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Molly: Presenting today we have Dr. Andrea Finlay, she is the HSR&D Career Development Awardee and Core Investigator for the Center for Innovation Implementation in VA Palo Alto Healthcare System. Also the Implementation Research Coordinator for Substance Use Disorder Quality Enhancement Research Initiative known as the SUD QUERI and that is also at the VA Palo Alto Healthcare System.

Joining her today, we have Dr. Joel Rosenthal the National Training Director and VHA of Veterans Justice Programs. I want to thank you both for joining us and as I said, in just a moment I am going to get Susan on the line and she will have some introductory comments. In the meantime I am going to turn it over to you Andrea, and can you go up and do full screen mode now? Perfect, thank you.

Dr. Finlay: Thank you Molly. Welcome everyone to our talk today which is entitled “Justice-Involved Veterans: Mental Health and Substance Use Disorder Diagnoses and Treatment Use” and this is some of the work that has come out of my CDI project so far.

Before I get started I just want to take a moment to acknowledge everyone who has contributed to this project definitely my research partners and especially my mentor Susan Frayne and my operational partners especially Joel, Jessica, Sean and the Veteran Justice Program Office. Thank you to all the VJO & HCRV Specialists, treatment providers both at VI and the community and others in the justice system. This work really represents years of hard work that you have been doing in the field so I wanted to take a moment to acknowledge that.

For our first slide we actually have a poll to hear who is joining us on the call and I apologize we only have five slots, I know there are people who might not fit in to every one of these categories. Molly I will turn it over to you at this point I believe.

Molly: Thank you. We do have the poll up on your screen at this time attendees. Who is joining us on the call: VA researchers; non-VA researchers; HCRV or VJO specialists; criminal justice systems partners and treatment providers or clinicians. As she mentioned, we did have a limited number of answer options here, however at the end of the presentation there will be a feedback survey with a more extensive list so it is possible you will find your title on that and can indicate it there. It looks like we have a nice responsive group today, already three-quarters of our audience has voted and the answers are still streaming in so we will give people a little bit more time to respond.

Okay looks like we capped off at about seventy-eight percent respondents. I am going to go ahead and close the poll now and I will share those results. It looks like twenty-three percent of our audience are VA researchers; five percent non-VA researchers; about half of our audience are HCRV/VJO specialists; fifteen percent are criminal justice systems partners; and eight percent are treatment providers and clinicians. I will turn it back to you now.

Dr. Finlay: Great thank you everyone for joining us again. Just a quick roadmap of what I am going to talk about today. I am going to review some background on Justice-Involved Veterans and some previous research on connection to VA services. I am going to turn the call over to Joel Rosenthal who will talk about the Veterans Justice Program and I will highlight three studies. The first one examines mental health and substance uses or diagnosis and treatment use among HCRV and VJO Veterans. The second study will get gender differences in those groups and the third study will look at all Veterans in fiscal year 2012 who are diagnosed with opioid use disorder and examine their access to pharmacotherapy for opioid use disorder. Finally I will touch on building research and operational partnerships before turning it back over to Joel to talk about some developing areas.

Justice-Involved Veterans comprise about ten percent of the incarcerated population. Approximately a hundred and fifty thousand Veterans are released from jails and prisons each year and an estimated ten to twelve percent of Iraq and Afghanistan Veterans have interacted with the Justice System since returning from deployment.

Homelessness is common among Justice-Involved Veterans about thirty percent of incarcerated Veterans have a history of homelessness and incarceration as an adult male is the single highest risk factor for ever being homeless. Part of these reasons are it disrupts social and family ties; it interferes with the ability to maintain appointment and housing and it can also interfere with medical and mental health treatment especially for adults who have chronic conditions.

Among adults who are released from prison they have a thirteen times higher mortality risk during the first two weeks post-prison release compared to the general population and Veterans also have a similar risk when they are actually in prison. VA benefits can serve as a protective factor against mortality but they have quite a high mortality risk.

In 2003, Jim McGuire who is the former Director of the Veteran Justice Program conducted a study where they looked at Veterans who were in jail who received outreach services and Veterans who are homeless in the community who received outreach services and they examined their connection to VA services. They found that Veterans in jail had higher rates of alcohol and drug problems and they are half as likely to use VA outpatient services. If you look at this table, you can see thirty-eight percent of jail Veterans and eighty-four percent of homeless Veterans used VA services. For mental health outpatient, thirty percent of jailed Veterans compared to seventy-three percent of Veterans used mental health outpatient services. This is prior to the HCRV and VJO programs as we know them now so they were Veterans who were in jail were having a harder time connecting with services once they exited jail.

Before I hand it over to Joel, we have one more poll just to see for our audience if we had any familiarity with the Veteran Justice Programs before today.

