Voiceover: Welcome to the VA HSR&D Investigator Insights podcast series. In this episode, QUERI Dissemination Coordinator, Diane Hinks, talks with Clinical Psychologist and Investigator, Dan Blonigen of the VA Palo Alto Healthcare System, about his work using moral reconation therapy to help reduce recidivism among justice-involved veterans.

Diane Hinks: I wanted to start off by asking you about moral reconation, and if you could just explain what that is briefly.

Dan Blonigen: So, moral reconation therapy, or MRT, it’s actually an intervention that was developed, I think, decades ago in jails and prisons so, [interruption] correctional settings. It’s intervention that – it uses groups to help justice-involved adults reduce their likelihood of criminal recidivism.   
  
So, it’s all focused on that but it uses sort of a workbook and exercises in the group format to help people change their criminal thinking styles, you can put it that way.

Diane Hinks: Is it prompting them to think about the moral rights and wrongs of what they did? Or is it something different?

Dan Blonigen: The name would suggest that. It’s not quite like that. To understand it, the term “conation” is an old psychoanalytic term that refers to conscious moral decision-making.   
  
So, the way in which it works, it uses – it’s called “cognitive behavioral principles” – but it helps people sort of understand their automatic thoughts and how those automatic thoughts can lead them towards behaviors that could get them involved in committing crimes. So, helping them kind of understand that they might have a tendency to think about always things that give them benefit in the moment, not thinking long-term.  
  
And the intervention’s all trying to use cognitive behavioral therapy to exercise these using cognitive behavioral techniques to help people to sort of reprogram, if you will, their criminal thinking to sort of become more planful, more thoughtful, figuring out how to better engage with people in a healthy way.

Diane Hinks: I wanted to ask you to tell us the purpose of the VA Mental Health Residential Rehabilitation Treatment programs and how they were involved in your study.

Dan Blonigen: Yes. And this is a great question because when it comes to the VA providing care, the VA can’t provide care in settings where the other settings already have a mandate to provide care. So, jails and prisons already [interruption] are required to.   
  
So, when there are veterans in jails and prisons, the VA can’t provide care in there but when they leave the system, those correctional settings, come to the VA; then, they can provide care for them. And we know a lot of veterans in residential programs have a long history of kind of being out of jails and prisons.   
  
That’s essentially what working with my partners in the veteran assistance programs, we talked a lot about, “Well, if we try to put MRT in the VA and see if it works, where are the most justice-involved veterans that could benefit from this?” And it seemed like the mental health residential programs probably were the place where there’s; A, a lot of veterans who have a long history of being in and out of jail; and B, also, those residential programs are relatively long in the sense that they kind of can be three- to six-month programs.   
  
And we used a specific type of mental health residential programs called “domiciliaries,” sort of veterans who have a history of mental health, substance use issues, and also, currently struggling with housing and/or employment. And those programs, in particular, have a lot of veterans who have a history of multiple charges.   
  
So, we figured that’s a population that veterans will be in there for a while and they also have – a lot of them could benefit from this. And the fact of them being there for a while is important because MRT is very intensive and long so, for people to kind of get through all these steps in moral development, they have to go to many, many sessions and give them that time to really get the full benefit of MRT.

Diane Hinks: Can you tell us about your findings and how they might impact the adoption and sustainment of MRT for veterans at risk of criminal recidivism?

Dan Blonigen: Our study was designed for two things. It was a randomized controlled trial, first of all. So, we wanted to see; is it effective, actually, for reducing recidivism and [interruption] …

Diane Hinks: Right, so, you had a control [overtalking] group.

Dan Blonigen: … a control group. And then, the second part of the study was sort of to understand more qualitatively why did people engage or not engage with intervention, understand the issues of implementation. You know, like if other VA mental health programs wanted to adopt MRT, what would be things that would help that?

Diane Hinks: Facilitates [overtalking] …

Dan Blonigen: Facilitate, exactly, that’s a big part of it. So, it was kind of this hybrid randomized controlled trial.   
  
