Outpatient Substance Use and Harm Reduction Model Community Forum

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Care, Treatment and Housing Program
Bureau of HIV Prevention and Control
NYC Department of Health and Mental Hygiene
February 3, 2011

Today's Agenda

- Welcome and Introduction
- Planning Council Process
- Outpatient Substance Use and Harm Reduction Model
- Behavioral Interventions
  - Community Reinforcement Approach
  - Therapeutic Education System
  - Seeking Safety
- Questions/Comments

Ground Rules

- Hold questions until the end
  - Q&A session 30 minutes, plus attendees can leave questions with DOHMH staff or email them to HIVCTHP@health.nyc.gov
- No discussion of RFP; only model
- RFP expected to be released in early Summer 2011
- New programs to begin on March 1, 2012

Why Rebid Now?

- Over 50% of current Harm Reduction, Recovery Readiness, Relapse Prevention (HRR) clients are HIV negative or status unknown
  - Need to align with guidance from our funder, the Health Resources and Services Administration
- In new model, HIV negative clients shall be referred to HIV prevention resources and utilize other sources of payment for Substance use Treatment and Harm Reduction Services.

Background

- **Substance use services can be delivered along a spectrum, which includes:**
  - *Drug treatment:* a medical based model with emphasis on abstinence from substance use
  - *Harm reduction:* an educational based model with emphasis on the client's well-being and priorities

The HRR service category has been part of the NYC EMA Part A portfolio since 1994

Service Category Designation

- *HRSA Service Category:* Outpatient Substance Use Treatment (core service)
- *NYC-Specific Service Category:* Substance Use Treatment and Harm Reduction Services
- Note: Harm reduction consists of public health principles that aim at reducing the negative consequences of drug use and sexual behavior and support strategies that range from a reduction of the harmful behavior to abstinence.

Priority Rank & Budget

- NYC EMA ranked HRR as Priority #5 (of 12) for FY 2011-2012
  - *Equal in previous year*
- ~13% of the total RW budget is allocated to HRR
  - *Base funding only, no MAI*
- The HRR program currently funds 25 programs in NYC
  - *Originally 27 agencies funded*
- The portfolio was rebid for FY 2007
  - *Performance-based contracts*

FY	$ Amount	% of Total Budget
2005	$12,652,561	10.7%
2006	$11,290,628	11.2%
2007	$10,509,931	10.4%
2008	$11,410,836	11.1%
2009	$12,082,026	11.8%
2010	$11,232,026	12.9%
2011	$12,032,026	12.6%

HIV and AOD Advisory Panel

Raquel Algarin
Executive Director
Lower East Side Harm Reduction Center

Valerie Bartlett
Administrator
Albert Einstein College of Medicine, Division of Substance Abuse

Lawrence S. Brown, Jr., MD, MPH, FASAM
Executive Senior Vice President, Addiction Research & Treatment Corporation
Clinical Associate Professor of Public Health, Weill Medical College, Cornell University

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Assistant Professor of Medicine and Public Health
Yale AIDS Program, Yale University School of Medicine

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Director, International Research Core, Center for Drug Use and HIV Research
Research Fellow, NDRI
Director of Research, Baron Edmond de Rothschild Chemical Dependency Institute, Beth Israel Medical Center
Professor of Epidemiology, Department of Epidemiology and Population Health, Albert Einstein College of Medicine

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Professor of Applied Psychology and Public Health
Director, Center for Health, Identity, Behavior & Prevention Studies (CHIBPS)
The Steinhardt School of Culture, Education, and Human Development at New York University

Petros Levounis, MD, MA
Director, The Addiction Institute of New York
Chief, Division of Addiction Psychiatry, St. Luke's & Roosevelt Hospitals
Associate Clinical Professor of Psychiatry, Columbia University College of Physicians & Surgeons

Edward (Ned) Nunes, MD
Professor of Psychiatry
New York State Psychiatric Institute
Columbia University College of Physicians & Surgeons

Jeffrey T. Parsons, PhD
Professor and Chair, Department of Psychology
Director, Center for HIV/AIDS Educational Studies and Training (CHEST)
Hunter College and the Graduate Center of the City University of New York (CUNY)

Michael Smith, MD, DAc
Director of Medical Acupuncture
HHC Lincoln Hospital Acupuncture Clinic

Susan Tross, PhD
HIV Center Associate Director
Research Scientist
Associate Professor of Clinical Psychology
Columbia University

Charles Shorter, MSW

Former, Community Co-Chair
Co-Chair, Integration of Care Committee
NYC HIV Health and Human Services Planning Council

Planning Council Process

- Reviewed literature
- Presentations by Key Opinion Leaders
- Worked with NYC DOHMH staff to develop Program Guidance document
- Committees Involved:
  - Needs Assessment
  - Integration of Care
  - Executive Committee
  - Planning Council

