MIDD Existing Strategy Briefing Paper

ES 12d Reentry Programs /Behavior Modification Classes for Community Center for Alternative Program (CCAP) Clients

Existing MIDD Program/Strategy Review ☒ MIDD I Strategy Number _12d_ (Attach MIDD I pages)
New Concept ☐ (Attach New Concept Form)
Type of category: Existing Program/Strategy NO CHANGE

SUMMARY: This existing MIDD I strategy enhances program services at offered at Community Center for Alternative Program (CCAP) the areas of behavioral health education and intervention, and addresses criminogenic risk factors specifically associated with domestic violence (DV). Since 2014, MIDD has supported a 1.0 Full Time Equivalent (FTE) clinician from Sound Mental Health (SMH) trained in Moral Reconation Therapy (MRT) and the specialized DV version to prepare and facilitate groups for one caseload of 15 men participants who are randomly assigned to the Moral Reconation Therapy-Domestic Violence (MRT-DV) program at CCAP for approximately 60 days. All MRT-DV participants have a substance use disorder, primarily involving alcohol and/or cannabis.[1] Participants are clinically assessed and enrolled in appropriate substance use disorder (SUD) treatment at CCAP per American Society of Addiction Medicine (ASAM) criteria and, if appropriate, referred to mental health services in the community.

Collaborators:

Name	**Department**
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Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization
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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New**

[1] Based on preliminary data.

Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?

This existing MIDD I strategy enhances program services at offered at Community Center for Alternative Program (CCAP) the areas of behavioral health education and intervention, and addresses criminogenic risk factors specifically associated with domestic violence (DV). Since 2014, MIDD has supported a 1.0 Full Time Equivalent (FTE) clinician from Sound Mental Health (SMH) trained in Moral Reconation Therapy (MRT) and the specialized DV version to prepare and facilitate groups for one caseload of 15 men participants who are randomly assigned to the Moral Reconation Therapy-Domestic Violence (MRT-DV) program at CCAP for approximately 60 days. All MRT-DV participants have a substance use disorder, primarily involving alcohol and/or cannabis.[2] Participants are clinically assessed and enrolled in appropriate substance use disorder (SUD) treatment at CCAP per American Society of Addiction Medicine (ASAM) criteria and, if appropriate, referred to mental health services in the community.

A victim advocate, under the supervision of the King County Prosecuting Attorney's Office (PAO) DV Unit, is in contact with each victim/survivor as part of the MRT-DV negotiated plea agreement. The victim advocate provides ongoing survivor support and assists with modification of No Contact Orders and Protection orders as needed, and functions as the conduit for feedback from the DV survivors. At the time of the initial contact, the advocate lets the victim/survivor know about the project's victim interview process and asks if the victim/survivor would be willing to be contacted by the interviewer to hear more about the process. If so, the advocate passes the victim/survivors contact information to the interviewer who attempts to reach the victim/survivor. If reached, the interviewer describes the interview process – which involves three 15 minute interviews: a baseline interview (at this first point of contact), another after six months (if the perpetrator has also reached ten (of 16) steps of MRT-DV which represents the 'minimum dosage' considered sufficient for the participant to achieve some behavior change), and again at one year. The victim/survivor is asked for their consent to be interviewed at these time points. If consent is obtained, the baseline interview proceeds. We have thus far had difficulty engaging victim/survivors in this process, and so are asking for modest incentive payments. Understanding the victim's experience is critical for determining the success of the program, as many domestic violence incidents go unreported.

MRT-DV is an innovative model that, when coupled with SUD treatment (and mental health services when necessary), may reduce DV recidivism. If successful, the intervention will be a very important breakthrough in the DV criminal justice community as other interventions have not been successful. The DV version of MRT was introduced at CCAP in 2014 on a pilot basis to educate and intervene with individuals charged with felony DV offenses in King County Superior Court and assigned, using a randomized design, by the King County Prosecuting Attorney's Office (PAO) to MRT-DV at CCAP. MRT-DV consists of "a cognitive-behavioral educational approach that confronts batterer's beliefs and behaviors *especially focusing on power and control issues*."[3]

The MRT-DV program includes the following features:

- All exercises and group tasks have a specific format and intent;
- Each program session addresses a fundamental issue;
- Training is required to implement MRT-DV and the program can't be adequately understood or utilized independent of the training provided; and

[2] Based on preliminary data.

[3] Gregory L. Little, Ph.D. and Kenneth D. Robinson, Ph.D. (2011), *Bringing Peace to Relationships: An MRT Educational Workbook*, Memphis, TN: Eagle Wing Books, Inc.; 3rd Revision: Workbook Introduction.

