

Trauma Informed Care for Adults/Veterans in the Criminal Justice System

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Fifty to ninety percent of all adults and children are exposed to a psychologically traumatic event (such as a life-threatening assault or accident, human-caused or natural disaster, or war) at some point in their lives. As many as 67% of trauma survivors experience lasting psychosocial impairment, including post-traumatic stress disorder (PTSD); panic, phobic, or generalized anxiety disorders; depression; or substance abuse. Symptoms of PTSD include the persistent, involuntary re-experiencing of traumatic distress, emotional numbing and detachment from other people, and hyper-arousal (e.g., irritability, insomnia, fearfulness, and nervous agitation). Studies show that many patients who seek physical healthcare have been exposed to trauma and experience PTSD but have not received appropriate mental health care. (A National Center for PTSD Fact Sheet, NA)

As with other anxiety disorders and depression, most patients with PTSD are not properly identified and are not offered education, counseling, or referrals for mental health evaluation. (A National Center for PTSD Fact Sheet, NA) The PTSD Fact Sheet also mentions that untreated PTSD can have devastating, far-reaching consequences for sufferers' medical and emotional functioning, relationships, their families, and for society. The Fact Sheet said that as with other anxiety disorders and depression, most patients with PTSD are not properly identified and are not offered education, counseling, or referrals for mental health evaluation.

In *NeuroPsychiatry Reviews*, March, 2008, Vol. 9, Number 3, it was noted that PTSD risk has tripled in deployed soldiers with combat exposure. Tyler C. Smith, Ph.D. and colleagues based this finding on 77,047 active military volunteers from the ongoing Millennium Cohort study, designed to prospectively answer health concerns associated with military service. The primary outcome measure was self-reported PTSD per the PTSD Checklist-Civilian version using DSM-IV criteria.

According to the Office of Actuary, Office of Policy and Planning with the Department of Veterans Affairs, Ohio has a population of about 957,889 veterans. A Bureau of Justice Assistance (BJA) report indicated that in 1998, over 225,000 veterans were held in the nation's prisons or jails. It stated that about 35% of veterans in state prisons, compared to 20% of nonveterans, were convicted of homicide or sexual assault. Also, in 1998, BJA estimated that about 69,300 veterans were in local jails and indicated that 1 in 5 incarcerated veterans saw combat duty during their service. This would lead us to assume that, with the PTSD risk increasing for those with combat exposure as mentioned above, about 20% of those incarcerated might have PTSD risks. A Rand study, completed in early 2008, indicated that approximately 300,000 current and former service members were suffering from PTSD and depression after serving in Iraq and Afghanistan. ("Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery," Rand Corporation, Health and National Security Research Divisions, 2008)

According to BJA statistics, veterans make up about 11% of the local jail populations. Utilizing this statistic, Ohio has, on any given day, about 20,100 people in local jails, giving us about 2211 veterans in our jails statewide.

The Ohio Department of Mental Health recognizes that untreated PTSD can have devastating consequences for people, their families and society. Although almost any event that is life-threatening or that severely compromises the emotional well-being of an individual may cause PTSD, such events usually include experiencing or witnessing a severe accident or physical injury, getting a frightening medical diagnosis, being the victim of a crime or torture, exposure to combat, disaster or terrorist attack, enduring any form of abuse, or involvement in civil conflict. (MedicineNet.com NA). During wartime, types of traumatic experiences include combat, blasts, sexual assault, witnessing death and injury, and living in severe conditions. (National Center for PTSD, NA). Experts believe PTSD occurs:

- In about 30% of Vietnam veterans,
- In as many as 10% of Gulf War (Desert Storm) veterans,
- In about 6% to 11% of veterans of the Afghanistan war (Enduring Freedom), and
- In about 12% to 20% of veterans of the Iraq war (Iraqi Freedom),

Other factors in a combat situation can add more stress to an already stressful situation and may contribute to PTSD and other mental health problems. These factors include one's job duties in the war, the politics of the war, where it is fought, and the type of enemy faced. Another cause of PTSD in the military can be military sexual trauma (MST). This is any sexual harassment or sexual assault that occurs while in the military. Over half of all veterans with MST are men. (National Center for PTSD FactSheet, NA).

Hoge, et. al. studied members of four U.S. combat infantry units (three Army units and one Marine Corps unit) using an anonymous survey that was administered to the subjects either before their deployment to Iraq (n=2530) or three to four months after their return from combat duty in Iraq or Afghanistan (n=3671). The outcomes included major depression, generalized anxiety, and post-traumatic stress disorder (PTSD), which were evaluated on the basis of standardized, self-administered screening instruments. Their findings indicate that a small percentage of soldiers and Marines whose responses met the screening criteria for a mental disorder reported that they had received help from any mental health professional, a finding that parallels the results of civilian studies. In the military, there are unique factors that contribute to resistance to seeking such help, particularly concern about how a soldier will be perceived by peers and by the leadership. Concern about stigma was disproportionately greatest among those most in need of help from mental health services. Soldiers and Marines whose responses were scored as positive for a mental disorder were twice as likely as those whose responses were scored as negative to show concern about being stigmatized and about other barriers to mental health care.

This finding has immediate public health implications. Efforts to address the problem of stigma and other barriers to seeking mental health care in the military should take into consideration outreach, education, and changes in the models of health care delivery, such as increases in the allocation of mental health services in primary care clinics and in the provision of confidential counseling by means of employee-assistance programs. Screening for major depression is becoming routine in military primary care settings, but their study suggests that it should be expanded to include screening for PTSD. Many of these considerations are being addressed in new military programs. Reducing the perception of stigma and the barriers to care among military personnel is a priority for research and a priority for the policymakers, clinicians, and leaders who are involved in providing care to those who have served in the armed forces. (Hoge, C. W. et. al., 2004)

Furthering the need for special attention to veterans, the National Center for PTSD, mentioned that forty percent of Vietnam theater veteran men have been divorced at least once (10% had two or more divorces), 14.1% report high levels of marital problems, and 23.1% have high levels of parenting problems. Almost half of all male Vietnam theater veterans currently suffering from PTSD had been arrested or were in jail at least once, 34.2% more than once, and 11.5% had been convicted of a felony. (National Center for PTSD, Richard A. Kulka et al. & Ronald C. Kessler et al.)