RFP Development Process since July

- Reviewed evidence-based behavioral interventions
- Reviewed surveillance, service data and research findings (MMP, CHAIN, etc)
- Met with HIV and AOD practitioners, scholars, academics and convened Panel
- Discussed ideas/proposals with DOHMH Bureau of Alcohol & Drug Use Prevention, Care & Treatment

Graham Harriman, MA

Director, Health Care Services Unit
HIV Care, Treatment and Housing Program/
Bureau of HIV Prevention and Control
NYC Department of Health and Mental Hygiene

Program Goals: Substance Use Treatment

- Provide easily accessible harm reduction and substance use services to HIV-positive individuals who are actively using or have recently used drugs or alcohol
- Promote access to and maintenance in HIV primary care
- Reduce the impact of alcohol and other drug (AOD) use by reducing substance use as measured by a standardized assessment tool.
- Enhance medication adherence

Related 2009-12 Comprehensive Strategic Plan Goals

- 2B: To increase retention in HIV care and treatment
- 3A: To improve medication adherence to a rate of 95%
- 3B: To increase viral suppression
- 3C: To improve immunological health (e.g., CD4 count)
- 4C: To reduce (and then maintain below significance) sociodemographic differences in retention in primary medical care

Service Model Components (1)

- *Targeted Case Finding*: should occur through outreach in locations where AOD users often frequent, including but not limited to:
  - shooting galleries
  - food pantries
  - methadone maintenance treatment programs
  - syringe access programs
  - Rikers Island Transitional Health Care Coordination Program
  - hospital emergency departments
  - HIV/AIDS Services Administration (HASA) sites
  - congregate housing facilities

Service Model Components (2)

- *Health Promotion:* evidence-based interventions, including:
  - addressing risky sexual behavior
  - adherence to HIV care and treatment.
- Curricula will be provided by the NYC Department of Health and Mental Hygiene.

Service Model Components (3A)

- *AOD Services*:
  - Assessment: use of standard measurement tool for AOD assessment for providers and patients (self-assessment)
  - Assessment and referral for mental health, sexually transmitted infections, and other co-morbid conditions
  - Development of a comprehensive care plan with individually defined milestones and goals

Service Model Components (3B)

- Services should utilize harm reduction principles and should be offered for all substances as appropriate, including but not limited to:
  - Alcohol
  - Methamphetamine
  - Heroin
  - Cocaine
  - Crack

Service Model Components (3C)

- Medication-assisted interventions, including the provision of:
  - Buprenorphine
  - Naltrexone
  - Methadone
  - Acamprosate
- Can be provided through provider or formal linkages

Service Model Components (3D)

- Acupuncture as referred by the enrolled individual's primary care provider (optional service)
- Syringe access, disposal, needle exchange programs (new guidance released on 12/30/10 from HRSA)
- Counseling and behavioral interventions (discussed later)
- Services should include individual, family and group counseling sessions.
- Programs should progress toward client graduation

Service Model Components (3E)

- *Linkage to HIV Primary Care:* all providers are required to assess that their clients are engaged in HIV primary care
- If not receiving primary care at enrollment, refer to primary care within 15 days and reassess whether they are linked to care every 30 days.

Service Model Components (4)

- *Accompaniment:* HIV-infected clients receiving AOD services may receive accompaniment services to their first primary care appointment.
- *Coordination of Care:* providers are required to ensure that their clients are also linked to other needed services and are enrolled in a medical case management program.

HIV Rapid Testing

- Programs are required to either offer rapid HIV testing or have a formal linkage with a rapid HIV testing program.

Training & Technical Assistance

- *Provider Training:* all service providers will be trained in evidence based counseling approaches, such as motivational interviewing and stages of change theory.
- Training will be coordinated by the NYC DOHMH.
- Technical Assistance Coordinator assigned to Providers to supplement agencies as they implement the new services.

Client Eligibility

- HIV-infected individuals meeting Ryan White eligibility criteria with active or recent (within past 12 months) use of both licit and illicit drugs and/or alcohol.
- Those who have been released from an institution in the past three months who have a history of substance use are also eligible to receive services.
- Individuals who are currently prescribed Methadone or Buprenorphine.
- Specific target populations including but not limited to Planning Council designated special populations
  - (young MSM of color, LGBT, women of color, immigrants and people over 50 years old) as well as women, youth, men who have sex with men, and racial and ethnic minorities

Agency Eligibility

- New York City community based organizations
- AIDS service providers
- hospitals and clinics
- social service agencies
- and/or other eligible not-for-profit agencies that are legally incorporated by the State of New York as not-for-profit organizations
- Demonstrated experience providing AOD services to HIV-infected persons
  - Co-location or affiliation (geographically close and aligned to provide available patient care) with HIV primary care provider
  - Co-location or affiliation (geographically close and aligned to provide available patient care) with mental health provider

What Did We Look For In The Chosen Behavioral Interventions?