Molly: Thank you very much. For our attendees you can see that new poll up on your screen at this time. Once again the question is – do you have familiarity with the Veterans Justice Programs? First answer option - No; second answer option – Yes, but I have not had contact with any Veterans in the Veterans Justice Programs; and the third option – Yes, and I have contact with Veterans in Veterans Justice Program. It looks like already just over eighty percent of our audience has voted. I am going to go ahead and close the poll now and I will share those results. Fourteen percent of our audience reports that they are not familiar with the Veterans Justice Program; sixteen percent said yes they are familiar but have not had contact with Veterans in the program; and a resounding seventy percent said yes and they have had contact with Veterans in the Veterans Justice Program. Thank you to our respondents and Andrea before we turn it over to Joel, if you would like we do have Susan on the line now.

Andrea: Okay, great.

Susan Frayne: Hi this is Susan Frayne, are you able to hear me.

Molly: We are thank you for your continued patience getting on.

Susan Frayne: Thank you I am so sorry about that everybody. Have there been introduction yet?

Molly: I just did titles and affiliations but did not really give any premise for the talk.

Susan Frayne: Okay. Could I go ahead and introduce Andrea and Joel now? Dr. Andrea Finlay is a Career Development Award Recipient in the VH R&D service and an Implementation Research Coordinator for the VA Substance Use Disorder QUERI. Her research focuses on Justice-Involved Veterans with mental health or substance use disorders. She emphasizes in identifying and addressing gaps in access and engagement and treatment, which you have probably heard a little bit already since this is coming after she spoke. Then Dr. Joel Rosenthal received his Ph.D. in Clinical Psychology from Georgia State University in 1988 and has been a licensed practicing clinical psychologist in California since 1990. For the past four and a half years he served as National Training Director of the VA Justice Programs. In that capacity Dr. Rosenthal is on the book for development and oversight training and education of the two hundred and seventy-five Veterans Health Administration staff who are responsible for outreach to justice involved Veterans in prisons, jails and courts throughout the United States. Prior to his current position, Dr. Rosenthal was on the staff of the Department of Veterans Affairs Palo Alto Healthcare System from 1987 to 2010. We are very grateful and excited about the opportunity for the partnership and the wonderful work that together Dr. Finlay and Dr. Rosenthal and the Veterans Justice Program are able to do. Thank you so much and again I apologize for the difficulty I had getting on.

Molly: Not at all we appreciate you joining us and with that introduction we will turn it over to Joel now.

Dr. Rosenthal: Thank you very much Susan and I would echo what you said about the partnership between our program and the folks here at VA Palo Alto and the growing interest around the country. It is very exciting and one of the things it has meant is that the efforts that we and other are involved with in trying to service justice-involved Veterans is beginning to get out there within the VA system but within the community more broadly. We feel like much of what we are doing is at the cutting edge of working with Veterans in this population so to have an opportunity to work with folks that can help us to demonstrate the efficacy of what we are doing is extremely exciting.

Most folks on the call obviously are familiar with our pogroms and have been working with Veterans in our programs. I am not going to belabor these initial slides about our program very much, just to touch on them for those who might be less familiar particularly those who are our justice partners out in the community who are on the call today.

You can see here on the screen is our mission and I will read through it for those who maybe do not have access to the slides. The mission of the Veterans Justice Program is to partner with the criminal justice system to identify Veterans who would benefit from treatment as an alternative to incarceration. VJP will ensure access to exceptional care, tailored to individual needs, for justice-involved Veterans by linking each Veteran to VA and community services that will prevent homelessness, improve social and clinical outcomes, facilitate recovery and end Veterans’ cyclical contact with the criminal justice system. Certainly ending with the last statement overall one of the big competencies and future directions for research will be to look at our impact on helping to keep Veterans from returning to the justice system. In addition to that really looking at the whole person and really trying to do everything we can to give Veterans another opportunity and to address all the things that may make a difference in terms of quality of life.

This is a slide that I presume most folks have seen before, it is a Sequential Intercept Model. It is a way of understanding the different points of entry that individuals have into the justice system. Starting with the contact with law enforcement and then moving all the way up through incarceration in jail and prison and then the follow up from there, which is probation and parole. What we have added to this slide is simply for you to be able to see how our two initiatives correspond with these different points of entry. So at the top you see most of the programs are linked to Veterans Justice Outreach, which is our initiative that started in 2009 that addresses the front end of the justice system so law enforcement, courts and the jails. Then the lower piece healthcare for reentry Veterans is our program, which is oriented towards work with Veterans who are incarcerated in the state and federal prison systems throughout the country.

This next slide is a way of articulating the types of services that we provide and broken out by the Veterans Justice Outreach and the Healthcare for Reentry Veterans Programs. First and foremost we are outreach oriented program so what we are trying to do before anything else is identify Veterans in the justice system from our VA colleagues. For those who are in the justice system who are not familiar with the VA one of the first things we want to do is determine whether they are eligible for VA services. If not, it certainly does not mean that we cannot work with them, but it means that we will need to look to community resources for treatment and other services. Basically our model is to do outreach in the prisons, the jails and with folks in the court system. And once we have determined where services may be available to them then work with them around what we consider a treatment plant matching assessment to help us and our justice partners determine how to match them up with the best resources for what their treatment and other care needs are.

