Chapter 7
Specialized Housing Units for Veterans Incarcerated in United States Prisons and Jails

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> When you combine the two factors, the factor of service in the military of this country… with the problems that go with the removal from society for crimes of one sort or another, you have a very vulnerable population, a population which in my opinion deserves not to be forgotten.
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> Statement of Hon. George E. Brown, Jr. of California during the hearings on *Incarcerated Veterans Rehabilitation and Readjustment Act* of 1989.

Manny is a 33-year-old Army veteran who deployed twice to Afghanistan over the course of 4 years in support of Operation Enduring Freedom (OEF). On his last deployment in 2012, he was "blown up" twice before he redeployed from theater to Walter Reed for recovery. Although Manny was recommended for extended treatment and enrollment in a Warrior Transition Unit (WTU) to focus on the Posttraumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) he sustained in Afghanistan, Manny's command hoped to return him to combat operations as quickly as possible given his specialized training and experience. Manny was placed on deployment orders to return to Afghanistan with his unit during the upcoming rotation in 2 months. Based on severe physical pain, Manny developed an opiate addiction. To sleep without memories of his combat experiences and lost comrades, Manny regularly consumed a case of beer each night until he slept due to fatigue and drunkenness. On the day of his scheduled deployment, Manny had overdosed on pain medications and alcohol and missed the movement of his unit. The command told him they were doing Manny a favor by urging him to accept an administrative discharge rather than court-martialing him. Manny was separated with an Other Than Honorable Discharge for Missing Movement, Disobeying an Order, and committing an act Prejudicial to Good Order and Discipline in the

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Armed Forces. All of these were purely military offenses with no comparable civilian crimes.

As is the case with an estimated 20% of justice-involved veterans (Rosenthal & McGuire, 2013), Manny's discharge characterization prevented him from obtaining disability compensation and comprehensive healthcare from the Department of Veterans Affairs (VA). Manny continued to experience severe symptoms, which began to affect his wife, Jasmine, and his toddler, Maxwell. In a moment of alcohol induced rage at his inability to obtain employment, Manny threw a bottle that shattered against the wall above Jasmine's head, permanently blinding her in her left eye. Manny was charged with felony domestic violence and, despite being considered for a local Veterans Treatment Court (VTC) where some of the treatment team members desired his participation, Manny was ultimately rejected from the program based on is discharge characterization. Although that VTC had in the past accepted felons and domestic violence perpetrators, the treatment team decided they did not want to violate the program's universal prohibition on enrolling participants who did not have discharges under honorable conditions.

Manny was incarcerated in a prison nicknamed "Gladiator School" based on its reputation for brutality and rampant gang involvement. Manny's exposure to the confined setting and acts of extortion, forced prostitution, and gang violence among members of the general population reminded Manny of life in a combat zone in Afghanistan—a "second tour" in which Manny had a set period during which he had to be subject to these conditions, he faced the threat of death and danger at all times, he was forced to adhere to specific rules for survival including being at the lowest level of a hierarchy of power, etc. Manny also experienced various triggers for his PTSD symptoms, including the sounds of victims of violence crying at night in their nearby cells like wounded comrades in Afghanistan and the sound of the automatically locking cell doors, which was not so different than automatic machine-gun fire. At times, Manny wanted to ask for help or medication to rid himself of these symptoms, except he knew that knowledge of visits to mental health can draw unwanted attention and perceptions of weakness and vulnerability to inmates who had more power and influence. Manny began to feel that his only method of surviving incarceration would be to align himself with a gang, which seemed similar to a military unit, aside from the drug dealing, extortion, and other illegal acts.

This illustration of an incarcerated combat veteran and his backstory is a composite of many stories we heard while working on a veteran's dorm in a Connecticut prison where a number of consistent patterns emerged: drug and alcohol addiction following combat and noncombat military service; subsequent and, in some cases temporary, loss of family support; history of trauma at some point in the course of their lives; turbulent relationships; outbursts of violent or self-destructive behavior; and insufficient resources in prisons and jails to support the needs of those who are incarcerated. We are far from alone in realizing the complex set of problems and needs veterans face before, during, and after their involvement with the criminal justice system. At least 24 states around the country have opened all-veterans units in jails and prisons at the local, state, and federal level in order to address the unsettling social problem of incarcerating veterans whose military service to their coun-

try may have contributed to drug addiction, poverty, mental health problems, and social isolation, all of which increase the risk of involvement with the criminal justice system (Seamone, 2016).