- Fit with needs of people living with HIV/AIDS
- Comprehensive model
- Evidence-based model
- Easily implemented at agency level

Petros Levounis, MD, MA

Director, The Addiction Institute of New York
Chief, Division of Addiction Psychiatry, St. Luke's & Roosevelt Hospitals
Associate Clinical Professor of Psychiatry, Columbia University College of Physicians & Surgeons

Community Reinforcement Approach

- Main behavioral intervention for all programs
- Can be implemented in-person and/or with internet intervention
  - To be discussed later in presentation
- Training and protocol will be provided by NYC DOHMH

Community Reinforcement Approach- What Is It?

- The Community Reinforcement Approach (CRA) is a comprehensive behavioral treatment model for working with people, including PLWHA, with substance use disorders.
- Fundamental to CRA is the belief that environmental contingencies—*behaviors the environment will reinforce or punish*—play a key role in encouraging or discouraging alcohol or drug misuse.

Source: http://www.rcptdc.ca/SiteCollectionDocuments/PT-Essentials%20of%20the%20Community%20Reinforcement%20Approach-2008(

Community Reinforcement Approach- What Is It?

- CRA employs familial, social, recreational and vocational behavioral reinforcement contingencies (reward system) to support the individual in the recovery process.
- The goal of CRA is to assist the individual in developing a lifestyle and environment where the *reduction of or abstinence from* use of alcohol or drugs is rewarded, and substance use or dependence is discouraged.

How Does CRA Work?

- The philosophy of CRA is to rearrange an individual's life so that non-using behavior becomes more rewarding than using behavior.
- The use of alcohol and other drugs can be highly rewarding. Therefore, CRA uses several treatment strategies to achieve its goal of re-arranging rewards in a client's life.

CRA Strategies (1)

Increasing Client Motivation

- CRA typically begins by exploring a client's motivations for change with the identification of positive reinforcers.
- Time is also spent with the client reviewing current and future negative consequences for their substance misuse.
- This assessment is done in an empathetic motivational interviewing style that encourages the client, not the therapist, to voice the advantages of change and the disadvantages of continued misuse.

CRA Strategies (2)

Functional Analysis

- The CRA Functional Analysis for alcohol or other substances is a structured interview that helps the client identify the triggers to, and the consequences of, the behavior they are wishing to change.
- The functional analysis also helps to identify the rewards that have been maintaining the alcohol or other substance misuse as well as high-risk situations that might contribute to relapse.

CRA Strategies (3A)

Trial Period of Abstinence

- CRA uses the concept of "sampling sobriety" for a limited period of time. This allows clients the freedom to negotiate a timeframe instead of feeling overwhelmed by the message that they can never drink or use again.
- Whether the client is one who would benefit from life-long abstinence or someone who wants to moderate their use, an initial period of sobriety is usually beneficial.

CRA Strategies (3B)

- Typically, the therapist starts by suggesting a 90-day period of abstinence and the client negotiates this request to one they believe will be both challenging and achievable.
- Whether the negotiated time period is 90 days or one day, the therapist assists the client in planning a strategy to maintain abstinence during that time.

CRA Strategies (4)

Increasing Positive Reinforcement

- As an individual becomes dependent on alcohol or other substances for positive reinforcement, or even for feeling "normal", their range of non-drinking and/or non-using activities narrows and they become increasingly isolated.
- Therefore, CRA offers several treatment modules to assist the client in finding enjoyable activities that do not involve drugs or alcohol. These all share the common goal of making the client's alcohol/drug-free life more rewarding than their "using life" and to re-engage the individual into the community.

CRA Strategies (5)

Enhancing Basic Social Skills

- Identifying and teaching new skills in areas of deficits is essential to the success of CRA. Communication skills, problem solving and drink/drug refusal are commonly worked on with the client.
- The CRA therapist models the use of these social skills and encourages the individual to practice these skills through role plays in the counseling setting and then to use these newly-acquired skills in life situations.

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Special thanks to:
Lisa A. Marsch, Ph.D., Chief Research Scientist, HealthSim, LLC
Director, Center for Technology & Health, National Development & Research In[illegible]

Web-based Psychosocial Treatment of Substance Use Disorders: *The Therapeutic Education System (TES)*

Need for Widespread Dissemination of Evidence-based Interventions for Substance Use Disorders

- Although effective programs focused on substance use treatment exist, their delivery is often challenging.
- Many interventions (e.g., psychosocial interventions) that have been shown to effectively produce behavior change in research settings are not routinely available in real-world settings.
- Evidence-based interventions can be expensive to implement, often requiring financial and staffing resources not typically available in many community-based systems.

