Mental Health and the Justice System

Behavioral Health Court Model Puts Teams on the Same Page

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Sarah Nudel, LCSW, Administrator San Diego BHC
Section Overview

Section 1: Statistics Related to Prison System & Mental Health

Section 2: Specific Model of These Programs

Section 3: Telecare’s RCCS Model Integrated Into Treatment

Section 4: The Need to Integrate Criminogenic Needs Into Treatment
The Beginnings of the Jail/Prison System

Prison expenses in the U.S.

$6 billion in the 1980s

$80 billion today

$317 million total cost

10 million adults in U.S. prisons have a serious mental illness
Local jails in the U.S. serve an estimated 2 million people with serious mental illness each year.
Non-Violent Crime & Recidivism

- Of all prison admissions, **75% are non-violent crime offenders**
- No evidence that longer sentences decrease recidivism
- Fourteen states have **no minimum age** for trying children as adults
- There is a **50% recidivism rate** within the first six months of release (48.9% for women, 62.4% for men)
- The more serious the crime is, the lower the recidivism is
  - Second-degree murder is 10.3%
  - Car theft is 72.5%
- **Recidivism decreases with age and increases with mental health issues**
  - 18 & 19 year-olds have 73.7%
  - 60 plus year-olds have 45.2%
People with severe mental illnesses are **10x more likely** to be victims of violent crimes than the general population.

- Only **3%-5%** of violent acts can be attributed to individuals living with a serious mental illness
- **Fewer than 5%** of the 120,000 gun-related killings in the U.S. between 2001-2010 were perpetrated by people diagnosed with mental illness
- Most people assume the contrary, mainly due to media coverage
• Roughly **1 in 38 persons** in the United States are under correctional supervision. *US DOJ-April 2018*

• As of 2016, approximately **30%** of the California Department of Corrections and Rehabilitation incarcerated population **has mental health needs** *COMIO 2016 annual report*

• **74%** of state prisoners and **76%** of local jail inmates who have a mental health problem **also met criteria for substance dependence or abuse** *bureau of justice statistics 2006*

• Female inmates have **higher rates** of mental health problems than male (state prison: 73% of females 55% of males; local jails 75% of females and 63% of males). *bureau of justice statistics 2006*

• **67.8%** of those released from state prison are **arrested again within 3 years** *US department of justice 2014*
Statistics, continued

• In the U.S., the prison population exploded beginning in the 1970s with the “War on Drugs”

• In the U.S., while drug use rates are generally equal among all races, the majority of men incarcerated for non-violent drug offenses are Black or Hispanic

• Individuals who earn a college degree while in or after prison are far less likely to re-offend

• Registered sex offenders typically have a low recidivism rate (approximately 11%)

Telecare JIMH Programs have had a lot of success at reducing recidivism
Jail, Prison, Probation & Parole

Jail
- A temporary holding facility run by the sheriff’s department

Prison
- A long term confinement that is run by either state or local government

Parole
- When people are released from prison to serve the remaining portion of their sentence in the community

Probation
- Traditionally when someone is placed on supervision in the community in lieu of a sentence
San Diego Behavioral Health Court (BHC)

Our Members

• 90% of our members have co-occurring disorders—both mental health & substance use issues

• Approximately two-thirds of our members range from ages 25 to 45
The Program Model

• BHC is an ACT model program that has some modifications to meet the Court Teams requests
• The program diverges from ACT by offering increased individual work at the program site (versus field) and the program has increased groups
• This is a 24/7, on-call program
• Program length is a minimum of 18 months, but members typically stay 2-3 years
• All members attend court 1 time per month for a status update on their participation in the program
Enrollment Criteria

- Must have an SMI diagnosis of schizophrenia, bipolar disorder, or major depression
- Must be 18 years or older
- Must be in jail at time of referral
- Must pass the initial screening performed by our screener and have the court teams approval
- Must be on probation while in the program
- No sex offenders and no one with a history of arson
- Incentive of successful completion—misdemeanors dropped and felonies reduced
The Collaborative Process & Multiple Stakeholders

Stakeholders
• The county
• Public defender
• Defense attorney
• Public counsel
• Probation
• Judge
• Members
• Sober living homes
• Behavioral health providers

The Collaborative Process
• Court sessions at least two times a month
• Collaborative meetings with entire court team
• Court reports are submitted to court team before each court session
• Continuous email communication
Time to Hear from a Successful Collaborative Team
Our Roles Compared to our Mental Health Providers

