Clinical and Criminal Justice Outcomes in the Jail Diversion and Trauma Recovery (JDTR) Program

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Clinical and Criminal Justice Outcomes in the Jail Diversion and Trauma Recovery (JDTR) Program

by

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy
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Keywords: veterans, peers, mental illness, crime, Risk-Needs-Responsivity, PTSD

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DEDICATION

This work is dedicated to Layla, Helena and Harrison whose love and support made this dissertation possible.
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For me, this dissertation is the culmination of a journey that started long before I entered the doctoral program. As such, it was not only a product of my academic efforts, but also my professional experiences and friendships. Given the extent of these influences, it would be impossible to mention everyone who helped me along the way, but I would be remiss not to acknowledge the amazing people below. It goes without saying before I do that all my love and appreciation go to my wife who carried me through to the end; and to my parents and sister who challenged me and supported me from the beginning.

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ABSTRACT

This mixed methods study evaluated clinical and criminal justice outcomes of the Florida Jail Diversion and Trauma Recovery (JDTR) program that utilized compensated veteran peer mentors. Quantitative results showed veteran participation in JDTR improved clinical outcomes, such as PTSD symptoms, function difficulty and depression scores, but not criminal justice outcomes such as re-arrest rates. Study limitations, however, prevent the drawing of conclusions regarding the potential effectiveness of veteran peer interventions improving criminal justice outcomes. Qualitative results showed participants overwhelmingly viewed their assigned veteran peer mentor as a "peer" and rated them as "very important" to their future success. Improvements in avoidance and numbing and depression symptoms also suggest peer interventions may be effective in improving responsivity to evidence-based criminal justice interventions. Overall, findings were consistent with the RNR model that views mental illness as a responsivity factor, not a criminogenic need. They were also consistent with research on "first generation" forensic mental health interventions that shows improvements in clinical outcomes do not result in reductions in recidivism. Social workers as well as other mental health clinicians and policy makers should be familiar with evidenced-based criminal justice strategies, such as RNR, that focus on reducing recidivism and should incorporate these strategies into the development, implementation and evaluation of "second generation" interventions. Future research should evaluate the fidelity of implementation of such interventions as well as the role of peer mentors and importance of the recovery model and therapeutic alliance in improving criminal justice outcomes and responsivity.
CHAPTER 1: INTRODUCTION

Background and Introduction to the Problem

The overrepresentation of persons with mental illness involved in the criminal justice system is a critical problem. Prevalence studies consistently show persons with mental illness are disproportionately represented in the criminal justice system despite efforts to improve access to treatment for this population (Skeem & Louden, 2006; Steadman, Osher, Robbins, Case, & Samuels, 2009). Veterans are an important subgroup of person with mental illness involved in the criminal justice system and have received considerable attention because of the wars in Iraq and Afghanistan. While veterans are not disproportionately represented in the criminal justice system, incarcerated veterans have higher rates of mental illness than non-veterans who are incarcerated, a trend that is likely to continue given the rates of PTSD, depression and traumatic brain injury (TBI) in veterans of Afghanistan - i.e., Operation Enduring Freedom (OEF) - and/or Iraq - i.e., Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) (Clark, McGuire, & Blue-Howells, 2010; Mumola, 2000; Tanielian et al., 2008). This study sought to evaluate the effectiveness of a specialized mental health jail diversion program and whether compensated veteran peer mentors improved clinical and criminal justice outcomes for veterans with trauma related mental illness.

Persons with mental illnesses are not only re-arrested at higher rates than persons without mental illness, they spend on average more days in jail than persons without mental illness (Morrissey, Cuddeback, Cuellar, & Steadman, 2007). Persons with mental illness may also receive inadequate mental health treatment and present significant management and safety
problems for correctional facilities as well as financial burdens for state and local correctional authorities (Cox, Morschauser, Banks, & Stone, 2001; Hartwell, 2003; Lamb & Weinberger, 2001; Lamb, Weinberger, & Gross, 2004; Veysey, Steadman, Morrisey, & Johnsen, 1997). Various mental health diversion programs have attempted to address the problem of the overrepresentation of persons with mental illness in the criminal justice system by linking persons with mental illness to treatment (Fisher et al., 2006; GAINS Center, 2010; Morrisey, Fagan, & Cocozza, 2009). Evidence on the effectiveness of these programs has been mixed, indicating that simply treating mental health symptoms is not a sufficient response to address the problem (Fisher et al., 2006; Steadman, Osher, Robbins, Case, & Samuels, 2009).

Criminological research sheds light on the reason for this. Wide-ranging studies consistently find the greatest predictors of crime and recidivism are non-clinical variables, while clinical variables are much weaker predictors. Included in the group of strongest predictors are antisocial behavior, antisocial cognition, antisocial attitudes, antisocial associates, family and/or marital problems, problems with school and/or work, leisure/recreation and substance abuse problems (Bonta, Hanson, & Law, 1998; Case, Steadman, Dupis, & Morris, 2009; Erickson et al., 2009; Lamberti, Weisman, & Faden, 2004; Philips et al., 2005, Skeem & Louden, 2006). Andrews and Bonta (2006) labeled these risk factors *criminogenic needs* for practical reasons, implying that when the “need” is met or reduced the probability of criminal involvement is decreased. While mental illness is not a *criminogenic need*, it contributes to the accumulation of criminogenic needs, as persons with mental illness have a higher number of these greatest risk factors than persons without mental illness (Osher et al., 2012).

Peer interventions, which are being implemented in some veterans treatment courts across the country, offer promise for improving criminal justice outcomes because peer
interventions potentially target many of these criminogenic needs by providing positive social reinforcers and social support that are enhanced by a "connection" rooted in shared experience (Clark et al., 2010). Research on peer interventions across a wide range of settings has consistently demonstrated that peers improve various clinical and social outcomes (Christensen & Jacobson, 1994; Gould, & Clum, 1993; Solomon, 2004). Hitherto, there is no published research on the effectiveness of peer interventions in adult criminal justice settings or with veteran populations.

Various theoretical models, such as social learning theory, social support theory, experiential knowledge theory, social comparison theory and the helper-therapy principle, and research on the importance of the therapeutic alliance partially explain why peer interventions appear to improve clinical and social outcomes and potentially explain why peer interventions may improve criminal justice outcomes (Solomon, 2004). Risk-Needs-Responsivity (RNR), an evidence-based criminal justice strategy to reduce crime that is informed by general personality and cognitive social learning theory, or GPCSCL, also offers guidance regarding how peer interventions may improve criminal justice outcomes (Andrews & Bonta, 2006; Andrews & Dowden, 2007).

According to social support theory, social support reduces psychological and physiological responses to stress and expands social networks that expose individuals to social controls and peer influences. Through the provision of social support, peer interventions may directly target risk and protective factors for crime or they may indirectly prepare persons and make them more responsive to other interventions that would target risk and protective factors for crime (Pettus-Davis, Howard, Roberts-Lewis & Scheyett, 2011).

Social learning theory provides a different context for understanding the potential role of
peer interventions in reducing recidivism. Social learning theory was adapted specifically to explain crime and deviance by building on Edwin Sutherland’s Differential Association Theory (Sutherland, 1947). Burgess and Akers (1966) refined social learning theory to explain crime by incorporating principles of operant conditioning into the understanding of how an excess of definitions that are favorable to crime influence procriminal behavior and by emphasizing that individuals learn criminal behavior through both observation and by interacting with others (Akers, 1985; Bandura, 1977, 1986; Cullen, Wright, Gendreau, & Andrews, 2003; Sutherland, 1947). In this conceptualization, peers influence both procriminal and anticriminal behavior because peers are perceived as more credible than non-peers. GPCSL theory builds on Burgess and Akers by considering other personality and biological factors as well as research on the greatest risk factors for crime. GPCSL not only attempts to explain crime and deviance, it seeks to understand the context and risk factors for crime in such a way that criminal strategies can be devised to effectively reduce crime (Andrews & Dowden, 2007). Given the theorized influence of relationship-focused peer interventions on cognition, beliefs and behavior and the importance of modeling prosocial behavior and teaching problem solving skills in behavior change, social support theory and social learning theory provide useful frameworks for understanding why peer interventions would work in a criminal justice setting. GPCSL and RNR draw from both of these theories and provide a framework for developing criminal justice strategies that reduce crime, of which peer interventions may play a significant role as they potentially target criminogenic needs and address issues of responsivity related to mental illness, i.e., low distress tolerance, lack of motivation and poor access to community resources.
Jail Diversion and Trauma Recovery Program

In 2009, the Substance Abuse and Mental Health Services Administration’s (SAMHSA), Center for Mental Health Services (CMHS) funded the Jail Diversion and Trauma Recovery (JDTR) initiative, with priority to veterans. The JDTR funding supported the development of statewide infrastructure and policy relevant to veterans involved in the criminal justice system with a focus on trauma informed services (Christy, Clark, Fei, & Rynearson-Moody, 2012; GAINS Center, 2011; U. S. Department of Health and Human Services [HHS], 2009). The SAMHSA JDTR grant program differed from many other SAMHSA funded projects in that grants were given to states, not counties or agencies. The goal of this approach was to foster state initiatives to address issues of diversion and trauma. Each of the 13 funded states implemented one or two pilot programs that involved diversion of veterans from the criminal justice system to trauma informed care. Florida implemented two pilots, with the first in Hillsborough County (Tampa), which focused on the implementation of a post-booking diversion program for veterans with trauma-related mental illness to increase the likelihood that veterans with trauma related difficulties had access to the full array of community services and that those services were flexible and responsive to the veterans’ unique and changing needs (Christy et al., 2012; GAINS Center, 2011). The second pilot was implemented in Pinellas County with the same focus but in a different community context with different agencies and resources and the inclusion of pre-booking diversions in addition to post-booking diversions.

Both pilots in Florida enhanced the traditional jail diversion model with the addition of veteran peers who provided case management and mentor/support services as well as evidence-based trauma recovery interventions. The goal of the JDTR program was to help justice-involved veterans recover from trauma-related difficulties by strengthening the veteran’s ties to
services, family and other support mechanisms during the critical post-release period through the use of veteran peers. Veteran peers provided case management services to assist with the coordination of needed treatment and support services as well as mentoring. Another JDTR pilot project goal was to offer Seeking Safety (Najavits, 2002), a manual-guided, evidence-based treatment for persons with co-occurring PTSD and addictions (Christy et al., 2012; GAINS Center, 2011).

The goal of the program was for veteran peer mentors to be assigned to all JDTR enrollees and veteran peer mentors to conduct periodic visits providing support, encouragement and assistance as needed. JDTR mentors differed from veteran peer mentors being implemented in most veterans treatment courts across the country in that JDTR mentors were compensated. There were several part-time peers at site 1, and one full-time peer at site 2. Training for peer certification with veteran specific endorsement through the Florida Certification Board was developed through the JDTR project (see Appendix A) for the Florida Certification Board Certified Recovery Peer Specialist - Veteran application). This certification was available to JDTR peer mentors, with the exam waived for the first several months of the certification process, which included the time period during which the site 1 pilot was conducted. Peer certification with veteran endorsement required peer mentors to: 1) meet specific competency and ethical conduct requirements; 2) possess minimum work and experience requirements; 3) possess minimum education and training requirements; 4) pass the written exam; and 5) complete minimum continuing education credits annually to maintain a current knowledge base (Florida Certification Board, 2014).
Significance and Aim of the Study

Mental health diversion programs that focus on linking persons with mental illness to treatment have grown from 52 to well over 560 since 1992, but rates of incarceration for persons with mental illness have remained alarmingly high (Case et al., 2009; Steadman, et al., 2009). One reason is that many of these diversion programs do not target criminogenic needs and, instead, focus on symptom reduction utilizing traditional mental health treatment services. Interventions such as these that focus on linkage to treatment assuming recidivism will be reduced with the reduction of mental health symptoms have been called "first generation interventions" (Epperson et al., 2011, p. 1). Research, therefore, is needed to assess other non-traditional diversion approaches that target both clinical symptoms and criminogenic needs.

While many traditional mental health diversion programs can increase formal social support for individuals, social support provided by peers is potentially more effective in improving criminal justice outcomes because peers have been shown to not only improve clinical and social outcomes, they also may target criminogenic needs and potentially improve the responsivity of individuals to other interventions that target criminogenic needs. Peer interventions are unique because peers are perceived as more credible than non-peers and thus more influential than non-peers, enabling peers to more effectively model prosocial behaviors and problem solving skills (Bandura, 1977).

Post 9/11 conflicts have raised awareness of the unique needs of returning OEF/OIF/OND veterans, many of whom experienced combat and many of whom have survived injuries that in past conflicts would have likely led to death (Gawande, 2004). Federal, state and local governments have supported new initiatives to support veterans with mental illness who become involved in the criminal justice system, including JDTR and veterans treatment courts,
which utilize veteran peer interventions. There is no published research about the effectiveness of veteran peers in improving criminal justice and clinical outcomes for veterans with trauma experience. Research is, therefore, needed to investigate peer interventions and non-traditional approaches to diversion programs. Such research is needed to not only improve services for justice-involved veterans, but to contribute to the development of other criminal justice interventions that can address the problem of the overrepresentation of persons with mental illness in the criminal justice system.

As mentioned previously, SAMHSA funded diversion programs with priority to veterans in 13 states. Many utilized veteran peer mentors. Florida’s JDTR program was unique in that it provided funding to pay and train veteran peer mentors to provide peer support. The aim of this study is to evaluate the effectiveness of JDTR and answer the question about whether JDTR and compensated peer mentors, in particular, significantly improved clinical and criminal justice outcomes for veteran offenders with trauma related mental illness.

Relevance to Social Work

Social workers are on the frontlines working with persons with mental illness in the criminal justice system and function as policy makers, administrators and direct practitioners - roles that directly and indirectly influence services for persons with mental illness. Social workers bring a unique perspective from which to view the problem of the overrepresentation of persons with mental illness in the criminal justice system. Eco-systems and person-in-environment perspectives, for instance, emphasize the importance of context as well as the interrelatedness of systems and take into account the various factors that affect individuals and society (Robbins, Chatterjee & Canda, 2006). Moreover, social workers have a long history of working closely with various disciplines and conducting and integrating wide-ranging,
multidisciplinary research into policy and practice (National Institute of Mental Health [NIMH], 1991). Social workers, therefore, are uniquely positioned to recognize the importance of peer mentor interventions and uniquely skilled to help solve the current problem of the overrepresentation of persons with mental illness in the criminal justice system by conducting and integrating research that will assist with the design, development and implementation of effective mental health and criminal justice programs that will assist justice-involved persons with mental illness in their mental health recovery through improved clinical and criminal justice outcomes.
Chapter 2: Literature Review

The Problem

Persons with Mental Illness in the Criminal Justice System

The problem of persons with mental illness involved in the criminal justice system cannot be overstated. It is estimated that 8% of the nation’s 13 million annual arrests involve persons with serious mental illness. Persons with mental illness are not only more likely to be arrested; they typically remain incarcerated longer than persons without mental illness with similar charges and generally receive inadequate mental health treatment while in jail or prison (Ditton, 1999; McNeil & Binder, 2007; More & Hiday, 2006; Veysey et al., 1997).

Jail and prison studies have found rates of persons with mental illness ranging from 6% to 31%, depending on the diagnostic or demographic focus or methodology of the study (Broner, Lattimore, Cowell, & Schlenger, 2004; Hiday & Wales, 2003; More & Hiday, 2006; Steadman, et al., 2009; Teplin, 1990; Teplin, Abram, & McClelland, 1996). Most recently, Steadman and colleagues (2009) found 14.5% of men and 31% of women in five jails in Maryland and New York had a serious mental illness, contrasting rates of 3% to 7% of persons with serious mental illness in the general population (HHS, 2002). Previously, Teplin and colleagues (1996) found 6.4% of men and 12.2% of women in the Cook County (Chicago) Illinois jail had a severe mental disorder, a definition less broad than that of serious mental illness.

Persons with mental illness are not only overrepresented in jails and prisons; they make up a disproportionate number of the nearly 7 million persons under correctional supervision. Current estimates suggest that at least 500,000 persons with mental illness are placed under
correctional supervision each year (Skeem & Louden, 2006). Compared to persons without mental illness, persons with a mental illness are also more likely to fail on supervision as the result of a technical violation or new offense (Skeem & Louden, 2006).

**Veterans in the Criminal Justice System**

Veterans represent an important subgroup of persons in criminal justice system. Estimates of the total number and percentage of justice-involved veterans have varied over the years. Although veterans decreased from approximately 27 million to 24 million between 1985 and 1998, the number of incarcerated veterans increased from 154,600 to 225,700. This occurred, surprisingly, as the percentage of incarcerated veterans decreased from 21% to 12% of the total incarcerated population. This, of course, was largely due to the 172% rise in incarceration rates for all persons during the same time period (Mumola, 2000). Studies that are more recent found a 9% incarceration rate for veterans, but these estimates used 2007 data before large numbers of OEF/OIF/OND veterans began returning (GAINS Center, 2008; Greenberg & Rosenheck, 2008). It is also important to note a significant majority of incarcerated veterans (82%) are estimated to qualify for Veterans Administration benefits and the disproportionate number of veterans in the jails with mental illness do not largely consist of veterans with dishonorable or bad conduct discharges (U.S. Department of Veteran Affairs, 2009).

While veterans are not overrepresented in the criminal justice system, research shows incarcerated veterans have higher rates of mental illness than non-veterans. Mumola (2000) found 25% of incarcerated veterans reported a current emotional or mental health condition or stay in mental hospital or treatment program compared to 15% of incarcerated nonveterans (Mumola, 2000). In addition, a 2002 Bureau of Justice Statistics (Bureau of Justice Statistics [BJS], 2006) survey found 29% of incarcerated veterans diagnosed with a bipolar, depressive,
psychotic and/or anxiety disorder. Saxon and colleagues (2001) found 39% of a convenience sample of 129 incarcerated veterans in Kings County, Washington screened positive for PTSD. Again, these data does not include a large number of returning OEF/OIF/OND veterans.

A 2008 Rand study shed light on some of the mental health problems facing returning OEF/OIF veterans (Tanielian et al., 2008). Of veterans returning between April 2007 and January 2008, Rand found high rates of PTSD (14%), major depression (14%) and probable traumatic brain injury (TBI, 19%), often referred to as the “signature wound” of the wars in Afghanistan and Iraq (Galarneau, Woodruff, Dye, Mohrle, Wade, 2008; Tanielian et al., 2008). Based on the 1.64 million service members deployed during OEF/OIF/OND, these findings showed approximately 300,000 (~18%) returning veteran have a diagnosis of PTSD or major depression and approximately 320,000 (~20%) returning veterans experienced a probable TBI during deployment. They also indicated approximately one-third will have at least one condition and 5 percent will have experienced symptoms of all three diagnoses. Altogether, these findings suggest high rates of mental illness and TBI will continue to exist among incarcerated veterans as more soldiers survive combat injuries (Gawande, 2004).

Perceived Causes of the Problem

Varieties of explanations for the overrepresentation of persons with mental illness in the criminal justice system have been cited. Many attribute the problem to deinstitutionalization and corollary phenomenon of transinstitutionalization and many believe the lack of community mental health services has contributed to the “criminalization” of persons with mental illness. Others argue the problem is more complex and point out that clinical factors are weak predictors of crime and that mental illness correlates with other risk factors that cause crime and that mental illness elevates risk factors that lead to crime causing persons with mental illness to comprise a
greater proportion of arrests (Andrews & Bonta, 2006; Draine, Salzer, Culhane, & Hadley, 2002). Understanding the possible causes of the current problem is important because how policy makers understand the problem influences the design of interventions to address the problem.

Deinstitutionalization is the most widely cited reason for the overrepresentation of persons with mental illness in the criminal justice system (Fisher et al., 2006; Steadman, Monahan, Duffee, Hartson, & Robbins, 1984; Torrey 1995, 2008). Deinstitutionalization describes a variety of events that led to the closing of state mental health hospitals between the 1950s and 1990s (Fisher et al., 2006; Steadman et al., 1984; Torrey, 1995, 2008). Statutory reforms made it increasingly difficult to commit and hold individuals in state mental hospitals, while revolutionary drugs, such as Thorazine, created alternatives to institutionalization allowing treatment in the community (Melton, Petrila, Poythress, & Slobogin, 2007; Petrila, 1992). Other factors contributing to deinstitutionalization included exposés of deplorable conditions in state hospitals that influenced public opinion against state institutions; budgetary constraints that motivated states to begin discharging patients; and the Community Mental Health Act of 1963 that created access for community treatment (Fisher et al., 2006; Steadman et al., 1984; Torrey, 1995, 2008).

Although funding for community mental health services increased through the creation and expansion of Medicaid and SSI, it largely remained inadequate (Frank, Goldman & Hogan, 2003; Petrila, 2001). The increased funding and expansion of Medicaid and SSI in the 1980s also had the unintended effect of speeding up deinstitutionalization. This led to the phenomena of transinstitutionalization, where psychiatric patients were transferred back and forth from community institutions, such as inpatient facilities and jails (Fisher et al., 2006; Frank et al.,
2003; Steadman et al., 1984; Teplin, 1983, 1984; Torrey, 2008). Consequently, many persons with mental illness were discharged from institutions without inadequate housing and social support (Torrey, 1988). Not surprisingly, as these events unfolded and homelessness and incarceration increased among persons with mental illness, so did the perception that the mental health system was failing in its mission to provide adequate services for persons with mental illness in the community (Fisher, 2006; McNeil, Binder & Robinson, 2005).

Criminalization

In 1972, the growing incarceration rate of persons with mental illness led a California psychiatrist to coin the term criminalization (Fisher et al., 2006). Since, criminalization has been linked to deinstitutionalization and widely used to describe the problem of the overrepresentation of persons with mental illness in the criminal justice system. Because of its influence, it is important to examine the concept of criminalization more closely.

The term criminalization has specific connotations. Most importantly, it implies jails and prisons became substitutes for state mental hospitals, presumably because persons, who were previously state hospital patients, were refusing treatment in the community or unable to access treatment in the community (Fisher et al., 2006). Junginger, Claypoole, Ranilo and Crisanti (2006) provided a detailed definition of the term distinguishing between symptoms that bring persons with mental illness to the attention of law enforcement and symptoms that directly or indirectly lead to arrest. They wrote:

Why persons with serious mental illness are more likely to be arrested and incarcerated is unclear, but a literal and popular interpretation of the criminalization hypothesis implies two possibilities. First, symptoms of serious mental illness have become de facto criminal offenses; that is, person with serious mental illness are arrested and incarcerated
for displaying psychiatric symptoms. Second, symptoms of serious mental illness motivate or otherwise cause actual criminal offenses (p. 879).

This description of criminalization is important because it clarifies what causes a person with mental illness to become “criminalized” and raises the question of whether persons with mental illness are being targeted for arrest or mental illness motivates or causes criminal offenses and whether these factors are contributing to the growing problem. While a full review of the literature investigating whether persons with mental illness are targeted for arrest or investigating the causal link between mental illness and crime is beyond the scope of this literature review, it is important to briefly discuss some of the evidence to better understand the validity of criminalization and its ability to explain the current problem.

The question of whether persons with mental illness are targeted for arrest has been addressed in a number of studies using prevalence data of incarcerated persons with mental illness, arrests rates of persons discharged from mental hospitals, and comparisons of arrest rates between persons with and without mental illness (Engel & Silver, 2001; Lamb & Weinberger, 1998; Rabkin, 1979; Teplin, 1984). Teplin (1984) compared persons displaying mental health symptoms in Cook County, Illinois and found an increased probability of arrest for those who were displaying such symptoms. On the other hand, when the problem was first becoming evident, Bittner (1967) found that police were “reluctant to take any official action (including arrest) ‘on the basis of the assumption or allegation of mental illness’ and that officers often chose to resolve such encounters informally” (p. 229). In addition, Bonvitz and Bonvitz (1981) found police were not likely to arrest non-committable persons with mental illness involved in non-dangerous incidents simply out of expediency. Engel and Silver (2001) also found police
were not more likely to arrest persons with serious mental illness or use arrest to manage persons with mental illness.

The question of whether there is a causal link between mental illness and crime has been researched extensively. Frank and McGuire (2010) conducted an extensive review and concluded there was convincing evidence for a small association between mental illness and crime, but it only applied to certain subgroups of persons with mental illness. They wrote:

a small fraction (Skeem et al., 2009 judge it to be one in ten) of criminals with mental illness commit crimes because of their current illness, but the elevated risk is small.

Current treatment can ameliorate current illness and symptoms, but cannot reverse the past effects of illness on the accumulation of other risk factors over a person’s lifetime (p. 4).

Frank and McGuire (2010) also noted that assessing the causal link between mental illness and crime was difficult for two reasons: 1) mental illness was correlated with factors that cause crime (e.g., criminal thinking), and 2) mental illness elevated risk factors that lead to crime (e.g., substance abuse). These findings do not exclude mental illness from being an indirect risk factor that should be considered. As noted, mental illness increases the accumulation of other risk factors for crime over a person's lifetime and persons with mental illness in the justice system have more of the greater, non-clinical risk factors than persons without mental illness in the justice system (Osher et al., 2012).

The central eight criminogenic risk factors will be discussed in more detail below; but for the purposes of clarification, they refer the greatest risk factors for crime, which do not include clinical factors, or symptoms mental illness.
Court Supervision Failure

Court-ordered supervision failure would be another cause of the problem. Research in court supervision failure, however, has also found there is only a small association between mental illness and supervision failure, which is a significant contributor to the incarceration rates of persons with mental illness. Skeem and Louden (2006) found three possible links between mental illness and supervision failure: a direct link, indirect link and spurious link. A direct link describes a situation where mental health symptoms, such as psychosis, directly cause a person to violate probation, e.g., delusional beliefs motivate a new offense such as assault. An indirect link describes a situation where mental health symptoms affect another factor, e.g., the inability to maintain employment causes a technical violation because of the probation requirement to work. Lastly, a spurious link describes a situation where another factor linked to both mental illness and supervision failure causes a person to violate. For example, the stigma associated with mental illness causes more intensive monitoring, which results in the discovery of a behavior that leads to violation.

Skeem and Louden (2006) further reviewed three studies that inform these possible relationships. In the first study, Dauphinot (1996) compared various reasons for supervision failure between probationers with and without severe mental illness and found those with a mental illness were less likely to have their probation revoked as the result of a new arrest, equally likely to have their probation revoked as the result of a felony conviction, and more likely to have their probation revoked as the result of a new misdemeanor conviction. In addition, probationers with a mental illness were more likely to have their probation revoked as the result of failure to pay fines or fees or for “other” violations, including failure to maintain employment, but equally likely to have a technical violation the result of not reporting to
probation or from a positive urinalysis as compared to probationers without mental illness.

Skeem and Louden (2006) interpreted these findings as supporting either an indirect or a spurious relationship in that severe mental illness appeared to impair probationer functioning and ability to follow standard conditions of probation (an indirect link) and/or that probation officers or judges may be setting different revocation standards (a spurious link) for persons with mental illness.

A second study reviewed appeared to support a spurious relationship as well. Solomon, Draine and Marcus (2002) followed 250 probationers with severe mental illness in specialty probation and parole programs over a twelve-month period and conducted interviews at three-month intervals to identify risk factors for incarceration. Overall, results found significant risk factors for violating supervision included both clinical factors and non-clinical factors, such as probationer criminal history, demographics and motivation for treatment as well as probation officer perceptions of motivation and probation officer strategies. For instance, probationers who participated in treatment were less likely to be arrested on a technical violation and the strongest predictors of incarceration for both new offenses and technical violations were probationer beliefs their medications were not helpful and probation officer’s perception that probationer treatment motivation was poor. Of significance, odds ratios showed probationers with mental illness incarcerated for a technical violation were six times more likely than probationers with mental illness not incarcerated for a technical violation to have received intensive case management and probation officers who collaborated with intensive case managers were 12 times more likely to threaten incarceration. Skeem and Louden (2006) also noted the finding regarding probation officer and case manager collaboration were consistent
with a previous study conducted by Solomon and Draine (1995) that showed collaboration between monitoring parties enhanced coercive interactions, further supporting a spurious link.

In a third study, Skeem, Encandela and Louden (2003) reviewed results from five focus groups to assess how probationers and probation officers viewed various factors that influenced supervision outcomes. Three factors appeared to contribute to poor supervision outcomes, each of which related to the quality of relationship between probationer and probation officer. The first included the use of negative pressures to promote compliance with treatment mandates by probation officers. The second included the perception of probationers that their probation officers were uncaring, unfair and/or disrespectful. The third factor identified included the limited resources that affected training opportunities, caseload size and ability to adapt to needs of probationers with severe mental illness. In conclusion, the quality of the relationship between probationer and probation officer was found to affect the range, nature and timing of strategies used to monitor clients and implement treatment mandates as well as supervision outcomes. Skeem and Louden (2006) interpreted these findings as supporting an indirect link as probationer risk factors related to mental illness affect contextual risk factors (limited resources, relationships, and monitoring strategies). Skeem and Louden further indicated, “The results also lend some support to a spurious relationship that involves increased monitoring” (p. 336).

Other research appears to support these findings and the importance of relationship quality in supervision outcomes. Skeem, Louden, Manchak and Haddad (2009) assessed 82 probationers with co-occurring disorders over eight months to examine the way in which social control is applied mediates its effect on behavior. Results from this study indicated satisfying relationships with clinicians and probation officers (although to a lesser degree) correlated to better supervision outcomes and higher rates of treatment adherence as well as lower rates of
perceived coercion. In addition, perceived coercion was associated with poor quality relationships as well as probationers not feeling involved with decision-making. In terms of relationships with clinicians, positive relationships correlated with feeling less coerced and better treatment attendance as well as fewer recent and future probation violations.

In addition, Skeem, Louden, Polaschek and Camp (2007) developed and validated the Dual-Role Relationship Inventory (DRI-R), to measure the quality of relationship of a probation officer and/or case manager functioning in a dual-role as case manager and agent of court. In this study, they hypothesized two domains (alliance and relational fairness) would impact supervision outcome based on previous studies which found:

…probationers with mental disorder and their officers believed that the quality of their relationships colored every interaction and strongly influenced clinical and criminal outcomes. Harmful relationships were described as authoritarian ones characterized by many demands, little flexibility, and belittling use of control. These relationships were perceived as ongoing stressors that compromised probationer’s mental state and functioning and sometimes engendered reactance to officer’s directives. In helpful relationships, the affiliative aspects of the therapeutic alliance were blended with social control (p. 399).

While validating the instrument, the dual relationship quality was found to involve caring and fairness, trust as well as authoritative style described as “firm but fair” but not “authoritarian”. The DRI-R was also found to be predictive of supervision outcomes.

**Risk Factors for Crime**

The mixed evidence that supports the presence of criminalization and the above research on supervision failure suggests criminalization as described by Junginger and colleagues (2006)
does not adequately account for the extent of the problem and overrepresentation of persons with mental illness in the criminal justice system. If this is true, what other factors shed light on the problem? In other words, what risk factors predict crime or correlate with mental illness?

Risk factors for crime that are common among individuals with mental illness include homelessness and substance abuse (Constantine et al., 2010; Lamberti et al., 2004; McNeil et al., 2005). Constantine and colleagues (2010) found two-thirds of a sample of justice-involved persons with serious mental illness in Pinellas County, Florida had a substance abuse diagnosis, and over 90% of these persons had a diagnosis or substance abuse service contact (e.g., detox). In addition, McNeil and colleagues (2005) found that 78% of inmates who entered the San Francisco County Jail system with a serious mental illness who had been homeless at the time of arrest had substance related disorders. These studies also found that homeless individuals with substance use spent longer time in jail than other people charged with similar crimes.

Other risk factors for crime common to persons with mental illness include low levels of education and low employment rates (Constantine et al., 2010; Lamberti et al., 2004; McNeil et al., 2005; Mocan & Tekin, 2006). For example, Breslau, Lane, Sampson and Kessler (2008) found individuals with a serious mental illness were more likely than those without mental illness to not complete high school and those who did complete were less likely to graduate from college. Rylance (1997) found high school dropout rates as high as 50% among youth with serious emotional disturbance. These lower levels of education would contribute to poorer job prospects. Not surprisingly, the President's New Freedom Commission on Mental Health (2003) suggested unemployment rates among individuals with serious mental illness were as high as 90%. Persons with serious mental illness, who are employed, also earn lower wages than persons without mental illness (Kessler et al., 2008).
Associations between criminal thinking and mental illness have also been found. For instance, Morgan, Fisher, Duan, Mandracchia and Murray (2010) found inmates with mental illness scored as high or higher on criminal thinking and attitude measures as compared with inmates without mental illness. In addition, childhood conduct disorder has been found at higher rates in adult schizophrenics and research has shown children with conduct disorder have an elevated risk to develop adult mental disorders (Frank & McGuire, 2010; Morgan et al., 2010).

