Florida Department of Children and Families

Jail Diversion and Trauma Recovery-Priority to Veterans Grant

Strategic Plan
Fall 2010
# STRATEGIC PLAN

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I. Introduction and Overview of the Strategic Plan

Veterans in Florida: The Situation – Good and Bad

Florida is blessed with a large cohort of American military veterans who have made this state their homes. Beginning in the years immediately following World War II and continuing throughout the six following decades that saw major U.S. wars in Korea, Viet Nam, the Middle East, and South Asia – as well as many lesser conflicts and emergency deployments by our military forces around the world – many hundreds of thousands of veterans chose Florida as their homes of record. Today, almost ten percent of the state population, nearly 1.8 million Floridians, can claim veterans’ status.

The vast majority of these individuals are law-abiding and productive citizens who have contributed immensely to Florida’s prosperity, proud heritage, and attraction to people from all parts of the nation and the world. From the large numbers of veterans of the World War II era (many of whom came to this state in the years immediately after that war, and even larger numbers who eventually chose Florida as their residences in retirement) to the almost 160,000 veterans of the current wars in Iraq and Afghanistan, Florida’s diverse veteran population has made a mark as being comprised of stable, hard-working individuals dedicated to building a better home for themselves and their progeny.

But military service is challenging and war and hardship take their toll. Even for those who are spared the trauma of physical wounds or injury, the exposure to combat and related stresses can exact a price on the human psyche. For service members and their families, stressful environments, traumatic events, uncertainty, loneliness, and fear can result in disruptions and altered lifestyles that overwhelm their coping mechanisms.

In the aftermath of Viet Nam – the last major war of long duration – the nation was late to realize the toll taken on veterans of that conflict. Almost 3.5 million Americans in uniform passed through Southeast Asia in the 1960s and 1970s. Over fifty-eight thousand of them died, and more than 150,000 were wounded. Aside from the killed and wounded, substance abuse and mental illnesses became two of the more serious outcomes for those that survived the war. Alcohol abuse and illegal drug use and addiction occurred at increasing rates throughout the long duration of the conflict, and continued for years afterward. Often, these two problems existed side-by-side, one exacerbating the effects of the other. Of those Viet Nam veterans diagnosed with PTSD, 79 percent were also alcohol dependent. Fifty-five percent smoked marijuana.

These disorders often led to anti-social behavior patterns that made it difficult for affected veterans to reintegrate successfully into civilian society. This, in turn, contributed to high incidences of homelessness and, sometimes, confrontations with law enforcement. The scale of the latter was not recognized until long after the war, too late to help mitigate the effects on the nation and on the hundreds of thousands of young veterans and family members experiencing difficulties in their personal lives long after the fighting in Viet Nam had ceased. In the 1980s, an exhaustive study of Viet
Nam veterans and the criminal justice system disclosed that an astonishing 43 percent of these veterans had been arrested by the time of the study. Approximately 12 percent of all Viet Nam veterans were convicted as felons. These are dramatic numbers under any circumstances, but even more so considering that each of the veterans came from a cohort of the population that passed relatively stringent criteria to gain entry into the military in the first place.

This nation’s current wars and their impact on the military personnel and their families bear both similarities and differences to wars of the past. Long and repetitive deployments away from home are the norm. Now in the ninth year of the global war on terror, many service men and women are returning to the combat zones for their fourth or fifth tour of duty, some of them for durations of 12 to 18 months. A generation of military children has been raised with only the infrequent presence of their service member parent. Spouses who have stayed behind have carried tremendous burdens of responsibility while suffering the continual fear of their loved ones being killed or injured. With no end in sight, despair for the deployed and those remaining behind are real and present dangers.

For those in uniform there is good measurement on the results of such stresses. The military has been meticulous in tracking data for those under its direct supervision. The same is not true for family members. There exist only anecdotal reports of the effects on spouses and children. What is known for sure is that the divorce rate among military families is the highest it has ever been in modern times.

The data that exists for service members are troubling. Mental health issues – only one manifestation of which is PTSD – are indicated in about one third of veterans of Iraq and Afghanistan, with women veterans showing higher rates of prevalence than male veterans. Florida’s “Green Paper” (accompanied as an addendum to this strategy) indicates that if Florida veterans suffered proportionately for PTSD present in all veterans of the current wars, then as many as 29,000 individuals have this illness. Alcohol abuse also continues to increase. Among active duty soldiers, the rate of alcohol-related incidents (e.g., DUs, DWIs, bar-room brawls, domestic abuse, etc.) have virtually doubled since the beginning of the current wars. Suicide rates among soldiers are up markedly. Military males are committing suicide at almost double the rate of their civilian male counterparts. The data are so alarming that the Army has created a suicide prevention task force under the leadership of a brigadier general. Similarly, the military reports widespread use of stimulant and pain medication in the combat zones, which in turn has led to concern about subsequent abuse and addiction among returning personnel. All of these manifest problems have led to some concern that if the correct actions are not taken, the tragedy of the post-Viet Nam experience among veterans could repeat itself.

Fortunately, however, the public outpouring of support for veterans of the current wars is much greater than it was in the 1960s and 1970s. Private citizens, advocacy groups, and government agencies have actively reached out to returning veterans – and
included in that effort veterans of past eras. The grant that this strategy seeks to implement is only one manifestation of this trend.

In Florida, communities have come together on behalf of veterans. Several locales (i.e. St. Petersburg, Fort Lauderdale, and Okaloosa County) are exploring the possibility of establishing veterans’ courts -- an outgrowth of the drug court system-- in Florida and the nation (Florida has 112 drug courts and 21 mental health courts currently in operation) that seek to divert non-violent third degree felony offenders or less from unnecessary incarceration to treatment and rehabilitation under the supervision of a joint court-treatment provider team. Private donors, such as the BRAIVE Fund and the Combat Injuries Project, have contributed substantial amounts of money to help both veterans and their family members obtain assistance in addressing some of the problems mentioned above. Advocacy groups such as the Florida Chapter of the National Alliance on Mental Illness and Florida Partners in Crisis are promoting a greater expansion of crisis intervention trainings for law enforcement personnel and other first responders that would help divert unnecessary arrests and instead refer individuals to appropriate treatment and other needed services.

