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# The U.S. Department of Veterans Affairs Veterans Justice Programs and the Sequential Intercept Model: Case Examples in National Dissemination of Intervention for Justice-Involved Veterans

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Veterans are a significant subpopulation in criminal justice populations, comprising between 9% and 10% of arrestee, jail, prison, and community-supervision populations. In order to address the needs of justice-involved veterans, the U.S. Department of Veterans Affairs (VA) Veterans Justice Programs (VJP) offer services to veterans at multiple points in their involvement in the criminal justice system. Within the context of the VA's national mandate to develop VJP, this article presents best practice case examples using the Sequential Intercept Model as the intervention frame, and discusses each in context of a community psychology framework for innovation dissemination. The case examples demonstrate how central program guidance is adapted locally to meet the national mandate using strategies that fit the local environment, illustrating the innovations in action orientation, boundary spanning, and flexibility of organizations. This review provides examples of creative reinvention that expand on the mandate and work to meet local needs. To optimize services to veterans released from custody or supervised in the community, future study of the implementation of this national mandate should examine all VJP sites to identify the full range of best practices in local program implementation.

*Keywords:* veterans justice programs, criminal justice intervention, Sequential Intercept Model, community psychology, program implementation

The psychological and physical wounds incurred by service members in combat are well documented and are believed to be connected to involvement with the criminal justice system (Institute of Medicine, 2010; Tanelian & Jaycox, 2008). The U.S. Department of Justice Bureau of Justice Statistics (BJS) has reported that approximately 10% of those arrested and incarcerated served in the U.S. military, large proportions of whom have serious psychiatric, medical, and social problems, including homelessness, unemployment, and prior involvement with the justice system (Mumola, 2000; Noonan & Mumola, 2004). BJS has estimated that 703,000 veterans were under correctional supervision during 2007 (Mumola & Noonan, 2008), highlighting this population's size and visibility as justifications for national systematic intervention. Their unique characteristics (e.g., older age, military service experience) make them an important population for targeted intervention (Blue-Howells & McGuire, 2007; McGuire, 2007). While there are a large number of justice-involved veterans, it is critical to note that most veterans are not justice-involved.[1]

Diversion and reentry intervention approaches with justice-involved populations typically provide access and linkage to health care services, including psychiatric, medical, and social services (Re-Entry Policy Council, 2005). Figure 1 depicts the five justice system intercept points that form the basic outline for planning justice system interventions (CMHS National GAINS Center, 2009). The U.S. Department of Veterans Affairs (VA) Veterans Justice Programs (VJP) target several of these intercept points through two nationwide programs, Veterans Justice Outreach (VJO) and Health Care for Reentry Veterans (HCRV), which are designated in the right margin of the graphic, including intercept 1, law enforcement and emergency services, intercept 2, initial detention and initial court hearings, intercept three, jails and courts, and intercept 4, reentry from jail and prison.

The range and quality of VA health care services and benefits available to justice-involved veterans has been described elsewhere (Clark, McGuire, & Blue-Howells, 2010; McGuire, 2007). In linking veterans in the justice system to health care services and

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[1] The 2007 veteran population was estimated at 22,892,000 (Census Bureau, American Community Survey), making justice-involved veterans approximately 3% of the overall veteran population.