Perhaps, the most important consideration when assessing the current problem is that substantive research suggests clinical factors are weak predictors of crime (Bonta, Hanson, & Law, 1998; Case et al., 2009; Erickson et al., 2009; Lamberti et al., 2004; Philips et al., 2005). In a meta-analysis of predictors of criminal or violent recidivism among offenders with mental disorders, Bonta et al. (1998) found “clinical or psychopathological variables were either unrelated to recidivism or negatively related” (p.139). Instead, a large body of research shows the greatest risk factors, or criminogenic needs, include non-clinical variables such as: antisocial behavior, antisocial cognition, antisocial attitudes, and antisocial associates, as well as family and/or marital problems, school and/or work problems, types of leisure/recreation activities, and substance abuse problems (Andrews, Bonta, & Wormith, 2006; Andrews & Dowden, 2007). While mental illness may contribute to the accumulation of these and other risk factors for crime, according to Bonta and colleagues (1998) findings from research are clear and “the major correlates of crime are the same regardless of race, gender, class, and the presence or absence of a mental illness” (p. 139).

Investigations of Assertive Community Treatment (ACT) program provide additional support for the findings that there is only a small association between mental illness and crime. ACT programs typically consist of a psychiatrist, psychiatric nurse, social worker, therapist and
other support staff who provide wrap around in-home services, which include medications and case management as well as therapy, supportive housing and supportive employment. Staff members visit clients frequently, often multiple times a week, and are typically available 24 hours a day, seven days a week to intervene in crises. Despite the intensity of treatment services provided, ACT programs have shown little or no effect on incarceration rates (Bond, Drake, Mueser, & Latimer, 2001; Erickson et al., 2009; Fisher et al., 2006; Lamberti, 2007; Lamberti et al., 2004; Mueser, Bond, Drake, & Resnick, 1998).

For example, Calslyn, Yonker, Lemming, Morse and Klinkenberg (2005) evaluated homeless persons with a co-occurring substance abuse and mental illness disorders randomly assigned to standard treatment, integrated treatment and assertive community treatment (ACT) and found approximately half were arrested and neither the diagnosis nor the type or dosage of mental health treatment predicted criminal behavior. The study also found prior criminal behavior was the strongest predictor of arrest. Another study found similar results. Solomon and Draine (1995) randomly assigned 200 homeless persons leaving jail in a large suburban area to either ACT, individual case managers or to the usual aftercare referral. Results indicated ACT clients were more likely to return to jail, which the authors attributed, in part, to the increase in informal monitoring.

ACT programs have not been effective in reducing arrests because they target primarily mental health symptoms, not criminogenic needs. In response, state mental health agencies have funded Forensic ACT (FACT) programs, which have shown promise reducing recidivism (Cusack, Morrissey, Cuddeback, Prins, & Williams, 2010; Lamberti et al., 2004). FACT programs differ from ACT programs in that FACT focus on improving criminal justice outcomes and working within the criminal justice system. Since FACT programs work closely with the
courts and probation officers, they improve the ability of these programs to utilize the leverage of the legal system to improve criminal justice outcomes (Lamberti et al., 2004). In a randomized clinical trial that assigned frequent jail users with serious mental illness to FACT and treatment as usual (TAU), Cusack et al. (2010) found those assigned to FACT at 12 months had fewer bookings and higher probability of avoiding jail. In addition, Erickson et al. (2007) examined predictors of arrest in a prototypical FACT program. In this study, demographics and clinical data from 130 persons treated in Project Link were merged with a statewide database. Results found variables associated with arrest in the program were similar to those seen in the general population, supporting the need to target criminogenic needs in treatment.

Veterans and Crime

In terms of risk factors for veterans and crime, a limited amount of research has evaluated the association between aspects of military service, in particular combat experience, and mental health problems, substance abuse and crime. Milliken, Auchterlonie and Hoge (2007) found soldiers who served in Iraq were at risk for various problems, including interpersonal conflicts and other problems, such as depression, PTSD, and suicidal and aggressive thoughts. The National Vietnam Veterans Readjustment Study (NVVRS) (1990) is perhaps the most widely cited study on the relationship between military trauma and post-deployment mental health problems and crime (Kulka et al., 1990). In addition to describing the relationship, NVVRS found nearly half of male combat veterans with current PTSD were arrested at least one time in the past and veterans with PTSD committed significantly more acts of violence than others without PTSD, 13.3 versus 3.54 violent acts per year (Kulka et al., 1990). Furthermore, Saxon et al. (2001) found incarcerated veterans with PTSD reported poorer health, higher rates of lifetime alcohol and drug use, risk factors for crime, as well as more serious legal charges.
These studies as well as anecdotal information have led some to speculate there is a link between PTSD and crime. It is hypothesized that symptoms of PTSD influence how individuals perceive, process and respond to others, which, in turn, causes them to misinterpret situations as threatening and react irrationally or disproportionately. Symptoms of PTSD may include changes in cognition, such as in the form of flashbacks, misinterpretations of perceived threats or extreme beliefs about justice. Symptoms may also include heighten psychophysiological arousal, such as increased anger or irritability, hyper-vigilance, or exaggerated startle responses; and/or cause emotional reactions, such as psychological distress or emotional numbing. Any of these symptoms may influence lifestyle choices and ways of coping that lead to behaviors that trigger a law enforcement response (Begic & Begic, 2001; Collins & Bailey, 1990).

More recently, Elbogen et al. (2012) investigated the theory that veterans exposed to a traumatic event who reported symptoms of irritability or anger were at increased risk of criminal conduct. By analyzing data from a national survey (N= 1,388) of Iraq and Afghanistan war era veterans, Elbogen and colleagues found results similar to other criminal justice literature that only a subset of veterans experiencing symptoms of irritability and anger were at risk of criminal arrest. They further concluded that "because arrests were more strongly linked to substance abuse and criminal history, clinicians should also consider non-PTSD factors when evaluating and treating veterans with criminal justice involvement" (p. 1098). Research, however, remains limited.

It is also worth commenting briefly on the association between PTSD and violence as considerable episodes of violence perpetrated by veterans returning from Iraq and Afghanistan have been documented in the media (Elbogen et al., 2014). Using multivariate modeling, Elbogen, Beckham, Butterfield, Swartz and Swanson (2008) analyzed a pooled sample of
veteran (N = 278) and non-veterans with serious mental illness for violence risk factors and
found that violence among veterans was associated with head injury, PTSD, substance abuse
and, notably, homelessness. They further conclude that "results support the view clinicians
assessing violence risk among veterans with SMI should consider a combination of
characteristics empirically related to violence by non-veterans with SMI (e.g., homelessness) and
veterans without SMI (e.g., PTSD)" (p. 113).

In addition, Elbogen et al. (2014) analyzed multiwave survey data from a random sample
of veterans who served after September 11, 2001 (N = 1090) to investigate the extent to which
PTSD and other factors predicted future violent behavior. Results found a marked increase in
violence and aggression for veterans with co-occurring PTSD and alcohol misuse, but for
veterans with no alcohol misuse, PTSD did not significantly predict severe aggression and only
marginally predicted other physical aggression. Researchers further concluded the importance of
evaluating the accumulation of non-clinical risk factors stating:

Attention to cumulative effects of multiple risk factors beyond diagnosis – including
demographics, violence history, combat exposure, and veterans’ having money to cover
basic needs like food, shelter, transportation, and medical care – is crucial for optimizing

Responses to the Problem

Public policy responses have continued to focused on symptom reduction and linking
persons to treatment in an effort to “decriminalize” mental illness despite the lack of evidence
that criminalization is a significant factor that has caused the overrepresentation of persons with
mental illness in the criminal justice system, and in spite of the evidence that shows clinical
factors are weak predictors of crime (Munetz & Griffin, 2006; National Alliance on Mental
Illness [NAMI], 2008). Fisher et al. (2006) observed this and commented that “focusing on the individuals who have been involved in the criminalization process has shifted the offending behavior’s theorized etiology from individual psychopathology to the socio-legal/system context in which deviant behavior is exhibited” (p. 546). Consequently, we have seen jail diversion programs grow considerably, from 52 to well over 560 since 1992, presumably to mediate the effects of deinstitutionalization (Case et al., 2009; Fisher et al., 2006; GAINS Center, 2010; Morrisey et al., 2009). Nevertheless, these programs, however effective in improving certain outcomes, have not reduced the overall rates of persons with mental illness in the criminal justice system, and have only shown mixed outcomes reducing recidivism for persons with mental illness (Case et al., 2009; Steadman & Naples, 2005).

**Jail Diversion and Sequential Intercept Model (SIM)**

The GAINS Center helped developed the Sequential Intercept Model (SIM) to assist local communities to prevent the unnecessary criminalization of persons with mental illness (Munetz & Griffin, 2006). The model conceptualizes how persons move through the criminal justice system and identifies five intercept points to develop strategies to prevent the deeper penetration of persons with mental illness into the system. Munetz and Griffin (2006) identified these intercept points as: 1) law enforcement and emergency services; 2) initial detention and initial hearings; 3) jail, courts, forensic evaluations, and forensic commitments; 4) reentry from jails, state prisons, and forensic hospitalization; and 5) community corrections and community support services.

Intercept 1 includes pre-booking programs that attempt to divert persons to treatment prior to arrest. Such programs emphasize specialized training for law enforcement and collaboration with mental health professionals and community agencies. Crisis Intervention
Teams (CIT) are an example of a widely implemented pre-booking program. CITs consist of police officers specially trained to prevent arrest through de-escalation and/or by transporting persons to emergency mental health treatment facilities for assessment rather than jail. Compton, Bahora, Watson, and Oliva (2008) reviewed the CIT literature and found CIT training had a positive effect on police officers in terms of improving their attitudes, beliefs, and knowledge about persons with mental illness and that CIT-trained officers felt better prepared to respond and handle calls involving persons with mental illness. In addition, Teller, Munetz, Gil and Ritter (2006) found CIT-trained officers transported more persons with mental illness to emergency psychiatric treatment facilities, although they found no significant changes in arrest rates for mental health calls.

Intercepts 2 and 3 include post-booking programs that divert persons with mental illness after arrest. While Intercept 2 focuses on diverting persons to treatment at the initial hearing and may include legal dispositions where charges are dropped prior to or after the completion of treatment, Intercept 3 focuses on diverting persons to treatment after the initial hearing. Intercept 3 also includes specialized dockets and treatment courts (GAINS Center, 2010; Munitz & Griffin, 2006; Steadman & Naples, 2005).

A number of multi-site studies have investigated the effectiveness of a broad range of post-booking diversion programs targeting persons with co-occurring mental illness and substance abuse disorders. Broner et al. (2004) conducted an analysis using data from the Jail Diversion Knowledge Development Application (KDA) initiative funded by Substance Abuse and Mental Health Service Administration (SAMHSA). In this study, Broner and colleagues investigated eight pre-and post-booking programs in eight states using quasi-experimental non-equivalent comparison groups and found diversion increased access to treatment but did not
significantly improve mental health symptoms or criminal justice outcomes. Broner et al. concluded outcomes were likely dependent on the type of intervention rather than the diversion itself. Using the same KDA data set, Steadman and Naples (2005) evaluated six pre-and post-booking programs in six states using a quasi-experimental non-equivalent comparison group as well and found persons diverted experienced reduced days in jail without increasing public safety risks, however, they did not find a significant reduction in arrests during the twelve-month follow up.

Mental health treatment courts located in Intercept 3 seek to use the leverage of the court to promote treatment adherence and connection to services. Mental health courts are modeled after drug treatment courts and include common components, such as on-going status hearings before the judge in court; mandatory completion of treatment; and negative sanctions for program infractions and/or positive rewards, including a graduation ceremony (Marlowe, Festinger, Dugosh, & Lee, 2005). Although research has not isolated effects of the key components of mental health courts to show what is causing positive outcomes, research on treatment courts suggest status reviews and interactions with the judge have a positive effect on treatment outcomes (Marlow et al., 2005). Overall, treatment courts have shown promise at reducing recidivism, perhaps because participants receive and observe encouragement and/or sanctions, including jail time, to motivate behavior change and promote treatment compliance and because treatment courts increase social support through linkage to community treatment services (Marlowe et al. 2005).

Using a 12-month pre-post comparison design, Herinckx, Swart, Ama, Dolezal and King (2005) conducted a secondary analysis of mental health and jail data of 368 misdemeanants with severe and persistent mental illness served by the Clark County Mental Health Court in
Vancouver, WA. This study found a significant reduction in overall crime rate for participants one year post-enrollment compared with one year pre-enrollment with graduation status being the most significant factor in crime reduction. In addition, using a pre–post and group comparison design, Turpan and Richards (2003) collected data during specific periods of observation at two mental health courts in Kings County Washington. Results from this study found mental health participants experienced a decrease in days spent in jail and an increase in linkages to mental health services as well as an increase in functioning. On the other hand, in a study of clinical outcomes assessed at one, four, and eight months using the Brief Psychiatric Rating Scale (BPRS), Boothroyd, Mercado, Poythress, Christy and Petrila (2005) found increased access to care did not lead to a reduction of mental health symptoms for participants in the Broward County Mental Health Court.

More recent studies continue to show promise. More and Hiday (2006) collected data from a mental health court in a county in the Southeastern United States and compared outcomes to a comparable traditional court and found mental health court participants had fewer arrests in the year following entry to mental health court than the comparison court. McNeil and Binder (2007) also found participants in a mental health court in San Francisco experienced fewer new charges, including charges of violent crime, than a comparable group who did not enter mental health court. Most recently, using administrative mental health and court data, Hiday and Ray (2010) compared arrest rates of participants in a mental health court in North Carolina two years prior to admission to mental health court and two years following and found a significant reduction in recidivism rates even after graduation when not being monitored by the courts.

Intercepts 4 and 5 focus on reentry from jails/prisons and corrections and include probation and parole. The emphasis in these Intercepts, therefore, is not on diversion but on
crime prevention and the provision of treatment and services that prevent recidivism and/or supervision failure. Correctional strategies for persons with mental illness include mandated treatment and specialty probation.

**Mandated Treatment and Specialty Probation**

Hitherto, the majority of research on criminal justice outcomes for persons with mental illness has focused on jail diversion and treatment courts. More recently, however, researchers have begun investigating the link between mental illness and supervision failure and the effectiveness of specialty probation on criminal justice and mental health outcomes (Skeem & Louden, 2006). While limited, findings have been consistent with other research that indicates criminal justice outcomes are not strongly related to clinical factors (Andrews, & Bonta, 2006; Bonta Hanson, & Law, 1998; Case et al., 2009; Frank, & McGuire, 2010; Lamberti, 2007). Studies evaluating specialty probation departments have found them to be effective at improving criminal justice outcomes for probationers with mental illness and emphasize the importance of relationship quality between probationer and probation officer and therapist. They also provide evidence that coercive probation officer strategies for motivating compliance have adverse effects on criminal justice outcomes, as do intensive mental health services (Skeem at al., 2009; Solomon et al., 2002).

In a national survey, Skeem, Emke-Francis and Louden (2006) identified five key features as making up a specialty probation department distinct from a traditional probation department: (1) exclusive mental health caseloads; (2) meaningfully reduced caseloads; (3) sustained probation officer mental health training; (4) integration of internal and external resources including working with treatment providers and attending treatment meetings; and (5) use of problem solving strategies rather than negative threats. In addition, they found that
specialty departments that deviated from these five features were less likely to engage in problem solving strategies and more likely to utilize revocation or the threat of revocation as a strategy. Extant literature on supervision outcomes, however, remains limited.

Skeem and Louden (2006) reviewed the following three studies that investigated such programs. Roskes and Feldman (1996), using only a small sample of 16 without a control group, found probationers with severe mental illness had lower rates of violations on specialty caseloads compared to probationers in traditional caseloads. Burke and Keaton (2004) randomly assigned probationers with severe mental illness to specialty probation, which included admission to an intensive case management program, or to traditional probation. Although there were high incompletion rates, those who completed were less likely to be arrested on a new offense or to be incarcerated in a six-month follow up. Skeem and Louden (2006) noted for this study that "specialty probation" did not “involve automatic access to a predefined, intensive case management program” (p.339). In a final study of the IM-PACT located in Orange County California, offenders were randomly assigned to four groups, including a control group not on probation, treatment only group, a specialty probation group and a traditional probation group. While incarceration rates were similar, specialty probationers received a larger dosage of mental health services, including more prescriptions.

**First Generation Interventions**

Considering the studies reviewed thus far, significant progress has been made in implementing mental health oriented criminal justice programs, treating persons with mental illness in the criminal justice system and improving collaboration between the mental health and justice systems. Investigations into various mental health jail diversion programs have shown these programs improve access to treatment and clinical outcomes and that they reduce the time
persons with mental illness spend in jail. Only mixed evidence, however, shows they reduce incarceration rates. In their monograph *The Next Generation of Behavioral Health and Criminal Justice Interventions: Improving Outcomes by Improving Interventions*, Epperson et al. (2011) recognized this and the fact that the problem of the disproportionate number of persons with mental illness in justice system was not being addressed. In response, they labeled these and other system responses to the problem (i.e., CIT, treatment courts and specialized probation programs) as "first generation interventions". Epperson et al. further characterized these first generation interventions as being united in their assumption that incarceration rates for persons with mental illness could be reduced simply with the provision of mental health treatment stating:

While some of the first generation interventions have demonstrated efficacy and several have earned recognition as evidence-based practices, a general consensus has emerged that collectively we are not maximizing the effectiveness of first generation interventions (Blitz, Wolff, Pan, & Pogorzelski, 2005; Skeem, Manchak, & Peterson, 2011). This is perhaps best illustrated by the aforementioned range of prevalence studies which, over the course of two decades, do not demonstrate any meaningful reduction in the over-representation of persons with SMI in the U.S. criminal justice system. Additionally, although several of these first generation interventions have made strides in developing collaborative efforts between mental health and criminal justice systems, these interventions tend to exist as primarily “mental health” or “criminal justice” interventions, and as such do not typically reflect integrated philosophies, services, and outcomes (p. 1). This is concerning in so far as recidivism, not criminalization *per se*, is the greatest contributor to the problem of the overrepresentation of persons with mental illness in
the criminal justice system. A more integrated approach that focuses on reducing recidivism, therefore, is needed. To this end, mental health policy makers may need to subordinate the goal of improving access to mental health treatment to the goal of reducing recidivism. Given this, it is worth reviewing a widely implemented, evidence-based strategy for reducing recidivism for persons without mental illness.

**Risk-Needs-Responsivity (RNR)**

Risk-Needs-Responsivity (RNR) is a widely used criminal justice strategy that has been found to be effective reducing recidivism for offenders without mental illness, which, more recently, is being adopted by mental health providers (Andrews & Bonta, 2003; Lowenkamp, Latessa, & Holsinger, 2006; Taxman & Marlowe, 2006; Taxman & Tanner, 2006). RNR consists of a set of principles that emphasize the importance of targeting risk factors for crime and matching services with offender characteristics (Andrews & Dowden, 2007). The *risk* principle implies that more intensive services should be provided to offenders who pose a higher risk of recidivism, while the *needs* principle emphasizes services should target criminogenic needs, or needs that are strong predictors of crime and can be changed. The *responsivity* principle, on the other hand, refers to matching services to offender characteristics, such as personality, learning styles and motivational level (Andrews & Dowden, 2007).

Research has supported the RNR model and shown that recidivism can be reduced if the level of treatment services are proportionate to the offender's risk to re-offend and that mismatching intensive treatment services to those who pose a lower risk will result in little or no improvement in recidivism, or worse, even increase the risk of reoffending (Andrews & Bonta, 2003). RNR acknowledges that offenders may have many treatment needs that warrant attention, but emphasizes the fact that not all of these needs are directly associated with criminal
behavior. RNR distinguishes between dynamic risk factors, such as employment, which can change, and static risk factors, such as race and gender, which do not. The greatest dynamic risk factors have been labeled *criminogenic needs* to draw focus to the *need* itself and highlight the fact that when the *need* is met or reduced, the risk of re-offending decreases.

While mental illness is not a criminogenic need, it is incorporated into the RNR model as a *responsivity* factor. Assessments and interventions that target criminogenic needs, therefore, should not neglect mental health symptoms. But, instead, should focus on maximizing responsivity to the "criminal justice" intervention by removing barriers to successful program participation. To achieve this, both external factors, such as staff and program characteristics, and internal factors, such as client background and learning styles, ought to be factored into any treatment equation. For example, Osher et al. (2012) wrote:

> Even though depression is considered a noncriminogenic need, case planners must be aware of symptoms or disorders that may impede the individual’s ability to adopt new skills. Because the majority of individuals under correctional control have extensive trauma histories, it is also necessary to incorporate trauma-informed principles in developing interventions. A case plan should address the “responsivity issues” that create barriers to successful program participation. However, targeting noncriminogenic needs should never supplant the focus on criminogenic needs (p.26).

In RNR theory, the "general responsivity" principle holds that social learning/cognitive behavioral approaches are more effective for offenders than other treatment approaches. The "specific responsivity" principle, on the other hand, takes into account individual learning styles, symptoms severity and motivation and represents a "fine tuning" of these various approaches (Andrews, 2010). Of note, social learning/cognitive behavioral approaches emphasize prosocial
modeling, teaching problem-solving skills and the use of positive rather than negative reinforcements.

The GAINS Center, which provides consultation and technical assistance for communities to help improve integrated behavioral health services and system collaboration, included RNR as an evidence-based practice (EBPs) for treating persons with mental illness involved in the criminal justice system (Rotter & Carr, 2014). Furthermore, Osher et al. (2012) recommended RNR as a foundational model that can assist behavioral health and justice systems coordinate and prioritize resources. Because behavioral health and justice systems have their own evidenced-based policies with competing agendas that allocate their limited resources accordingly with the justice system focusing on public safety and the behavioral health system focusing stabilization and advancing recovery, a strategy is needed that brings them together. Osher et al. (2012) recommend RNR as being able to do this because RNR, in its emphasis on reducing recidivism and its understanding of mental illness as a responsivity factor, connects behavioral health needs to criminogenic risks.

Veteran-specific Responses

While Title 38 Code of Federal Regulations 17.38(c)(5) prohibits the provision of treatment for incarcerated veterans, Congress mandated in Public Law 107-95, Section 2022 the development of a coordinated outreach plan to target veterans at-risk of homelessness, including incarcerated veterans (Department of Veterans Affairs, 2009). This mandate led to the establishment of the Homeless Care for Reentry Veterans (HCRV) program that provides outreach to veterans in prison. In 2009, the Veterans Health Administration (VHA) expanded criminal justice outreach to local jails and courts by strongly recommending VA Medical Centers to staff a Veterans Justice Outreach Specialist (VJO) (Clark et al., 2010; Department of Veterans
VJOs work with local courts, jails and law enforcement to insure veterans have access to needed VA and community-based treatment and services.

In response to the growing number of returning OEF/OIF/OND veterans with combat related mental health problems, many local communities have implemented veterans treatment courts to assist justice-involved veterans. Veterans treatment courts are modeled after drug and mental health treatment courts that seek to facilitate access to treatment and promote treatment adherence. As of June 30, 2012 there were 104 veteran treatment courts in (National Association of Drug Court Professionals [NADCP], 2015). The Buffalo Veterans Treatment Court, which began in January of 2008, has provided the model for which other veterans’ treatment courts are planned. Like other treatment courts, veterans’ treatment courts are collaborative and non-adversarial and seek to motivate treatment adherence through the use of encouragement, feedback, sanctions and linkages to individualized treatment and services.

Various state and federal legislative initiatives have been enacted or are in development to assist with the promulgation of veterans treatment courts (National Association of Drug Court Professionals, 2011; Clark et al., 2010). As of yet, however, there are no published outcome studies as to their effectiveness (Clark et al., 2010). What, perhaps, is most distinctive about veterans treatment courts strategies is the implementation of veteran peer mentors to assist justice-involved veterans in recovery. According to Clark et al. (2010) all veterans treatment courts currently in operation as of 2010 either used or planned to use veteran peer mentors as a treatment intervention. However, there is no current data on the percentage of veterans treatment courts that utilize veteran mentors. The use of peer mentors is based on the belief that veterans will respond and relate more favorable to individuals who have similar experiences as they have.
The *Buffalo Veterans Court: Mentoring and Veterans Hospital Program Policy and Procedure Manual* describes the mentor role as follows:

The role of the Volunteer Veteran Mentor is to act as a coach, a guide, a role model, an advocate, and a support for the individuals she/he is working with. The mentor is intended to encourage, guide and support the mentee as she/he progresses through the court process. This will include listening to the concerns of the veteran and making general suggestions, assisting the veteran determine what their needs are, and acting as a support for the veteran at a time when they may feel alone in a way that only another veteran can understand (NADCP, 2011)

The Buffalo Veterans Treatment Court mentoring program continues to serve as a model for other veterans treatment courts and requires peer mentors complete initial and ongoing training and commit to a minimum of six months. All mentors in the Buffalo Veterans Treatment Court are volunteers and not compensated.

In addition to being implemented in veterans treatment courts, veteran peer mentors are being implanted across the county in the JDTR program. The Florida JDTR is not part of a formal treatment court and the local VJO assigned to the geographical area does not have a formal role working with the JDTR program. The local VJO does provide some limited informal coordination of services between the courts, JDTR program and local VA medical center.

**Peer Interventions & Mental Health Recovery**

Peers have been used as an intervention to assist persons with mental illness and substance abuse problems in various ways over the past 30 years. The first use of peers in the treatment of persons with mental illness can be traced to Harry Stack Sullivan in the 1920s who recruited “recovered” young men with mental illness as aids on an impatient unit outside of
Baltimore (Davidson, Chinman, Kloos, Weingarten, Stayner, & Tebes, 1999). Despite Sullivan’s prescience and the success of mutual support groups in treating addictions, the use of peers for treating persons with mental illness was not revisited until the 1970s and modern Mental Health Consumer Movement that emphasized the recovery model and use of mutual support groups and peer-run services (Davidson et al., 1999; Frese, & Davis, 1997). These trends were further reinforced by the passage of the Americans with Disabilities Act in 1990, which provided the legal support for the use of peers in the workplace by preventing discrimination based on psychiatric history (Davidson et al., 1999).

Since the 1970s, peer support strategies have evolved. Informal interventions have included naturally occurring support groups and internet groups, whereas formal interventions have included peer-delivered services that require a higher level of organization and training, such as peer-run programs, peer partnerships, and peer employees (Davidson et al., 1999; Solomon, 2004). In peer-run programs (e.g., drop-in centers, vocational programs and clubhouses), peers exclusively plan, operate and administer the program, whereas in peer partnerships, peers share control with persons without psychiatric diagnoses (Davidson et al., 1999; Mead, Hilton, & Curtis, 2001; Solomon, 2004). Peer employees include qualified peers hired as providers in either unique “peer” positions, such as peer mentors, or traditional mental health positions, such as case managers or counselors (Davidson et al., 1999; Solomon, 2004).

The peer concept is rooted in the notion of mutual support of persons with shared experiences. In its most basic form, Davidson et al. (1999) described mutual support as “a process by which persons voluntarily come together to help each other address common problems or shared concerns” (p. 168). Peer support has also been defined as “a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual
agreement of what is helpful” (Mead, Hilton, & Curtis, 2001, p. 135), and as “social, emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change” (Solomon, 2004, p. 393). Implicit in peer interventions is the notion that shared experiences engender a sense of “connection” or “affiliation” that increases self-understanding and facilitates interactions that challenge behaviors and perceived limitations, moving the persons beyond socially or individually imposed constraints and negative labels (Davidson et al., 1999; Mead, Hilton, & Curtis, 2001).

**Underlying Theories that Explain Peer Psychosocial Processes**

Various theories and models help explain the underlying processes that make peer interventions beneficial. Salzer (2002) described five, including social learning theory, social support, experiential knowledge theory, social comparison theory, and helper-therapy principle. Although these theories and models are helpful in explaining the underlying processes that may lead to beneficial outcomes, these processes have been mostly been inferred within the context of self-help groups, and not empirically tested (Solomon, 2004).

In social learning theory, peers are viewed as more influential than non-peers because peers are perceived as more credible (Bandura, 1977). Peers “have been there” and know what it was like to live with the specific challenges of the illness. Accordingly, peers motivate positive behavior changes through modeling and reinforcement, which, in turn, builds the self-efficacy necessary to meet the challenges of the illness (Salzer, 2002; Solomon, 2004).

Social support refers to various types of support, including emotional support, instrumental support, informational support, companionship support, and validation (Salzer, 2002). Support can buffer against external factors, enhance coping skills and facilitate a sense of
connectedness. Peers not only provide encouragement, reassurance and advice; they also assist by providing direct services, which meet basic needs. These supports reduce stress and by buffering against external factors and encourage positive behavior by enhancing coping mechanisms. Peers also expand support networks and reduce social isolation, which increases one’s sense of acceptance and community as well as self-understanding and autonomy (Davidson et al., 1999).

Experiential knowledge acquired from others provides alternative worldviews, which challenge conventional ways of viewing society and social roles. These new perspectives validate peer experiences and redefine the role of patient, countering the messages sent in structured treatment settings run by persons who do not have mental illness. These alternative views about treatment also provide peers with an “antidote” to the “passivity that may result from the participation” in certain treatment settings (Salzer, 2002, p. 6). In addition, the experiential process between peers is interactive rather than passive and promotes “choice and self-determination that enhance empowerment” (p. 6).

According to social comparison theory, people naturally seek out and compare themselves to others who are similar in order to support their self-perceptions and understanding of the world. Thus, interactions with peers perceived as better off motivate individual efforts at self-improvement. In addition, interactions with peers perceived as less well-off enhances an individual’s sense of self by creating the perception that their circumstances could be worse off, thus reinforcing a positive relationship dynamic between peers (Salzer, 2002; Solomon, 2004).

The helper-therapy principle focuses on the benefits of assisting others rather than receiving assistance. Skovholt (1974) theorized helpers experience four possible benefits from the helping process: 1) an increase in interpersonal confidence, 2) a feeling of equality, 3) an
increase in personally relevant knowledge, and 4) an increase in social approval. While the helper principal primarily applies to peers who provide assistance to others, helping behaviors also promote helping behaviors in others when the perceived benefits of helping others are observed.

**Peer Outcome Studies**

Existing literature and meta-analytic reviews suggest various types of self-help interventions and peer services, such as peer support groups, peer-run services, and peer employees, are as effective or are more effective than treatment provided by mental health professionals (Christensen & Jacobson, 1994; Gould, & Clum, 1993; Solomon, 2004). Studies on the use of peers as case managers and support specialists for treating persons with mental illness are consistent with these findings and indicated *peer mentors* are an effective mental health intervention strategy and improve various clinical outcomes, such as quality of life, self-image and employment, as well as problem behaviors and mental health symptoms.

Studying the use of peer support specialists in treatment, Felton et al. (1995) used a quasi-experimental, longitudinal, nonequivalent control group design and compared three intensive case management programs, including programs with peer specialists, programs with only non-consumer assistants, and programs with case managers only and no peers or assistants. In this study, data was collected at baseline and three six-month intervals for 104 clients and analyzed using a repeated measure ANOVA. Between group differences indicated programs with peer specialists had more contacts with their case managers and better outcomes in quality of life, self-image, social support and major life problems than the other groups. No differences were found between groups with non-consumer assistants and case managers causing the authors
to conclude the integration of peer specialist into intensive case management programs enhances quality of life and improves the effectiveness of case management.

In another study of peer support specialists, Klein, Cnaan and Whitecraft (1998) compared outcomes of co-occurring clients in intensive case management groups to co-occurring clients receiving intensive case management plus services through *Friends Connection*, a peer social support program in Pennsylvania. Results indicated crisis events and hospitalizations for those without peer social support were significantly higher than those with peer social support. Quality of life was also reported as higher for those with peer social support leading the authors of the study to conclude peer support is a promising intervention for improving system and client outcomes.

In a follow up study of *Friends Connection*, Min, Whitecraft, Rothbard and Slazer (2007) analyzed administrative data from county mental health and state Medicaid programs and data from the peer program. The study sample included those who had participated in *Friends Connection* over a two year period who had a serious mental illness and co-occurring substance abuse disorder. The comparison group included persons who had no participation in *Friends Connection* and had been hospitalized in a previous two year period and discharged with a co-occurring diagnosis. Results found significantly fewer persons participating in *Friends Connection* were hospitalized than in the comparison group, suggesting peer support facilitates recovery and reduces hospitalizations.

In addition, Kaufmann (1995) studied the use of peer support specialists used in conjunction with a vocational rehabilitation program for persons with serious mental illness. In this study, 161 unemployed individuals with either a diagnosis of schizophrenia, schizoaffective disorder, or major affective disorder were randomly assigned to an experimental or control
group. Outcomes measured at six months and one year indicated significant improvement in employment outcomes including hours worked and time on present job for those assigned to vocational rehabilitation with peer support. Kaufmann concluded, “[s]elf-help and mutual peer support groups may be an effective component to professional vocational rehabilitation services” (p. 159).

In a study of a peer, case-management program, Solomon and Draine (1995) randomly assigned 94 mental health consumers to an intensive case-management program run and operated by mental health consumers and to an intensive case management program with non-consumer case managers. Using a pretest posttest design and hierarchical block regression analysis of the data, the authors found data supported their hypothesis that there would not be a significant difference between groups in terms of behavioral symptomology and other clinical and social outcomes. The study found clients assigned to consumer, case-management programs were less satisfied with their treatment.

In another peer case management study, Chinman, Rosenheck, Lam and Davidson (2000) compared clinical, occupational and functional outcomes of clients at six different sites funded by the Center for Mental Health Services (CMHS) that provided both peer case management and non-peer case management services for persons who were homeless and had a severe mental illness. Data were collected at baseline, 3 months and 12 months on depression, psychosis and social support, as well as number of days of substance abuse, paid employment and homelessness and analyzed using a series of repeated ANOVAs. Even though clients at peer case management sites had more difficulties at baseline, results found no differences between both groups in clinical, occupational and functional outcomes over a twelve-month period,
leading the authors to conclude the “equivalence in outcomes was even more impressive” (p. 448).