CULTURAL ISSUES WITH VETERANS AND PTSD

Chalsa M. Loo, Ph.D. wrote in the National Center for PTSD Fact Sheet that race and ethnicity are important indicator variables that help further our understanding of posttraumatic stress disorder (PTSD). Studies of ethnic minority veterans have helped us understand how race and ethnicity relate to PTSD. Ethnic minority Vietnam veterans, through their participation in surveys, research studies, and clinical case studies, have made a major contribution toward our understanding of PTSD in these special populations. She further indicated that despite study differences, the trend suggests that being an ethnic minority may cause one to be more “at risk” for PTSD.

A study done in 1995, explored the effect of veterans' race and of the pairing of veterans' and clinicians' race on the process and outcome of treatment for war-related PTSD and suggested that ethnic minority veterans may be more likely to disclose problems or engage in treatment when paired with a clinician of the same race (Rosenheck, R. A, et. al).

Dr. Loo also mentioned that among Vietnam veterans, Hispanics had higher rates of PTSD than Whites and rates of PTSD among American Indian Vietnam veterans ranged from 22% to 25% (depending on the tribe). She pulled data from T. Holm (1992) and E.R. Parson (1984), clinical case studies of African American and American Indian veterans that described psychological tension and ambivalence because these participants associated the condition of the Vietnamese with that of their own people. Dr. Loo also mentioned a study she and others did with Chinese, Filipino, Korean, Japanese, Hawaiian, Chamorro, and Asian-mixed race Vietnam veterans that found that 37% suffered from PTSD, using the Mississippi Scale as the measure of PTSD. She said this

percentage was within the range or what had been found for African-Americans, Hispanics, Native Americans, and Native Hawaiians in other studies using this measure.

CURRENT ACTIVITIES IN OHIO

One initiative is the All Hazards initiative that involved all of the Boards in the state. As a result of this effort there is an All Hazards coordinator at every Board in the state who is expected to coordinate BH responses with their community in times of disaster and/or crisis. Two large conferences related to trauma were held. One was primarily the All Hazards network development and the other was associated with the military and the OHIOCARES initiative. Both of those program initiatives have grown significantly following those conferences. Our current Governor Ted Strickland was in attendance as a Congressman at the time at the Ohio Cares conference.

OHIOCARES is a collaboration of state and local agencies supporting the behavioral health of veterans and their families and was created through a partnership of the Ohio Adjutant General, the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services. This partnership identifies community-based behavioral health resources to assist in service members and their families' successful transition and reintegration into their local community.

The purpose of OHIOCARES is to enhance the "safety net" community of behavioral health services for military personnel and their families and to complement the services available through the Department of Veterans Affairs and Vet Centers by linkages with county alcohol, drug and mental health boards and behavioral health care providers.

OHIOCARES members comprise key behavioral health leadership with representation from the Ohio National Guard, Department of Mental Health, the Department of Alcohol and Drug Addiction Services, statewide behavioral health provider associations, the Veteran Services Administration, Local Behavioral Health Boards, Vet Centers, Traumatic Brain Injury Association of Ohio, university and other partners.

Other initiatives include the following. ODMH and the Ohio Justice Alliance for Community Corrections (OJACC) will hold a series of four classes on TREM (Trauma Recovery and Empowerment Model) and M-TREM (for men). ODMH and OJACC will sponsor and support trainers from Community Connections, the developers of TREM/ M-TREM. These classes are two day trainings for clinicians working in Ohio's Community Based Correctional Facilities (CBCFs) and half-way houses. The training will enable the CBCFs and half-way house staff to begin providing groups in the facilities on TREM and M-TREM.

Ohio also has two pilot Trauma, Addiction, Mental Health and Recovery (TAMAR) program sites in Ohio. The Corrections Center of Northwest Ohio (CCNO) is one of several regional jails in the state, encompassing both urban (Toledo) and rural communities. CCNO houses both pre- and post-conviction offenders. Through the efforts of the women's program, CCNO is now pursuing means of implementing a men's

program, M-TREM. Hamilton County (Cincinnati) has been working on women's issues in the jail for ten years, and included TAMAR among several programs already operating. In Hamilton County, TAMAR is being offered in the Justice Center jail, a typical big city lock-up, and the Queensgate facility, a treatment friendly environment.

TAMAR is a jail-based program with community follow-up that consists of 15 group therapy modules. The modules include didactic and expressive components designed to begin a healing process in incarcerated women. Much adaptation was needed to make this model fit Ohio's criminal justice system. In November 2007 the pilot site program staff attended a training on the TREM (Trauma Recovery and Empowerment Model) intended to strengthen their understanding of trauma care, assist in further adaptations, and provide direction for future Ohio programs.

A second component of the TAMAR program is a 2-3 hour training for all jail staff who work with women inmates. This training is designed to introduce the concept of trauma informed care, thereby reducing the incidence of retraumatization.

These pilot programs have been operating for two years, and recidivism data is just beginning to be analyzed. Preliminary data and anecdotal results are very favorable, and staff at both sites report enthusiastic positive observations. One lesson learned from our experience with these pilots is the importance of an aftercare, post-release component, providing both a trauma-informed therapeutic approach, and wraparound capability to support everyday issues.