Parole/Probation/Court Partners

**Behavioral Health Professionals**
- Focus on mental health treatment
- Sensitive to privacy
- Recovery-focused
- Community linkages
- Mental health visits at home/in the field
- Teach effective choice-making
- Power aware
- Seek to awaken internal motivation

**Justice Partners**
- Focus on accountability
- Community supervision
- Monitor conditions of release (COR)
- Community linkages
- Perform visits and searches at home
- Focused on compliance, not choice
- Power-over
- Use COR and sanctions as external motivation
Statistics from BHC (total census 50)

- **6** Average enrollments per month
- **1** Average successful graduates a month
- **15** Average number going to school
- **60%** Average number who don’t recidivate once enrolled
- **97%** Increase in education days
Statistics from BHC (total census 50)

78% Reduction in total number of emergency interventions
32% Reduction in hospital days
79% Reduction in incarceration days
100% Reduction in Homeless Days
63% Increase in employment days
Integrating Telecare’s Recovery-Centered Clinical System (RCCS) philosophy in our treatment with our members helps everyone succeed.
Program Culture as an Intervention in JIMH Services
The Five Awarenesses

- Power
- Respect
- Judgment
- Motivation
- Uniqueness
Awarenesses & JIMH

The Use of Program Culture as a Primary Intervention

- **Power Awareness**: Using partnership rather than control-oriented power
- **Non-Judgment**: Avoiding a judgmental environment
- **Individual Uniqueness**: Avoiding labeling and valuing the uniqueness of others
- **Motivational Awareness**: Using relationships to enhance motivation and readiness for change
- **Respect and Dignity**: Conveying respect and providing a welcoming environment in all aspects of a program
Telecare’s Approach Using the RCCS

The Use of the RCCS Conversations to Address Criminogenic Needs

- **Exploring Identity**: Explore values, identity, and story
- **Awakening Hope**: Develop a recovery plan
- **Making Choices**: Teach the skill of making choices again
- **Reducing Harm**: Teach dialectical behavior therapy (DBT) skills to reduce harm and increase self-control
- **Making Connections**: Explore connections with self, others, and one’s spirituality
STEREOTYPES ARE AWESOME!
But only one of them is a convicted felon
Risk Needs Responsivity
Risk

Risk Needs Responsivity (RNR)

• Level of service should match client’s risk of reoffending
• More resources to the highest-risk/needs clients
• Interventions target individual’s specific criminogenic needs
• Risk levels are determined by examining factors linked to re-offense
• Static factors: cannot be changed (age, gender, criminal history, age of first arrest)
• Dynamic factors: can be changed through successful interventions (substance abuse, education deficiencies, antisocial patterns, and pro-criminal attitudes)
## Criminogenic Needs

### Risk Needs Responsivity (RNR)

<table>
<thead>
<tr>
<th>Major Risk/Need Factor</th>
<th>Indicators</th>
<th>Intervention Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial personality pattern</td>
<td>Impulsive, adventurous pleasure seeking</td>
<td>Build self-management skills, teach anger management</td>
</tr>
<tr>
<td>Pro-criminal attitudes</td>
<td>Rationalization for crime, negative attitudes towards the law</td>
<td>Counter rationalizations with pro-social attitudes; build up a prosocial identity</td>
</tr>
<tr>
<td>Social supports for crimes</td>
<td>Criminal friends, isolation from prosocial others</td>
<td>Replace pro-criminal friends and associates with prosocial friends and associates</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Abuse of alcohol &amp; drugs</td>
<td>Reduce substance abuse, enhance alternatives to substance abuse</td>
</tr>
<tr>
<td>Prosocial recreational activities</td>
<td>Lack of involvement in prosocial leisure activities</td>
<td>Encourage participation in prosocial recreation activities</td>
</tr>
<tr>
<td>School/work</td>
<td>Poor performance, low levels of satisfaction</td>
<td>Enhance work/study skills, nurture interpersonal relationships</td>
</tr>
</tbody>
</table>

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Telecare Corporation | Respect. Recovery. Results. | [www.telecarecorp.com](http://www.telecarecorp.com)
Responsivity

Risk Needs Responsivity (RNR)

• Provide treatment at the individual’s level
• Matching intervention to client’s learning style
• Generational poverty
• Abilities (what’s strong instead of what’s wrong)
• Strengths (what’s working)
• What will motivate someone to change
The **Risk Needs Responsivity (RNR)** model has been displayed to be very successful. It is based on the premise that treatment should be tailored for each individual and centered on criminal justice risk and criminogenic needs. The three principles of the RNR model are:

- **Risk (Who):** The level/frequency of service should match client’s risk of reoffending. Different tools that are utilized criminogenic risk (e.g. FROST, CTP, Proxy, COMPASS) to determine risk of re-offending.

