Implementation Barriers and Facilitators of Treatments for Criminogenic Thinking in the Veterans Health Administration

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• No conflicts of interests

• The views expressed in this presentation are those of the author and do not necessarily reflect the position or policy of the Department of Veteran Affairs.

Publication:

Outline

- Policy shift in management of criminal offenders

- Best practices for reducing risk for criminal recidivism:
  - Treatments for *antisocial cognitions and behaviors* ("criminogenic thinking")

- Implementation potential of treatments for criminogenic thinking in non-correctional settings.

- Qualitative study:
  - Barriers and facilitators to implementation of treatments for criminogenic thinking in Veterans Health Administration (VHA)
Policy Shift: From Incarceration to Diversion

Behavioral health services increasingly called upon to treat offenders and reduce their risk for recidivism.  

Samuels et al. (2013)
Best Practices for Reducing Recidivism Risk

- Antisocial cognitions and behaviors ("criminogenic thinking") is the strongest risk factor for recidivism.
  - e.g., impulsivity; blame externalization

- Cognitive-behavioral treatments for criminogenic thinking are best practices for reducing recidivism risk:
  - Moral Reconciliation Therapy (MRT)
  - Thinking 4 a Change (T4C)
  - Reasoning & Rehabilitation

Andrews & Bonta (2010); Blodgett et al. (2013); Wilson et al. (2005)
Moral Reconation Therapy (MRT)

- Manualized, cognitive-behavioral intervention
- Group format (open enrollment)
- Structured exercises and homework assignments aimed at modifying antisocial thought patterns.
- Move participants through 12 steps of moral development:
  - Completion requires 24-36 sessions, on average!

Little & Robinson (1988; 2013)
Implementation in non-correctional settings?

- Treatments for criminogenic thinking were developed for use within correctional settings.

- The implementation potential of these treatments in non-correctional settings is unknown.

- VHA expanding implementation of Moral Reconation Therapy in behavioral health services:
  - No data to guide these efforts

Blonigen et al. (2016)
The current study

- Identify barriers to implementation of treatments for criminogenic thinking in VHA, and facilitators that could serve as solutions to these barriers:
  - Qualitative methods

- **Funding**: Department of Veterans Affairs (HSRD/QUERI)
  - RRP 12-507 (PI: Blonigen)

- Partnership with the VHA’s **Veterans Justice Programs (VJP)**:
  - Nationwide outreach and linkage service for veterans involved in the criminal justice system.
Veterans Justice Programs (VJP)

“...ensure access to exceptional care for justice-involved Veterans by linking each Veteran to VA and community services that will prevent homelessness, improve social and clinical outcomes, and end Veterans’ cyclical contact with the criminal justice system.”

Mission carried out by VJP Specialists (staffed at all VA Medical Centers)

Clark et al. (2010)
Sequential Intercept Model

Intercept 1: Law enforcement/Emergency Services
- Local Law Enforcement
  - Arrest
    - Initial Detention
      - First Appearance Court
        - Specialty Court
          - Dispositional Court
            - Jail - Pretrial
              - Jail - Sentenced
                - Community
              - Prison
                - Community
            - Probation
              - Community
            - Parole
              - Community

Intercept 2: Initial detention/Initial court hearings
- Initial detention/
  - Initial court hearings
    - Community

Intercept 3: Jails/Courts
- Specialty Court
  - Jail - Pretrial
    - Jail - Sentenced
      - Community
    - Prison
      - Community
  - Dispositional Court
    - Probation
      - Community
    - Parole
      - Community

Intercept 4: Reentry
- Community corrections/Community support
  - Community

Intercept 5: Community corrections/Community support
- Community

Blue-Howells et al. (2013)
Study Design

• A semi-structured phone interview with VJP Specialists to describe their practices regarding treatment of risk factors for recidivism among justice-involved veterans.
  • N=63 (3 randomly selected from each of the VHA’s 21 networks)

• 35% of participants (n=22) had been trained in a treatment for criminogenic thinking:
  • Moral Reconciliation Therapy (MRT) (n=19)
  • Thinking 4 a Change (T4C) (n=6)
  • Reasoning & Rehabilitation (n=0)

• Interview guide included supplement to query on implementation potential of MRT and T4C in the VHA.
Interview Guide Supplement

- RE-AIM framework:
  - Reach, Effectiveness, Adoption, Implementation, Maintenance

- Sample items:
  - [Reach]
    - “What are some things that would make a Veteran more likely to participate in Moral Reconation Therapy?”
  - [Adoption]
    - “What are the greatest barriers to VHA providers adopting Moral Reconation Therapy?”