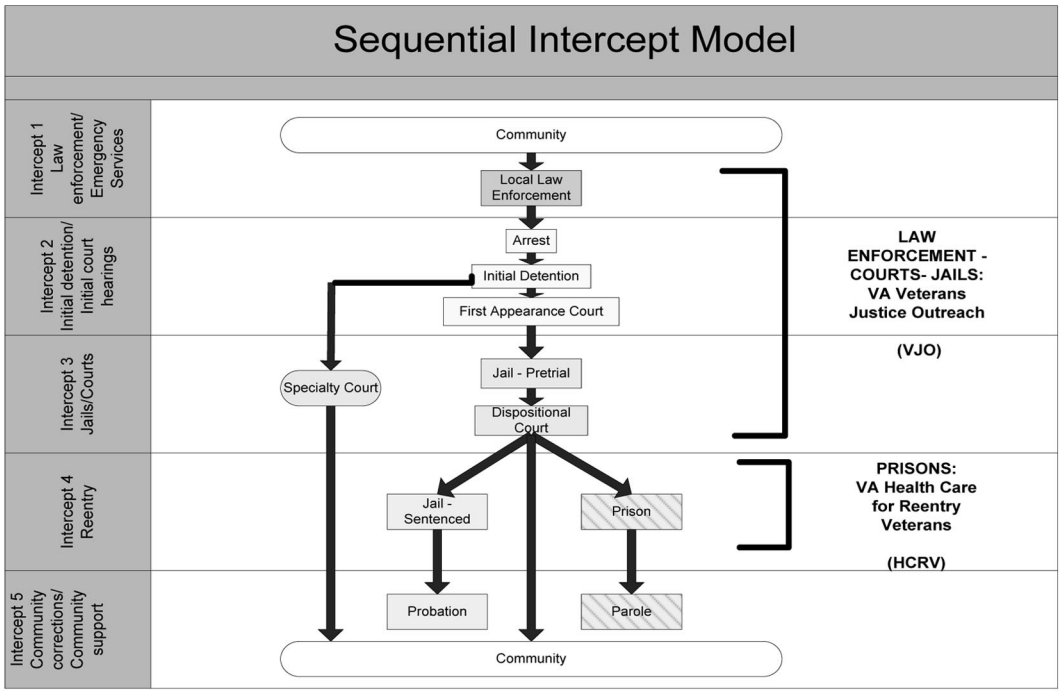


*Figure 1.* Points of intervention along the criminal justice continuum. Adapted from: CMHS National GAINS Center. (2009). *Developing a comprehensive plan for mental health and criminal justice collaboration: The Sequential Intercept Model.* Delmar, NY: Policy Research Associates.

benefits, VJP has employed Motivational Interviewing, which has been shown to improve rates of follow-up with VA substance abuse treatment after release from incarceration (Davis, Baer, Saxon, & Kivlahan, 2003). Importantly for treatment for justice-involved veterans, VA has a wide range of evidence-based mental health treatments (Karlin et al., 2010), treatments which other community diversion programs struggle to provide (Steadman & Naples, 2005).

Wilson and Kizer (1997, page 200) first recognized VA's role as an "unrecognized national safety net," heralding an era of expanded VA-community engagement which has continued in a number of arenas such as long-term care, homelessness services, outpatient primary care, and mental health clinics. In recent years, this expanded engagement has come to include justice outreach as well. In developing its justice outreach initiatives, VA reviewed internal policy and program authority, consulted with justice system partners at the national level (e.g., the American Correctional Association and the Judicial Leadership Initiative), and announced its commitment to serving justice-involved veterans system-wide through a national mandate to devote resources and attention to that population. This process unfolded within a context of national public and political support for reducing correctional costs and increasing the availability of treatment interventions to justice-involved populations (Jacobson, 2005; Re-Entry Policy Council, 2005; Second Chance Act, 2007).

The operational core of VJP consists of the field-based HCRV and VJO specialists who provide coverage across the United States and function as both program coordinators and clinical service providers. They are experienced mental health social workers, psychologists, and addictions clinicians, often with work histories in both VA and correctional systems. Forty-four full-time HCRV specialists serve the VA health care system's 21 regions (known as Veterans Integrated Services Networks, or VISNs); 166 full-time VJO specialists are stationed at VA medical centers. The core function of each of these specialists is to gain access to the justice system at one or more of the identified intercept points, identify veterans and assess their needs, refer and link them to care, and assist with access to care barriers that veterans may experience. Specialists provide longer-term case management for veterans involved in treatment courts.

Implementation of both VJP models required local (state, county, and city) needs assessments, local resource inventories, and the development of locally informed strategies, a method which has been promoted nationally through local community planning based on the Sequential Intercept Model (SIM; Munetz & Griffin, 2006). Implementation of these local VA strategies has provided a variety of models for examination and several best practices have emerged. This article uses seven case examples to illustrate locally designed, locally informed strategies for implementing a national mandate. It examines the implementation of these strategies using both the SIM and a community psychology dissemination of innovation framework.

## Review Framework

Case examples of local VJP implementation will be examined using two frameworks. The first is the SIM (Munetz & Griffin, 2006), which is used in many communities to plan interventions to improve access to mental health treatment for individuals in contact with various points in the criminal justice system. These

interventions are designed to divert offenders from the criminal justice system into treatment, where appropriate, with the ultimate goals of improving individuals' functioning in the community and reducing recidivism. The utility of the SIM lies in its reduction of the complex and locally variable criminal justice process to five simple, universal components; it has provided a common point of reference for local planning efforts, and a common system for categorizing interventions according to target population (CMHS National GAINS Center, 2009). Intercept points that will be examined here include 1) arrest; 2) post arrest-initial detention and hearings; 3) postinitial hearing jail and court; and 4) reentry from jail and prison.