- **Needs (What):** The assessment identifies what criminogenic needs to focus on in treatment to reduce the likelihood of reoffending.

- **Responsivity (How):** Treatment should be delivered in a way that is responsive to the client’s learning style.
Criminogenic Needs

Foundation for Effective Treatment for Our Members

• Criminogenic needs are issues, risk factors, characteristics and/or problems that directly relate to a person’s likelihood of committing another crime

• Treatment programs that target criminogenic needs help clients reduce recidivism
## Criminogenic Needs and Treatment

<table>
<thead>
<tr>
<th>Criminogenic Need</th>
<th>Treatment Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antisocial Behavior</strong></td>
<td>Exploitive, aggressive, or harmful behavior towards others</td>
</tr>
<tr>
<td></td>
<td>Increase pro-social behaviors, reinforce pro-social beliefs, support crime-free lifestyle. Develop clear, consistent, and proximate reward and consequences for behavior. Teach, model, and reinforce pro-social skills in high-risk situations.</td>
</tr>
<tr>
<td><strong>Antisocial Personality Pattern</strong></td>
<td>Impulsive, sensation-seeking, risk-taking, aggressive, manipulative, and exploitive</td>
</tr>
<tr>
<td></td>
<td>Increase self-control and delayed gratification skills, anger and conflict management, problem-solving. Reinforce pro-social interpersonal interactions.</td>
</tr>
<tr>
<td><strong>Antisocial Cognition</strong></td>
<td>Values, beliefs, feelings, and cognitions that contribute to personal identity that favors and reinforces criminal behavior</td>
</tr>
<tr>
<td></td>
<td>Address cognitive distortions and rationalizations that maintain a criminal identity. Build, practice, and reinforce new cognitions and attributions though cognitive restructuring and cognitive-behavior therapies.</td>
</tr>
<tr>
<td><strong>Antisocial Peers</strong></td>
<td>Preferring to associate with pro-criminal peers and isolation from anti-criminal peers and social contexts</td>
</tr>
<tr>
<td></td>
<td>Reduce and eliminate association with delinquent peers and increase opportunities for regular association with anti-criminal peers and institutions (school, church, clubs, sports teams, and other structured and supervised activities).</td>
</tr>
</tbody>
</table>
# Criminogenic Needs and Treatment

<table>
<thead>
<tr>
<th>Criminogenic Need</th>
<th>Treatment Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family</strong></td>
<td>Increase pro-social communication, nurturance, structure, supervision, and monitoring in the family. Address dysfunctional boundaries and role confusion. Provides for consistent rewards for pro-social family interactions.</td>
</tr>
<tr>
<td>Chaotic and poor-quality family relationships that have minimal or no pro-social expectations regarding crime and substance use</td>
<td></td>
</tr>
<tr>
<td><strong>School/Work</strong></td>
<td>Increase school and/or work performance through education, vocational training, or alternative placement. Provide rewards and consequences to increase consistent attendance and progress at school and/or work.</td>
</tr>
<tr>
<td>Poor performance and limited engagement with school or work resulting in dissatisfaction and avoidance of them</td>
<td></td>
</tr>
<tr>
<td><strong>Leisure &amp; Recreation</strong></td>
<td>Expose to a variety of pro-social leisure and recreational activities. Increase opportunities for regular involvement in preferred activities and reward progress.</td>
</tr>
<tr>
<td>Limited involvement in anti-criminal leisure activities</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td>Reduce substance use through targeted treatment, supervision, and access. Reduce exposure to substance abusing peers. Increase capacity to cope with stressors through lifestyle changes in exercise, sleep, and nutrition.</td>
</tr>
<tr>
<td>Use and abuse of alcohol and/or drugs</td>
<td></td>
</tr>
</tbody>
</table>

