Chapter 5
Veterans Treatment Courts

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> *"The court reflects the structure of a military unit: The judge becomes the commanding officer; the volunteer Veteran mentors act as fire team leaders; the court team becomes the company staff; and the Veteran defendants become the troops"*
>
> —Bryan Lett, Reporter for Disabled American Veterans (DAV), April 11, 2017

Abbreviations

ACLU	American Civil Liberties Union
AUDIT	Alcohol Use Disorders Identification Test
DAST	Drug Abuse Screening Test
DAV	Disabled American Veterans
DoD	Department of Defense
DWI	Driving while intoxicated
IOM	Institute of Medicine
MOAS	Modified Overt Aggression Scale
NADCP	National Association of Drug Court Professionals
NIJ	National Institute of Justice
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PCL	PTSD Checklist
PHQ	Patient Health Questionnaire
PTSD	Posttraumatic stress disorder
SDVTRC	San Diego, California, Veterans Treatment Review Calendar

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U.S.	United States
VA	Department of Veterans Affairs
VJO	Veterans Justice Outreach
VTC	Veterans Treatment Court

Introduction

Treatment courts, also known as problem-solving courts, offer an alternative to incarceration in the form of mandated individualized treatment. Born from the need to address the root cause of criminal conduct among many justice-involved Veterans—untreated behavioral health needs that are often related to trauma incurred during the Veteran's military service—Veterans Treatment Courts (VTCs) operate as a collaborative effort among the presiding judge and the prosecuting and defense attorneys in the courtroom, the Veterans Justice Outreach (VJO) Program of the United States Department of Veterans Affairs (VA), and partners from multiple medical, legal, criminal justice, social services, and community-based entities. For a substantial number of Veterans, reintegration into civilian life is rife with the complexities of navigating various interlocking challenges such as battling alcoholism or substance abuse, treating trauma, and addressing service-related mental health needs. By offering eligible justice-involved Veterans treatment focusing on these issues and tailored to their individual needs, VTCs demonstrate that the law, through its procedures and rulings, can be a therapeutic agent, serving as an active force to effect change in a defendant's life and guiding court interventions for the purpose of improving defendants' lives.

VTC Participant Characteristics

According to the 2016 demographics report on the Profile of the Military Community (United States Department of Defense (U.S. DoD), 2016), the average age of the Active Duty force is 28.5 years, which is younger than the median adult age in the United States (37.8 years) (U.S. Census Bureau, n.d.-a). Eighty-five percent of officers in the Armed Forces compared to 31% of the national population have a Bachelor's degree or higher (U.S. Census Bureau, n.d.-b; U.S. DoD, 2016). In terms of racial diversity in the Armed Forces, while nationally 24% of the population is non-white, among Active Duty members nearly one-third (31%) identify themselves as a racial minority (i.e., Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Multi-racial, or Other/Unknown) (U.S. Census Bureau, n.d.-b; U.S. DoD, 2016). Overall, 41% of military personnel have children (U.S. DoD, 2016). Additionally, individuals who are recruited into military services are often "selected against factors that are correlated with community crime, such as a history of mental illness, a prior criminal record,

or a history of drug abuse" (Guy Gambill, Soros Senior Justice Fellow, Justice Policy Institute, as cited in Cartwright, 2011). However, sometimes what we find is that when service members return to civilian life, the process of their civilian reintegration may include the presence of trauma—both physical and psychological—that are tied to their deployment and combat exposures.

Veterans experience a range of comorbid physical health needs and yet, given the increase in popularity of the VTC model across the country, little is known about the medical care profiles among Veterans who become VTC participants. Studies on Veterans, who are not justice-involved, have reported complications stemming from comorbid posttraumatic stress disorder (PTSD) and chronic pain (Outcalt, Hoen, Yu, Franks, & Krebs, 2016); greater comorbid health problems, including liver disease, among dually diagnosed Veterans with major depressive disorders and alcohol use disorder (Yoon, Petrakis, & Rosenheck, 2015); and key treatment priorities among female Veterans to include depression, pain management, and coping with chronic general medical conditions (Kimerling et al., 2014). The physical and psychological traumas experienced by Veterans are also linked to increased risk of the development of behavioral health disorders (Miller, Pederson, & Marshall, 2017; Seal et al., 2011). Unfortunately, for some Veterans, these traumas remain unaddressed and complications from untreated behavioral health needs may result in justice involvement. For example, a 2019 scoping study reviewing literature on the health and healthcare of Veterans involved in the criminal justice system reported substance use disorders (e.g. alcohol use disorder, opioid use disorder, co-occurring substance use and other mental health diagnoses) as the most common condition examined in their sample of 191 studies (Finlay et al., 2019). Several articles in Finlay et al. (2019) also examined experiences related to PTSD and trauma. For justice-involved populations, this is particularly salient as studies have provided supporting evidence for the link between PTSD and crime (Collins & Bailey, 2007; Kulka et al., 1990; Wilson & Zigelbaum, 1983).

Moreover, recent research suggests that for those serving in the U.S. Armed Forces the unique circumstances of the wars in Afghanistan and Iraq (Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF)) pose significant challenges. For example, those serving in these current conflicts are faced with an increased number of multiple and lengthier deployment. According to the Institute of Medicine (IOM) (2013), the average length of deployments is 7.7 months—from an average of 4.5 months in the Air Force to an average of 9.4 months in the Army. As suggested by the IOM, "if deployment itself is considered an exposure, the 'dose' may impact health, so more deployment time would theoretically be worse for subsequent health outcomes." Furthermore, for military members, the importance of a period of time between deployments, also known as "dwell cycle," helped urge a 24-month dwell cycle in the Army, however, due to demand for personnel, average dwell time was 21 months (ranging from 16 months in the Marine Corps to about 22 months in the Army and Navy) for military personnel with two or more deployments (IOM, 2013). In addition, advancements in technology have enabled military personnel to survive traumatic combat experiences that would have likely been deadlier in previous conflicts (Tanielian & Jaycox, 2008). Thus, Veterans of OEF/

OIF conflicts are exposed to combat that is more frequent and of longer duration placing these Veterans at a higher risk of PTSD (Cavanaugh, 2011). Approximately 10–20% of troops returning from OEF/OIF conflicts exhibit psychological problems that warrant treatment (Tanielian & Jaycox, 2008).