Need for Widespread Dissemination of Evidence-based Interventions for Substance Use Disorders (continued)

- Even if evidence-based programs are initiated in community-based programs, it is often difficult to ensure the fidelity of intervention delivery (e.g., given staff turnover, patient caseloads, limited time).
- Further, the availability of services may not fully meet demand in some areas.
- Innovative approaches to bridging the gap between clinical research and practice are needed, thus allowing findings from clinical research to have a markedly increased public health impact.

Promoting Widespread Reach of Evidence-based Behavior Change Interventions

- Technology-based therapeutic tools offer great promise for enabling the widespread dissemination of evidence-based interventions targeting substance use disorders and other behavioral health issues.
- Technology-based (e.g., web-based) interventions allow complex interventions to be delivered with fidelity at a low cost, without increasing demands on staff time or training needs, thus having high potential for widespread dissemination.

Potential Benefits of Technology-Delivered Interventions

- Low Cost
- Accessible in a wide array of settings
- Easily exportable
- Fidelity/Replicability is assured
- May be less threatening when addressing sensitive topics
- Requires active responding
- Can be readily modified
- Permits temporal flexibility
- Permits more rapid diffusion
- May increase adoption of science-based interventions
- Tailoring/Customization Readily Accomplished
- Permits expansion of treatment

The *Therapeutic Education System (TES):* Web-based Psychosocial Treatment of Substance Use Disorders

- *Therapeutic Education System (TES):* an interactive, psychosocial intervention for substance use disorders

  Grounded in the Community Reinforcement Approach (CRA) + Contingency Management (Motivational Incentives) Behavior Therapy + HIV Prevention

- The science-based content in TES is delivered via informational technologies and multimedia approaches of demonstrated efficacy.

The *Therapeutic Education System (TES)*

- **TES has been evaluated with a diverse array of substance users** in community-based systems (including ongoing studies in NIDA's multi-site, Clinical Trials Network [CTN] platform and on NIDA's CJ-DATS platform with individuals in prisons).
- **Results from research studies** to date have demonstrated that TES is *as efficacious as* science-based interventions delivered by highly trained clinicians and highly acceptable to the target audience
- **TES may be particularly useful as part of a Clinician Extender Model**
  - Increase time for clients with multiple challenges
  - Focus on services requiring clinical expertise and interaction
  - Clients review repetitive but necessary skills training without extensive clinician time

The *Therapeutic Education System (TES)* for Substance Use Treatment

- Composed of 65 interactive modules grounded in the efficacious Community Reinforcement Approach (CRA) psychosocial intervention
- Program is self-directed & includes a Training Module
- Patients complete evidence-based program modules on skills training, interactive exercises and homework in accordance with their plan
- All module content includes accompanying audio
- Electronic reports of patients' activity available to therapists
- Can track earnings of incentives dependent on urine results or other target behavior

List of Module Topics in Therapeutic Education System (TES)

1 Training Module
2 What is a Functional Analysis?
3 Conducting a Functional Analysis
4 Self-Management Planning
5 Drug Refusal Skills Training
6 Awareness of Negative Thinking
7 Managing Negative Thinking
8 Managing Thoughts About Using
9 Managing Negative Moods and Depression
10 Introduction to Problem Solving
11 Effective Problem Solving
12 Progressive Muscle Relaxation Training
13 Receiving Criticism
14 Seemingly Irrelevant Decisions
15 Other Drug Use
16 Coping with Thoughts About Using
17 Introduction to Assertiveness
18 How to Express Oneself in an Assertive Manner
19 Introduction to Anger Management
20 How to Become More Aware of the Feeling of Anger
21 Coping with Anger
22 Introduction to Relaxation Training
23 Progressive Muscle Relaxation Generalization
24 Introduction to Giving Criticism
25 Steps for Giving Constructive Criticism
26 Receiving Criticism
27 Giving and Receiving Compliments
28 Sharing Feelings
29 Vocational Counseling
30 Naltrexone
31 Limited Alcohol Use
32 Financial Management
33 Insomnia
34 Time Management
35 Relationship Counseling Part 1
36 Relationship Counseling Part 2
37 Relationship Counseling Part 3
38 Alcohol and Disulfiram
39 Communication Skills
40 Nonverbal Communication
41 Social Recreational Counseling
42 Attentive Listening
43 HIV and AIDS
44 Sexually transmitted infections (STIs)
45 Hepatitis
46 Sexual transmission of HIV and STIs
47 The Female Condom
48 Birth control use and HIV and STIs
49 Drug Use, HIV and Hepatitis
50 Alcohol use and risk for HIV, STIs and hepatitis
51 Getting Tested for HIV, STIs and Hepatitis
52 Finding More HIV, STI and Hepatitis Information
53 Negotiating Safer Sex
54 Decision-Making Skills
55 Identifying/managing triggers for risky sex
56 Identifying and Managing Triggers for Risky Drug Use
57 Increasing-Self-Confidence in Decision Making
58 Taking Responsibility for Choices
59 Living with Hep C: Managing Treatment, Promoting Health
60 Living with Hep C: Coping Skills
61 Living with HIV: Coping skills and managing stigma
62 Living with HIV: Comm. skills for disclosing HIV status
63 Living with HIV: Managing treatment and medications
64 Living with HIV: Drug use and Immune System
65 Living with HIV: Daily routines to promote health