You will see on the slide we currently have just under two hundred and fifty Veterans Justice Outreach Specialists throughout the country. Those are typically affiliated with one of our hundred and fifty-two medical centers. Obviously we have a number of medical centers that have multiple VJO specialists that cover the local catchment area affiliated with that medical center. Then in our other program Healthcare for Reentry Veterans we have forty-four specialists and the scope of their work is more connected to VA’s regional structure, which are VISN’s Veterans Integrated Service Networks, and so they are covering all the state, federal prisons in those areas. You will see the scope of the work that we have done through the end of fiscal year 2014. We have had contact through VJO with eighty-seven thousand Veterans and through HCRV sixty-three thousand incarcerated Veterans in state or federal prison.

A few things I just want to mention in terms of our role. Again it is primarily outreach focused and so there is nothing that prohibits any outreach activities for Veterans regardless of where they are at at the justice system. What we cannot do in the VA is provide a care or treatment to an incarcerated Veteran even if they are eligible for VA services, they cannot get that care from us until they have been released from the incarceration. That is much of the mode that we work in is to coordinate with folks in the justice system who are providing care and treatment while folks are incarcerated. And then to help with the reentry planning to connect them with services upon release as well as to work with those Veterans who are in the community where there are not the restrictions in terms of care.

I believe this is my last slide of this section and this is our strategic goals for our justice programs and I will just mention them briefly, there are five of them. The first one is improve Veteran identification so basically goes back to what I described before that we were very intent on trying to identify Veterans throughout the justice system and then to be able to assist them from there. One of the things that we have developed in that respect is what we call Veterans Reentry Search Service. And it is a system that any justice partner, county, court or a state department of corrections or federal facility can partner up with us in a way that with some data input, you are able to be provide the names of any Veteran, anybody who has served in the military who is in your setting on any given day. And that is a system that we would be happy to talk with any of you about developing in your local venue. Our second strategic goal is to Build staff capacity and skill and that is simply we were very dedicated to the training and education of our staff so they are providing the most quality services that are possible. Thirdly a match Veterans to appropriate treatment. I mentioned before our model of using treatment matching assessment to link folks to the appropriate services. Fourth is to reduce stigma. As we began to launch it to this going back to 2006, at that time it was still very clear that there was a lot of preconceived notions about folks who are involved in the justice system. One of the big efforts that we have done is to try to do everything we can to make sure there is good information out there about these folks. Lastly, and is highlighted by this seminar, very, very intent on working with folks to demonstrate the efficacy of the work that we are doing and from that to look at the directions to go to best serve this population.

Dr. Finlay: Thank you Joel. Now I am going to jump into the studies conducted and the results and we will have some opportunities in the middle of our presentation to stop for questions so please feel free to type in any questions or reactions to the webinar screen.

The first study the research questions are: what are the Mental Health and Substance Use Disorder Treatment needs in Veterans while in the criminal justice system who are served by HCRV and VJO? Are they connecting then to VHN mental health and substance use disorder treatment? The sample for the first study I used VA National Administrative health records. I identified Veterans in the program using a 591 code for Veterans in the HCRV program and a 592 code for Veterans in the VJO program. You can see the fiscal years are a little bit different for HCRV it was Veterans who had at least one instance, an HCRV code from fiscal year 2008 to 2012 and for VJO it was from fiscal year 2010 to 2012 and the program started on different years so that is the only reasons for that. There were about fifteen hundred Veterans who had both an HCRV and VJO clinic code so in those cases we just put them in the group with the first cod that appeared in their record so that we had two mutually exclusive samples. There are some Veterans who are seen by specialists out in the field, but for whatever reason they do not have a 591 or 592 clinic code we were not able to include them in our sample. We also excluded Veterans who were ineligible for our services at VHA. That left us with almost twenty-three thousand Veterans in the HCRV program and a little over thirty-six thousand Veterans in the VJO program?

We used the HCRV and VJO visit as their index visit and then looked at one year from the next visit through one year and we looked at socio-demographic characteristics such as gender, marital status, homeless and service-connected disability rating. We also looked at diagnosis so if they had a one or more instances of mental health or substance use disorder ICD-9 diagnosis code in their record in that one year period. For treatment use we counted the number of mental health or substance use disorder treatment visits they had including outpatient, inpatient or residential treatment or pharmacotherapy for alcohol or opioid use disorder. For the purposes of this talk I have really just we are going to talk about entry treatments and whether they had any use of either mental health or substance use disorder treatment and engagement, which we coded as six or more outpatients visits, or one or more residential days in the one year period.

In terms of the patient characteristics, women are a very small minority of Veterans who were served by the HCRV and VJO programs. So two percent of HCRV Veterans are women and four percent of VJO Veterans are men. This is slightly lower than the general Veteran population of VJO I think it is about 6.5% for overall for women Veterans.

