King County

Community Services Division

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IMPLEMENTATION PLAN
2012 – 2017 Veterans and Human Services Levy
Activity 3.2: Veteran and trauma competency training

1. Goal

Increase self-sufficiency of veterans and vulnerable populations.

2. Strategy

The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of increasing access to behavioral health services through the integration of medical and behavioral health services. Activity 3.2, Veteran and trauma competency training expands behavioral health services through primary care and other providers by investing in training mainstream service providers on veterans' culture, trauma awareness and sensitivity and understanding traumatic brain injury.

3. Activity 3.2: Veteran and trauma competency training

Activity 3.2 Veteran and trauma competency training will support trainings for mainstream service providers on veterans' culture, trauma awareness and sensitivity including understanding TBI. Training will be provided to primary care providers, behavioral health providers in the mental health and substance abuse systems, and housing providers who are providing supportive services. Training will also be provided to the jails, schools and social service programs.

4. Service Needs, Populations to be Served, and Promotion of Equity and Social Justice

a) Service Needs

Veterans, Military Personnel and their Families

King County is home to at least 127,000 men and women who are current or former active duty members of the US Military, Reserves, and National Guard [1] with a growing number of recently returning veterans from Iraq and Afghanistan.

Among surviving soldiers wounded in combat in Iraq and Afghanistan, TBI appears to account for a larger proportion of casualties than it has in other recent U.S. wars. According to the Joint Theater Trauma Registry, compiled by the U.S. Army Institute of Surgical Research, 22 percent of the wounded soldiers from these conflicts who have passed

[1] 2010 American Community Survey, U.S. Census Bureau

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through the military's Landstuhl Regional Medical Center in Germany had injuries to the head, face, or neck. This percentage can serve as a rough estimate of the fraction who have TBI, according to Deborah L. Warden, a neurologist and psychiatrist at Walter Reed Army Medical Center who is the national director of the Defense and Veterans Brain Injury Center (DVBIC). Warden said the true proportion is probably higher, since some cases of closed brain injury are not diagnosed promptly.

Soldiers with TBI often have symptoms and findings affecting several areas of brain function. Headaches, sleep disturbances, and sensitivity to light and noise are common symptoms. Cognitive changes, diagnosed on mental-status examination or through neuropsychological testing, may include disturbances in attention, memory, or language, as well as delayed reaction time during problem solving. Often, the most troubling symptoms are behavioral ones: mood changes, depression, anxiety, impulsiveness, emotional outbursts, or inappropriate laughter. Some symptoms of TBI overlap with those of post-traumatic stress disorder.

The trans-generational effects of trauma are the residual impacts of the soldier's war trauma upon his or her family members. The VA reports that of the 1.3 million active duty forces, there are 1.8 million family members stateside; of the 829,000 soldiers in the reserve component, there are 1.1 million family members at home. Current deployments of military personnel can range from 12-18 months and the impact on both the soldier and the family begins even before deployment. When the soldier returns home from service in a combat zone, there is an increased risk of substance abuse, domestic violence, family instability, with negative implications for children. The Washington State Department of Veterans Affairs PTSD Program in conjunction with the University of California Los Angeles and Madigan Army Hospital is conducting research that is examining the impact of war zone deployment on school aged children (ages 6-12) among the National Guard and active duty components (Schumacher, 2007).

In 2005, Army Col. Charles Hoge, Chief of Psychiatry and Behavior Services, Walter Reed Army Institute of Research told a House subcommittee that surveys show 19 percent to 21 percent of troops who have returned from combat deployments meet the criteria for PTSD, depression or anxiety.[2]

According to *both civilian* and the Defense Department's (DoD) Mental Health Task Force, providers of mental health care within DoD are not "sufficiently accessible" to military personnel and are inadequately trained. Hoge et al (2005) also found stigma associated with mental health care, which affected those needing care the most, created barriers to mental health care. An extension of this phenomenon has been the observation that upon discharge those most needing care are again least likely to obtain services once home. If they are in the National Guard or military reserves, their avoidance is complicated by their continued fears that their military careers will be harmed if they seek help. Often, a cascade of mental health and social problems must overtake and force these veterans to seek help.