For Veterans, justice-involvement presents further obstacles and more service complexity when engaging services to meet their health care needs. If the Veteran has been incarcerated, the Veteran will likely face new barriers upon release related to poverty and lower socioeconomic status, including access to ongoing health care—especially if the Veteran's character of discharge from the military excludes them from enrolling in the VA's healthcare system. Securing health care benefits, accessing care, and ensuring continuity of care for former prison inmates upon release remains a nationwide public health concern. Thus, it is not surprising that most justice-involved Veterans remain at risk for poor health outcomes. According to the general population of OEF/OIF Veterans surveyed in a 2008 RAND study, only 53% of Veterans had sought professional help in the previous year, and only half of those who did seek care received adequate treatment. The potential association between stigma and accessing mental health treatment could be particularly salient for female Veterans who also experience high rates of military sexual trauma that have been associated with PTSD (Kimerling et al., 2010; Kimerling et al., 2014; Yaeger, Himmelfarb, Cammack, & Mintz, 2006). The opportunity for team-based access to health and mental health services presented by a VTC program could also potentially connect the minority of justice-involved female Veterans to needed assessments and services.

As we continue in this chapter, it has been important to acknowledge the context and characteristics of individuals who serve in the U.S. Armed Forces, the conditions of their service that are associated with their civilian reintegration, and the risks posed to Veterans who may become involved in the justice system. For Veterans who are identified and referred into a VTC program, the assessing VJO Specialist will likely focus on areas such as mental health, substance use, trauma exposure, physical health, family relationships, social support, housing, employment, and education needs (Please see Chap. 3 for further descriptions on VJOs).

We would like to now provide you with a description of known characteristics of VTC participants as recently reported in a large national study of VTCs. Among 7, 931 Veterans in the VJO program across 115 associated VA sites, the majority of VTC participants were white, male, with at least a high school education, aged in their 40s, and less than half were employed in the past three years (Tsai, Finlay, Flatley, Kasprow, & Clark, 2018; Tsai, Flatley, Kasprow, Clark, & Finlay, 2017). Compared to non-VTC participants who were also criminal justice-involved, VTC participants were more likely to have served in Iraq and Afghanistan, to have reported combat exposure, and to have a drug offense (Tsai et al., 2017). Notably, over one-third of VTC participants were judged to have probable PTSD (Tsai et al., 2018). A separate 2018 scoping study that examined 15 VTC-related articles similarly reported that most VTC participants were white, male, middle-aged (30–50 years of age), and had mental health and substance use disorders (McCall, Tsai, & Gordon, 2018). In one of the national studies, some Veterans entering a

VTC program were characterized as not being stably housed, less than half were employed in the past three years, and over half reported symptoms consistent with substance use disorders (Tsai et al., 2018). Another national study compared Veterans who were justice-involved to VTC participants and found that VTC participants were less likely to be in jail at program admission, to be chronically homeless, to have a probation offense, to have any prior psychiatric hospitalizations, and to report having spent fewer days in a corrections institution in the past month (Tsai et al., 2017). Among this discussion of VTC participant characteristics, we do not want to neglect the demographic of female Veterans who, in most studies, are consistently reported in the minority, accounting for a range of only 4–12% of VTC study populations (Ahlin & Douds, 2016; Baldwin & Rukus, 2015; Hartley & Baldwin, 2019; Knudsen & Wingenfeld, 2016; Tsai et al., 2017). Finally, we want to also mention that VTCs may differ in their choice about whether to admit violent offenders and in their decisions about whether to limit their services to Veterans who served in a combat zone. In a 2016 national study on VTCs, Baldwin reported that more than half of the VTCs in her study (57%) excluded some type of violent felony charge, and approximately half reported military discharge and conduct exclusions (46%) or violent felony charge exclusions (43%) (Baldwin, 2016).

Despite this knowledge of extensive health and behavioral health needs among Veterans who are justice-involved, VTCs are confronted by critics who may argue that medical care does not fall under the jurisdiction of the courts; however, it is widely acknowledged that VTCs use an interdisciplinary team approach to address Veterans' health care needs while under the close supervision of the court system, which becomes a major component in the efforts to coordinate the Veterans' subsequent civilian reintegration efforts.

Origins of Problem-Solving Courts

As we have just presented the characteristics that are common among VTC participants, this segment of the chapter presents the history of the problem-solving court, and its trajectory as becoming a space to practice therapeutic jurisprudence. While present-day practices in problem-solving courts recognize the needs of the defendant and employ the help of behavioral health interventions and a close interaction with a treatment team, recognizing the root causes of criminal justice involvement and addressing treatment remedies in the court system are only concepts adopted in the last 30 years.

