

## Meadows Mental Health Policy Institute

### Briefing: The Needs of Justice-Involved Texas Veterans – May 2014

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#### Overview

The needs summarized in this briefing were identified during the May 2014 Justice-Involved Veterans Conference sponsored by the Texas Veterans Commission and the Department of State Health Services. MMHPI staff took notes on key issues discussed during the conference and developed this summary.

Texas is home to 1.7 million Texas veterans, with 250,000 (and growing) post-9/11 returning veterans and one million Texas veterans over age 55 (400,000 from the age 55 to 64 years). It is estimated that Texas is home to 5.3 million veterans, active duty military members, and their families. Texas is also home to over 24 million people who are not veterans, but who share a deep obligation to welcome our fellow Texans home.

Based on general population data, in one year approximately eight percent (8%) of Texas veterans will have severe mental health and substance abuse needs (140,000) and approximately three percent (3%) will have severe and persistent mental illness (50,000).

#### Cross-Cutting Issues

The decision to honor the goal to “Leave No Veteran Behind” rests on how Texas veteran-serving agencies determine to take programs that are working in Texas to scale. To pursue these efforts, certain policy questions need to be addressed. For example:

- Are veterans a priority in agencies’ service contracts and performance standards?
- What are the barriers to providing best practices to veterans using existing funding (example of “Seeking Safety” being delivered by volunteers because LMHAs and other providers see contract requirements as prohibiting the model)?

Another potential barrier to providing services to veterans and their families revolves around the question of whether veterans are being screened out of state- and community-funded services until they prove they are not eligible for VA benefits. Examples include the following:

- Non-VA hospitals refusing law enforcement drop off of veterans;
- Reports of VA facilities requiring medical clearance at non-VA facilities;
- LMHA contract language “Contractor shall utilize non-contract funds and other funding sources (e.g., . . . other Federal . . . funding sources) *whenever possible* to maximize Contractor’s financial resources”;
- Does the term “veteran” appear in an agency’s service contracts and performance standards?

These issues raise the question: Is there a need for a surge – a time limited effort to go above and beyond in order to meet the needs of veterans and their families?

- Even if these efforts just focus on trying to coordinate existing services to support care across the intercepts – “Intercept 0” to Intercept 5 – it will be crucial to identify who is in charge of coordination and planning across agencies at the local level (using, for example, approaches such as the Community Blueprint).
- This surge would also need to include plans for ensuring military cultural competence for every provider, law enforcement agency, other first responder, prosecutor, and judge (e.g., Austin has systematic training for first responders; CIT training in Bexar County includes 1.5 hours of focus on veterans).

We would also need to determine how to track veteran status systematically across agencies, from service providers, hospitals (not just VA), law enforcement, booking / magistration, jail, prison, state agency, and federal agency.

- We need to ask directly and specifically about service and not just “are you a veteran?”
- We also need to know this about family members and children of veterans.

### **Intercept 1: Law Enforcement Contact**

Considerations include the following:

- Broadly: How can policy promote systematic “diversion at the earliest possible point” for veterans (and possibly all Texans with divertible behavioral health needs)?
- How can access to CIT/CIRT, including a veterans’ specialist, be universal in Texas?
- How can we help law enforcement identify veterans?
- How do local hospitals (including but not limited to the VA) support diversion?
  - How do we ensure a systemic response?
  - How do we help every Texas community identify a place (or places) where law enforcement can be guaranteed of a diversion-focused response for veterans with mental health and substance abuse needs?

### **Intercept 2: Initial Detention / Hearing**

#### **Diversion Before Court Involvement**

Considerations include the following:

- We heard that the most common offenses are potentially divertible: DWI, evading arrest, assault on a public servant, misdemeanor/felony possession of controlled substances.
- How do we systematically identify for all detentions and bookings:
  - Current and past service status?
  - Mental health and substance abuse needs (e.g., Bexar County example)?

- How do we get systematic measures of criminogenic risk (e.g., Texas Risk Assessment System) fully implemented across Texas? How long is reasonable to wait for this requirement to be met by local jurisdictions? And then, what are the implications in the use of the Texas Risk Assessment System (TRAS) with veterans?

### **Intercept 3: Courts and Jails**

**Veterans Courts.** Considerations include the following:

- How do we sustain what we have?
  - Courts are funded through time-limited funds through the Texas Veterans Commission and other sources.
  - “Once that grant money is gone, there is no one around.”
  - How do we move from one-time to ongoing funding?
- Should every court in Texas across 122 Judicial Districts have the capacity for a pre-adjudication track for veterans?
  - Should this be required?
  - Are there ways to better support the set-up of regional courts?
  - Are there ways to better support cross-jurisdiction transfers?
- For which veterans should capacity be developed?
  - Should development be systematic or should it simply be up to the preferences of local officials without guidance?
  - Can there be general guidance about the types/classes of offenses that make the most sense to include/exclude? These will of course vary from court to court, but guidance on what makes sense to include may be helpful.
  - How can systematic measures of criminogenic risk be incorporated?
  - Should there be a more systematic approach to eligibility in terms of veteran status?