Under the strong leadership of a number of government agencies, Florida is organizing itself to address veterans’ issues early, before they become overwhelming to individual veterans or to the communities in which they reside. For example, in early 2009, the Florida Department of Veterans’ Affairs, the Florida Office of Drug Control, and the Florida Department of Children and Families published the “Green Paper”, an action plan for assisting returning veterans and their families with substance abuse and mental health needs. Earlier (in March, 2008), the late Executive Director of the Department of Veterans' Affairs, Rear Admiral (Ret.) LeRoy Collins, Jr., formed a “Veterans Team” that, in addition to the state agencies mentioned above, included the Florida National Guard, the Florida Agency for Workforce Innovation, and the Florida Agency for Health Care Administration (the state’s Medicaid/Medicare agency), as well as the former Florida Substance Abuse and Mental Health (SAMH) Corporation (a duly appointed body tasked to advice state leaders in all three branches of government on the subjects included in their title). (NOTE: THE SAMH CORP. WAS DISBANDED VIA LEGISLATION EFFECTIVE 6/30/2010)

In short, while the needs of veterans in Florida are great, the state is well positioned to take advantage of the will of Floridians to honor and care for veterans. The combination of public and private resources being made available to render assistance is great, in spite of the fact that economic recession has caused state revenues to decrease, Federal Medicaid reimbursements to diminish, and community services to gradually evaporate. Simultaneously, Florida’s recent initiatives within its criminal justice system (e.g., drug courts, mental health courts, crisis intervention training, criminal law modifications, etc.) offer a solid basis on which to build appropriate (and safe) incarceration diversion processes for non-violent veteran offenders. Several interagency agreements already in place (such as the aforementioned “Green Paper” and a Memorandum of Agreement between the Florida Department of Corrections and the U.S. Department of Veterans’ Affairs arranging for the handoff of medical care for
inmates who are veterans upon their release from prison) will facilitate the integration of effort and close any gaps that would otherwise exist in providing necessary services. Finally, although there remain some gaps in its information base, Florida has done a reasonable job of tracking relevant data that should assist in the building of an efficient model for appropriate veterans’ incarceration diversion.

The strategy that follows seeks to build on what is already in place in Florida, while taking advantage of the additional resources and guidance that the grant it addresses has made available. Florida believes that with a clear vision of how it wishes to care for the needs of its population of veterans and their family members, a mission-oriented direction to help achieve that vision, and the goals and supporting objectives to support that mission accomplishment, the state not only can help veterans in Florida, but can also serve as a model to the rest of the country on accomplish these tasks.

II. Statement of Vision and Mission, Goals, Objectives and Activities

A. Vision Statement

Florida will develop and implement a model state system for identifying veterans with mental health and substance abuse histories and reducing their criminal justice involvement, giving priority of veterans with trauma-related symptoms. The program seeks to do this by diverting these veterans from incarceration and providing to them and their families the necessary support systems to best enable them to live successfully in their communities.

B. Mission Statement

To develop and operate two or more representative pilot programs that will demonstrate the way to transform Florida’s behavioral health continuity of care systems to better serve veterans through diversion from incarceration, when appropriate, and provide them with trauma informed care and support services that will enable them and their families to function as responsible and law-abiding citizens in their communities.

C. Measurable Goals and Objectives

GOAL A: Establish and operate a program of integrated criminal justice and social services that will serve to divert veterans from incarceration and provide them and their families with the means to be contributing, law-abiding citizens in two or more communities in Florida.

Objective 1: Implement a model veterans’ incarceration diversion and support system in Hillsborough County within three months of approval of the strategy by the State Advisory Council.

Objective 2: Establish a model veterans’ incarceration and support system in at least one other locale in Florida, the first of these within 24 months of approval of the strategy by the State Advisory Council.
Objective 3: Provide screening for all booked arrestees to indicate and confirm veterans’ status.
Objective 4: Screen a minimum of 200 individuals for eligibility for diversion per year; divert and serve (through case management and peer support) at least 40 veterans per year; and, provide trauma recovery services to at least 15 of those diverted, per year.

GOAL B: Develop each community program to foster collaborative relationships across local and state levels so that the program can serve as a model to communities across Florida and beyond.

Objective 1: Form a joint council of state and local agency representatives in each community to ensure coordination and collaboration across all aspects of diversion and trauma recovery.
Objective 2: Integrate community efforts among national, state, and local agencies and organizations and will collaborate with the private sector for optimal outcomes for program participants.
Objective 3: Identify early on and work to overcome the policy, legal, social, and other barriers to the permanent implementation of the established programs.
Objective 4: Work to expand the number of similar programs throughout Florida (and the nation) over the years.

GOAL C: Each community program will develop a comprehensive service delivery system to provide trauma informed care and serve diverted veterans and their family members.

Objective 1: Deliver a comprehensive mental health, substance abuse, physical health, employment, housing, life skills training, psychosocial rehabilitation, and vocational training system to diverted veterans and to their family members as needed.
Objective 2: Adapt and modify treatment to meet the unique needs of program participants.
Objective 3: Establish and maintain a peer-to-peer counseling system among veterans so that each diverted veteran can be mentored by a fellow veteran and other individuals with similar life experiences.
Objective 4: Not less than 10 percent of relevant community public employees working in the dual areas of criminal justice diversion and trauma recovery will have been trained in trauma informed care within 18 months of program inception.
Objective 5: Not less than two staff members of all private entities (both for-profit and not-for-profit) will be trained in Trauma Informed Care practices at any given time.
Objective 6: One hundred percent of public and private treatment provider entities will implement best known practices.

GOAL D: Maintain effective outcome-oriented operation of all programs during and beyond the duration of the federally funded grant.

Objective 1: Demonstrate the efficacy of the ongoing programs through data reflecting numbers of veterans successfully diverted, recidivism rates among them, numbers of
full-time and part-time jobs held, cost-savings by the criminal justice system, and accrued community benefits in terms of crime data, taxes paid, and other relevant information, by the time of grant termination.

**Objective 2:** Establish and maintain a “train-the-trainer” system that is self-perpetuating among all programs.

**Objective 3:** Foster a long-term commitment among all participating agencies through a series of interlocking and renewable memoranda of understanding/agreement supportive of program outcomes.

**Objective 4:** Record and maintain critical data and lessons learned to allow continual improvement toward the program’s mission and goals, and serve as a model for replication elsewhere.

### D. Activities, Timeline and Persons Responsible

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
<th>Responsible Party</th>
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<tbody>
<tr>
<td><strong>Infrastructure Activities</strong></td>
<td></td>
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<tr>
<td>State Advisory Council (SAC) Meets</td>
<td>4X December 2010-September 2010</td>
<td>SAC</td>
</tr>
<tr>
<td></td>
<td>2X Yearly October 2010-September 2014</td>
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<tr>
<td>Evaluation and training contracts complete</td>
<td>May 2010</td>
<td>Department of Children &amp; Families (DCF)</td>
</tr>
<tr>
<td>Project Reports to SAMHSA</td>
<td>Yearly, March and September</td>
<td>Project Director, DCF</td>
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<tr>
<td>Grant Continuation Application</td>
<td>Yearly, March</td>
<td>Project Director, DCF</td>
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<td>Strategic Plan Completed</td>
<td>October 2010</td>
<td>SAC, DCF, and Local Advisory Council (LAC)</td>
</tr>
<tr>
<td>Selection of Second Pilot Site</td>
<td>December 2011</td>
<td>SAC</td>
</tr>
<tr>
<td>Replication Guide and Sustainability Plan completed</td>
<td>April 2014</td>
<td>LAC, SAC</td>
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<tr>
<td><strong>Pilot Project Activities</strong></td>
<td></td>
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<tr>
<td>Local Advisory Council meets</td>
<td>Monthly</td>
<td>LAC</td>
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<tr>
<td>Execute contract with local provider</td>
<td>Site 1 March 2010 Site 2 March 2012</td>
<td>Regional DCF</td>
</tr>
<tr>
<td>Hire local project staff</td>
<td>Site 1 by September 2010 Site 2 by September 2012</td>
<td>Northside Mental Health Center, University of South Florida (USF), Florida Certification Board (FCB) (site 1) Site 2-to be determined</td>
</tr>
<tr>
<td>Training for local project</td>
<td>Site 1 August 2010</td>
<td>FCB</td>
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<tr>
<td>Activity</td>
<td>Timeline</td>
<td>Responsible Party</td>
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<tr>
<td>staff begins</td>
<td>Site 2 August 2012</td>
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<tr>
<td>Training Boosters and technical assistance</td>
<td>Site 1 September 2010 Site 2</td>
<td>FCB</td>
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<td>September 2012</td>
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<tr>
<td>Local Service Delivery</td>
<td>Site 1 by Oct 2010 Site 2 by</td>
<td>Northside Mental Health Center</td>
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<tr>
<td></td>
<td>Sept 2012</td>
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<tr>
<td>Local data collection activities begin</td>
<td>Ongoing October 2010 to September 2014</td>
<td>Evaluators-USF</td>
</tr>
<tr>
<td>Submission of required TRAC data as required</td>
<td>Ongoing October 2010 to September 2014</td>
<td>Evaluators-USF</td>
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### III. Project Planning and System Development

