Evidence-based Practices for Promoting Recovery and Reducing Recidivism

California Mental Health and Substance Use Policy Forum
March 13, 2014

Kristin Dempsey
Percy Howard
Karen Kurasaki
Shoshana Zatz
Seeking Safety

An Evidence Practice for a Trauma Informed Correctional Community

Kristin L. Dempsey, MFT
Senior Associate, CiMH
Creating Trauma-Informed Correctional Care: Program Goals and Environmental Changes

• Review of literature comparing gendered responses, implications for men’s facilities, and the compatibility of trauma recovery goals and forensic programming goals.

• Results: Trauma informed care (TIC) demonstrates promise in increasing offender responsivity to evidence-based cognitive behavioral programming that reduces criminal risk factors and in supporting integrated programming for offenders with substance abuse and co-occurring disorders.

Prevalence of Trauma Among Inmates

• Women in prison – sexual or interpersonal violence – 90% (Commonwealth of MA, 2005; Women in Prison Project, 2006)
• History of sexual abuse is risk factor for both females and males.
• Those who have been sexually abused are more likely to be arrested (Hubbard, 2002), and to experience future trauma(Council of State Governments, 2005; Najavits, 1997).
• Sexual abuse interferes with female inmates’ ability to benefit from programs – triggers, lack of emotional regulation, dissociation, lack of engagement.
• Principles of TIC along with interventions aimed at trauma stabilization are a priority for women offenders. (Miller, Najavits, 2012).
Prevalence of trauma among inmates

- Male prisoners the most commonly reported trauma is witnessing someone being killed or seriously injured (Sarchiapone, Carlia, Cuomoa, Marchettia, and Roy, 2008), followed by physical assault (Johnson, et al, 2006), and childhood sexual abuse (Weeks and Widom, 1998).
- Higher rates of trauma and earlier age of trauma onset is associated with increased violence and victimization in prison (Komarovskaya, 2009).
- 38% of men in substance abuse treatment have PTSD (Najavits, 2006).
Dynamics of Trauma in Prison

• Both men and women may under-report sexual violence and symptoms of sexual trauma because they do not seem them out of the ordinary (Moses, et al, 2003) or because they do not see their experiences as out of the ordinary.

• Inmates also learn to not report psychiatric symptoms as a ways to have more autonomy and reduce perceived vulnerability.

• Men with histories of sexual abuse are more at risk for being sexually assaulted in prison. (Beck and Harrison, 2010)
Seeking Safety Background

• Integrating treatment for both trauma and substance use demonstrates better outcomes for both issues; the integrated treatment results in less overall relapse and prevents the overall treatment from being derailed.

Seeking Safety – developed to address the specific needs of trauma survivors with trauma history

• Seeking Safety is present-focused, coping skills approach that can be used for integrated treatment of substance use and trauma-related disorders.

• It does not require delving into the past, but it can be used with trauma-processing methods.

Najavits, 2001
Seeking Safety in the TIC Correctional System

- Seeking Safety provides an opportunity to practice verbal trauma de-escalation prompts.
- Redirecting offenders and inmates who bring up trauma details.
- SS uses cognitive-behavioral interventions which has been determined effective in prison populations (Andrews and Bonta, 2003).
- SS works on restructuring criminal thinking and developing pro-social skills, both of which are supported by the National Institute of Corrections.
Core Principles of Seeking Safety

• Safety as the priority of treatment
  – When a person has both substance abuse and PTSD, the most urgent clinical need is to establish safety.
  – Safety includes discontinuing substance use, reducing Suicidality and self-harm behavior, ending dangerous relationships, and gaining control over symptoms of both disorders.
  – Safety is taught through *Safe Coping Skills, a Safe Coping Sheet, a Safety Plan*, and a report of safe and unsafe behavior in each session.
Seeking Safety – Providing Skills as Part of Correctional TIC

• Trauma-informed correctional environments need to be highly structured and safe, with predictable, consistent limits, incentives and boundaries, as well as consistent and swift consequences that are applied equally and fairly. (Council of State Governments, 2010)
  – Seeking Safety has a consistent, predictable structure, that can be applied flexibly.
• SS allows for members to be educated on trauma-related symptoms, behaviors, adaptations and their function.
• Grounding role plays and demonstration teaches emotional regulation.