The RC findings, actually, we aren’t finalized yet so, we actually don’t – we don’t know “Did it work?” We’ll probably know in a couple months. But we do have our qualitative findings, which is what the talk that I'm giving tomorrow is all about where we talk to veteran patients and then, also, all the staff at three sites, residential programs that helped us implement the MRT groups.

Diane Hinks: How many patients were in each group?

Dan Blonigen: For the overall RCT, the overall study, we enrolled 344, I believe. And then, we interviewed 36 patients for our more in-depth qualitative interviews. We tried to get people to range of level of engagement in the intervention so, of those 36, 12 would be classified as low engagers and went into a couple of groups or [interruption] …

Diane Hinks: And said, “That’s it, that’s not for me.”

Dan Blonigen: Yes, definitely [overtalking].

Diane Hinks: Whatever.

Dan Blonigen: Exactly. Because people went to a moderate amount, maybe six to nine groups, and then, we had a high-engager group of veteran patients that went to 12 or more. One person even, we enrolled really early from one of the sites loved it so much he went to every group we offered for the course of like two years and [interruption] we had like 168 groups.   
  
So, we had [interruption] …

Diane Hinks: Is he teaching now? Is he like a peer specialist?

Dan Blonigen: Well, essentially, a peer mentor for others [interruption] in the intervention group, which is actually how MRT is designed to be. It’s designed to have people who are farther along in the program [interruption] \_\_\_\_\_ [00:06:09] come back and help other people with the program. So, it worked out great.  
  
So, we have veterans with different levels of engagement. And then, we had - well, 36 of them we interviewed. And then, we interviewed 13 staff in these residential programs that were …

Diane Hinks: Oh, that’s good.

Dan Blonigen: Yes, [overtalking] they even were actually the facilitators of the groups or staff within the residential programs, administrators of the programs, as well.   
  
And what we learned from them is a few things. One; we learned that in terms of patient engagement, what was the big issue that was a barrier, and not surprisingly, was the length and intensity of the curriculum.   
  
Most veterans, even ones that dropped out early, a lot of them seemed to disliked that it – they got exposed to the group at least a little bit, they thought, “Well, this is an interesting group,” they said, “I'm just overwhelmed with everything else I have to do. This is a lot of work involved here.”

Diane Hinks: Was there homework? Was there like a lot of paperwork?

Dan Blonigen: There’s a [overtalking] lot of homework.

Diane Hinks: Yes.

Dan Blonigen: That’s the thing with MRT is that the bulk of the work is done as homework in between the sessions. And so, you have to have a lot of time …

Diane Hinks: You have to time …

Dan Blonigen: … and motivation.

Diane Hinks: … time to do that, yes.

Dan Blonigen: You have to do that. And these residential programs, they have other – there’s other classes and groups the veterans have to go to as part of being in that residential program. And so, a lot of them tell us, “You know, it seems like a good program but, you know, I'm just overloaded with all these other programs I already have to go to.” And they would say things like, “Well, if MRT was a program, if that was kind of a program on its own, then, maybe I would do that.” Or they would say that MRT should be kind of its own program. It can’t just be a class or a group you stick into a residential program; it has to be kind of all-encompassing.

Diane Hinks: Yes.

Dan Blonigen: And the staff would say the same thing. They said that yes, MRT was hard. It was just so intensive and too long for a lot of our veterans that we would have to completely restructure our program to really do it justice.  
  
So, that told us – it wasn’t surprising to us. We knew that MRT was pretty intensive and that came through in the patient and the staff interviews. So, we learned that.  
  
But we also learned that in terms of what would facilitate adoption – and this is a question I had going in the study – was; Would staff feel like this is something they should be doing? Or would they feel like these kind of MRT groups are already redundant with what they’re already doing in the programming?  
  
