinking / Attitudes	Antisocial Behavior / Personality

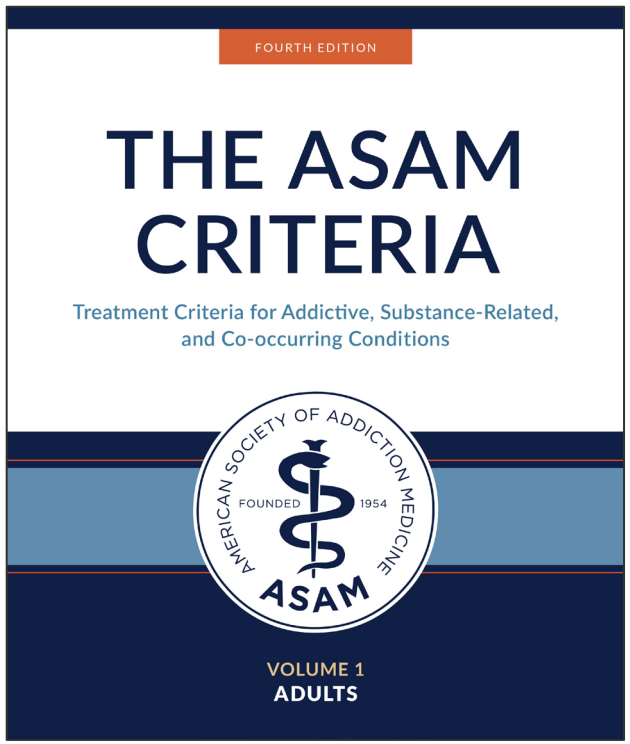
The ASAM Continuum: Multidimensional Assessment

Examines the patient's:

- *needs*
- *obstacles*
- *liabilities*
- *strengths*
- *assets*
- *resources*
- *support structure*



The Fourth Edition reorders the dimensions from the Third Edition. Readiness to change is now considered within each dimension, and the Third Edition Dimensions 5 and 6 were shifted to Dimensions 4 and 5, respectively, in the Fourth Edition. The new Dimension 6: Person-Centered Considerations considers barriers to care (including social determinants of health), patient preferences, and need for motivational enhancement.



The ASAM Criteria Dimensions and Subdimensions

Dimension 1 – Intoxication, Withdrawal, and Addiction Medications

- **Intoxication and associated risks**
- **Withdrawal and associated risks**
- **Addiction medication needs**

Dimension 2 – Biomedical Conditions

- **Physical health concerns**
- **Pregnancy-related concerns**
- Sleep problems

Dimension 3 – Psychiatric and Cognitive Conditions

- **Active psychiatric concerns**
- **Persistent Disability**
- Cognitive Functioning
- Trauma exposure and related needs
- Psychiatric and cognitive history

Dimension 4 – Substance Use Related Risks

- **Likelihood of risky substance use**
- **Likelihood of risky SUD-related behaviors**

Dimension 5 – Recovery Environment Interactions

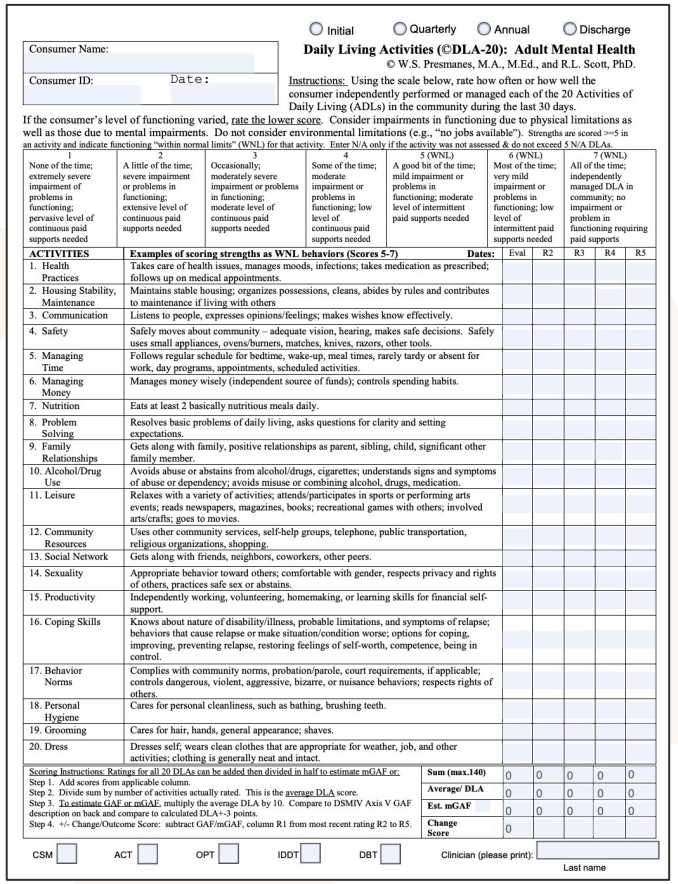
- **Ability to function in current environment**
- **Safety in current environment**
- **Support in current environment**
- Cultural perceptions of substance use

Dimension 6 – Person-Centered Considerations

- Patient preferences
- Barriers to care
- Need for motivational enhancement

Identifying Barriers to Engagement

- Cognitive / Learning Needs
- Mental Health / Emotional Regulation
- Motivation / Readiness Language / Communication
- Social / Relational Dynamics
- Basic Needs / Practical Barriers
- Learning Style / Preferences
- Health / Physical Considerations
- Systemic / External Pressures
- Accessibility Limitations



Initial Quarterly Annual Discharge

Consumer Name:

Consumer ID: Date:

Daily Living Activities (©DLA-20): Adult Mental Health

© W.S. Presmanes, M.A., M.Ed., and R.L. Scott, PhD.

Instructions: Using the scale below, rate how often or how well the consumer independently performed or managed each of the 20 Activities of Daily Living (ADLs) in the community during the last 30 days.

If the consumer's level of functioning varied, rate the lower score. Consider impairments in functioning due to physical limitations as well as those due to mental impairments. Do not consider environmental limitations (e.g., "no jobs available"). Strengths are scored >=5 in an activity and indicate functioning "within normal limits" (WNL) for that activity. Enter N/A only if the activity was not assessed & do not exceed 5 N/A DLAs.