Most Justice-Involved Veterans are aged forty-five or older. As you can see the green bars are the VJO programs so they tend to be a little bit younger than the HCRV Veterans but overall most people are forty-five and older.

Most Justice-Involved Veterans are Black, African American or White so it is thirty-nine percent of HCRV and thirty-two percent of VJO Veterans are Black or African Americans; fifty-four percent of HCRV and fifty-nine percent of VJO Veterans are White.

Most Justice-Involved Veterans are either single or divorced/separated, very few are married or widowed.

Twenty-five percent of HCRV Veterans and twenty-one percent of VJO Veterans live in rural areas and this is really important because they are fewer VHA facilities and services it is just more challenging to access when you are in a rural area.

Seventeen percent of Veterans in HCRV and twenty-three percent of Veterans in VJO are homeless.

You can see in the pie charts the purple area for HCRV and the green area for VJO are the Veterans who have a service connected disability rating and this is a disability that was caused by or exacerbated during military service. It is linked with the kind of care that a Veteran can receive and it is a very complicated system that I am not well versed on but definitely plays into the care that a Veteran can receive so I wanted to report those numbers.

I am linger on this slide for a minute. Once we had the initial sample when we looked at mental health or substance use disorders we limited the sample to Veterans who had a subsequent VHA healthcare visit after their initial HCRV or VJO outreach visit. The reason we did that is because the specialists in the field are doing assessments to link Veterans to treatment but they are not diagnosing the Veterans so they needed to come in to a VHA facility and see a physician or psychologist in order to receive one of these diagnoses. As you can see at the bottom here for HCRV fifty-nine percent of the initial sample came in to a VA facility subsequently and eighty-eight percent of the VJO sample came in to a VA facility subsequently. There are some HCRV Veterans who are still incarcerated after one year but I was not able to identify them from the records we have.

As you can see mental health and substance use disorders are common for Veterans. Over half of HCRV Veterans are diagnosed with a mental health disorder or a substance use disorder. About three-quarters of VJO Veterans are diagnosed with a mental health disorder or substance use disorder and substantial percentage of both groups are diagnosed with both mental health and substance use disorder.

This figure depicts the prevalence of mental health disorders they are quite common, depression is the most common disorder and PTSD is second most common and then anxiety.

The substance use disorders are also quite common, alcohol use disorder is the most common followed by other drugs and then cocaine use disorder. For opioid use disorder, which is getting a lot of attention these days it is about nine percent of HCRV Veterans and thirteen percent of VJO Veterans are diagnosed with opioid use disorder.

Once we identified who was diagnosed with a mental health or substance abuse disorder we then limited our sample first to Veterans who were diagnosed with mental health disorder then we looked at their treatment engagement in mental health clinic. For HCRV Veterans, ninety-three percent entered any mental health treatment so that is outpatient, inpatient or residential and ninety-seven percent of VJO Veterans entered any mental health treatment after their outreach visit. Sixty-four percent of HCRV Veterans and seventy-eight percent of VJO Veterans engaged in mental health treatment so that was six or more outpatient visits or one or more residential days. You can see the race for substance use disorders are much lower so among Justice-Involved Veterans who were diagnosed with a substance use disorder fifty-seven percent of HCRV and seventy-two percent of VJO Veterans enter substance use or treatment. Thirty-seven percent of HCRV and fifty-four percent of VJO engaged in treatment and then form of other alcohol use disorder five percent of HCRV Veterans and eleven percent of VJO Veterans who were diagnosed with alcohol use disorder received pharmacotherapy. Twelve percent and twenty percent of Justice-Involved Veterans received pharmacotherapy for opioids use disorder. Now steps for pharmacotherapy for opioid use disorder these treatment rates are actually much higher than the general Veterans population seen at VI so I am just giving you a little context of what we are seeing with Justice-Involved Veterans compared to other Veterans.

In summary the mental health and substance use disorder treatment user substantial for this group, the HCRV and VJO programs are linking a majority of Veterans with mental health and substance use disorder treatment. Entry and engagement in substance use disorder treatment may represent a window of opportunity for program enhancements. I will stop here for a minute and see if we have any questions.

Molly: Thank you Andrea. We do not have any pending questions at this time but I just want to remind people to submit a question or comment, use the question section on your Go To Webinar dashboard, just click the plus sign next to the word question and then you can type it in. Thank you.

Dr. Finlay: In that case I will move on to our next study. This study I am using the exact same sample that I just presented to you but this time we are looking at gender differences in mental health and substance use treatment and diagnoses. As a reminder two percent of HCRV Veterans and four percent of VJO Veterans are women.

I just selected a few of the more interesting contrasts. Women tend to be younger than men as you can see from the dark purple and dark green bars for under forty-five as our women in HCRV and VJO programs. There is a larger percentage of them that are younger than men and that reflects general trends within the VA.

Looking at rural areas, HCRV women and VJO women and men all have a similar percentage who live in rural areas, but HCRV men have about twenty-four percent live in rural areas.