#### A. Key Stakeholders, State and Local SAC, Consumer Representation

The controlling body for implementation of the strategy statewide is the State Advisory Council (SAC). The SAC will ensure that program parameters are complementary to the guidelines set by federal authority as administered within Florida by the Department of Children and Families. In essence, the SAC accepts full responsibility for overall guidance and direction of the state level responsibilities for the fulfillment of the grant conditions as set by the grantee, the Substance Abuse and Mental Health Services Administration (SAMHSA).

While the SAC is responsible for the overall direction of the state effort, individual communities within which the model programs are established (i.e. Hillsborough County and other locales yet to be determined) have both the authority and the responsibility to design and implement their own particular programs so long as they operate within the general guidelines of this strategy. It is recommended that in doing so each selected community appoints its own council and publishes its own plan. Council membership at state and local levels should be, in part, overlapping.

Collaboration and mutual support will be the standard for the councils at state and local level. Likewise, that standard will apply to participating governmental and private entities. Such will be the norm in all ongoing operations. Nonetheless, as practicable, interagency memoranda of agreement will be sought to standardize cross-organizational operations throughout the duration of the grant and in the years beyond.

The SAC will organize itself into committees that work to accomplish the specific goals and objectives identified in this strategy. The committees will coordinate with the SAC as a whole and among one another to ensure that continued progress is made and that operations unfold in accordance with the implementing concepts outlined in this strategy.
The SAC, in accordance with the authorities of the Department of Children and Families, shall set the apportionment of grant monies among the model programs as they are formed and in accordance with the time-lines set out in this strategy. At the end of every twelve months the SAC will review the progress made toward the specific goals and objectives of this strategy. Modifications of goals and objectives may be made, but only by majority vote of the SAC and within the parameters of the terms of the SAMHSA grant. All modifications must remain consistent with the vision and mission of this strategy.

Veterans Diversion Grant State Advisory Council (SAC) Members

<table>
<thead>
<tr>
<th>Member Name and Title</th>
<th>Organization</th>
<th>Contact Info</th>
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<tr>
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</tr>
<tr>
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</tr>
<tr>
<td>Member Name and Title</td>
<td>Organization</td>
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| Term Care and Behavioral Health Bureau of Medicaid Svcs. | Administration | Tallahassee, FL 32308  
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<table>
<thead>
<tr>
<th>Member Name and Title</th>
<th>Organization</th>
<th>Contact Info</th>
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<tbody>
<tr>
<td>Dave Kershaw, Ph.D., Director of Acute Care Services</td>
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<tr>
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<tr>
<td>Member Name and Title</td>
<td>Organization</td>
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**Veterans Diversion Grant Local Advisory Committee (LAC) Members**

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<thead>
<tr>
<th>Member Name and Title</th>
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<th>Contact Info</th>
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<td>Jeff Watts, Adult Mental Health Director</td>
<td>Department of Children and Families (DCF) Substance Abuse and Mental Health Circuit Office</td>
<td>Department of Children and Families Office of Substance Abuse and Mental Health 9393 North Florida Ave. Tampa, FL 33612 (813) 558-5706 Email: <a href="mailto:jeff_watts@dcf.state.fl.us">jeff_watts@dcf.state.fl.us</a></td>
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<tr>
<td>Elizabeth Statzer, Adult Mental Health</td>
<td>Department of Children and Families (DCF) Substance Abuse and Mental Health Circuit Office</td>
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<tr>
<td>Dave Kershaw, Ph.D.,</td>
<td>Northside Mental Health Center</td>
<td>12512 Bruce B Downs Blvd</td>
</tr>
<tr>
<td>Director of Acute Care</td>
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<td>Marsha Lewis-Brown,</td>
<td>Northside Mental Health Center</td>
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<tr>
<td>Executive Director</td>
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<td>Thomas Homlin, LCSW,</td>
<td>Northside Mental Health Center</td>
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<tr>
<td>Brad Baker, Peers</td>
<td>Northside Mental Health Center</td>
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<tr>
<td>Asha Terminello,</td>
<td>Agency for Community Treatment services,</td>
<td>4612 North 56th Street</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>Inc. (ACTS)</td>
<td>Tampa, Florida 33610</td>
</tr>
<tr>
<td>Ann Herman, Captain,</td>
<td>Hillsborough County Sheriff’s Office</td>
<td>HCSO Jail Division</td>
</tr>
<tr>
<td>Inmate Support Bureau</td>
<td></td>
<td>Post Office Box 3371</td>
</tr>
<tr>
<td>Marie Marino, Assistant Public Defender</td>
<td>Office of the Public Defender, Circuit 13</td>
<td>Public Defender’s Office- 13th Circuit</td>
</tr>
<tr>
<td>Frank Strom, Manager,</td>
<td>Hillsborough County Veteran’s Affairs</td>
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<tr>
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<td></td>
<td>10119 Windhorst Road</td>
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<tr>
<td>Robert Parkinson,</td>
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</tr>
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<td>Manager, Crime Prevention and Coordinating Unit</td>
<td>Hillsborough County</td>
<td>10119 Windhorst Road, Tampa, FL 33619</td>
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<tr>
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</tbody>
</table>
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| Research Assistant Professor  | Louis de la Parte Florida Mental Health Institute |                                                           |
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B. Barriers

Barriers to implementing the grant program include:

• **Funding** for needed services in the mental health and criminal justice arenas has seriously eroded. Florida continues to struggle with general revenue reductions, and the forecast for next year’s legislative session is calling for additional budget cuts. The state invests enormous sums of taxpayer dollars into costly, back-end services but does little to provide services needed to facilitate community re-entry and reintegration.