1 None of the time; extremely severe impairment of problems in functioning; pervasive level of continuous paid supports needed	2 A little of the time; severe impairment or problems in functioning; extensive level of continuous paid supports needed	3 Occasionally; moderately severe impairment or problems in functioning; moderate level of continuous paid supports needed	4 Some of the time; moderate impairment or problems in functioning; low level of continuous paid supports needed	5 (WNL) A good bit of the time; mild impairment or problems in functioning; moderate level of intermittent paid supports needed	6 (WNL) Most of the time; very mild impairment or problems in functioning; low level of intermittent paid supports needed	7 (WNL) All of the time; independently managed DLA in community; no impairment or problem in functioning requiring paid supports

ACTIVITIES	Examples of scoring strengths as WNL behaviors (Scores 5-7)	Dates: Eval	R2	R3	R4	R5
1. Health Practices	Takes care of health issues, manages moods, infections; takes medication as prescribed; follows up on medical appointments.					
2. Housing Stability, Maintenance	Maintains stable housing; organizes possessions, cleans, abides by rules and contributes to maintenance if living with others					
3. Communication	Listens to people, expresses opinions/feelings; makes wishes know effectively.					
4. Safety	Safely moves about community – adequate vision, hearing, makes safe decisions. Safely uses small appliances, ovens/burners, matches, knives, razors, other tools.					
5. Managing Time	Follows regular schedule for bedtime, wake-up, meal times, rarely tardy or absent for work, day programs, appointments, scheduled activities.					
6. Managing Money	Manages money wisely (independent source of funds); controls spending habits.					
7. Nutrition	Eats at least 2 basically nutritious meals daily.					
8. Problem Solving	Resolves basic problems of daily living, asks questions for clarity and setting expectations.					
9. Family Relationships	Gets along with family, positive relationships as parent, sibling, child, significant other family member.					
10. Alcohol/Drug Use	Avoids abuse or abstains from alcohol/drugs, cigarettes; understands signs and symptoms of abuse or dependency; avoids misuse or combining alcohol, drugs, medication.					
11. Leisure	Relaxes with a variety of activities; attends/participates in sports or performing arts events; reads newspapers, magazines, books; recreational games with others; involved arts/crafts; goes to movies.					
12. Community Resources	Uses other community services, self-help groups, telephone, public transportation, religious organizations, shopping.					
13. Social Network	Gets along with friends, neighbors, coworkers, other peers.					
14. Sexuality	Appropriate behavior toward others; comfortable with gender, respects privacy and rights of others, practices safe sex or abstains.					
15. Productivity	Independently working, volunteering, homemaking, or learning skills for financial self-support.					
16. Coping Skills	Knows about nature of disability/illness, probable limitations, and symptoms of relapse; behaviors that cause relapse or make situation/condition worse; options for coping, improving, preventing relapse, restoring feelings of self-worth, competence, being in control.					
17. Behavior Norms	Complies with community norms, probation/parole, court requirements, if applicable; controls dangerous, violent, aggressive, bizarre, or nuisance behaviors; respects rights of others.					
18. Personal Hygiene	Cares for personal cleanliness, such as bathing, brushing teeth.					
19. Grooming	Cares for hair, hands, general appearance; shaves.					
20. Dress	Dresses self; wears clean clothes that are appropriate for weather, job, and other activities; clothing is generally neat and intact.					

Scoring Instructions: Ratings for all 20 DLAs can be added then divided in half to estimate mGAF or:
Step 1. Add scores from applicable column.
Step 2. Divide sum by number of activities actually rated. This is the average DLA score.
Step 3. To estimate GAF or mGAF, multiply the average DLA by 10. Compare to DSMIV Axis V GAF description on back and compare to calculated DLA+-3 points.
Step 4. +/- Change/Outcome Score: subtract GAF/mGAF, column R1 from most recent rating R2 to R5.

	Eval	R2	R3	R4	R5
Sum (max.140)	0	0	0	0	0
Average/ DLA	0	0	0	0	0
Est. mGAF	0	0	0	0	0
Change Score	0				

CSM ☐ ACT ☐ OPT ☐ IDDT ☐ DBT ☐ Clinician (please print): Last name

HTTPS://RECOVERYTECHNOLOGY.ORG/WP-CONTENT/UPLOADS/DLA20-ADULT-ASSESSMENT-OF-FUNCTIONING09.PDF

Risk Need Responsivity (RNR)

RISK (How Much?)

- Level of Risk (to re-offend)
- Match Risk & Supervision Level

NEED (What Type?)

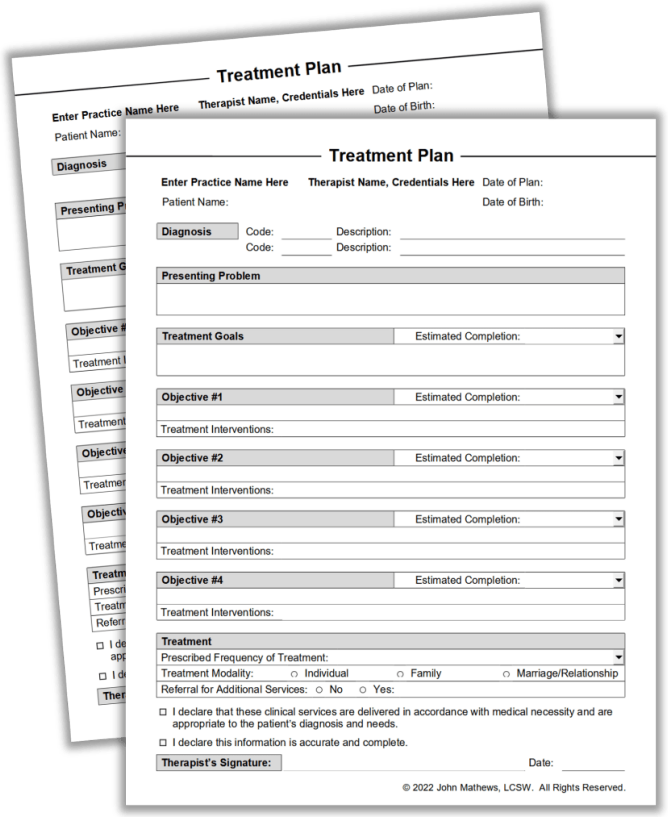
- Factors that drive criminogenic risk (Central 8)
- Mitigate these factors = reduction in recidivism

RESPONSIVITY (How to Deliver It?)