While research has shown peers have been effective improving various outcomes - e.g., quality of life, self-image, employment, inpatient hospitalizations and other clinical measures - to date there is limited published research on their use in criminal justice settings or with veteran populations (Davidson et al., 1999; Solomon, 2004). Given the effectiveness of peers in various settings improving clinical and social outcomes, the underlying psychosocial processes at work in peer interventions may also have a moderating influence on criminal justice outcomes for veterans and non-veterans. They may, however, be insufficient alone to improve criminal justice outcomes without interventions that target criminogenic needs.

Peer Mentors, Training and Veteran Peers

Peer trainings and certifications have been offered throughout the country for a number of years. These training programs vary considerable but emphasize some common competencies that emphasize the recovery process, use of one's recovery story to help others, the importance of relationships and practicing self-care (Katz & Salzer, 2006). There are various peer-to-peer program models, including peer mentor, support group, community health worker and peer educator. Money and colleagues (2011) described the peer mentor as such:

In the peer mentor model, the mentor typically meets one-on-one with the individual. For instance, a peer mentor may be assigned to a group of individuals in a clinical treatment setting, or the individual may choose a peer mentor from a group of trained peer supporters. In all models, the peer mentor’s role is to provide a positive example of someone who has experienced the same or similar situation/issues. Peer mentors receive
training in communication skills, available resources and steps to take if a situation requires expertise beyond their level of training (p. 6)

Key ingredients of peer support programs include: 1) social support, 2) experiential knowledge, 3) trust, 4) confidentiality and 5) easy access (Money et al., 2011).

The Veterans Administration has seen the value of peer-to-peer programs, in particular those that emphasize the peer mentor model. August 2012 Executive Order, *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*, approved the hiring of 800 veteran peer support specialist 2013 (U.S. Department of Veteran Affairs, 2014). Since the Veteran's Health Administration (VHA) has expanded and developed a national peer support program. The VHA has developed core competencies for professional veteran peer support specialists which includes receiving peer certification. These core competencies emphasize addressing stigma, developing cultural competence, building communication and group facilitation skills and developing an understanding of the recovery process, recovery principles and recovery tools (Table 2.1)

Veteran peers working in the VHA may receive training in the VA, but must also receive peer certifications from approved certification programs (U.S. Department of Veteran Affairs, 2014; Money et al. 2011). Some of these peer training programs not only provide peer certification, they also include specific endorsements for veteran peers (Florida Certification Board, 2014). These peer certification programs emphasize the role of the peer specialist to promote recovery by instilling hope and removing stigma, done in the context of the peer relationship, by teaching how to develop skills, through the modeling behavior and provision of emotional and instrumental support as well as through advocacy. The Florida Certification
Board (2014) defines the Certified Recovery Peer Specialist - Veteran (CRPS) role specifically as:

Advocating for the needs of the consumer and his or her family; teaching the consumer how to develop skills necessary to advocate for himself/herself; serving as a mentor to the consumer, instilling a sense of hope that resiliency and recovery are achievable goals; and assisting the veteran in navigating multiple service systems, including obtaining veteran’s benefits, if eligible (Florida Certification Board, 2014).

The Recovery Model and the Criminal Justice Context

Because of peer origins in psychosocial rehabilitation and emphasis in peer interventions, it is important to also briefly discuss the recovery model. The recovery model, or recovery approach to psychiatric disorders, is considered an outgrowth of the consumer movement in the 1960s and 1970s that focused on the value of the consumer perspective (Davidson et al., 1999; Frese, & Davis, 1997). It advances the rehabilitation and community support models by stressing empowerment, de-stigmatization and inclusion at all levels of treatment and is more an overarching philosophy than theoretical model that can be tested (SAMHSA, 2014).

Recovery has been defined in terms of outcomes, the lack of evidence of mental health symptoms, and as a process where persons progress through predictable stages of change. While improved outcomes are part of recovery, mental health providers have focused on more on defining "recovery" as a journey or process of change that emerges from hope and supportive relationships with or without total relief from symptoms, where through increased use of coping skills persons with mental illness are able to live a self-directed, satisfying and empowered life (Kondrat & Teater, 2012). The recovery model emphasis on a person-centered approached that focuses individual strengths, abilities and the patient's perspectives has often contrasted with the
medical model's emphasis on a person's pathologies, disabilities and diagnosis and treating the illness first before pursuing rehabilitation.

Because the process of recovery is deeply personal, it means different thing to different people. There, however, has been increasing agreement in the mental health community that it is an ongoing and interactional process of change that is focused on the removal of stigma, restoration of a sense of purpose and rebuilding of life in the community (Anthony, 1993; Bledsoe, Luken, Onken, Bellamey & Cardillo-Gellar, 2008; Onken, 2004; Resnick, Fontana, Lehman, & Rosenheck, 2005). Drawing on input from wide-ranging partners, SAMHSA proposed a working definition of recovery calling it: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2014). SAMHSA also describes four dimensions of a person's life that support recovery - i.e., health, home, purpose and community - as well as ten guiding principles. The guiding principles recognize the subjective nature of recovery and that it is not linear and there are many pathways to recovery. Recovery is also viewed as holistic and encompassing a person's whole life as well as person-centered with an emphasis on self-determination and self-direction. Moreover, these principles stress that recovery emerges from hope in a social context where relationships "lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation" (SAMHSA, 2014).

The recovery model is informed by principles that have both clinical and empirical and support. Extensive research has measured varying aspects of recovery including consumer and provider attitudes toward recovery, outcomes of recovery oriented practices, peer support programs, service contexts which hinder or support recovery and individual stages of change in recovery (Scheyet, DeLuca & Morgan, 2013). In addition, other factors related to recovery such
as the mobilization hope and increased internal locus of control (self-efficacy) also connect to research findings and support the benefits of recovery oriented programs and practices (Bledsoe, et al., 2008; Carpenter, 2002; Reisner, 2005). Of particular importance to the criminal justice context is research on peer supported services which are grounded in recovery principles, as veteran peers have been incorporated into criminal justice setting and are being used widely in veteran treatment courts across the country.

A recovery oriented approach in the criminal justice system can be understood in the context of the community dimension and community integration. The social context is essential to the recovery process, which relies on peers, family and support from the community to facilitate change. Completing court imposed requirements is also essential to rebuilding a life within the community and can be viewed as one step toward full reintegration into society. The criminal justice setting, therefore, is another place to foster recovery through interactional processes to help individuals reintegrate into the community and develop a positive sense of self. The criminal justice context also reflects non-linear aspect of recovery, and criminal justice involvement can be viewed as one aspect of the many pathways of recovery and as one of the many challenge in a lifelong journey where empowerment, self-determination and self-direction are possible, despite the seemingly limiting options and coercive nature of the criminal justice context.

By emphasizing recovery principles, peers mentors can assist persons with mental illness counter the coercive and dehumanizing aspects of the criminal justice system. Through the interactional processes of the court system, peers can foster recovery by modeling and teaching coping and illness management skills so persons with mental illness can complete court ordered requirements, not recidivate and live a life of dignity. In these contexts as well as many others,
the recovery model provides an overarching philosophy and non-judgmental approach that works to remove stigma and instill hope in a setting that all too often stigmatizes and fosters despair. As such, the recovery modal also has the potential to improve the motivation and responsivity of persons with mental illness to various interventions as they move through their own process of change.

**Therapeutic Alliance**

Although there is limited research measuring the effect of the therapeutic alliance between peer mentors and mentees on clinical outcomes, its importance as a factor in any therapeutic intervention is widely accepted in the mental health literature. Over the years, research predicted a generic variable(s) based on consistent findings of treatment efficacy and outcome variance across a wide range of interventions (Horvath, & Greenberg, 1989). Lambert and Bergin (1994) calculated therapist behavior and personal style accounted for at least 25% of the variance in treatment outcomes. Inquiry into this generic variable has focused on four theoretical formulations: client-centered theory as articulated by Rogers (1951); Strong’s (1968) social influence theory; as well as a variety of psychodynamic perspectives, especially those theorized by Greenson (1967); and, most influentially, Bordin’s (1975) integrationist formulation of the *working alliance* (Horvath, & Greenberg, 1989).

According to Bordin, the strength of the working alliance hinges on provider/client agreement on *goals*, collaboration on *tasks* and overall bonds - all of which are aspects of a peer mentor/mentee relationship (Horvath, & Greenberg, 1989). Bordin also viewed the therapeutic alliance and the integration of these components as a core part of change process which lessens the significance of the type of intervention type in treatment outcomes. Accordingly, his theory assumes four propositions: 1) the working alliance is at the core of *every* therapy; 2) the strength
of the working alliance completely or partially contributes to treatment effectiveness; 3) each
type of therapy makes distinctive demands on the provider and client; and 4) the strength of the
working alliance is a result of how closely the demands of the therapy align with the individual
aspects of provider and client (Ross, Polascheck, & Ward, 2008). Naturally, these propositions
would apply to peer interventions. Since professional peers are a relationship-based intervention
premised on mutual support and shared experience, it follows that the strength of the working
alliance and agreement on goals, collaboration on tasks and overall bonds between peer mentor
and mentee would have a significant effect on clinical outcomes.

**Therapeutic Alliance in Criminal Justice Literature**

The therapeutic alliance between offenders and therapists and the importance of trust in
the intent of treatment providers has been emphasized in the criminal justice literature. In a
review of the research on the role of the therapist in offender treatment, Marshall and Serran
(2004) highlighted the process issues between therapist and offenders in an attempt to shed light
on the importance of therapist behavior in treatment strategies and concluded:

The evidence reviewed in the present paper indicates that offenders will be motivated to
effectively participate in treatment when the therapist creates a supportive and
encouraging environment. The generation of this type of environment is maximized
when therapists adopt a warm, empathic style that is complemented by rewards and
encouragement, and when clients view the therapists as having adopted this style (p. 315).

Several studies have included measurement of the therapeutic alliance between offender and
treatment provider and its effect on criminal justice and clinical outcomes for both juveniles and
adults. In a study of male juvenile offenders, Florsheim, Shortorbani, Guest-Warnick and
Hwang (2000) measured the therapeutic alliance between 120 boys ($M$ age = 15.6 years) and treatment staff at one of several residential programs. Data on therapeutic alliance and behavioral and emotional functioning were collected at three week and three month intervals and recidivism data was collected one year following placement from state records. Results indicated that positive therapeutic alliance scores at three months predicted lower rates of recidivism and psychological changes; although a positive therapeutic alliance at 3 weeks was associated with negative outcomes. These results led the authors to conclude initial optimism of the therapeutic relationship for some delinquent youth may be predictive of slow treatment progress and failure. Subjects in this study, however, were not randomly assigned and no control group was used.

In a study of male adult offenders, Borcato and Wagner (2008) measured 141 individuals with a substance abuse diagnosis that met DSM criteria who were mandated to treatment. Participation was voluntary and consecutive admissions were approached for participation in the program. Data was collected on motivation to change and therapeutic alliance at four intervals and analyzed using hierarchical multiple regression. Results indicated that retention in the program and completion rates were positively related to motivation to change and that motivation to change was positively related to the therapeutic alliance between offender and treatment provider and that changes in motivation in response to treatment were positively related to the therapeutic alliance between offender and treatment provider.

In addition, Polashek and Ross (2010) examined the extent to which early therapeutic alliance and motivation to change in psychopathic violent prisoners predicted treatment completion and behavior change. In this study, data was collected over 3.5 years from 50 prisoners in 7 consecutive cohorts at four intervals (2, 10, 28 and 26 weeks) and analyzed using
repeated ANOVAs. Results found that therapeutic alliance and motivation in early stages was not predictive on behavior changes; however, those prisoners whose therapeutic alliance scores changed the most demonstrated the most behavior changes. The authors of this study concluded by suggesting future research should not be restricted to measuring initial therapeutic alliance and that an offender’s early engagement in change should affect decisions regarding who to engage in treatment and that treatment does not need to be directed to persons well-motivated at the start.

As described previously when discussing court supervision outcomes, Skeem and colleagues (2007) developed an instrument to measure the unique characteristics of relationship quality between persons in a dual role (i.e., probation officers) responsible for “caring for” and “having control over” probations with mental illness. Informed by the Working Alliance Inventory (WAI), the authors redefined and validated the Dual-Role Relationship Inventory (DRI-R), which measures relationship quality in mandated treatment, and found the dual-role relationship to consist of three domains, caring blended with fairness, trust and authoritative (not authoritarian) style. The instrument and relationship quality were found to be predictive of probation violations and revocations.

Research not only supports the importance of the therapeutic relationship in a traditional therapeutic environment, it shows its importance in the criminal justice context. Therapeutic alliance is a key, even core, factor in any intervention. A strong therapeutic alliance not only creates an environment of trust, it also has the potential to improve a person motivation and responsivity to interventions. In terms of peer interventions, a strong therapeutic alliance is a key factor that can facilitate motivation to change, encourage receptivity to prosocial modeling and learning problem solving skills. Because peer interventions are by their nature relationship
focused, they are in their very conceptualization an intervention that assumes the existence of a healthy therapeutic alliance. But is this enough to improve criminal as well as clinical outcomes?

**Therapeutic Alliance and Clinical Outcomes for Persons with PTSD.**

In addition to studies that have investigated the effect of therapeutic alliance on criminal justice outcomes, limited research has been conducted on the importance of therapeutic alliance on treatment with persons with PTSD. Studies found therapeutic alliance may be associated with PTSD treatment outcomes. For example, Chemtob, Navaco, Hamada, and Gross (1997) found PTSD-related anger symptoms affected the therapeutic relationship compromising treatment outcomes; and Tarrier et al. (1999), in a randomized trial of cognitive therapy and imaginal exposure for treating chronic PTSD, found client feelings regarding provider credibility predicted non-completion.

Cloitre, Koenen, Cohen and Han (2002) studied the effect of therapeutic alliance in a two-phase treatment program for woman with PTSD related to childhood abuse. In this study, women were randomly assigned to a cognitive-behavioral treatment or to a minimal attention wait list. Phase 1 consisted on skills training in affective and interpersonal regulation and phase 2 consisted of eight sessions of prolonged exposure therapy. Results indicated that therapeutic alliance and negative mood regulation skills measured in phase 1 predicted success in reducing PTSD in phase 2. The authors concluded by emphasizing the importance of “preparatory” stage for assessing weakness and strengths and developing skills allowing for a good therapeutic relationship to develop.

In a similar study, Cloitre, Stovall-McClough, Miranda and Chemtob (2004) analyzed combined data from two randomized clinical trials of females who had child abuse-related PTSD
and assigned to the same two-phase treatment of skills training in affective and interpersonal regulation and exposure therapy treatment. In this study, 49 persons were assigned to treatment group and 34 completed treatment. Data was analyzed using hierarchical regression and results found the strength of early therapeutic alliance predicated improvements in PTSD following treatment leading the authors to conclude therapeutic alliance and the mediating influence of emotion regulation appear to significantly affect treatment outcomes.

Keller, Zoellner and Feeney (2010) sought to understand the factors associated with early therapeutic alliance in PTSD. In this study, 188 men and woman were randomly assigned to a treatment condition of exposure therapy or sertraline and data was collected over the course of 10 weekly sessions. Results found early therapeutic alliance was associated with exposure therapy treatment adherence and treatment completion. A history of childhood sexual abuse, however, did not affect early therapeutic alliance.

**Other Theoretical Models**

**Social Support Theory and Crime**

Social support theory is helpful for understanding peer interventions in criminal justice settings because of its importance in helping persons become more responsive to treatments. There are wide ranging theoretical definitions of social support, most of which have been classified into five categories: 1) type of support; 2) perceptions of support; 3) intentions or behaviors of the provider of support; 4) reciprocity of support or exchange of support; and 5) social network support (Hupcey, 1998; Pettus-Davis, Howard, Roberts-Lewis & Scheyett, 2011). Generally speaking, social support refers to emotional support and/or instrumental support. According to Pettus-Davis et al. (2011):
Social support occurs in the context of relationships, and refers to the provision or exchange or resources that individuals perceive as available or those that are actually provided by others (House, 1981) - social support has both material and psychological aspects (p. 480).

Social relationships influence cognitions, beliefs and behaviors and have been theorized to improve wide-ranging health, mental health, substance abuse and criminal justice outcomes (Cohen, Underwood & Gottlieb, 2000; Pettus-Davis et al., 2011; Sarason & Sarason, 2009). Various theories attempt to explain such a moderating/mediating relationship. Cohen et al. (2000) proposed two models that incorporate most of the research on social support to date, i.e., the stress-buffering model and the main-effect model (Pettus-Davis et al., 2011). Referring to the stress-buffering model, Pettus-Davis et al. (2011) wrote that "perceived or received social support operates by reducing maladaptive physiological or psychological responses to stress" and provides "a distraction from or solution to the problem" (p.483). The main-effect model, on the other hand, provides benefits regardless of stress and holds that "social support is a result of integration into a social network" and that "the social network exposes individuals to social controls and peers that influence adaptive (normative) health behaviors" (p. 483). Social support may improve maladaptive responses simply by reducing stress itself, or social support may influence improvements mediated through social interconnectedness. In both explanations, social support contributes to psychological states that make a person more receptive to behavior change and the influence of others.

Social support can be either positive or negative and influence various risk factors and protective factors for crime. Dynamics factors for crime that are influenced by social relationships include criminal thinking, anti-social substance using peers, stress and low social
supports (Andrews et al., 2006; Pettus-Davis et al., 2011; Skeem et al., 2009), while protective factors against crime include reliable partnerships, stable families and positive social support (Andrews et al. 2006; Bersani, Laub, & Nieuwbeerta, 2009; Pettus-Davis et al., 2011). Research has shown the importance of social supports on criminal and substance abuse outcomes. For instance, Giordano, Cernkovich and Holland (2003) studied 127 female and 127 male former prisoners over 13 years post-release and found spousal and friend criminality predicted criminal behavior. Seal, Eldridge, Kacanek, Binson and MacGowen (2007) similarly found 89 former prisoners with mostly negative social support had significantly higher rates of substance misuse than those with positive social support. In the context of the RNR model, social support would be considered a significant factor that might influence prosocial or criminal behavior through improving social interconnectedness, which may in turn mediate behavior change and reinforce certain behaviors, or by reducing stress itself and improving responsivity to other factors/interventions that affect behavior change.

**Social Learning Theory and Crime**

Social learning theory is also helpful to the understanding of the use of peers in a criminal justice context because it emphasizes learning occurs in a social context. There have been various proponents of social learning theory, notably Albert Bandura. According to Bandura (1986), social learning occurs through observation and the modeling of behaviors, which is mediated through cognitive and social factors consisting of four process components: *attention*, *retention*, *reproduction*, and *motivation*. For modeling to occur, a person must pay *attention* and focus on relevant stimuli. The person must also *retain* what was observed, have the ability to *reproduce* the behavior and be *motivated* to adopt the behavior.
Burgess and Akers (1966) further adapted social learning theory to explain crime building on Edwin Sutherland’s differential association theory (Andrews & Bonta, 2006). Differential association theory rejected prevailing biological and economic explanations of deviant behavior, and instead emphasized the importance of antisocial attitudes and associates as significant factors. Differential association theory also posited specific principles that explain criminal behavior:

1. Criminal behavior is learned.
2. Criminal behavior is learned in interaction with other persons in a process of communication.
3. The principal part of the learning occurs within intimate personal groups.
4. The learning includes techniques of crime and the specific direction (procriminal vs. anticriminal) of motives, drives, rationalizations, and attitudes.
5. The process of learning by association with criminal and anticriminal patterns involves all of the mechanisms that are involved in any other learning.
6. A person becomes a criminal because of an excess of definitions favorable to violation of law over definitions unfavorable to violation of law.

Akers (1985) continued to develop social learning theory to explain crime, and, like Sutherland, he emphasizes crime is learned in the context of social interactions, or differential associations, through either instrumental learning or vicariously by the imitation or observation of consequences. Both Akers and Sutherland emphasize differential associations shape cognitive definitions, or “one’s own attitudes or meaning that one attaches to given behaviors” (p. 195).
Cognitive definitions indicate potential consequences in a given context and can be approving or disapproving of crime, producing conforming or deviant behaviors. Both Sutherland and Akers thus explain crime as the result of an excess of definitions that are favorable to law violations.

Akers (2001), however, incorporated principles of operant conditioning into Sutherland's mode and included the concept of reinforcement and the notion that imitation or “the engagement in behavior after the observation of similar behavior in others” (p. 196) can play a role in crime. These “differential reinforcements” are defined as “the balance of anticipated or actual rewards and punishments that follow or are consequences of behavior” (p. 195). While reinforcements may be social or non-social (e.g., physical from taking drugs), social reinforcers are considered more important. According to Akers (1998):

The probability that persons will engage in criminal and deviant behavior is increased and the probability of their conforming to the norm is decreased when they differentially associate with others who commit criminal behavior and espouse definitions favorable to it, are relatively more exposed in-person or symbolically to salient criminal/deviant models, define it as desirable or justified in a situation discriminative for the behavior and have received in the past and anticipate in the current or future situation relatively greater reward than punishment for the behavior (p. 50).

Akers (1998) further emphasized reinforcers coming from social groups closest to the person are “the most salient behavioral models” (p. 52) and, consequently, the most influential.

Given the emphasis on the social context of learning and relative influence of social groups in affecting procriminal and anticriminal behaviors, social learning theory provides a useful framework from which to understand peer mentor interventions. Pratt et al. (2010) summarized the importance of social factors influencing criminal behavior in social learning
theory stating, “the stability of criminal behavior is therefore more likely when an individual is embedded in a social environment where misconduct is reinforced and where differential association with pro-criminal definitions and behavior patterns is readily available” (p. 769.). Thus, implicit in social learning theory is the notion that peer mentors shape cognitive definitions that influence behavior associated with crime.

**RNR Theory: General Personality Cognitive Social Learning (GPCSL)**

Andrews and Bonta (2006) expand social learning theory by incorporating general personality theory and research on risk factors for crime in their explanation of criminal conduct. With the influence of general personality theory, biological factors are considered in this theoretical formulation. General personality and cognitive social learning (GPCSL), therefore, recognizes behavior can be willful or predisposed biologically and, consequently, mediated under personal control, interpersonal control and/or automatic control (Andrews & Bonta, 2006; Andrews & Dowden, 2007).

Behavior that is mediated by personal control may be governed by social mores or standards of conduct through the use of self-regulation and coping that take in account rewards and consequences (Andrews & Dowden, 2007). Behavior may also be influenced by people and mediated under interpersonal control where "the direct actions of others may signal the appropriateness of particular actions, enable some actions, and function directly as rewards or costs" (p. 442). Because GPCSL recognizes biological predispositions and conditioning histories, it understands behavior is may also be mediated under automatic control, "whereby repeated associations among stimuli, responses, and behavioural outcomes can produce automatic, non-conscious cognitive regulation of motivation, perception, and behaviour" (p. 443).
Altogether, GPCSL holds that behavior is influence by multiple factors and that "motivations (potential reinforcements) and controls (potential costs) operate simultaneously" and that non-mediated behavior is "best assessed through examination of a history of antisocial behaviour; in particular, involvement from an early age in a number and variety of antisocial activities" (p. 443). Thus, it is important to assess the person's sources of cognition, emotional regulation and self-control skills and what type of behavior is being modeled, whether that pro-criminal, neutral or anti-criminal. Other variables, such as age, ethnicity, and mental illness are important insofar as they influence the major risk factors for crime (Andrews & Bonta, 2006; Andrews & Dowden, 2007).

Accordingly, antisocial peers are the most significant factor when predicting crime because antisocial peers not only influence behavior that is under personally mediated control; they also influence behavior that is under interpersonally mediated control. While social support and the quality of interpersonal relationships is a key factor in understanding risk factors for crime, GPCSL considers the "big four" risk factors for crime as antisocial peers, antisocial attitudes and antisocial cognitions and, most obviously, an antisocial personality pattern and history of criminal behavior. The other major factors such as problems with family, employment, poor use of leisure time and substance abuse are significant factors but only affect the exposure to the rewards for prosocial behavior and prospect of punishment for deviant behavior (Andrews & Bonta, 2006; Andrews & Dowden, 2007).

The significance of peers in affecting outcomes in this theoretical formulation, again, stresses the importance of this study and investigating whether veteran peer mentors significantly influence behavior through their provision of social support and role in expanding of social networks, modeling of prosocial behavior, teaching of problem solving skills and reducing of
stress, among other things. In such a model, peer interventions may improve criminal justice outcomes by directly targeting criminogenic needs or by improving responsivity to other interventions that do.

**Summary**

The overrepresentation of persons with mental illness in the criminal justice system is a critical social problem. Over the past twenty years, various criminal justice and mental health strategies have attempted to address the problem with mixed results. Mental health treatment courts have shown promise, perhaps because of their use of mandated treatment, graduated sanctions and status hearings to motivate positive behavior changes. Other diversion programs that simply link individuals to traditional mental health treatment programs, however, have been less effective reducing recidivism. This is likely because these "first generation interventions" focus on linking to treatment and symptom reduction instead of targeting criminogenic needs.

Peers interventions have been shown to improve clinical and other social outcomes for persons with mental illness. They also potentially target criminogenic needs and build on first generation approaches. Peer interventions are effective because peers are perceived as more credible than non-peers and have a greater ability to influence behavior compared to non-peers. Peer interventions are theorized to work for a variety of reasons that would support their use in a criminal justice context. Peers model behaviors and ways of coping that positively influence values, or cognitive *definitions*, that individuals attach to certain behaviors and perceived rewards. They also increase social support, thus reducing psychological and physiological responses to stress and expose individuals to greater social controls and positive peer influences. Because of this they are likely to me more influential teaching problem solving skills and more
likely to improve the responsivity of persons with mental illness involved in the criminal justice system to other interventions that target criminogenic needs.

Moreover, compensated peers, who are certified, would be steeped in the recovery model and its principles, which may foster responsivity as well. The recovery model's emphasis and assumption that the debilitating effects of mental illness can be overcome, if not eliminated, supports the notion of viewing criminal justice involvement as an obstacle and mutual goal, like mental health symptoms, that can be overcome and eliminated in the future. Furthermore, peer interventions support self-determination, autonomy and responsibility and thus how choices affect a person's life, all essential in the criminal justice context. Peers also empower change and the ability to utilize strengths so persons with mental illness can complete court ordered requirements and not return.

As a relationship focused intervention that is based on mutual support and shared experiences, peer interventions assume in their very conceptualization not only the importance of a therapeutic alliance in treatment outcomes but the existence of a healthy therapeutic alliance. This "connection" is further enhanced with peer training steeped in the recovery model whose principle can be easily transferred and adopted in the criminal justice context. Given this and the influence of peers on procriminal or anticriminal behavior, peer interventions may directly or indirectly target many of the criminogenic needs identified as risk factors for recidivism.

The implementation of veteran peer interventions across the country to assist justice-involved veterans has increased steadily over the past two years. The reasoning for these programs is that veterans identify with other veterans and share a connection with them because they know what it is like to "walk in their shoes", especially when the veteran has experienced trauma while in the military. Given the increasing number of veterans returning from Iraq and
Afghanistan with high incidents of trauma, it is important to evaluate interventions that focus on this population and utilize peer interventions and whether they improve both clinical and criminal justice outcomes. Such research will not only improve services for veterans, it will contribute to development of criminal justice interventions that can address the problem of the overrepresentation of persons with mental illness in the criminal justice system. JDTR is unique in that it incorporates compensated veteran peers into traditional mental health treatment services. The aim of this study, therefore, is to evaluate the effectiveness of JDTR and answer the question about whether JDTR and compensated peer mentors, in particular, significantly improve clinical and criminal justice outcomes for veteran offenders with trauma related mental illness.
### Table 2.1
Department of Veterans Affairs (VA) Draft Peer Support Competencies

<table>
<thead>
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<th>Competency</th>
<th>Description</th>
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| **Addressing Stigma**             | • Managing internalized stigma  
                                  | • Managing environmental stigma                                                              |
| **Communications Skills**         | • Effective listening and asking questions  
                                  | • Communication styles (passive/aggressive/ assertive) and verbal and nonverbal communication |
                                  | • Conflict resolution                                                                       |
| **Cultural Competence**           | • Understand how ethnicity, race, spirituality, gender, sexual orientation, local community and other sub-cultures may influence recovery |
| **Group Facilitation Skills**     | • Understanding group dynamics and interactions  
                                  | • Knowing how to use support groups                                                           |
| **Managing Crisis and Emergency Situations** | • Early warning signs of illness' symptoms worsening  
                                  | • Crisis prevention, using resources early  
                                  | • Crisis interventions  
                                  | • An understanding of suicide prevention  
                                  | • Ability to work through challenging situations with veterans who are under the influence of substances, angry, in psychosis or a non-verbal state  
                                  | • Personal safety issues                                                                     |
| **Peer Support Principles**       | • Being a role model  
                                  | • Instilling hope  
                                  | • Being an advocate  
                                  | • Knowing principal duties of peer support staff                                              |
| **Professional Development & Workplace Skills** | • Ethics  
                                  | • Boundary issues and dual relationships  
                                  | • Ability to work effectively with professionals on an interdisciplinary team                |
| **Recovery Tools**                | • Solving problems using solution-focused strategies  
                                  | • Telling your personal recovery story, being mindful of who you are addressing               |
                                  | • Participating in self-help groups  
                                  | • Teaching others how to manage self-talk and combat negative self-talk                        |
| **Recovery Principles**           | • Overview of psycho-social rehabilitation  
                                  | • Components of recovery  
                                  | • Stages of recovery  
                                  | • Peer support role in psycho-social rehabilitation                                           |
| **Understanding Different Illnesses** | • Major psychiatric conditions in DSM IV  
                                  | • Addictive disorders  
                                  | • Co-occurring disorders  
                                  | • Medications and side effects                                                               |
| **TOTAL**                         | **33 Critical Competencies**                                                                 |

CHAPTER 3: METHODOLOGY

Overview of the Study

This study sought to determine whether the Florida JDTR program and veteran peer mentors specifically significantly improved criminal justice and clinical outcomes for veterans with trauma experience. It used secondary data collected as part of the SAMHSA JDTR program evaluation and employed a one-group, pretest-posttest research design to assess criminal justice and clinical outcomes. Clinical data measured at the time of enrollment in JDTR were compared with clinical data measured at six months for Site 1 only. Arrest data one year prior to enrollment in JDTR were compared to arrest data one year after enrollment in JDTR for pilot Site 1 and pilot Site 1 and 2 combined for participants who completed six months of JDTR. Seeking Safety, peer case management and peer mentoring dosages were collected by JDTR throughout the program and along with other variables were analyzed to determine what variables correlated with re-arrest or clinical changes. A qualitative analysis was also conducted using a questionnaire to assess peer mentee perceptions of the importance of the peer relationship in the mentee's future success and to explore what factors were considered important qualities that constituted a veteran peer relationship.

Study Sample and Data Collection

Participation in the JDTR program was voluntary and consisted of three basic criteria: 1) being a veteran with a discharge status other than dishonorable or bad conduct, 2) trauma experience, and 3) agreement of key stakeholders to divert. The Statewide Advisory Council for the SAMHSA JDTR project decided to exclude those with traffic offenses and those who were
registered sex offenders or with a current sex related criminal offense. Veterans accepted in JDTR program included those with Honorable, General and Other than Honorable discharges, as well as those with medical discharges. Persons with Dishonorable discharges, however, were not eligible for JDTR. Mental health diagnostic criteria included a history of any type of significant trauma, including military or civilian trauma as well as childhood or sexual trauma.

Diversion refers to a diversion from prosecution (e.g., pre-trial intervention or charges being dropped outright), reduction in jail time, reduction in sentence (e.g., probation time or time served), or diversion from prison (e.g., reinstatement of probation). Criminal diversion for JDTR pilot Site 1 referred to any post-booking criminal justice involvement (misdemeanor or felony) and voluntary participation in the JDTR program. Pilot Site 2 included any post-booking or pre-booking diversion. Pilot Site 1 was implemented by Northside Mental Health in Hillsborough County and accepted diversions from SIM intercepts 2 and 3 (i.e., preliminary appearance court and other referral locations) and operated from December 12, 2010 to June 30, 2012. Pilot Site 2 was implemented by ACTS in Pinellas Count in Pinellas County and included diversions at SIM intercept 1 (i.e., Safe Harbor Shelter) as well as 2 and 3 (i.e., Pinellas County Drug Court, which included a veteran's docket) and operated from October 1, 2012 to September 30, 2014.

Safe Harbor is a Pinellas County Sheriff run shelter where law enforcement can bring people instead of booking them into jail for nuisance crimes, such as trespassing, or civil infractions. It is considered a diversion at intercept 1 in that it provides an alternative to incarceration and functions much like a CIT diversion where a CIT officer transports a person with mental illness to a local ER or mental health agency for triage to assess criteria for inpatient admission, instead of arresting that person. For admission to Safe Harbor, individuals could be charged and brought to the shelter with a notice to appear in court at a later date, or not charged.
Because of the significant differences in pilot Sites 1 and 2 and the low number of enrollees at pilot Site 2 (N = 23), a decision was made to conduct clinical pre-test, post-test analyses using only pilot Site 1 data in order to preserve the integrity of the data and validity of the results. When specified, data from pilot Site 2 was included in the analyses for comparative purposes or when the larger N did not significantly compromise the integrity of the data and the validity of the results.