• The **justice system**, by default, serves as the safety net for the public mental health system and is ill-equipped to do so. Florida’s jails and prisons have been forced to house an increasing number of individuals who are unable to access critically needed and competent care in the community.

• **Stigma** significantly impacts the behavioral choices that veterans make about mental health care. The consequences of stigma associated with mental illnesses are well known; however, within the culture of the military, even more powerful stigmatizing attitudes may be held by many military personnel (Greenburg et al., 2007). Many service personnel describe substantial concerns that being labeled a psychiatric patient will be detrimental to their careers (ibid) and would be seen as a sign of weakness which, if revealed, would expose them to ridicule.

• **Lack of veteran peer support** is also an important barrier to view within a military context. The military culture encourages mutual support between personnel (the “buddy system”), expecting individuals to closely rely on each other for both physical and potential psychological needs (Gould, 2006). A distressed soldier may feel that he/she has let him/herself and his/her buddies...
down if he/she asks for help outside of his/her peer group (Applegate, 2003). Veterans helping veterans in Florida is loosely organized and is not necessarily focused on assisting veterans in obtaining needed services, and supporting a peer veteran’s recovery.

- **Difficulties in ready access to Veterans’ Administration services** pose a barrier due to perceived long wait times for appointments at VA facilities. Additionally, Florida has large numbers of Reservists and National Guard members whose benefit availability may be limited, triggering increased utilization of community treatment resources rather than the VA.

C. Organizational Changes

All primary community mental health providers in Hillsborough County will routinely ask persons who are seeking or obtaining services about their military service history as part of the persons’ mental health assessments and/or psychosocial histories. Inquiries will be specific as to the era in which they served and, if pertinent, in which war they may have fought. This will be done in order to better provide for peer to peer counseling and mentoring of both the veteran and the veteran’s family, to screen for signs of mental distress (and to be especially wary of any indications to inflict self harm), and to identify the range of services and benefits that may be applicable.

D. Workforce Recruitment, Training and Retention

Recruitment and retention of adequately trained personnel is a priority of the local pilot program. Preference will be given to veterans for all new positions funded by the program. Developing and maintaining an effective workforce requires the same sort of highly planned and systematic approach as any other organizational function.

*Recruitment* – One reason that it is difficult to recruit personnel into mental health jobs, particularly at the paraprofessional level, is that salaries for entry-level or frontline jobs in mental health are often comparable to less demanding entry level positions. Moreover, mental health agencies often have poor track records in recruiting. This project will have high visibility in the pilot communities and must take a proactive approach to employee recruitment. While the issue of low wages cannot be adequately addressed through this project, every effort will be made to provide career advancement opportunities for project staff members. The diverse array of community partners involved in the project assists in widening the net for finding qualified candidates.

Another issue in workforce recruiting is that some veteran peers may not be prepared for full-time employment. Using a flexible hiring pattern of part-time placement allows the project to hire staff members who are still working on their own reintegration process. In addition, it assists in providing the option for hiring a wider diversity of peer specialists so that all project participants may be matched with a “true peer”.


Training – The project employs a comprehensive training approach for staff members of the project and community partners. Training is focused on evidence-based programs and best practices in trauma-informed care, co-occurring disorders and community reintegration. Training for the project consists of the following provided through project funds and other leveraged partnerships:

- Basic training in Trauma-Informed Care for representatives of all agencies in the community continuum of care for the project
- Training in Seeking Safety – Veteran’s version for staff of the key provider agency, including Veteran Peer Specialists
- Training in Seeking Safety - for other community mental health and substance abuse providers
- Training in Motivational Interviewing for key project staff and supervisors and selected community partners
- Basic Peer Support Specialist Training for Veteran Peer Specialists
- NAMI Peer-to-Peer Training (Train the Trainer) for Veteran Peer Specialists
- Training in Illness Management and Recovery model for clinical staff at the provider agency.

All grant funded staff will complete the full orientation/training required by the provider, Northside Mental Health Center, for all new clinical staff. This curriculum includes but is not limited to, corporate compliance, cultural and age based competencies, abuse reporting, clinical risk assessment, Florida laws regarding civil commitment and patient rights, documentation standards, infection control, fire safety, verbal de-escalation, and confidentiality.

Retention - Some of the common factors cited by mental health workers who intend to leave their positions or have left their positions are: poor compensation (salary and benefits), stress/burnout, little or no advancement potential, better opportunities in another field, attainment of higher education, and lack of administrative support. One strategy employed by this project to improve retention is the recognition of the Veteran Peer Support Specialists as critical parts of the clinical team. This status will help staff members to maintain a sense of involvement in project success and recognition of their contributions to positive outcomes for project participants.

The creation of the Certified Recovery Peer Support Specialist –Veterans (CRPSS-V) credential provides a level of professional recognition for project employees and a clear description of the scope of practice within a range of identified competencies. All Peer Specialists employed by the pilot projects will be assisted in obtaining this credential. The specialized Veteran Peer Support credential is unique in the civilian human services system and can create a national model for this type of work. Once certified, the Peer Specialist have access to a wider stream of employment opportunities. Ongoing continuing education requirements for certification assure that CRPSS-Vs will receive up-to-date training on best practices in the field.

IV. Implementation Strategies and Considerations
The State Advisory Council will ensure that at least two model programs that successfully divert eligible veterans away from potential incarceration to treatment and other support services are established in Florida during the course of the SAMHSA grant entitled Veterans’ Jail Diversion and Trauma Recovery.

The first of these model programs will be established in Hillsborough County. The second and any subsequent programs will be established in communities yet to be determined. It will be the responsibility of the State Advisory Council, working with state and local authorities and contributing entities, to designate, plan for, and allocate resources to the selected sites.

Each program will be self-sustaining beyond the life of the Veterans’ Jail Diversion and Trauma Recovery grant.

Systems will be established to screen for veterans’ status for all booked arrestees within the jurisdiction of each program. Veterans’ status and eligibility for VA benefits must be an integral part of the program and will be determined by appropriate military, legal, and clinical ruling.

Screening and verification must be done in quick order so as to not interrupt the expeditious course of the criminal justice system. At the same time, diversion of eligible veterans must be done in a timely manner in order to avoid the interruption of VA entitlements commensurate with incarceration.

Law enforcement and treatment/service support personnel must work as a team toward the common vision of this strategy. Similarly, state and local entities must collaborate to maximize available resources, ensure mutually supporting policies and procedures, and avoid conflicting and unnecessarily time-consuming obstacles to the smooth integration of effort.

Formal training addressing proper methods of trauma informed care will be given to the requisite number of public officials working within the program; not less than ten percent of them will be current in such training. Programs will strive to train as many individuals in this manner as practicable. Trained individuals will lend their expertise to all others working in the areas of diversion and trauma recovery.

All other entities (e.g., not-for-profit and for-profit organizations) who partner and/or contract with public agencies and officials working the established programs will similarly ensure that a critical mass of their individual staffs are also formally trained and current in trauma informed care. That critical mass is defined as not less than two individuals per organization. However, the larger the organization, the greater the number of trained individuals would be a desired practice.