In the late twentieth century, the United States experienced a surge in corrections spending and a growing prison population. In 1975, 27% of the total sentenced federal prison population (20,692) was serving time due to a drug offense. Over the next ten years, this number had grown to reflect 34% (27,623) by 1985 (Maguire, 2003). During the mid-1990s' peak of the "tough on drugs" policy approach, 61% of the total sentenced population (80,872) was serving time in federal prison due to drug offenses (Maguire, 2003). During this tough-on-crime era, the number of peo-

ple in federal prisons for drug offenses increased 1,950% between 1980 and 2010 growing from 4,749 people to 97,472 people. At the time, the War on Drugs was in full-force, demonstrated by the increases in numbers of offenders, many of whom who were dealing with active substance use and addiction. For example, among nonviolent state prisoners, drug offenders (44%) reported the highest incidence of drug use at the time of the offense (Mumola & Karberg, 2006). As reported in the Bureau of Justice Statistics' 2006 report on drug use and drug dependence, 32% of state prisoners and 26% of federal prisoners committed their offense under the influence of drugs (Mumola & Karberg, 2006).

Around the country, jurisdictions had become increasingly aware of the opportunity to shift classes of offenders away from costly incarceration while maintaining offender accountability to the offense and addressing rehabilitation and criminogenic needs via the provision of alternative sentencing. The emergence of the drug court, as a specialized court or a specialized court docket for drug offenders, offered an alternative to incarceration while also applying therapeutic jurisprudence to this special class of offenders. In drug courts, addiction was believed as a root cause which, left untreated, may promote criminal behavior. Drug courts are judicially supervised and handle the cases of nonviolent, substance-addicted offenders under the adult, juvenile, and family justice systems. Drug courts operate under a model that combines intensive judicial supervision, mandatory drug testing, escalating incentives and sanctions, and treatment. Often, it is the relationship between the offender and judge that drives adherence of a drug treatment program and its related court appearances. For example, in a 2011 multi-site drug court evaluation funded by the National Institute of Justice (NIJ), drug court participants who received higher levels of judicial praise, judicial supervision, and case management reported fewer crimes and fewer days of drug use (Rossman et al., 2011). The level of supervision in drug court permits the program to support the recovery process, but also allows program supervisors to react swiftly to impose appropriate therapeutic sanctions or to reinstate criminal proceedings when participants do not comply with the program.

The designation of specialized court dockets and courts for specialized populations in the United States have been documented for at least the last 30 years. The first drug court prototype was established in Miami-Dade, Florida in 1989, presided over by Judge Stanley Goldstein, grounded in procedures combining teamwork, cooperation, and collaboration, and drawing from the framework of therapeutic jurisprudence. Family treatment court (which is addressed in Chap. 6), is a model that seeks to improve parent(s)' treatment retention and family reunification rates in the child welfare system. The family treatment court has been described as the firm foundation of success upon which a rational and humane approach to protect children is built (Marlowe & Carey, 2012). It was in 1995 that the first family treatment courts began concurrently in Reno, Nevada and Pensacola, Florida (National Association of Drug Court Professionals (NADCP), 2018). By the year 2000, as many as 472 drug treatment courts were in operation across the United States. By 2006, at least 1,621 treatment courts were in operations, and by 2009 there were 2,459 treatment courts in the United States (NADCP, 2018). As of June 2015, there

were 1,558 adult drug courts in the United States. However, the estimated total number of drug courts operating in the U.S. is over 3,000 of which the majority target adults including DWI (driving while intoxicated) offenders, Veterans, and other drug courts which address juvenile, child welfare, and others (National Institute of Justice, 2018). Among VTCs, the first can be traced to 2004 in Anchorage, Alaska (Hawkins, 2010; Holbrook & Anderson, 2011; Johnson et al., 2016) and the 2008 VTC from Buffalo, New York (Cavanaugh, 2011; Johnson et al., 2016). The Buffalo VTC was the first instance of manualizing and operationalizing a VTC into its component parts. Today, there are at least 461 operational VTCs and Veterans dockets within drug, mental health, or criminal courts (Flatley, Clark, Rosenthal, & Blue-Howells, 2017).

Components of Veterans Treatment Courts

VTCs defy a "one size fits all" approach. Studies demonstrate that each VTC maintains its own standards and employs its own methods concerning justice-involved Veterans, sometimes leading to tremendous procedural variety among these courts (Arno, 2015; Baldwin, 2016). However, there are certain broad elements that typically appear in most, if not all, of these tribunals.

Eleven years ago, the ground-breaking Buffalo VTC established a set of ten key components for the successful operation of VTCs which is outlined in Table 5.1 (Huskey, 2017). Today, several widely used training programs for VTCs use this document as the basis for their guidance to court personnel. A few states even enacted laws requiring all of their VTCs to abide by these ten principles (Pomerance, 2018).

Similar to the United States Department of Justice's January 1997 document titled "Defining Drug Courts: The Key Components"—the document on which the Buffalo VTC based their creation—the key components for VTCs include early identification and placement of eligible VTC participants; interdisciplinary education of all VTC staff concerning topics such as military cultural competence and criminal justice system goals; monitoring and enforcement of abstinence from drug and alcohol abuse among program participants; and close collaboration among actors within the legal, mental health, drug and alcohol rehabilitation, and Veterans' services systems (Arno, 2015; Rogers, 2018). Taken together, this document provides a starting point for the types of processes, policies, ideals, and objectives that many VTCs share. It is neither, however, a mandate for all VTCs nationwide, nor does every VTC follow each of these ten key components in the same manner (Baldwin, 2016; Baldwin & Brooke, 2019). A closer look, therefore, is necessary to determine the measures that VTCs commonly take to perform their work.