And surprisingly – maybe not surprisingly – but like an interesting thing was that the patients and staff, a lot of them felt that the groups actually filled a nice niche. They felt that it actually complemented what the programs were already doing in terms of usual care. It had this kind of benefit. It was a unique thing that wasn’t the same as other groups are already doing. It was filling a gap for a lot of the veterans that were justice-involved and had been in and out of prison. They felt like, “There’s nothing like this that we already have in our program so, this is a unique thing that we would like to do.”   
  
And many of the programs – the three sites, at least, that we had in our study – is that they, after the study ended, we plan to try to have these groups set as a regular part of a program going forward, if we can figure out how to fit it in.  
  
So, there’s a lot of interest there so, I think that was something that was encouraging to us in the sense that people didn’t think that – or thought that there was a place for this in the programs.  
  
Part of that, too, was people thought in terms of if you want to adopt it VA-wide or if I have other residential programs adopt it. It’s good to make sure you’re clear to them that there’s benefits to patients beyond this recidivism reduction, like I mentioned earlier.

Diane Hinks: Yes, yes, right.

Dan Blonigen: You know, to us in the \_\_\_\_\_ [00:09:34] staff would say it wasn’t as clear kind of what MRT helped benefit our patients but it benefits them in a lot of different ways. It’s not just reducing the risk of crime, and the patients would say the same thing. And they said that it’s important to kind of message that to the patients early on when they first start the groups of why they might want to take part in the groups. And staff also said that it’s important for us to make sure that we communicate that – or that any sites taking up MRT could communicate that to other staff in the residential programs to get buy-in from them.

Diane Hinks: Right.

Dan Blonigen: Because they said initially, they didn’t have a lot of buy – the ones who ran the groups for us bought in but they said there wasn’t a lot of buy-in from other staff in their programs. But then, over time, when other staff would start to better understand that, “Oh, it’s not just a group for reducing crime; this group can help our veterans be less impulsive, have better relationships, and help them be able to just get organized enough to find housing and find a job. Then, they would buy in more.” So, that was an encouraging finding.  
  
And then, another thing I’ll mention in terms of our findings was – well, I mentioned, I guess, earlier the issue of not just having external motivation but, also – or external acceptance – but, also, having internal incentives and some kind of motivational interviewing type thing to help veterans be able to reflect on why they might want to do this and get more engaged.   
  
And then, I guess, a final thing, or kind of a bigger finding, was that, you know, those programs have a lot of services but a lot of the providers we interviewed felt that if another site took this up in terms of adoption or sustainment, that it’s good to have – or be important to have a very – those programs establish a broad network of people across their mental health services through VA, as well as within non-VA correction services.   
  
So, would say things like, “It’ll really be important if a residential program picked this up, that they partnered with a veterans’ treatment \_\_\_\_\_ [00:11:38].” Or they partnered with their local veterans’ justice outreach specialist to help have a referral stream into the program, to help have that kind of external incentives for the veterans, to kind of at least get jumpstarted on the program and just to kind of really help better with like continuity of care as veterans are coming in from the prisons to the program, then, they go to outpatient services.   
  
So, that kind of broad network seemed to be [interruption] something people \_\_\_\_\_ [00:12:04].

Diane Hinks: Is there anything that you would like our listeners to know about the benefits or challenges of working within VA Research or working with veterans?

Dan Blonigen: Well, I’d say that a huge benefit – and I’ve experienced now being in the VA for 12 years and doing research in the VA for 12 years – is that especially doing health services research in the VA, is that it’s very much partner-based research. You’re not necessarily just coming up with your own theories or research questions and doing them kind of in a silo. You’re working, more often than not, closely with a partner.

Diane Hinks: Do you have an Operations partner?

Dan Blonigen: Yes. So, the Veterans’ Justice Program is our operation partner. In fact, they’re the ones who, they had worked with – I didn’t mention this earlier – but MRT had been around, I guess, for decades. But the Veterans Justice Programs and the VA had partnered with the developers of MRT Correctional Counseling, Inc. about ten years ago to create a veteran version of their workbook; try to use more veteran language and examples. Even used more recovery-oriented language that’s common in VA.  
  