Homelessness varies less for women so twenty percent of HCRV and nineteen percent of VJO women are homeless compared to men where seventeen percent of HCRV compared to twenty-four percent of VJO Veterans are homeless.

A higher percentage of women have a service connected disability rating for the two sets of bars on the left you can see that there is not a huge difference between women and men for HCRV or VJO for the less than fifty percent service connected. For greater than fifty percent service connected, twenty-three percent of HCRV women compared to eleven percent of HCRV men are service connected and for VJO it is thirty-six percent of women compared to twenty-seven percent of men. I believe this also reflects general trends in the VA women compared to men.

As with the slide that I presented earlier, we had our initial sample and we limited to Veterans who came into the VA for a subsequent visit. Seventy-six percent of women who were seen by an HCRV specialist came into the VA subsequently compared to fifty-nine percent of men. For VJO it was ninety-five percent of women and eight-eight percent of men.

As you can see mental health and substance use disorders are quite common for both genders but women tend to have a higher prevalence of mental health disorders so seventy-six percent of HCRV women and eighty-eight percent of VJO women were diagnosed with a mental health disorder compared to fifty-six percent of HCRV men and seventy-six percent of VJO men.

For substance use disorders, women tend to have a lower prevalence than men, fifty-one percent of HCRV women were diagnosed with substance use disorder compared to fifty-five percent of HCRV men. For VJO group fifty-eight percent of women and seventy-two percent for men.

This figure shows the prevalence of different commissions for women and men in the groups. As you can see the darker bars, purple and green, are women so for all types of mental health disorders, women have higher prevalence of that disorder compared to men. The only place it was not statistically significant was schizophrenia for VJO in women and men. Women have higher prevalence of mental health disorders across the board.

Substance use disorders women tend to have a lower prevalence then men, which is mostly explained by alcohol use disorder. You can see that first set of bars on the left women have much lower prevalence of alcohol use disorder. There is also for cannabis and cocaine there are some gender differences that for opioid use and other drug use disorders, there was not really significant difference between the genders. It is really when we look at substance use disorders it is really driven by alcohol use disorders the gender difference.

I will not go through this slide in great detail, but I wanted to include it so you could look at it later. The message is that women in both programs enter and engage in treatment more than men and that is what we see in the general Veteran population as well. Virtually all types of treatment that are entering and engaging more. The only type of treatment that women are less likely to receive is mental health residential treatment.

In summary, women have a higher prevalence of mental health disorders and a lower prevalence of substance use disorders. They enter and engage in treatment higher than men. For both women and men substance use disorder treatment enter and engagement could be a quality improvement target.

Now I will stop again to see if there are any questions.

Molly: Yes we do have a couple of pending questions. The first one – why is the VA unable to offer services to incarcerated Veterans?

Dr. Finlay: I will let Joel answer that one.

Dr. Rosenthal: It is by regulation so there is no wiggle room I guess would be the best way to say it. It has been longstanding and i think there has been a little discussion at the upper levels or maybe at the congressional level about the possibility of change. My prediction from having been in the VA system for a very long time is I do not think that is very likely, it would have huge implications in a few ways certainly fiscally. But the other piece is that basically the restriction is for providing care to anyone who is in the custody of another entity who has the responsibility for providing that care. From that standpoint for example if someone is incarcerated at the state prison it is the responsibility of the state to provide that care. That is really a lot of where the issue would come up and I think even if this was loosened up in any particular way there would be very significant issues in terms of how to accomplish this in a way that could be coordinated across systems. The short answer to the question is it is by regulation and probably not likely to change. So that is why our work is very much a partnering effort to try to collaborate with the system that has responsibility for care to try to help in any way we can; provide information that would be useful in that care and then to prepare folks for their successful transition once we can provide that care.

Molly: Thank you for that response. We do have a few more pending questions. The next one – are mental health disorders self-reported? Women may be more likely to report mental health problems than men.

Dr. Finlay: I am sorry can you repeat that question?

Molly: Yes. Are mental health disorders self-reported? Women may be more likely to report mental health problems than men. Also is tobacco use part of your substance abuse definition?

Dr. Finlay: These are not self-reported, these are diagnoses that are entered into the health record by VHA physicians or psychologists who see the patient in a clinic. I have not included tobacco in this because it is really complicated to identify those records but that is something I am hoping to look at in the future because I know that should be included along with the other substance use variable.

Molly: Thank you. The next question our writer says – you may have spoken to this already but if not please explain. Is it possible that the reason the number for mental health disorders and engagement and treatment is higher for women than men is tied together because if you do not engage or enter treatment you are less likely to receive a diagnosis in the first place.

Dr. Finlay: Not necessarily. A person could go to a primary care visit and be diagnosed with a mental health or substance use disorder in that clinic. Then the mental health and substance use disorder treatment variable that we use were the specialty clinic specific to mental health or substance use disorder. Someone could go to primary care and then we looked at their treatment, but that is something I hope to dig into more in the future, is really getting into the nuances of where they received the diagnosis and then where they subsequently received treatment.