VTC participant eligibility requirements differ by jurisdiction and one of the challenges in establishing eligibility for VTCs is the availability of identification protocols for Veterans who are entering the criminal justice system. There is a general lack of uniformity in intake questionnaires (Baldwin, 2013; Christy, Clark,

Table 5.1 The ten key components of Veterans Treatment Court

Key Component #1
Veterans Treatment Court integrate alcohol, drug treatment, and mental health services with justice system case processing
Key Component #2
Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights
Key Component #3
Eligible participants are identified early and promptly placed in the Veterans Treatment Court program
Key Component #4
Veterans Treatment Court provide access to a continuum of alcohol, drug, mental health and other related treatment and rehabilitation services
Key Component #5
Abstinence is monitored by frequent alcohol and other drug testing
Key Component #6
A coordinated strategy governs Veterans Treatment Court responses to participants' compliance
Key Component #7
Ongoing judicial interaction with each Veteran is essential
Key Component #8
Monitoring and evaluation measure the achievement of program goals and gauge effectiveness
Key Component #9
Continuing interdisciplinary education promotes effective Veterans Treatment Court planning, implementation, and operations
Key Component #10
Forging partnerships among Veterans Treatment Court, Department of Veterans Affairs, public agencies, and community-based organizations generates local support and enhances Veteran Treatment Court effectiveness

Frei, & Rynearson-Moody, 2012). In addition, Veterans' identification occurs across various stages of their involvement with the criminal justice system (refer to Chap. 3 for Sequential Intercept Model). While prior military service is reported among 8% of incarcerated individuals in the United States (Bronson, Carson, Noonan, & Berzofsky, 2015), the majority of participants of VTCs are not identified in incarcerated settings. In Baldwin's 2016 study, she reported that among her national survey of 79 VTCs, the majority of Veterans who were potential participants in VTCs were not incarcerated and were identified elsewhere in the justice system: 70% of VTCs reported that potential participants were identified at booking, 62% of VTCs reported that Veterans were identified at pretrial services, 46% of VTCs identified potential participants at the time of arrest, and nearly 71% of Veterans were identified at arraignment (Baldwin, 2016). Furthermore, in a 2017 study, Tsai and colleagues compared VTC participants with non-treatment court participants and reported that VTC participants were less likely to have been in jail at VTC admission. Baldwin and colleagues' study found that only 2.5% of VTC participants were Veterans who had been convicted and were identified during incarceration (Baldwin, 2016).

Once accepted into a VTC, a justice-involved Veteran may likely be linked by the court with a Veteran peer mentor (Arno, 2015; Perlin, 2013). To increase the likelihood of mentor and mentee developing a bond based on shared experiences, VTCs typically try to match mentors and mentees from the same branch of service and the same era of service. Most courts also try to link mentors and mentees of the same gender. This last objective has proved challenging, however, as many VTCs face an overall scarcity of female Veteran mentors. In most VTCs, these peer mentors are all volunteers, at times creating difficulties when the ever-rising out-of-pocket costs of travel to and from court appearances and mentor-mentee meetings, courthouse parking, and other recurring expenses of mentorship understandably provoke some mentors to leave the program (Jaafari, 2019).

Like drug courts, the vast majority of VTCs establish a treatment team of subject-matter experts who collectively link a justice-involved Veteran with key resources, guide the Veteran through the assigned VTC steps, and monitor and evaluate the Veteran's progress (Baldwin, 2016). Where possible, each member of the treatment team in a VTC should have particular experience and expertise in working with Veterans, ensuring that the people providing both the assistive tasks and the oversight functions of the court possess the cultural competence necessary to give the justice-involved Veteran the best possible chance of success (Jones, 2014). One crucial member of the VTC team is a VJO Specialist from the VA, linking Veterans with localized healthcare services and other fundamental forms of assistance. Veterans Service Officers often play an important role on treatment teams, too, connecting justice-involved Veterans with the federal, state, and local benefits for which they are eligible by virtue of their military service—benefits about which a substantial number of Veterans are often completely unaware (Pomerance, 2019). Other key treatment team members commonly include alcohol and substance abuse specialists, social workers, and employment counselors. Again, while the members of the treatment team do not necessarily need to be Veterans, successful VTCs emphasize a high level of military cultural competence among the members of these teams (Shah, 2014).

VTCs often go to significant lengths to distinguish themselves from a traditional courtroom setting. The implicit environment of a VTC may resemble military culture as a reimagining and interpretation for use within the courtroom. The military experience is one that Veterans have self-reported as a distinguishing feature and likened to membership of a subculture (Ahlin & Douds, 2016; Baldwin & Rukus, 2015). Additionally, prosecutors and defense attorneys interact in a non-adversarial manner, with the judge working with both lawyers and with the justice-involved Veteran in a less-formal manner than one typically witnesses in a criminal court proceeding (Russell, 2009; Seamone, 2019). Some judges even abandon their customary place on the bench to create a more collegial atmosphere in the courtroom (Shevory, 2011). Placing military flags or patriotic insignia in the courtroom in recognition of the service rendered by the justice-involved Veterans coming before the court is another common practice.

Individualization of treatment plans is another central component of VTCs (Cartwright, 2011; Seamone, 2019). Every justice-involved Veteran entering a

court may receive a set of assignments, goals, and strategies that are uniquely tailored by the treatment team and the presiding judge to that particular Veteran's pre-military, military, and post-military experiences (Shah, 2014). While every treatment team takes their own unique approach regarding which factors to apply and how much emphasis to place upon each element, the most common criteria that treatment teams consider include the presence of any diagnosed medical conditions, the existence of any substance use histories on illegal drugs and/or alcohol, the nature and resolution of any prior criminal convictions on the Veteran's record, the degree to which family members play an active role in the Veteran's life, the stability or instability of the Veteran's housing situation, the Veteran's current and future educational and employment prospects, and other bedrock elements of rehabilitating the Veteran from present status to a more constant and sustainable life (Baldwin, 2016).