- CBT Interventions/Programming
  - Learning styles, motivation, abilities, & strengths
  - Individual characteristics and demographics

...and the two shall become one

Clinical Treatment Plan



Treatment Plan

Enter Practice Name Here Therapist Name, Credentials Here Date of Plan:
Patient Name: Date of Birth:

Diagnosis Code: Description:
Code: Description:

Presenting Problem

Treatment Goals Estimated Completion:

Objective #1 Estimated Completion:
Treatment Interventions:

Objective #2 Estimated Completion:
Treatment Interventions:

Objective #3 Estimated Completion:
Treatment Interventions:

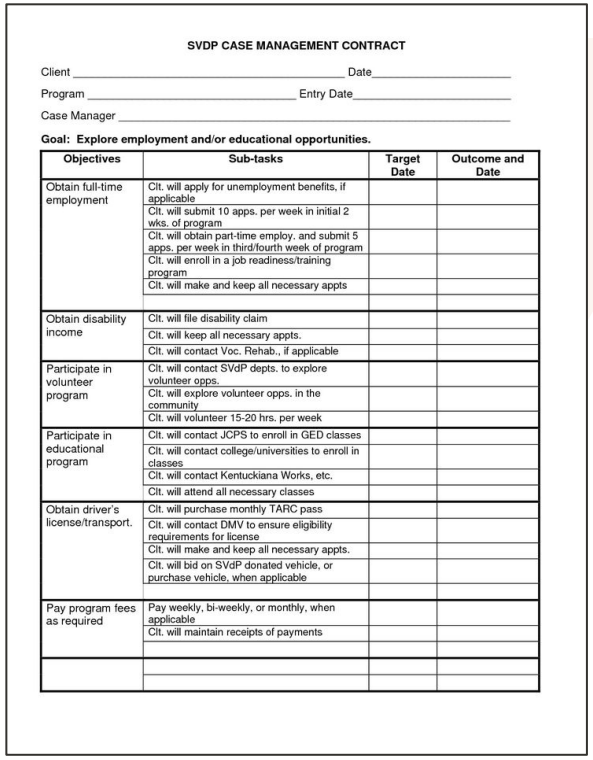
Objective #4 Estimated Completion:
Treatment Interventions:

Treatment
Prescribed Frequency of Treatment:
Treatment Modality: ○ Individual ○ Family ○ Marriage/Relationship
Referral for Additional Services: ○ No ○ Yes:

☐ I declare that these clinical services are delivered in accordance with medical necessity and are appropriate to the patient's diagnosis and needs.
☐ I declare this information is accurate and complete.

Therapist's Signature: Date:

Supervision Case Plan



SVDP CASE MANAGEMENT CONTRACT

Client _____ Date_____

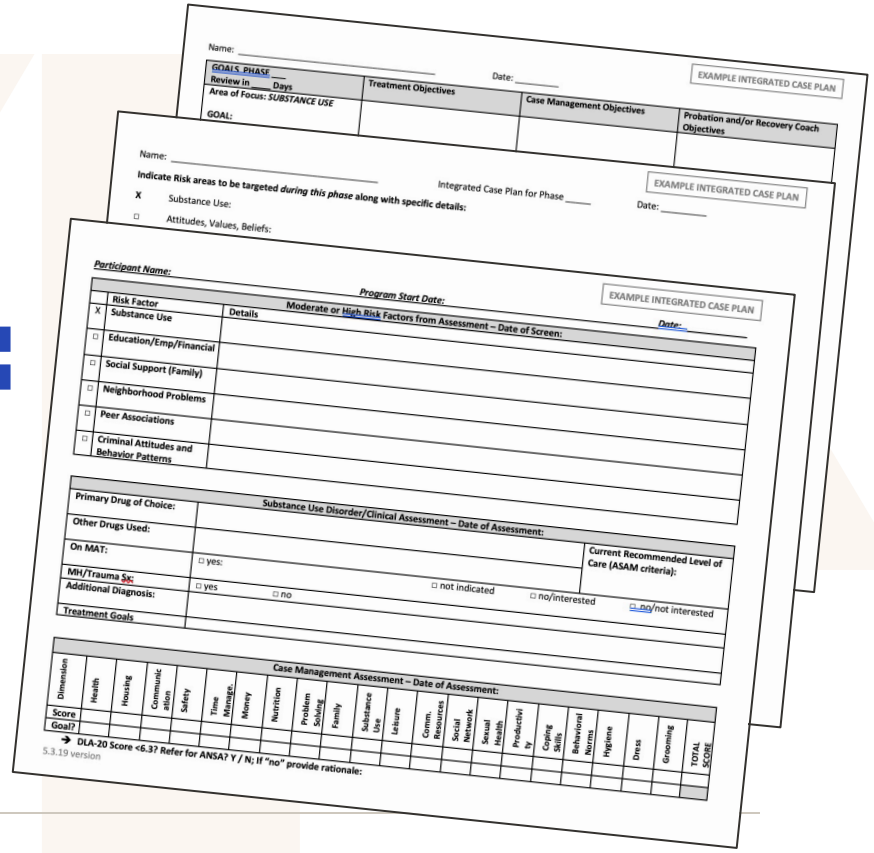
Program _____ Entry Date_____

Case Manager _____

Goal: Explore employment and/or educational opportunities.