- MRT-DV participants must complete work prior to coming to group and then process their work in accordance with the underlying issue of the exercises performed by trained facilitators.

The designers of MRT, an evidence-based practice,[4] have long seen behavior as learned and capable of being changed through altering beliefs and habits. MRT-DV, a promising practice, is designed to change how DV offenders think and change behavior to one of equality and acceptance. The curriculum used in MRT-DV is a social learning approach that assumes that DV and power and control behaviors are learned—and that they can be unlearned. This is repeatedly stressed during extensive training that is required before facilitating the program.[5]

The DV offender must meet legal eligibility criteria from the King County PAO and undergoes a short pre-plea screening. Moreover, there must be a reasonable basis to believe the offender can successfully complete the CCAP MRT-DV pilot after taking into consideration factors such as: offender's mental and/or physical health, past performance in treatment, and living and employment situation.[6]

The program goal is to realize an increase in the scope and effectiveness of the services offered at CCAP and appropriately address the changing service needs of court-ordered participants. Specifically, the MRT-DV pilot was implemented to intervene and provide a holistic array of services including outpatient SUD treatment with court monitoring to promote participant behavior change and recovery, and reduce recidivism and victimization.

The randomized design pilot is being evaluated by an evaluator employed by the DCHS Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD). The purpose of the pilot is to determine whether the MRT-DV intervention is superior to King County's "intervention-as-usual," which is DV education at CCAP. Outcomes are expected in 2017.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

☐ **Crisis Diversion** ☐ **Prevention and Early Intervention**

☒ **Recovery and Re-entry** ☐ **System Improvements**

Please describe the basis for the determination(s).

This Existing Strategy fits under the Recovery and Reentry area, as it represents an intervention focused exclusively on promoting recovery and behavior change for individuals charged by the court with DV who have SUDs.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

[4] L. Myles Ferguson and J. Stephen Wormith (2013), *A Meta-Analysis of Moral Reconation Therapy*, International Journal of Offender Therapy and Comparative Criminology, September 2013, vol. 57 no. 9: 1076-1106.

[5] https://www.ccimrt.com/programs/domestic-violence. Accessed 11-18-15.

[6] Cited from MRT-DV pilot summary documents (2014) authored by Debra Srebnik, Ph.D., pilot evaluator.

DV is predictive of all forms of violent crime. An analysis of thousands of offenders in Washington State showed that felony DV conviction is the single greatest predictor of future violent crime among men.[7] Men practice their violence in the home first. Thus, to prevent violent crime, curbing domestic violence is a good place to start.

There is no lack of DV cases in King County and across the state. DV offenders commit approximately 30,000 misdemeanor DV offenses every year in Washington and 5,000-6,000 felonies. And, domestic violence offenders have a 20 percent higher rate of criminal recidivism for general crime than non-DV offenders.[8]

For two decades attorneys requested, and judges imposed, state-certified batterer treatment in DV cases. Many believed batterer treatment was the best way to reduce recidivism and keep victims safe. Today, that belief is in question.[9] DV offenders have the highest rates of violent recidivism,[10] and research suggests that the batterer treatment available to date has no measurable effect on recidivism.[11] Current research indicates traditional "one size fits all" treatment for domestic violence has been ineffective. The research community has called for DV intervention reform and highlighted the need to utilize treatment approaches grounded in science and theory and/or empirically supported treatments rather than adherence to old standards of treatment.[12]

In particular, in 2013, the Washington State Institute for Public Policy (WSIPP) published a review of the literature that tests whether DV treatment has a cause-and-effect relationship with DV recidivism. They identified 11 rigorous evaluations to examine, none from Washington State. WSIPP concluded that interventions similar to those used in Washington State have "no effect on DV recidivism".[13] WSIPP noted that five studies reviewed showed some impact on DV recidivism, but the models were so varied that it was not possible to draw conclusions about the specific interventions that were effective. The report recommended further research and listed a number of interventions that might hold promise, including MRT-DV.[14]

The King County PAO currently handles a caseload of approximately 400 filed DV cases at any time. The PAO filed 1211 felony DV cases in 2002 and 1017 such cases in 2013 with an average of 1181 over the 12 year period. One-third of the filed cases were reduced from a felony to a misdemeanor charge during

[7] Barnoski, R., and Drake, E. (2008). Washington's Offender Accountability Act. Washington State Insttute of Public Policy (WSIPP); http://www.wsipp.wa.gov/ReportFile/977/Wsipp_Washingtons-Offender-Accountability-Act-Department-of-Corrections-Static-Risk-Instrument_Full-Report-Updated-October-2008.pdf.