**In Jails and Prisons.** Considerations include the following:

- Veterans are not eligible for VA care while in jail and prison. Military pensions stop in prison.
- How can we systematically promote in-reach to reconnect to benefits, as well as access to and coordination of care (e.g., continuity of medication)? And not just for mental health services, but also for substance abuse treatment (for which the need is far more prevalent).

### **Intercept 4: Reentry**

Considerations include the following:

- Texas is the nation’s leader in successful reentry programs.
- How do we ensure restoration of benefits post-release? It can take up to three months after release for the VA to process a request to resume benefits.

- The Texas Department of Criminal Justice (TDCJ) is developing capacity to identify individuals with federal benefits.
- For veterans, TDCJ has them meet with a case manager six months prior to release to complete the paperwork needed to resume benefits. The veterans also meet with a peer who will connect them with veteran communities.
- Can this be used generally across state jail/prisons?
- Can this be adapted for use in county jails?
- Can technology help?
- Housing is essential to successful reentry (and to recidivism prevention).
  - How do we systematically promote a Housing First model?
  - How can we do this for homeless veterans with children?
- How do we promote linkages (and capacity) for the following in every Texas community:
  - Meaningful work?
  - Family reunification, particularly with domestic violence issues?
  - Communication and collaboration with community treatment systems (building on best practices currently in place in some communities)?
  - Substance abuse and mental health treatment post-release?

### **Intercept 5: Community Corrections**

Considerations include the following:

- Identifying veterans is critical. As noted previously, what is needed to make this universal?
- How can specialty probation and parole be developed (and what about parole of any type for state jails)?

### **“Intercept 0”: Intervention Before Criminal Justice System Involvement**

Considerations include the following:

- How do we systematically supplement VA capacity:
  - For the veterans who meet eligibility criteria but are not eligible currently?
  - For the veterans who do not meet eligibility criteria?
  - For the veterans who are eligible, but for whom current capacity is inadequate or not desired?
  - Do Texas veterans lose the right to non-VA services (analogy to Native Americans)?
- How do we dispel the persistent myth of “the big three” mental health diagnoses (schizophrenia, bipolar disorder, depression)?
  - Current LMHA contracts target “other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.”
- How do we coordinate and manage a crisis system at the population-level?

- Under Crisis Redesign, LMHAs “shall serve individuals with monies allocated through Crisis Redesign, for engagement, transition, and intensive ongoing services.”
- LMHAs take an important lead role in planning and coordination.
- System-wide management exceeds the role of any single agency and requires a collaborative framework.
- How do we ensure systematic access for both mental health and substance abuse treatment for veterans?
- How do we help veterans with PTSD access evidence-based practices that are proven to work – prolonged exposure (PE) therapy and cognitive processing therapy (CPT) – as well as other models like Seeking Safety?
- How do we help veterans with PTSD successfully complete treatment?
  - UT-Dallas/UTSW Center for BrainHealth and others are working on treatments for complex PTSD.
  - How do we help veterans access these treatments more broadly?
- Veterans also need housing and integrated co-occurring disorder (COD) treatment tailored to their experiences and issues – how do we ensure access and engagement in services to prevent criminal justice involvement?
- What about children and families of veterans?
  - Domestic violence: Family issues can bring veterans into care long before they get arrested because they are motivated to not hurt their loved ones, and domestic violence is a sentinel event for criminal justice system involvement.
  - The rate of child death by violence in military families is twice the civilian rate.
  - The highest risk and best prevention target are children of military veterans who have repeated calls related to domestic violence.
  - There are successful models to break the cycle of intergenerational family violence (e.g., Harker Heights Police Department in Killeen, state accredited Batterers Intervention Program/BIP at Fort Hood).
  - Additional considerations:
    - Incarceration of a parent is a trauma for children and families, and often a repeat of the initial difficult separation that they experienced with deployment (e.g., we are not just arresting veterans, but we are re-traumatizing their children).
    - Veterans and their family members who are homeless with homeless children (e.g., women, particularly sexually assaulted women).
- Substance use issues are profound: Nationally, there are more U.S. military/veteran deaths by motor vehicle accidents than U.S. military deaths in Afghanistan.
- How do we better promote screening in primary care?
- How do we coordinate and help veterans and their families make sense of the “Sea of Good Will” – 60 thousand organizations nationally, mostly uncoordinated and often competitive with each other, all trying to help?