All organizations (both public and private) will become knowledgeable of and operate in compliance with “best-known-practices” in their respective fields.
Since each program is to serve as a model for other communities, operational techniques must be replicable. Data must be recorded and maintained; outcomes must be measured. Both successes and setbacks must be analyzed and recorded as lessons learned so that others can avoid pitfalls and streamline their procedures in order to achieve successful outcomes. In so far as possible, the model program should offer other communities the opportunity to learn from its own experiences.

Each program must offer a wide range of support to address risk factors that contribute to the potential of the veterans’ interface with the criminal justice system. It is insufficient to merely divert eligible veterans from incarceration. Programs must include an assessment of needs and make arrangements to provide for those needs with an eye to the veteran (or relevant family members) eventually assuming responsibility for self-support.

The scope of services must include – when relevant – mental health and substance abuse treatment, health care in general, housing, employment skill training and job placement, life skills management, psycho-social rehabilitation, and other life support services as needed. In addition, those eligible will be referred and linked with any Veterans’ Administration benefits or services to which they are entitled.

Veterans and relevant family members must be involved in the solutions to their own problems and resolution of their own issues. They must be encouraged to develop an ethos of self-support, civic responsibility, and respect for and compliance with the laws and norms of society.

Effective programs will serve as the linchpin connecting all supporting entities to the needs of the veterans. Integration of effort should supersede independent resolution of the separate facets of the veterans’ particular difficulties. Organizational and policy procedures that maximize communication, cooperation, and specialization of effort by affiliated entities will be the goals. Agility and accuracy in identifying needs and responding to them in a timely manner must be the standard.

Care will be taken to mold the menu of services toward the individual veteran and/or family member(s). Programs will avoid a “one-size-fits-all” mentality. Case assessments will be individualized, based on background information and direct interface with the targeted veteran. All information must be verified and terms of support mapped out in coordination with the contributing entities and the veteran. Both the supporters and those being supported must have clear objectives that in their totality constitute mutual effort toward trauma recovery and eventual resolution of the impediments to the veterans’ adjustments into accepted norms of behavior within the community.

While local programs will have ultimate responsibility for their own organizational structure and operational procedures, they must integrate all government capabilities and available resources from local, state, and national levels. Whenever practicable
and not in conflict with program standards, assistance and support from private entities will be integrated into the mix of support services. The combined effort must invariably contribute to optimal outcomes for the individual veteran and relevant family members.

Treatment will be based on clinical evaluation and will be programmed to meet the needs of the individual within the capacity of available resources.

Peer-to-peer relationships will be established that best match the background of the veterans being served (e.g., gender, generational cohort, military experiences, etc.). Similar peer-to-peer relationships will be considered for family members.

All activities and involvement of local supporting entities (both governmental and non-governmental) will be organized with the intention of continuing commitments long beyond the duration of the federally funded grant. As a minimum, programs must be prepared to continue not less than three years beyond the grant funding flow and should be designed to last for years after that.

Outcome measurements are critical to the demonstrated worth of the program. All data must be objective and analysis thereof unbiased. The paramount purpose of the program goes beyond the limited success that may be realized within a given community or of serving the needs of individual veterans and their families therein. Instead, the paramount purpose must be to serve as a model for other communities in Florida and elsewhere that wish to similarly ensure proper diversion of veterans from incarceration while meeting their and their families’ underlying support needs and addressing their risk factors.

As appropriate, mutual agreement among government agencies should be acknowledged as a matter of routine (a letter of understanding, for example, would suffice; memoranda of agreement or understanding would be ideal as the occasion demands) in order to build toward long standing commitments and integration of effort.

Education as to what works and what does not must be continuous and shared widely among participants – both beneficiaries and supporters – in the program. Lessons learned and “train-the-trainer” techniques must be embedded constructs of each program.

A. Process for Referral, Recruitment, Screening & Diversion

Pilot Area Diversion and Intervention Strategies

Overview

The Hillsborough County Jail Diversion Trauma Recovery program (JDTR) identifies and engages veterans with trauma related illnesses at arraignment and subsequent court hearings and will attempt to divert eligible veterans from jail and prison into
meaningful recovery-oriented activities. The JDTR program provides post release peer support, case management, and trauma-recovery interventions.

The front end diversion processes involving referral, identification, and tracking are described below. These processes are greatly facilitated by the incorporation of two key, non-grant funded entities: the Forensic Behavioral Health Unit of the Office of the Public Defender and the Veteran’s Justice Outreach Clinician (VJO). Both the Forensic Behavioral Health Intervention Unit (FBHI) of the Public Defender’s Office and a Veteran Justice Outreach clinician (VJO) (who is employed full-time by the local VA) are integrally involved in the tracking of veterans through the criminal justice process.

The back end intervention services are described below. An important aspect of the intervention is the prominent use of veteran peer specialists as the foundation for a continuous, consistent, and supportive relationship with trauma afflicted persons during incarceration, at the transition between jail and community, and during active, community treatment that includes an evidence based trauma recovery intervention, Seeking Safety.

**Process for Referral, Screening, and Diversion**

Referral, identification, screening, and diversion are planned to occur at arraignment and in dispositional courts. The Sequential Intercept Model (Munetz and Griffen, 2006) was used as a framework to guide thinking about diversion strategies and to develop a process for referral, recruitment, and diversion of veterans. In order to divert veterans from jail with the widest range of possible charges, diversion activities will occur at Intercept II during arraignment for misdemeanor charges and, for more serious charges, at Intercept III during pre or post adjudication stages in dispositional courts including special docket violation of probation and drug courts. The relation between the JDTR staff, VJO and Public Defender’s Office within the sequential intercept model is illustrated in Appendix 1. Because the target population of this grant is veterans involved in the criminal justice system who have a trauma related issues, eligibility criteria includes veteran status as well as certain clinical and legal requirements. These criteria are summarized below in Table 1.

**Table 1. Eligibility Criteria**

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<td><strong>Inclusion</strong></td>
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<td>General (without honorable conditions)</td>
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<td>Other charges not on excluded list that provider and State Attorney agree as</td>
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Veteran Status Initial Identification

The project has adopted a “trust then verify” approach to initial veteran identification in which veterans self-identify their veteran status at initial intercept at arraignment or more downstream in the criminal justice processing. The JDTR staff has established two direct contacts within the local VA medical center to verify eligibility using their databases. Each day two files are emailed separately to the local VA medical Center Department of Social Work and the VA Justice Outreach Clinician. The first file contains a numbered list of the names of all persons self-identified as a veteran in first appearance court or other courtroom within the past day and a notation that they are clinically eligible or ineligible for the program. A second file contains a numbered list of the corresponding last four digits of each person’s Social Security Number and their date of birth. Within 24 hours of initial email receipt, the VA staff returns the first list with verified veteran status information. Using this procedure, the VA Justice Outreach Clinician becomes a single point of contact for referrals to the VA system of care for all persons identified by JDTR staff regardless of program eligibility.