[8] Ibid, Barnoski and Drake (2008).

[9] See "Why Domestic Violence Prevention Programs Don't Work" at http://www.nbcnews.com/storyline/nfl-controversy/why-domestic-violence-prevention-programs-dont-work-n217346.

[10] Drake, E., Harmon, L., & Miller, M. (2013). *Recidivism Trends of Domestic Violence Offenders in Washington State,* Olympia: Washington State Institute for Public Policy.

[11] See U.S. Department of Justice web page "Batterer Intervention Programs Often Do Not Change Offender Behavior" : http://www.nij.gov/nij/topics/crime/intimate-partner-violence/interventions/batterer-intervention.htm

[12] Julia C. Babcock, Charles E. Green and Chet Robie (2004), *Does batterers' treatment work? A meta-analytic review of domestic violence treatment*, Clinical Psychology Review, January 2004, vol. 28 no. 8: 1023-1053.

[13] Miller, M., Drake, E., & Nafziger, M. (2013). *What works to reduce recidivism by domestic violence offenders?* Olympia: Washington State Institute for Public Policy; George, Thomas (2012), *Domestic Violence Sentencing Conditions and Recidivism*, May 2012, Olympia: Washington AOC.

[14] Drake, E., & Miller, M. (2013), *Recidivism Trends of Domestic Violence Offenders in Washington State.* Olympia: Washington State Institute for Public Policy, Aug. 2013.

plea negotiations.[15] All DV survivors involved in these cases are assigned a victim advocate by the PAO DV Unit.

The pilot will examine the effectiveness of MRT-DV relative to DV "treatment-as-usual" for adult male offenders court ordered to CCAP. The King County PAO randomly assigns adult male offenders who have received court orders to DV programming at CCAP to either MRT-DV or DV 'education' (the 'treatment-as-usual' condition). Each eligible DV offender is assigned a random number (0 or 1); "1" represents assignment to MRT-DV and "0" represents assignment to DV education at CCAP.[16] Both occur within a 60-day court order to CCAP. In both conditions, individuals will also receive SUD treatment at CCAP, depending on findings of a comprehensive clinical assessment provided to all CCAP participants.

If the MRT-DV pilot is discontinued prior to completion of an outcomes evaluation using a randomized design, then King County will not learn of the efficacy or non-efficacy of integrating SUD treatment with MRT-DV, a promising practice designed to modify participants' behavior and promote recovery.

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

MRT-DV is a promising practice listed in the article published by Miller, Drake & Nafziger (2013)[17] and was introduced at CCAP due to questions being raised locally about the effectiveness of state-certified batterers' treatment without holistically addressing the DV offenders' behavioral health disorders. MRT-DV introduces a more holistic approach and participants are enrolled in SUD treatment at CCAP as indicated per validated assessment using the Global Appraisal of Individual Needs-Lite[18] version. Additionally, participants may be referred to off-site mental health services, as necessary and appropriate, which will be integrated at CCAP via Behavioral Health Integration beginning in April 2016.

The MRT model uses a positive group dynamic to alter inappropriate thought and behavior in DV offenders. The MRT-DV adaptation is a cognitive-behavioral program designed to change how DV offenders think (beliefs) and change behavior to one of equality and acceptance. The MRT-DV adaptation takes approximately 55 sessions to complete, which are conducted twice weekly at CCAP. Both the MRT-DV and standard DV education occur within a 60-day court order to CCAP. The 60 days pertain to days of reporting, and do not need to be consecutive days. Thus, the twice weekly intervention, which takes about six months to complete, can still be fulfilled within the 60-day court order.

MTR-DV pilot program participant outcomes are being studied by MHCADSD. This Existing Strategy addresses the need to evaluate the effectiveness of a promising practice based on Moral Reconation Therapy, an evidence-based practice, with concurrent SUD treatment using a randomized design.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD**

[15] Data reported by the King County Prosecuting Attorney's Office (KCPAO), Domestic Violence Unit, and received via email from David Martin, Chair, KCPAO Domestic Violence Unit on November 30, 2015.
[16] Cited from MRT-DV pilot summary documents (2014) authored by Debra Srebnik, Ph.D., pilot evaluator.
[17] Ibid, Miller, Drake & Nafziger (2013).
[18] http://gaincc.org/gaini. Accessed 12-8-15.

Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

For decades the criminal justice system in WA State has imposed state-certified batterers' treatment in DV cases with the belief that such treatment, without holistically addressing behavioral health disorders, is an effective way to reduce recidivism and keep victims safe. However, a study conducted by the WSIPP raised questions about DV batterers' treatment because DV offenders were found to have higher rates of violent recidivism compared with non-DV offenders.[19]

> **"Any recidivism:** Domestic violence offenders have higher rates of recidivism than non-domestic violence offenders. For example, for offenders with a current domestic violence offense, 36 percent were convicted for a new felony or misdemeanor within 36-months compared to 30 percent of non-domestic violence offenders.
>
> **Domestic violence recidivism:** Domestic violence offenders have higher rates of domestic violence recidivism than non-domestic violence offenders. For example, for offenders with a current domestic violence offense, 18 percent were convicted for a new domestic violence felony or misdemeanor within 36-months compared to four percent of non-domestic violence offenders."[20]

There is long-standing evidence that the use of alcohol or drugs by one or both of the individuals involved is a component of DV in the vast majority of cases. The Department of Justice has stated that about 61 percent of DV offenders also have problems with substance abuse, and alcohol is commonly a factor in violence where the DV offender and the survivor know each other.[21] Even when a DV offender who is alcoholic is sober, the abuse is 1) more likely to occur and 2) likely to be more violent.[22]

All MRT-DV participants have been screened and clinically assessed as having a SUD, with alcohol and cannabis identified as the primary drugs of choice, and are concurrently enrolled in intensive outpatient SUD treatment at CCAP as indicated. Additionally, participants may be referred to residential SUD treatment or off-site opioid substitution treatment or mental health services, as necessary and appropriate. Outpatient SUD and mental health treatment will be integrated at CCAP via Behavioral Health Transformation/Integration beginning in April 2016.

Preliminary data indicate that participants who have not benefited from MRT-DV were not enrolled in the program long enough to complete the minimum dosage hypothesized to elicit behavior change. In late spring 2016 MHCADSD anticipates having enough participants who have had a year since they began the MRT-DV program to begin analysis of correctional outcomes.[23]

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Promising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

[19] Ibid, WSIPP Report, Aug. 2013.
[20] Ibid, WSIPP Report, Aug. 2013, p. 5.
[21] James J. Collins and Donna L. Spencer (1999), *Linkage of Domestic Violence and Substance Abuse Services,* Research in Brief submitted to U.S. Department of Justice in April 2002, Document No. 194122.
[22] https://ncadd.org/about-addiction/alcohol-drugs-and-crime. Accessed 11-23-15.
[23] Cited from MRT-DV at CCAP Brief Progress Report (Dec. 2015) authored by Debra Srebnik, Ph.D., pilot evaluator.

This Existing Strategy addresses the need to evaluate the effectiveness of a promising practice based on Moral Reconation Therapy, an evidence-based practice,[24] with concurrent SUD treatment using a randomized design.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

The County hopes to see reduced recidivism and victimization as a result of the investment in the Existing Strategy pilot. The MRT-DV pilot evaluation will examine the following outcomes by comparing change from the year prior to and the year starting with MRT-DV programming at CCAP:

- DV charges;
- King County jail bookings and jail days;
- Municipal jail bookings and days (Enumclaw, Kent, South Correctional Entity, Kirkland);
- Police reports;
- Orders of protection; and
- DV survivor interviews.

The evaluation will also examine change in substance use and mental health symptoms from the point of enrollment to discharge (end of court ordered treatment). Almost all (N=47) participants thus far carried an alcohol or drug abuse diagnosis. Ten had also been diagnosed with a mood disorder (typically depression), and three had an anxiety disorder (two being Post-Traumatic Stress Disorder). One person had been diagnosed with a psychotic disorder.[25]

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☐ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☒ **Adults**	☐ **Immigrant/Refugee**
☐ **Older Adults**	☒ **Veteran/US Military**
☒ **Families**	☐ **Homeless**
☐ **Anyone**	☐ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**

☒ **Other – Please Specify:** Adult males charged with domestic violence who have histories of substance use disorders and are court-ordered to CCAP.

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

[24] L. Myles Ferguson and J. Stephen Wormith (2013), *A Meta-Analysis of Moral Reconation Therapy*, International Journal of Offender Therapy and Comparative Criminology, September 2013, vol. 57 no. 9: 1076-1106.
[25] Ibid, MRT-DV at CCAP Brief Progress Report (Dec. 2015).