The screening process included collection of information necessary to determine eligibility (see Appendix B). People were approached about their willingness to participate in the program. Site staff verified veteran (discharge) status with the cooperation of people from one of the two local veterans administration hospitals. Veterans could be enrolled in the JDTR program for up to one year, with clinical outcome data collected at baseline, six-month and twelve-month intervals, although each service component was applied for less than one year based on the person’s individual needs and court related requirements. Data were collected through the 12-month period regardless of intervention length. Participation in the evaluation was not a requirement of participation in the intervention. Two people from Site 1 chose to participate in the intervention, but to NOT participate in the evaluation.

The Jail Diversion and Trauma Recovery (JDTR) Program made available: 1) peer mentoring, 2) peer case management, and 3) “Seeking Safety” (Najavitz, 2002), a trauma-recovery intervention. Peer support was provided for up to 12 months post-release. Peer support specialists encouraged recovery by providing assistance to individuals in accessing both formal and natural services/supports; all enrollees were assigned a peer support specialist. Case management services were provided by peers and were offered either as short-term case management for 30 days post-release or long-term case management for up to 180 days post-
release. During the first 30 days post-release, a formal assessment was completed to determine if long-term case management was needed. Program staff utilized either the Level of Care Utilization system (LOCUS 2000) or ASAM-PPC-R2 (American Association of Community Psychiatricists [AACP], 2000; American Society of Addictions Medicine [ASAM], 2014) tools when needed to assess level of care. Peer case management was offered as needed. Seeking Safety groups were offered to JDTR participants, although groups were not held regularly, especially at Site 2. Clinicians and peer specialists at Northside and ACTS were trained in the Seeking Safety model. Part of the focus of the JDTR funding to Florida was to fund training, both for providers involved in the two pilots but also for larger community of people in need of such training. These training events were coordinated by the Florida Certification Board and focused on topics such as Seeking Safety, motivational interviewing and understanding VA health care access and benefits. Seeking Safety was offered on a voluntary basis,

The participants of this study included veterans with a trauma-related mental illness who were diverted from criminal justice sanctions at two pilot sites in Florida. The first year of the five years of funding focused on development of a strategic plan by the JDTR Statewide Advisory Committee (SAC). SAMHSA approved the strategic plan. SAMHSA did not approve commencement of the first pilot until the strategic plan was approved. Local Advisory Committees (LAC) guided the decisions made about the pilot sites. The SAC guided planning for training, diversion and service delivery as well as the design and implementation of various programs with the goal of disseminating knowledge about effective pilot projects in order to replicate them in other communities. Advocates for Human Potential (AHP) oversaw the multi-site data collection for the 13 states receiving JDTR funding. AHP also provided guidance about enrollments and recommended that they end six months prior to the termination of
funding. Goals specified in the strategic plan included 200 screens per year and 40 enrollments per year. The total enrollments, however, came up significantly short of this goal (Table 4.5).

Staff for Site 1 (Northside) and Site 2 (ACTS) conducted the screening, which included the completion of SAMHSA required forms as well as additional elements added by the local sites. Faculty and staff in the Department of Mental Health Law & Policy at the Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida (USF) assisted the sites with the approach to screening and with the entry of screening data. USF faculty staff approached people enrolled in the intervention about their participation in evaluation once they had signed a release allowing Northside/ACTS staff to provide their contact information to USF. A consent procedure was completed for those who agreed to participation in the evaluation. The study was approved by the University of South Florida Institutional Review Board (see Appendix C). USF staff conducted face to face interviews at baseline, six months and 12 months post-enrollment using a SAMHSA approved protocols (see Appendixes D and E). A Veteran Service Use and Peer Mentorship Questionnaire was added to the Florida sites to assess service utilization and perceptions of peer qualities and importance (Appendix F). AHP oversaw all data collection and entry into SPSS and scoring all standardized instrument approved by SAMHSA and accounted for all missing data per instrument guidelines.

Instrumentation

The Behavior and Symptom Identification Scale (BASIS-24). The BASIS-24 (Eisen, Normand, Belanger, Spiro, & Esch, 2004) is a refinement of the BASIS-32 developed in 1984 to measure mental health treatment outcomes (see Appendixes D, E & F). The refined version consists of 24 self-report items that assesses six domains of mental health symptom and functioning difficulties, including depression and functioning (6 items), interpersonal
relationships (5 items), self-harm (2 items), emotional lability (3 items), psychotic symptoms (4 items), and substance abuse (4 items) (Eisen et al., 2004). Changes in the measure were made based on readability analysis as well as feedback from researchers, administrators, clinicians, and consumers and the use of item response theory (IRT), instead of classic test theory (CTT), to improve scoring (Eisen et al., 2004). Internal consistency (Cronbach alpha) was found to be acceptable for the six domains, ranging from 0.75 to 0.89 (inpatients) and from 0.77 to 0.91 (outpatients), and test–retest reliability coefficients were found to be acceptable, ranging from 0.81 to 0.96 (inpatients) and from 0.89 to 0.96 (outpatients). In addition, the BASIS-24 was able to discriminate among groups expected to differ in mental health status and correlated with other mental health measures, supporting discriminant and construct validity respectively (Eisen et al., 2004). In a separate study, the measure was validated among non-Latino whites, non-Latino blacks, and Latinos as well (Eisen et al., 2006).

**Posttraumatic Stress Disorder Checklist (PCL-C).** The PTSD Checklist-Civilian Version (PCL-C) (Weathers, Litz, Huska, & Keane, 1994) is a 17-item self-report instrument that asks respondents to rate the degree to which they have been bothered by PTSD symptoms resulting from any past traumatic event during the previous 30 days using a 5-point scale, where 1 is refers to *not at all* and 5 to *extremely bothered* (see Appendixes D and E). The PCL-C items corresponds to *DSM-IV* PTSD symptom Criteria B, C, and various studies support its use as a reliable screening instrument, with high internal consistency and diagnostic efficiency (e.g., Keen, Kutter, Niles, & Krinsley, 2008; Ruggiero, Del Ben, Scotti, & Rabalais, 2003). Although a military version of the PCL exists, the civilian version is recommended in most settings because it does not ask questions specific to military experiences and rates symptoms related to any "stressful experiences", allowing it to be used with any population. In addition, symptoms
do not have to relate to any one event and can be related to multiple stressful events. Total scores can be used to calculate severity of PTSD and combinations of subscale scores can be used to diagnose PTSD (Appendixes D and E).

**Recovery Enhancing Environment Measure - Revised (REE).** The REE (Appendices C and D) revised is a 24 item self-report survey for individuals who use mental health services and asks them where they are in the recovery process (Ridgway, 2004). Responses to each item range from 1 (strongly agree), 2 (agree), 3 (disagree), and 4 (disagree) and they rate the importance of certain variables, such as hope, sense of meaning and wellness, in their recovery as well as the programs associated with these variables. Total scores can range from 23 to 92 and lower total scores represent more positive responses. The REE assists evaluating the extent to which a program enhances recovery and can help organizations become more recovery-oriented (Ridgway, 2004).

**Arrests.** USF faculty and staff obtained data on the timing, nature (charges), and number of arrests for the respective county of target arrest and Site participation (Hillsborough or Pinellas) for each participant prior to enrollment in JDTR. Post-enrollment arrests were collected through a review of Hillsborough and Pinellas County Sheriff's public records. Post-enrollment arrests that were not in the county of the target charge and post-enrollment were not included in the data set or analysis. Arrest data were collected one year prior to enrollment and JDTR and one year after enrollment in JDTR.

**Peer, case management and Seeking Safety dosage.** Northside and ACTS billing records were reviewed by FMHI staff, which was allowed because evaluation participants signed multi-party releases at the time of study enrollment. All dosage was measured in hours. Peer dosage included outreach, support, mentoring and transportation and case management dosage.
all other contacts. Seeking Safety dosage was measured by group attendance. Dosage data could not be collected by the JDTR program participants who did not authorize the USF evaluation team to view their records (as part of a process that includes having participants sign a release to view records).

**Veteran Service Use and Peer Mentorship Questionnaire.** The local evaluation team developed a list of questions about service use and peer mentorship that were added to the interview protocol for at baseline, six month and 12 months. The same questionnaire was used at each interval to better understand utilization of VA services and veteran perceptions of peer mentorship. The questionnaire, however, was not added until six months after enrollment in JDTR began (Appendix F).

**Analysis**

**Overview**

This study utilized dependent $t$ tests to compare data pre-intervention and post-intervention to assess criminal justice and clinical outcomes for program participants. Clinical data measured at the time of enrollment in JDTR was compared with clinical data measured at six months for Site 1 only. Arrest data 1 year prior to enrollment in JDTR was compared to arrest data 1 year after enrollment in JDTR for pilot Site 1 and pilot Site 1 and 2 combined for participants who completed six months of JDTR. This study also utilized Pearson product-moment coefficients to compute correlations to assess relationships between certain variables (e.g., demographic, dosage and clinical baseline scores) and re-arrest 1 year post enrollment and clinical changes. A qualitative analysis was also conducted using a questionnaire to assess peer mentee perceptions of the importance of the peer relationship in the mentee's future success and
to explore what factors were considered important qualities that constituted a veteran peer relationship (Appendix F).

**Preanalysis Data Screening**

All data were screened prior to being analyzed using various methods discussed below and in the results sections. Deidentified data were sent by USF to AHP in required monthly data sends. Some data were entered by USF into QDS, including the use of QDS to administered most interviews via a laptop. A few interviews were conducted using paper protocols, as circumstances dictated, and entered into QDS. Other data were entered into Access. All data were put in the format and used file naming conventions required by AHP for the monthly sends. AHP then merged and cleaned data from these multiple format and converted the data into an SPSS file. AHP ran code against the SPSS file, such as to create scales and sub-scales for standardized instruments and accounted for missing data per measurement guidelines. This de-identified file was sent back to USF and was used in this study for analysis. How all other missing data and outliers were handled in the JDTR data set is discussed in the corresponding results section.

As part of the pre-analysis data screening for paired sample *t* tests, histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Kolmogorov-Smirnov tests the null hypothesis that the population is normally distributed, and a rejection of the null hypothesis, or significance level of *p* < .05, indicates the population is not normally distributed (Mertler & Vannatta, 2005). If population differences were not normal, the non-parametric Wilcoxon signed-ranks test was conducted.

As part of the pre-analysis data screening for Pearson product-moment correlations, scatter plots were inspected to check for linearity and outliers. The Kolmogorov-Smirnov test
was also used to check for normality of distributions. If outliers were found, they were either removed or transformed. Attempts were made to transform non-normal distributions using logarithmic and square root transformations. Because of the low $N$ and lack of symmetry for many of the other non-normal variables and because Pearson's product-moment correlations studies have shown one or both variables can be very non-normal with the probability of a false positive still approximately 0.05, Pearson's product correlation was chosen to analyze the data rather than a non-parametric statistic that would be significantly less sensitive to detecting relationships (Edgell & Noon, 1984).

**Paired sample $t$ tests.** Dependent $t$ tests compare mean scores from two samples or a single sample measured at two different times. While $t$ tests are quite robust, frequency distributions will be conducted to assess whether there is a positive or negative skew/kurtosis in the distribution (Weinbach & Grinnell, 2007). Descriptive statistics will also be used to check for outliers and missing data and to insure there are no values outside of the range of possible values. Data transformations and substitutions will be used to address missing data, outliers and frequency distribution skewness/kurtosis, as indicated by the data.

**Wilcoxon signed-rank test.** The Wilcoxon signed-rank test is a non-parametric statistical test for repeated measurements of paired samples that assess differences in population mean ranks (Weinbach & Grinnell, 2007). It assumes data are measure on the ordinal level, are from the same population and that pairs are chosen randomly and independently. It does not, however, assume paired differences are normally distributed and is used when normality cannot be assumed for paired sample $t$-tests. It is more powerful when paired differences are approximately symmetric around the median (Lowery, 2013).
**Pearson's product-moment coefficient.** Pearson's correlation coefficient measures the relationship between two variables. It is not robust and assumes variables are continuous ratio or interval variables; they are linear and normally distributed; and there are no outliers. If both variables do not meet the assumptions, there are various ways to handle the data including transforming variables and deleting outliers (Weinbach & Grinnell, 2007). Attempts will be made to address the above assumptions. However, Pearson's correlations will still be used for non-normal data because of the low $N$ in this study and because similar nonparametric correlation statistics have significantly less power to detect relationships and because varying Pearson's correlation studies have shown one or both variables can be very non-normal with the probability of a false positive still approximately 0.05. According to Edgell and Noon (1984):

Simulations were performed to study the effects of violations of the normality assumption on the test of the Pearson product-moment correlation coefficient.

It was found that as long as the variables were independent, the test was robust to violations of normality, even extreme violations in combined distributions (p. 576).

**Qualitative analysis.** To better understand the nature of the peer relationship and its importance and qualities that make a peer relationship a qualitative content analysis was conducted. Answers from the *Veteran Service Use and Peer Mentorship Questionnaire* (Appendix F) were analyzed, coded and organized into themes and categories (Table 4). To assess the validity of the results, categorized themes were triangulated by comparing with results with another survey question that asked the peer mentee to rate the importance of that peer mentor to the mentee's future success, choosing between "not important", "somewhat important", "important" and "very important" (Fig. 4.1). Results were also compared to another survey question asking peer mentees to rank the importance of certain peer qualities choosing between
"not important", "somewhat important", "important" and "very important" (Fig. 4.2).

Participants completed questionnaires at baseline, six months and twelve months.

Questionnaires, however, were not added to the study until six months after enrollments at pilot Site 1 began.

Research Questions, Hypotheses, Variables and Statistical Analyses

1. Does JDTR significantly improve trauma related symptoms (measured by PCL-C) for veteran offenders with trauma related mental illness?

H1: It was hypothesized that the JDTR program would significantly reduce PTSD symptoms as measured by PCL-C full scale and subscale scores for veteran offenders with trauma related mental illness who participated in at least six months of JDTR for pilot Site 1.

Independent Variable: JDTR

Dependent Variable: Pretest-posttest PCL-C sum severity scores; PCL-C category B (persistent re-experiencing of the traumatic event) scores; PCL-C category C (persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness) scores; and PCL-C category D (persistent increased arousal) scores.

Analysis: paired-samples $t$ tests or Wilcoxon signed-rank test

2. Does JDTR significantly improve mental health symptoms and problem severity (measured by BASIS-24) for veteran offenders with trauma related mental illness?

H2: It was hypothesized that JDTR will significantly improve mental health symptoms and problem severity as measured by the Basis-24 full scale and subscale scores for veteran offenders with trauma related mental illness who participated in at least six months of JDTR for pilot Site 1.
Independent Variable: JDTR

Dependent Variable: Pretest-posttest BASIS-24 full scale scores; BASIS-24 depression and functioning subscale scores; BASIS-24 depression and functioning subscale scores; BASIS-24 relationship problems subscale scores; BASIS-24 self-harm problems subscale scores; BASIS-24 emotional lability scores; BASIS-24 psychosis subscale scores; and BASIS-24 substance abuse subscale scores.

Analysis: paired-samples t tests or Wilcoxon signed-rank test

3. Does JDTR significantly improve recovery markers (measured by the REE-Revised) for veteran offenders with trauma related mental illness?

H₃: It was hypothesized that JDTR will significantly improve recovery markers as measured by the REE-Revised for veteran offenders with trauma related mental illness who participated in at least six months of JDTR for pilot Site 1.

Independent Variable: JDTR

Dependent Variable: REE-Revised mean full scale scores

Analysis: paired-samples t tests

4. Does JDTR significantly reduce arrests for veteran offenders with trauma related mental illness?

H₄: It was hypothesized that JDTR will significantly reduce arrests 1 year post-enrollment for veteran offenders with trauma related mental illness who participated in at least six months of JDTR.

Independent Variable: JDTR

Dependent Variable: arrests 1 year post-enrollment

Analysis: paired-samples t test or Wilcoxon signed-rank test
5. Is there a relationship between certain variables - i.e., age, income, nights homeless, baseline clinical scores (PCL-C and BASIS-24 full scale and subscale scores), pre-enrollment arrests, peer dosage, case management dosage and seeking safety dosage - and clinical improvements (i.e., changes in PCL-C and BASIS-24 scores) and arrests 1 year post-enrollment?

H5: It was hypothesized that there would be a relationship between certain variables - i.e., age, income, nights homeless, baseline clinical scores (PCL-C and BASIS-24 full scale and subscale scores), pre-enrollment arrests, peer dosage, case management dosage, seeking safety dosage - and clinical improvements (i.e., changes in PCL-C and BASIS-24 scores) and arrests 1 year post-enrollment.

Independent Variables: age at time of enrollment; income 30 days prior to enrollment; nights homeless 30 days prior to enrollment; baseline clinical scores (PCL-C and BASIS-24 full scale and subscale scores); arrests 1 year pre-enrollment; peer dosage; case management dosage; and seeking safety dosage.

Dependent Variable: changes in PCL-C and BASIS-24 full scale and subscale scores and arrests 1 year post-enrollment.

Analysis: Pearson's product-moment correlation

6. Research Question 6: How did JDTR peer mentees perceive their JDTR peer mentors? More specifically, what qualities made a mentor a "peer" and how important was the peer mentor relationship to the peer mentee's future success?

Analysis: qualitative and descriptive.
CHAPTER 4: RESULTS

Descriptive Analysis

JDTR pilots operated in two locations in Florida. Pilot 1 was implemented by Northside Mental Health in Hillsborough County and accepted diversions from intercepts 2 and 3 (i.e., first appearance/magistrate court and other referral locations) and operated from December 12, 2010 to June 30, 2012. Site 1 conducted 240 screenings, of which 44 (17.9%) participants completed baseline interviews and were enrolled in JDTR. Site 2 was implemented by ACTS in Pinellas County and included diversions at intercept 1 (Safe Harbor Shelter) as well as 2 and 3 (Veteran's Court and Drug Court and other referral locations) and operated from October 1, 2012 to September 30, 2014. Site 2 conducted 276 screenings, of which 23 (8.3%) participants completed baseline interviews and were enrolled.

Results for both Sites (N = 67) show the overwhelming majority of participants were males 62 (92.5%), while only 5 (7.5%) were females. In terms of age, 14 (20.9%) participants were between 20 and 30 years of age; 11 (16.4%) participants were between 31 and 40; 21 (31.3%) participants were between 41 and 50; 16 (23.9%) participants were between 51 and 60; and only 5 (7.5%) participants were older than 61 years of age. Of all participants, 45 (67.2%) identified as White and 22 (32.8%) as Black or African American, while 6 (9%) participants identified as American Indian, of which 1 participant identified as both American Indian and Black or African American and 5 participants identified as White and American Indian. Table 4.1 provides a breakdown between Sites 1 and 2.
Regarding employment status for all participants (N = 67), only 9 (13.4%) reported working full time (35 + hours a week) and 6 (9%) reported working part time. Of those not working, 25 (37.3%) participants reported they were unemployed and looking for work and 18 (26.9%) indicated they were disabled, whereas only 4 (6%) participants were not looking for work and 3 (4.5%) were retired. As for educational level, more than half of the participants, 34 (50.7%), reported attending some college and 22 (32.8%) reported completing the 12th grade or obtaining a high school equivalent diploma (GED). Only 4 (6%) participants reported attending some technical school and 3 (4.5%) reported not completing the 12th grade. Of those attending college, 4 (4.5%) reported completing college and 1 (1.5%) reported attending graduate school. Table 4.2 provides a breakdown between Sites 1 and 2.

Regarding military service, 44 (65.6%) participants served in the Army; 12 (17.9%) participants served in the Navy; 8 (11.9%) participants served in the Marine Corps; 3 (4.5%) participants served in the Air Force; and 1 (1.5%) served in the Coast Guard. Data included one person who served in both the Army and the Navy. Of these participants, none served during the Korean War Era or WWII and only 1 (1.5%) served between Korea and Vietnam. The majority of participants served immediately after the Vietnam War Era, 35 (52.2%), while only 9 (13.4%) served during the Vietnam War Era. A meaningful number of Veterans served during the Persian Gulf War 19 (28.4%) and the Afghanistan/Iraq War Eras 25 (37.3%). Almost half of the participants, 30 (44.8%), served in a combat zone; and 20 (29.9%) participants reported receiving service-connected disability benefits from the VA. Three quarters, 50 (74.6%), received Honorable discharges. Of the remaining participants, 12 (17.9%) received General discharges Under Honorable Conditions; 3 (4.5%) received Medical (including section 8) discharges; and 2 (3%) received General discharges that were Other Than Honorable. No
participants reported receiving a *Dishonorable* discharge, not surprising given that dishonorable discharge status was an exclusionary criterion. Table 4.3 provides a breakdown between Sites 1 and 2.

As for the level of the criminal charge for the qualifying arrest, 43 (64.2%) were felonies; 18 (26.9%) were misdemeanors; and 1 (1.5%) was a charge lower than a misdemeanor. No formal charges were filed against 3 (4.3%) participants and data was missing for 2 (3%) participants. Almost all of the diversions occurred after booking, 63 (94%), and only 4 (6%) participants were diverted prior to booking. Not including the qualifying arrest, there were 48 total arrests for all participants one year prior to enrollment. Prior arrest data also shows that 41 (61.2%) participants had not been arrested one year prior to enrollment; 14 (20.9%) participants had 1 arrest 1 year prior to enrollment; 5 (7.5%) participants had 2 arrests 1 year prior to enrollment; and 5 (7.5%) participants had 3 or more arrests 1 year prior to enrollment. Prior arrest data was missing for 2 (3%) program participants. There were 41 total arrests 1 year post-enrollment for all participants. Post arrest data indicates 37 (55.2%) participants were not arrested 1 year post-enrollment; 18 (26.9%) participants had 1 arrest 1 year post-enrollment; 7 (10.4%) participants had 2 arrests 1 year post-enrollment; and 2 (3%) participants had 3 or more arrests 1 year post-enrollment. Post enrollment arrest data was missing for 2 (3%) participants. Table 4.4 provides a breakdown between Sites 1 and 2.

Baseline PCL-C scores showed the majority of participants in the program, 42 (62.7%) scored within the provisional PTSD diagnostic range, while 25 (37.3%) participants did not meet the provisional PTSD diagnostic range. Moreover, 20 (29.9%) participants experienced at least one episode of homelessness during the 30 days prior to enrollment. Of those participants, 7 (10.4%) experienced between 1 and 10 nights homeless; 4 (6%) experienced between 11 and 20
nights homeless; and 9 (13.4%) experienced between 21 and 30 nights homeless. Of those participants who completed baseline interviews (N = 67), only 31 (46.3%) participants completed six month interviews and considerably less participants, 16 (23.9%), completed twelve month interviews. Table 4.5 provides a breakdown between Sites 1 and 2.

In terms of peer, case management and Seeking Safety dosage for both sites, 66 participants received a total of 986 hours of documented peer services (e.g. outreach, support, mentoring and transportation services directly from veteran peer mentors); 64 participants received a total of 542 hours of case management services, and 22 participants received total of 110 hours of Seeking Safety. Peer dosage ranged from 0 to 83 hours and the average participant received 14.94 (Mdn = 10.50; SD = 15.65) hours of peer services. Case management dosage ranged from 1 to 33 hours and average participant received 8.47 hours (Mdn = 8; SD = 5.56) of case management services. Seeking Safety dosage ranged from 1 hours to 14 hours with the average participant received 5 (Mdn = 4; SD = 3.3) hours of peer seeking safety. Table 4.6 provides a breakdown between Sites 1 and 2.

Quantitative Analysis

Research Question 1: Does JDTR significantly improve trauma related symptoms (measured by PCL-C) for veteran offenders with trauma experience?

It was hypothesized that the JDTR program would significantly reduce PTSD symptoms as measured by PCL-C full scale and subscale scores for veteran offenders with trauma related mental illness who participated in at least six months of JDTR at pilot Site 1 (n = 25). A series of t tests were conducted comparing baseline and six month PCL-C full scale and subscale scores to address the question of whether the JDTR program would significantly reduce PTSD
symptoms for Site 1 JDTR participants who completed at least six months of JDTR. The assumptions of normality were tested. An alpha level of .05 was set for all statistical tests.

Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test revealed the population difference of PCL-C sum severity scores, $D(25) = 0.137, p = 0.200$ were normally distributed. Therefore, a paired-samples $t$ test was used.

Results of the paired-sample $t$ test of sum total severity PCL-C scores indicate that there was a significant decrease in PCL-C scores from baseline to six months for Site 1 JDTR participants, $t(25) = 2.669, p < .013$ (two-tailed). The correlation between the baseline and six month PCL-C scores was .589 ($p < .002$). The mean difference between the baseline and six month PCL-C scores was 7.32 (baseline PCL-C $M = 51.64, SD = 13.27$; six month PCL-C $M = 44.32, SD = 16.35$). The standardized effect size index, which was calculated using the baseline mean minus the six month mean divided by the pooled $SD$, was $d = .49$. The mean PCL-C score at baseline was greater than 50 which is considered a significant level of symptom severity (Weathers et al., 199), whereas the mean six month PCL-C score fell below 50 to 44.32 which is considered a moderate to moderately high level of symptom severity.

The categories of symptoms were scored to provide a provisional diagnosis of PTSD, treating responses of 3–5 as symptomatic and responses of 1–2 as non-symptomatic and then use the DSM criteria for a diagnosis. To meet criteria for PTSD per the DSM IV, PTSD must include all of the following:

1. At least 1 symptomatic response in category B, which includes questions about persistent re-experiencing of the traumatic event and require, (Appendixes D and E, Questions 1–5);
2. at least 3 symptomatic responses in category C, which includes questions about persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness and requires (Appendixes D and E, Questions 6–12); and

3. at least 2 symptomatic responses in category D, which includes questions about persistent increased arousal and requires (Appendixes D and E, Questions 13–17).

Of those who completed both baseline and six month PCL-C measures for Site 1, 17 (68%) scored within the provisional PTSD diagnostic range at baseline and 11 (44%) scored within the provisional PTSD diagnostic range at six months, resulting in a 24% decrease in provisional diagnoses of PTSD from baseline to six months.

Comparisons of baseline and six month PCL-C scores for Category B, C, and D were conducted separately. Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population difference of PCL-C category B (persistent re-experiencing of the traumatic event) scores, $D(25) = 0.140$, $p = 0.200$ were normally distributed. Therefore, a paired-samples $t$ test was used. There was no statistical difference between baseline and six month PCL-C scores for category B symptoms (persistent re-experiencing of the traumatic event) scores, $t(25) = 1.74$, $p < .094$.

Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population differences from baseline and six month PCL-C category C scores, $D(25) = 0.235$, $p = .000$ were not normally distributed. Since the population differences were symmetric, the non-parametric Wilcoxon signed-ranks test was used to compare differences in category C scores. Results of the Wilcoxon signed-ranks test showed a
significant decrease in category C symptoms in Site 1 participants (avoidance of stimuli associated with the trauma and numbing of general responsiveness) from baseline ($Mdn = 11.29$) to six months ($Mdn = 9.75$), $Z = -2.707, p < .007, r = -.54$.

Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population differences from PCL-C category D scores, $D(25) = 0.201, p = 0.010$ were not normally distributed. Since the population differences were symmetric, the non-parametric Wilcoxon signed-ranks test was conducted. Results of the Wilcoxon signed-ranks test indicated there was no significant decrease in category D symptoms (persistent increased arousal) in Site 1 participants from baseline ($Mdn = 10.23$) to six months ($Mdn = 6.75$), $Z = -1.750, p < .08$.

Research Question 2: Does JDTR significantly improve mental health symptoms and problem severity (measured by BASIS-24) for veteran offenders with trauma related mental illness?

It was hypothesized that JDTR will significantly improve mental health symptoms and problem severity as measured by the Basis-24 full scale and subscale scores for veteran offenders with trauma related mental illness who participated in at least six months of JDTR at pilot Site 1 ($n=25$). A series of t tests was conducted comparing baseline and six month BASIS-24 full scale and subscale scores to address the question of whether the JDTR program would significantly improve mental health symptoms and functioning for Site 1 JDTR participants who completed at least six months. The assumptions of normality were tested. An alpha level of .05 was set for all statistical tests.
Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population difference of BASIS-24 full scale scores, $D_{(25)} = 0.173$, $p = 0.052$ were normally distributed. Therefore, a paired-samples $t$ test was used.

Results of the paired-sample $t$ test BASIS-24 full scale scores indicate that there was a significant decrease of full scale scores for Site 1 JDTR participants from baseline to six months, $t(25) = 2.115$, $p < 0.045$ (two-tailed). The correlation between the baseline and six month full scale scores was $0.276$ ($p < 0.181$). The mean difference between the baseline and six month full scale BASIS-24 scores was $0.361$ (baseline full BASIS-24 full scale scores $M = 1.55$, $SD = 0.67$; six month BASIS-24 full scale scores $M = 1.19$, $SD = 0.75$). The standardized effect size index, which was calculated using the baseline mean minus the six month mean divided by the pooled $SD$, was $d = 0.51$.

Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population difference of BASIS-24 depression scores, $D_{(25)} = 0.122$, $p = 0.200$ were normally distributed. Therefore, a paired-samples $t$ test was used.

Results of the paired-sample $t$ test BASIS-24 depression and functioning subscale scores indicate that there was a significant decrease of depression and functioning scores for Site 1 JDTR participants from baseline to six months, $t(25) = 2.572$, $p < 0.017$ (two-tailed). The correlation between the baseline and six month BASIS-24 depression and functioning subscale scores was $0.085$ ($p < 0.688$). The mean difference between the baseline and six month BASIS-24 depression and functioning subscale scores was $0.654$ (baseline BASIS-24 depression and functioning subscale scores $M = 1.94$, $SD = 0.87$; six month BASIS-24 depression and
functioning subscale scores $M= 1.29, SD = .99$. The standardized effect size index, which was calculated using the baseline mean minus the six month mean divided by the pooled $SD$, was $d = .70$.

Histgrams and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population difference of baseline and six month BASIS-24 relationship scores, $D (25) = 0.139, p = 0.200$ were normally distributed. Therefore, a paired-samples $t$ test was used. There were no statistical difference between BASIS-24 baseline and six month interpersonal relationships subscale scores $t(25) = .99, p < .34$.

Histgrams and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population differences from baseline and six month BASIS-24 self-harm scores, $D (25) = 0.386, p = 0.001$ were not normally distributed. Since the population differences were symmetric, the non-parametric Wilcoxon signed-ranks test was conducted. Results of the Wilcoxon signed-ranks test indicated there was no significant decrease in BASIS-24 self-harm scores from baseline ($Mdn = 3.25$) to six months ($Mdn = 4.00$), $Z = -.531, p < .595$.

Histgrams and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population difference of baseline and six month BASIS-24 emotional lability scores, $D (25) = 0.153, p = 0.132$ were normally distributed. Therefore, a paired-samples $t$ test was used. There were no statistical difference between BASIS-24 baseline and six month emotional lability subscale scores $t(25) = .87, p < .395$. 

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Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population difference of baseline and six month BASIS-24 relationship scores, $D(25) = 0.154$, $p = 0.128$ were normally distributed. Therefore, a paired-sample $t$ test was used. There were no statistical difference between BASIS-24 baseline and six month psychotic symptoms subscale scores $t(25) = .85$, $p < .405$.

Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population differences from baseline and six month BASIS-24 substance abuse scores, $D(25) = 0.191$, $p = 0.019$ were not normally distributed. Since the population differences were symmetric, the non-parametric Wilcoxon signed-ranks test was conducted. Results of the Wilcoxon signed-ranks test indicated no significant decrease in BASIS-24 substance abuse scores from baseline ($Mdn = 11.11$) to six months ($Mdn = 4.00$), $Z = -.202$, $p < .840$.

**Research Question 3: Does JDTR significantly improve recovery markers (measured by the REE-Revised) for veteran offenders with trauma related mental illness?**

It was hypothesized that JDTR will significantly improve recovery markers as measured by the REE-Revised for veteran offenders with trauma related mental illness who participated in at least six months of JDTR for pilot Site 1 (n=25). A comparison of baseline and six month REE scores was conducted to address the question of whether the JDTR program would significantly improve recovery REE scores for Site 1 JDTR participants who completed at least six months. The assumption of normality was tested and an alpha level of .05 was set.
Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population differences of baseline and six month REE scores, $D(25) = 0.122, p = 0.200$ were normally distributed. Therefore, a paired-samples $t$ test was used. The paired-samples $t$ test REE scores indicated that there was no significant changes from baseline to six months for the total REE score $t(25) = -1.35, p < .189$.

**Research Question 4: Does JDTR significantly reduce arrests for veteran offenders with trauma related mental illness?**

It was hypothesized that JDTR will significantly reduce arrests 1 year post-enrollment for veteran offenders with trauma related mental illness who participated in at least six months of JDTR at pilot Site 1 ($n=25$). A comparison of pre and post enrollment arrests was conducted to address the question of whether the JDTR program would significantly reduce arrests for JDTR participants who completed at least six months Site 1. The assumption of normality was tested and an alpha level of .05 was set.

Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population differences from PCL-C category D scores, $D(25) = 0.298, p = .000$, were not normally distributed. Since the population differences were symmetric, the non-parametric Wilcoxon signed-ranks test was conducted. Results of the Wilcoxon signed-ranks test indicated no significant decrease in arrests from 1 year prior to enrollment ($Mdn = 7.50$) and 1 year post-enrollment ($Mdn = 5.50$), $Z = -.489, p < .625$ for those who completed at least six months of JDTR at Site 1.
Participants from pilot Site 2 who completed six months of JDTR (n = 6) were added in a second analysis that combine pilot Sites 1 and 2 (n=31). A comparison of pre-enrollment and post-enrollment arrests was conducted to address the question of whether the JDTR program would significantly reduce arrests for JDTR participants who completed at least six months of the program. The assumption of normality was tested and an alpha level of .05 was set.

Histograms and normal Q-Q plots were inspected and the Kolmogorov-Smirnov test was used to check for normality of distributions. Results from chart analysis and the Kolmogorov-Smirnov test of normality revealed the population differences between pre-enrollment arrests and post-enrollment arrests, $D (31) = 0.273, p = .000$, were not normally distributed. Since the population differences were symmetric, the non-parametric Wilcoxon signed-ranks test was conducted. Results of the Wilcoxon Signed Ranks test indicated no significant decrease in arrests 1 year prior to enrollment ($Mdn = 7.75$) and 1 year post enrollment ($Mdn = 7.31$), $Z = -.393, p < .694$) for those who completed at least six months of JDTR.

**Research Question 5: Is there a relationship between certain variables - i.e., age, income, nights homeless, baseline clinical scores (PCL-C and BASIS-24 full scale and subscale scores), pre-enrollment arrests, peer dosage, case management dosage and seeking safety dosage - and clinical improvements (i.e., changes in PCL-C and BASIS-24 scores) and arrests 1 year post-enrollment?**

It was hypothesized that there would be a relationship between certain variables - i.e., age, income, nights homeless, baseline clinical scores (PCL-C and BASIS-24 full scale and subscale scores), pre-enrollment arrests, peer dosage, case management dosage, seeking safety dosage - and clinical improvements (i.e., changes in PCL-C and BASIS-24 scores) and arrests 1 year post-enrollment. Pearson's product correlations were conducted and results showed there
was a strong positive correlation between arrests 1 year pre-enrollment and arrests 1 year post-
enrollment, Pearson’s $r(64) = .465, p < .001$. In addition, nights homeless 30 days prior to
enrollment were positively correlated with arrests 1 year post-enrollment, Pearson’s $r(64) = .309,$
$p < .013$. Moreover, seeking safety dosage was negatively correlated with a change in PCL-C
category C symptoms for participants at both pilot sites who completed six months of JDTR, 
Pearson’s $r(9) = -.701, p < .036$, but there was no significant correlation for Site 1 alone and
small $n$ due to a low utilization rate of Seeking Safety (Table 4.7).

Not surprisingly, there were significant correlations between baseline BASIS-24 scores
and changes in BASIS-24 scores for those completing six months of JDTR. There was a strong
positive correlation between baseline BASIS-24 full scale scores and a change in BASIS-24 full
scale scores for those completing six months of JDTR at pilot site 1 and pilot sites 1 and 2
combined, Pearson’s $r(25) = .543, p < .005$ and Pearson’s $r(31) = .486, p < .006$. Baseline
BASIS-24 full scale scores were positively correlated with a change in BASIS-24 depression
scores for those completing six months of JDTR at pilot site 1 and pilot sites 1 and 2 combined,
Pearson’s $r(25) = .617, p < .001$ and Pearson’s $r(31) = .589, p < .001$. Baseline BASIS-24
depression scores were positively correlated with a change in BASIS-24 full scale scores for
those completing six months of JDTR at pilot site 1 and pilot sites 1 and 2 combined, Pearson’s
$r(25) = .510, p < .009$ and Pearson’s $r(31) = .454, p < .01$. Baseline BASIS-24 depression scores
were also positively correlated with a change in BASIS-24 depression scores for those
completing six months of JDTR at pilot site 1 and pilot sites 1 and 2 combined, Pearson’s $r(25) = 
.632, p < .001$ and Pearson’s $r(31) = .599, p < .001$. Baseline BASIS-24 relationship scores
were positively correlated with a change in BASIS-24 full scale scores for those completing six
months of JDTR at pilot site 1 and pilot sites 1 and 2 combined, Pearson’s $r(25) = .488, p < .013$
and Pearson’s $r(31) = .488, p < .005$. Finally, baseline BASIS-24 relationship scores were positively correlated with a change in BASIS-24 depression scores for those completing six months of JDTR at pilot site 1 and pilot sites 1 and 2 combined, Pearson’s $r(25) = .551, p < .004$ and Pearson’s $r(31) = .551, p < .002$ (Table 4.7).

Since Pearson's product correlations are sensitive to outliers, all data were inspected for outliers. Two outliers were identified in pre-enrollment arrests, subject #57, 101 arrests (an apparent typo) and subject #68, 12 arrests (likely accurate). Subject #57 data were deleted but subject #68 was re-coded as 6 arrests to accurately reflect the high number of arrests (12) and removed the outlier while preserving the integrity of the data. Linearity and normality were also tested using chart analysis and Kolmogorov-Smirnov test. Pre-enrollment, post-enrollment arrests, nights homeless, peer dosage, case management dosage, baseline BASIS-24 self-harm, baseline BASIS-24 substance abuse scores and baseline PCL-C category C scores were found to not be normally distributed. Logarithmic transformations were attempted and made successfully to peer dosage and baseline PCL-C category C scores. Based on the low $N$ and lack of symmetry for many of the other non-normal variables and because Pearson's correlations studies have shown one or both variables can be very non-normal with the probability of a false positive still approximately 0.05, Pearson's product correlation was chosen to analyze the data rather than a non-parametric statistic that would be significantly less sensitive to detecting relationships (Edgell and Noon, 1984).

Qualitative Analysis

Research Question 6: How did JDTR peer mentees perceive their JDTR peer mentors? More specifically, what qualities made a mentor a "peer" and how important was the peer mentor relationship to the peer mentee's future success?
Participants were to identify who they primarily worked with and whether they considered that person a peer. Respondents were then asked if they replied "yes" to explain why they considered this person a peer and if "no" why they did not consider this person a peer. Responses are shown in Table 4.8. Participants were to identify who they primarily worked with and whether they considered that person a peer. Respondents were then asked if they replied "Yes" to explain why they considered this person a peer and if "No" why they did not consider this person a peer. Participants completed questionnaires (Appendix F) at baseline, six months and twelve months. Questionnaires, however, were not added to the study until six weeks after the start of pilot site 1.

Because the questionnaire was completed at multiple time intervals some were completed more than once. The overwhelming majority of participants consider the primary person they worked with to be peer. Of the 83 completed questionnaires, 71 (86%) reported "yes" at all-time intervals (baseline, six months and 12 months), whereas only 12 (14%) reported "no". Unique responses (i.e., the participant's first response, which was either baseline or six months) totaled 55. Of those, 48 (87%) reported "yes" and 7 (13%) reported "no", representing no significant difference. Responses are shown in Table 4.8. To add to the richness of this content analysis, all responses (N= 71) were coded and categorized. After analyzing coded responses, five primary categories were identified from the "yes" responses: 1) Served in Military, 2) Quality of Relationship, 3) Similar Background/Experiences, 4) Helpful, Knowledgeable, Practical and 5) Mental Health Substance Abuse History or Other "Issues". Responses were totaled and only one response was counted for each category per participant, even if a category was identified multiple times in the participant's response. Of all 71 responses, 59 responses were coded under Served in Military; 29 responses were coded under Quality of Relationship; 27 responses were
coded under *Similar Background/Experiences*; 12 responses were coded under *Helpful, Knowledgeable, Practical*; and 11 responses were coded under *Mental Health Substance Abuse History or Other "Issues"* (Table 4.8).

After analyzing coded response, four primary categories were identified in "No" responses: 1) *Not Familiar with Mentor/Don't Know Them Well*, 2) *Didn't Know They Were a Veteran*, 3) *Quality of Relationship*, 4) *Not Similar*. Responses were totaled and only one response was counted for each category per participant, even if a category was identified multiple times in the participant's response. Of all 12 responses, 59 responses were coded under *Not Familiar with Mentor/Don't Know Them Well*; 5 responses were coded under *Didn't Know They Were a Veteran*; 2 responses were coded under *Quality of Relationship*; and 2 responses were coded under *Not Similar* (Table 4.9).

Following up with the previous question, participants were asked:

Thinking of the person from JDTR that you previously identified (as a peer), how important is your involvement with this person to your future success, (such as not getting rearrested and addressing substance use, mental health or trauma issues) (see Appendix F)?

Ratings of the importance included: not important, somewhat important, important and extremely important. Scores were totaled using only the first completed questionnaire from each respondent (N = 55) to insure unique responses (Fig. 4.1). Of these, more than half, 28 (51%), rated their peer mentor as "very important" to their future success. Nearly half, 22 (40%), rated their peer mentor as either "important" or "somewhat important" to their future success. Of those, 11 (20%) rated their peer mentor as "important" and 11 (20%) rated their peer mentor as
"somewhat important". Only 4 (7%) rated their peer mentor as "not important" to their future success. One respondent's data was missing but still included in the analysis.

Peer mentors were also asked to rank these various qualities in importance. Ratings of the importance of peer qualities included: not important, somewhat important, important and extremely important. For the purpose of comparison, responses were scored 0 to 3 with "not important" scored as zero, "somewhat important" scored as 1, "important" scored as 2, and "extremely important" scored as 3. Scores were totaled for each quality using only the first completed questionnaire from each respondent (N = 55) to insure unique responses (Fig 4.2). These were consistent with findings that being a veteran and qualities regarding life experiences were more important than labels (branch of service, rank or veteran status) or demographics (age, race or gender.)
Table 4.1
Participant Demographics

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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sample Population</strong></td>
<td>N = 44</td>
<td></td>
<td>N = 23</td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>42</td>
<td>95.5%</td>
<td>20</td>
<td>87%</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>4.5%</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>11</td>
<td>16.4%</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>31-40</td>
<td>8</td>
<td>11.9%</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>41-50</td>
<td>15</td>
<td>22.4%</td>
<td>6</td>
<td>26.1%</td>
</tr>
<tr>
<td>51-60</td>
<td>7</td>
<td>10.4%</td>
<td>9</td>
<td>39.1%</td>
</tr>
<tr>
<td>61-74</td>
<td>3</td>
<td>4.5%</td>
<td>2</td>
<td>8.7%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian</td>
<td>2*</td>
<td>4.5%</td>
<td>4**</td>
<td>17.4%</td>
</tr>
<tr>
<td>Alaska Native</td>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td>16</td>
<td>36.4%</td>
<td>6</td>
<td>26.1%</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific Islander</td>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>28</td>
<td>63.6%</td>
<td>17</td>
<td>73.9%</td>
</tr>
</tbody>
</table>

* One participant identified as Black or African American and one participant identified as White and American Indian
** Four participants identified as White and American Indian
Table 4.2  
Employment & Education

<table>
<thead>
<tr>
<th>Sample Population</th>
<th>N</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed full time (35 hours + a week)</td>
<td>5</td>
<td>11.4%</td>
</tr>
<tr>
<td>Employed part time</td>
<td>5</td>
<td>11.4%</td>
</tr>
<tr>
<td>Unemployed, looking for work</td>
<td>15</td>
<td>34.1%</td>
</tr>
<tr>
<td>Unemployed, disabled</td>
<td>13</td>
<td>29.5%</td>
</tr>
<tr>
<td>Unemployed, retired</td>
<td>2</td>
<td>4.5%</td>
</tr>
<tr>
<td>Unemployed, not looking for work</td>
<td>3</td>
<td>6.8%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2.3%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 12th grade</td>
<td>1</td>
<td>2.3%</td>
</tr>
<tr>
<td>12th grade/High School diploma/Equivalent (GED)</td>
<td>12</td>
<td>27.3%</td>
</tr>
<tr>
<td>Voc Tech Diploma</td>
<td>3</td>
<td>6.8%</td>
</tr>
<tr>
<td>Some College or University</td>
<td>24</td>
<td>54.5%</td>
</tr>
<tr>
<td>Bachelor's Degree (BA, BS)</td>
<td>3</td>
<td>6.8%</td>
</tr>
</tbody>
</table>
Table 4.3
Military Service

<table>
<thead>
<tr>
<th>Site 1</th>
<th>Sample Population</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 44</td>
<td></td>
</tr>
<tr>
<td><strong>Branch</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Army</td>
<td>31</td>
<td>70.5%</td>
</tr>
<tr>
<td>Navy</td>
<td>6</td>
<td>13.6%</td>
</tr>
<tr>
<td>Marine Corps</td>
<td>5</td>
<td>11.1%</td>
</tr>
<tr>
<td>Air Force</td>
<td>2</td>
<td>4.5%</td>
</tr>
<tr>
<td>Coast Guard</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Era</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre WWII</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>WWII</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Pre-Korean War</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Korean War</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Between Korea and Vietnam</td>
<td>1</td>
<td>1.7%</td>
</tr>
<tr>
<td>Vietnam</td>
<td>5</td>
<td>8.3%</td>
</tr>
<tr>
<td>Post-Vietnam</td>
<td>21</td>
<td>35%</td>
</tr>
<tr>
<td>Persian Gulf-Middle East</td>
<td>15</td>
<td>25%</td>
</tr>
<tr>
<td>Afghanistan/Iraq</td>
<td>18</td>
<td>30%</td>
</tr>
<tr>
<td>Served in Combat Zone</td>
<td>21</td>
<td>47.7%</td>
</tr>
<tr>
<td><strong>Discharge Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honorable</td>
<td>34</td>
<td>77.3%</td>
</tr>
<tr>
<td>General (under honorable conditions)</td>
<td>5</td>
<td>11.4%</td>
</tr>
<tr>
<td>General (other than honorable)</td>
<td>2</td>
<td>4.5%</td>
</tr>
<tr>
<td>Medical (including section 8)</td>
<td>3</td>
<td>6.8%</td>
</tr>
<tr>
<td>Dishonorable</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Service Connected</strong></td>
<td>18</td>
<td>40.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site 2</th>
<th>Sample Population</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 23</td>
<td></td>
</tr>
<tr>
<td><strong>Branch</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Army</td>
<td>13*</td>
<td>56.5%</td>
</tr>
<tr>
<td>Navy</td>
<td>6*</td>
<td>26.1%</td>
</tr>
<tr>
<td>Marine Corps</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>Air Force</td>
<td>1</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
Table 4.3 (Continued)

<table>
<thead>
<tr>
<th>Era</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre WWII</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>WWII</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Pre-Korean War</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Korean War</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Between Korea and Vietnam</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Vietnam</td>
<td>4</td>
<td>13.8%</td>
</tr>
<tr>
<td>Post-Vietnam</td>
<td>14</td>
<td>48.3%</td>
</tr>
<tr>
<td>Persian Gulf-Middle East</td>
<td>4</td>
<td>13.8%</td>
</tr>
<tr>
<td>Afghanistan/Iraq</td>
<td>7</td>
<td>24.1%</td>
</tr>
<tr>
<td>Served in Combat Zone</td>
<td>9</td>
<td>39.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Status</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Honorable</td>
<td>16</td>
<td>69.6%</td>
</tr>
<tr>
<td>General (under honorable conditions)</td>
<td>7</td>
<td>30.4%</td>
</tr>
<tr>
<td>General (other than honorable)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Medical (including section 8)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Dishonorable</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

| Service Connected          | 2     | 8.7%       |

* One participant served in the Army and Navy

** Service eras often overlapped and total more than the number of participants enrolled.
Table 4.4  
Criminal Justice

<table>
<thead>
<tr>
<th>Site 1</th>
<th>N=44</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felony</td>
<td>28</td>
<td>63.6%</td>
</tr>
<tr>
<td>Misdemeanor</td>
<td>16</td>
<td>36.4%</td>
</tr>
<tr>
<td>Violation/Ticket/Infraction (Lower than a Misdemeanor)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>No formal charges</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Missing data</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

*Diversion Intercept*

<table>
<thead>
<tr>
<th>Site 1</th>
<th>N=44</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-booking diversion</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Post-booking diversion</td>
<td>44</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Arrests 1 Year Prior to Enrollment*

<table>
<thead>
<tr>
<th>Site 1</th>
<th>N=44</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total prior arrests</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Participants with 0 prior arrests pre-enrollment</td>
<td>26</td>
<td>59.1%</td>
</tr>
<tr>
<td>Participants with 1 prior arrest pre-enrollment</td>
<td>11</td>
<td>25%</td>
</tr>
<tr>
<td>Participants with 2 prior arrests pre-enrollment</td>
<td>5</td>
<td>11.4%</td>
</tr>
<tr>
<td>Participants with 3 prior arrests pre-enrollment</td>
<td>2</td>
<td>4.5%</td>
</tr>
<tr>
<td>More than 3 prior arrests pre-enrollment</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Missing data</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site 2</th>
<th>N=23</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felony</td>
<td>15</td>
<td>65.2%</td>
</tr>
<tr>
<td>Misdemeanor</td>
<td>2</td>
<td>8.7%</td>
</tr>
<tr>
<td>Violation/Ticket/Infraction (Lower than a Misdemeanor)</td>
<td>1</td>
<td>4.3%</td>
</tr>
<tr>
<td>No formal charges</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>Missing data</td>
<td>2</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

*Diversion Intercept*

<table>
<thead>
<tr>
<th>Site 2</th>
<th>N=23</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-booking diversion</td>
<td>4</td>
<td>17.4%</td>
</tr>
<tr>
<td>Post-booking diversion</td>
<td>19</td>
<td>82.6%</td>
</tr>
</tbody>
</table>

*Arrests 1 Year Prior to Enrollment*

<table>
<thead>
<tr>
<th>Site 2</th>
<th>N=23</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total prior arrests</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Participants with 0 prior arrests</td>
<td>15</td>
<td>65.2%</td>
</tr>
<tr>
<td>Participants with 1 prior arrest</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>Participants with 2 prior arrests</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Participants with 3 prior arrests</td>
<td>2</td>
<td>8.7%</td>
</tr>
<tr>
<td>More than 3 prior arrests</td>
<td>1</td>
<td>4.3%</td>
</tr>
<tr>
<td>Missing data</td>
<td>2</td>
<td>8.7%</td>
</tr>
</tbody>
</table>
Table 4.4 (Continued)

<table>
<thead>
<tr>
<th>Arrests 1 Year Post Enrollment</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total arrests post enrollment</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Participants with 0 arrests post enrollment</td>
<td>13</td>
<td>56.5%</td>
</tr>
<tr>
<td>Participants with 1 arrest post enrollment</td>
<td>5</td>
<td>21.7%</td>
</tr>
<tr>
<td>Participants with 2 arrests post enrollment</td>
<td>1</td>
<td>4.3%</td>
</tr>
<tr>
<td>Participants with 3 arrests post enrollment</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>More than 3 arrests post enrollment</td>
<td>1</td>
<td>4.3%</td>
</tr>
<tr>
<td>Missing data</td>
<td>3</td>
<td>13%</td>
</tr>
</tbody>
</table>
Table 4.5
Other Variables

<table>
<thead>
<tr>
<th>Site 1</th>
<th>Sample Population</th>
<th>N = 44</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meets PTSD criteria at baseline</strong></td>
<td></td>
<td>29</td>
<td>65.9%</td>
</tr>
<tr>
<td><strong>Nights homeless 30 days prior to enrollment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience an episode of homelessness</td>
<td>11</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>1 to 10 nights homeless</td>
<td>3</td>
<td></td>
<td>6.8%</td>
</tr>
<tr>
<td>11 to 20 nights homeless</td>
<td>3</td>
<td></td>
<td>6.8%</td>
</tr>
<tr>
<td>21 to 30 nights homeless</td>
<td>5</td>
<td></td>
<td>11.4%</td>
</tr>
<tr>
<td><strong>Program Retention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Six months</td>
<td>25</td>
<td></td>
<td>56.8%</td>
</tr>
<tr>
<td>Twelve months</td>
<td>14</td>
<td></td>
<td>31.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site 2</th>
<th>Sample Population</th>
<th>N = 23</th>
<th>Mode Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meets PTSD criteria at baseline</strong></td>
<td></td>
<td>13</td>
<td>56.5%</td>
</tr>
<tr>
<td><strong>Nights homeless 30 days prior to enrollment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience an episode of homelessness</td>
<td>9</td>
<td></td>
<td>39.1%</td>
</tr>
<tr>
<td>1 to 10 nights homeless</td>
<td>4</td>
<td></td>
<td>17.4%</td>
</tr>
<tr>
<td>11 to 20 nights homeless</td>
<td>1</td>
<td></td>
<td>4.3%</td>
</tr>
<tr>
<td>21 to 30 nights homeless</td>
<td>4</td>
<td></td>
<td>17.4%</td>
</tr>
<tr>
<td><strong>Program Retention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Six months</td>
<td>6</td>
<td></td>
<td>26.1%</td>
</tr>
<tr>
<td>Twelve months</td>
<td>2</td>
<td></td>
<td>8.7%</td>
</tr>
</tbody>
</table>
Table 4.6  
Peer, Case Management & Seeking Safety Dosage

<table>
<thead>
<tr>
<th></th>
<th>Site 1</th>
<th>Site 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Peer Dosage N = 44</td>
<td>Case Management Dosage N = 44</td>
</tr>
<tr>
<td>Average hours</td>
<td>12.6</td>
<td>7.7</td>
</tr>
<tr>
<td>Median hours</td>
<td>7.5</td>
<td>7.5</td>
</tr>
<tr>
<td>SD</td>
<td>13.1</td>
<td>4.1</td>
</tr>
<tr>
<td>Minimum hours</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Maximum hours</td>
<td>61</td>
<td>20</td>
</tr>
<tr>
<td>Total hours</td>
<td>555</td>
<td>338</td>
</tr>
<tr>
<td>Average hours</td>
<td>20.5</td>
<td>10.2</td>
</tr>
<tr>
<td>Median hours</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>SD</td>
<td>19.2</td>
<td>7.7</td>
</tr>
<tr>
<td>Minimum hours</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Maximum hours</td>
<td>83</td>
<td>33</td>
</tr>
<tr>
<td>Total hours</td>
<td>431</td>
<td>204</td>
</tr>
<tr>
<td></td>
<td>Arrests 1 Year Post Enrollment</td>
<td>Change in BASIS-24 Full Scale Scores</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Arrests 1 Year Prior to Enrollment***</td>
<td>.465** n = 64</td>
<td>-.115 n = 25</td>
</tr>
<tr>
<td>Age</td>
<td>.124 n = 64</td>
<td>154 n = 25</td>
</tr>
<tr>
<td>Income</td>
<td>-.024 n = 63</td>
<td>-.145 n = 25</td>
</tr>
<tr>
<td>Nights Homeless 30 Days Prior To Enrollment***</td>
<td>.309* n = 64</td>
<td>.026 n = 25</td>
</tr>
<tr>
<td>Peer Dosage***</td>
<td>.002 n = 64</td>
<td>-.065 n = 25</td>
</tr>
<tr>
<td>Case Management Dosage***</td>
<td>-.072 n = 63</td>
<td>-.121 n = 25</td>
</tr>
<tr>
<td>Combined Peer &amp; Case Management</td>
<td>-.015 n = 63</td>
<td>-.168 n = 25</td>
</tr>
<tr>
<td>Seeking Safety Dosage</td>
<td>-.056 n = 21</td>
<td>-.356 n = 5</td>
</tr>
<tr>
<td>Baseline REE Scores</td>
<td>-.179 n = 64</td>
<td>-.195 n = 25</td>
</tr>
<tr>
<td>Baseline PCL-C Sum Scores</td>
<td>-.116 n = 64</td>
<td>.112 n = 25</td>
</tr>
<tr>
<td>Baseline PCL-C Category B Scores</td>
<td>-.088 n = 64</td>
<td>.163 n = 25</td>
</tr>
<tr>
<td>Baseline*** PCL-C Category C</td>
<td>-.063 n = 62</td>
<td>.014 n = 25</td>
</tr>
<tr>
<td>Baseline PCL-C Category D Scores</td>
<td>.059 n = 64</td>
<td>-.123 n = 25</td>
</tr>
</tbody>
</table>
Table 4.7 (Continued)

<table>
<thead>
<tr>
<th></th>
<th>Arrests 1 Year Post Enrollment</th>
<th>Change in BASIS-24 Full Scale Scores</th>
<th>Change in BASIS-24 Depression Scores</th>
<th>Change in PCL-C Sum Severity Scores</th>
<th>Change in PCL-C Category C Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline BASIS-24 Full Scale Scores</td>
<td>.068 n = 64</td>
<td>.543** n = 25**</td>
<td>.617** n = 25**</td>
<td>.289 n = 25</td>
<td>.003 n = 25</td>
</tr>
<tr>
<td>Baseline BASIS-24 Depression Scores</td>
<td>.099 n = 64</td>
<td>.510** n = 25**</td>
<td>.632** n = 25**</td>
<td>.171 n = 25</td>
<td>.076 n = 25</td>
</tr>
<tr>
<td>Baseline BASIS-24 Relationship Scores</td>
<td>.081 n = 64</td>
<td>.488** n = 25**</td>
<td>.551** n = 25**</td>
<td>.314 n = 25</td>
<td>.047 n = 25</td>
</tr>
<tr>
<td>Baseline BASIS-24 Self Harm Scores****</td>
<td>-.048 n = 64</td>
<td>-.030 n = 25</td>
<td>-.014 n = 25</td>
<td>.056 n = 25</td>
<td>-.174 n = 25</td>
</tr>
<tr>
<td>Baseline BASIS-24 Emotional Lability</td>
<td>-.008 n = 64</td>
<td>.348 n = 25</td>
<td>.328 n = 25</td>
<td>.366 n = 25</td>
<td>.091 n = 25</td>
</tr>
<tr>
<td>Baseline BASIS-24 Psychosis Scores</td>
<td>-.042 n = 64</td>
<td>.271 n = 25</td>
<td>.288 n = 25</td>
<td>.105 n = 25</td>
<td>-.251 n = 25</td>
</tr>
<tr>
<td>Baseline BASIS-24 Substance Abuse Scores****</td>
<td>.160 n = 64</td>
<td>.011 n = 25</td>
<td>-.061 n = 25</td>
<td>.049 n = 25</td>
<td>-.178 n = 25</td>
</tr>
</tbody>
</table>

* = p < .05, ** = p < .01

*** Variables transformed using logarithmic transformation

**** Variables were not normally distributed; transformations were attempted but did not result in a normally distributed population.

Notes: n = 25 includes all participants who completed six months of JDTR in Site 1.
n = 5 or 9 were because of the low utilization of Seeking Safety
n = 31 includes all participants who completed six months of JDTR in Site 2.
n > 61 includes all JDTR participants in pilot sites 1 and 2 less non-paired and missing data.
Table 4.8
Why person identified as peer mentor was considered a peer.

| Responses | Served in Military | Quality of Relationship | Similar Background/Experiences | Helpful, Knowledgeable, Practical | Mental Health/Substance Abuse History Or Other "Issues"
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 57</td>
<td>n = 29</td>
<td>n = 27</td>
<td>n = 12</td>
<td>n = 11</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>About same age, similar experience</td>
<td></td>
<td>mental health/emotional aspects</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>both homeless together</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>similar situations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>Given directions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>I relate more to him</td>
<td>yes because he has been there done that</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td>being veterans</td>
<td>We have that in common,</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td>because they are vets, helping vets they are veteran-minded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td>you feel more comfortable talking with someone who gets it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td>I can relate to him</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td>we spent a lot of time together and could talk with each other. He was genuine about being in the military and treating vets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td>They are positive.</td>
<td>people who guide me and helped me</td>
<td></td>
</tr>
</tbody>
</table>

| Responses | Served in Military | Quality of Relationship | Similar Background/Experiences | Helpful, Knowledgeable, Practical | Mental Health/Substance Abuse History Or Other "Issues"
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>military background</td>
<td>it's a common bond</td>
<td></td>
<td>Because of their understanding</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Being a vet</td>
<td>being injured in service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>both military</td>
<td>similar responsibilities</td>
<td></td>
<td>Give basic knowledge; appointment helps w/ VA stuff including voc rehab; gives ride</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>being a veteran</td>
<td>having similar experiences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>fellow vet</td>
<td>Understand situation and treated with respect...knew where I was coming from</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Because she is a veteran</td>
<td>can understand and relate to me and my issues, very helpful, nice conversations</td>
<td>have a connection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>because they are veterans;</td>
<td></td>
<td>is a combat vet like me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>she is a vet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>veteran</td>
<td></td>
<td></td>
<td></td>
<td>MH issues</td>
</tr>
<tr>
<td>22</td>
<td>Veterans</td>
<td>Genuine nice</td>
<td>can understand how it feels things bother them differently - loud noises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Because he is a vet</td>
<td></td>
<td>has had similar exp.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Because he is a veteran</td>
<td></td>
<td>used to smoke</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Responses | Served in Military | Quality of Relationship | Similar Background/Experiences | Helpful, Knowledgeable, Practical | Mental Health/Substance Abuse History Or Other "Issues"
---|---|---|---|---|---
25 | being veterans | | | | been thru same and more that I've been through in terms of mental health issues and setbacks I am having
26 | | Friendly, non-confrontational | | | 
27 | she is a veteran | | been through similar experiences | | 
28 | … is a veteran | Can relate to ..communicate well with | went to court w him | | has previous SA issues
29 | they are veterans | | | | 
30 | she was in the military | | knowledgeable and informative | | 
31 | she was in the military | | | | 
32 | they are military | relate to experiences | | | 
33 | Served in military | | trauma experience | | 
34 | vet | Combat | re-adjustment issues, | | 
35 | | Can relate to situation and feelings of client | Knowledgeable about things client is going through | | 
36 | | we have a good rapport; | Some in common; | | 
37 | because he's a vet | | | has had issues | 
38 | | easy to talk to, could talk about anything with him. | | | 
39 | she's a vet | easy to relate to | been through tough times | | 
40 | they are vets | | | | 
41 | veteran | | | has similar issues/troubles |
Table 4.8 (Continued)

| Responses | Served in Military | Quality of Relationship | Similar Background/Experiences | Helpful, Knowledgeable, Practical | Mental Health/Substance Abuse History Or Other "Issues"
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>because they are vets</td>
<td></td>
<td>we are friends with... - both Christians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>he is vet</td>
<td></td>
<td>from north, I am from up north too</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>a veteran</td>
<td>nice, caring epitome of a lady;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>She has served</td>
<td>she is easy to talk to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>they are vets</td>
<td>can talk to them;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>because he is a vet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>a vet</td>
<td>is easy to talk to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>vet</td>
<td>bonded over service, very comfortable with her, nice person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>vet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>vet</td>
<td>he is a good person that can be trusted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>he is a vet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>he is a veteran</td>
<td></td>
<td></td>
<td></td>
<td>he is guiding and helping me</td>
</tr>
<tr>
<td>54</td>
<td>he is a vet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>veteran</td>
<td>easy to relate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56</td>
<td></td>
<td>reached out to me and I feel a connection to her</td>
<td></td>
<td>because she's helpful</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>is a vet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>as a vet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>he is a veteran</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>he is a vet</td>
<td>feel comfortable talking with... Feeling more comfortable talking with non-vets</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4.8 (Continued)

<table>
<thead>
<tr>
<th>Responses</th>
<th>Served in Military</th>
<th>Quality of Relationship</th>
<th>Similar Background/Experiences</th>
<th>Helpul, Knowledgeable, Practical</th>
<th>Mental Health/Substance Abuse History Or Other &quot;Issues&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>he is a vet</td>
<td>is relatable... and explains things, doesn’t throw me to the wolves... communication - a mutual relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td></td>
<td>and I can relate to him</td>
<td>like that he is older - closer in age to me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>military background</td>
<td></td>
<td>Because of her experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64</td>
<td></td>
<td>sympathetic to</td>
<td>Most in common from staff; common background life situations</td>
<td></td>
<td>common issues</td>
</tr>
<tr>
<td>65</td>
<td>veterans</td>
<td>similar age</td>
<td></td>
<td>trauma - SA recovery</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td></td>
<td></td>
<td></td>
<td>knowledgeable;</td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>is a veteran</td>
<td>life experiences</td>
<td>knows resources available...will find info if he doesn’t know answer</td>
<td></td>
<td>history of trauma</td>
</tr>
<tr>
<td>68</td>
<td>he is a veteran</td>
<td>were relatable... showed care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td></td>
<td>felt comfortable immediately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>because he is a vet</td>
<td>branch is army...similar to me in age/interest rock station on radio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>because he is a veteran</td>
<td>easier to talk to, treats like part of his unit</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: N = 71
Table 4.9
Why they were not a peer.