Intercept II – Arraignment

Veterans will be identified by self-report at arraignment using a self-report question recommended by the Bureau of Justice Statistics for veteran identification in the criminal justice system. Persons who respond affirmatively will be asked to complete the brief eligibility screen (see Appendix 2). If a person’s legal charges preclude diversion at arraignment but he/she may be divertible at a more “downstream” intercept, (e.g., in a dispositional court), JDTR staff will provide contact information so that the person may re-engage program staff a later point in the criminal justice process, JDTR staff will also notify the VJO and FBHI for tracking and potential follow-up.

Intercept III – Post Arraignment

Post arraignment, veterans will be identified though several different mechanisms. In VOP court where rapid acceptance into diversion program is required to keep the docket moving, grant staff will be available in the courtroom for eligibility screening. It is anticipated that in many cases, a screening will have occurred prior to court appearance at the request of defense counsel or the defendant. In other dispositional courts where rapid release is less likely and there is time to craft a diversion plan prior to release (e.g., drug court), eligibility screening may occur prior to or during appearance and may be performed by court, VA, or provider staff who have been trained on the screening
tool. A flowchart of the arraignment and post arraignment identification and screening process is attached as Appendix 3.

Other Referral/Identification Mechanisms. In addition to case findings by staff, outreach to potential participants will be achieved by using the computerized information kiosks that are located in every housing unit at the jail. A toll free number to reach grant staff and the VJO will be loaded into the kiosk information.

Verification of Self Reported Veteran Status:

The Veteran Justice Outreach clinician or designee will check VA database systems for veteran status. The following databases will be checked.

- HINQ – HINQ contains information for all veterans served in VA hospital system;
- VBA – BIRLS contains information for all veterans in the military after 1968 and those who served prior to 1968 and who have applied for disability or educational benefits); and
- If veteran status cannot be verified through the above data bases, information will need to be obtained through Military Records.

Eligibility Screening

Once an inmate/defendant is identified as a possible veteran, Peer Specialists, the VJO, or other provider staff will complete a brief face to face interview to determine clinical and legal eligibility for this program. The brief (less than five minutes) screening tool (see Appendix 2) includes questions reflecting veteran, clinical, and legal status related to program eligibility.

Military Discharge Status

Potential participants will be asked to identify their military discharge status and provide demographic/biographic information so that this information can be verified by the VJO.

Clinical Screening

The clinical items on the screening tool include presence of PTSD and depression related symptoms and history of exposure to possible trauma related events. For PTSD screening, a four item primary care PTSD screen will be used (PC-PTSD, Prins et al, 2003). The PC-PTSD is a four-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the

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VA. The screen includes an introductory sentence to cue respondents to traumatic events. The screen does not include a list of potentially traumatic events, but additional questions regarding exposure/witnessing of traumatic events have been added to the screening tool used in this diversion program. For depression, staff use two depression-related questions from the Structured Clinical Interview for DSM-IV (SCID-CV; First et al, 1996)\(^3\). Any person who endorses three or four items on the PC-PTSD screen, or either of the depression-related questions and who has a history of traumatic events will have a presumptive trauma related illness. In cases where a trauma related disorder is suspected but not detected in the screening process, the VJO or the licensed JDTR staff can perform supplementary assessment to evaluate clinical eligibility.

**B. Intervention Strategy Post Diversion Services**

**Provision of Services**

The Jail Diversion and Trauma Recovery Program will work closely with veterans who exhibit trauma-related difficulties, their families, and significant others to ensure that the veterans have access to the full array of needed and appropriate community services and to ensure that services are flexible and responsive to individuals’ unique and changing needs.

The proposed service model has three distinct components for grant funded services: 1) peer support; 2) case management; and 3) trauma-recovery interventions such as “Seeking Safety” or individual cognitive behavioral therapy. Together, these three interventions help persons recover from trauma related difficulties by strengthening the individuals’ ties to services, family, and other support mechanisms, providing practical support during the critical post release period, directly providing empirically based trauma recovery interventions, and indirectly encouraging and supporting participation in other recovery oriented interventions (e.g., alcohol and drug treatment, vocational training etc). The maximum time that a person may be enrolled in the grant is one year, although each service component may be applied for durations less than a year, based on each person’s individual needs and court related requirements.

**Peer Support**

Peer support will be provided for up to 12 months post release. The program anticipates that as many as six part-time veteran peer specialists will be hired. Peer specialist services can be provided as an overlay/adjunct to services already received by veterans involved in community based care, or can supplement legally mandated treatment. Peer support specialists provide a hopeful model for recovery and provide assistance to individuals in accessing both formal and natural services/supports.

**Case Management**

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Case management services will be offered at two durations: 1) short-term case management for 30 days post release; and 2) long-term case management for up to 180 days post release. The first 30 days after jail release is a high risk period for legal recidivism and all participants will receive short-term case management. Without immediate access to medications, housing, and recovery support services, persons with behavioral health histories are particularly vulnerable to re-arrest. During the first 30 days post release, a formal level of care assessment will be completed in order to justify on-going case management and to guide transition to other levels of care. If needed, a level of care assessment can be performed prior to diversion in order to recommend to legal decision makers the post diversion interventions that are best suited to address a veteran’s clinical risk factors for re-arrest. Program staff will utilize either the Level of Care Utilization system (LOCUS 2000 AACP) or ASAM-PPC-R2 tools. Specific referral forms will be used to refer a consumer to another program within the provider agency and the service delivery subcommittee will codify referral pathways/procedures to programs outside of the provider agency.

Trauma Informed Care

Seeking Safety: All persons enrolled in this program shall participate in a trauma recovery intervention. Northside Mental Health Center (NMHC) will offer weekly groups using the “Seeking Safety” curriculum and offer individual cognitive behavioral therapy, as appropriate. Clinicians and peer specialists at NMHC will be trained in the Seeking Safety model and will co-facilitate these groups. A licensed master’s level clinician will hold the lead Veteran Peer Support Coordinator position, with the expectation that individual, trauma recovery oriented cognitive behavioral therapy can be provided by program staff as well. Persons may receive trauma recovery services at other programs if appropriate (e.g., VA services, residential drug treatment).

Phases of Intervention

Services may be provided for up to one year and are planned to occur in three phases to promote recovery by setting therapeutic and services expectations and program boundaries. Time frames are approximate.

Phase 1 – Engage/Assess/Link, 0-1 month post release

Services - All three service components provided.

- During the first 30 days after admission, veterans will receive a comprehensive assessment in which severity, chronicity, and disability levels will be determined and diagnostic issues clarified. Within those first 30 days post release, program staff and the veterans will collaboratively develop an individually tailored plan of care incorporating evidence based practices and specialized services targeting the unique experiences and needs of each of the individuals. This plan will be coordinated and
integrated with the treatment plans developed by other treatment providers.