Miller and Najavitz, 2012
Core Principles of Seeking Safety

• Four Content Areas: Cognitive, Behavioral, Interpersonal and Case Management
  – Originally designed as a CBT approach, was expanded to include interpersonal and case management domains.
  – Interpersonal work is important to help clients learn how to establish safe, trusting, honest relationships. Case management assists with “cleaning up wreckage” by engaging clients in services so they can receive housing, job counseling, benefits, etc.
Twenty Five Topics

• Interpersonal Topics:
  – Asking for Help
  – Honesty
  – Setting Boundaries in Relationships
  – Healthy Relationships
  – Community Resources
  – Healing from Anger
  – Getting Others to Support Your Recovery
Twenty Five Topics

• Behavioral Topics:
  – Detaching from Emotional Pain
  – Grounding
  – Taking Good Care of Yourself
  – Red and Green Flags
  – Commitment
  – Coping with Triggers
  – Respecting Your Time
  – Self-Nurturing
Twenty Five Topics

• Cognitive Topics:
  – PTSD
  – Taking Back Your Power
  – Compassion
  – When Substances Control You
  – Recovery Thinking
  – Integrating the Split Self
  – Creating Meaning
  – Discovery
Twenty Five Topics

• **Combination Topics:**
  – Introduction to Treatment/Case Management
  – Safety
  – Life Choices Game (Review)
  – Termination
Balance of Structure and Flexibility

• Check in
• Quotation
• Handouts
• Check out
  – Creating structure works to contain the chaos which is typical of both disorders
  – The topics, handouts and modalities can be flexibly applied
Seeking Safety – Key Features

• Manual is both a **therapist guide** and offers extensive **handouts**.

• [www.seekingsafety.org](http://www.seekingsafety.org) also provides implementation guidelines, current research, sample chapters and exercises, and a list of therapists trained in the technique.

• Trainers can be found at [www.seekingsafety.org](http://www.seekingsafety.org), but there is no proprietary relationship that mandates trainers or training.
  – The manual provides significant guidance for implementation
    • (Per conversation with L. Najavits, 4/2011)
Cost of Seeking Safety

• Individual manuals: $43.84 per manual on Amazon.
• Trainers charge about $1600 to $2000 per day:
  – One day training includes overview of the model
  – Demonstration of the techniques
  – Practice applying techniques
• Clinical model, but peers, interns, non-licensed staff are very well-received as co-facilitators and can provide valuable case management support.
Seeking Safety – Highly Flexible Model

• Designed for groups, but....
  – Can use structure and handouts for individual work.
  – Can modify groups to use more or less of the handouts, so the pacing of material can be adjusted to the needs of the group.
  – Has been successful used in a variety of settings - outpatient clinics, inpatient, residential treatment, correctional facilities, schools and homeless centers.
  – Can be names something more amenable to the group: e.g. “Finding our Strength”.
For More Information on Seeking Safety

• [www.seekingsafety.org](http://www.seekingsafety.org)
  – The Official website – summary of the approach, sample lessons, trainers list, research and implementation articles

• Kristin Dempsey, MFT at [kdempsey@cimh.org](mailto:kdempsey@cimh.org)
Moral Reconciliation Therapy

Substance Abuse and Prosocial Skills Development Intervention for Offender Populations

Percy Howard, LCSW, Associate Director CiMH Evidence-Based Practices Team
Moral Reconation Therapy (MRT) Background

Moral Reconation Therapy or MRT®, an NREPP program, is the premiere cognitive-behavioral program for substance abuse treatment and for offender populations. Developed in 1985 by Dr. Gregory Little and Dr. Kenneth Robinson, over 120 published outcome studies have documented that MRT-treated offenders show significantly lower recidivism for periods as long as 10-years after treatment. Research consistently shows that, in comparison to appropriate controls, MRT treated offenders have re-arrest and re-incarceration rates from 25% to 75% lower than expected.
Target Populations