The first SIP recognized that one of the greatest unmet service needs was the recognition and treatment of trauma and post-traumatic stress disorder. At the time the SIP was written, information regarding the relationship between traumatic brain injury (TBI) and PTSD was

[2] http://www.veteransforamerica.org/ArticleID/7942

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not as available. Because current research shows that some of the TBI symptoms overlap with those of post-traumatic stress disorder, this implementation plan includes training regarding TBI behavioral symptoms as well. Levy funds will also be sued to raise awareness and to train primary care providers, behavioral health providers in mental health and substance abuse systems for the population groups mentioned above.

Other Persons in Need

The SIP also sets aside funding for training in the recognition and treatment of trauma and post-traumatic stress disorder to those providers who serve vulnerable individuals and families who are experiencing difficult life circumstances. These circumstances include mental illnesses and/or other chronic health conditions, problems with drug use or addiction, periodic or long-term homelessness, poverty, and domestic violence.

Public Health-Seattle & King County's Health Care for the Homeless Network (HCHN) contracts with community agencies to improve access and provide services for homeless and formerly homeless people.

The 2012 One Night Count of people who are homeless in King County took place during the night of January 26-27, 2012. At least 8,937 people were homeless in King County on this winter night. This represents the minimum number of people homeless on that particular night. National research suggests that at least three times that many people will be homeless in King County over the course of a year. (2007 Annual One Night Count, Report Prepared by Seattle/King County Coalition on Homelessness)

Persons that are homeless also have a disproportionately high level of trauma/PTSD. A global percentage of the problem is estimated between 40 – 60 percent for trauma/PTSD typically the catalyst for a person becoming homeless (North, Smith, 1992).

Sexual assault is the most under-reported crime, according to the National Center for Victims of Crime (Kilpatrick, et al, 1992). Approximately 16 percent of sexual assaults are reported to law enforcement authorities. During the past 20 years, researchers have documented the widespread problem of rape trauma following sexual assault. Sexual assault causes severe psychological distress and long-term physical health problems. Sixty-six percent of victims display symptoms of PTSD referred to as rape trauma. Ninety percent of sexual assault victims experience the onset of PTSD within one month of the assault. One-third of victims of sexual assault display symptoms more than six months later.

Finally, the state-funded General Assistance-Unemployable (GA-U) Program eligibility is restricted to low income people who are physically and/or mentally incapacitated and unemployable for more than 90 days. Many of the GA-U clients are challenged by poverty, physical illness, mental and substance abuse issues, and lack of housing. In King County, there are approximately 2,500 individuals who may be eligible for time-limited GA-U benefits.[3] State data also shows that around 45 percent of this population has an identified mental health issue.[4]

b) Populations to be Served

[3] Verbal Communication with Betsy Jones, Community Health Plan consultant to GA-V Pilot, August 2007

[4] Bennet, Amandalei, "GA-V Managed Care Pilot: Report to the Legislature." Health and Recovery Services Administration, Division of Program Support Office of Care Coordination. Washington State DSHS, January 2006.

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This implementation plan will focus on training two population groups. The first group will be primary care providers, behavioral health providers in the mental health and substance abuse systems, and housing providers who are providing supportive services. The second group will be jails, schools, social service programs and employers. Priority for training will be those providers who serve a significant number of veterans; family members of veterans and military personnel, and school age children of veterans and military personnel.

These providers will become PTSD and trauma-informed and better equipped to assist and treat veterans, military personnel and their families, people with histories of homelessness, individuals and families who have experienced domestic violence or physical or emotional abuse, and individuals who have been incarcerated.

c) Promotion of Equity and Social Justice

There is much national research which cites that a disproportionate number of veterans of color have negative life and health outcomes. In King County, 14 percent of the veteran population is comprised of veterans of color. On the other hand, 48 percent of KCVP clients are veterans of color.