All VTCs must establish a process for deciding whether a justice-involved Veteran is eligible for admission into a VTC. Typically, this process involves some variety of dialogue among the judges presiding over the traditional criminal court and the VTC, as well as the District Attorney's Office and the justice-involved Veteran's defense counsel, focusing on the balancing of interests between public safety concerns and the desire to avoid unnecessary incarceration when rehabilitative options are reasonably available. Courts differ regarding the level of involvement and influence for each of these parties in making this decision. In some locations, for instance, the District Attorney's Office plays the key "gatekeeping" role in deciding whether a justice-involved Veteran should be eligible for admission to a VTC, while other jurisdictions permit the VTC's presiding judge to make this final call (Pomerance, 2018). From court to court, the assessment instruments used to decide whether an individual presents a low risk of recidivism and a substantial likelihood for rehabilitation differ as well (Baldwin, 2016). This allows local legal systems the flexibility necessary to make case-by-case decisions without the rigidity that has led to criticism in other areas of criminal law, but also creates understandable questions about whether greater standardization in this process is necessary (Arno, 2015).

Similarly, VTCs maintain a set of standards concerning when a justice-involved Veteran is eligible to graduate from the treatment court program, as well as a set of policies regarding the rewards for successfully reaching all of the assigned milestones (McMichael, 2011). Sometimes, graduation from a VTC can result in full dismissal of the criminal charges against the justice-involved Veteran. Other times, graduation leads to withdrawal of the criminal charges in exchange for the justice-involved Veteran accepting a non-criminal disposition or a lower-level criminal offense (Baldwin, 2016). In a minority of jurisdictions, these standards are codified in state statutes (Pomerance, 2018). Most VTCs, however, are free to set whatever policies they deem most appropriate, with the approval of their state's judicial oversight agency (McMichael, 2011). On the negative side, all VTCs must determine what penalties will be imposed if a justice-involved Veteran fails to timely complete the milestones on the assigned treatment court plan (McMichael, 2011). This assessment includes the decision of when a VTC will expel a justice-involved

Veteran from the program, as well as the consequences—a list that customarily involves incarceration—that result from an individual's dismissal (Hawkins, 2010; Jones, 2014). Again, while a minority of states maintains laws that address this issue, most VTCs possess the authority to set these standards without any statutory authority (Pomerance, 2018).

A final commonality among most VTCs is the positive political and mainstream media attention that most of these courts have received. Starting with the creation of the Buffalo VTC in 2008, the opening of new VTCs has been hailed with largely glowing news reports, as well as acclamation by politicians from all sides of the political aisle (Renz, 2014). One can logically presume that this bipartisan positive attention encouraged a continually growing number of jurisdictions to establish and sustain VTCs (Pomerance, 2018). While critics of these courts undoubtedly exist, the fact that VTCs have received lofty acclamation and substantial funding from both Barack Obama and Donald Trump, and praise-filled reports from media outlets of seemingly every political affiliation, VTCs will likely be kept in the spotlight of criminal justice reform conversations for the foreseeable future (Arno, 2015; Jaafari, 2019; Renz, 2014).

Outcomes for VTC Participants

The question as to whether VTCs are effective remains an important one that drives VTC scholarship and practices today. Varied measures have been used when reporting on outcomes for VTC programs. Among existing studies, VTC outcomes have been measured as a reduction in participants' criminal recidivism, a reduction in adverse health conditions, successful community reintegration, and reductions in recidivism, among others. For example, one jurisdiction's VTC program reported on its six program goals which included: reduced criminal recidivism, promotion of participant sobriety, increased compliance with treatment and court-ordered conditions, improved access to VA benefits and services, improved family relationships and social support connections, and improved life stability (Caron, 2012). In a national study on VTCs, outcomes included domains such as housing stability, employment, receipt of VA benefits, and criminal justice (Tsai et al., 2018). Another study reported on 24 infractions (such as failure to complete treatment, missed hearings, failure to comply with judge's order) and 18 types of sanctions (such as verbal reprimand, behavioral contract, and community service) as outcome metrics used in their analyses (Johnson, Stolar, Wu, Coonan, & Graham, 2015). A variety of outcome studies are essential as they can demonstrate effectiveness, efficiency, and key behavioral changes necessary for a Veteran to complete a VTC program and be released into the community.

Given the centrality of the behavioral health needs as root problems among VTC participants, an important outcome for VTCs is the reduction of behavioral health challenges which have triggered criminal involvement among Veterans. For example, Derrick et al. (2018) reported on 82 participants of the San Diego,

California, Veterans Treatment Review Calendar (SDVTRC) Pilot Program and examined 12 clinical measures from baseline to 12-months using the following scales: PTSD Checklist (PCL) a 17-item Likert-type checklist that measures PTSD symptoms (Weathers, Litz, Herman, Huska, & Keane, 1993); Modified Overt Aggression Scale (MOAS) a 16-item Likert-type scale (Cicerone & Kalmar, 1995); Drug Abuse Screening Test (DAST-10) a 10-item yes/no inventory to measure illegal drug use over the prior four weeks; Alcohol Use Disorders Identification Test (AUDIT-C) a three-question tool that measures frequency and volume of alcohol consumption over the prior four weeks; Patient Health Questionnaire-9 (PHQ-9) a 9-item Likert-type scale to measure symptoms of depressed mood over the prior two weeks. For 52 participants with both a baseline and 12-month scores, Derrick et al. (2018) reported reductions in drug use; depressed mood; trauma and four subscales measuring re-experiencing, avoidance, hyperarousal, and total trauma and stress; and anger and aggression subscales including verbal aggression, physical aggression toward objects, physical aggression toward others, physical aggression toward self, and total anger and aggression. Improvements in behavioral health measures such as emotional well-being, social functioning, reductions in self-harm, reductions in substance use were also reported in Knudsen & Wingenfeld's, 2016 study on 86 Veterans.