• Adult Offenders with Substance Abuse History
• Juvenile Offenders with Substance Abuse History
• Domestic Violence Perpetrators
• Hospital-Based Non-Offender Populations

The Practice is manualized in a specific manner for each population described above.
Clinical Setting for Groups

- Group Setting
- 24 Modules
- Open-Ended Groups, group members can enter a group at any time, as the modules are constructed to facilitate continuity of learning at any point.
Conation

• A term derived from the philosopher Rene DeCartes to describe the point where body, mind and spirit are aligned in decision making. Reconation refers to altering the process of how decisions are made.
Moral Reconciliation Therapy

- MRT® seeks to move clients from egocentric, hedonistic (pleasure vs. pain) reasoning to levels where concern for social rules and others become important.
- Research of MRT® has shown that as clients pass steps, moral reasoning increases in adult and juvenile clients.
MRT® Focus

• Confrontation of beliefs, attitudes, and behaviors
• Assessment of current relationships
• Reinforcement of positive behavior and habits
• Positive identity formation

• Enhancement of self-concept
• Decrease in hedonism
• Development of frustration tolerance
• Development of higher stages of moral reasoning
Unique Program Attributes

1. Open-ended and self-paced
2. Usable across systems
3. Culturally neutral and encompasses a range of learning styles
4. Utilizes an inside-out process
5. Standardized curriculum provides facilitator structure and accountability
6. Program emphasizes feedback and client reflection
7. Enhances personal problem solving and self-direction
8. Help clients identify their unique strengths
Program Goals for MRT

• Decrease high program dropout rates
• Improve program completion rates
• Improve outcomes with minority populations
• Provide integration of programming across the continuum of treatment levels
• Reduction of relapse/recidivism
MRT™ Client Group Process

- MRT™ typically has groups of 5-15 client participants with one facilitator or co-facilitators where desired.
- Groups are designed to last approximately one and one half to two hours.
- Depending on client and site characteristics, groups are usually held at least once or twice weekly.
- Institutional settings typically have two or more meetings per week with community-based sites having one meeting per week.
- Clients in MRT® typically prepare step exercises and tasks prior to group attendance and process their exercises in group or exercises are given to the facilitator for review and approval.
MRT™ Client Group Process

• MRT® is designed to be completed by the average client in 20-30 sessions.
• Completion is defined when the client successfully passes MRT®'s 12th Step.
• MRT® is specifically designed for clients with open-ended groups where participants can enter at any time and work at their own pace.
• MRT® can be used at any point in an client’s treatment, but it is most often used as a re-entry tool.
• Participants enter ongoing groups at any time, begin the treatment process, and process exercises and tasks sequentially as part of the ongoing group process. This procedure facilitates the change process, enhances the group process, and allows for continuation of ongoing groups.
Kohlberg’s Six Stages of Moral Reasoning

**Level 3 (Post-Conventional Morality)**
STAGE 6: Universal-Ethical Principles
STAGE 5: Social Contract

**Level 2 (Conventional Morality)**
STAGE 4: The Rules are The Rules, The Law is The Law
STAGE 3: Interpersonal Concordance (Approval Seeking)

**Level 1 (Pre-Conventional Morality)**
STAGE 2: Instrumental Relativist (Backscratching)
STAGE 1: Punishment And Obedience (Pain Vs. Pleasure)
Why MRT Works

• The delivery of MRT is both highly structured and directive, which gets clients engaged and keeps them on track.
• Achievements of each step in the program are clearly understood and client progress can be documented at every stage of the program.
• Clients quickly establish ownership of their participation in the program because the program emphasizes feedback and client reflection. Each step in the program involves completing specific assignments and reporting on how they completed the step.
Why MRT Works

• The program is culturally neutral and gender sensitive.