Evidence-Based Informational Technologies employed in Interventions

Fluency-Based Computer-Assisted Instruction (CAI)

A learning technology that involves testing, providing immediate feedback, & requiring participants to demonstrate mastery of the information & skills being learned

- Selectively presents information
- Requires active, overt responding by the user to multiple choice and fill-in-the-blank questions
- Evaluates and provides immediate feedback on user's responses
- "Read & Response timing parameters" are manipulated in promoting fluency

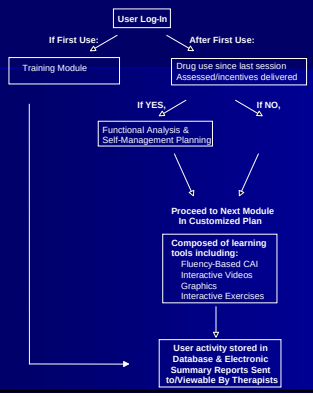
Interactive Video-based Computer Simulation

- Simulates real-world experiences and enables "what if" scenarios & behavioral modeling
- Enables exploration of various behavioral choices in "experiential learning" paradigm

TES features a comprehensive "motivational incentives" system , with the following features:

- Flexible schedules of reinforcement
- Flexible number and type of target behaviors and/or assessments
- Flexible reward system including cash vouchers or fishbowl draws
- Features an animated, virtual fishbowl for cashing in fishbowl draws
- Accounting system for tracking debits/credits in a participant's account
- Real-time graphing of assessments and target behavior results

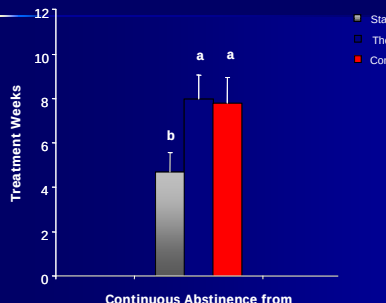
Therapeutic Education System (TES) Flow of User Activity



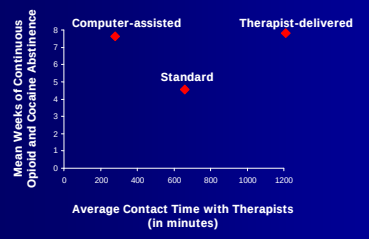
Randomized Controlled Trial

- Participants were opioid-dependent individuals in buprenorphine maintenance treatment for 23 weeks
- Participants randomly assigned to one of three groups:
  - *Therapist Delivered CRA:* 30 mins. 3x/wk. w/therapist + vouchers
  - *Computer Assisted CRA:* 30 mins.3x/wk. computer; 1 biweekly w/therapist + vouchers
  - *Standard Counseling:* 30 mins. 1/wk. w/therapist - focus on rehabilitation & compliance with treatment program
- Vouchers for both cocaine and opioid-free urine samples

Continuous Abstinence from Opiates and Cocaine



Abstinence Plotted by Therapist Contact Time



Summary of Clinical Trial Results

- The therapist-delivered and computer-assisted CRA plus vouchers interventions produced comparable weeks of continuous opioid & cocaine abstinence and significantly greater weeks of abstinence than the standard intervention, yet participants in the computer-assisted CRA condition had over 80% of their intervention delivered by an interactive computer program.
- The comparable efficacy obtained with computer-assisted and counselor-delivered therapy may enable more widespread dissemination of the evidence-based CRA plus vouchers intervention in a manner that is cost-effective and ensures treatment fidelity.
- Clinicians can use this tool to ensure that their patients have access to evidence-based skills training relevant to their treatment (and can optionally guide the focus of the intervention).

Susan Tross, PhD

HIV Center Associate Director
Research Scientist
Associate Professor of Clinical Psychology
Columbia University

Seeking Safety (1A)

- Supplemental behavioral intervention for organizations who have clients experiencing Post Traumatic Stress Disorder (PTSD)
- Implemented in-person
- Training and protocol to be provided by NYC DOHMH

Seeking Safety (1B)

- Developed as a group treatment for PTSD/SUD women
- Based on CBT models of SUDs, PTSD treatment, women's treatment and educational research
- Educates patients about PTSD and SUD's and their interaction
- Goals include abstinence and decreased PTSD symptoms
- Focuses on enhancing coping skills, safety and self-care
- Active, structured treatment - therapist teaches, supports and encourages
- Case management

Seeking Safety (2)

- Seeking Safety is based on five central ideas:
  - Safety as the priority of treatment
  - Integrated treatment
  - A focus on ideals
  - Four content areas: cognitive, behavioral, interpersonal, and case management
  - Attention to clinician processes.
- Other features include simple, human language and themes (i.e., accessible language that avoids jargon); treatment methods based on educational strategies to increase learning; a focus on potential; emphasis on practical solutions; and an urgent approach to time.
- It is the only psychotherapy model for co-occurring PTSD and substance use thus far that has enough studies to be classified as "effective".