<table>
<thead>
<tr>
<th>Response</th>
<th>Not Familiar with Mentor/Don't Know Them Well</th>
<th>Did Not Know They Were a Veteran</th>
<th>Quality of Relationship</th>
<th>Not Similar</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 5</td>
<td>n = 2</td>
<td>n = 2</td>
<td>n = 2</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>haven't had enough contact,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>barely spoke with her</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>- not sure about similar...</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>but no heart;...overtalking, talking but not listening.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>not enough exposure to know them yet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Not familiar; haven't had time to connect yet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>No, didn’t know was a vet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>unsure of his experiences,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>No, wasn’t aware she was a veteran</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>felt like Chris had an attitude and couldn’t relate;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td>not as someone like me,</td>
</tr>
</tbody>
</table>

Notes: N = 12
Figure 4.1 Peer mentee rating of their peer mentor's importance to their future success. $N = 55$. 
Figure 4.2 Mentee rankings of peer qualities by importance.  $N = 55$
CHAPTER 5: DISCUSSION AND CONCLUSION

Discussion

The aim of the present study was to evaluate the effectiveness of JDTR and answer questions about whether JDTR and compensated peer mentors, in particular, significantly improved clinical and criminal justice outcomes for veteran offenders with trauma related mental illness. Results showed significant improvements in clinical outcomes, including reductions in PTSD symptoms, depression symptoms and function difficulty scores, but no improvement in criminal justice outcomes or reductions in re-arrest rates. Results also showed a positive correlation between pre-enrollment arrests and post-enrollment arrests, but no correlation between baseline PTSD sum severity scores or other baseline symptom severity scores as measured by the BASIS-24 and re-arrest rates.

Peer interventions have been shown to improve clinical outcomes (Christensen & Jacobson, 1994; Gould, & Clum, 1993; Solomon, 2004) and hold for promise improving criminal justice outcomes because they potentially target criminogenic needs and facilitate behavior change by providing positive social reinforcers and social support and by improving problem solving skills (Andrews & Bonta, 2006; Clark et al., 2010). Results from this study, however, only provided support that JDTR and compensated peer mentors improved clinical outcomes, not criminal justice outcomes. This suggests JDTR and compensated peer mentors, as they were implemented, functioned primarily as a mental health intervention, not a criminal justice intervention focused on reducing recidivism. As such, findings were consistent with the substantive body of criminal justice and mental health literature that shows mental health
treatment and improvements in clinical outcomes do not result in improvements in criminal justice outcomes (Andrews & Bonta, 2010; Epperson et al., 2011; Osher et al., 2012). Findings were also consistent with literature that shows prior arrests are strongly associated with recidivism, while clinical factors are not. They also support the notion that criminalization does not adequately explain the problem of the overrepresentation of persons with mental illness in the criminal justice system (Bonta et al., 1998; Fisher et al., 2006; Steadman, Osher, Robbins, Case, & Samuels, 2009).

Study limitations, which are discussed below, prevent the drawing of conclusions regarding the potential effectiveness of peer interventions in improving criminal justice outcomes. Altogether, favorable participant perceptions of their peer mentors confirm that peer mentors were an important and essential ingredient in JDTR. Participants overwhelmingly viewed their assigned veteran peer mentor as a "peer" and rated their peer mentor as "very important" to their future success. These findings suggest that even if the peer intervention did not directly target criminogenic needs, the strong relationship bond could potentially improve participant responsivity to other evidence-based criminal justice interventions that did. This improved responsivity is supported by improvements in category C PTSD symptoms of avoidance and numbing and suggest JDTR improved participant engagement. Decreases in depression and function difficulty scores support improved participant engagement as well.

In addition, study findings showed that quality of relationship was an important factor that made a veteran peer mentor a "peer". In terms of the total number of coded responses, the quality of relationship was considered second only to being a "veteran" as a factor that made a veteran peer mentor a "peer". Given the importance of relationship quality in criminal justice outcomes (Skeem & Louden, 2006), the use of peer interventions in criminal justice settings
continues to show promise. The "connection" of being a veteran peer and its ability to foster a therapeutic alliance may not only influence motivation to change, it may directly influence positive behavior change through prosocial modeling and the teaching of problem solving skills (Borcato & Wagner, 2008; Cloitre, Koenen, Cohen & Han, 2002; Cloitre, Stovall-McClough, Miranda & Chemtob, 2004; Horvath, & Greenberg, 1989; Keller, Zoellner & Feeney, 2010; Marshall & Serran, 2004; Polashek & Ross, 2010; Skeem et al., 2007).

Another significant finding from this study is the lack of change in recovery markers as measured by the REE. Given that mental health "recovery" is a focus of peer interventions, one would expect to see a significant increase in recovery markers in any program that incorporated peer interventions (Davidson et al., 1999; Frese, & Davis, 1997; SAMHSA, 2014). This lack of improvement reveals a programmatic deficit and an area that can be improved upon. An improvement in recovery markers may also correlate with an improvement in criminal justice outcomes, which, in itself, may be all that is needed to maximize the potential benefits of peer interventions to promote positive behavior change (Bledsoe, et al., 2008; Carpenter, 2002; Reisner, 2005).

Moreover, this study supports the literature that shows criminalization does not adequately explain the problem of the disproportionate number of persons with mental illness in the criminal justice system. Criminalization assumes persons with mental illness are either being arrested because of their mental illness or because of limited access to mental health services. Improved access to treatment services and improved clinical outcomes in this study, however, did not translate into a reduction of re-arrests.

Altogether, these findings are consistent with the substantive body of criminal justice and mental health literature and should not be surprising. They also confirm the utility of RNR as a
criminal justice strategy that can be applied to forensic mental health programs and show that mental illness is better understood as a responsivity factor, not risk factor for crime. In this context, peer interventions show considerable promise as, at least, one component of a forensic mental health program, if not more. Recommendations regarding forensic mental health programs and their design, development, implementation and evaluation are discussed in the implications below.

**Limitations**

There are multiple limitations in this study, the most significant being the lack of an experimental design and random assignment of participants to experimental and comparison group(s). The lack of experimental design exposed this study to various threats. Historical events, or events not part of JDTR, may have influenced outcome variables, i.e., *historical threat*. Changes may also have been the result of normal development rather than JDTR, i.e. *maturation threat*. In addition, initial high PTSD scores and depression and difficulty functioning scores may inaccurately show statistical improvements due to *statistical regression* and the tendency of high scores to regress toward the means. Moreover, the lack of experimental design exposed this study to *testing threats*, where the pre-test and act of being tested itself influenced the outcome of post-tests.

These threats prevent causal inferences and the ability to rule out alternative explanations for any observed effect. To improve the validity of the results the experimental group could have been compared to a control group consisting of either persons with similar charges that were not diverted to JDTR or a control group consisting of persons diverted to an intervention without veteran peer mentors. That said it would not have been feasible to use random assignment with the JDTR program because this SAMHSA funded program, like most other
SAMHSA funded projects, did not require or provide funding to carry out a randomized design. In addition, the heterogeneity of participants and charges made it difficult, if not impossible, to find a similar comparison group, and this prevented the study from being quasi-experimental as well.

Compounding these study limitations were problems identifying and retaining participants. The original goal for pilots 1 and 2 combined was to screen 800 individuals and enroll 160 participants, or 20% of total screenings. However, only 516, or 35% below the original goal, were screened, and only 67 were enrolled, or 58% below the enrollment goal. In addition, less than half of those enrolled, 31, completed six months of JDTR, and less than one-fifth, 16, completed twelve months of the program. Data on the prevalence of veterans involved in the criminal justice system (i.e., arrest rates of around 10% in multiple recent studies) suggest that many veterans were not being screened for the program (BJS, 2006; Mumola, 2000; Noonan, & Mumola, 2004).

The inability to meet these goals and retain the majority of participants in the program speaks to program design and implementation issues as well as to the complexity of developing and implementing a program that overlaps multiple systems with competing priorities (Osher et al., 2012). Not meeting enrollment and retention goals, of course, also limited the small sample size and thus the study's power and ability to detect differences. Furthermore, these low numbers necessitated the addition of pilot Site 2 data in the analysis of criminal justice outcomes, which invariably affected validity due to the dissimilarities in Sites and their implementation. Low enrollments also affected the normal distribution of data for certain variables creating the need to transform data and use nonparametric measures to compare differences.
Since this was a secondary data analysis, certain important measures were not included as well. It would have been useful to measure the quality of the mentor/mentee relationship as well as criminal thinking. Not having a standardize instrument to quantitatively measure the quality of the mentor/mentee relationship prevented analyzing the extent to which the quality of relationship affected outcomes. The lack of a standardized instrument to measure criminal thinking and criminogenic needs also prevented the ability to control for other factors that were contributing to outcomes. These and other factors opened the study to the potential of Type I errors, or detecting a change that did not occur, as well as Type II errors, or not detecting a change that did occur. The lack of correlation between dosage and outcomes further highlight these limitations and reveal the "black box" dilemma. Even though participation in JDTR was associated with some clinical improvements, JDTR was, in effect, a "black box", and we cannot say with any certainty what was causing these improved outcomes. This, of course, limited our ability to draw conclusions about the effectiveness of peer interventions, specifically.

Furthermore, because participation in the three components of the program (i.e., case management, peer mentors and Seeking Safety) was voluntary, many of those engaging in these components may have been intrinsically more motivated for treatment and thus more motivated for making positive changes in their life, thus causing a sample bias. Again, the generalizability of findings was limited and the study cannot tell us specifically what in the program was influencing an observed effect. It was, nevertheless, useful as a program evaluation and exploratory study that can help in the development of future programs and offer direction for future studies about crime prevention strategies, in particular peer intervention strategies. The findings garner greater validity when understood in the context of the large body of criminal
justice literature that shows mental illness is a weak predictor of crime and that improved clinical outcomes does not lead to improved criminal justice outcomes.

Moreover, it can be argued using the findings from this study in the context the large body of research that there is strong support for the use of peers in a criminal justice setting. This greater support, however, is for the use of peers as a mental health intervention to improve responsivity to treatment, not as a criminal justice intervention per se - although their use as an intervention that targets criminogenic needs cannot be ruled out. The implication here is that policy makers should not solely rely on peer interventions to reduce arrests, but that peer interventions could be included and "fine-tuned" to be used with other criminal justice strategies that target criminogenic needs.

**Implications for Social Work Practice and Mental Health Policy**

There are important implications of this study for social workers and other clinicians working with veterans with trauma related mental illness, as well as for criminal justice and mental health policy makers and administrators who are attempting to address the problem of the disproportionate number of persons with mental illness in the criminal justice system. To best understand these implications and put this study into perspective, it is helpful to understand JDTR as a "first generation intervention" (Epperson et al., 2011). The primary characteristic of first generation programs is that they focus on linking persons to mental health treatment with the expectation that mental health treatment will result in improved criminal justice outcomes (Epperson et al., 2011; Osher et al., 2012). Other characteristics of first generation programs are that they reduce the time persons remain in jail and improve access and linkages to mental health services. First generation interventions, however, do not assess for risk factors for crime, target persons who pose the greatest risk of reoffending or use evidence-based strategies or practices.
As stated previously, the goal of the JDTR program was to help justice-involved veterans recover from trauma-related difficulties by strengthening the veteran’s ties to services, family and other support mechanisms during the critical post-release period through the use of veteran peers. Similar to other first generation interventions, the focus of JDTR was on mental health treatment and linking to services and support mechanisms, with the expectation that these efforts would improve criminal justice outcomes. JDTR, however, did not assess risk/needs or incorporate targeted, evidenced-based criminal justice interventions and, consequently, improvements in clinical outcomes did not result in improved criminal justice outcomes.

The implication of this study, therefore, would be to use these findings to help design, develop and implement "second generation interventions" for justice-involved persons with mental illness. To achieve this, there first needs to be a change in the way the problem is conceptualized. Whereas first generation interventions were informed by the assumptions of criminalization and emphasized linking persons with mental illness to treatment; second generation interventions will need to be informed by criminal justice research and emphasize the reduction of arrests. As such, the reduction of recidivism should be viewed as the primary goal of any forensic mental health program. To this end, the focus of mental health treatment would be on improving responsivity to criminal justice interventions. The reduction of arrests, of course, is important to social workers because the reduction in crime not only improves the lives of individual offenders; it improves outcomes for society at large.
Developing, Implementing and Evaluating Second Generation Interventions

The literature shows that RNR is an effective strategy for reducing recidivism rates for persons without mental illness and shows promise for developing second generation strategies to reduce recidivism for persons with mental illness (Andrews & Bonta, 2006, GAINS). Social workers, therefore, should be well versed in RNR and be able to apply RNR principles when developing, implementing and evaluating forensic mental health programs. Based on literature and using the RNR model for guidance, characteristics of such second generation interventions would include the following important elements: 1) assessing criminogenic needs; 2) targeting more intensive interventions for persons who pose the greatest risk of offending; 3) using evidence-based criminal justice strategies/practices to reduce recidivism; 4) understanding mental illness as a responsivity factor that should be addressed in order to target the criminogenic needs; and 5) emphasizing coordinated systems response that reflects collaboration between the criminal justice and mental health systems (Andrews & Bonta, 2010; Epperson et al., 2011; Lamberti, 2007; Osher et al., 2012).

Competent social working functioning as clinicians would need to be familiar with evidence based practices that are effective at reducing crime and be able to adapt these to local settings for persons with mental illness involved in the criminal justice systems. CBT and motivation interviewing, for instance, are considered effective, evidence-based criminal justice interventions and show promise reducing recidivism for persons with mental illness involved in the criminal justice system (GAINS Center, 2015; Lamberti, 2007). Other promising strategies and interventions for improving criminal justice outcomes for persons with mental illness that social workers should be familiar with include: trauma specific interventions, Forensic ACT
models, supported employment, integrated substance abuse and mental health treatment, and Illness Management and Recovery (GAINS Center, 2015).

Moving forward, a high degree of specialization and expertise will be required to develop and implement second generation interventions. Specialized training and skills will, therefore, be essential for social workers working in such programs. There also needs to be a focus on research that investigates the effectiveness of various interventions, including peers, as well as the fidelity of program implementation.

Training

Findings from this study suggest that low screenings, enrollments and retention rates may have been improved if JDTR staff were better able to navigate the complex criminal justice and mental health systems. Specialized training should not only be required for social workers and clinicians, it should be required for criminal justice professionals, including judges, court staff, probation officers and others working directly with justice-involved person with mental illness as well. Training/cross-training would need to focus on developing competent boundary spanners who are not only able to navigate the complex systems but are also knowledgeable about mental health and criminal justice literature (Steadman, 1992). Ideally, training would also focus on promoting mental health recovery in these settings with competing priorities and stress the importance of relationship quality between clinicians and offenders as well as offenders and criminal justice providers such as probation officers (Skeem & Louden, 2006; Skeem, Emke-Francis & Louden, 2006; Skeem Ecandela & Louden, 2006).

Knowledge of the recovery model and recovery principles is an essential part of being a competent forensic social worker and peer mentor. Of course, certified peers are specifically trained in recovery and instilled with recovery principles, but forensic mental health programs
should also be developed and implemented with recovery principles in mind, with a focus on improving recovery markers. Without seeing improvements in recovery markers and being able to compare with criminal justice outcomes, we cannot know the extent to which mental health recovery improves criminal justice outcomes or offender responsivity to treatment. In addition, JDTR case managers and peer mentors provided updates to the court regarding treatment progress and, in essence, functioned in a *dual role* as both mental health provider and agent of the court. Thus, there is also a need for specialized training on how best to function in such a *dual role* without jeopardizing the therapeutic alliance.

**Research**

Further research is needed to investigate whether an emphasis on recovery education in treatment will result in improved criminal justice outcomes and responsivity to criminal justice interventions. Investigating the use of the recovery model as a practice orienting perspective that can assist social workers function in a dual role would be important as well. Research should also investigate what types of treatment interventions improve responsivity and investigate the extent to which improvements affect treatment outcomes. Furthermore, the therapeutic alliance is a significant factor that should be evaluated to see if higher scores improve responsivity as well as outcomes. It would also be important to measure the fidelity of program implementation to the RNR model.

**Conclusion**

Altogether, the findings discussed here are consistent with current literature that emphasizes mental health treatment and linkages to services are not sufficient to address the problem of the overrepresentation of persons with mental illness in the criminal justice setting. As such, JDTR is best understood as a first generation intervention. Moving forward, second
generation interventions that incorporate RNR strategies to reduce recidivism are needed. Second generation interventions will prioritize reducing recidivism and understand mental illness as a responsivity factor that needs to be addressed to target criminogenic needs. Peers are a potential mental health intervention that may improve both clinical and criminal justice outcomes and should be considered when designing and implementing second generation interventions. Second generation interventions require a high degree of specialization and social workers and other providers will need to be adequately trained to develop, implement and evaluate such programs. Further investigation is needed into various interventions, such as peer mentors, and their role in improving responsivity. Research is also needed on the recovery model and therapeutic alliance as factors influencing responsivity and treatment outcomes. Research should also explore the dynamics of the dual role and its effect on therapeutic alliance and treatment outcomes and should investigate the fidelity of program implementation to RNR principles as well.
REFERENCES


APPENDIX A:

CERTIFIED RECOVERY PEER SPECIALIST - VETERAN APPLICATION

This booklet includes:

1. Easy to follow instructions.

2. Your personal application form.

3. Mandatory forms to collect training documents and recommendations.
Preface

The Florida Certification Board (FCB) is a nationally recognized, non-profit professional credentialing organization. In our 25+ years of experience, we have certified over 10,000 health and human services professionals performing work in the related fields of addictions, prevention, criminal justice, mental health, child welfare and behavioral health.

In order to be certified as an Recovery Peer Specialist - Veteran in the State of Florida, you must:

1. Meet specific competency and ethical conduct requirements;
2. Possess minimum work and experience requirements;
3. Possess minimum education and training requirements;
4. Pass the written exam; and
5. Complete minimum continuing education credits annually to maintain a current knowledge base.

Mission

To protect the health, safety, and welfare of the citizens of Florida by regulating our certified professionals through experience, education, and compliance with professional and ethical standards.

Property of the Board

Materials submitted to the FCB as part of the certification process are considered property of the Florida Certification Board. Materials include but are not limited to applications, recommendations, transcripts, and certificates. Applicants are encouraged to keep copies of all materials and paperwork submitted for certification.

All certificates and certification cards are the property of the FCB and must be surrendered upon Board request.
Board Policy and Procedures

All FCB requirements, policies and procedures are maintained on our website at www.flcertificationboard.org. Applicants and certified professionals are individually responsible for ensuring they are following current FCB policy and procedures.
Introduction

Certified Recovery Peer Specialists fill a unique role among health and human services professionals in providing quality care to consumers. The Florida Certification Board (FCB) has designed a credentialing system that will evaluate each applicant’s competency and grant recognition to those professionals who meet the specified minimum standards. In creating this process, the FCB examined credentialing systems of other states, gathered input from state and national groups, and incorporated the most appropriate elements to form the basis of this system.

The FCB recognizes that Certified Recovery Peer Specialists work in a wide range of disciplines and have diverse educational and experiential backgrounds. The FCB’s certification process identifies and defines the core functions, responsibilities, knowledge, and skill areas required of Certified Recovery Peer Specialists regardless of work setting, approach, and educational or professional training. This process does not endorse any one particular philosophy, treatment modality or service delivery approach. We encourage and require the development of professional skills and competencies for all Certified Recovery Peer Specialists.

Purpose

The purpose of a certification system for Certified Recovery Peer Specialist - Veteran is to:

1. Assure the public a minimum level of competency for quality services by Certified Recovery Peer Specialists.

2. Give professional recognition to qualified Certified Recovery Peer Specialists through a process that examines demonstrated work competencies.

3. Assure an opportunity for ongoing professional development for Certified Recovery Peer Specialist.

4. Promote professional and ethical practice by enforcing adherence to a Code of Ethics.
Definition of a Certified Recovery Peer Specialist - Veteran (CRPS-V)

A Certified Recovery Peer Specialist - Veteran provides peer mentoring and support to veterans who are consumers of mental health and substance abuse service systems to assist in achieving their individual recovery goals. The CRPS-V must be a true peer; this means that the peer specialist is a veteran who has been a consumer of public or private mental health, substance abuse or trauma services.

The role of the Certified Recovery Peer Specialist - Veteran includes but is not limited to:

- **Advocating** for the needs of the consumer and his or her family
- **Teaching** the consumer how to develop skills necessary to advocate for himself/herself
- **Serving** as a mentor to the consumer, instilling a sense of hope that resiliency and recovery are achievable goals
- **Assisting** the veteran in navigating multiple service systems, including obtaining veteran's benefits, if
## Certification Standards

The Certified Recovery Peer Specialist - Veteran (CRPS-V) credential is for veterans who possess the knowledge and experience necessary to safely and effectively provide support services to persons receiving mental health and substance abuse services. The following certification standards are the minimum requirements that must be documented in order to earn certification during the grandfathering period.

### CRPS-V Standards

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>High School Diploma, General Equivalency Degree or higher</td>
</tr>
<tr>
<td>Experience</td>
<td>500 hours of formal work and/or volunteer experience with consumers of public or private mental health, substance abuse or trauma services</td>
</tr>
</tbody>
</table>
| Training         | 40 total clock hours of specified education/training divided among the following content areas. A minimum of 2 hours must be earned for each content area; the remaining 16 hours can be spread across any of the topic areas. Training Content Areas:  
- System Navigation and Services Access
- Legal Issues/Confidentiality/HIPPA
- Stigma/Discrimination Issues
- Adult Education/Teaching Skills
- Identification & Treatment of Mental Health Disorders
- Identification and Treatment of Substance Abuse Disorders  
  • Effective Advocacy
  • Interpersonal Communication
  • Cultural Competence
  • Professional Ethics
  • Community Reintegration |
| Recommendations   | 3 letters of recommendation for certification                               |
| Code of Ethics    | Must sign statement agreeing to follow the FCB’s Code of Ethics              |
| Written Exam      | Recovery Peer Specialist Exam                                                |
| Renewal           | 10 CEUs annually                                                            |
APPENDIX B:
SCREENING PACKET

CMHS Jail Diversion and Trauma Recovery Initiative Priority to Veterans
EVENT TRACKING INFORMATION FORM (Required by SAMHSA)

No identifying information should be written on this form

Red text = Information provided to clarify, explain, or give direction

1. Initial Screening Date: ____ ____/____ ____ /____ ____ ____ ____(MM/DD/YYYY format)

2. Referred/Identified from (circle referral source):
   a. Preliminary Presentation (PP) Court   e. Pretrial Intervention (PTI)
   b. Public Defender’s Office   f. Drug Court
   c. Veteran Justice Outreach Specialist (VJO)  g. Pre-book ing
   d. Violation of Probation/Parole (VOP) Court  h. Other: specify ->

3. Gender (circle one): 1. Male          2. Female         3. Other

4. Month & Year of Birth: ____ ____/____ ____ ____ ____ (MM/YYYY format)

5. Hispanic or Latino/a (circle one): 1. Yes  2. No

6. Race (select one or more):
   a. American Indian   d. Black or African American
   b. Alaskan Native   e. Native Hawaiian or Other Pacific Islander
   c. Asian   f. White

If you initially circle one discharge status but verification indicates a different discharge status,
then CHANGE the discharge status by crossing out the original choice and circling the status as
verified.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Have you been discharged from the US armed services? 1. Yes  2. No *If yes, continue to b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. What was your discharge status?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Honorable (includes discharges that have been converted to honorable since leaving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. General (honorable conditions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. General (other than honorable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Medical (including section 8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Undesirable (end here and put form in folder for USF staff to pick up)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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6. Bad Conduct (end here and put form in folder for USF staff to pick up)
7. Refused (end here and put form in folder for USF staff to pick up)
8. Don’t Know
*Please note: person does not have to be eligible for VA benefits/healthcare; time in service is not a factor for this grant

Veteran’s status verified: Yes No
Notes:_____________________________________
Verification date: _____ ____/_____ ____/_____ ____ _____ (MM/DD/YYYY format)

8. Most Serious Charge Category (see “Charge Codes” Table on p. 6 & select one of these categories):
   a. Crimes Against Persons (Violence)  e. Major Motor Vehicle (excluding DUI/DWI)
   b. Crime Against Person Other        f. Public Order
   c. Property Crime                   g. Other - specify
   d. Alcohol or Drug RelatedOffense (including DUI/DWI)

9. Charge Level for Most Serious Charge (circle one):
   a. Felony
   b. Misdemeanor
   c. Violation/Ticket/Infraction (Lower than a Misdemeanor)
   d. Technical Violation (Probation/Parole)
   e. Unspecified
   f. No Formal Charge

10. Legally eligible at this point

   People with DUI/DWI charges or who are sexual offenders cannot be enrolled (“No” below). Other issues related to charges may still need more discussion/decisions, which can occur later (and documented on the court decision form (see page 6). If people are still possibly eligible based on their charges at this point then choose “yes” below.

   1. Yes  2. No, specify why below  If no end here and put form in folder for USF staff to pick up

INTERNAL CLINICAL STATUS SCREEN

A1. Trauma History
   (Read the following question to the individual being screened)
   “In your lifetime have you experienced, witnessed or had to deal with an extremely
traumatic event that included actual or threatened death, serious injury, other threat to the self or another person’s physical integrity.” (circle one):  Yes*  No

*If Yes, identify type(s) of trauma experienced in chart below (ask each type of event & circle if affirmative)

<table>
<thead>
<tr>
<th>Military combat</th>
<th>Child</th>
<th>Adult</th>
<th>Witnessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual assault</td>
<td>Child</td>
<td>Adult</td>
<td>Witnessed</td>
</tr>
<tr>
<td>Emotional/Physical Abuse</td>
<td>Child</td>
<td>Adult</td>
<td>Witnessed</td>
</tr>
<tr>
<td>Medical Threats</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural and human generated disasters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious accident</td>
<td>Witness</td>
<td>Victim of</td>
<td></td>
</tr>
<tr>
<td>Violent Crime</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A2. Trauma Impact

For each trauma event indicated, above ask
“Does your experience of (insert type of event) continue to significantly affect your emotions, behavior, or thoughts” (circle one):  Yes  No

B. Primary Care PTSD Screen (PC-PTSD) –

Read the following:
“For the events noted above, in the past month have you:

1. Have had nightmares about it or thought about it when you did not want to? Yes  No
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? Yes  No
3. Been constantly on guard, watchful, or easily startled? Yes  No
4. Felt numb or detached from others, activities, or your surroundings? Yes  No

C. Primary Care Depression -

(Read the following questions to the individual being screened)

1. During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes  No
2. During the past month, have you often been bothered by little interest or pleasure in doing things? Yes  No
3. Have you felt sad, low, or depressed most of the time over the past two years Yes  No

D. Psychiatrically Eligible  Yes  No

<table>
<thead>
<tr>
<th>Northside Use Only</th>
<th>Vet Cat #</th>
<th>Depress Yes  No</th>
<th>Trauma Hx Yes  No</th>
<th>T Impact Yes  No</th>
<th>PTSD Yes  No</th>
</tr>
</thead>
</table>

11. Eligibility (at this time) circle one:
Eligibility refers to being eligible based on clinical and legal factors as well as veteran’s status. You may still be verifying information at this point (such as veteran status info), but unless the person is known to NOT meet these requirements at this point then choose “a. eligible at this stage, referred for further evaluation”

a. Eligible at this stage, referred for further evaluation
   • In most cases you will go to page 6 and complete info about the court decision once that decision is made (go to item 15)

b. Individual declined participation

c. Provider (Northside) declined offer of participation in JDTR based on:______________________
   (For example, risk)

d. Not Eligible (please indicate all reasons below in item 11a)

11a. NOT eligible: circle all reasons that apply
   a. Not eligible, psychiatric criteria.
      Explain:___________________________________________
   b. Not eligible, legal criteria
   c. Not eligible, substance abuse criteria
   d. Not eligible, released from jail
   e. Not eligible, not competent
   f. Not eligible, location/jurisdiction of arrest
   g. Not eligible, location of residence
   h. Not eligible, dropped out of initial screening
   i. Not eligible, other reason.
      Specify:________________________________________________

*If Judge decides early in the process (such as right after the person agreed to participate) that the person may not participate in JDTR program please complete the court decision on p.6

Based on the current set up for recruitment at the Hillsborough site, it is likely that you will not complete a subsequent assessment. You will only use this page if you have a second face-to-face contact with the client where you ask about information relevant to eligibility prior to the court decision date OR if after your initial screening something occurs that changes the eligibility of the individual. If there is not a 2nd meeting and/or nothing occurs to change the individuals’ eligibility, skip to page 6 item number 16.
12. Subsequent Assessment Date: ___ ___/___ ___/___ ___ ___ ___
(MM/DD/YYYY Format)

13. Most Serious Charge Category (see “Charge Codes” Table on p.6 & select one of these categories):
*Complete this section only if charge category and/or charge level has changed from when the initial screening was completed.*

If charge category and level remain the same (i.e., no change since initial screening), check here □ and skip to item number 15

a. Crimes Against Persons (Violence Crimes Against Persons (Violence)
b. Crime Against Person Other
c. Property Crime
d. Alcohol or Drug Related Offense
e. Major Motor Vehicle (excluding DUI/DWI)
f. Public Order
g. Other, please specify:_____________________________________________________

14. Charge Level for Most Serious Charge (circle one):
   a. Felony
   b. Misdemeanor
   c. Violation/Ticket/Infraction (Lower than a Misdemeanor)
   d. Technical Violation (Probation/Parole)
   e. Unspecified
   f. No Formal Charge

15. Eligibility (at this time) circle one:
   a. Eligible at this stage, referred for further evaluation
      i. In most cases you will go to page 5 and complete info about the court decision once that decision is made (go to item 15)
   b. Not Eligible (please indicate all reasons below in item 14a)

15a. If NOT eligible – circle all reasons that apply.
   a. Not eligible, psychiatric criteria. Explain:
      __________________________________________________________
   b. Not eligible, legal criteria
   c. Not eligible, substance abuse criteria
   d. Not eligible, released from jail
   e. Not eligible, not competent
   f. Not eligible, location/jurisdiction of arrest
   g. Not eligible, location of residence
   h. Not eligible, dropped out of initial screening
1. Not eligible, other reason.
   Specify: __________________________________________________

16. Court Decision Date: ____ ____/____ ____/____ ____ ____ ____(MM/DD/YYYY Format)

*If not eligible, stop here and put this form in the folder for USF staff to pick up

17. Most Serious Charge Category (see “Charge Codes” Table on p. 7 & select one of these categories):
   *Complete this section only if charge category and/or charge level has changed from when the initial screening was completed.

   If charge category and level remain the same, check here □ and skip to item number 19

   a. Crimes Against Persons (Violence)
   b. Crime Against Person Other
   c. Property Crime
   d. Alcohol or Drug Related Offense
   e. Major Motor Vehicle (excluding DUI/DWI)
   f. Public Order
g. Other, please specify: __________________________________________________

18. Charge Level for Most Serious Charge (circle one):
   a) Felony
   b) Misdemeanor
c) Violation/Ticket/Infraction (Lower than a Misdemeanor)
d) Technical Violation (Probation/Parole)
e) Unspecified
f) No Formal Charge

19. Eligibility (at this time) circle one:
   a) Yes, Eligible/Accepted (go to item number 20)
   b) Not Eligible (please indicate all reasons below in item 19a)

19a. If NOT eligible – circle all reasons that apply:
   a. Not eligible, psychiatric criteria.
      Explain: __________________________________________________
   b. Not eligible, legal criteria
   c. Not eligible, substance abuse criteria
   d. Not eligible, released from jail
   e. Not eligible, not competent
   f. Not eligible, location/jurisdiction of arrest
   g. Not eligible, location of residence
   h. Not eligible, dropped out of initial screening
   i. Not eligible, other reason.
      Specify: __________________________________________________
*If not eligible, stop here and put this form in the folder for USF staff to pick up.

20. Individual Agrees to Enter Diversion Program at this Stage

*Complete only if “yes” to item number 19, individual is eligible at this time.

Circle one.
Yes    No    If NO – Please indicate reason below and put this form in folder for USF staff to pick up

If Yes – complete Yellow form and put these forms (Blue Packet with Yellow Form attached) in folder for USF staff to pick up

Charge Codes for Most Serious Charges
APPENDIX C:

INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

9/23/2014

Colleen Clark, Ph.D.
Mental Health Law and Policy
13301 Bruce B. Downs Blvd
Tampa, FL 33612

RE: Full Board Approval for Continuing Review
IRB#: CR4_Pro00000276
Title: Jail Diversion and Trauma Recovery Evaluation

Study Approval Period: 10/15/2014 to 10/15/2015

Dear Dr. Clark:

On 9/19/2014, the Institutional Review Board (IRB) reviewed and APPROVED the above application and documents outlined below.

Approved Item(s):
Protocol Document(s):
Veterans Jail Diversion Grant Evaluation Section V2 9.27.12

This research involving prisoners as participants continues to be approved under 45 CFR 46.306(a)(2)(iv): Research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subject. In cases in which those studies require the assignment of prisoners in a manner consistent with protocols approved by the IRB to control groups which may not benefit from the
research, the study may proceed only after the Secretary has consulted with appropriate experts, including experts in penology, medicine, and ethics, and published notice, in the FEDERAL REGISTER, of the intent to approve such research.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John Schinka, Ph.D.,
Chairperson USF Institutional Review Board
**APPENDIX D:**

**BASELINE INTERVIEW PROTOCOL**

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**CMHS Jail Diversion and Trauma Recovery Initiative**

**Priority to Veterans**

*REVISED*

### Baseline Instrument

---

**Interview Date:**

/  /  

**Study ID#:**

(Site Code) (Prog #) (Grp #) (Subject ID #)

**Interviewer Name:**

**Interviewer ID:**

**Interview Type**

1. Baseline  2. Six month  3. Twelve Month

---

<table>
<thead>
<tr>
<th>Site Code</th>
<th>Program Pilot</th>
<th>Group Code Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Connecticut</td>
<td>1. Pilot Site 1</td>
<td>1. Pre-booking Diversion</td>
</tr>
<tr>
<td>02. Colorado</td>
<td>2. Pilot Site 2</td>
<td>2. Post-booking Diversion</td>
</tr>
<tr>
<td>03. Georgia</td>
<td>3. Pilot Site 3</td>
<td>3. Probation/Parole Violation</td>
</tr>
<tr>
<td>04. Illinois</td>
<td>(TBD with sites)</td>
<td></td>
</tr>
<tr>
<td>05. Massachusetts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06. Vermont</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Location of Interview**

1. Community setting (e.g. any residence, restaurant, research offices, university, outdoors)
2. Services Site (e.g. Hospital, Treatment facility/program, Shelter, Transitional housing)
3. Jail
4. Court
5. Other (specify:___________)

Was anyone else present during the interview?