The target population is adult male offenders charged with felony DV in King County Superior Court. These individuals face jail sentences (365 days of incarceration or less) rather than prison. They are typically not eligible for supervision by the Washington State Department of Corrections (DOC) due to statute. Many DV programs deal solely with misdemeanants, but MRT-DV is dealing with some of the most complex cases; addressing offenders with criminal charges and complex re-entry risks and needs including treatment for behavioral health disorders. Specific eligibility criteria are listed below.

Eligible Crimes

1. A offender whose Felony Violation of No Contact Order charge falls under the two prior conviction prong involving consensual or invited contact may be eligible depending on a full review of the available domestic violence history;
2. A offender whose current Felony Violation of No Contact Order charge falls under the assault prong with limited injury and a full review of the available DV history;
3. DV Property crimes including Possession of Stolen Property, Theft 1 & 2, Trafficking in Stolen Property 1 & 2, and Theft of Stolen Vehicle; and
4. Certain cases involving Felony Harassment, Felony Assault, and Burglary where or when the Prosecutor agrees to an amendment of the charge, and the Prosecutor, Defense, and Court all agree that CCAP MRT DV is appropriate.

Factors that Disqualify Offender

1. Current offense involving a weapon, stalking, an aggravating factor, or occurrence within sight/sound of a minor child;
2. Offender has reported or unreported history of DV;
3. Offender has a high risk score on the ODARA DV risk assessment[6] or the DOC static risk assessment for crimes of violence as determined by the DOC at the time of charging;
4. Evidence that offender tampered with, intimidated, or targeted the DV survivor or witnesses in an attempt to undermine the prosecution;
5. Prior misdemeanor or felony sex offense, violent felony offenses, violations of the Uniform Firearms Act, Theft 2 offenses involving a Firearm, Promoting Prostitution or Stalking; and
6. DV survivor opposition to CCAP MRT-DV.

Demographics: Data collected through November 2015 on 50 offenders who started MRT-DV show the following characteristics.[26]

Average Age and Range: 32.3 years, ranging from 18-60 years old.

Diagnoses: Almost all (N=47) carried an alcohol or drug abuse diagnosis. Ten had also been diagnosed with a mood disorder (typically depression), and three had an anxiety disorder (two being Post-Traumatic Stress Disorder). One person had been diagnosed with a psychotic disorder.

Race/Ethnicity	N	%
White	21	42%
African-American	16	32%
Hispanic	3	6%
Mixed	3	6%
Asian/Pacific Islander	3	6%
Native American	2	4%
Other	2	4%

[26] Ibid, MRT-DV at CCAP Brief Progress Report (Dec. 2015).

Total	50	100%

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional information that discusses the basis for the selection**: Seattle

Although CCAP is located in downtown Seattle, the pilot is available to individuals who reside anywhere within King County and commute to Seattle for services. Based on data collected by the King County Community Corrections Division from June 2014 through June 2015[27], CCAP participants reside in the following areas:

- Seattle = 38 percent
- South King County = 32 percent
- East King County = 7 percent (includes Snoqualmie Valley)
- North King County = 5 percent (primarily Northshore area)
- Other = 8 percent
- Homeless = 10 percent

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

Collaborations are necessary with the King County PAO, King County Superior Court, King County Community Corrections Division (CCD), King County Coalition Against Domestic Violence and the contracted treatment provider (currently SMH). Expanding access to MRT-DV to King County District Court has been proposed by the PAO, possibly integrating the pilot into two therapeutic courts in King County: Regional Mental Health Court (RMHC) and Regional Veterans Court (RVC). The District Court's Executive Committee has authorized the convening of a stakeholder group involving the PAO, Public Defense, Judicial Administration, Adult Probation, SMH and CCD to review the efficacy of expanding access to MRT-DV at CCAP to King County District Court offenders/participants charged with DV who have SUDs, some of whom may also have mental health disorders. The Family Support Unit within the PAO may also be utilized to assist with child support orders as is currently being done in RMHC and RVC.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

MRT-DV at CCAP is a pilot program that is being evaluated for participant outcomes and efficacy using a randomized design. Data are being collected over a multiyear period and, if outcomes are poor or marginal, then the MRT-DV pilot program should be discontinued or modified. In late spring 2016, as previously mentioned, MHCADSD anticipates having enough participants who have had a year since they began the MRT-DV program to begin analysis of correctional outcomes.