EBPs Used at WIT
Our Members

• We have a soft contract for 100 members and currently serve 134

• All of our members have co-occurring disorders—both mental and substance abuse issues

• Around two-thirds of our members range from 25 to 45 years old
Our Program

• Typically, members stay in the program between 24 and 36 months
• We provide services within the ACT model as well as provide services in a Day Treatment model
• WIT treatment is a collaborative process with probation, the county, and the court
• At time of graduation, members are transitioned either to the same level of care or lower level of care depending on symptom presentation
<table>
<thead>
<tr>
<th>Phases</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Phase 4</th>
<th>Phase 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court Appearance Per Month</td>
<td>2 (minimum)</td>
<td>1 (minimum)</td>
<td>1 (minimum)</td>
<td>1 (minimum)</td>
<td>1 (minimum)</td>
</tr>
<tr>
<td>Days Sober Prior to Advancement</td>
<td>14 Days Clean Drug Tests</td>
<td>30 Days Clean Drug Tests</td>
<td>49 Days Clean Drug Tests</td>
<td>60 Days Clean Drug Tests</td>
<td>120 Days Clean Drug Test</td>
</tr>
<tr>
<td>Compliance with Court, Treatment &amp; Supervision Directatives</td>
<td>Develop Case Plan</td>
<td>Participate in Case Plan</td>
<td>Participate in Case Plan</td>
<td>Participate in Case Plan</td>
<td>Participate in Case Plan</td>
</tr>
<tr>
<td>Probation Office Visits</td>
<td>Weekly</td>
<td>Weekly</td>
<td>Two Times Per Month (minimum)</td>
<td>Two Times Per Month (minimum)</td>
<td>Two Times per Month (minimum)</td>
</tr>
<tr>
<td>Home Calls</td>
<td>1 (minimum)</td>
<td>1 (minimum)</td>
<td>1 (minimum)</td>
<td>1 (minimum)</td>
<td>1 (minimum)</td>
</tr>
<tr>
<td>Drug Testing</td>
<td>3 per Week Random</td>
<td>3 per Week Random</td>
<td>2 per Week Random</td>
<td>2 per Week Random</td>
<td>Random</td>
</tr>
<tr>
<td>Curfew</td>
<td>8 pm – 5 am</td>
<td>10 pm – 5 am</td>
<td>10 pm – 5 am</td>
<td>11 am – 5 am</td>
<td>12 am – 5 am</td>
</tr>
<tr>
<td>Financial Obligations to Victim, Court, HCA and Probation</td>
<td>Interview</td>
<td>Set Up Financial Plan</td>
<td>Comply with Financial Plan</td>
<td>Comply with Financial Plan</td>
<td>Comply with Financial Plan</td>
</tr>
<tr>
<td>Treatment Meet with PSC</td>
<td>Weekly (minimum)</td>
<td>Minimum of Two Times per Month</td>
<td>Minimum of Two Times per Month</td>
<td>Minimum of Two Times per Month</td>
<td>Minimum of Two Times per Month</td>
</tr>
<tr>
<td>Housing</td>
<td>Temporary Plan</td>
<td>Shelter Plus Care</td>
<td>Housing List</td>
<td>Permanent Placement</td>
<td>Permanent Housing</td>
</tr>
<tr>
<td>Employment/Training / Education (College, HS Diploma / GED)</td>
<td>Develop Individualized Plan</td>
<td>Continue to develop plan</td>
<td>Implement Plan</td>
<td>Continue</td>
<td>Continue</td>
</tr>
<tr>
<td>Productive Use of Time</td>
<td>TBD</td>
<td>10 Hours per Week</td>
<td>15 Hours per Week</td>
<td>20 Hours per Week*</td>
<td>20 Hours per Week*</td>
</tr>
<tr>
<td>Individual Counseling</td>
<td>Crisis Intervention</td>
<td>*One Time per Week</td>
<td>*Two Times per Month</td>
<td>*One Time per Month</td>
<td>Private Therapy</td>
</tr>
<tr>
<td>Treatment Groups</td>
<td>10 Groups/4 Days a Week at Program</td>
<td>10 Groups/4 Days a Week at Program</td>
<td>8 Groups/4 Days a Week at Program</td>
<td>8 Groups/4 Days a Week at Program</td>
<td>4 Groups/2 Days a Week at Program</td>
</tr>
<tr>
<td>Medical Needs Assessment</td>
<td>Medical Needs Assessment</td>
<td>Refer for Medical Treatment</td>
<td>Continue</td>
<td>Continue</td>
<td>Aftercare Plan</td>
</tr>
<tr>
<td>Curriculum Based Treatment (MRT, etc.)</td>
<td>Assessment</td>
<td>Start</td>
<td>Start/Continue</td>
<td>Continue</td>
<td>Complete</td>
</tr>
<tr>
<td>Budget Plan</td>
<td>Apply for benefits</td>
<td>Develop Budget</td>
<td>Follow Budget</td>
<td>Follow Budget</td>
<td>Follow Budget</td>
</tr>
<tr>
<td>Plan to Alter Negative People, Places and Things</td>
<td>Assessment</td>
<td>Change</td>
<td>Develop Peer Support</td>
<td>Strengthen Peer Support</td>
<td>Strengthen Peer Support</td>
</tr>
<tr>
<td>Staff Help Meetings Per Week &amp; Sober Network</td>
<td>Assessment</td>
<td>Per Case Plan</td>
<td>Sponsor and Sober Network per Case plan</td>
<td>Sponsor and Sober Network per Case plan</td>
<td>Sponsor and Sober Network per Case plan</td>
</tr>
<tr>
<td>Aftercare Plan</td>
<td>Start</td>
<td>Aftercare Planning</td>
<td>Continue</td>
<td>Aftercare Planning</td>
<td>Present Aftercare Plan</td>
</tr>
</tbody>
</table>
Phases