• Standardized curriculum and facilitator training ensures consistent program delivery and quality assurance.

• Finally, MRT is extremely cost-effective compared to other programs.
Moral Reconation Therapy (MRT®) was selected for inclusion on the National Registry of Evidence-based Programs and Practices (NREPP) sponsored by the Substance Abuse and Mental Health Services Administration in 2008.
NREPP is an on-line registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The registry was created to assist the public in identifying approaches to preventing and treating mental and/or substance use disorders that have been scientifically tested and that can be readily disseminated to the field.
NREPP is one way that SAMHSA is working to improve access to information on tested interventions and thereby reduce the lag time between the creation of scientific knowledge and its practical application in the field.
A Meta-Analysis of Moral Reconation Therapy

Myles Ferguson and J. Stephen Wormith

This study reports on a meta-analysis of moral reconation therapy (MRT). Recipients of MRT included adult and juvenile offenders who were in custody or in the community, typically on parole or probation. The study considered criminal offending subsequent to treatment as the outcome variable. The overall effect size measured by the correlation across 33 studies and 30,259 offenders was significant ($r = .16$). The effect size was smaller for studies published by the owners of MRT than by other independent studies.

*International Journal of Offender Therapy and Comparative Criminology, 2012, XX(X) 1–31*
A Meta-Analysis of Moral Reconation Therapy

Myles Ferguson and J. Stephen Wormith

It was statistically significant with potential for substantial social significance. The current meta-analysis is consistent with studies which show that MRT is effective in reducing recidivism. In our view, it warrants serious consideration by any correctional agency that has designs to influence the antisocial and criminal attitudes, behavior, and lifestyle of its clientele. We also encourage more detailed, descriptive, and analytic research on this meritorious mode of offender treatment.

MRT™ TRAINING OUTLINE

DAY 1

8:30 am – 10:00 am  Introductory Remarks
On the Cutting Edge of Treatment Introduction and
History of MRT™
Criminal Justice Statistics

10:00 am – 10:15 am  Break

10:15 am – 12:00 pm  Characteristics of Effective Client Interventions
Introduction to Moral Reconation Therapy
Problems in Treating Sociopaths and Other Treatment
Resistant Groups

10:00 am – 12:00 pm  Historical Background of Antisocial Personality

1:00 pm – 3:00 pm  Disorder Evolution of APD treatment

3:00 pm – 4:30 pm  Cognitive-Behavioral Treatment
MRT™ TRAINING OUTLINE

DAY 2

8:30 am – 10:00 am  Moral Reasoning as an Essential Treatment Variable
   Moral Reasoning as the “Missing Element”
   Dr. Lawrence Kohlberg’s moral reasoning levels
   Methods of measuring moral reasoning.

10:00 am – 12:00 pm  MRT® Personality Theory
   How the Personality Forms - Attitudes, Habits, Beliefs
   The concept of the “Inner Self”
   Defense Mechanisms – Insulators of the Inner Self
   Identity Formation – Good and Bad
   Happiness as a measurable construct.

1:00 pm – 2:00 pm  Research on MRT® Effect on Recidivism & Rearrests
   Relationship of Moral Reasoning to Recidivism

2:00 pm - 4:30 pm  MRT® Steps and Personality Stages
   Disloyalty-the stage of most clients; low moral reasoning, sociopathic beliefs and behaviors. (Steps 1 & 2)
MRT™ TRAINING OUTLINE

DAY 3

8:30 am – 10:00 am  **Opposition** – Low moral reasoning, confrontational, manipulative, and hostile (Step 3)

10:00 am – 12:00 pm  **Uncertainty** – Indecisive, no direction with rapidly swinging behavior and moral judgments (Step 4)

1:00 pm – 4:30 pm  **Injury** – Awareness of injury, feelings of inadequacy, worthlessness, low self-esteem (Steps 5 & 6)
MRT™ TRAINING OUTLINE

DAY 4

8:30 am – 10:00 am  Nonexistence – No identity, unsure of control in life, no sense of direction. (Steps 7 & 8)

