Jail Diversion & Trauma Recovery – Priority to Veterans

With many service members returning home from overseas duty and given the risk for justice system involvement posed by untreated posttraumatic stress disorder (PTSD) and trauma-related disorders, SAMHSA launched the Jail Diversion and Trauma Recovery – Priority to Veterans initiative in 2008 to support the implementation of trauma-integrated jail diversion programs for justice-involved veterans and other individuals with PTSD and trauma-related disorders through community-based pilot jail diversion programs and statewide infrastructure building activities (United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008).

The Jail Diversion and Trauma Recovery initiative has reshaped how communities and states address the behavioral health service needs of justice-involved veterans in numerous ways.

Since September 2008 SAMHSA has awarded five-year grants to 13 state mental health authorities (SMHA). Two RFAs[1] have been issued, with six grants each awarded in 2008 and 2009. A thirteenth grant was awarded in March 2010. The SMHAs in Colorado, Connecticut, Georgia, Illinois, Massachusetts, and Vermont were awarded in September 2008, followed by the September 2009 awards to the SMHAs in Florida, New Mexico, North Carolina, Ohio, Rhode Island, and Texas. The Commonwealth of Pennsylvania was awarded a grant in March 2010.

These grants support activities at both the community and state levels to address service access, systems integration, workforce development, training, and policy development. The two-pronged approach of community pilot programs and statewide infrastructure building activities is necessary because jail diversion occurs in communities but states have the opportunity to develop and promulgate policy and to disseminate knowledge and practices by working with communities throughout the state.

At both the pilot and state levels, the grant called for partnership and stakeholder development, including with the United States Department of Veterans Affairs, the state's Department of Veterans Affairs, veteran service organizations, community behavioral health agencies, and persons with lived experience.

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- Extending traditional criminal justice/behavioral health partnerships to the U.S. Department of Veterans Affairs and veterans service organizations to secure access to services for people in the VA system and in the community.
- Addressing the pervasive effects of trauma on individuals and their families through the expansion of trauma-specific services and trauma-informed care training.
- Coordinating services between the Veterans Health Administration and community-based service providers.
- Developing a strong presence of peers on the advisory committees and as service providers.

[1] The two RFAs issued by SAMHSA were SM-08-009 and SM-09-004. They are available from SAMHSA's grants archive, http://www.samhsa.gov/Grants/archives.aspx.