Phase 1
60 days

Phase 2
90 days
Orientation & Treatment Plan

Phase 3
90 days
Early Recovery

Phase 4
90 days
Active Recovery

Phase 5
90 days
Sustaining Recovery
Phases of Program Treatment

Phase 1
Adjustment and support acquisition of basic needs

Phase 2
Developing insight and understanding of symptoms and symptom management

Phase 3
Skill building to support community integration

Phase 4
Symptom management in “real world” setting

Phase 5
Maintenance
How the Program Phases Mirror the Stages of Motivational Interviewing

Phase 5
Living a life (maintenance)

Phase 4
Participating in meaningful activity and transitioning to independent Living (action)

Phase 3
Identify the who, what, where, and how to live with mental health issues and/or substance use disorder (preparation)

Phase 2
Focus on symptom management (contemplative)

Phase 1
Engaging (pre-contemplative)
## WIT Sample Group Schedule: Mon. & Tues.

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 a.m. Sign-In</td>
<td>10:00 a.m. Sign-In</td>
</tr>
<tr>
<td>11:00 a.m. – 12:00 p.m.</td>
<td>10:30 a.m. – 11:30 p.m.</td>
</tr>
<tr>
<td>• I Am Not Giving Up with Shannon</td>
<td>• I WIN!!!!!!! with Alicia</td>
</tr>
<tr>
<td>• Chess Club with Kory M.</td>
<td>• MRT with Shannon (Closed Group)</td>
</tr>
<tr>
<td>• Peer Support Through Self-Care with Rodney</td>
<td></td>
</tr>
<tr>
<td>12:00 p.m. Lunch Break</td>
<td>12:30 p.m. – 2:30 p.m.</td>
</tr>
<tr>
<td>1:30 p.m. – 2:30 p.m.</td>
<td>• COPE with Stacey</td>
</tr>
<tr>
<td>• Continuum of Care Applications with Melanie (By Appointment Only)</td>
<td>12:30 p.m. – 1:30 p.m.</td>
</tr>
<tr>
<td>• Independent Study</td>
<td>• I Used to Run, Now I Walk with Rocky</td>
</tr>
<tr>
<td>2:30 p.m. Sign-Out</td>
<td>• Cooking with Sonja Morgan with Robin (Closed Group)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2:30 p.m. – 3:30 p.m.</td>
</tr>
<tr>
<td></td>
<td>• CBT with Amanda S</td>
</tr>
<tr>
<td></td>
<td>• Men’s Group with Shahab</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3:30 p.m. Sign-Out</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Thursday</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>10:00 a.m.</td>
<td>10:00 a.m.</td>
</tr>
<tr>
<td>Sign-In</td>
<td>Sign-In</td>
</tr>
<tr>
<td>11:00 a.m. – 12:00 p.m.</td>
<td>10:30 a.m. – 11:30 p.m.</td>
</tr>
<tr>
<td>• COEG with Patrick</td>
<td>• You Talkin’ to Me? with Alicia</td>
</tr>
<tr>
<td>• Continuum of Care Applications with Melanie</td>
<td>• A Parallel Universe with Heather (Closed Group)</td>
</tr>
<tr>
<td>• Independent Study</td>
<td>• MRT with Nicole (Closed Group)</td>
</tr>
<tr>
<td>12:30 p.m. – 1:00 p.m.</td>
<td>12:00 p.m.</td>
</tr>
<tr>
<td>• Community Meeting</td>