Objectives	Sub-tasks	Target Date	Outcome and Date
Obtain full-time employment	Clt. will apply for unemployment benefits, if applicable		
	Clt. will submit 10 apps. per week in initial 2 wks. of program		
	Clt. will obtain part-time employ. and submit 5 apps. per week in third/fourth week of program		
	Clt. will enroll in a job readiness/training program		
	Clt. will make and keep all necessary appts		
Obtain disability income	Clt. will file disability claim		
	Clt. will keep all necessary appts.		
	Clt. will contact Voc. Rehab., if applicable		
Participate in volunteer program	Clt. will contact SVdP depts. to explore volunteer opps.		
	Clt. will explore volunteer opps. in the community		
	Clt. will volunteer 15-20 hrs. per week		
Participate in educational program	Clt. will contact JCPS to enroll in GED classes		
	Clt. will contact college/universities to enroll in classes		
	Clt. will contact Kentuckiana Works, etc.		
	Clt. will attend all necessary classes		
Obtain driver's license/transport.	Clt. will purchase monthly TARC pass		
	Clt. will contact DMV to ensure eligibility requirements for license		
	Clt. will make and keep all necessary appts.		
	Clt. will bid on SVdP donated vehicle, or purchase vehicle, when applicable		
Pay program fees as required	Pay weekly, bi-weekly, or monthly, when applicable		
	Clt. will maintain receipts of payments		

Integrated Service Plan



Name: Date: EXAMPLE INTEGRATED CASE PLAN

GOALS PHASE ___ Review in ___ Days
Area of Focus: SUBSTANCE USE
GOAL:

Treatment Objectives	Case Management Objectives	Probation and/or Recovery Coach Objectives

Name: Date: EXAMPLE INTEGRATED CASE PLAN

Indicate Risk areas to be targeted during this phase along with specific details:
Integrated Case Plan for Phase ___
X Substance Use:
☐ Attitudes, Values, Beliefs:

Participant Name: Program Start Date: EXAMPLE INTEGRATED CASE PLAN

Moderate or High Risk Factors from Assessment – Date of Screen: Date:

	Risk Factor	Details
X	Substance Use	
☐	Education/Emp/Financial	
☐	Social Support (Family)	
☐	Neighborhood Problems	
☐	Peer Associations	
☐	Criminal Attitudes and Behavior Patterns	

Substance Use Disorder/Clinical Assessment – Date of Assessment:

Primary Drug of Choice:
Other Drugs Used:
On MAT: ☐ yes: Current Recommended Level of Care (ASAM criteria):
MH/Trauma Sx: ☐ yes ☐ no ☐ not indicated ☐ no/interested ☐ no/not interested
Additional Diagnosis:
Treatment Goals

Case Management Assessment – Date of Assessment:

Dimension	Health	Housing	Communication	Safety	Time Manage.	Money	Nutrition	Problem Solving	Family	Substance Use	Leisure	Comm. Resources	Social Network	Sexual Health	Productivity	Coping Skills	Behavioral Norms	Hygiene	Dress	Grooming	TOTAL SCORE
Score																					
Goal?																					

→ DLA-20 Score <6.3? Refer for ANSA? Y / N; If "no" provide rationale:

5.3.19 version

If Integration is not Possible

Collaborate on the two plans to ensure timing and who is responsible for assisting the client.

Buy- In: A critical component

Buy-in refers to the client's psychological and emotional commitment to the treatment process. It's the extent to which they:

- **Understand** the purpose of treatment,
- **Believe** it is relevant and can help them,
- **Feel ownership** over their goals, and
- **Are willing** to participate actively.

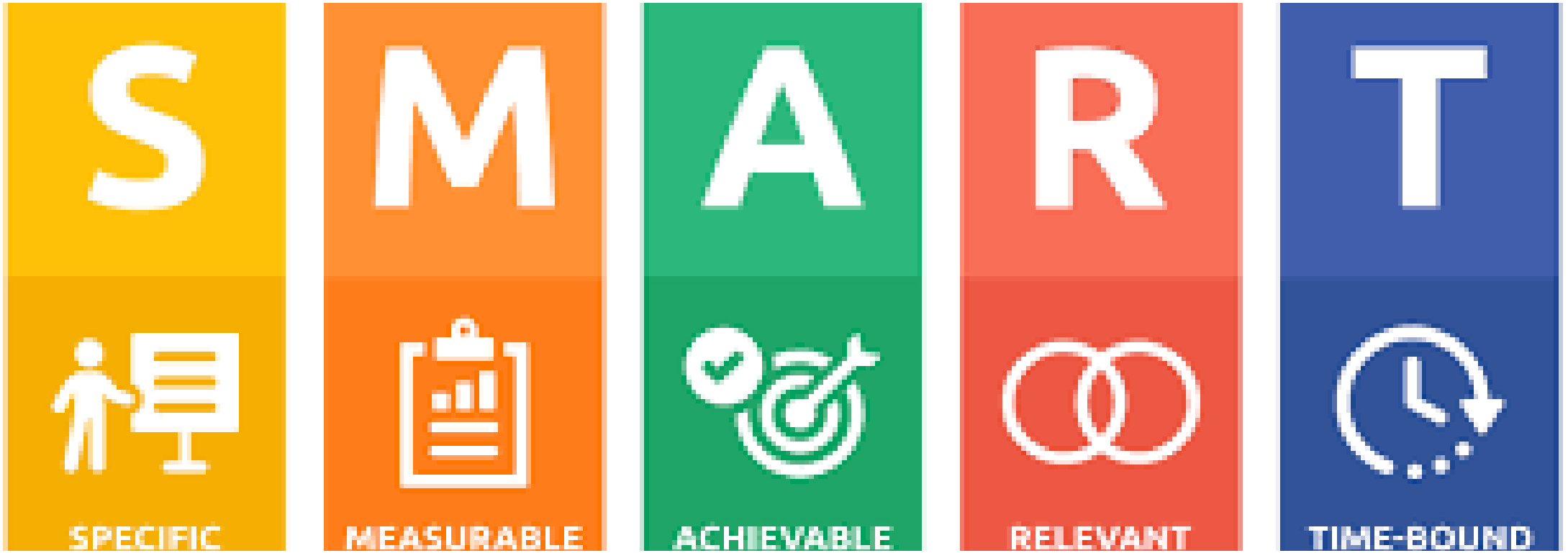
Collaborative Case Plans require:

- Full participation from individual
- Input & engagement from family, when possible
- Input and engagement from all members of the Treatment Court Team; and other service providers, as appropriate
- Ongoing monitoring and evaluation
- Regular and consistent review and revisions
- Person-centered and strength-based language; and integration of individual's own words
- Incentives and accountability for individual; as well as for team members & service providers

Collaborative Case Plans include:

- Assessed areas of criminogenic risk & clinical needs for participant, family, and team
- Identify 2 - 3 SMART goals targeting individuals assessed risk & needs
- Identify responsivity concerns or other potential barriers / obstacles to attaining goals
- Identify specific treatment interventions, services, & supports to assist individual in achieving goals
- Outline specific actions and expectations for participant, family, team, and service providers
- Identify projected outcomes and how these will be measured

SMART Goal Criteria



Participant Name: ***Program Start Date:*** ***Date:***

Moderate or High Risk Factors from Assessment – Date of Screen:		
	Risk Factor	**Details**
X	**Substance Use**	
□	**Education/Emp/Financial**	
□	**Social Support (Family)**	
□	**Neighborhood Problems**	
□	**Peer Associations**	
□	**Criminal Attitudes and Behavior Patterns**	

Substance Use Disorder/Clinical Assessment – Date of Assessment:		
Primary Drug of Choice:		**Current Recommended Level of Care (ASAM criteria):**
Other Drugs Used:		
On MAT:	□ yes: □ not indicated □ no/interested □ no/not interested	
MH/Trauma Sx:	□ yes □ no	
Additional Diagnosis:		
Treatment Goals		

Case Management Assessment – Date of Assessment:																					
Dimension	**Health**	**Housing**	**Communication**	**Safety**	**Time Manage.**	**Money**	**Nutrition**	**Problem Solving**	**Family**	**Substance Use**	**Leisure**	**Comm. Resources**	**Social Network**	**Sexual Health**	**Productivity**	**Coping Skills**	**Behavioral Norms**	**Hygiene**	**Dress**	**Grooming**	**TOTAL SCORE**
Score																					
Goal?																					

➔ **DLA-20 Score <6.3? Refer for ANSA? Y / N; If "no" provide rationale:**

5.3.19 version

https://allrise.org/wp-content/uploads/2023/05/Integrated-Case-Plan-Template1.docx

EXAMPLE INTEGRATED CASE PLAN

Name: _____ Integrated Case Plan for Phase _____ Date: _____

Indicate Risk areas to be targeted *during this phase* along with specific details:

X Substance Use:

☐ Attitudes, Values, Beliefs:

☐ Peer Associations:

☐ Personality Characteristics:

☐ Family:

☐ Education/Employment:

☐ Leisure/recreation:

Responsivity Factors to be addressed:

☐ Instability or Lack of Social Supports (e.g. safe housing, etc.):

☐ Mental Health Symptoms:

☐ Medical/Health Needs:

☐ Transportation:

☐ Motivation:

☐ Insurance:

☐ Child Care/Family Needs

☐ *OTHER* _____

Resiliency factors that support success:

☐ _____

☐ _____

☐ _____

5.3.19 version

https://allrise.org/wp-content/uploads/2023/05/Integrated-Case-Plan-Template1.docx

Collaborative Case Plan

Participant: _____ Program Start Date: _____ Current Phase: _____ Phase Start Date: _____

Goal Section	Review in _____ Days		
Problem Statement:			
Area of Focus (Criminogenic Need): _____ GOAL: _____ _____ _____ Responsivity factors to address: 1. _____ 2. _____ 3. _____ Resiliency Factors in place: 1. _____ 2. _____ 3. _____ Incentive: _____	Treatment Objectives/Strategies:	Supervision/Case Management Objectives/Strategies:	Recovery/Prosocial Support Objectives/Strategies:

Notes/Updates:

_____

_____

https://allrise.org/wp-content/uploads/2023/05/Integrated-Case-Plan-Template1.docx

Sample Process for Integrated Case Planning

1. CM obtains appropriate ROI's from participant to engage & share information with all parties
2. Upon admission and following each phase advancement the participant, family members, team members, peer mentor, and treatment providers meet together to develop / revise case plan
3. Participant and appropriate team members present results of risk & need assessments, identify responsivity issues, and update group re: current status/progress in treatment, supervision, and ancillary services
4. CM elicits feedback & facilitates discussion to prioritize 2 – 3 goals targeting specific risks / needs identified in assessment

Sample Process for Integrated Case Planning, continued

5. Participant (and group) provide specific objectives (actions, steps) to be taken
6. Team members & services providers identify specific objectives (actions, services & supports) to be provided to assist client in achieving goals
7. CM will complete Case Plan for review by all in attendance
8. CM, Participant, and team members (if applicable) will sign completed plan
9. If supervision, treatment, etc. are required to have separate treatment/supervision case plans; these are attached as addendums to Integrated Case Plan.
10. Written case plan will be provided to Participant, Treatment Court Team, and relevant service providers

Sample Process for Integrated Case Planning, continued

11. Team members will report on progress toward objectives at staffing, at predetermined intervals, and for phase promotion
12. A new plan will be developed at each phase; and may be reviewed as necessary if there are concerns with one's progress or when additional risks, needs, responsivity issues are identified

Effective Practices in Correctional Settings (EPICS-II)

Risk Assessments tell us what areas needing targeted intervention, but not the how or why

- Antisocial Peers identified as an area, but not the how these peers fit into the offending patterns or how the individual ends up around these peers
- Unemployment identified, but not the why past experience is can make money faster selling drugs or has no work history, resume, or job seeking skills

EPICS (Relationship, Assessment, Intervention, & Bridging Skills) help individual and team:

- Understand past and current behaviors
- Identify high risk people, places, things and thoughts or situations
- Focus on skills to avoid the people, places, things or situations OR cope with the situation

Behavioral Analysis (BA)

Recommend completing a BA as soon as possible upon start of supervision (EPICS-II Training Manual).

Assist with creating better case plans.