Within specific intercept points, Mayer and Davidson's (2000) review of innovation dissemination will serve as a framework for the case examples' depiction of a new program taking shape, while the SIM's descriptive treatment of the criminal justice system provides the backdrop against which the action takes place. While dissemination of innovation is examined in a number of disciplines, in community psychology it is applied to the use of new social programs or policies in community settings, with the goal of positive social change. Actual implementation of an innovative program or policy requires action-oriented steps to change existing operations, boundary spanning between systems implementing a new program or policy, and flexibility of formal and structural characteristics of organizations. In addition, creative reinvention of a new program, in which the centralized model is modified to fit local needs or has new components added to meet local circumstances, can increase effectiveness.

We captured implementation examples at the intercepts through interviews with field specialists. Because of our focus upon VA's work to implement these services, we did not include interviews with corrections personnel, so implementation is described from the VA perspective. Sites are not individually identified, and for practices that emerged in a number of areas, an overview of the practice across sites is presented. The intent in this presentation of examples is to demonstrate the complexity of program dissemination when systems change involves the interface between a large federal agency and local communities, as well as to highlight creative solutions to encourage the spread of best practices that are emerging in the field.

Case examples are organized by their place in the SIM and the innovation practice. For clarity, Table 1 lays out the example, the SIM intercept point, and the innovation practice.

## Implementation Case Examples

### SIM Point 4 and Action Orientation

In order for VJP to carry out the mandate to provide outreach to incarcerated veterans, VA staff must gain access to prisons and jails. A model in use in a number of states is for HCRV specialists (conducting outreach at Intercept 4, prisons) to develop a relationship with State Department of Corrections leadership and negotiate access to all prison facilities within that state. This model has involved working relationships between the HCRV specialists and the Director or Deputy Director of the Department of Corrections. The specialists go through centralized security screening and volunteer or staff training, and then are issued a state identification badge, contractor's badge allowing access to all facilities, or a memorandum authorizing access to all facilities for the specific HCRV specialist. In this model the Department of Corrections executive exerts influence on each facility in a state; the HCRV specialist then develops relationships with the leadership in each facility to ensure HCRV follows all local policies regarding nonemployees in prison facilities.

Reviews of successful reentry programs (Re-Entry Policy Council, 2005) stress the importance of continuity of care between incarceration and community services. Providing in-reach and transition planning are both viewed as best practices in the community for ensuring the best possible reentry process (Munetz & Griffin, 2006; Osher, Steadman, & Barr, 2002). Adopting these practices required VA to assume an action orientation as promoted by Mayer and Davidson (2000) to 1) leave VA medical centers and work in communities, 2) build initial relationships with nonfederal agencies, and 3) maintain ongoing relationships to ensure prison outreach remains possible at non-VA controlled sites.

### SIM Point 1 and Boundary Spanning

The near-universal challenge to VJP implementation is forging working relationships between VA and agencies with which it has no shared operational history, and often a legacy of misunderstanding. Although this is changing rapidly, VA medical centers have historically been perceived as unenthusiastic partners with non-VA service providers. Similarly, law enforcement officers have frequently been viewed as resistant to input from clinicians about how to intervene with individuals with mental health problems. As the VJO program took shape, embodying VA's increased focus on

Table 1
*VJP Case Examples*

| Case example | SIM intercept point | Innovation practice |
|---|---|---|
| Access to prisons and jails | 4 | Action orientation |
| VA-community police partnership | 1 | Boundary spanning |
| Justice system identifying veterans | 1, 2, 3, 4 | Flexibility of organizations |
| VA clinician assigned to VTC | 3 | Flexibility of organizations |
| In-prison telephone screenings | 4 | Reinvention |
| Prison/jail facility veterans housing units | 4 | Reinvention |
| C&P exams while incarcerated | 4 | Reinvention |

*Note*. C&P = compensation and pension; SIM = Sequential Intercept Model; VA = U.S. Department of Veterans Affairs; VTC = veterans treatment courts.

early intervention with justice-involved veterans, this gap had to be bridged; veterans typically enter the justice system via contact with law enforcement (Intercept 1). An example is a community where the city police and VA police had an openly hostile relationship. Because the problem was pervasive across both systems, it required a systems-level solution. The VA medical center convened a high-level stakeholders' meeting to secure buy-in from both organizations' leadership, and to get these individuals accustomed to seeing one another as colleagues with a shared mission. Attendees included the chief and key staff from the city police department, the VA medical center director, VA chief of police, emergency department chief, nurse executive, and other supervisory clinical staff. This group met once a month for 4 months, and then on a twice-yearly basis. The result was a joint Standard Operating Procedure (SOP) to facilitate city police bringing veterans with clinical needs to the VA medical center's emergency department for rapid assessment and treatment, instead of to jail. The SOP enabled each party to accomplish its mission by linking veterans in crisis with needed care.

