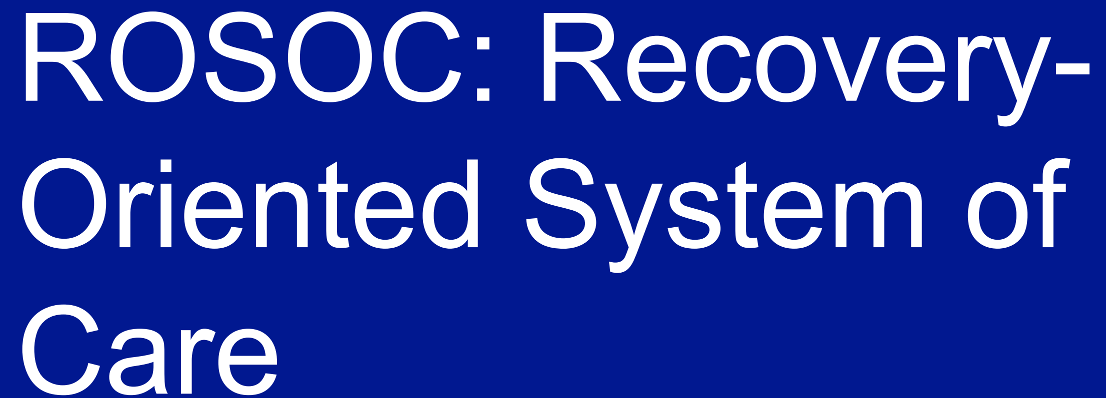


ROSOC: Recovery-Oriented System of Care

The Metamorphosis of a Multidisciplinary Collaborative Project in Mendocino County, California

Brief history of our agency

Mendocino County AIDS/Viral Hepatitis Network (MCAVHN)

- Opened in 1987 as an all volunteer agency to assist persons who were struggling with an AIDS diagnosis
- Provided in-home support, buddy system, linkage to medical
- Opened an AIDS hospice residence in the early 90's – closed by the mid-nineties

History - Continued

- Focused on the mission to serve those living with and dying with AIDS, before medication began to change lives
- Addressing the co-morbidities of HCV, mental illness, substance use as well
- Realized the need to be a prevention-focused agency; not just focusing on care
- Wrote and received grants for outreach to the entire area of the county; including our local Native populations

History - continued

- Services delivered primarily through **Community Health Outreach Workers** (CHOW's) – very successful grant, which helped us to understand the amount of injection drug use (IDU) in our county
- **Instituted syringe exchange** services in light of this issue; knowing that about 40% of HIV infections were from IDU
- How would we accomplish this **public health intervention?**

History - continued

- Received small grants for harm reduction supplies; delivered completely by volunteers – and completely "**underground**" between 1998 and 2000
- Starting in 2000, we had to receive an "**emergency**" action by the County Board of Supervisors every two weeks
- **Outreach driven**; we hired four outreach staff in 2002 through the State Office of AIDS/Public Health Prevention, to cover our county due to high-rate of IDU/HCV

History - continued

- **Syringe exchange** programs are **legal** in California, but some counties barred their existence and continued to make it illegal
- Our county was fortunate to be able to stop the "emergency" status when CA legalized in 2006
- Began our **in-house exchange** in 2003, which helped us make trusting connections with IDU's and an SSE program when funding for outreach was lost

How this project began…….

- **Community partners** were chosen from a wide range of service providers to address the issues of **emergency room over-utilization and recidivism** – initiated by concerns for cost cutting measures by our largest local hospital

1. Community hospital
2. Local FQHC
3. AOD treatment center
4. County Sheriff's Department (jail medical services)
5. HIV/HCV case management and harm reduction agency

Why This Population?

1. **Problem defined:**

- Complex co-occurring conditions or disorders (e.g. those with at least a dual-diagnosis) and other co-morbidities
- Over-utilization of inefficient crisis-oriented, **high-cost** service provision; **excessive** emergency room **admissions;** psychiatric hospitalizations; incarcerations
- **Financial, medical, psychosocial, housing and transportation challenges**

Why? - continued

- High majority of our participants are **homeless** individuals who are **struggling** with basic **survival** issues
- Begin by helping to resolve basic human requirements for **food, shelter, income**; basic **stabilization** etc.
- Make **positive connections**; making assessments of capabilities; with more substantial assistance in the beginning of the partnership

Before Transition

Who Exactly <u>Were</u> We Serving?

- **Struggles** over eligibility criteria – what did "we" believe were the issues and needs, and were those going to be in sync with the funder's priorities?
- **Differing views** of who we should assist
- **Who** was to make or receive the referrals
- Interagency **"approvals"** for everyone before intake

Who Should Provide CM

Very Different Priorities

- Case management and prevention/harm reduction agency

  or

- Drug and alcohol treatment facility

(very different working paradigms)

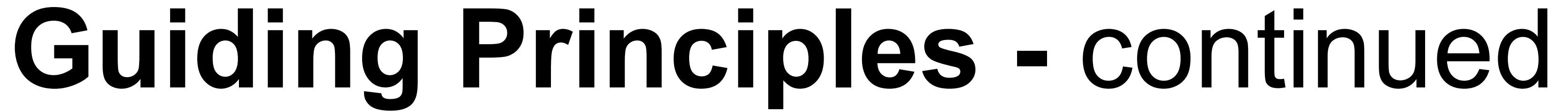
Models Adapted for Project

- HIV case management
- HCV case management
- Prevention/harm reduction case management paradigm
- "Housing First" theory in action
- Recovery-oriented systems of care (ROSC) case management
- Working with multiple co-morbidities and co-occurring disorders

(Treatment facility provided a very specific focus of care management and "graduation")