The King County PAO has asked the Washington State Department of Social and Health Services to reopen sections of Chapter 388-60 Washington Administrative Code entitled *Domestic Violence*

[27] Cited from Adult Operational Master Plan (AJOMP) III preliminary study results presented to the AJOMP III Steering Committee by the Honorable Jim Rogers, King County Superior Court, Chief Criminal Judge on November 16, 2015.

Perpetrator Treatment Program Standards, specifically regarding DV assessments and interventions. This legislation will likely be revised in 2016.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

None, the pilot program is already implemented.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

None. The program is being rigorously evaluated for outcomes/efficacy and, if outcomes are poor or marginal, then the MRT-DV pilot program should be discontinued or modified.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

The unintended consequences of not implementing this pilot program may result in adversely impacting DV survivors. WSIPP published a review of the literature in 2013 that tests whether DV treatment has a cause-and-effect relationship with DV recidivism. They identified 11 rigorous evaluations to examine, albeit none from Washington State. WSIPP concluded that interventions similar to those used in Washington State have "no effect on domestic violence recidivism".[28] Thus, it is critical to implement and evaluate promising approaches to ascertain those models that postively effect behavior modification, promote recovery, and reduce victimization.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

Alternative approaches have not produced positive outcomes in terms of reducing DV recidivism. This Existing Strategy is very cost effective given that it entails a contracted 1.0 FTE Clinician to facilitate MRT-DV groups and associated planning and documentation; a victim advocate is provided on an in-kind basis by the King County PAO's DV Unit. In addition, a small amount of funds are needed for staff training due to occasional staff turnover at CCAP. This strategy is unique and is being evaluated via a randomized design. Thus, merging with another approach would compromise the study.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

This Existing Strategy fits within the continuum of care by providing an appropriate intervention for justice involved adults charged with DV who have concomitant behavioral health disorders. Behavioral Health Integration will link to this effort, which will allow for more integrated services for those participants who have co-occurring mental health and SUDs. Best Starts for Kids will fit within the

[28] Ibid, WSIPP (2013) and Washington AOC (2012).

continuum of care by investing in prevention and early intervention for children, youth, families, and communities. Best Starts for Kids will invest in healthy, safe communities that reinforce progress[29] – which will reduce overall victimization and retraumatization of children in the home.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

The designers of MRT have long seen behavior as learned and capable of being changed through altering beliefs and habits. MRT-DV, a promising practice, is designed to change how DV offenders think and change behavior to one of equality and acceptance. The program in no way blames DV survivors, coerces or mandates survivor participation, and does not include any form of couples, marriage, or family therapy. The MRT-DV program has no psychodynamic basis or methods, nor does it use communication enhancement or anger management linking anger as the primary cause. It does not present poor impulse control or psychopathology as the cause of violence. Rather, the curriculum used in MRT-DV is a social learning approach that assumes that DV and power and control behaviors are learned—and that they can be unlearned. This is repeatedly stressed during extensive training that is required before facilitating the program.[30]

The pilot program is rooted in the principles of recovery with the integration of SUD treatment for participants who are randomly assigned to the MRT-DV pilot. There is long-standing evidence that the use of alcohol or drugs by one or both of the individuals involved is a component of DV in the vast majority of cases.[31] Almost all (N=47) MRT-DV participants thus far carried an alcohol or drug abuse diagnosis and were immediately linked to concurrent SUD treatment at CCAP. Ten had also been diagnosed with a mood disorder and three had an anxiety disorder; one participant had been diagnosed with a psychotic disorder.[32] These participants were referred to appropriate mental health services in the community; mental health services will be integrated at CCAP with Behavioral Health Integration beginning in April 2016.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

The MRT-DV pilot is based at CCAP, an out-of-custody alternative to jail. The pilot is focused on recovery and is available to eligible male individuals from throughout King County regardless of age, race or cultural background. If proven effective through the randomized research design described herein, the County intends to expand and extend this program to women DV offenders and additional caseloads as necessary.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

The Existing Strategy is currently based at the Yesler Building in downtown Seattle where CCD Administration and CCAP are located. Most of the resources needed to administer the MRT-DV pilot are currently available; however, additional funds are requested staff training and participant workbooks. Ongoing funding is necessary until the MRT-DV outcomes evaluation is completed.

[29] http://www.kingcounty.gov/elected/executive/constantine/initiatives/best-starts-for-kids.aspx.
[30] Ibid, https://www.ccimrt.com/programs/domestic-violence.
[31] Ibid, Research in Brief submitted to U.S. Department of Justice in April 2002.
[32] Ibid, MRT-DV at CCAP Brief Progress Report (Dec. 2015).