Boundary spanning here by both VA and community law enforcement demonstrates willingness to engage in consistent dialogue to forge a common understanding of shared mission and a new practice model to meet each agency's needs. Without boundary spanning on both sides, the partnership and the tool of an SOP would not have been developed and maintained.

## SIM Points 2, 3, and 4 and Flexibility of Organizations

Justice system work with VJP has required organizational flexibility in a number of ways. Numerous examples cluster around a critical process for which there is no standard across institutions: identifying veterans. In states and counties that have systematic procedures for veteran identification, corrections has instituted a process at intake and classification (SIM points 2 and 4) where corrections staff ask incoming inmates if they have ever served in the United States military.

Corrections then continues to partner with VJP in one of two ways. The first is to develop a process to issue reports to the VJP specialist on an ongoing basis with military service information, housing location, and projected release date, which allows the VJP specialist to plan outreach. The second, seen so far only in HCRV (SIM point 4), is for a state to certify HCRV specialists to have read-only access to prison databases, so HCRV specialists may view the information on an ongoing basis to organize visits and plan their work. Corrections systems that identify veterans in a coordinated way have shown a high level of flexibility in recognizing veterans as an important subpopulation, and in changing their intake and classification processes to include this information.

Another example is specific to VJO, which works in courts (along with jails, courts constitute SIM point 3)—to respond to the needs of the justice system while maintaining the integrity of VA's own operations. As a health care system, VA collects and maintains highly sensitive medical information on the veterans in its care; the security of that information is critical for VA. As the VA began a focused effort to develop working relationships with drug, mental health, and veterans treatment courts (VTC), it became clear that an effective information sharing protocol would be essential. In one drug court the judge told a VA clinician there were several veterans on the docket who said they were in treatment with VA, but the judge had no way to verify their accounts of compliance with treatment. With authorization from these veterans to share basic information about their treatment with the court, VA staff were able to respond to periodic requests to keep the judge apprised. Soon, the judge launched a dedicated VTC. To support the VTC's higher demand for information and operational coordination, VA assigned a clinician to the court's interdisciplinary treatment team. A laptop computer with a secure connection to the VA network allowed the clinician not only to provide treatment updates, but to determine whether new veteran defendants had already received treatment from VA, and to schedule clinic appointments on the spot. Working so closely with a court was a novel arrangement for VA, but flexible, creative thinking enabled it to do so while meeting its ongoing commitment to the security of veterans' personal information.

VA's partnership with a drug court demonstrated flexibility by expanding its traditional definition of the appropriate site for clinical intervention and appropriate use of release of information to maintain veteran engagement in treatment. As has been described elsewhere (Clark, McGuire, & Blue-Howells, 2010; Russell, 2009), the VTC model has been built from successful drug court and mental health court models, and courts are now operational in approximately 100 locations in the United States (Gould, 2012).

## SIM Point 4 and Reinvention

A critical element of VJP's national mandate – referral and linkage to resources – provides examples of creative and additive reinvention. A first example relates to accessing VA resources post release, which can be complicated by uncertainty over the point at which corrections control of the veteran ends, clearing the way for VA to offer treatment services to the veteran.[2] Two resourceful approaches have developed to address this. The first is the use of telephone screenings for reentry veterans (in prison, at SIM point 4), which are coordinated between the veteran, HCRV specialist, prison reentry case manager, and the VA residential program. In this practice, HCRV obtains a release of information that allows the prison reentry case manager to hold a telephone conference between the VA residential screening coordinator, the veteran, and the reentry case manager. While seemingly simple, this arrangement required significant efforts on all sides: the residential program changed its policy that the veteran be physically present for screening, the prison changed its process to allow the veteran to make calls to coordinate aftercare, and HCRV coordinated a release of information so that prison and VA personnel could discuss medical and mental health treatment issues directly.

[2] 38 CFR § 17.38 (c) (5) excludes veterans incarcerated from the medical benefits package: (c) In addition to the care specifically excluded from the "medical benefits package" under paragraphs (a) and (b) of this section, the "medical benefits package" does not include the following: (5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to veterans who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house).