Source: http://www.seekingsafety.org

Seeking Safety: How Does it Work? (1)

- *Seeking Safety* offers 25 treatment topics, each with a clinician guide and client handouts.
- The model was designed so that you can do as many or as few as the provider has time for. Each of the 25 topics is independent of the others and the provider can decide which ones you want to conduct, in any order and in any number.
- The model was designed for a very high level of flexibility as clients with trauma and/or substance use appear in so many different settings, with varied lengths of stay.

Seeking Safety: How Does it Work? (2)

- The seven interpersonal topics are:
  - Asking for Help
  - Honesty
  - Setting Boundaries in Relationships
  - Healthy Relationships
  - Community Resources
  - Healing from Anger
  - Getting Others to Support Your Recovery.

Seeking Safety: How Does it Work? (3)

- The seven behavioral topics are:
  - Detaching from Emotional Pain: Grounding, Taking Good Care of Yourself
  - Red and Green Flags
  - Commitment
  - Coping with Triggers
  - Respecting Your Time
  - Self-Nurturing

Seeking Safety: How Does It Work? (4)

- The seven cognitive topics are
  - PTSD: Taking Back Your Power
  - Compassion
  - When Substances Control You
  - Recovery Thinking
  - Integrating the Split Self
  - Creating Meaning
  - Discovery
- In addition, four combination topics are Introduction to Treatment / Case Management, Safety, The Life Choices Game (Review), and Termination.

Is the goal of Seeking safety abstinence from substances?

- The method chosen will depend on the philosophy of your program, the client's needs, and other factors.
- It provides various options for reducing use, in keeping with current research and understanding about addiction.
- Can include:
  - *abstinence* model
  - *harm reduction* (decreasing use, perhaps with a goal of ultimately reaching abstinence)
  - *controlled use* (decreasing use to a manageable level with a goal of remaining there).

Is Seeking Safety relevant for complex trauma/personality disorders?

- Yes. It was developed and tested on clients who typically had multiple traumas, often based in childhood, and often chronic. Moreover, in one study that evaluated co-occurring personality disorders, 65% of the sample met criteria for one or more personality disorders. Thus, complexity is often the norm.
- The format and content of Seeking Safety appear helpful for such clients, and the case management part of the treatment also helps to engage them in additional resources that may be beneficial for them.

Can Seeking Safety be used for simple or recent trauma?

- It has been used across the full spectrum of people with PTSD, including recent PTSD, "simple PTSD" (a single incident in adulthood), to complex and chronic PTSD. It has also been used for subthreshold PTSD (people who meet some of the criteria for the disorder, but not all).
- When used for recent or simple PTSD, the work typically moves more quickly; there may be a need for fewer sessions; and clinicians may choose to emphasize some topics over others. However, the basic elements of the work do not change in major ways.

Is Seeking Safety encouraging people to avoid the past?

- Seeking Safety focuses on the present but this does not mean it encourages avoidance of the past. Clients are encouraged to name their traumas as part of Seeking Safety and to discuss how it impacts them.
- The key principle is "headlines not details"—they are simply asked not to go into detailed exploration of it, as that would be a different type of therapy that is not part of Seeking Safety.
- Seeking Safety can be used with any other therapy or treatment the client needs or wants, including past-focused models (e.g., exposure therapy or EMDR for PTSD). Many clinicians have found that Seeking Safety helps client tolerate past-focused models as it strengthens their general ability to cope.

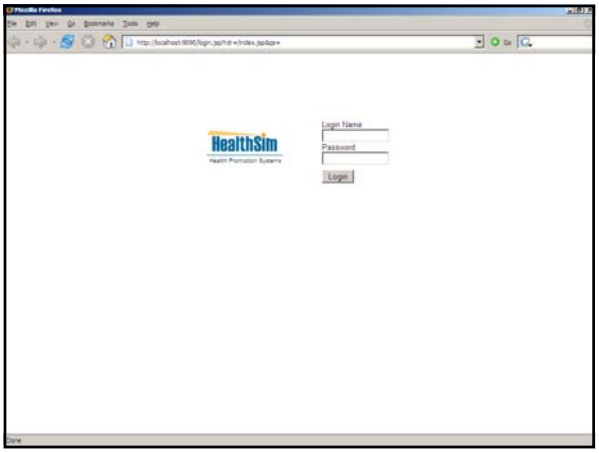
Seeking Safety: Who Can Do It?