Glasgow et al. (1999)
Qualitative Data Analysis

- Audio-files of interviews transcribed and de-identified.
- Interviews coded by two independent raters in ATLAS.ti
- Thematic coding and pile-sorting techniques used to identify barrier and facilitator themes.
Patient-level themes

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Potential Solutions (i.e., Facilitators)</th>
</tr>
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<tbody>
<tr>
<td>• Time-intensive curricula of MRT and T4C limit patient engagement in these treatments.</td>
<td>• Offer incentives and other acknowledgements to patients for reaching treatment milestones.</td>
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<td></td>
<td>• Streamline the MRT and T4C treatment process.</td>
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<td>• Implement them within long-term residential programs.</td>
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“There’s always a lot of compliance issues that they’re actually doing the [MRT] homework. It’s just tough in outpatient – you won’t get great compliance. A long-term residential program where someone is in there for four months or so, that would be the right setting.” [Participant 14]

MRT = Moral Reconation Therapy; T4C = Thinking 4 a Change
Patient-level themes

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<tr>
<td>• Insufficient attention to patients’ internal motivations for participation in MRT or T4C.</td>
<td>• Use veteran mentors and testimonials to increase patients’ engagement in MRT or T4C.</td>
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<td>• Use motivational interviewing to help patients explore internal motivations to participating in MRT and T4C.</td>
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</tbody>
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“I think through motivational interviewing, building rapport and trying to roll with that resistance of ‘oh, this is just another group, another thing being forced upon me by probation or by the judge.’ ...Identifying what's important to them and what their goals are would be helpful in selling these groups.” [Participant 24]

MRT = Moral Reconciliation Therapy; T4C = Thinking 4 a Change
### Provider-level themes

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<tr>
<td>• Stigma and bias toward patients with “antisocial” tendencies.</td>
<td>• Market MRT and T4C as treatments for criminogenic “tendencies” rather than antisocial “personalities.”</td>
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<td>• Organize national calls to provide education that MRT and T4C address problems that are common among veterans in behavioral health services (e.g., substance abuse; homelessness)</td>
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“We say [MRT] helps veterans stay in recovery. One of the providers did come up with a handout or brochure. I think that’s the sort of thing that has helped – saying that these veterans are more likely to avoid becoming homeless, more likely to stay connected to their families.” [Participant 44]

**MRT** = Moral Reconation Therapy; **T4C** = Thinking 4 a Change
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<tr>
<td>• Time and resource constraints on VJP Specialists and behavioral health providers.</td>
<td>• Use peer support and other para-professional staff to assist with delivery of MRT and T4C.</td>
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<td>• Establish partnerships between Justice Program Specialists and behavioral health services in the implementation and delivery of MRT and T4C groups.</td>
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“I think [MRT] ought to be a co-facilitated group. It would be nice to see partnership between substance abuse and maybe Veterans Justice Outreach on a project like that. I think it allows for continuity of care.” [Participant 59]

MRT = Moral Reconciliation Therapy; T4C = Thinking 4 a Change
## System-level themes

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<td>• Stakeholders outside the criminal justice system are not familiar with the evidence base of MRT or T4C.</td>
<td>• Conduct formal and non-formal research studies.</td>
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<td>• Leverage support from multiple stakeholders across the healthcare and criminal justice systems.</td>
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“I think working with your treatment court, enlisting our justice community. I’m just sitting here going through in my head the judges in my county and I know that if they knew that [MRT or T4c] was an option that they would ask that that be done.” [Participant 59]

**MRT** = Moral Reconciliation Therapy; **T4C** = Thinking 4 a Change
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<td>• Uncertainty of sustained funding to support ongoing costs of criminogenic treatments.</td>
<td>• Use a train-the-trainers model and establish facilitation groups led by national champions.</td>
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“A call of facilitators, a monthly call to talk about kind of how the group is going and get consultation from other group facilitators. Maybe identify some kind of superstars nationally who have been leading and facilitating the group for a while who have a good understanding and feel confident about their knowledge of Moral Reconation Therapy.” [Participant 46]
Summary

- With rise of specialty courts, behavioral health services are increasingly called upon to treat criminal offenders.

- Findings serve as a guide for various stakeholders in behavioral health services who seek to promote best practices for reducing recidivism among offenders.

- Findings directly inform efforts to expand access to and implementation of Moral Reconation Therapy in VHA:
  - VJP and Mental Health Service training initiative
Limitations and Considerations

- Findings limited to perspectives of VJP Specialists:
  - VA-funded Hybrid 1 RCT of Moral Reconation Therapy will obtain patient and behavioral health provider input.

- Many suggested facilitators require empirical validation prior to wider-scale implementation.

- Moral Reconation Therapy and Thinking 4 a Change combined in analyses.

- Value of evaluating implementation barriers concurrently with quantifiable measures of program feasibility:
  - e.g., provider time; patient dropout rates
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References