1. Yes
2. No

If Yes- who?
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Education, Employment and Income</td>
<td>9</td>
</tr>
<tr>
<td>2. Military Service Questions</td>
<td>12</td>
</tr>
<tr>
<td>3. Lifetime Mental Health/Substance Use Service Questions</td>
<td>14</td>
</tr>
<tr>
<td>4. Drug and Alcohol Use</td>
<td>15</td>
</tr>
<tr>
<td>5. Services</td>
<td>16</td>
</tr>
<tr>
<td>6. Criminal Justice Questions</td>
<td>17</td>
</tr>
<tr>
<td>7. Functioning</td>
<td>18</td>
</tr>
<tr>
<td>8. Social Connectedness</td>
<td>18</td>
</tr>
<tr>
<td>9. Traumatic Events</td>
<td>19</td>
</tr>
<tr>
<td>10. Posttraumatic Stress Disorder Checklist (PCL-C)</td>
<td>21</td>
</tr>
<tr>
<td>11. BASIS 24</td>
<td>23</td>
</tr>
<tr>
<td>12. REE: Recovery Markers –Revised</td>
<td>25</td>
</tr>
</tbody>
</table>
**Interviewer Instructions**

This interview form comprises the questions that are being collected across all study sites. This part should be administered to the respondent in its entirety prior to your project specific interview.

1. There is a short introductory paragraph that should be adapted to your project’s study, program, and consent process. Please take time to review it prior to beginning the interview.

2. Read all questions exactly as they are worded so that each respondent is asked the same questions in the same manner.

3. Responses in capital letters should not be read to respondents. Instructions to the interviewer are in italics. Also, NEVER read ‘NA’ ‘RF’ or ‘DK’ response categories.

4. If paper interview is being administered, please be sure to review the entire instrument for completeness and accuracy of recording. Specifically, review the interview for: missing data, recording errors and inconsistencies, complete cover page information, and legibility.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Duty</td>
<td>Military members who are currently serving full time in their military capacity, with military pay and allowances in the armed forces.</td>
</tr>
<tr>
<td>Adequate</td>
<td>Enough or good enough.</td>
</tr>
<tr>
<td>Advocate</td>
<td>To support or speak in favor of something.</td>
</tr>
<tr>
<td>Alimony</td>
<td>An allowance that a court orders paid by one’s spouse or former spouse as a part of a legal separation or divorce.</td>
</tr>
<tr>
<td>Combat Zone</td>
<td>A zone designated by the President by Executive order, it is a geographical area defined as an area of armed conflict.</td>
</tr>
<tr>
<td>Competitive Employment</td>
<td>Work in the competitive labor market that is performed on a full-time basis and paid no less than wages for same or similar work performed by individuals who are not disabled.</td>
</tr>
<tr>
<td>Concentrate</td>
<td>Focusing attention on something.</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Refers to maintaining privacy, by not sharing or divulging to a third party privileged or entrusted information. Matters discussed in confidence are held in secret, except in the rare instances when the information presents a clear threat to the health and well-being of another person, or in cases in which public health may be compromised by not revealing the information. In these instances, it is unethical and illegal not to disclose the information.</td>
</tr>
<tr>
<td>Conviction</td>
<td>Being found guilty of a crime.</td>
</tr>
<tr>
<td>Crisis or Respite</td>
<td>A system that provides regular or special relief to persons or families providing care for persons unable to care for themselves.</td>
</tr>
<tr>
<td>Criticize</td>
<td>To judge, negatively or unfavorably, to find fault.</td>
</tr>
<tr>
<td>Deployment keeping</td>
<td>Deployment is in preparation for battle or work including peace or training.</td>
</tr>
<tr>
<td>Family, Partner, Significant Other Contribution</td>
<td>Voluntary contribution separate from court-ordered child support.</td>
</tr>
<tr>
<td>Foster Care</td>
<td>A situation in which a child or children are raised by people other than their biological parents or adoptive parents.</td>
</tr>
<tr>
<td>Group Home/</td>
<td>An institution for the care and housing of persons with mental illness &amp;/or substance abuse problems.</td>
</tr>
</tbody>
</table>
Group Home
A non-secure program in which a group of young people (under the age of 18) live and receive services at the program facility under the supervision of adult staff.

Guilty
Feelings or awareness of having done something wrong.

Hotel or Motel
An establishment that provides lodging, paid for either by the Individual or system/shelter/program.

Inpatient Treatment
Treatment that requires at least on overnight stay at a facility.

Intoxication
(Alcohol intoxication) the quantity of alcohol the person consumes exceeds the individual's tolerance for alcohol and produces behavioral or physical abnormalities. In other words, the person's mental and physical abilities are impaired.
(Drug intoxication) excessive dosage (varies from individual to individual) of drug can cause undesirable side effects.

Jail/Prison/Detention Center
A state or federal confinement facility having custodial authority over adults sentenced to confinement; a confinement facility administrated by an agency of local government, typically a law enforcement agency, entered for adults but sometimes also containing juveniles, which holds persons detained pending sentencing and/or persons committed after sentencing, usually those committed on sentences of a year or less.

Job Training
Training whose main objective is to prepare people for a work.

Medicaid & Medicare
Health care programs funded by the federal and state governments that pay the medical expenses of people who are unable to pay some or all of their own expenses.

Moderate
Not great or severe - in the middle of mild and severe.

National Guard/Reserve
Civilian military recruited by stated and equipped by the government that can become part of the national army if there is war or national emergency.

Necessities
Items to meet basic needs, such as personal care items (e.g. deodorant, shampoo).

Outpatient
Treatment that takes place without the client being checked into a hospital or treatment center. This treatment may take place in an office, clinic or other type of care facility.

Probation
A punishment given out as part of a sentence where instead of jailing person, she/he is released to the community subject to certain conditions and is under the supervision of the court

Program Staff
Employees of the housing/treatment program

Recreational Services
Services involving some form of play, amusement or relaxation.

Restraining Order/Order of Protection
No contact and order of protection are court orders that prohibits a person from having any kind of contact with another individual usually the victim of a crime.

Self-help/Peer Support
Self-help and peer support refers to activities organized by people with psychiatric diagnoses (or other characteristics in common) to share their strengths and help each other cope and grow. It does not include support groups led by service providers who are not peers.
<table>
<thead>
<tr>
<th><strong>Service-Connected Disability</strong></th>
<th>A disability that the US VA has determined was incurred or aggravated in the line of duty during active military, naval or air service.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sheltered Workshop</strong> or <strong>Supported Housing or Certified Apartment Program</strong></td>
<td>Subsidized work where an individual is paid a stipend by a program agency, because she is unable to work in a competitive work setting.</td>
</tr>
<tr>
<td><strong>Staff</strong></td>
<td>People who are paid to provide various services to individuals.</td>
</tr>
<tr>
<td><strong>Supported Housing or Certified Apartment Program</strong></td>
<td>Services that assist individuals in finding and maintaining appropriate housing arrangements.</td>
</tr>
<tr>
<td><strong>Tour of Duty</strong></td>
<td>A period of time in which those enrolled in the armed forces spend in combat or performing operational duties for their Armed Forces branch. Tours of duty can be anywhere from 5 months or to several years.</td>
</tr>
<tr>
<td><strong>Transitional Housing</strong></td>
<td>It is a type of housing that is used to assist the movement of homeless individuals and families to permanent housing. In general, transitional housing is time-limited, provides services beyond survival services, it generally offers more privacy than a shelter, and is viewed as a step between shelter and permanent housing.</td>
</tr>
<tr>
<td><strong>Traumatic</strong></td>
<td>Painfully emotional or shocking, often producing lasting psychological effects.</td>
</tr>
<tr>
<td><strong>V.A.</strong></td>
<td>The United States Department of Veterans Affairs (VA) is a government-run military veteran benefit system. It is responsible for administering programs of veterans' benefits for veterans, their families, and survivors.</td>
</tr>
<tr>
<td><strong>Vocational Trade/Tech Diploma</strong></td>
<td>Education, training, a school, etc. intended to prepare one for an occupation or trade, such as nurses' assistant, electrician, mechanic, etc.</td>
</tr>
</tbody>
</table>
Introduction

Interviewer read to respondent*

Hi, I’m (your name) and I work for the Jail Diversion Evaluation Study. This study is funded by the Center for Mental Health Services within the federal government. The findings from this study will be used to improve jail diversion programs. Thank you for agreeing to talk with me today. I appreciate your time and cooperation in participating in this interview and the study.

You will receive a payment of $XX for this interview and $XX for each of the two follow-up interviews, the first of which will be in about 6 months.

Your answers will be kept confidential and will in no way affect your legal status or any other services or money you receive. The information you give will only be seen by research staff.

Before we start, I want to review a few things. First, you should know that your participation is completely voluntary – you do not need to do this interview and if you decide not to, it will not affect any services you receive or your standing in the diversion program. Also, you can choose not to answer any question I ask, or stop the interview at any time. Second, this interview asks a lot of personal questions, some of which may be difficult to think about. Please let me know if you are feeling upset, or need a break. Before we start, please read and sign this consent form.

[HAND RESPONDENT INFORMED CONSENT FORM, REVIEW IT WITH THEM, AND ASK THEM TO SIGN IT]

Thank you. Do you have any questions? (If so, note questions and responses).

Okay, let’s start. I’m going to read you a set of questions exactly as they are worded so that each person is asked the same questions. In some cases, you’ll be asked to answer questions in your own words and I’ll write down your answers. In other cases, you’ll be given a list of answers and asked to choose the one that is best for you. We are interested in your personal opinions about these questions. There are no right or wrong answers. Please take your time. Feel free to ask me questions if you are not sure what is wanted. Some of the questions I will ask you may sound repetitive or may not apply to you, but I have to ask them anyway.

Remember that your answers are confidential.

This interview will last about 45 minutes. I will need to keep things moving along so I hope that I do not sound rude if I tell you we need to move on to the next question.

If at any time you feel you need to take a break or stop the interview. Please let me know.
Now, I think we are ready to begin. I am going to ask you some questions about yourself. Sometimes I will ask you about a specific time frame, like the past week or the last 30 days, and sometimes I will ask you about things that have happened during your lifetime. I’ll try to be clear, but please ask me if you are not sure about the time period involved. Do you have any questions before we begin?
1. **Demographics**

For the first few questions, I am going to ask you some basic questions about yourself.

D1. What is your gender?

1. Male
2. Female
3. Other (Specify: __________)  
7. REFUSED
8. DK

D2. Are you Hispanic or Latino?

1. YES
2. NO- SKIP TO QD4.
7. REFUSED
8. DK

D3. If yes, what ethnic group do you consider yourself?

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Yes</th>
<th>No</th>
<th>REFUSED</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central American</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>Cuban</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>Dominican</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>Mexican</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>South American</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>Other: specify_</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
</tbody>
</table>

D4. What is your race? (Select one or more)

<table>
<thead>
<tr>
<th>Race</th>
<th>Yes</th>
<th>No</th>
<th>REFUSED</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>Alaska Native</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific Islander</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
<tr>
<td>White</td>
<td>1</td>
<td>2</td>
<td>-7</td>
<td>-9</td>
</tr>
</tbody>
</table>

D5. What is your date of birth?

_ _ / _ _ / _______  _ __
M M D D Y Y
2. Education, Employment and Income

In this next section, I will be asking you about your current activities, including school, job training and work. By “current,” I mean your activities in the community right before you were arrested or picked up for the offense which led you to the diversion program. That is before __/__/ [Enter target arrest/incident date from front cover and use calendar to orient respondent to this time frame].

E1. Are you currently enrolled in school or a job training program?
   1. Not Enrolled
   2. Enrolled Full Time
   3. Enrolled Part-time
   4. Other (Specify:_____________
   7. REFUSED
   8. DK
   99. MISSING

E2. What is the highest level of education you have finished, whether or not you received a degree?
   1. less than 12th grade
   2. 12th grade/High School diploma/ Equivalent (GED)
   3. VOC/Tech Diploma
   4. Some College or University
   5. Bachelor’s Degree (BA, BS)
   6. Graduate Work/Graduate Degree
   7. REFUSED
   8. DK

E3. Are you currently employed?
   [Clarify by focusing on status during most of the previous week, BEFORE the arrest or incident for which the client was diverted, determining whether client worked at work at all or had a regular job but was off of work]
   2. EMPLOYED PART TIME
   3. UNEMPLOYED, LOOKING FOR WORK
   4. UNEMPLOYED, DISABLED
   5. UNEMPLOYED, VOLUNTEER WORK
   6. UNEMPLOYED, RETIRED
   7. OTHER, SPECIFY________________________
   77. REFUSED
   99. MISSING

E4. IF EMPLOYED, Is this employment competitive or sheltered?
   1. Competitive Employment
   2. Sheltered Employment
   7. REFUSED
   8. DK
I am going to read you a list of possible sources of money that you may have received in the past 30 days.

By the past 30 days, I mean the 30 days before you were arrested or picked up for the offense which led you to the diversion program. Please remember that any information that you give me on your income is strictly confidential and your responses will not affect any services or money you receive. Approximately, how much did YOU receive in the past 30 days from …

[Interviewer: Unless otherwise specified, all questions refer to pre-tax individual income]

<table>
<thead>
<tr>
<th>[Repeat if needed] In the past 30 days, did you receive…</th>
<th>YES</th>
<th>NO</th>
<th>RF</th>
<th>DK</th>
<th>(If YES, ask) How much?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Wages or money from paid employment. This includes any wages or money received from legal AND “under the table” employment.</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>b. SSI, SSDI, or Disability (Non-Veteran)</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>c. Social Security Income (SSA)</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>d. Food Stamps</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>e. Public assistance or other benefits, such as welfare, general assistance, or TANF (Temporary Assistance to Needy Families)</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>f. Veteran’s benefits (including disability or other compensation)</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>g. Unemployment or Worker’s Compensation</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>h. Child support or alimony</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>i. Income from a spouse or partner’s wages or other money</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>j. Money from family members or friends to buy food, pay rent, get medical care or anything else</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>k. Retirement</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
<tr>
<td>l. Income from other sources that I did not mention [If YES, specify source(s)]</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>How much?</td>
</tr>
</tbody>
</table>
**E6. In the past 30 days, where have you been living most of the time?**

_Circle one only_

1. Owned or Rented house, apartment, trailer, room  
2. Someone else’s house, apartment, trailer, room  
3. Homeless (Shelter, Street/Outdoors, Park)  
4. Group Home  
5. Adult Foster Care  
6. Transitional Living Facility  
7. Hospital (Medical)  
8. Hospital (Psychiatric) 
9. Correctional Facility (Jail/Prison)  
10. VA Hospital  
11. Nursing Home  
12. Veteran’s Home  
13. Military Base  
14. Other Housed, Specify:  

77. REFUSED  
88. DK  

**E7. If Homeless, is that…**

1. In a homeless shelter  
2. On the street or some place like an abandoned building, park or car  
7. REFUSED  
8. DK/Missing  

**E8. Did you ever live in foster care or a group home before you became 18?**

1. YES  
2. NO  
7. REFUSED  
8. DK/Missing
3. **Military Service Questions**

Now I am going to ask you some questions about your military service.

M1. Did you serve in the US Armed Forces?  
1. YES  
2. NO (SKIP TO SECTION 4, page 13)  
7. REFUSED  
8. DK

M2. In what branch(es) of the US Armed Forces did you serve?  
Select all that apply  
1. Army (include Army National Guard/Reserve)  
2. Navy (include Reserve)  
3. Marine Corps (include Reserve)  
4. Air Force (include Air Natnl Guard/Reserve)  
5. Coast Guard (include Reserve)  
6. Other (Specify: ________________)  
7. REFUSED  
8. DK

M3. When did you first enter the Armed Forces?  
___ (Month)  
___   ___(Year)  

Please provide the month and year.

Now I am going to ask you about your current status in the military.

M4. Are you… (read choices)  
1. Still in the Military  
2. Separated from service -SKIP TO M7  
7. REFUSED  
8. DK

M5. If you are still in the military, which of the following best describes your current status?  
1. Active Duty -SKIP TO M10  
2. Guard/Reserve  
7. REFUSED  
8. DK

M6. If Guard/Reserve, is that….  
SKIP TO QUESTION M10
<table>
<thead>
<tr>
<th>1. Traditional/part-time guard reserve</th>
<th>time/Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Currently Activated/Full-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. REFUSED</td>
</tr>
<tr>
<td></td>
<td>8. DK</td>
</tr>
</tbody>
</table>

M7. If separated from service, which best describes your current military status?

1. Retired
2. Discharged with Severance or Military Disability Payments
3. Discharged without severance or Payment
4. Other specify: ______________________
7. REFUSED
8. DK
M8. When were you last discharged from the military?  
_____ (Month)  
_____   _ _   (Year)  
Please provide the month and year.

M9. What type of discharge did you receive?  
1. Honorable (includes discharges that have been converted to honorable since leaving the military)  
2. General (honorable conditions)  
3. General (other than honorable)  
4. Undesirable  
5. Bad conduct  
6. Dishonorable  
7. Medical (including Section 8)  
97. REFUSED  
98. DK

M10. Please indicate which of the following eras you have served?  
97. REFUSED  
98. DK  
1. Pre WWII (11/18-11/41)  
2. WWII (12/41-12/46)  
3. Pre-Korean War (1/47-6/50)  
4. Korean War (7/50-1/55)  
5. Between Korean -Vietnam Eras (2/55-7/64)  
6. Vietnam Era (8/64-4/75)  
7. Post-Vietnam (5/75-7/90)  
8. Persian Gulf-Middle East Era (8/90-9/01)  
9. Afghanistan/Iraq (1/02-present)  
97. REFUSED  
98. DK

M11. Has your military service caused or contributed to any medical problems you may have?  

M12. Has your military service caused or contributed to any mental health or emotional problems you may have?  

M13. Do you have a VA determined Service-Connected Disability?  

M14. Have you ever served in a combat theater/zone?  

M15. How many tours of duty have you served?  

M16. Have you been deployed in the past 12 months?

1. YES
2. NO
7. REFUSED
8. DK

1. YES
2. NO
7. REFUSED
8. DK

1. YES
2. NO
7. REFUSED
8. DK

1. YES
2. NO- (SKIP TO SECTION 4, page 13)
7. REFUSED
8. DK

# tours

97. REFUSED
98. DK

1. YES
2. NO
7. REFUSED
8. DK
4. **Lifetime Mental Health/Substance Use Service Questions**

I am now going to ask you some questions about mental health and substance abuse services.

| MH1. Have you ever received | 1. YES  
| outpatient mental health services, including counseling or therapy? | 2. NO  
| | 7. REFUSED  
| | 8. DK  
| MH2. Have you ever received mental health inpatient care or been hospitalized for psychiatric or emotional problems? | 1. YES  
| | 2. NO  
| | 7. REFUSED  
| | 8. DK  
| MH3. Have you ever participated in mental health self-help or peer support services? | 1. YES  
| | 2. NO  
| | 7. REFUSED  
| | 8. DK  
| MH4. At what age did you have your first contact with mental health services? | ___ years old  
| | 97. REFUSED  
| | 98. DK  
| | 99. NOT APPLICABLE  
| MH5. Have you ever received outpatient substance abuse services, including substance abuse counseling or therapy? | 1. YES  
| | 2. NO  
| | 7. REFUSED  
| | 8. DK  
| MH6. Have you ever received inpatient treatment for substance abuse, including detox? | 1. YES  
| | 2. NO  
| | 7. REFUSED  
| | 8. DK  
| MH7. Have you ever participated in any voluntary self help groups for recovery such as Alcoholics Anonymous, Narcotics Anonymous? | 1. YES  
| | 2. NO  
| | 7. REFUSED  
| | 8. DK  


MH8. At what age did you have your first contact with substance abuse services? 

_____ years old

97. REFUSED
98. DK
99. NOT APPLICABLE
5. **Drug and Alcohol Use**

For the following questions, I am going to ask you about your use of alcohol and drugs in the past 30 days. Again, when I say past 30 days, I am referring to the 30 days before you were arrested or picked up for the offense which led you to the diversion program. Please remember that this information is confidential and will only be used for research purposes.

**SA1. During the past 30 days, how many days have you used the following?**

<table>
<thead>
<tr>
<th>Option</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Any alcohol (beer, wine, liquor)</td>
<td></td>
</tr>
<tr>
<td>b. Alcohol to intoxication (5+ drinks in one setting)</td>
<td></td>
</tr>
<tr>
<td>c. Street or Illicit Drugs (e.g. marijuana, crack, cocaine, heroin, amphetamines, hallucinogens, or other substances)</td>
<td></td>
</tr>
<tr>
<td>d. Non-medical use of prescription drugs that were prescribed for you or someone else</td>
<td></td>
</tr>
</tbody>
</table>

The following questions refer to your feelings and behavior over your whole life. Please listen to each statement and indicate with a ‘yes’ or ‘no’. Please give the answer that is right most of the time.

**SA2. Have you ever felt you should cut down on drinking?**

1. YES
2. NO
7. REFUSED
8. DK

**SA3. Have people annoyed you by criticizing your drinking?**

1. YES
2. NO
7. REFUSED
8. DK
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA4. Have you ever felt guilty about your drinking?</td>
<td>1. YES</td>
</tr>
<tr>
<td></td>
<td>2. NO</td>
</tr>
<tr>
<td></td>
<td>7. REFUSED</td>
</tr>
<tr>
<td></td>
<td>8. DK</td>
</tr>
<tr>
<td>SA5. Have you ever taken a drink in the morning to steady your nerves or</td>
<td>1. YES</td>
</tr>
<tr>
<td>get rid of a hangover, or</td>
<td>2. NO</td>
</tr>
<tr>
<td>as an eye opener?</td>
<td>7. REFUSED</td>
</tr>
<tr>
<td></td>
<td>8. DK</td>
</tr>
</tbody>
</table>
6. **Services**

In this next section, I am going to ask you about services that you may have received in the past 30 days. Again, when I say past 30 days, I am referring to the 30 days before you were arrested or picked up for the offense which led you to the diversion program.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>[IF YES] Altogether for how many nights/times?</th>
<th>NO</th>
<th>RF</th>
<th>DK</th>
<th>MISS ING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SV1. Inpatient Treatment for:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Physical complaint</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>ii. Mental or emotional difficulties</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>iii. Alcohol or substance abuse</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td><strong>SV2. Outpatient Treatment for:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Physical complaint</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>ii. Mental or emotional difficulties</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>iii. Alcohol or substance abuse</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td><strong>SV3. Emergency Room Treatment for:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Physical complaint</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>ii. Mental or emotional difficulties</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>iii. Alcohol or substance abuse</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>
7. Criminal Justice Questions

Next, I am going to ask you about arrests and nights you have spent in jail in the past 30 days. For these questions, please INCLUDE the offense for which you were arrested or picked up, leading you to the diversion program, even if this arrest/incident occurred MORE THAN 30 days ago.

CJ1. In the past 30 days, how many times have you been arrested? ____ # times arrested
97. REFUSED
98. DK

CJ2. In the past 30 days, how many nights have you spent in prison/jail? ____ # nights jail/prison
97. REFUSED
98. DK

Now I am going to ask you about your involvement with the criminal justice during your lifetime.

CJ3. At what age were you first arrested, booked, or taken into custody by the police? ____ years old
97. REFUSED
98. DK

CJ4. Have you ever been on probation? 1. YES
2. NO
7. REFUSED
8. DK

CJ5. Have you ever spent time in jail or prison because of a conviction? 1. YES
2. NO (SKIP TO Question CJ7)
7. REFUSED
8. DK

CJ6. How many times have you been in jail or prison in your life? ____ # times incarcerated
97. REFUSED
98. DK
CJ7. Has someone ever had a restraining order, no contact order or an order of protection against you?

1. YES  
2. NO (SKIP TO NEXT SECTION)  
7. REFUSED  
8. DK

CJ8. Does someone currently have a restraining order, no contact order or an order of protection against you?

1. YES  
2. NO  
7. REFUSED  
8. DK
8. Functioning

In order to provide the best possible mental health services, we need to know what you think about how well you were able to deal with your everyday life during the last 30 days.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Refuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1. I deal with problems effectively.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>F2. I am able to control my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>F3. I am able to deal with crisis</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>F4. I am getting along with my family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>F5. I do well in social situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>F6. I do well in school and/or work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>F7. My housing situation is satisfactory</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>F8. My symptoms are not bothering me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

9. Social Connectedness

Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with persons other than your mental health provider in the past 30 days.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Refuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC1. I am happy with the friendships I have.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>SC2. I have people with whom I can do enjoyable things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>SC3. I feel I belong in my community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>SC4. In a crisis, I would have the support I need from family or friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>


10. Traumatic Events

Now I am going to ask you some questions about events in your life that are upsetting or stressful to most people. Some of these questions may not apply to you, but I have to ask them as is. Please think back over your whole life when you answer these questions—**but do not include your experiences in military combat situations.** Some of these questions may be about upsetting events people don’t usually talk about. Your answers are important to us, BUT you DO NOT have to answer any questions that you do not want to. Also, remember that your answers are completely confidential and will be used only for research purposes.

<table>
<thead>
<tr>
<th>TE1. Have you ever witnessed someone seriously injured or killed due to an unnatural event such as a shooting, stabbing, or hit-and-run accident?</th>
<th>YES</th>
<th>NO</th>
<th>RF</th>
<th>DK</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. [IF YES] Did this occur before the age 18?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>b. Did this occur in the past 12 months?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TE2. Have you ever witnessed a physical or sexual assault against a family member, friend, or other significant person?</th>
<th>YES</th>
<th>NO</th>
<th>RF</th>
<th>DK</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. [IF YES] Did this occur before the age 18?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>b. Did this occur in the past 12 months?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TE3. Has an immediate family member, partner, or very close friend died as a result of an accident, homicide, suicide, or in a war?</th>
<th>YES</th>
<th>NO</th>
<th>RF</th>
<th>DK</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. [IF YES] Did this occur before the age 18?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>b. Did this occur in the past 12 months?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TE4. Have you ever been stripped searched, forcibly restrained, or held against your will, including in a jail or hospital, by a provider of mental health or substance abuse services or by someone else?</th>
<th>YES</th>
<th>NO</th>
<th>RF</th>
<th>DK</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. [IF YES] Did this occur before the age 18?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>b. Did this occur in the past 12 months?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TE5. Have you ever experienced physical violence, such as being slapped, kicked, bitten, hit, choked, strangled, smothered, or being threatened or assaulted with a weapon by someone you did not know?</th>
<th>YES</th>
<th>NO</th>
<th>RF</th>
<th>DK</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. [IF YES] Did this occur before the age 18?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>b. Did this occur in the past 12 months?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TE6. Have you ever experienced physical violence, such as being slapped, kicked, bitten, hit, choked, strangled, smothered, or being threatened or assaulted with a weapon by someone you knew?</th>
<th>YES</th>
<th>NO</th>
<th>RF</th>
<th>DK</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. [IF YES] Did this occur before the age 18?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>
TE7. Have you ever experienced sexual assault or sexual molestation, such as being forced to touch your or someone else’s private parts, forced to have sex or any other sexual molestation by someone you did not know?

   a. [IF YES] Did this occur before the age 18?
   b. Did this occur in the past 12 months?

TE8. Have you ever experienced sexual assault or sexual molestation, such as being forced to touch your or someone else’s private parts, forced to have sex or any other sexual molestation by someone you knew?

   a. [IF YES] Did this occur before the age 18?
   b. Did this occur in the past 12 months?

Thank you for answering these questions.

<Interviewer: Conduct Safety Assessment>
I’m going to read a list of problems and complaints people sometimes have in response to stressful life experiences. For each item, please tell me how much you’ve been bothered by that problem in the past month.

### Posttraumatic Stress Disorder Checklist (PCL-C)

<table>
<thead>
<tr>
<th>In the past month how much have you been bothered by...</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>RF</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>TR1. Repeated disturbing <em>memories, thoughts, or images of a stressful experience from the past?</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR2. Repeated, disturbing dreams of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR3. Suddenly acting or feeling as if a stressful experience from the past <em>were happening again</em> (as if you were reliving it)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR4. Feeling very upset when something reminded you of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR5. Having physical reactions (e.g. heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR6. Avoiding thinking about or talking about a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR7. Avoiding activities or situations because they reminded you of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR8. Trouble remembering important parts of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR9. Loss of interest in activities that you used to enjoy?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>RF</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>TR10. Feeling <em>distant or cut off from other people?</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR11. Feeling <em>emotionally numb or being unable to have loving feelings for those close to you?</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR12. Feeling as if your <em>future will somehow be cut short?</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR13. Trouble <em>falling or staying asleep?</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR14. Feeling <em>irritable or having angry outbursts?</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR15. Having difficulty <em>concentrating?</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR16. Being “<em>super-alert</em> or watchful or on guard?”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR17. Feeling <em>jumpy or easily startled?</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>
### 13. REE: Recovery Markers – Revised

*Copyrighted material – intentionally deleted.*

---

**END OF THE INTERVIEW**

*This is the end of the interview. I want to remind you that all of your answers will be kept confidential; we will not share them with anyone outside of the research team.*

Thank you for your time and participation.

*Pay respondent and have them sign the receipt.*

We will be contacting you in about 5 months to conduct another interview, and then again for the 12-month interview. Before we end the interview, I want to review some of the ways we might get in contact with you.

*Interviewer- Complete Locator Information and information releases.*

### Interviewer Observations

| IO1. Please estimate the respondent’s understanding of the interview. | 1. No difficulty- no language or comprehension problems  
2. Just a little difficulty- few language or comprehension problems  
3. A fair amount of difficulty- some language or comprehension problems  
4. A lot of difficulty- considerable language or comprehension problems |
|---------------------------------------------------------------|
| IO2. How accurate do you think the respondent’s answers were? | 1. Very accurate  
2. Fairly accurate  
3. Not very accurate  
4. Not accurate at all |
APPENDIX E:

SIX MONTH INTERVIEW PROTOCOL

CMHS Jail Diversion and Trauma Recovery Initiative
Priority to Veterans

************

Six Month Instrument- REVISED

<table>
<thead>
<tr>
<th>Site Code</th>
<th>Program Pilot</th>
<th>Group Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Connecticut</td>
<td>1. Pilot Site 1</td>
<td>1. Pre-booking Diversion</td>
</tr>
<tr>
<td>02. Colorado</td>
<td>2. Pilot Site 2</td>
<td>2. Post-booking Diversion</td>
</tr>
<tr>
<td>03. Georgia</td>
<td>3. Pilot Site 3</td>
<td>3. Probation/Parole Violation</td>
</tr>
<tr>
<td>04. Illinois</td>
<td>(TBD with sites)</td>
<td></td>
</tr>
<tr>
<td>05. Massachusetts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06. Vermont</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Location of Interview

1. Community setting (e.g. any residence, restaurant, research offices, university, outdoors)
2. Services Site (e.g. Hospital, Treatment facility/program, Shelter, Transitional housing)
3. Jail
4. Court
5. Other
   (specify:___________)

Was anyone else present during the interview?
1. Yes
2. No

If Yes- who?
Table of Contents

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2. Drug and Alcohol Use ......................................................................................................................... 13
3. Criminal Justice Questions .................................................................................................................. 14
4. Functioning .......................................................................................................................................... 15
5. Social Connectedness ........................................................................................................................ 15
6. Traumatic Events ................................................................................................................................. 16
7. Posttraumatic Stress Disorder Checklist (PCL-C) .............................................................................. 17
8. BASIS 24 ............................................................................................................................................ 19
9. REE: Recovery Markers –Revised ................................................................................................... 21
10. Services Used .................................................................................................................................... 23
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**Instructions**

This interview form comprises the questions that are being collected across all study sites. This part should be administered to the respondent in its entirety prior to your project specific interview.

1. There is a short introductory paragraph that should be adapted to your project’s study, program, and consent process. Please take time to review it prior to beginning the interview.

2. Read all questions exactly as they are worded so that each respondent is asked the same questions in the same manner.

3. Responses in capital letters should not be read to respondents. Instructions to the interviewer are in italics. Also, NEVER read ‘NA’ ‘RF’ or ‘DK’ response categories.