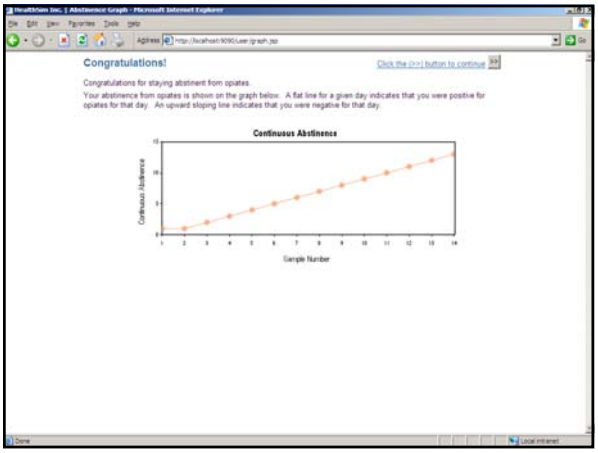
- Seeking Safety has been successfully conducted by a very wide range of clinicians (substance use or mental health counselors, social workers, psychologists, psychiatrists, bachelor's level counselors, case managers, nurses, clinical trainees, domestic violence advocates, school counselors, etc.).

Questions? Comments?

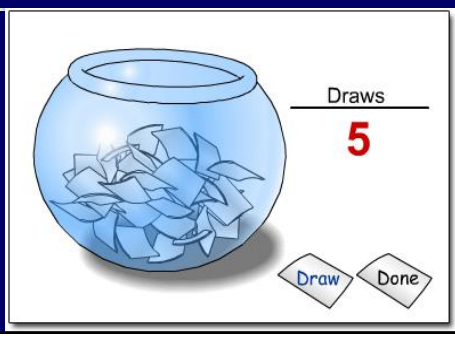
Thank You!