<td>Lunch Break</td>
</tr>
<tr>
<td>1:30 p.m. – 2:30 p.m.</td>
<td>12:30 p.m. – 2:30 p.m.</td>
</tr>
<tr>
<td>• Whole Person Care with Amanda G</td>
<td>• COPE with Eileen</td>
</tr>
<tr>
<td>• A psychoeducation group</td>
<td>12:30 p.m. – 1:30 p.m.</td>
</tr>
<tr>
<td>• Get Your Work On! with Nicole (closed group)</td>
<td>• Stress-Relief Art with Evan</td>
</tr>
<tr>
<td>1:30 p.m. – 3:00 p.m.</td>
<td>2:30 p.m. – 3:30 p.m.</td>
</tr>
<tr>
<td>• Softball with Heather and Shahab</td>
<td>COEG with Shahab</td>
</tr>
<tr>
<td>3:00 p.m.</td>
<td>• I’m Stronger than I Think I Am with Patrick (Closed Group)</td>
</tr>
<tr>
<td>Sign-Out</td>
<td>3:00 p.m.</td>
</tr>
<tr>
<td>Sign-Out</td>
<td>Sign-Out</td>
</tr>
</tbody>
</table>
# WIT Sample Group Schedule: Fri. & Sat

<table>
<thead>
<tr>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00 a.m.</td>
<td>10:00 a.m.</td>
</tr>
<tr>
<td>• Sign-In</td>
<td>• Sign-In</td>
</tr>
<tr>
<td>• Laundry Group with Shahab</td>
<td>10:30 a.m. – 11:30 p.m.</td>
</tr>
<tr>
<td>11:00 a.m. – 12:00 p.m.</td>
<td>• Seeking Safety with Patrick</td>
</tr>
<tr>
<td>• Seeking Safety with Stacey</td>
<td>• Mindfulness with Alicia</td>
</tr>
<tr>
<td>• Quit Bugging Me with Alicia (Closed Group)</td>
<td>12:30 p.m. – 1:30 p.m.</td>
</tr>
<tr>
<td>• Ignorance is not Bliss with Robin, Theresa, and Edwin</td>
<td>• 12-Step Meeting with Brad</td>
</tr>
<tr>
<td>12:00 p.m. – 1:00 p.m.</td>
<td>1:30 p.m. – 2:30 p.m.</td>
</tr>
<tr>
<td>• Independent Study</td>
<td>• A Better Tomorrow with Stacey</td>
</tr>
<tr>
<td>• Continuum of Care Application with Melanie (By Appointment)</td>
<td>• Walking Group with Shahab</td>
</tr>
<tr>
<td>1:30 p.m. – 2:30 p.m.</td>
<td>2:30 p.m.</td>
</tr>
<tr>
<td>• Mindfulness with Eileen</td>
<td>• Sign-Out</td>
</tr>
<tr>
<td>• Me, Myself, and I with Amanda S.</td>
<td>2:30 p.m.</td>
</tr>
<tr>
<td>• DBT with Heather (closed group)</td>
<td></td>
</tr>
<tr>
<td>2:30 p.m. Sign-Out</td>
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Goal: Increase Assessment of Group Impact

Program Vision

The four main areas of focus will be:

- Co-Occurring Program Extension (COPE)
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Moral Reconation Therapy (MRT)
Residential Treatment vs. COPE

• Introduced in FY 16/17, the COPE Program appears to be more successful in engaging members in **Substance Use Disorders (SUD)** treatment than residential treatment alone.

• In FY16/17, and in 8 months of programming, members identified for SUD treatment and who participated in the COPE program, 38% remained at program versus FY 15/16 where members who participated in residential treatment, only 6% remained at treatment.