4. If paper interview is being administered, please be sure to review the entire instrument for completeness and accuracy of recording. Specifically, review the interview for: missing data, recording errors and inconsistencies, complete cover page information, and legibility.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Duty</strong></td>
<td>Military members who are currently serving full time in their military capacity, with military pay and allowances in the armed forces.</td>
</tr>
<tr>
<td><strong>Adequate</strong></td>
<td>Enough or good enough.</td>
</tr>
<tr>
<td><strong>Advocate</strong></td>
<td>To support or speak in favor of something.</td>
</tr>
<tr>
<td><strong>Alimony</strong></td>
<td>An allowance that a court orders paid by one's spouse or former spouse as a part of a legal separation or divorce.</td>
</tr>
<tr>
<td><strong>Combat Zone</strong></td>
<td>A zone designated by the President by Executive order, it is a geographical area defined as an area of armed conflict.</td>
</tr>
<tr>
<td><strong>Competitive Employment</strong></td>
<td>Work in the competitive labor market that is performed on a full-time basis and paid no less than wages for same or similar work performed by individuals who are not disabled.</td>
</tr>
<tr>
<td><strong>Concentrate</strong></td>
<td>Focusing attention on something.</td>
</tr>
<tr>
<td><strong>Confidentiality</strong></td>
<td>Refers to maintaining privacy, by not sharing or divulging to a third party privileged or entrusted information. Matters discussed in confidence are held in secret, except in the rare instances when the information presents a clear threat to the health and well-being of another person, or in cases in which public health may be compromised by not revealing the information. In these instances, it is unethical and illegal not to disclose the information.</td>
</tr>
<tr>
<td><strong>Conviction</strong></td>
<td>Being found guilty of a crime.</td>
</tr>
<tr>
<td><strong>Crisis or Respite Program--</strong></td>
<td>A system that provides regular or special relief to persons or families providing care for persons unable to care for themselves.</td>
</tr>
<tr>
<td><strong>Criticize</strong></td>
<td>To judge, negatively or unfavorably, to find fault.</td>
</tr>
<tr>
<td><strong>Deployment</strong></td>
<td>Deployment is in preparation for battle or work including peacekeeping or training.</td>
</tr>
<tr>
<td><strong>Family, Partner, Significant Other Contribution</strong></td>
<td>Voluntary contribution separate from court-ordered child support.</td>
</tr>
<tr>
<td><strong>Foster Care</strong></td>
<td>A situation in which a child or children are raised by people other than their biological parents or adoptive parents.</td>
</tr>
<tr>
<td><strong>Group Home</strong></td>
<td>An institution for the care and housing of persons with mental illness &amp;/or substance abuse problems.</td>
</tr>
</tbody>
</table>
**Group Home**

A non-secure program in which a group of young people (under the age of 18) live and receive services at the program facility under the supervision of adult staff.

**Guilty**

Feelings or awareness of having done something wrong
Hotel or Motel
An establishment that provides lodging, paid for either by the individual or system/shelter/program.

Inpatient Treatment
Treatment that requires at least one overnight stay at a facility.

Intoxication
(Alcohol intoxication) the quantity of alcohol the person consumes exceeds the individual's tolerance for alcohol and produces behavioral or physical abnormalities. In other words, the person's mental and physical abilities are impaired. (Drug intoxication) excessive dosage (varies from individual to individual) of drug can cause undesirable side effects.

Jail/Prison/Detention Center
A state or federal confinement facility having custodial authority over adults sentenced to confinement; a confinement facility administrated by an agency of local government, typically a law enforcement agency, entered for adults but sometimes also containing juveniles, which holds persons detained pending sentencing and/or persons committed after sentencing, usually those committed on sentences of a year or less.

Job Training
Training whose main objective is to prepare people for work.

Medicaid & Medicare
Health care programs funded by the federal and state governments that pay the medical expenses of people who are unable to pay some or all of their own expenses.

Moderate
Not great or severe - in the middle of mild and severe.

National Guard/Reserve
Civilian military recruited by state and equipped by the government that can become part of the national army if there is war or national emergency.

Necessities
Items to meet basic needs, such as personal care items (e.g. deodorant, shampoo).

Outpatient
Treatment that takes place without the client being checked into a hospital or treatment center. This treatment may take place in an office, clinic or other type of care facility.

Probation
A punishment given out as part of a sentence where instead of jailing a person, she/he is released to the community subject to certain conditions and is under the supervision of the court.

Program Staff
Employees of the housing/treatment program

Recreational Services
Services involving some form of play, amusement or relaxation.

Restraining Order/Order of Protection
No contact and order of protection are court orders that prohibits a person from having any kind of contact with another individual usually the victim of a crime.

Self-help/ Peer Support
Self-help and peer support refers to activities organized by people psychiatric diagnoses (or other characteristics in common) to share their strengths and help each other cope and grow. It does not include support groups led by service providers who are not peers.
<table>
<thead>
<tr>
<th><strong>Sheltered Workshop</strong> or Staff</th>
<th><strong>Supported Housing or Certified Apartment Program</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidized work where an individual is paid a stipend by a program agency, because she is unable to work in a competitive work setting.</td>
<td>People who are paid to provide various services to individuals.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Supported Housing or Certified Apartment Program</strong></th>
<th><strong>Tour of Duty</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Services that assist individuals in finding and maintaining appropriate housing arrangements.</td>
<td>A period of time in which those enrolled in the armed forces spend in combat or performing operational duties for their Armed Forces branch. Tours of duty can be anywhere from 5 months or to several years.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Transitional Housing</strong></th>
<th><strong>Traumatic</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>It is a type of housing that is used to assist the movement of homeless individuals and families to permanent housing. In general, transitional housing is time-limited, provides services beyond survival services, it generally offers more privacy than a shelter, and is viewed as a step between shelter and permanent housing.</td>
<td>Painfully emotional or shocking, often producing lasting psychological effects.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>V.A.</strong></th>
<th><strong>Vocational Trade/Tech Diploma</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The United States Department of Veterans Affairs (VA) is a government- run military veteran benefit system. It is responsible for administering programs of veterans’ benefits for veterans, their families, and survivors.</td>
<td>Education, training, a school, etc. intended to prepare one for an occupation or trade, such as nurses’ assistant, electrician, mechanic, etc.</td>
</tr>
</tbody>
</table>
Introduction

*Interviewer read to respondent*

Hi, I’m (your name) and I work for the Jail Diversion Evaluation Study. This study is funded by the Center for Mental Health Services within the federal government. The findings from this study will be used to improve jail diversion programs. Thank you for agreeing to talk with me today. I appreciate your time and cooperation in participating in this interview and the study.

You will receive a payment of $XX for this interview and $XX for the next follow-up interview in about 6 months.

Your answers will be kept confidential and will in no way affect your legal status or any other services or money you receive. The information you give will only be seen by research staff.

Before we start, I wanted to review a few things. First, you should know that your participation is completely voluntary – you do not need to do this interview and if you decide not to, it will not affect any services you receive or your standing in the diversion program. Also, you can choose not to answer any question I ask, or stop the interview at any time. Second, this interview asks a lot of personal questions, some of which may be difficult to think about. Please let me know if you are feeling upset, or need a break. Before we start, please read and sign this consent form.

[HAND RESPONDENT INFORMED CONSENT FORM, REVIEW IT WITH THEM, AND ASK THEM TO SIGN IT]

Thank you. Do you have any questions? (If so, note questions and responses).

Okay, let’s start. I’m going to read you a set of questions exactly as they are worded so that each person is asked the same questions. In some cases, you’ll be asked to answer questions in your own words and I’ll write down your answers. In other cases, you’ll be given a list of answers and asked to choose the one that is best for you. We are interested in your personal opinions about these questions. There are no right or wrong answers. Please take your time. Feel free to ask me questions if you are not sure what is wanted. Some of the questions I will ask you may sound repetitive or may not apply to you, but I have to ask them anyway.

Remember that your answers are confidential.
This interview will last about 45 minutes. I will need to keep things moving along so I hope that I do not sound rude if I tell you we need to move on to the next question.

If at any time you feel you need to take a break or stop the interview. Please let me know.

Now, I think we are ready to begin. I am going to ask you some questions about yourself. Sometimes I will ask you about a specific time frame, like the past week or the last 30 days, and sometimes I will ask you about things that have happened during your lifetime. I’ll try to be clear, but please ask me if you are not sure about the time period involved. Do you have any questions before we begin?
1. **Education, Employment and Income**

In the first few questions, I will be asking you about your current activities, including school, job training and work.

<table>
<thead>
<tr>
<th>E1. Are you currently enrolled in school or a job training program?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Not Enrolled</td>
</tr>
<tr>
<td>2. Enrolled Full Time</td>
</tr>
<tr>
<td>3. Enrolled Part-time</td>
</tr>
<tr>
<td>4. Other (Specify:______________)</td>
</tr>
<tr>
<td>7. REFUSED</td>
</tr>
<tr>
<td>8. DK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E2. What is the highest level of education you have finished, whether or not you received a degree?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. less than 12&lt;sup&gt;th&lt;/sup&gt; grade</td>
</tr>
<tr>
<td>2. 12&lt;sup&gt;th&lt;/sup&gt; grade/High School diploma/ Equivalent (GED)</td>
</tr>
<tr>
<td>3. VOC/Tech Diploma</td>
</tr>
<tr>
<td>4. Some College or University</td>
</tr>
<tr>
<td>5. Bachelor’s Degree (BA, BS)</td>
</tr>
<tr>
<td>6. Graduate Work/Graduate Degree</td>
</tr>
<tr>
<td>7. REFUSED</td>
</tr>
<tr>
<td>8. DK</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E3. Are you currently employed? [Clarify by focusing on status during most of the previous week, BEFORE the arrest or incident for which the client was diverted, determining whether client worked at all or had a regular job but was off of work]</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. EMPLOYED FULL TIME (35 HOURS PER WEEK)</td>
</tr>
<tr>
<td>2. EMPLOYED PART TIME</td>
</tr>
<tr>
<td>3. UNEMPLOYED, LOOKING FOR WORK</td>
</tr>
<tr>
<td>4. UNEMPLOYED, DISABLED</td>
</tr>
<tr>
<td>5. UNEMPLOYED, VOLUNTEER WORK</td>
</tr>
<tr>
<td>6. UNEMPLOYED, RETIRED</td>
</tr>
<tr>
<td>7. OTHER, SPECIFY______________</td>
</tr>
<tr>
<td>77. REFUSED</td>
</tr>
<tr>
<td>99. MISSING</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E4. IF EMPLOYED, Is this employment competitive or sheltered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Competitive Employment</td>
</tr>
<tr>
<td>2. Sheltered Employment</td>
</tr>
<tr>
<td>7. REFUSED</td>
</tr>
<tr>
<td>8. DK</td>
</tr>
<tr>
<td>9. MISSING</td>
</tr>
</tbody>
</table>
E5.
I am going to read you a list of possible sources of money that you may have received in the past 30 days. Approximately, how much did YOU receive in the past 30 days from … [Interviewer: Unless otherwise specified, all questions refer to pre-tax individual income]

<table>
<thead>
<tr>
<th>[Repeat if needed] In the past 30 days, did you receive…</th>
<th>Yes</th>
<th>NO</th>
<th>RF</th>
<th>DK/NA</th>
<th>(If YES, ask) How much?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wages or money from paid employment.</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>This includes any wages or money received from legal AND “under the table” employment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. SSI, SSDI, or Disability (non-veteran) 1 2 7 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Social Security Income (SSA)</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>4. Food Stamps</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>5. Public assistance or other benefits, such as welfare, general assistance, or TANF (Temporary Assistance to Needy Families)</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>6. Veteran’s benefits (including disability or other compensation)</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>7. Unemployment or Worker’s Compensation</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>8. Child support or alimony</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9. Income from a spouse or partner’s wages or other money</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>10. Money from family members or friends to buy food, pay rent, get medical care or anything else</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>11. Retirement</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>12. Income from other sources that I did not mention [If YES, specify source(s)]</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>
E6. In the past 30 days, where have you been living most of the time?

1. OWNED OR RENTED HOUSE, APARTMENT, TRAILER, ROOM
2. SOMEONE ELSE’S HOUSE, APARTMENT, TRAILER, ROOM
3. HOMELESS (SHELTER, STREET/OUTDOORS, PARK)
4. GROUP HOME
5. ADULT FOSTER CARE
6. TRANSITIONAL LIVING FACILITY
7. HOSPITAL (MEDICAL)
8. HOSPITAL (PSYCHIATRIC)
9. CORRECTIONAL FACILITY (JAIL/PRISON)
10. VA HOSPITAL
11. NURSING HOME
12. VETERAN’S HOME
13. MILITARY BASE
14. OTHER HOUSED, SPECIFY: ___________
77. REFUSED
88. DK
99. MISSING

E7. If Homeless, is that...

1. In a homeless shelter
2. On the street or some place like an abandoned building, park or car
7. REFUSED
8. DK
9. MISSING
2. Military Service Questions

Now I am going to ask you some questions about your military service.

M1. Did you serve in the US Armed Forces?
   1. YES
   2. NO (SKIP TO SECTION 3, page 12)
   7. REFUSED
   8. DK

M2. Are you... (read choices)
   1. Still in the Military (SKIP TO Q. M6)
   2. Separated from service
   7. REFUSED
   8. DK

M3. If separated from service, which best describes your current military status?
   1. Retired
   2. Discharged with Severance or Military Disability Payments
   3. Discharged without severance or Payment
   4. Other: _____________________________
   7. REFUSED
   8. DK

M4. When were you last discharged from the military?
   Please provide the month and year.
   ____ (Month)
   ____ _ ____ (Year)

M5. What type of discharge did you receive?
   1. Honorable (includes discharges that have been converted to honorable since leaving the military)
   2. General (honorable conditions)
   3. General (other than honorable)
   4. Undesirable
   5. Bad conduct
   6. Dishonorable
   7. Medical (including Section 8)
   97. REFUSED
   98. DK

M6. Do you have a VA determined Service-Connected Disability?
   1. YES
   2. NO
   7. REFUSED
   8. DK
Military sexual assault is a pervasive problem, and therefore we feel it is important to ask about these events. Please remember that this information is confidential and will only be used for research purposes.

| M7. During your military service, were you ever sexually assaulted? | 1. YES  
| 2. NO  
| 7. REFUSED  
| 8. DK |
M8. Have you ever served in a combat theater/zone?

1. YES  
2. NO- (SKIP TO SECTION 3, page 12)  
7. REFUSED  
8. DK

Below is a list of experiences military personnel often have in combat situations. Please indicate how if you have experienced the following, in any of your tours of duty with a ‘Yes’ or ‘No’. Some of these experiences may be difficult to talk about. Please remember that all responses are confidential. Just do the best you can and remember that you can choose not to answer any questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>RF</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>M9. Being attacked or ambushed?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>M10. Being shot at or receiving fire, including incoming artillery or mortar fire?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>M11. Shooting or directing fire at the enemy?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>M12. Patrolling areas (or riding) where there were landmines or IEDs (Improvised Explosive Devices), or heard explosions from enemy IED, landmine or mortar?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>M13. Clearing or searching homes, buildings, or bunkers?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>M14. Being wounded or injured?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>M15. Providing aid to someone seriously injured or wounded?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>M16. Seeing someone seriously injured or killed?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>M17. Seeing, smelling or handling dead bodies?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>M18. Believing that you were responsible for the death of someone?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

M19. Were you ever a prisoner of war?

1. YES  
2. NO  
7. REFUSED  
8. DK

Thank you for answering these questions

### 3. Drug and Alcohol Use

For the following questions, I am going to ask you about your use of alcohol and drugs in the **past 30 days**. Please remember this information is confidential and will not be shared with the program or program staff.

**SA1. During the past 30 days, how many days have you used the following?**

<table>
<thead>
<tr>
<th>Category</th>
<th>Days Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Any alcohol (beer, wine, liquor)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>97. REFU</td>
</tr>
<tr>
<td></td>
<td>SED</td>
</tr>
<tr>
<td></td>
<td>98. D</td>
</tr>
<tr>
<td></td>
<td>DK</td>
</tr>
<tr>
<td>b. Alcohol to intoxication (5+ drinks in one setting)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>97. REFUSED</td>
</tr>
<tr>
<td></td>
<td>98. DK</td>
</tr>
<tr>
<td>c. Street or Illicit Drugs (e.g. marijuana, crack, cocaine, heroin, amphetamines, hallucinogens, or other substances)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>97. REFUSED</td>
</tr>
<tr>
<td></td>
<td>98. DK</td>
</tr>
<tr>
<td>d. Non-medical use of prescription drugs that were prescribed for you or someone else</td>
<td></td>
</tr>
<tr>
<td></td>
<td>97. REFUSED</td>
</tr>
<tr>
<td></td>
<td>98. DK</td>
</tr>
</tbody>
</table>
4. Criminal Justice Questions

Next, I am going to ask you about arrests and nights you have spent in jail in the past 30 days.

CJ1. In the past 30 days, how many times have you been arrested?

   _____ # times arrested
   97. REFUSED
   98. DK

CJ2. In the past 30 days, how many nights have you spent in prison/jail?

   _____ # nights jail/prison
   97. REFUSED
   98. DK

CJ3. Does someone currently have a restraining order, no contact order or an order of protection against you?

   1. YES
   2. NO
   7. REFUSED
   8. DK

CJ4. Since the baseline interview (that is since Baseline Date), have you been under probation, parole or court supervision as a condition of your diversion?

   1. YES
   2. NO
   7. REFUSED
   8. DK
### 5. Functioning

In order to provide the best possible mental health services, we need to know what you think about how well you were able to deal with your everyday life during the last 30 days. Please indicate your disagreement/agreement with each of the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Refuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1. I deal with problems effectively.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>F2. I am able to control my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>F3. I am able to deal with crisis.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>F4. I am getting along with my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>F5. I do well in social situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>F6. I do well in school and/or work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>F7. My housing situation is satisfactory.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>F8. My symptoms are not bothering me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

### 6. Social Connectedness

Please indicate your disagreement/agreement with each of the following statements. Please answer for relationships with person other than your mental health provider in the past 30 days.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Refuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC1. I am happy with the friendships I have.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>SC2. I have people with whom I can do enjoyable things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>SC3. I feel I belong in my community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>SC4. In a crisis, I would have the support I need from family or friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>
7. **Traumatic Events**

Now I am going to ask you some questions about events that may have happened in the past 6 months that are upsetting or stressful to most people. Some of these questions may not apply to you, but I have to ask them as is. Please think back over your whole life when you answer these questions. Some of these questions may be about upsetting events people don’t usually talk about. Your answers are important to us, BUT you DO NOT have to answer any questions that you do not want to. Also, remember that your answers are completely confidential and will be used only for research purposes.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>RE</th>
<th>DK</th>
<th>MS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TE1. In the past 6 months, have you witnessed someone seriously injured or killed due to an unnatural event such as a shooting, stabbing, or hit-and-run accident?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>TE2. In the past 6 months, have you witnessed a physical or sexual assault against a family member, friend, or other significant person?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>TE3. In the past 6 months, has an immediate family member, partner, or very close friend died as a result of an accident, homicide, suicide, or in a war?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>TE3. In the past 6 months, have you been stripped searched, forcibly restrained, or held against your will, including in a jail or hospital, by a provider of mental health or substance abuse services or by someone else?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>TE4. In the past 6 months, have you experienced physical violence, such as being slapped, kicked, bitten, hit, choked, strangled, smothered, or being threatened or assaulted with a weapon by someone you did not know?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>TE5. In the past 6 months, have you experienced physical violence, such as being slapped, kicked, bitten, hit, choked, strangled, smothered, or being threatened or assaulted with a weapon by someone you knew?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>TE6. In the past 6 months, have you experienced sexual assault or sexual molestation, such as being forced to touch yours or someone else’s private parts, forced to have sex or any other sexual molestation by someone you did not know?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>TE7. In the past 6 months, have you experienced sexual assault or sexual molestation, such as being forced to touch yours or someone else’s private parts, forced to have sex or any other sexual molestation by someone you knew?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>
8. **Posttraumatic Stress Disorder Checklist (PCL-C)**

I’m going to read a list of problems and complaints people sometimes have in response to stressful life experiences. For each item, please tell me how much you’ve been bothered by that problem in the past month.

<table>
<thead>
<tr>
<th>In the past month how much have you been bothered by...</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>RF</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>TR1. Repeated disturbing memories, thoughts, or images of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR2. Repeated, disturbing dreams of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR3. Suddenly acting or feeling as if a stressful experience from the past were happening again (as if you were reliving it)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR4. Feeling very upset when something reminded you of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR5. Having physical reactions (e.g. heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR6. Avoiding thinking about or talking about a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR7. Avoiding activities or situations because they reminded you of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR8. Trouble remembering important parts of a stressful experience from the past?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR9. Loss of interest in activities that you used to enjoy?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

2 Weather, Litz, Huska, & Keane; National Center for PTSD - Behavioral Science Division.
<table>
<thead>
<tr>
<th>In the past month how much have you been bothered by...</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>RF</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>TR10. Feeling <em>distant or cut off from other people?</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR11. Feeling <em>emotionally numb</em> or being unable to have loving feelings for those close to you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR12. Feeling as if your future will somehow be <em>cut short</em>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR13. Trouble <em>falling or staying asleep</em>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR14. Feeling <em>irritable</em> or having angry outbursts?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR15. Having difficulty <em>concentrating</em>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR16. Being “<em>super-alert</em>” or watchful or on guard?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>TR17. Feeling <em>jumpy or easily startled</em>?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>
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Copyrighted material - intentionally deleted.

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11. Services Used

First, I am going to ask you about services you have used in the past 30 days. During the past 30 days, did you receive:

<table>
<thead>
<tr>
<th>Services Used</th>
<th>YES</th>
<th>IF YES</th>
<th>NO</th>
<th>RF</th>
<th>DK</th>
<th>MISS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SV1. Inpatient Treatment for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Physical complaint</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>ii. Mental or emotional difficulties</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>iii. Alcohol or substance abuse</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>SV2. Outpatient Treatment for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Physical complaint</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>ii. Mental or emotional difficulties</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>iii. Alcohol or substance abuse</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>SV3. Emergency Room Treatment for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Physical complaint</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>ii. Mental or emotional difficulties</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>iii. Alcohol or substance abuse</td>
<td>1</td>
<td>_______ nights/times</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

Now I am going to ask you about services you may have received since the baseline interview, that is, since _/__/_. Please indicate with a ‘yes’ or ‘no’ if you have received the following services.

Since the baseline interview (DATE)……

<table>
<thead>
<tr>
<th>Services Received</th>
<th>YES</th>
<th>NO</th>
<th>REFUSED</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>SV4. Did you receive outpatient mental health treatment, such as individual, family, group therapy, day treatment, or other outpatient treatment? (do not include case management services)</td>
<td>1. YES</td>
<td>2. NO</td>
<td>7. REFUSED</td>
<td>8. DK</td>
</tr>
</tbody>
</table>

IF YES- Where did you receive mental health outpatient treatment services?

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
</tr>
</thead>
</table>
Since the baseline interview (DATE)……

SV5. Did you receive any trauma-specific treatment; that is, groups or services specifically addressing traumatic experiences and responses to these experiences (e.g., TREM (Trauma Recovery Empowerment Motivation) groups, Seeking Safety Groups, etc.)?

1. YES  
2. NO  
7. REFUSED  
8. DK

IF YES- Where did you receive trauma-specific treatment services?

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
</tbody>
</table>

SV6. Did you see a doctor or nurse about psychiatric medications that you are taking or planning to take?

1. YES  
2. NO  
7. REFUSED  
8. DK

IF YES- Where did you see the doctor(s) and/or nurse(s) about psychiatric medication services?

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
</tbody>
</table>

SV7. Did you receive treatment in a substance abuse program where you stayed overnight, or in a detox program?

1. YES  
2. NO  
7. REFUSED  
8. DK

IF YES- Where did you receive inpatient or detox substance abuse treatment?

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
</tbody>
</table>
SV8. Did you receive any outpatient substance abuse treatment?  
1. YES  
2. NO  
7. REFUSED  
8. DK  

**IF YES**- Where did you receive outpatient substance abuse treatment?  

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
<td>4.</td>
</tr>
</tbody>
</table>

SV9. Did you live in a residential treatment facility, group home, adult home, or halfway house or other community setting where you received treatment?  
1. YES  
2. NO  
7. REFUSED  
8. DK  

**IF YES**- Where was the residential treatment facility, group home, adult home, halfway house or other community setting treatment services?  

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
<td>4.</td>
</tr>
</tbody>
</table>

SV10. Did you receive any case management services?  
1. YES  
2. NO  
7. REFUSED  
8. DK  

Case management refers to a person or team that helps you obtain or coordinate services, entitlements (Medicaid, SSI) and advocates on your behalf.  

**IF YES**- Where did you receive case management services?  

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
<td>4.</td>
</tr>
</tbody>
</table>

SV11. Did you receive any vocational or rehabilitation services, such as supported employment, vocational counseling, clubhouse program or supported education? (see glossary for definitions)

1. YES
2. NO
7. REFUSED
8. DK

IF YES- Where did you receive vocational or rehabilitation services?

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
</tbody>
</table>

SV12. Did you receive any help with housing services; for example, help finding shelter or housing, dealing with a landlord or eviction, help getting a housing subsidy?

1. YES
2. NO
7. REFUSED
8. DK

IF YES- Where did you receive housing services?

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
</tbody>
</table>

SV13. Did you receive any help with transportation to meet basic needs; for example, help getting to work or appointments?

1. YES
2. NO
7. REFUSED
8. DK

IF YES- Where did you receive transportation services?

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
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<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
</tbody>
</table>
SV14. Did you participate in any self-help or peer support services?

Self-help and peer support refers to activities organized by people with psychiatric diagnoses (or other characteristics in common) to share their strengths and help each other cope and grow. It does **not** include support groups led by service providers who are not peers.

**IF YES- Where did you receive self-help or peer support services?**

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
</tbody>
</table>

SV15. did you receive any childcare services; that is, help finding childcare or obtaining a subsidy or other financial support for childcare?

**IF YES- Where did you receive childcare services?**

<table>
<thead>
<tr>
<th>Facility Name, Street, City State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
</tbody>
</table>

SV16. did you receive help with social or recreational activities, such as help finding or planning enjoyable things to, for play or relaxation?

**IF YES- Where did you receive help with social or recreational activities?**

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
</tbody>
</table>
SV17. did you receive any other services not yet mentioned?

If YES: __________________________________________

1. YES
2. NO
7. REFUSED
8. DK

IF YES- Where did you receive these services?

<table>
<thead>
<tr>
<th>Facility Name, Street, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
</tbody>
</table>
12. Perception of Care

In order to provide the best possible mental health services, we need to know what you think about the services you received during the past 30 days, the people who provided it, and the results. Please indicate your disagreement/agreement with each of the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Refuse</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC1. Staff here believe that I can grow, change, and recover.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC2. I feel free to complain.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC3. I was given information about my rights.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC4. Staff encouraged me to take responsibility for how I live my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC5. Staff told me what side effects to watch out for.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC6. Staff respected my wishes about who is and who is not to be given information about my treatment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC7. Staff were sensitive to my cultural background (race, religion, language, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC8. Staff helped me obtain the information I needed so that I could take charge of my illness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC9. I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC10. I felt comfortable asking questions about my treatment and medication.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC11. I, not staff, decided my treatment goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC12. I like the services I received here.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC13. If I had other choices, I would get services from this agency.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>PC14. I would recommend this agency to a friend or family member.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

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END OF THE INTERVIEW

This is the end of the interview. I want to remind you that all of your answers will be kept confidential; we will not share them with anyone outside of the research team.

Thank you for your time and participation. <Interviewer, thank the respondent in your own words>

Pay respondent and have them sign the receipt.

We will be contacting you in about 5 months to conduct the final interview. Before we end the interview, I want to review some of the ways we might get in contact with you.

Interviewer- Complete Locator Information and information releases.
Interviewer Observations

IO1. Please estimate the respondent’s understanding of the interview.

1. No difficulty- no language or comprehension problems
2. Just a little difficulty- few language or comprehension problems
3. A fair amount of difficulty- some language or comprehension problems
4. A lot of difficulty- considerable language or comprehension problems

IO2. How accurate do you think the respondent’s answers were?

1. Very accurate
2. Fairly accurate
3. Not very accurate
4. Not accurate at all
APPENDIX F:

VETERAN SERVICE USE AND PEER MENTORSHIP QUESTIONNAIRE

Subject ID Number______________________    Date________________

Interview (baseline, 6 month, 12 month) ______________________________

Additional Questions for Veteran Service Use

1. Have you ever received services from the VA (for example, medical, mental health, substance use, housing)?

<table>
<thead>
<tr>
<th>No</th>
<th>(go to item 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>(complete follow up questions then skip to question 4)</td>
</tr>
</tbody>
</table>

   Check all below that apply
   - Ever (in your lifetime)
   - Within the past year?
   - Now?

2. If you have not received services from the VA then why not? (check all that apply)

   - Not eligible (complete #3)
   - have bad feelings about the military
   - afraid services may affect benefits
   - too much paperwork
   - too much wait time for appointments
   - Do not feel safe at the VA
   - not convenient- time
   - not convenient-distance
   - prefer to stay with non-VA provider you go to
   - have not needed or receive any services anywhere
   - poor quality of services
   - Other – specify:___________________

3. If indicated not eligible - How do you know you are not eligible?
   (Be sure to probe for the extent to which they were formally told by the VA that they are not eligible as opposed to thinking they are ineligible for certain reasons). Try to determine if the person has ever tried to determine eligibility, if so for how long, and if not why not.
   (End veteran service use questions here)
4. **Indicate the type of VA care you have received.** *(check all that apply)*

<table>
<thead>
<tr>
<th>Check all that apply</th>
<th>Category of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently</td>
<td>Past Year</td>
</tr>
<tr>
<td>Currently</td>
<td>Past Year</td>
</tr>
<tr>
<td>Currently</td>
<td>Past Year</td>
</tr>
</tbody>
</table>

5. **For those receiving VA healthcare now - Why do you receive services at the VA?** *(Choose all that apply)*

- Cannot any get coverage for care elsewhere
- Can get coverage for care outside VA, but because VA care is still more affordable I seek out VA care
- Ease of claim process
- Variety of services offered
- Quality of service
- Convenient location
- Convenient appointment times
- Like being around other veterans
- Other – *specify:* __________________________

6. **For those who have received VA healthcare in the past do not receive it now: Why do you no longer receive VA healthcare?**

- Not eligible for services needed
- Have bad feelings about the military
- Afraid services may affect benefits
- Too much paperwork
- Too much wait time for appointments
- Not convenient- time
- Not convenient-distance
- Prefer to stay with non-VA provider you go to
- Have not needed or receive any services anywhere
- Poor quality of services
- Other – *specify:* __________________________

7. **Have you received services outside of the VA**
   a. No *(Skip to question 9)*
   b. Yes
8. **Indicate the type of services you have received in the community (outside of the VA).**
   *(check all that apply)*

<table>
<thead>
<tr>
<th>Check all that apply</th>
<th>Category of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently</td>
<td>Medical</td>
</tr>
<tr>
<td>Past Year</td>
<td>Behavioral Health (such counseling, PTSD clinic, substance abuse, etc.)</td>
</tr>
<tr>
<td>Ever</td>
<td>Housing services (such as shelters or transitional housing)</td>
</tr>
</tbody>
</table>

9. **Of all the services you receive, about how much of your services do you receive at the VA?**
   a. No services
   b. Some of my services
   c. Half of my services
   d. Most of my services
   e. All of my services

**Questions about Peer Mentorship**

1. **Who do you primarily work with at Northside Mental Health Center/ACTS (the mental health center that is doing the diversion)?**
   *(Do not give list; write down responses, in the form of first names or initials only. If participant does not know the name of the person then indicate this).*

2. **Do you consider this person a peer?**
   *(prompt if necessary: By peer we mean someone with a similar experience who you consider to be similar to you in life experience in at least some way).*
   Yes – If yes, why do you consider this person a peer?
   No – If no, why do you not consider this person a peer? What role do they play with your involvement in this program?
3. What are qualities you feel are important for a peer to have to work with you in this program?

<table>
<thead>
<tr>
<th>Quality</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Important</th>
<th>Extremely Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having served in the US Armed Forces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same era of service as you (such as OEF/OIF, Gulf War, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same branch as you</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same status as you (such as reserve or national guard)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same rank as you</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lived experience in a combat zone/theater</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Lived experience with Mental Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lived experience with substance abuse issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lived experience with trauma related issues</td>
<td></td>
<td></td>
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<tr>
<td>Lived experience with the criminal justice system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same gender as you</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Similar age as you</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same race as you</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Thinking of the person from Northside that you previously identified, how important is your involvement with this person to your future success (such as not getting rearrested and addressing substance use, mental health or trauma issues?)

   a. Not important
   b. Somewhat important
   c. Important
   d. Very important

5. In the past month how much contact (in person or over the phone) have you had with this person

   a. Daily
   b. Weekly (at least once a week on average)
   c. 2 or three times during the month
d. One time during the month  
e. None

6. Has this person assisted you with VA benefits issues (pension, healthcare, housing)?  
   a. No  
   b. Already receiving benefits-no help needed  
   c. Yes – if so explain

7. Has this person helped you access VA healthcare services?  
   a. No  
   b. Already receiving healthcare services-no help needed  
   c. Yes – if so explain

8. Has this person ever gone to a court hearing with you? If so, describe what they did at court for you.

9. Has this person helped you with other aspects of your life? (If necessary give examples, such as transportation, meeting to talk, information about veterans service organizations).