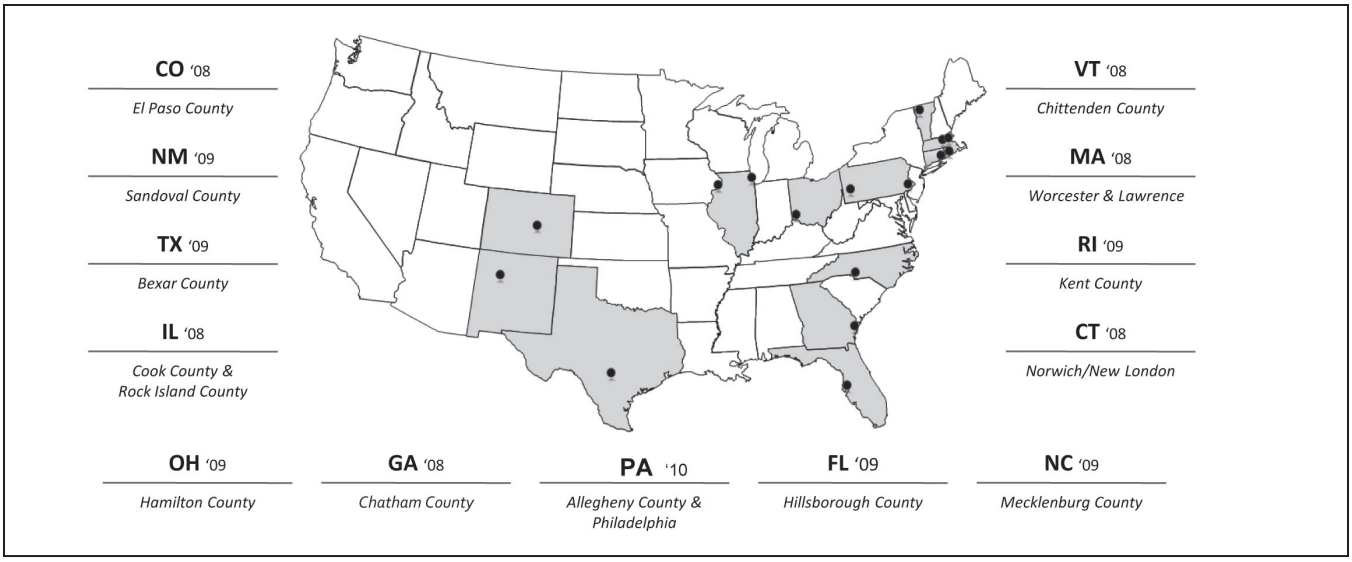

Figure 1. States and Sites

Pilot Site Activities

Each grant supports at least one pilot site. Three of the grants are operating two pilot sites.

- Illinois – Cook County and Rock Island County
- Pennsylvania – Allegheny County and Philadelphia
- Massachusetts – Worcester County and Essex County

Illinois and Pennsylvania have operated two pilot sites since the time of grant award. Massachusetts launched a second pilot site, in Lawrence, during its second year. During the first year of the grant Colorado planned to operate two pilot sites – Colorado Springs and Denver – but only launched the former in 2009. The pilot sites are identified in Figure 1.

The pilot sites are required to develop jail diversion programs for veterans with trauma disorders. Some grantees also serve non-veterans, which is allowed under the terms of the grant. These jail diversion interventions can be implemented by law enforcement, at initial detention, or through the courts, including for people who have violated conditions of probation or parole. The pilot sites in the states of Colorado and Ohio are diverting people through veterans treatment courts, a specialized court docket first established in 2008 in Buffalo, NY. These jail diversion programs must also screen for PTSD and other behavioral health service needs, provide trauma-integrated behavioral health and recovery support services, and provide trauma-informed care training to stakeholders and service providers.

The grant is divided into three stages that define the activities at both the pilot site. These three stages are (1) pre-implementation, (2) early implementation, and (3) full implementation. During pre-implementation (months 1 – 12), the State forms an advisory committee and authorizes a community to serve as a pilot location. The pilot site forms an advisory committee and develops a strategic plan. This phase culminates in a strategic plan to guide the implementation of the jail diversion program. The plan is reviewed and approved by the GPO. The fifteen elements of the strategic plan are identified in Figure 2. In the second phase, early implementation (months 13 – 24), the pilot site implements the jail diversion program, hires and trains staff, and conducts trauma-informed care trainings for stakeholders and service providers. The remaining 36 months (months 25 – 60) are the pilot's full implementation phase. The beginning of this phase involves using data gathered as part of the evaluation to fine tune the program model. The pilot site also works with the state leadership in preparing the model for dissemination.