Another important outcome for a problem-solving court is reducing recidivism, which is the reduction of an offender's tendency to reoffend. Reoffense can be measured as new arrests, new incarcerations, or new offenses. In some outcome studies, recidivism reduction is measured as the percentage difference of number of arrests at VTC program entry compared to number of arrests at VTC program exit. For example, in Hennepin County, Minnesota's 2012 VTC program review, 83% of Veterans had fewer number of charges at six months after entering their VTC program compared to six months prior to their start of their VTC program, and 72% of Veterans had fewer number of charges at 24 months after entering their VTC program compared to 24 months prior to their start of their VTC program. For VTC participants in Hennepin County, Minnesota, 66% of active VTC participants and 76% of VTC graduates did not have any misdemeanor or felony reoffenses within 12 months of VTC program entry; at 24 months of program entry, 40% of active VTC participants and 56% of VTC graduates did not have any misdemeanor or felony reoffenses (Caron, 2012). In Smith's, 2012 study on the Anchorage, Alaska VTC, recidivism was defined as a return to custody or a violation of probation. In the Smith (2012) study, a recidivism rate of 45% was reported, which was presented in comparison to the 50% recidivism rate experienced by offenders of the state system who were not participants in the VTC. In Tsai et al.'s 2018 national study, they reported that 20% of VTC participants received jail sanctions and 14% reported a new incarceration within an average of nearly one-year in a VTC program, which is lower than the 23–46% one-year recidivism rate found among U.S. prisoners. Finally, in Hartley and Baldwin's (2019) study of 144 Veterans in a VTC and a control group of 157 VTC-eligible Veterans, they reported that the VTC group had lower total number of arrests (34 compared to 44) and a lower recidivism rate (14% compared to 17%). In addition, Hartley and Baldwin (2019) also compared their

VTC graduates to VTC terminations and found that the Veterans who graduated has the lowest recidivism rate overall (8%) and the Veterans who were terminated from the VTC program had the highest recidivism rate (56%).

Outcome measures have also included community reintegration domains such as housing and employment indicators. In Caron's 2012 report which included 41 VTC graduates, 35% maintained their level of employment or student status throughout their VTC participation, and 19% increased their level of employment throughout their VTC participation. In terms of living situation, it was reported that among VTC graduates, 73% did not experience changes to their private residence status, and 15% increased their housing stability during the course of their VTC participation (Caron, 2012). In Johnson et al.'s 2017 study of 1,224 Veterans, lower rates of incarceration during VTC participation was more likely associated with having stable housing (compared to being homeless), and with program referrals to substance use treatment (which authors had noted that nearly all VTCs utilized this treatment approach). In the national study by Tsai et al. (2018), 58% of VTC participants were in private residence at program exit, which was an increase from 48% measured at VTC program admission. They also reported that 28% of VTC participants were employed at program exit compared to 27% at admission, and 50% were receiving VA benefits compared to 38% at admission (Tsai et al., 2018).

Given the delivery of a VTC and its use of sanctions and rewards, some outcomes for VTC participants can also take the form of increased jail sanctions, increased new arrests, and increased new incarcerations for VTC participants. Outcomes for an intensive program like the VTC where the VTC participant is subjected to more program requirements, more drug testing, and more careful surveillance by program officials also affords the VTC participant more opportunities to accumulate sanctions while remaining a program participant. In a 2016 study, researchers described predictors of program termination across 302 VTCs and Veterans' dockets in a treatment court and reported higher rates of termination were associated with phase progression based on measurable goals, programs that permitted post-plea Veterans, programs that accepted outside of jurisdiction Veterans, programs that conducted more frequent drug and alcohol testing, programs with more severe sanctions for meeting immediate goals versus long-term goals, and programs classified Veterans' courts as opposed to other treatment courts with Veterans dockets (Johnson et al., 2016). Johnson et al. (2016) also reported that lower rates of termination from these Veterans court programs included those programs that allowed National Guard/Reserve participants, programs that permit later phases to have less stringent testing, programs utilizing behavioral contracts, programs utilizing brief incarcerations, and programs that work closely with a VA Health Care Network. Increases in sanctions, arrests, and incarcerations were experienced by VTC participants when compared to non-treatment court participants in a national study (Tsai et al., 2017). While relapse and failure are components of the recovery and rehabilitation process for individuals in substance use treatment, some VTC programs may penalize relapse as a violation of program compliance and thus result in a participant's discharge from the VTC program. A retrospective study of 100 participants in the Harris County, Texas VTC reported that arrests after discharge from a VTC were predicted

by a prior diagnosis of opiate misuse as well as arrests during VTC enrollment (Johnson et al., 2015). Thus, some scholars have urged that VTC administrators examine ways of continuing enrollment for Veterans at highest risk of recidivism.

Criticisms of Veterans Treatment Courts

Despite the abundant positive attention lavished upon VTCs since their inception, plenty of observers criticize these courts for a variety of reasons. Some critics condemn VTCs for offering too many second chances to criminal court defendants. Others insist that VTCs are traps for the unwary, leading defendants to unwittingly forfeit basic legal rights. Still others allege that these courts, while well-intentioned, perpetuate stereotypes and stigmas that harm Veterans overall. Finally, some critics state that VTCs can establish a system of fundamental unfairness in statewide criminal justice structures, conferring some privileges upon certain defendants in particular jurisdictions that may not be available in neighboring jurisdictions. In this section, we summarize each of these common critiques.