Molly: Thank you for that reply. For Veterans in rural areas with little to no or impacted VA resources for treatment, will the Choice Card Program be utilized?

Dr. Finlay: I think that they should be eligible, if they are eligible for VA services and they are more than forty miles from a VA or I forget what the time period is for the waitlist then they would be able to access community resources. I think one of the challenges is that community resources are also really strapped especially in rural areas it is still going to be challenging even if you have a car it still might be hard to get into one of those community clinics. I do not think we have solved that issue one hundred percent yet but they will be able to use as far as I understand the community resources with the Veterans Choice Card.

Dr. Rosenthal: That is correct and I would also just say that VA is actually has been quite aggressive in developing rural resources. There are services that are available I would say linked to virtually to every one of our medical centers, some more than others. That said, the issues that is being raised is certainly a limitation but between the Choice Card Program now and the development of rural resources in the VA we certainly hope to be able to provide more and certainly continuing high quality services to Veterans in those areas.

Molly: Thank you both for that reply. We do have one more pending question and before I get to it just a quick comment somebody wrote in. I would think that in addition to a VENA policy issue that VA does not treat incarcerated Vets due to issue of practicality. Thank you for that comment.

The final question – with more Veteran courts, dorms and programs becoming available, wouldn’t the VA be able to coordinate and offer services within those specific programs be beneficial for the Veterans during these critical times and not just eligible when say released from custody?

Dr. Rosenthal: well indeed that would be optimal. We do actually work very closely with the institution that have Veterans dorms and our outreach program I think is effective in that way. The bottom line is the regulation precludes us from providing that treatment so again there is no way around that. We do have some folks that provide educationally oriented groups in those facilities, so again about what VA has to offer around planning for release that sort of thing. The kinds of issues that Andrea is raising that are in need of pretty much mental health and treatment issues or medical issues our providers are not able to provide that care. On the last slide I will talk a little bit about a project that we have going that is a small partial answer to a piece of the issue but I will go back to a later discussion.

Molly: Thank you that is our final pending question at this time so I will turn it back over to your slides.

Dr. Finlay: Thank you Molly. I am just going to briefly talk about this last study which this we use a different sample then the previous two studies I talked about. These are all Veterans who were served at VHA in fiscal year 2012 who were diagnosed with opioid use disorder. I was interested in examining access to pharmacotherapy for opioid use disorder and whether it varied by justice program status. For the therapy I am referring to methadone clinics, buprenorphine, or naltrexone. For our sample there were a little over twelve hundred HCRV Veterans about four thousand VJO Veterans and forty-eight thousand Veterans who were not in one of those two programs who were diagnosed with opioid use disorder.

The rate of receipt eighteen percent of HCRV Veterans; twenty-six percent of VJO Veterans and twenty-seven percent of Veterans not in justice programs received some sort of pharmacotherapy for opioid use disorders. So methadone, buprenorphine, or naltrexone, most people received one or the other between methadone, buprenorphine or naltrexone but there are some people who received both kinds of treatment.

Then I ran some multilevel model logistic progression models where I controlled for a patient factor such as demographic characteristics and medical and mental health comorbidities and also for facility level factors such as availability of services and number of treatment providers per patient at a facility. We looked at the odds of receiving pharmacotherapy. As you can see eon the first line for both HCRV and VJO Veterans they have lower odds of receiving pharmacotherapy for opioid use disorders so .66 for HCRV and .88 for VJO controlling for all these other factors. I went back and I looked at outpatient and residential treatment for substance use disorders to see if it was true for other kinds of treatment. And actually for HCRV and VJO they are more likely to receive outpatient substance use disorder treatment or residential treatment and for pharmacotherapy for alcohol use disorder VJO Veterans are more likely to receive pharmacotherapy for alcohol use disorder and HCRV Veterans are as likely to receive pharmacotherapy for alcohol use disorder compared to Veterans not in justice programs. There seems to be something going on with pharmacotherapy for opioid use disorder that is making it more challenging for Veterans n the HCRV and VJO programs to access this treatment.

Hopefully my next study will be to try to examine these barriers to pharmacotherapy for opioid use disorder a little bit more among Veterans in the VJO and HCRV program.

The last thing I am going to touch on today is just to talk a little bit about building partnerships between research and operations. When I joined the VA three years ago this was something I heard a lot around our office how important it is to build these partnerships. I know that is going to look different for everyone depending in what you study and who your operational partner is, but I thought it would give you some details about how I have managed to find a balance.