• Fiscal impact is that the WIT program saved more than 100k on residential treatment that only benefited 2 members in FY15/16.
Matrix Model

- **An integrative treatment.** It includes aspects of many different therapeutic styles and psychological orientations

- **An intensive outpatient program (IOP).** It entails several hours of treatment each day, several days per week, while allowing the client to still live at home

- **A highly-structured program.** The entire model is thoroughly designed and engineered with planned topics and sequencing for each session and phase of treatment

- **A time-limited treatment.** The model is intended to last for 16 weeks, but it can be extended for a year depending on the needs of the client

- **A proven treatment.** Multiple studies have shown benefit of the treatment based on extending recovery and client consistency. Beyond stimulants, the model is helpful for a range of substance use issues. The efficacy has been so clear that many organizations support the treatment protocol, including the National Institute on Drug Abuse (NIDA)
COPE: Chapter 1

Recognizing Self-Delusion

• Some people use addiction as a form of escape
• They use it to avoid feelings of hurt, betrayal, worry
• It’s important to get people to acknowledge that they have a problem

Overcoming Denial

• Members list reasons they believe they don’t belong in a drug therapy group
• “It isn’t like I’m using it everyday”
• “My kids aren’t hurt because I only use when they’re away”
• “I am an adult, I can make my own decisions”
• Most addicts discover there’s no excuse for their behavior
COPE: Chapter 2-3

• In the 1930s and 1940s, alcoholics and drugs addicts were seen as untreatable
• Today, we see addiction as an illness
• Alcoholics tend to put alcohol above everything else including their friends, their spouse, their children etc.
• Addictive behavior includes preoccupation, ritualization, compulsion, and despair
• The brain can change chemically and structurally through addiction, but it can recover over time
COPE: Chapter 4

Steps to fix problem:

• Recognize that there are things you can’t control by yourself
• Ask for help from others
• Focus on what you can do
• Don’t give up or pretend to be something you’re not
• Addictive behavior continues until you learn your lesson

Members asked questions:

• What age did you start?
• What were early developments of addiction?
• Were there periods of your life when addiction escalated?
• What were critical events during these periods of escalation?
• How much have you spent on your addiction? Include medical, lost time at work, lawsuits, divorce settlements, etc. Reflect on the total.
COPE: Chapter 5

“You choose your behavior, but the world chooses your consequences” – Pat Mellody

Addicts believe:

- No one knows the extent of my problem
- I can change behavior by myself
- I can always figure out or force a way to handle problems
- I work best alone
- No one is hurt by what I have done
- I have not been hurt by what I have done

We teach them:

- I can be honest
- I must create support networks
- Trustworthy people get the whole story
- Integrity must become how I get my needs met with a lot less hassle
COPE: Chapter 6-7

“We tend to get what we expect” – Norman Vincent Peale

• We give addicts a list of challenges they have to establishing sobriety
• They rate each criteria from 1-5, with 5 being the most challenging and 1 being the least
• The placebo effect is strong in addicts
• A group was given two wines, and they reported getting more drunk from the wine that they thought was more expensive
• Some of their enjoyment of the product has to do with their expectations and beliefs about it
COPE: Chapter 8

“Practical experience shows that nothing will so much insure immunity from drinking as intensive work with other alcoholics. It works when other activities fail.” - AA

This chapter mentions 12 steps of Alcoholics Anonymous.

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.
COPE: Chapter 9

“Do or do not. There is no ‘try’.” - Yoda

- Many addicts have failed because they did not believe it was possible for them to recover
- They could acknowledge the possibility of others’ success, but in their heart of hearts they believed they were too defective so succeed
- They always seem to want credit for trying
Goal: Increase Assessment of Group Impact

- Tracking of groups relative to desirable results
- Use of MHSA outcomes to verify data
- Decrease in flash incarcerations, decrease in absconds, decrease in hospitalizations, increase in vocational participation
Non-Violent Crime & Recidivism

• There is a 50% recidivism rate within the first six months of release (48.9% for women, 62.4% for men)

• The more serious the crime is, the lower the recidivism is
  • Second-degree murder is 10.3%
  • Car theft is 72.5%

• Recidivism decreases with age and increases with mental health issues
  • 18 & 19 year-olds have 73.7%
  • 60 plus year-olds have 45.2%

At the WIT program, the recidivism rate while in treatment hovers consistently at 15%
Questions?