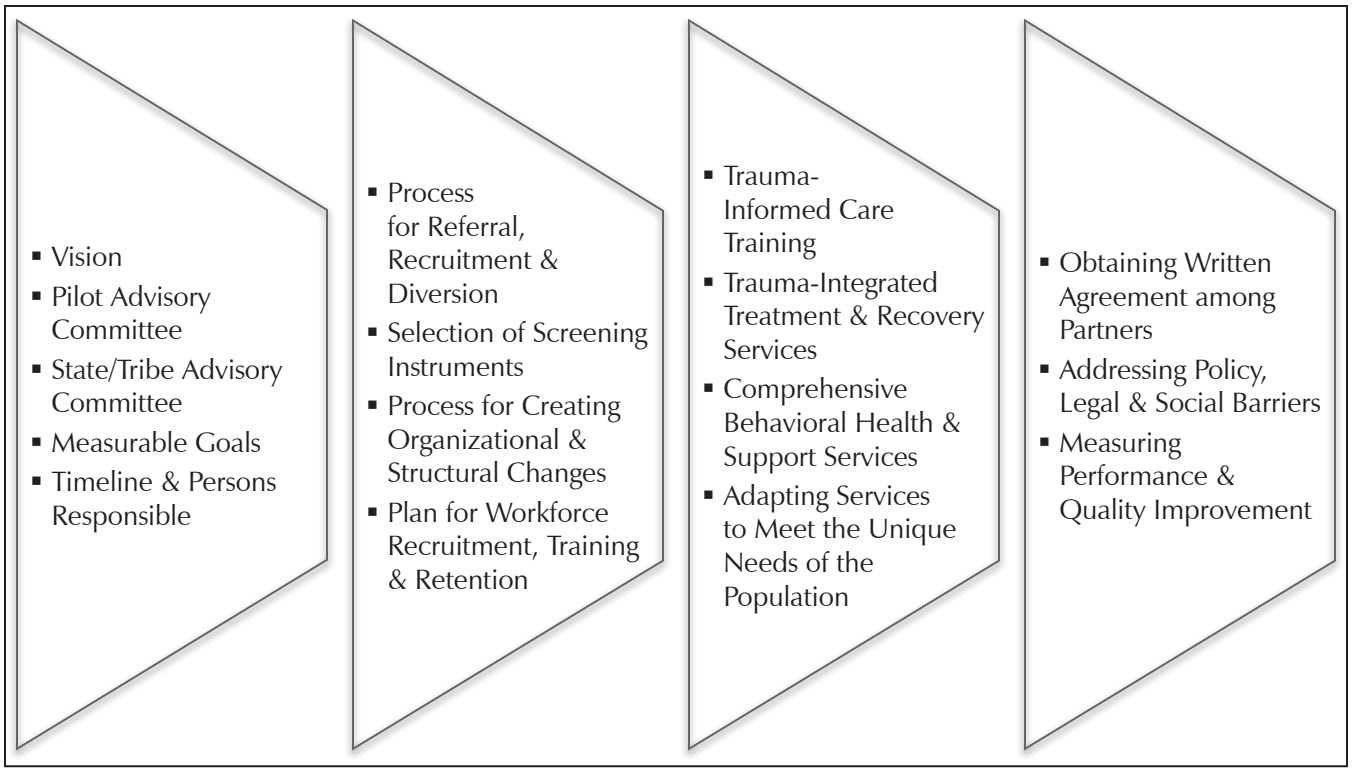

Figure 2: Elements of the Pilot Site Strategic Plan

Each of the grantees has tackled a number of issues when putting together their pilot sites. Review of some of those issues follow.

Target Population

Although the terms of the award allow for the pilot sites to serve veterans and other justice-involved people with trauma disorders, the majority of grantees are serving only veterans. Defining "veteran" can be tricky, since organizations that serve veterans often employ different definitions of the term. Is the definition based on discharge status, whether a person was ever deployed, or whether they served in a combat or support role during deployment? Moreover, while the focus of the pilot sites is on veterans of OEF/OIF, it may be Vietnam or Persian Gulf veterans who are identified by law enforcement, in jail, or in court. In Connecticut, the Pilot Area Advisory Board conceived of the target population as a dart board representing all veterans, but OEF/OIF veterans occupied the central circle – the bull's eye.

Screening for Veterans

Identifying justice-involved veterans requires more than asking "Are you a veteran?" In fact, many people who are veterans in the eyes of the VA are not veterans in their own eyes (e.g., veterans who never served in theater). Asking a similar question as a lead-in ("Did you ever serve in the U.S. armed forces?"), used by the Bureau of Justice Statistics when surveying jail inmates, is considered more effective. Such self-report questions are only a starting point when determining a veteran's eligibility for health and other benefits.

In an attempt to identify and intervene with veterans at the specific intercept points, the pilot sites are using various strategies to screen for military status. In Colorado, the pilot site coordinator worked with the county jail to add an item to the electronic intake system. Now the pilot site staff persons know within 24 hours if a veteran has been arrested and detained in jail. In Illinois, the Cook County pilot site has developed an advanced training — focused on veterans, trauma, traumatic brain injury, and domestic violence — for Chicago police department officers who are in the Crisis Intervention Team cadre.

Connecticut Jail Diversion and Trauma Recovery Services for Veterans Program

In Connecticut the Pilot Area Advisory Board established a set of guiding principles and values to help direct them as they developed the pilot site jail diversion program. These are the principles and values:

- The project is an equal collaborative effort between Veterans, their family members and the involved providers of service. We are partners in this effort.
- Leadership of the project and the goals/interventions and evaluation must include and be driven by Veterans and their families.
- Involvement with police or the criminal justice system is often considered a symptom or cue that a Veteran is in crisis. Early engagement and intervention of Veterans could result in less involvement with police or the criminal justice system.
- Family members can be instrumental in identifying cues that a Veteran is experiencing problems and may be heading toward a crisis situation.
- Individuals serving in a combat zone are exposed to what the military has termed combat operational stress. This is viewed as a normal consequence of service in war.
- Multiple studies report that while approximately 18% of returning combat Veterans are diagnosed with PTSD, a majority of returning Veterans experience a range of trauma-related PTSD symptoms, which may not meet the diagnostic threshold for PTSD. Conceptually, returning combat Veterans' symptoms present along a spectrum of war zone stress response, with perhaps the homecoming transition experience at its base and a full diagnosis of PTSD at its apex.
- Veterans have learned how to use their resources to be successful in deployment and in-theater. These same resources can be used and cultivated to readjust and reintegrate to civilian life.
- There are physiologic responses and changes that occur for individuals when training for combat, experiencing combat, and re-entering civilian life. These responses can be adjusted through education and a variety of traditional and alternative interventions.
- We will strive to identify Veterans in crisis at the earliest possible moment prior to their involvement with the criminal justice system, and intervene to assist them in handling the immediate and trauma-related stressors in their lives.

Developing or Expanding Jail Diversion Infrastructure

Establishing a new jail diversion program requires a lengthy process of developing the necessary infrastructure, including partnerships, screening and assessment protocols, service packages, and linkage protocols. The development of new jail diversion programs can be a slow process as the development of non-traditional partnerships is uneasy and cause for caution among stakeholders.

Expanding into an existing jail diversion infrastructure not only speeds the time required for planning, but allows the program to focus more on workforce development and fine tuning services than on partnership development. This strategy also allows the pilot program to determine an accurate estimate of the prevalence of the new target population by adding items to the existing screen in advance of implementation. This approach allows for a more accurate estimate of the service capacity and needs.

Trauma-Integrated Services

To meet the behavioral health service needs of their participants, the pilot sites are offering an array of trauma-specific services. Most are offering Seeking Safety or the Trauma Empowerment (TREM) model in groups. Some pilot sites are also offering cognitive processing therapy, eye movement desensitization and reprocessing therapy, and the TAMAR group model.

From Pilot Programs to Statewide Implementation

The role of the SMHA in the grant is to provide oversight of the pilot site through the formation of a state advisory committee and to develop and implement an infrastructure building plan for the non-pilot communities in the state.

State Advisory Committee

Per the RFA, the state advisory committee formed by the SMHA must comprise representatives from state "departments of mental health, substance abuse treatment, health, corrections, parole and probation, representatives from military components such as the National Guard, active duty and/or reserve units, United States Department of Veterans Affairs, State Department of Veterans Affairs, State/Tribe judiciary, State Medicaid, pilot sites, veterans' organizations, veterans families, provider organizations and universities interested in the study, training and treatment of trauma." The role of the state advisory committee is to provide oversight of the pilot site activities, not limited to strategic plan development, the jail diversion approach, training activities, and the service packages.

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Integration with Other State Entities

In North Carolina the Division of Mental Health, Development Disabilities, and Substance Abuse Services (DMHDDSAS) leveraged an existing body, the Governor's Focus on Servicemembers, Veterans, and Their Families, as the skeleton for the state advisory committee. In Pennsylvania, the project director from the Office of Mental Health and Substance Abuse Services in the Department of Public Welfare also represents the link between state advisory committee and the PA CARES Task Force (Pennsylvania Americans showing Compassion, Assistance, and Reaching out with Empathy for Servicemembers).

Trauma Informed Care Trainings

Expanding trauma-informed care knowledge to behavioral health service providers and criminal justice agencies throughout the state is important, at the very least, because of the high rate of trauma among justice-involved people with mental illness. In Georgia, trauma-informed care trainings were provided to service providers throughout the state.

Expansion to Other Communities

The State advisory committee also designs and implements a strategy to replicate or expand jail diversion programs in other parts of the state, based, in part on the success of the pilot. In 2010 Massachusetts expanded the reach of its pilot site, allowing for referrals to come from all courts in Worcester County. It also established an expansion site at the Lawrence court in Essex County. Connecticut is using the existing jail diversion infrastructure in its 20 geographic area courts as a method to disseminate knowledge and expand the reach of the program. An 18 hour Veterans Resource Representative Training Program is being provided to all court clinicians over the next two years. By April 2010 approximately half of the court clinicians in the state had received the training.

Looking Ahead

Through January 2011, 160 persons have been enrolled in six of the programs that are accepting participants. It is anticipated by September 2012, the end of the third and second year of funding for the first and second set of cohorts, approximately 750 persons will be enrolled.