I think the first thing to keep in mind is it is a really long timeframe. Research in general is a really long timeframe but building a partnership is also taken years so it was two years ago that I first met with Joel and Jim O’byer [ph] to start talking about my ideas related to justice-involved Veterans. We continued to work together over that time. We have managed with the Veteran Justice Programs office they are amazing. And we have a really dynamic partnership where I will find some results, share it with them and they will give me some feedback and really help me contextualize the work what I am doing with what they are seeing out in the field through their specialists or other policies, things that they know about. So it has been really helpful in that way. I have taken some time to work on my clinical education so I am a hundred percent research so I really needed a little more educating on the clinical side, so I have gone out to some Veterans ports and done some observations, I will be shadowing a VJO specialist soon as he is out in the jail. I am also listening in on the VJO and HCRV calls just to hear the issues that are coming up in the field and how people address those issues. And it has been helpful for me in thinking about research and how what I am doing on the research side can help answer some of the questions that they have in the field.

Finally I just try and listen to operational needs both through the HCRV and VJO calls and also through SUD QUERI. I have been on a number of work groups where there are other operational partners and hearing what they are interested in, getting some answers from research or other things that come up in their offices has been really helpful for me as I move forward and try to adjust my work to be fundable. That is a little background on the balance I manage the time between research and operations. On that note I will turn it over to Joel again.

Dr. Rosenthal: The last thing that I and we wanted to present are some areas that our office and certainly in collaboration with our specialists our programs around the field, are involved in. I just wanted to mention those, I think most of the folks on the call who are part of our staff are familiar with these and may be involved in these directly. But for those of you who are from the Justice System may be less familiar with them.

For starters we are engaged in a three-year comprehensive program evaluation that we have contracted for and we have five sites around the country that have been identified that reflect integrated and rather extensive work in both the VJO and HCRV programs. What we are doing is we are drawing research subjects among those that we see from each of the prisons, jails and courts so folks that have contact with us in each of those three settings and looking at a wide range of variables as we follow folks over a three year period of time. Looking at a range of psycho-social variables and then of course we will also be looking at engagement and treatment, impact of treatment and of course the big issue of recidivism and rearrest.

Secondly on here is what we have described as police intervention skill development. One of the elements of the Veterans Justice Outreach Program is liaison and training of law enforcement both VA and community law enforcement. We do a lot of training of officers out in the community but we also embark on a project to train all VA police officers, which numbers about thirty-two hundred officers. So we have done that through a train-the-trainer model where we have trained teams at every medical center in our system. And each of those teams includes two police officers, the VJO specialist and one additional mental health person and we are doing a range of skills development for intervening with Veterans as well as education around mental health and addiction related issues.

A third project is one of the projects that begins to get a little bit at the question around treatment and the limitations of the VA and being able to provide that to incarcerated Veterans. There are three treatments out there that are targeted for and have proved efficacious for reduction of recidivism with adults and that is more reconation therapy, thinking for a change and reasoning and rehabilitation. We have actively encouraged our staff and other VA staff to get trained in those approaches and to be able to make those services available since that appears to be an area that certainly has never been addressed in a formal way in the VA system previously. And it is an area that we believe will really make a difference for this population in terms of changes in their lives. The piece around being restricted from providing treatment to those who are incarcerated one of the models we have been using for this is to try to get our folks trained but also to have partners who they are working with in the system. For example it was mentioned that the facility that had Veterans dorms, the model that we have encouraged is that our staff and staff of the dorm programs would get trained together and then individuals would begin to get that treatment while incarcerated and then be able to transition into VA provided services for those same treatments upon release.

Along those same lines is the other project that I foreshadowed earlier that is a part answer to the restrictions on the VA for providing care. That is obviously one of the areas that VA has a lot of expertise in as in providing trauma related care. The obvious question was what could we at least come into the prisons and provide that sort of care to Veterans who are incarcerated in prisons or potentially jail. Again, we cannot but what we have done is at the request of a psychologist in the California state prison system we have now trained a significant number of California state prison clinicians in trauma in processing therapy, which is one of the evidence based treatments for trauma that has been provided in the VA systems. So we have included them in our training and then in six month consolation following the training so they are then actually able to provide this treatment to Veterans in the prison system and we are looking to expand that into some of the jails and some of the court systems as well.

A few other projects that I will just mention very briefly is that we are actively working to develop what we call Telejustice services so using video teleconferencing to enhance and augment the outreach that we do in the institutions and with the courts as well. We have a very active project going where because the VA also cannot provide legal support to Veterans we have set up a system so any VA campus can provide the space for a group of community attorneys to provide pro bono legal services. And we have I believe somewhere around the vicinity of about eighty campuses that have made that available now. And that is not necessarily to address criminal issues so much as the other kinds of legal issues that often face Veterans in these situations. It is issues about child support or issues with a tenant/landlord situation that kind of thing.

The last thing I will mention is that we currently have a project going with the folks at VA Commonwealth and they are close to finishing a document that is a structured evidence review to look at the employment made the justice-involved Veterans and the problems and practices for addressing those. It is the second contact we have had with the folks at VA Palo Alto to do something like that. The first one was for mental health treatment needs and associated interventions for those types of issues. Those are some of the projects that we have going in addition to the focal outreach we do as a program.