The VA reports that lifetime prevalence rates for PTSD in Vietnam veterans were higher among all veterans of color samples than among self-identified Caucasian veterans. A study of Vietnam veterans found that African-American and Hispanic Vietnam veterans reported more mental health and life adjustment problems. For PTSD in particular, Hispanic male veterans had the highest prevalence rate. Race-related stressors and personal experiences of racial prejudice or stigmatization are potent risk factors for PTSD, as is bicultural identification and conflict when one ethnically identifies with civilians who suffered from the impact or abuses of war. During Vietnam, communities of color were disproportionately represented in combat theaters.

Providers who work with veterans of color need to understand the additional complications these veterans may have experienced in order to assess and treat the full range of problems faced by veterans of color.

This implementation plan is committed to improving equity and social justice for the veterans and other vulnerable individuals who have longer-term negative life experiences and life options, in the following ways:

- Applicants in the RFP process will be asked to describe their strategy in addressing systemic racism through training materials developed for this procurement plan.
- Demonstrate knowledge and partnerships with culturally relevant community-based agencies.
- Provide training materials that are culturally appropriate to engage clients of color.
- Solicit feedback and recommendations from recipients of training services.
- Work with and obtain guidance from service organizations in the community which serve veterans of color
- Undertake an education/advocacy across systems and with partners to bring attention to terms such as “disproportionality.”

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5. Activity Description

The goal of this implementation plan is to raise awareness and skills and support the creation of trauma-informed and trauma-sensitive programs across systems to minimize the effects and consequences of trauma/PTSD on veterans and their families.

The secondary goal is to raise awareness that trauma/PTSD also affects people with histories of homelessness, individuals and families who have experienced domestic violence or physical or emotional abuse and individuals who have been incarcerated.

Veteran Awareness Trainings
The SIP emphasizes the need to inform and enhance the ability of community and veteran providers to respond and treat veterans, military personnel and their families. Community service providers offer a variety of services to people throughout King County; currently, however, agencies do not universally identify clients' military background as a contributing factor leading to assistance. The training will address ways to identify veterans, outline the unique factors experienced by both combat and non-combat military members, and enhance information available to those who are already assisting veterans. In addition, all veterans and current U.S. military personnel will benefit from an enhanced awareness of the issues unique to military service.

The Veterans Training Support Center (VTSC) is funded by the levy through a contract with the Washington State Department of Veterans Affairs. The VTSC provides continuing educational opportunities and professional development to those who provide direct service to veterans and their family members including employers. Their aim is to raise awareness and understanding on issues specific to veterans such as invisible wounds like Post Traumatic Stress Disorder and Traumatic Brain Injury, and to encourage agency and institution staff and employers to establish promising best practices that will empower this population in their reintegration and pursuit of personal, academic, and meaningful career goals.

Trauma Trainings
The greatest single unmet service feature among veterans, their school age children, veterans with histories of homelessness, individual veterans and families who have experienced domestic violence, physical, or emotional abuse, veterans of color, women veterans, and veterans who have been incarcerated, is the recognition and skilled treatment of post-traumatic stress disorder (page 22 of SIP). Training will raise awareness of trauma issues and the skills needed to address these areas of need, as well as support the creation of trauma-informed and trauma-sensitive programs within jails, courts, emergency services, schools, social services, primary care, employers and housing programs. A critical component of trainings will be a focus of the issues faced by the returning soldiers serving in the Global War on Terrorism, and their family members.

Priority for these trainings will be primary care providers, behavioral health providers in the mental health and substance abuse systems and housing providers who offer supportive services to veterans, their school age children, veterans with histories of homelessness, individual veterans and families who have experienced domestic violence, physical, or emotional abuse, veterans of color, women veterans, and veterans who have been

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incarcerated. Also included in this priority group for training will schools who serve significant numbers of school age children whose families suffer from homelessness. \

Training Format & Curriculum

Trainings will be provided through a large conference type format held at least once a year for the next four years. Each yearly conference will highlight national and local experts in the field of trauma and PTSD. Each conference/training will have a main topic, for example, "War and its Consequences on Those Exposed." However, at each conference the following three topics, to some extent, will be addressed: 1) Military Culture; 2) Clinical Practice/Treatment Methods; and, 3) Research in the Field of Trauma and Post-Traumatic Stress.