Behavioral Analysis (BA) Worksheet

More of the How & Why: Common Drivers for Criminogenic Domains

Antisocial Personality Traits vs Antisocial Attitudes & Thinking Patterns

ANTISOCIAL PERSONALITY TRAITS

Characterized by long-term patterns of behavior:

- Disregard for rules & social norms
- Deceitfulness & manipulation
- Impulsivity & recklessness
- Lack of remorse or guilt
- Difficulty forming stable relationships

ANTISOCIAL ATTITUDES & THINKING PATTERNS

A person's belief, values & thought patterns that justify or rationalize antisocial behavior:

- Negative attitudes toward authority
- Rationalize rule-breaking
- Tolerance for deviance
- Lack of empathy

Drivers

SUBSTANCE USE/MISUSE OR ALCOHOL & DRUG PROBLEMS

- Antisocial Attitudes or Thinking toward the use of alcohol and/or drugs
- Poor Coping Skills
- Family & Social Relationships
- Lack of Prosocial Relationships or Activities
- Mental Health
- Physical Addiction- DSM-V Diagnosis

EDUCATION/EMPLOYMENT/ FINANCIAL

- Interpersonal Skill Deficit
- Educational/Vocational Skill Deficit
- Antisocial Attitudes/Cognitions
- Substance Use
- Medical or Mental Health Needs
- Logistical Barriers

Drivers

FAMILY/MARITAL

- Antisocial Attitudes and/or Thinking
- Antisocial Peers or Family
- Abuse, Neglect, or Trauma
- Dysfunctional Family or Significant Other Relationships

RESIDENCE/NEIGHBORHOOD

- Lack of Stability
- Lack of Contact with Prosocial People/Environment
- Housemates and/or Neighborhood with Antisocial Influences/Tendencies
- Substance Abuse
- Logistical Barrier(s)

Drivers

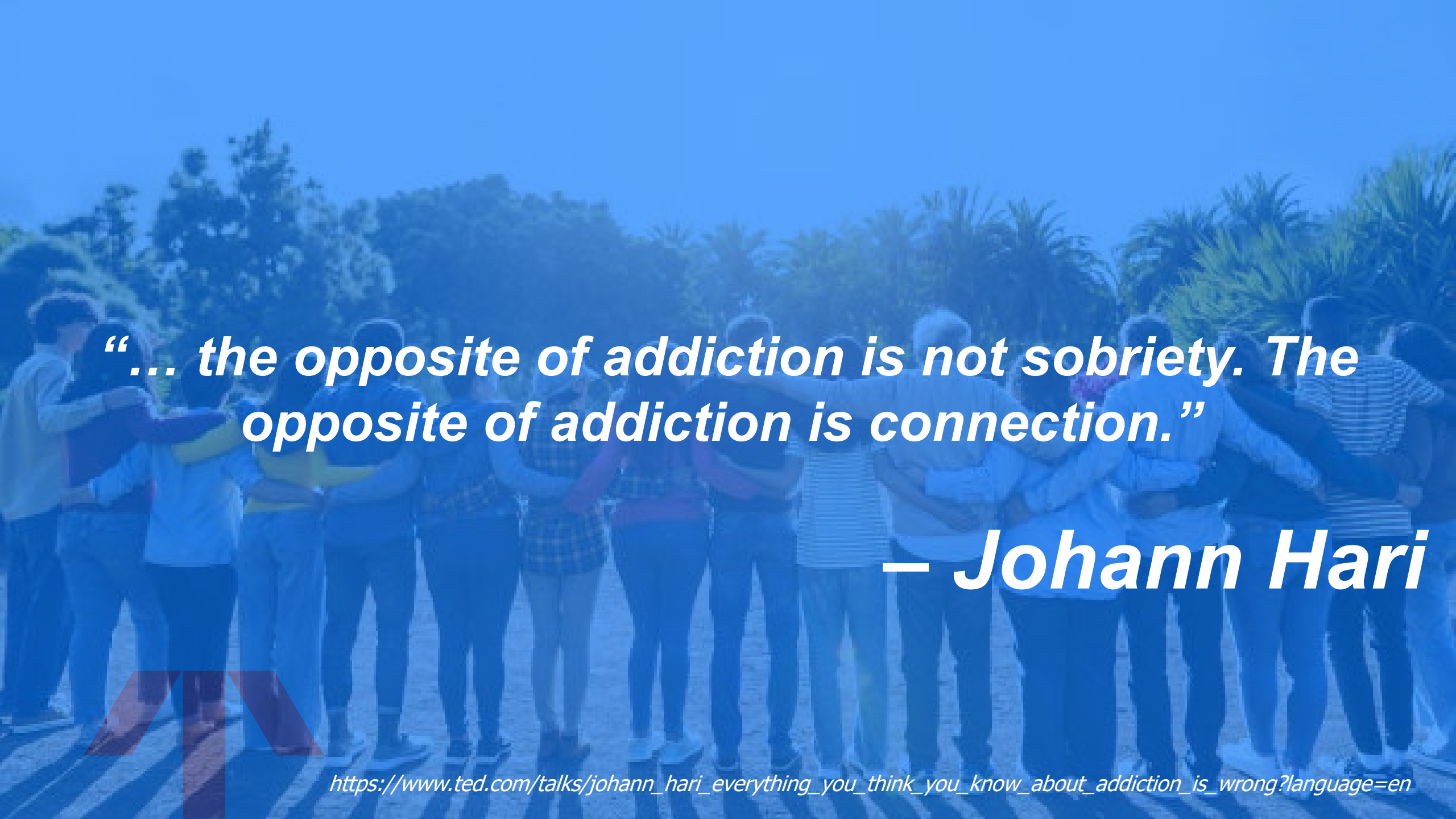
ANTISOCIAL ASSOCIATIONS

- Peer Pressure
- Desire for Acceptance or Status within Antisocial Peer Groups
- Isolation from Prosocial Peers and Mentors

LEISURE/RECREATION

- Lack of Structured, prosocial recreational activities
- Boredom or Lack of Purpose
- Social Environments that Encourage Criminal Behavior