So, created the workbook called *Winning the Invisible War*; that’s the MRT curriculum for veterans. So, they were a big component of MRT. They thought, “Well, a lot of our specialists are getting trained on this, they’re running groups, and they seem to be interested in this. We want to see if it works for our veterans.”  
  
So, I already had a working relationship with the National Training Director of the Veterans Justice Programs, Joel Rosenthal, and he talked a lot about his interest in MRT and testings effective for veterans. So, he was a big supporter of this research, helped me kind of craft my thinking around it.  
  
I guess long and short of it is that in the VA, doing health services research, it’s really nice to work that closely with an Operations partner who has a priority that if you craft the research study well, can really make an impact on that partner’s initiatives and maybe make a more direct impact in veteran care, or at least more quickly.

Diane Hinks: Right.

Dan Blonigen: And I find that very satisfying and my experiences working with those partners in these programs, was VA partners’ services have been very rewarding. It’s been a great part of it.  
  
The challenge has always been, I guess, the timing of – or I guess you’d say the pace of research [interruption] …

Diane Hinks: Not fast, usually [overtalking].

Dan Blonigen: … relative to the pace of – yes, relative to the pace of clinical care and operations where things move quickly. They have needs, questions they have that need to get answered relatively quickly, and the research takes a lot of time. It takes time to get funding, it takes time to do the research well.   
  
So, we’re close to having our RCT findings to find out if it was effective, and that answer will come five years after our partners first asked it.   
  
And so, that sometimes can be, obviously, challenging for partners. But challenging for me because I want to give the information sooner but feel like I need to time to kind of, you know …

Diane Hinks: Yes, you want it to be right.

Dan Blonigen: I want it to be right, yes. But [interruption] oftentimes, in any healthcare system, they need to take a lot of time to – any program office needs to sort of make decisions, do something for the veterans that they serve.  
  
So, the veterans assistance programs, they actually – it was a couple of years now, just two or three years ago – they had some funds they wanted to put towards training or doing a larger dissemination and national training rollout, if you will, of MRT. And they have funds that have a lot of these outreach specialists on their teams at different facilities go get trained in MRT and they encourage other mental health and addiction providers to just always get trained in MRT.   
  
And essentially, it was a rollout of MRT and this was, you know, about two or three years ago. And I remember talking to my partners, being like, “I think that’s great. I don’t have any data for you to say if it’s effective or not so, I hope it is.” Although we do have data outside the VA that suggests it’s promising and so, it’s not like we’re starting from scratch.  
  
But that’s another thing where, as a researcher, I have to be comfortable with the fact that my partners are going to move forward with things before I can give them the hard data.

Diane Hinks: And working with the veterans; they’re wanting to work, knowing that it’s part of research?

Dan Blonigen: It’s been great. I can’t say I’ve experienced any particular challenges. My experience has been when I have a research study, whether it’s this one with MRT or another research study, and I say – especially when I frame it as my research and I try to be honest with them so, I think I'm being honest – that I'm doing Research Study X because I think it’s going to help other veterans with this issue. And that messages seems to resonate with …

Diane Hinks: The most, yes.

Dan Blonigen: … most veterans. Yes, they’re like they seem to be, “Okay, yes, I want to help my fellow veterans.”  
  
I think more than any other population I’ve worked with that when you talk about research as having impact on their fellow veterans, that they’re really eager to help out if they can.

Diane Hinks: Yes, I think it’s because they have that family mentality.

Dan Blonigen: Yes.

Diane Hinks: They’re my brothers, they’re my sisters, so, I want to help.

Dan Blonigen: Yes, absolutely, yes. They think of fellow service members as it’s family and I think that they want to give back if they can.

Voiceover: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D-funded research and do not necessarily reflect current or to-be-implemented VA policy.   
  
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