Objectives
- Assessment of immediate needs and level of care
  - During the 30 day engagement period a formal level of care assessment will be used to help determine if case management services will continue beyond 30 days from enrollment. The LOCUS or ASAM-PPC-R2 will be completed by the veteran’s lead clinician to help guide entry into a case management clinical pathway
  - mTBI screen for mild head injury
  - LSI-R, LSI-SV or other criminogenic risk/need tool
- Psychiatric Evaluation/Medication management obtained according to fund source, availability, and consumer preference. Whenever possible, the VA shall be used for pharmacy benefit and medication management
- Stabilization of acute symptoms if needed
- Motivational enhancement (all staff will be trained in motivational interviewing techniques)
- Develop Recovery-Oriented Action plan
- Address/link to services for educational/vocational/social recovery
- Actively problem solve to address immediate needs (housing/medical)
- Engage participant with local NAMI Peer-to-Peer or Family-to-Family groups or internal peer support group meetings.

Phase 2 - Active Treatment, 1-9 months post release

Services
- Peer Support
- Case management provided for up to six months if supported by level of care assessment (ASAM-PPCR2 or LOCUS)
- Trauma recovery interventions (NMHC, Vet Center or other provider); Continue monitoring/support
- Participation in other recovery oriented activities (e.g., vocational rehab, educational/vocational pursuits)

Objectives
- Initiate and sustain active treatment for trauma related difficulties
- Strengthen natural supports and relationships
- Complete referral/application process for ancillary services
- Sustain participation in other program such as drug treatment

Phase 3 - Transfer of care/termination 9 -12 months post release

Services
- Peer Support
No formal case management offered but peer specialists can consult with staff to problem solve availability/access issues

- Trauma recovery intervention

Objectives

- Completion of trauma recovery interventions
- Transfer to appropriate provider if needed

After jail release, all participants can receive grant funded peer support and trauma-recovery interventions for up to one year. Case management services, while available to all participants during the first 30 days post release, will be available to participants beyond 30 days if they demonstrate a need for this service, but then only up to six months post release. Local experience with previous diversion and reentry programs suggests that the majority of persons diverted require some degree of immediate assistance in the first month following diversion/release. In an existing local jail/prison re-entry program, many persons with mental illnesses who return to the community require frequent contact/assistances for several weeks post release but exhibit a diminished need for case management services as their immediate needs are addressed. The program anticipates that a majority of participants will benefit from short-term case management, but only a minority will require case management beyond 30 days. Regarding other interventions within the community behavioral health system of care, the program anticipates that a veteran will likely participate in a number of non-grant funded services in order to reach self-identified recovery goals. Ideally, the selection of services and interventions would be consumer-centered and guided by consideration of consumer stage of change and phase of recovery. However, the program recognizes that participation in treatment services may be required as a condition of release, probation, or pre-trial intervention.

Figure 1. Availability of grant funded service components

<table>
<thead>
<tr>
<th>Service Component</th>
<th>Month after Diversion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5 6 7 8 9 10 11 12</td>
</tr>
<tr>
<td>Peer Support</td>
<td>Available to all participants</td>
</tr>
<tr>
<td>Case Management</td>
<td>Can receive if Level of Care criteria meet</td>
</tr>
<tr>
<td>Group Trauma Recovery</td>
<td>Available at NMHC</td>
</tr>
<tr>
<td>Individual Trauma Recovery</td>
<td></td>
</tr>
</tbody>
</table>

A service delivery subcommittee of the local advisory group will be convened quarterly to examine the service array and help ensure that the veterans' needs are being addressed. This service delivery subcommittee should include VOA, Voc Rehab, ACTS, DACCO, Tampa Crossroads, Homeless Coalition, VA, to coordinate services and give program management a local point of contact if access issues emerge).

V. Interagency Cooperation
A. Memorandum of Understanding and Partnership Agreements

The success of the Jail Diversion and Trauma Recovery Program will largely depend on how well the numerous state, local, and private agencies coordinate in order to provide efficient services to veterans. Though many of the agencies involved in this project have implicitly agreed to work together by participating on state and local Advisory Councils, the Program is seeking to formalize these relationships in the form of memoranda of understanding (MOU). Please see Appendix 4 for copies of the signed Hillsborough County Veterans Jail Diversion Trauma Recovery Project Memoranda of Understanding.

Some of the agencies participating in the Jail Diversion and Trauma Recovery Program already have an agreement to work together. For example, The Florida Department of Corrections has a Memorandum of Agreement with the U.S. Department of Veterans Affairs’ local VISNs, which will facilitate the work of this program. See Appendix 5.

B. Contracts

In addition to the MOUs the Program also has reached contractual agreements with the local mental health provider in Hillsborough County (Northside Mental Health, Inc.), the University of South Florida (evaluation), and the Florida Certification Board (training and peer certification), to provide the services described in this strategy. See Appendices 6-8.

VI. Ongoing Program Refinement, Evaluation and Sustainability

A. Refining to Meet Consumer Needs

Based on our preliminary work with the target population we do not anticipate making any changes to the basic Seeking Safety curriculum or to the type of services provided by the peer specialists, case managers, or therapist employed in this program. Local data about the needs of persons re-entering the community after incarceration had been previously gathered using the GAINS re-entry checklist for persons with SMI who are returning to the community after a period of incarceration. While this data provides some guidance on the type of services that may be needed, we expect that veterans, as a group, will have a somewhat different pattern of needs than justice involved persons with severe mental illness and will certainly have a different set of referral pathways open to them. All participants will participate in an end of service evaluation of their own progress and the programs ability to meet their needs. These data will be reviewed within existing continuous quality improvement processes at the provider agency and within the grant’s local advisory council. Larger system level service gaps and program modifications can be addressed within ongoing acute care system stakeholder meeting, a region wide Veteran Homeless Recovery Demonstration Project meeting and the Sate Advisory council meeting.
The Jail Diversion/Trauma Recovery Program (JDTR) is a part of the Acute Care Services Division of Northside Mental Health Center, Inc. The JDTR is staffed with four fulltime equivalent (FTE) staff, including a full time licensed Master’s prepared clinician/case manager supervisor and a mix of peer specialists and case managers, not to exceed three FTEs.

**Minimal Numbers Served** - Based on pilot data taken from arraignment and through informal polling of staff in Violation of Probation (VOP) and drug court, the following target numbers are anticipated

<table>
<thead>
<tr>
<th>Numbers Served</th>
<th>Year One</th>
<th>Year Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened during Arraignment or in Dispositional Courts</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Diverted (Intercept II or III)</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Served by Peer Specialists after Diversion (any duration)</td>
<td>40/year</td>
<td>40/year</td>
</tr>
<tr>
<td>Served by Case Manager for &lt;30 days</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Served by Case manager for &gt;30 days&lt;180 days</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Trauma Recovery Intervention at NMHC</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

**B. Evaluation**

Measuring performance and assuring quality improvement.