Dr. Finlay: That is it for our talk. I am just going to leave our contact information up, please feel free to contact me with any questions and I have also listed the COINs. For people who are interested in research I think there is a lot of interesting and important work that still needs to be done. I am happy to try to connect you with researchers in your area or just brainstorm in ways to try to do more research on this important population.

Molly: Joel did you have any last thoughts?

Dr. Rosenthal: Really appreciate the opportunity and we really welcome, for those of you from outside the VA and the Justice System, absolutely welcome any partnering around both the response to these Veterans, the treatment as we have highlighted the evaluation and research of the work that we are all doing together.

Unidentified Female: Molly if there are any last questions, take those now.

Molly: Great well we do have a lot of thank you's coming for an excellent presentation. For our attendees we do have a few minutes left if you want to submit any final questions or comments. Also, I can open it up, Susan did you also want to give any concluding comments?

Susan Frayne: I would just say this work really represents research operations partnership at its best. It really helps to ensure that researcher’s remains aligned with the real world priorities as the operations leaders. I am delighted that Dr. Finlay and Dr. Rosenthal had this opportunity to highlight the Veterans Justice Program in part because other investigators in the VA can remain attune to justice-involved Veterans as a special population that may require attention in their work as well. I also just want to thank Dr. Finlay and Dr. Rosenthal for this wonderful presentation and the meeting participants for very thoughtful questions and comments.

Molly: Thank you also Susan for joining us as well. We do have a few questions and comments that have come in. Is there any thinking about putting together a homelessness JIV QUERI?

Dr. Finlay: Not that I am aware of. Although I think that is a great idea. I am happy to talk with people who are interested in that.

Molly: Thank you. Another person writes – thank you very much this was very informative. We have the Alternative to Violence Program being taught to Veterans and staff at Pierce County Jail in Tacoma, Washington. Thank you to our submitter, that is encouraging to hear.

Dr. Finlay: Molly Joel wants to contribute to the QUERI question.

Dr. Rosenthal: I was just going to add that in spite of that entity not existing, both the mental health and the substance use QUERI’s have really made the work with justice-involved Veterans an important focal area for their attention. It is getting attention in that way but again the idea of a Homeless Justice-Involved QUERI would actually be a terrific idea.

Molly: Thank you for that reply. We do have a few more questions that came in. If any of our attendees have to leave since it is the top of the hour when you exit out please wait just a moment while the feedback survey populates on your screen as we do look at your responses very closely and it hopes us decide which sessions and topics to support with our program.

The next question - how can individual VHA sites go about supporting research ideas locally and would this be helpful?

Dr. Finlay: I think finding researchers if this is coming from someone in operations finding a researcher at your Center who is doing some work that somehow fits in with the Justice-Involved Veterans. There is a lot of work around here on mental health and substance use disorder so that is one of the ways I found my way to the Justice-Involved Veteran population. Then also just trying to think about what is unique at your VA in terms of the justice work that is being done. So Joel mentioned to me that one place might have a clinic that is delivering really different services or there might be some sort of special training or something that is really unique at your Center with your criminal justice partners. I think that is worth focusing on and really trying to highlight through some local research.

Dr. Rosenthal: What I would add is I think people often do not recognize the extent of the research resources within the VA so certainly to look at those. But also not to be shy about knocking on the door at your academic institutions. Virtually every VA has an academic affiliation and this is an area that really is compelling and a lot of folks are interested in or I think their interest can be courted. I would encourage you to do that. The other things is sometimes what is helpful is people just are not real sure where to start or what to do and I think I could make this offer for both Andrea and myself is that you are welcome to call either one of us. We have worked with several people where they called and they had some ideas or just having a discussion about what is going on at your VA or that sort of thing. We can help you to at least shape a little bit of the ideas that you may want to try to go forward with.

Molly: Thank you both for those replies. We have another question – Joel do you work specifically with VRFS software, which assists jails and prisons in early identification? If so any information or direction regarding this would be extremely helpful.

Dr. Rosenthal: Our office does. Fortunately I am not the one who has that direct responsibility so Sean Clark who is our National Coordinator for the Veterans Justice Outreach Program has the lead on that project. If somebody is interested in trying to partner up to get access to that system, you can certainly contact me and I will link you up with Sean. It is [sean.clark2@va.gov](mailto:sean.clark2@va.gov). And Sean is S-e-a-n but you also can contact me and I will link you up to Sean.

Molly: Excellent. Thank you. Just one more comment about the QUERI. The submitter wrote – I am with HIV QUERI and we also have focused on these populations and I think JIV QUERI is a great idea. Thank you again for that comment. That is the last of our questions so I just want to thank the two of you for lending your expertise to the field. We very much appreciated your presentation and of course thank you to our attendees for joining us. Please keep an eye out for the next CDA announcement that will be coming to your inbox soon. Thank you once again everyone and this does conclude today’s HSR&D Cyberseminar presentation. Have a great day.

Unidentified Female: Thank you everyone.