HIVCTHP@health.nyc.gov

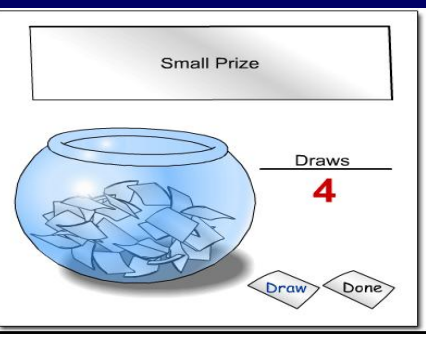


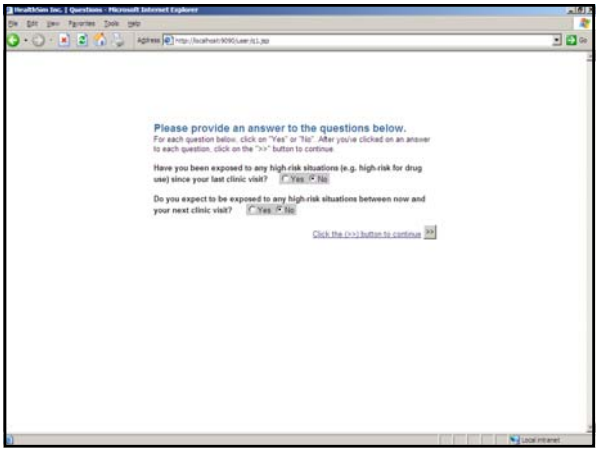


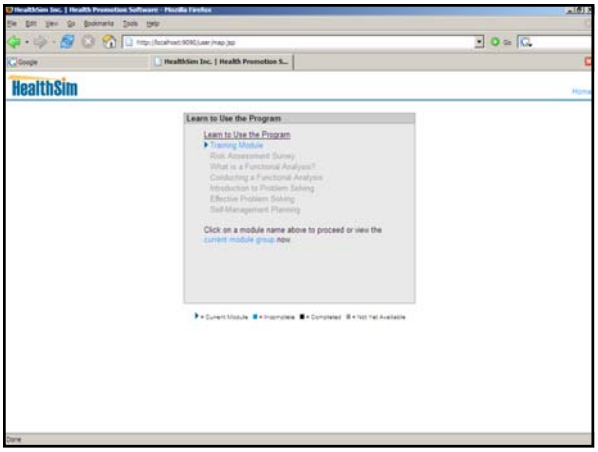
Virtual “Fishbowl” Example

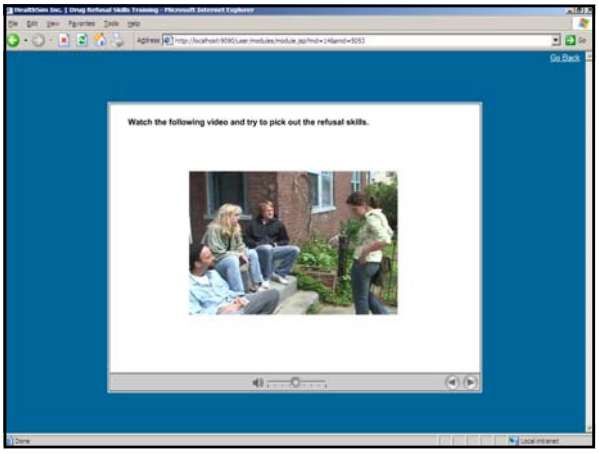


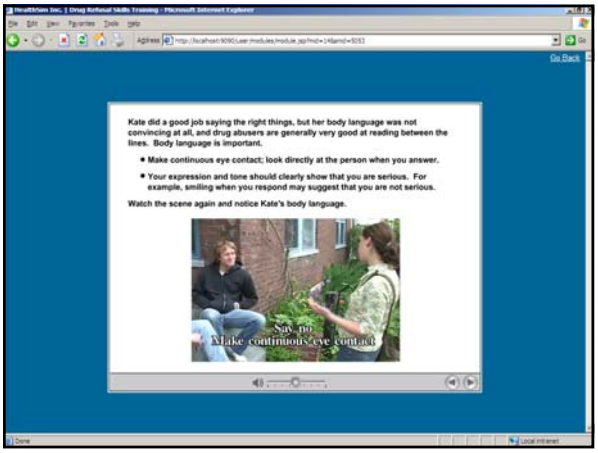
Example of Prize Incentive in Virtual “Fishbowl”

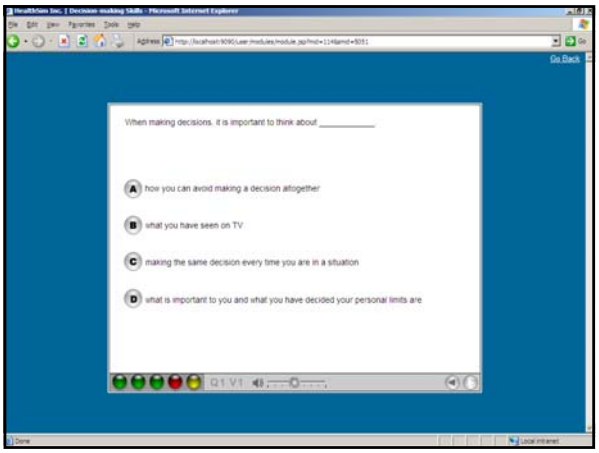


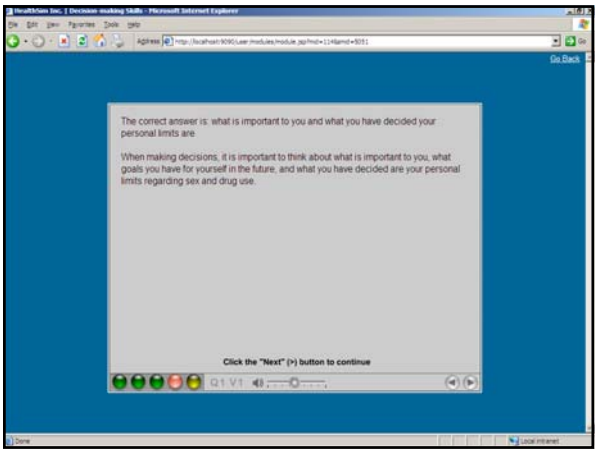


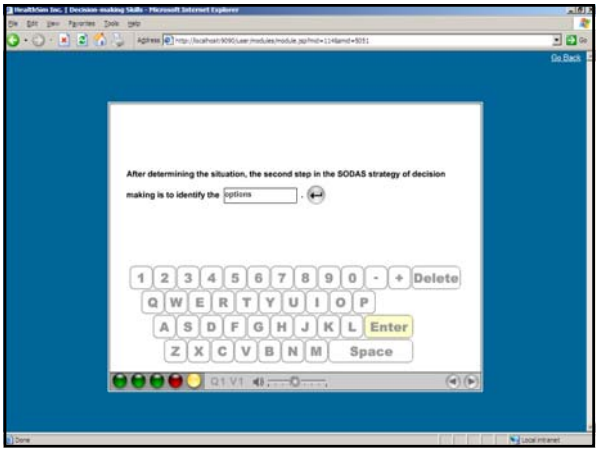







When making decisions, it is important to think about _____
A how you can avoid making a decision altogether
B what you have seen on TV
C making the same decision every time you are in a situation
D what is important to you and what you have decided your personal limits are


The correct answer is: what is important to you and what you have decided your personal limits are
When making decisions, it is important to think about what is important to you, what goals you have for yourself in the future, and what you have decided are your personal limits regarding sex and drug use.
Click the "Next" (>) button to continue


After determining the situation, the second step in the SODAS strategy of decision making is to identify the options .
1 2 3 4 5 6 7 8 9 0 - + Delete
Q W E R T Y U I O P
A S D F G H J K L Enter
Z X C V B N M Space