The evaluation plan is in compliance with the cross-site plan developed by the technical assistance team for SAMHSA in both performance and outcome measures. The evaluation plan includes identification of veterans at the pilot project, which are incorporated into the initial screening process. Because the Hillsborough County Sheriff’s office is unable to add an additional question to its booking procedure immediately, a plan has been developed that will involve identifying veterans pre and post arraignment via multiple avenues. The Veteran Justice Outreach specialist from the James V. Haley VA has worked extensively at the central booking jail for Hillsborough County. He will refer people who he identifies through his work that he feels are a fit with the SAMHSA JDTR diversion. Pertinent data will be put on computerized information kiosks that are located in each housing unit in the jail asking people to self-identify as having been in the US armed forces and a toll free number will be provided. Such self-identification will occur at arraignment (also known as "preliminary presentation" or "first appearance court"), which is held daily and typically within 24 hours of being booked into jail. Post arraignment people will be identified via contacts grant staff have with the Public Defenders' Office and violation of probation or VOP court staff. Once people are identified by any of these means an additional screening will be conducted by study staff to determine eligibility for the program. Specific protocols for the collection of screening information for these various scenarios will be developed so that: a) the required screening data can be collected; and b) the FMHI evaluation team can be notified of the need to approach the persons for
enrollment in the evaluation study so that they can approach people for enrollment within the required 14 day window.

Hillsborough County currently utilizes the Brief Jail Mental Health Screen as part of its criminal justice screening process. In addition, the Local Advisory Council has developed a brief screening tool to determine a person’s eligibility for the project. Eligibility for the program will be based on veteran status, trauma related issues, and legal status. Those with mental health issues who do not meet the threshold for trauma, or who are not veterans, will be referred to community services independent of the pilot project. Once determined to be eligible, the veterans will be asked about their interest in enrolling in the program. Baseline assessment of the veterans will occur within 14 days of the veterans’ enrollment in the program. Eligible veterans meeting the threshold for trauma and legal status will receive a baseline assessment, including the SAMHSA protocol local instruments to be determined. The program is currently considering the Working Alliance Inventory to better understand the impact of the peer counselors and the Level of Service Inventory Revised (LSR-V; Andrews & Bonta, 1995). The LSR-V is a measure of criminogenic need and measures four general types of risk factors (criminal history, criminal attitudes, criminal associates, and antisocial personality).

As required by the multi-site research protocol, data will be collected as baseline, 6 months and 12 months. FMHI research staff will work with JDTR staff to follow and locate participants. CMHS NOMS data will be entered into the TRAK website as required. FMHI will finalize all data collection tools and procedures and submit an application to the University of South Florida’s Institution Review Board (IRB) to ensure that data collection complies with all applicable federal and state regulations regarding the protection of human subjects. Research staff will obtain a signed informed consent approved by the IRB before any data are collected from participants and staff. This includes surveys, information from charts, information from other sources, and instruments required by the cross-site technical assistance team. Releases of information will also be obtained in order to obtain information from criminal justice databases and medical records. Staff approved by the IRB as investigators on this research project will obtain a signed informed consent approved by the IRB before any data are collected from participants and staff, as well as a signed release of information before any chart information is collected.

The frequent contact with the Veteran Justice Outreach Specialist from the Haley VA (Tampa) and involvement of the Veteran Peer Support Specialist will aid in retention of project participants. The very nature of diversion programs also provides a strong incentive for program completion when jail time may be the alternative.

The evaluators understand that the interaction of the Statewide Advisory Committee or SAC to the pilot project and the evaluators is an integral part of this project. DCF staff will collect data on the infrastructure changes, with the data collated by USF evaluation

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4 See [http://www.educ.sfu.ca/alliance/allianceA/](http://www.educ.sfu.ca/alliance/allianceA/)
5 See [https://ecom.mhs.com/(S(bajmxs45xmpvbyo5zgj45))/searchgl.aspx?q=Level%20of%20Service%20Inventory](https://ecom.mhs.com/(S(bajmxs45xmpvbyo5zgj45))/searchgl.aspx?q=Level%20of%20Service%20Inventory)
staff. The evaluators will provide quarterly updates to the SAC on the progression of the pilot, including enrollment, referral, retention, data collection, and any other issues that arise during the study. SAC members will use data compiled by the evaluation team to direct further infrastructure development and redirect resources as needed to meet the goals and objectives of the project. The evaluators understand that the SAC requests that the evaluation team look at information relevant to overcoming barriers, increasing fidelity to the program model, etc. The evaluation team will also assist the SAC in interpreting feedback from the SAMHSA Project Director to bring the plan into compliance with the requirements of the sponsor.

**Fidelity to evidence-based practices**

The Florida Certification Board will ensure that fidelity to evidence-based practices will be maintained by providing the following:

- Training and Coaching for Clinical Supervisors regarding adherence to Motivational Interviewing Principles
- Providing follow-up coaching with *Seeking Safety* trainers is response to fidelity concerns cited by FMHI staff in their ongoing monitoring
- Providing checklists for individual practitioners and agencies regarding adhering to principles of trauma-informed care.

In addition, FCB will work with the State Advisory Council to address issues regarding fidelity to evidence-based practices as they may arise during the course of project implementation.

FMHI evaluation staff will conduct fidelity evaluations on the “Seeking Safety” group offered at Northside Community Mental Health Center for the first time after the group has been established, and on an annual basis thereafter.

**Second pilot site.** As this site is still to be determined, the exact mechanics including intercept points and enrollment points have not been determined. However, the general evaluation plan will be consistent with that developed for the first site.

**C. Program Sustainability**

While it is clear that the program will be able to use the funding of the SAMHSA Veterans’ Jail Diversion grant for its duration (i.e., for five years from inception), it is equally clear that the program cannot depend on those funds alone during the initial five years of program operations. Moreover, it is the intention of both the grant and this strategy to continue operations in the established programs beyond the life of the grant and its commensurate funding.

Therefore, the program views the grant funding as both a temporary and only partial assist in channeling available resources toward mission accomplishment. Other government and private entities – many of them already established and operating in support of veterans – will be brought together to create the synergy and greater
resource pool necessary to successfully divert eligible veterans from incarceration, and subsequently provide adequate support services to them and their natural support systems.

Veterans entitled to VA benefits will have their status verified and, with the cooperation of the U.S. Veterans’ Administration, will have those benefits provided as appropriate. However, the totality of support needs will necessarily be provided by the sum of the entities involved in the established programs. No single entity can be expected to carry the lion’s share of the support load. All must contribute according to their abilities and responsibilities, concentrating their assistance within their particular areas of expertise.

The program does not envision a request for more public funding beyond normal adjustments for inflation and population increases. What the program does envision is better use of available public resources through a concentrated and streamlined effort toward mission accomplishment. To public funding the program plans to add private resources (e.g., foundation, business, and individual) to the support pool of the model programs. In Florida, such programs’ participation has been significant. With demonstrated success through the operation of the model programs – and widespread public messaging on those successes – the program hopes to enlist even greater support.

One vital part of the model programs will be peer-to-peer mentoring. Given the vast numbers of veterans residing in Florida – from cohorts that span the generations – the program expects to have no difficulty in recruiting those who are both able and willing to help.

Given the nation’s empathy toward veterans of its current wars, this program is confident that as the models programs show their effectiveness the program can expect a continued outpouring of support. The program understands, however, that such report will come more readily if it can demonstrate through objective measurement the viability and ultimate wisdom of the model programs put into place.