Critique 1: Veterans Treatment Courts Offer Unnecessary Favoritism to Certain Criminals

Individuals and groups advancing this argument state that VTCs provide a particular group of lawbreakers with a baseless pathway to escape incarceration. To the surprise of many observers, the American Civil Liberties Union (ACLU) has strenuously objected to the creation of many VTCs (Shevory, 2011). According to the ACLU, these courts needlessly favor Veterans over other criminal court defendants whose traumatic life experiences are equally deserving of the treatment, mentorship, sustained assistance, and second chances that justice-involved Veterans receive in a VTC (Perlin, 2013). Barry Schaller opined that this model runs afoul of the Equal Protection Clause of the Fourteenth Amendment, stating that VTCs improperly offer privileges to Veterans because of "who they are rather than what they are accused of doing or what problems they have" (Schaller, 2012). Allison Jones raised similar concerns in a law review article that examined whether VTCs unjustly establish a special class of criminal court defendants, offering options to Veterans that are not available to civilians without a legitimate basis for doing so (Jones, 2014). A justice-involved Veteran with PTSD can receive a multitude of services in a VTC, Jones pointed out, while a civilian with equally severe PTSD does not receive these benefits and services, even if the civilian's PTSD directly contributed to that civilian committing the charged criminal offense.

Some commentators voice concerns that VTCs proliferated throughout the United States substantially because of emotionally patriotic responses, not because

empirical research solidly demonstrated that these courts truly possess the capacity to advance the public good (Baldwin & Brooke, 2019; Huskey, 2017; Jaafari, 2019). Julie Baldwin, the associate director for research for justice programs at American University in Washington, D.C., pointed out in 2019 that VTCs "evolved like many of the other specialty courts, just out of [judges who] believed there was a need from what they saw in their courtrooms … and it spread without scientific evaluation" (Jaafari, 2019). As we have previously discussed in this chapter, despite the fact that VTCs have existed for more than a decade, more empirical data about the efficacy of these courts remains scarce, leading to questions about why separate court dockets and special privileges for justice-involved Veterans should exist in the absence of clear signs that these courts are functioning in a manner that benefits society overall (Baldwin & Brooke, 2019; Jaafari, 2019; Rogers, 2018; Schaller, 2012).

Lastly, some critics consider VTCs acceptable conceptually, but object to these courts admitting certain categories of offenders (Jones, 2014; Kravetz, 2012). Pamela Kravetz, for instance, is one of many commentators arguing that VTCs should not accept Veterans charged with crimes of intimate partner violence (Kravetz, 2012). To Kravetz, and to other observers who echo her comments, "Veterans courts are a dangerous forum for intimate partner violence cases until reliable research has uncovered the complicated interplay between symptoms of combat trauma and domestic violence and evidence-based interventions have proved effective." Similar arguments exist from individuals who believe that VTCs should reject all cases involving the possession of a weapon, all cases involving any form of violent act by the defendant, and—in the views of some critics—all cases involving any felony offense (Arno, 2015; Cartwright, 2011; Cavanaugh, 2011; Merriam, 2015; Shah, 2014).

Critique 2: Veterans Treatment Courts Trap Veterans into Forfeiting Fundamental Rights

In a rare instance of uniformity, jurisdictions offering one or more VTCs legally view admission to such courts as a privilege, not a right (Merriam, 2015). Consequently, a justice-involved Veteran seeking to participate in a VTC must acquiesce to the conditions established by the leadership of that particular court. Commonly, these conditions may include entering a guilty plea for the crimes with which the Veteran has been charged (Baldwin, 2016; McMichael, 2011).

The National Association of Criminal Defense Lawyers objects to this practice, calling the requirement of pleading guilty "a forced waiver of rights" (Brown, 2012). These attorneys fear that a Veteran facing criminal charges will view a VTC as an "easy way out," far simpler than defending their case in a traditional criminal court, and will plead guilty to all of the offenses even if they are innocent of some or all of the charges. As a result, some members of the criminal defense bar object

that VTCs are a tool that prosecutors can use to rid themselves of complex criminal cases by enticing a Veteran into the VTC rather than engaging in a trial (Brown, 2012; Shah, 2014). This prevents such Veterans and their attorneys from presenting evidence and calling witnesses in their own defense, cross-examining hostile witnesses, confronting their accusers, demonstrating any existing violations in law enforcement practices, and other due process rights that a criminal court defendant would otherwise possess.

Other critics claim that VTCs are false friends to justice-involved Veterans, promising far more benefits than they could ever possibly deliver. Barry Schaller argues that “[c]ourts are not agencies created or equipped to solve the social problems of society through policymaking and delivery of social services” (Schaller, 2012). Again, due to the lack of empirical data nationwide regarding VTCs, it is difficult to definitively refute this claim that these courts are not fully equipped to provide the services and supports that encourages justice-involved Veterans to waive their due process rights in the first place. Notably, though, this critique does fail to acknowledge that the most effective VTCs do not attempt to manage all of these issues internally. On the contrary, a VTC’s success typically depends on the ability of the court to cultivate and utilize public sector and private sector partnerships with providers of these essential services (Renz, 2014; Russell, 2009; Shevory, 2011).

Critique 3: Veterans Treatment Courts Create Inequity Within the States Where They Exist

Only a handful of states have statutes governing the conduct of VTCs within their borders (Pomerance, 2019; Shah, 2014). Of these states, an even smaller number maintain laws that truly standardize and regulate the activities of VTCs. Thus, the vast majority of states lack statutory uniformity for their VTCs. While some commentators have discussed the desirability of enacting state laws containing standards by which all VTCs in the state must abide, such laws appear in only a minority of jurisdictions (Arno, 2015; Pomerance, 2019; Shah, 2014). So, when states lack statutory uniformity for VTCs, fundamental differences can—and do—exist between any two VTCs within the same state (Arno, 2015; Pomerance, 2019; Shah, 2014). For instance, one VTC may accept only justice-involved Veterans with an honorable discharge from the military, while a VTC in a neighboring county may welcome all Veterans regardless of their character of discharge. One VTC may be willing to admit Veterans charged with a violent felony offense, depending on the facts and circumstances of the case, while another VTC located only a few miles away may maintain an automatic ban on all cases involving an act of violence. The list of significant distinctions exists leading to extreme inconsistencies in the standards for admission, participation, and graduation among the VTCs in virtually any given state (Arno, 2015; Baldwin, 2016; Pomerance, 2019; Shah, 2014).