Additional specialized training formats in more intimate settings will also be developed. An example would be specific training for those providing supportive housing to veterans or for school counselors who serve a large number of children affected by trauma/PTSD. Also, all trainings will address topics mentioned in the paragraph above regarding military culture, clinical practice and research in the field of trauma and PSTD.

Military Culture

This element will address the differences in the military services, what is expected of military personnel, the impact of serving in the military on the entire family, assimilation back into civilian life, and services available to military personnel during and after military service. In addition, this element will also focus on the impact of military culture on veterans of color and female veterans.

Clinical Practice/Treatment Methods

This element will bring information on the most effective treatment approaches and models currently used, as well as, those being developed. It will provide a chance for those entering the field to learn proven techniques and access to practitioners who have had success using them.

Research

The field of post-traumatic stress is robust with exciting and meaningful scientific information with significant implications for future services. The trainings will bring up to date information on important past studies, current research, as well as, any implications for future treatment and services.

6. Funds Available

The 2012 Service Improvement Plan identified the following allocations for this activity:

	2012	2013	2014	2015	2016	2017
Veterans Levy	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000
Human Services Levy	**$50,000**	**$50,000**	**$50,000**	**$50,000**	**$50,000**	**$50,000**
Total	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$250,000**	**$625,000**

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7. Evidence-based or Promising Practices

A wealth of scientific information exists on trauma, PTSD, and its co-occurring variants, some of the current approaches available include individual therapy (Cognitive Behavioral Therapy, and Cognitive Process Therapy), therapeutic groups, case management, medication management, and skills development.

Historically, the field of traumatology has also had to evolve treatment approaches and therapist attitudes, perspectives, and skills so as to manage symptoms found within combat forces that go beyond the diagnoses of PTSD. These problems occur when soldiers, sailors, and airmen are forced to kill others, sometimes civilians, women, and children at very close range. These troubling experiences go far beyond typical PTSD reactions, and involve all of the combatant's senses, definitions of self, entitlement to be alive, legitimacy of social membership, and a host of other personal, spiritual, and societal issues not often considered in the training and practice experiences of the majority of therapists. This often precipitates a more complex presentation of PTSD.

Though this list of services utilized is not all inclusive, it would be incumbent upon this procurement plan to provide a variety of promising practices including an extensive review of current evidence-based practices and "centers of excellence," such as Washington State University in Pullman and other programs which may show improvement with clients suffering from trauma and PTSD. Creativity and a basic understanding of PTSD are paramount in promoting and furthering development of innovative approaches that work.

In addition, it is common for veterans to present co-occurring disorders such as depression, anxiety disorders, panic, substance abuse, and/or addiction. Matching the best approach with the individual is very challenging and demands innovative approaches. Groups such as persons who are or have been incarcerated, homeless, suffering from mental health or substance abuse problems have disproportionate rates of PTSD and are in need of access to not only methods that are proven but new and innovated approaches applicable to the diverse nature of veterans and their families. Again the key to influencing this is the strength of the clinical relationship, the knowledge base of the clinician, and his/her ability to apply this within the clinical relationship.

The purpose of this procurement plan is not to advance one particular model as universal, but to identify all options, encourage appropriate application with the individual client, and to stimulate participants to apply this new knowledge to better serve persons with the appropriate and effective care.

8. Service Partnerships

The King County Veterans Program Coordinator and the Deputy Director of the Community Services Division have been working with the Seattle Division of the VA Puget Sound Health Care System, The Veterans Administration Regional Office, the Washington Department of Veterans Affairs, Public Health-Seattle & King County which is responsible for Strategy 3.1 *Increasing Access to behavioral Health Services Available through Community Health Centers, Public Health Centers, and Other Safety Net Clinic*s (page 22 of SIP) and other community service providers in the development of this procurement plan. Together, this

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group has worked to ensure a successful training/conference series. The intent is to bridge and better connect the criminal justice system, community and mental health systems, including substance abuse services, in order to enhance knowledge and access to veterans' services.