2. **Estimated ANNUAL COST. $100,000 or less Provide unit or other specific costs if known.**

Annual costs include $90,000 for the 1.0 FTE contracted clinician/facilitator, $5,000 for staff training, $2,000 for workbook materials, and $1,000 for DV victim/survivor interview incentive payments ($25 per interview times 40 interviews per year). The total annual cost is $98,000.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

No, not at this time.

4. **TIME to implementation: Currently underway**
    a. **What are the factors in the time to implementation assessment?**
    There are no factors in implementation as this is an ongoing strategy and can continue without interruption.
    b. **What are the steps needed for implementation?**
    The program is already implemented; however, additional staff training is necessary due to occasional staff turnover.
    c. **Does this need an RFP?**
    No.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

This program is a relatively small pilot program, serving a maximum caseload of 15 male participants at a time. It currently does not serve women because the vast majority of DV offenders are men. According to the U.S. Department of Justice, between 1998 and 2002,

- Of the almost 3.5 million violent crimes committed against family members, 49 percent of these were crimes against spouses.
- 84 percent of spouse abuse survivors were females, and 86 percent of survivors of dating partner abuse were female.[33]

If proven effective, however, the County intends to expand and extend this program to women DV offenders if funding is secured. Additionally, if proven effective, funding should be made available for victim services, including parenting classes on using and practicing nonviolent communication.

[33] Matthew R. Durose et al., U.S. Department of Justice, NCJ 207846, *Bureau of Justice Statistics, Family Violence Statistics: Including Statistics on Strangers and Acquaintances, at 31-32 (2005)*, available at http://www.ojp.usdoj.gov/bjs/pub/pdf/fvs.pdf.

Strategy Title: Expand Re-entry Programs

Strategy No: 12d – ~~Urinalysis Supervision~~ Behavior Modification Classes for Community Center for Alternative Program Clients

County Policy Goal Addressed:

- A reduction of the number of people who cycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

The King County Community Corrections Division's Community Center for Alternative Programs (CCAP) is an effective jail diversion resource for individuals who are deemed by the court to not be in need of secure detention but who are required by a court to complete certain conditions while reporting daily to CCAP. This strategy will enhance program services at CCAP in the areas of substance abuse and mental health education and intervention, and address criminogenic risk factors, utilizing evidence-based practices the majority of which have been proven effective with criminal justice populations.

~~The King County Community Center for Alternative Programs (CCAP) is an effective diversion resource for individuals who no longer need secure detention but who are required by a court to complete certain conditions for release, such as urinalyses. This strategy will increase the efficiency in operation of CCAP. Currently, community corrections staff conducts urinalyses on their clients to assure compliance with court requirements.~~

◊ *B. Reason for Inclusion of the Strategy*

Additional program services are needed at CCAP to address substance abuse and mental health education needs for CCAP general population clients who may not be appropriate for, or enrolled in, intensive outpatient (IOP) substance abuse treatment or outpatient mental health services.

~~It is more cost-efficient and clinically appropriate to have designated non-Community Corrections staff perform this service. In addition, the Community Corrections staffing patterns do not always assure that staff of the same gender as the client is available to complete the monitored urinalyses.~~

◊ *C. Service Components/Design (Brief)*

Evidence-based behavior modification approaches including (but not limited to) Rational Emotive Behavioral Therapy, Moral Reconation Therapy (MRT), Cognitive Behavioral Therapy, and Dialectical Behavioral Therapy will be added to the program curricula at CCAP via a Mental Health, Chemical Abuse and Dependency Services

Division (MHCADSD) contract with the existing IOP and mental health services provider, Sound Mental Health (SMH).

~~A contract with an independent agency for a Urinalysis Technician(s) to provide analyses for both female and male clients of CCAP will be developed. Urinalyses will be done for those who are ordered by the court to have one or more urine samples taken and analyzed each month. Monitored urinalyses samples will be taken on-site at the CCAP location (presently located in the Yesler Building in Seattle).~~

◊ *D. Target Population*

King County Community Corrections Division's CCAP clients who have been mandated by Superior Court or District Court to report daily to CCAP and participate in treatment or general population classes.

~~King County Community Center for Alternative Program clients who have been mandated by Superior Court or District Court to report to CCAP and participate in treatment.~~

◊ *E. Program Goals*

An increase in the scope and effectiveness of the services offered at CCAP and appropriately address the changing service needs of court-ordered participants.