Even more complicated are situations where a Veteran's ability to access a VTC depends entirely on the county in which the Veteran is charged with the crime. In New York State, for example, a Veteran arrested in the Bronx may be eligible for entry into the Bronx County VTC. However, as of this writing, a Veteran arrested for the same crime only a few miles away across the border of Westchester County would not have this opportunity, as Westchester County has not created a VTC. States that do not establish a VTC in every county, and that fail to enact legislation allowing the transfer of a case from a traditional criminal court in a county with no VTC into a VTC in a nearby county, create a damaging inequity for justice-involved Veterans within their state (Pomerance, 2019). Access to the services, resources, and advantages of a VTC should not depend on the county within the state in which the Veteran happened to wind up in the criminal justice system.

Critique 4: Veterans Treatment Courts Encourage Unwanted Stigmatization of Veterans

Paradoxically, the courts that were created to focus on unique needs and take into account the unique experiences of Veterans run the risk of arousing undesirable social stereotypes about individuals who serve in the military. Yale Law School's Jerome N. Frank Legal Services Organization, for example, has criticized VTCs for perpetuating the wide military-civilian divide in the United States. "Veterans' courts prevent civilians from learning from Veterans and vice versa," stated members of this legal clinic in public testimony. "It is important for the general population to see Veterans so they can understand and sympathize with them. In addition, it is important for Veterans to witness civilians being held accountable for their actions." According to the members of this clinic, VTCs ran contrary to these goals by segregating Veterans from the other members of society. "When Veterans are secluded in Veterans' courts none of these observations and interactions can occur," the clinic's testimony concluded. "Moreover, Veterans' courts prevent reintegration by ghettoizing Veterans and secluding them from the general population" (Levy, 2015).

Other critics raise an equally concerning issue: the possibility that the widespread publicity surrounding VTCs perpetuate an all-too-common myth that the vast majority of Veterans struggle with mental health conditions, alcoholism or substance abuse, suicidal ideation, heightened risk of homelessness, criminal behavior, or are otherwise "broken" in some form. For instance, Anne Douds and Eileen Ahlin point out that "labeling a court a 'Veterans court' may lead some to speculate that the number of Veteran offenders is so disproportionally high that they need a new court just to process them" (Douds & Ahlin, 2019). Such assumptions can unjustly stigmatize not only justice-involved Veterans, but all Veterans, placing the people who served our country at risk of anti-Veteran discrimination by employers, landlords, creditors, and other individuals who believe that they are taking a

heightened risk whenever they engage in an interaction with a Veteran. Such prejudices toward Veterans already exist in multiple forms and forums throughout this nation (Perlin, 2013). Without question, every effort must be made to ensure that any initiative, no matter how well-intentioned, does not inflame the biases and assumptions that already exist throughout the United States concerning Veterans.

Conclusions

VTCs typically are able to tailor many of their methods to the needs presented in individual cases, this flexible system can be—for better and for worse—devoid of foundational standards. While certain attributes are common to the majority of VTCs, and the "Ten Key Components" drafted in Buffalo, NY, more than a decade ago remains a keystone document to which most of these courts look for guidance, the lack of standardization and consistency raises concerns among some commentators who fear that VTCs are too loosely constructed to meet their purported societal objectives. An overall lack of a strong empirical foundation from evaluations of these courts creates concerns that the growth and development of VTCs is based largely on popular sentiment rather than evidence-based practices. Although a handful of states have enacted statutes standardizing eligibility requirements, standards for participation, and graduation requirements, the majority of jurisdictions do not have such laws. Again, this leads to substantial variances among the VTCs in the states without a governing statute, meaning that two VTCs in neighboring counties are permitted to implement and maintain entirely different procedures and standards. As we have presented in this chapter, the implementation of these well-intentioned problem-solving courts does not come without legitimate concerns.

Despite these critiques, this still-young judicial movement offers plenty of life-changing benefits for their participants and graduates, and thus provides substantial hope for their future. Given the extremes to which many members of the military are subjected during their service, a program insisting that these individuals are not abandoned by their government's justice system when they struggle during their reintegration to civilian life is not only reasonable, but ethically and morally imperative. VTCs appear to offer plenty of praiseworthy benefits for justice-involved Veterans throughout this country, including suggestions for cost-savings by way of carefully tailored rehabilitation rather than widespread incarceration and social benefits on the class of Veterans who have served the United States. Graduates of VTCs have perceived the program to be life-changing and have expressed gratitude toward the VTC treatment team, the path toward treatment readiness, and the success of their civilian reintegration (McCall, Rodriguez, Barnisin-Lange, & Gordon, 2019; Montgomery & Olson, 2018). A treatment-based approach focusing on the unique aspects and impacts of military service fulfills two basic premises of justice: to ensure that the full story of an individual charged with a crime is heard by the court and to provide a framework in which eligible individuals receive the best

possible opportunity for genuine rehabilitation. Thus, the VTC as a widely popular, innovative, multi-faceted, and individualized treatment program further encourages the pursuit of increased understanding and evaluation of its components, and the enhanced pursuit of a fair balance between individualization and standardization, particularly as VTCs continue to rapidly proliferate across the country.

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