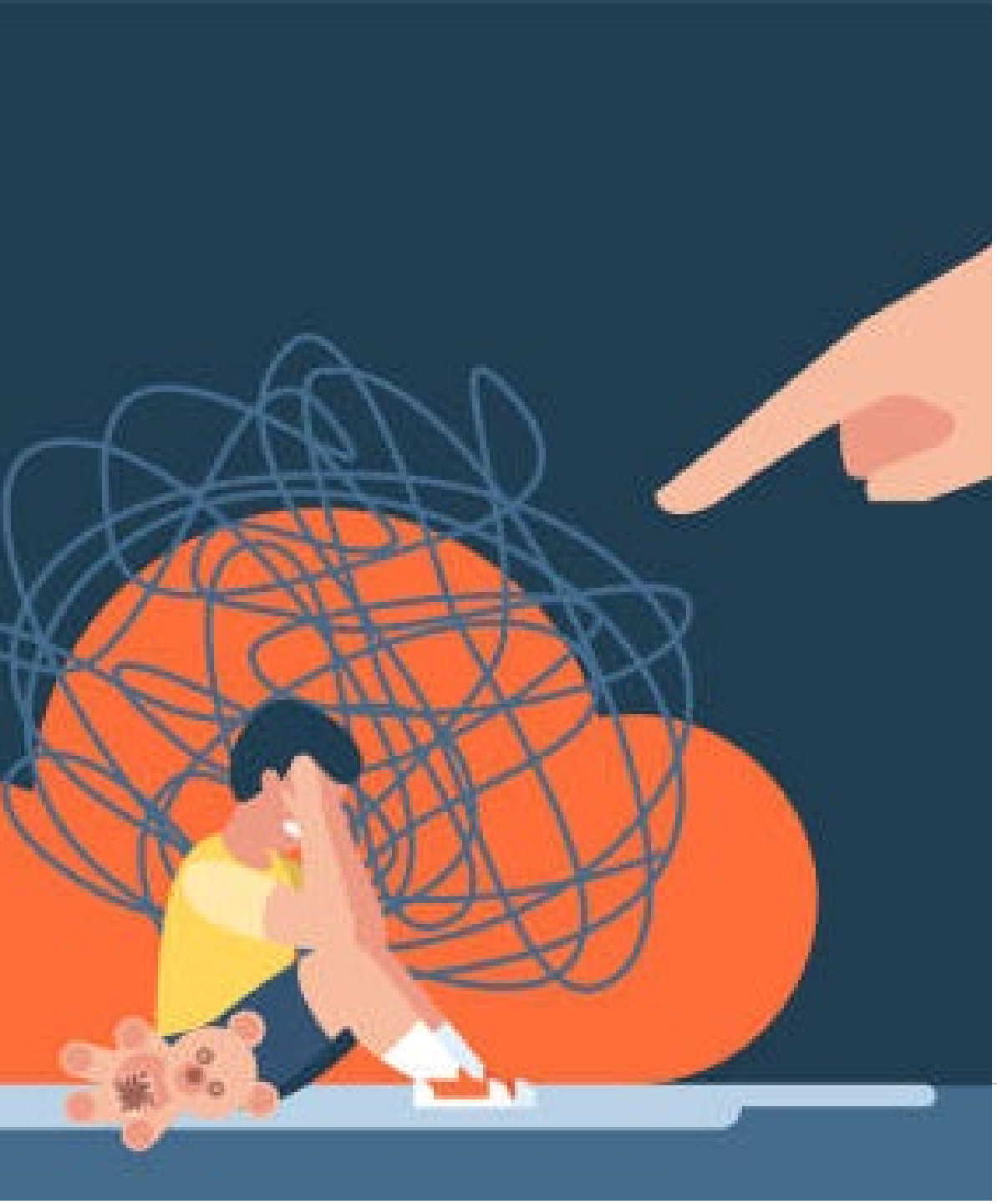
The Linchpin: Recovery Capital



https://www.ted.com/talks/johann_hari_everything_you_think_you_know_about_addiction_is_wrong?language=en