~~An increase in the efficiency of the services offered at CCAP. Assure gender-specific staff is available for the collection of urine samples.~~

◊ *F. Outputs/Outcomes*

1. Increase the number and scope of evidence-based practices at CCAP.
2. Serve 100 participants in behavior modification classes at CCAP.
3. A minimum of 75% of behavior modification program participants will show positive behavior change, as demonstrated via a pre- and post-program survey.
4. A minimum of 50% of behavior modification program participants will complete their court-ordered time at CCAP.
5. Reduce jail bookings and jail days, post-program admission, for behavior modification class participants.

~~Increased number of urinalyses each month collected and a decrease in CCAP staff time dedicated to providing this service~~

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
Jan – Dec 2009	Sound Mental Health begins providing behavior modification classes at CCAP	$75,000

	Total Funds 2009	**$75,000**
Ongoing Annual	**Total Funds**	**$75,000**

~~Dates~~	~~Activity~~	~~Funding~~
~~Sept- December~~	~~Plans for office space and equipment are finalized with Facilities by CCD. Funding pays for office space modifications and fixtures. Request for Proposal (RFP) developed, issued and rated and contract negotiated.~~	~~$20,000~~
	~~**Total Funds 2008**~~	~~**$20,000**~~
~~Jan – Dec 2009~~	~~New provider begins urinalyses on schedule determined by CCD.~~	~~$75,000~~
	~~**Total Funds 2009**~~	~~**$75,000**~~
~~Ongoing Annual~~	~~**Total Funds**~~	~~**$75,000**~~

3. Provider Resources Needed (number and specialty/type**)**

◊ *A. Number and type of Providers (and where possible FTE capacity added via this strategy)*

A single provider and at least 1.0 FTE will be needed to facilitate the behavior modification classes at CCAP.

~~A single provider of one FTE will be needed. Time and staffing will need to include both male and female Urinalysis Technicians.~~

◊ *B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)*

Current staff resources at MHCADSD and the Department of Adult and Juvenile Detention (DAJD)/Community Corrections Division (CCD) are adequate to develop the contract amendment, establish a timeline for the project, and conduct staff training in MRT and other behavioral modification approaches.

~~Current staff resources at Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) and Community Corrections Division (CCD) are adequate to develop the request for proposals and establish a timeline for the project~~.

◊ *C. Partnership/Linkages*

This strategy will involve a partnership with CCD that operates CCAP. Planning will include the scheduling of classes, securing of necessary office space and equipment and outlining referral protocols between CCAP Case Workers (who maintain the schedule and provide reports to the courts) and Sound Mental Health.

~~This strategy will involve a partnership with the King County Department of Adult & Juvenile Detention/Community Corrections Division (CCD) that operates CCAP. MHCADSD/CJI staff will work with CCD/CCAP managers to plan for locating space for monitoring and processing of urinalyses and developing a request for proposals upon approval. Planning will include the securing of necessary office space and equipment and outlining referral and processing protocols between CCAP Case Workers and the contracted provider.~~

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Dates:	Activity:
Jan – Mar 2009	Contract amendment issued with Sound Mental Health
April – Dec 2009	Sound Mental Health begins providing behavior modification classes at CCAP.

◊ *B. Procurement of Providers*

MHCADSD currently contracts with Sound Mental Health for outpatient chemical dependency treatment services at CCAP. Since this is an expansion of an existing program, no RFP is required at this time. King County contract staff will amend the existing Sound Mental Health contract to add funding and FTE dedicated to the program.

◊ *C. Contracting of Services*

March 2009 - Contract negotiations completed.

◊ *D. Services Start Date(s)*

Services to clients will begin April 1, 2009.

~~**4. Implementation/Timelines**~~

~~◊ *A. Project Planning and Overall Implementation Timeline*~~

~~Dates~~	~~Activity~~
~~Sept- December 2008~~	~~Plans for office space and equipment are finalized with Facilities by CCD. Funding pays for office space modifications and fixtures (portable fixtures will be considered as an option).~~
~~Sept- December 2008~~	~~RFP developed, issued and rated, and contract negotiated.~~
~~Jan – Dec 2009~~	~~Contract issued. New provider begins urinalyses on schedule determined by CCD.~~

◊ ~~*B. Procurement of Providers*~~

~~Sept - November 2008 – RFP developed, issued and rated. and award selection/notification made.~~

◊ ~~*C. Contracting of Services*~~

~~December 2008 - Contract negotiations completed.~~

◊ ~~*D. Services Start Date(s)*~~

~~Services to clients will begin February 1, 2009.~~