Guiding Principles of Harm Reduction

1. **Pragmatism** – accepting that some mind-altering substances are inevitable in our societies
2. **Focus on harms** – reduction of harmful consequences in spite of continued use
3. **Prioritization of goals** – prioritize goals with a focus on the immediate reduction in drug-related harm, that may or may not lead to the eventual long-term goal of abstinence



Guiding Principles - continued

4. **Flexibility** of intervention or options
5. **Autonomy** – client’s use is viewed as a personal choice in many instances
6. **Evaluation** – health and functional stability of the individual and also the impact on the greater community

Housing First/Harm Reduction Concepts

- MCAVHN **addresses the needs of people** living with AIDS and/or HCV, those who are active users, mentally ill that others deem **"too challenging"** and those in all stages of recovery
- The methodology is an **alternative** to the current system practiced in our county
- Premised on the belief that at-risk individuals and families are more responsive to interventions after they are in their own housing

Concepts - continued

- **Harm reduction philosophy** views abstinence as an eventual goal, it focuses on achieving specific behavior changes that lower the individual, social and community risks as long as the individual continues use

What Has Transformed

- Original funding excluded many individuals
- Priority was given to those who had 6 or more E.R. admissions per year
- Priority given dependent on actual number of jail bookings & subsequent chaos
- Some of the collaborating agencies had very specific ideas about what constituted **positive outcomes** – not necessarily those of the entire group – decisions were made within CM agency

Transformation - continued

The Ideological Wars

- Who “deserves” services
- Silos of care vs. integration
- Abstinence vs. harm reduction (can’t it just be a part of the continuum?)
- Sharing the “wealth”
- Feeling threatened
- Different outcomes constitute “success” or “graduation”

Who Are the Current Players?

- Current funding provided by AB 109 through the County Probation Department, but **collaborators include**:
- **Public Defender's** office,
- **District Attorney's** office,
- **Probation** officers,
- Mendocino Community **Health Clinic**,
- **Sheriff's Department**, and
- Hospital **Discharge Planning** Department

Current Players - continued

- Inland **homeless shelter**
- Mendocino County **AOD Services**
- Mendocino County **Mental Health/Ortner Management Group** (private contractor)
- Manzanita – **peer mental health** services

*__MCAVHN__ delivers the **sole** care coordination services for the program; making decisions about referrals; working with program participants on personal goals in conjunction with legal sanctions

1. Successful **re-entry** for recently/formerly incarcerated individuals
2. Identifying recent or life-long **barriers** to health and well-being; establishing a medical home
3. **Housing** & housing maintenance
4. **Deferment** from jails and prisons **to treatment** and other stabilizing services for co-occurring disorders
5. Treatment for **co-occurring disorders**

6. Financial resources
7. Vocational rehab
8. Assistance with legal issues – sanctions or advocacy

What the Program Provides

- **Intensive** case management/care coordination services – hands on; focus on relationships, and then incremental steps, especially in the earliest stages
- **Centrally** coordinated medical and psychosocial services coordinated; delivered by partners & a medical home
- **Daily** intra-agency case conferencing
- **Weekly** interagency case conferencing
- **Monthly** service planning with all CM staff

What it provides - continued

- Personal **linkage** to services - making appointments and helping clients keep on track with calendars/reminders
- **Accompanying** those who are fearful or reticent to do what hasn’t worked before
- Using a **team** approach within our agency as well as **conferencing** with other agencies (e.g. housing, AOD treatment, benefits applications, harm reduction counseling, probation contacts by team members)

What it Provides - continued

- When we are unable to place clients within a **dual-diagnosis treatment** facility, care coordinators work on **AOD** supportive counseling, **harm reduction** counseling, and therapeutic **mental health services** with staff who have an understanding of (preferably previous experience treating persons with **co-occurring disorders)**

Housing as the Bottom Line

- One of our staff spends a large portion of her time securing temporary, transitional and permanent housing assistance
- We are a **Shelter Plus Care** case management agency – providing housing case management for our clients with HIV, hepatitis C, and those with dual-diagnosis
- We believe in the **“Housing First”** Model
- Within the paradigm of **harm reduction**

Housing Ready vs. Housing First

Housing Ready

- SA Treatment first

Dominates the landscape:

a) Clean time
b) Compliance with rules and restrictions for a specified period of time
c) Circumstances are outlined for the client

Housing First

- Housing stability first

Alternative approach:

a) Home as constancy
b) Day-to-day routine of human existence
c) Control over ones life and free of surveillance
d) Home is a secure base where identities are constructed

Opportunities to Grow

- Positioned for the emerging **Mental Health Court** ("11 O' clock calendar")
- Medi-Cal **(Medicaid) certification**
- Funding opportunities come from **mental health, co-occurring disorders, drug and alcohol, chronic disease management** resources...we just need to be creative and keep an open mind
- With **HCR/ACA** come new community-based care coordination opportunities

A Wider Community of Care

- Hard to break out of the **AIDS service agency paradigm** we have in the community – even with "partners"
- The **Red-Headed Stepchild** of providers
- Often hard to get asked to the table
- Sometimes simply **overlooked**
- **Marginalized** through misinformation that is too easily believed

Big Hurdles Ahead

- Funding emergency again (unexpected)
- Politics at play (strength of opposing programs and individuals with power)
- Homeless shelter closing
- County budget issues
- New mental health “system”
- Etc, etc, etc.

- **Determination** will carry us
- **Passion** for our vision and the people we serve
- **Never give up** (even when the support is weak)
- A **strong team**
- **Support** in “low” and “high” places
- **Adaptability**

Q and A: discussion

- Contact info:

Libby Guthrie, Executive Director

libbyguthrie@yahoo.com

mcavhn@yahoo.com

Joann Brewer, Care Coordinator

707-462-1932

www.mcavhn.org