10:00 am – 12:00 pm  Danger – Has a sense of identity and personal goals. (Steps 9 & 10)

1:00 pm – 2:00 pm  Emergency – Goals not as self-serving and egocentric. Tries to do too much out of commitment. (Step 11)

2:00 pm- 2:45 pm  Normal – Lives life in a manner that leads to the fulfillment of needs rather easily. (Step 12)

2:45 pm – 3:30 pm  Grace – Reached by few people; feels at one with things, sees thing in totality. (Steps 13-16)


4:00 pm – 4:30 pm  Conclusion, Wrap-up, Questions & Answers.
For More Information on MRT

Khani Gustafson, MSW, CiMH Associate
kgustafson@cimh.org

Percy Howard, LCSW, Associate Director, CiMH Evidence-Based Practices Team
phoward@cimh.org
SOAR: SSI/SSDI Outreach, Advocacy and Recovery

An Evidence Practice for Enhancing Benefits Acquisition Efforts Through Collaboration

Shoshana Zatz
CA SOAR State Lead
CiMH
What is SOAR?

• SOAR is an evidence based program intended to increase access to Social Security Administration (SSA) disability benefits for people who are homeless or at risk of homelessness and who have a mental illness, a co-occurring substance use disorder or other serious medical condition.
SOAR Technical Assistance Initiative

- SOAR: SSI/SSDI Outreach, Access and Recovery
- Sponsored by SAMHSA in collaboration with SSA
- No direct funding to states
- 50 states currently participate
- Helps States and communities increase access to SSI/SSDI through:
  - Collaboration and strategic planning
  - Training
  - Technical assistance
SSI and SSDI: The Basics

- **SSI**: Supplemental Security Income:
  - Needs based
  - $877.40/month in CA in 2014
  - Provides immediate Medi-Cal upon approval

- **SSDI**: Social Security Disability Insurance;
  - Amount depends on earnings put into SSA system
  - Medicare provided after 2 years of eligibility in most instances

The disability determination process for both programs is the same.
SSA’s Criteria for Disability

1. Must have a medically determinable physical or mental impairment that either meets or is equivalent to the listing of impairments that DDS considers

2. Duration of the impairment must have lasted or be expected to last 12 months or more or result in death

3. Person must show significant functional problems caused by the medical impairment
Why is SSI/SSDI Important?

SSA disability benefits can provide access to:

- Income
- Housing
- Health insurance
- Treatment
- Other supportive services
Myths About SSI and SSDI

• Everybody is denied the first time
• You will be denied 3 times before you are approved
• You need an attorney to be approved
• You can’t get benefits if you use alcohol or other drugs
• If you go to work, you’ll lose your health insurance and your benefit check
The Problem

- Only about 10-15 percent of homeless adults are approved on initial application
- Only about 32 percent of all applicants are approved on initial application
- Appeals can take a year or longer
- Many people give up and do not appeal
What We Know Is Possible with SOAR

☐ As of June 2013, 50 states reported outcomes:
  – More than 19,000 individuals were approved for SSI/SSDI on initial application
  – 66 percent approval rate

• In an average of 98 days, compared to 1-2 years

☐ In 2013 alone, SSI brought close to $162 million into the state and local economies of participating states.

☐ An average of $9753 in Medicaid reimbursement per person approved, as a result of SOAR
How Is This Model Different?

• Case managers actively assist applicants and develop evidence
• Focuses on the initial application – “Get it right the first time!”
• Avoids appeals and consultative exams whenever possible
• Focuses on documenting the disability
Uses SAMHSA’s Stepping Stones to Recovery Training Curriculum

- Two-day comprehensive training on disability determination process and SOAR critical components
- Engagement, relationship, and assessment are integral parts of project and curriculum
- Comprehensive approach to individual’s needs with income as the “hook.”
- Tools to expedite applications and improve approval rates

• NEW: Online SOAR training
SOAR in California

- California Institute for Mental Health has been the SOAR CA State Lead since 2012.
- Provide the 2-day “Stepping Stones to Recovery” trainings
- Field requests for training
- Coordinate training organization and response
- Track newly trained staff along with agency leads for SAMHSA SOAR TA Center
- To the extent possible, provide logistical support to trainers working closely with local/regional planning teams
- Monitor trainings offered to support trainers and to ensure that adequate training is provided
- Monthly CA SOAR trainers call
With ACA in Effect, Why Bother with SOAR?