The King County Veterans Program believes that the better informed service providers are regarding issues facing today's veteran and their families, the better the chance that appropriate and effective services will be provided. These conferences/trainings will ultimately provide the tools for cross system collaboration and effective services for veterans, military personnel and their families that will result in positive outcomes.

Currently the King County Veterans Program Coordinator, the Deputy Director of the Community Services Division and the Veterans and Human Services Manager have participated in discussions regarding leveraging resources with its current partners in veteran related services such as the Seattle Division of the VA Puget Sound Health Care System, Veterans Administration Regional Office, Washington Department of Veterans Affairs, and other veteran service providers. The resource leverage will be in-kind support such as consultation, planning assistance, participation in committee and workgroups as it relates to curriculum development and training. Memorandums of Agreement and Resource Sharing agreements are in the negotiation stage with the agencies listed above.

9. Performance Measures

The following performance measures were identified by the Levy's Evaluation Team. Performance measures are reviewed annually. Updated performance measures can be found in the *2012 - 2017 Levy Evaluation Plan Implementation Plan and Activity Level Evaluation Templates* on the Levy web site:
http://www.kingcounty.gov/operations/DCHS/Services/Levy.aspx

Objectives	Service Outputs/ Measures PTSD	Most Recent Performance	2012 Target(s)	Data Source
System Improvements/Capacity Building	• Number of professionals trained	1,450	752	Report Card – Services
	• Number of mainstream providers trained	91	748	Report Card – Services
	• Number of training sessions		74	Report Card – Services
	• Completion of one-day retreat for VHS Levy providers		1	Report Card – Services
	• Number and percent of professionals integrating treatment/service strategies		1,275 85%	Report Card - Outcomes

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Objectives	Service Outputs/ Measures PTSD	Most Recent Performance	2012 Target(s)	Data Source
System Improvements/Capacity Building	• Number of Trainers trained	N/A	5	Report Card – Services
	• Number of providers trained		100	Report Card – Services
	• Number of advanced trained professionals		10	Report Card – Services
	• Number and percent of professionals integrating MRT treatment/service groups in their work		85%	Report Card – Outcomes (based of follow-up fidelity review)
	• Number of MRT groups conducted for clients by trained cohort		?	Report Card – Outcomes
	Number of veterans and non-veteran clients participating in MRT groups		?	

This proposed training program will include trainers who have a clear perspective about the linkage between cultural and racism issues and the acquisition and expression of PTSD and war trauma. This would include the understanding of war trauma exposure in the field, identification with oppressed peoples who are considered the enemy, and the perceptions of veterans of color by civilians and other veterans once home. While the military has become one of the least racially biased institutions in the nation, veterans from earlier wars, and current veterans returning home, may not see the absence of racial bias in the civilian community. These differences potentially complicate recovery, improved mental health functioning, educational access, and employment. These educational efforts will include participation from communities of color in all the training phase level events.

10. Cultural Competency

The Washington State Department of Social and Health Services/Mental Health Division's Mental Health Transformation Committee has begun a specific cultural competency training effort that will improve our ability to attend to the important issues related to veteran and veterans of color status. The Mental Health Transformation Committee effort, in conjunction with Washington State University, is creating an on-line training module which will permit statewide access. This module will include training regarding the special life experiences of the disabled, people of color, alternative life orientation, and veterans. The proposed training effort will help to enhance the need for service providers and therapists to be more aware of these issues as well as those providers we contract with. The trainings will include features that give voice to the importance of multi-cultural backgrounds and the special stresses that these features introduce into the treatment process. The RFP for the consultant and the team of trainers will include questions about cultural competency and specific training. As

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mentioned previously, it also important to understand and recognize military culture in a similar context and training in this regard shall be specifically addressed.

A major effort in this training is to increase culturally competent veteran services which should enhance access to appropriate services for veterans and their families. As much as possible trainings will be designed to meet specific needs of veterans who are homeless and/or incarcerated, and demand special attention. Investments in training for high needs clients, complex PTSD, and trans-generational trauma will be a priority as well as properly introducing and training new and developing professionals. The nature of trauma and PTSD is complex and training should be viewed as a continuous process over time. This plan will train/inform providers across systems of veteran resources.

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