A second example is development of an in-facility veterans housing unit. In this example, corrections analyzed the information gathered by asking about U.S. military service at intake and classification, and determined that there were enough veterans in the system to create a veterans housing unit. After planning the housing reorganization and dedicating corrections staff to the unit, corrections coordinated community resources to bring rehabilitation classes to the unit, and then reorganized inmates into new housing. This effort has met with tremendous support from corrections leadership, and allows VA and community agencies who provide services to veterans to engage in targeted reentry planning with veterans to support their housing, employment and treatment needs upon reentry. It is particularly helpful in allowing VJP specialists, who often cover multiple facilities spread over a large area, to take time they would otherwise use traveling between facilities and spend it working with veterans in a single location. The unit harnesses veteran peer support in productive activity. This model is in use in at least two state prison systems, and a number of large urban jails.

A third example is a work group of VA and State Department of Corrections leadership to facilitate access to compensation and pension exams for veterans while they are incarcerated. VA has a duty to provide exams for incarcerated veterans who have submitted benefits claims, yet conducting these exams is a significant logistical challenge for both VA and corrections staff. In one partnership, state leaders agreed to coordinate inmates' movement to a prison medical unit in close proximity to a VA medical center. From there, state corrections officers transport the incarcerated veteran to the VA medical center for an exam, in coordination with VA police. This partnership has made it possible for veterans to have access to benefits exams to which they are entitled while they are incarcerated, a challenge faced in many states.

These three examples exemplify reinvention, all at SIM point 4. In each situation, the local program found a need to be addressed in the context of VJP services, and worked with local corrections systems to find an adaptation that solved the issue. As noted by Mayer and Davidson (2000, p. 429) implementation of new programs often requires local modification to accomplish program goals.

## Discussion

VA medical centers have undertaken a complex mission with justice-involved veterans and have been given significant latitude in operationalizing VJP. The unique characteristics of each community's justice system, its available resources, policy priorities and procedures must be accounted for, and the diverse implementation examples reviewed here attest to the flexibility of both the VJP concept and the individuals who operationalize it. With SIM as the planning frame, the case examples presented in this paper have drawn on a community psychology framework of implementing wider system innovation, focusing on the areas of boundary spanning, action orientation, flexibility of organizations, and reinvention of the innovation. Some of the examples presented, such as identifying veterans, have been implemented at many sites, while others, such as law enforcement-medical center coordination, have been implemented at fewer sites.

A challenge for VJP is facilitating the spread of best practices in ways that can be adapted to meet the needs of communities without a VJP presence. There are a number of plans in place to identify and spread best practices, including ongoing training for VA staff on best practices, ongoing national and local consultation with corrections leaders to build strong VJP partnerships and practices, and mentoring initiatives to promote high quality programs. This includes a focus on how to plan local interventions with community input based on the SIM. A key piece of this work is engaging field specialists themselves as implementation experts. Engaging field staff is accomplished through a 2012 effort to train specialists as expert faculty to deliver training to their newer peers in VJP and field representation on curriculum planning committees to ensure nationally delivered training accurately reflects the needs of field staff.

There is much local variation in implementation and the overall impact of VJP to date has been significant. In the short period that VJP has been operational, VA workload data show that nationally VA clinicians have seen 18,303 veterans in VJO, and 37,390 veterans have received reentry services through HCRV. HCRV contacts veterans in 1,006 state and federal prisons across the United States (input from HCRV specialists, summer 2011). VJP has consulted stakeholders outside of VA, including other federal agencies, State Departments of Corrections and Veterans Affairs, county and city agencies, judicial and corrections professional groups, and veterans service organizations and advocacy organizations. To our knowledge, this level of effort to serve a subpopulation in the justice-involved population is unprecedented in its goal of serving veterans across the intercept points in the SIM, its partnership with outside stakeholders, and its investment of direct staff resources to contact, engage, assess, and, following release, treat justice-involved veterans.

This article reviewed several examples of successful, locally designed implementation of a national mandate; however, comprehensive evaluation of implementation strategies and practices is a promising area for future research. Such research would include field interviews with all sites where the range of VJP program elements was implemented, and would uncover additional local variations in implementation and expanded reinventions of the mandate. Information from the field could be analyzed to determine common elements across all examples of implementation, measure how best practices have diffused across the country, and highlight newly emerging best practices that developed to meet the needs of more mature VJP programs.

VJP has grown to reach across the United States in its short history, and its implementation has prompted organizations in partnership to develop solutions responsive to local conditions; these solutions have often changed the landscape of services available to justice-involved veterans. Providing effective reentry assistance through interorganizational collaboration is complicated and difficult. The work described here illustrates how cross-institutional collaboration can overcome local challenges to implementation of a national mandate, in order to support those who strive for a more productive life back in the community.

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