• Eligible individuals are not automatically enrolled – they will still have to apply for Medi-Cal

• SOAR case managers are especially poised to help individuals who are homeless to enroll

• The health care reform law only provides access to Medi-Cal; income supports, such as SSI and SSDI are critical for safe and stable housing, food and clothing, which in turn lead to better health outcomes
If Incarcerated...

SSI
– Is suspended when a person is in a jail/prison for a full calendar month
– After 12 months, SSI benefits are terminated; must re-apply upon release

SSDI
– Continues while in jail/prison until convicted of a felony; after conviction benefits are suspended during incarceration
– Upon release – no need to reapply; just ask SSA to reinstate
– Legal proof of release is required to reinstate benefits
SOAR in Correctional Settings

In 2012, collaborations with corrections were reported by 30 communities:

- Jail in-reach and collaboration with parole and probation to coordinate services
- Jail diversion programs
- Pre-Release planning from state prison
- Training in state departments of correction
Applying Prior to Release from Jail or Prison

- Individuals can apply for SSI benefits within 30 days of their release.
- Institutional pre-release agreements with SSA, may allow applications to be submitted up to 120 days prior to release.
- Agreements usually made between jail/SSA or DOC/SSA for all prisons.
- Payment starts after release.
Successful Models of Collaboration Between SOAR and Corrections

Sing Sing Prison, NY
- 89% of 100 pre-release SSI applications approved in 59 days on average

Oklahoma DOC:
- 90% approval on pre-release apps

Michigan DOC
- 72 SSI applications filed; 60% approved in 105 days on average
- **Impact on recidivism:** 2% of people approved for SSI were readmitted to DOC compared to 17% of those denied benefits

Miami-Dade County jail:
- Recidivism reduced from 70% to 22% for misdemeanor and to 5% for felony defendants
SOAR Online Curriculum

http://soarworks.prainc.com
- Free – Available to anyone at no charge
- Flexible
  - Enroll and complete at your own pace
  - Return to any section at any time for refresher
- Practical
  - Requires submission of a practice application packet
- Packet is reviewed by staff at the SOAR TA Center
  - Opportunity to revise and resubmit packet or retake the course
  - 16 CEUs provided by National Association of Social Workers
- Linked to SOAR effort in State
  - State Team Lead notified when Certificate of Completion is awarded
  - Each state has a page to provide state-specific details on participation in SOAR
Advantages

• Standardization of training
• Expands SOAR to new geographic areas and audiences
• Practice application packet requirement limits involvement to those most likely to complete applications
• Allows state and local SOAR leads and trainers to:
  – Coordinate follow-up training on state-specific processes
  – Provide support to persons assisting with applications
  – Ensure high quality and complete applications
  – Track and monitor outcomes
• Stepping Stones to Recovery Participant Guides will continue to be available for those who choose to conduct 2-day in-person trainings
Local and State SOAR Leads

- Coordinate SOAR Steering Committee meetings
- Collaborate with community providers, SSA and DDS to plan and implement SOAR
- Conduct periodic SOAR fundamental and state-specific trainings
- Meet regularly with persons assisting with SSI/SSDI applications
- Review quality of applications and provide feedback
- Monitor outcomes of applications
- Work closely with the SOAR State Lead
Conclusion

☐ Focusing on expediting benefits as a tool for recovery works!

☐ It’s a win-win for the individual, for states, localities, and for community programs

☐ A major tool in recovery for persons with serious mental illnesses and other disabilities
QUESTIONS ?
THANK YOU !