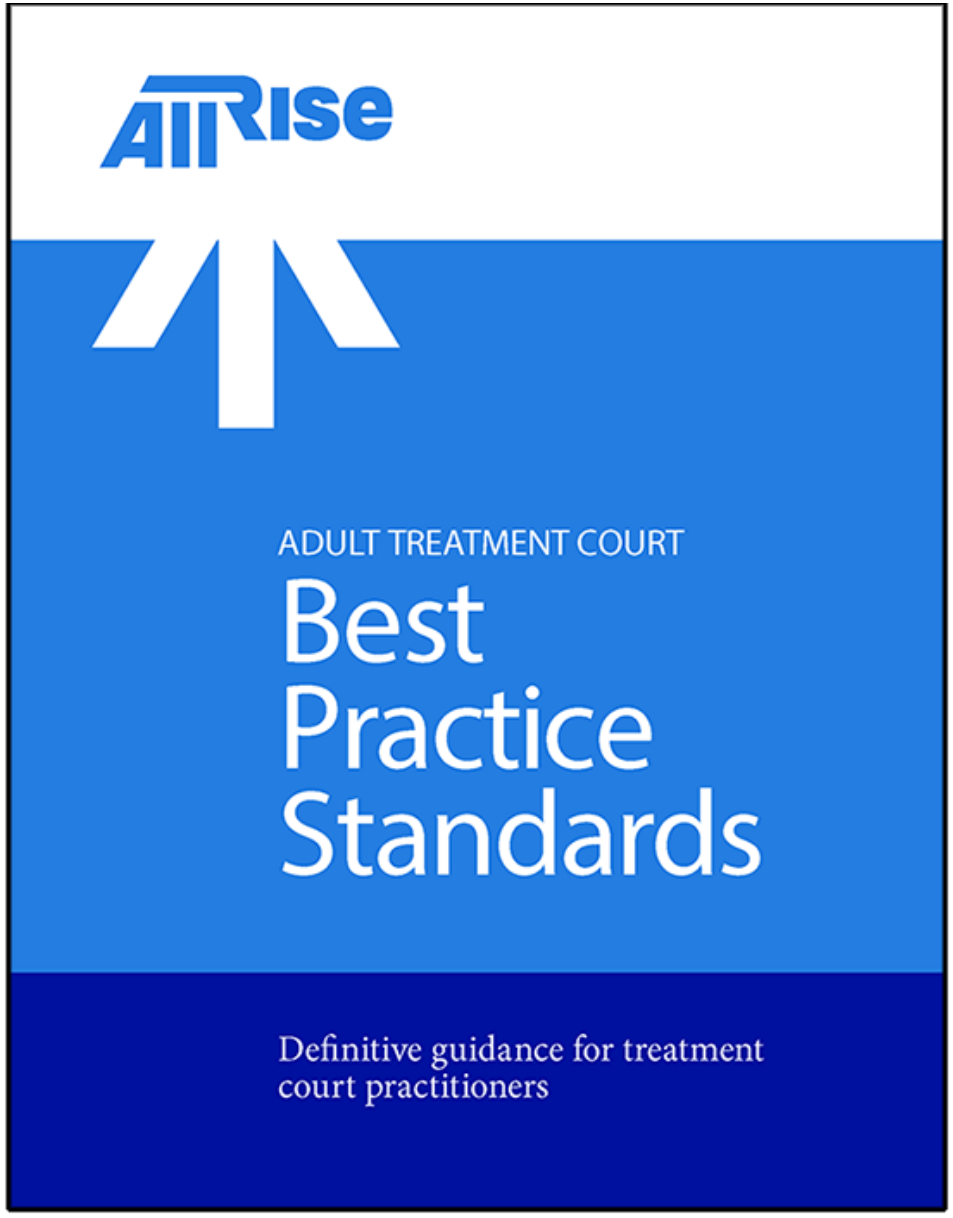
Recovery Capital: It's About Connection

- Connection to Self
- Connection to Others
- Connection to Resources



THE IMPACT OF TRAUMA

- ALL 10 statements in the ACEs Questionnaire are related to a rupture of interpersonal relationship.
- 12 of the 14 statements in the ACEs resiliency questionnaire are related to interpersonal connection.
- Individuals with ACE scores ≥5 are seven to 10 times more likely to report illicit drug addiction compared to those without ACEs.
- Each ACE increased the likelihood for early initiation 2- to 4-fold.



- Higher levels of parental and familial support are associated with significantly better outcomes in treatment courts and other criminal justice programs, whereas family conflict or parental distress is associated with significantly poorer treatment.
- A multisite study of 69 adult drug courts found that programs offering family counseling and parenting services were approximately 65% more effective at reducing recidivism than those not offering these services.
- A study of 142 treatment courts found that the racial disparities in outcomes in programs offering family or domestic-relations counseling were 78% smaller than in programs not offering these services.

Putting It All Together!

Meet with, treatment and supervision/case management, outside of staffing (in person or Zoom)

Emails

Shared document drive

Use of collaborative case plan form

Ask the Expert

https://allrise.org/trainings/ask-the-expert/

Office Hours

Scheduled times with experts on various key topics

Submit a Question

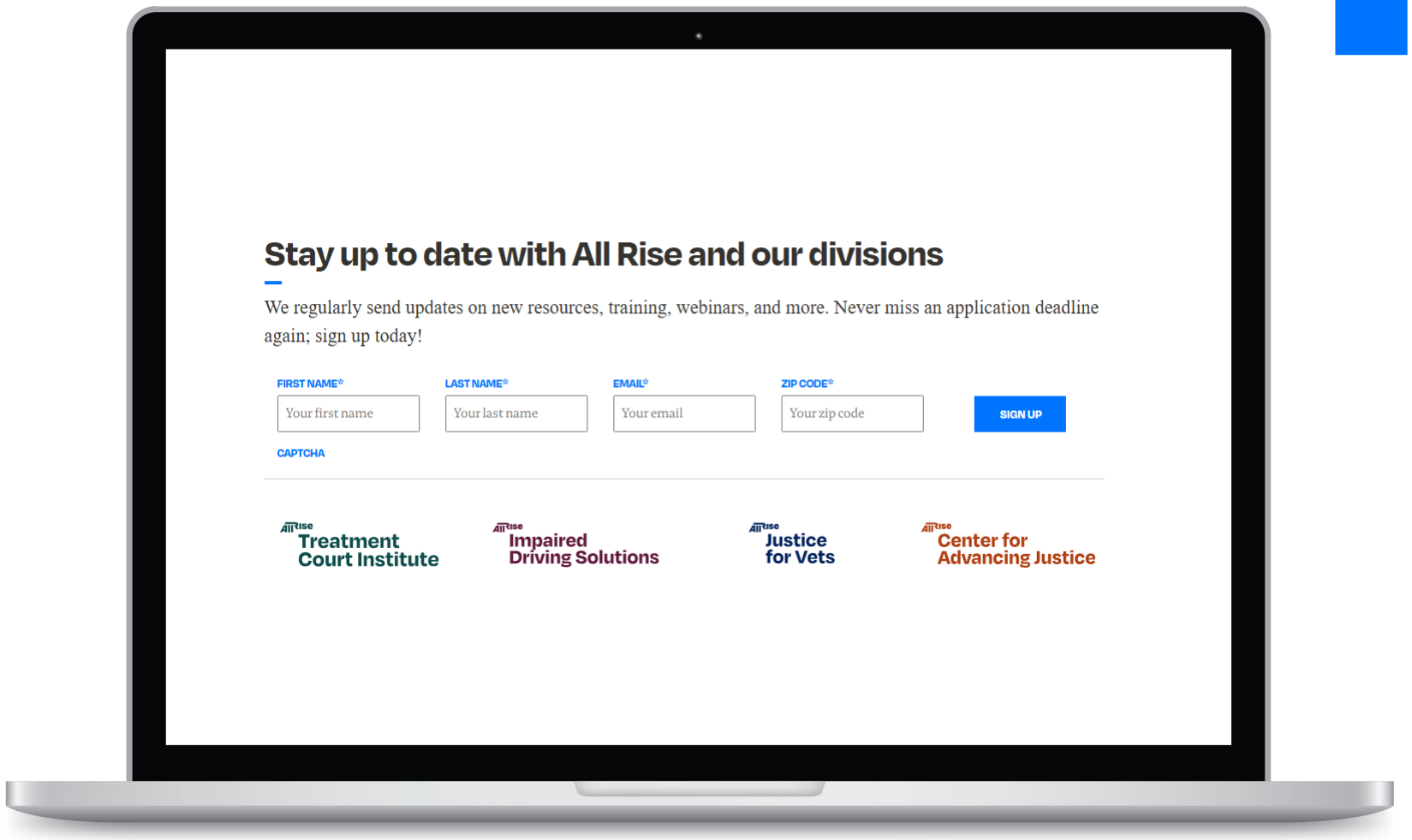
Submit a question to the All Rise team

Schedule a Consultation

Schedule a consultation with the All Rise team

All Rise Email Blast

Scroll to the bottom of AllRise.org to sign up!



Evaluations

1. On your compatible phone or tablet, open the built-in camera app.
2. Point the camera at the QR code.
3. Tap the banner that appears on your phone or tablet.
4. Follow the instructions on the screen to complete the evaluation.
5. After completion, you will be provided with a certificate that can be saved and printed.

Questions?

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