There have been major challenges to providing needed mental health and substance abuse treatment for incarcerated veterans. Glynn et al. (2016) noted that less than 60% of treatment offered in prison for substance use disorders is evidence-based. Similarly, trauma treatment has been almost non-existent despite the extremely high levels of trauma exposure in the prison population. With growing concern regarding recidivism, prisons have become increasingly open to innovation in treatment (Miller & Najavits, 2012). In this chapter, we will provide a general overview of how these units came to be, the philosophical perspectives which have informed them, and the various forms they take in different facilities around the country. By looking at examples from existing units, we will discuss patterns that emerge among the units and prevalent themes in their designs. Readers will also gain an understanding of the population served by these units in terms of demographics, experiences, and needs following release from prison. In addition, we will address what is currently known about outcomes following veterans' participation in the dorms. Given the relatively recent development of specialized veterans units, we will identify areas of study which would benefit from further exploration over time.

Genesis and Underlying Principles

A Brief History of Veterans in Prison

The idea to gather incarcerated veterans together for the purpose of appropriate treatment and rehabilitation is not a new one, despite minimal attention to the issue in contemporary discourse. According to Seamone (2013), a legal scholar, practicing attorney, and major in the U.S. Army Reserve, efforts to address the specific needs of incarcerated veterans goes back to the period following World War I, when it became clear that veterans were suffering and having difficulty readjusting after returning from combat. In addition to a thorough history (2013), Seamone (2016) also summarized some important historical considerations for incarcerated veterans in an educational webinar. Seamone (2013, 2016) pointed to an article published in the American Legion (Casey, 1923), which directly addressed the issue and used the example of efforts in Wisconsin, where "fully 25% of all prisoners in the state prison system were former soldiers, and in 20% of the case the crime was attributable in some way to military life" (Severo, Miller, Milford, Sheehan-Miles, & Ebook Library, 2016, p. 192).

Casey (1923) wrote that Governor Blaine of Wisconsin was so perturbed by incidents of veterans being incarcerated, largely for petty property crimes committed for purposes of meeting basic needs (Severo et al., 2016, p. 192), that he

commissioned a study by two veterans with expertise in psychiatric care, W. F. Lorenz and W. S. Middleton. The findings were clear:

> Nothing in war is uplifting, at least not for the humbler participants. Those who actually got into battle and witnessed or took part in the dreadfulness of war may later in civil life have committed some overt act which by comparison with compulsory military duty seemed inconsequential. That such cases might be regarded in the light of war experiences brought into civil life requires no great stretch of the imagination (Casey, 1923).

Given this, it was their position that specialized prison units for veterans would be essential to address the set of issues that brought them into the justice system and help them to secure employment opportunities.

Going back as far as the 1920s, veterans were struggling with very similar issues to those witnessed today, and it was also in the 20s that the first iteration of what we now know as the Department of Veterans Affairs (VA) was created. Many veterans were battling substance use problems with alcohol, which was an illicit substance at the time under the Volstead Act, as well as physical and mental health issues related to combat. According to Casey's article, the Wisconsin study concluded decisively that veterans who were incarcerated needed treatment and that their military experiences necessitated that this be done by keeping veterans together in a space or unit while they were completing their sentences and receiving the targeted assistance they required. It is not clear to what extent this vision was ever realized.

Following World War II (WWII), further efforts were made on this front. The VA, formally enacted by Herbert Hoover in 1930, began to provide outreach and counselors to incarcerated veterans for a period of time. In addition, Seamone (2016) described a program in an Indiana correctional institution, Indiana State Farm at Green Castle, where veterans were encouraged to become more fully engaged in civic life following their stark removal from it during war time (Virgil & Hawkins, 1946). The program encouraged veterans to process their reintegration to the community and even connected them with veterans who were not incarcerated to foster connection and mentorship. Peer support has continued to be an important aspect of healing the wounds of war and has been a component of all the veterans' programs prisons being developed today, which we will address that in more detail later in the chapter.

While the aftermath of WWII brought with it a deep respect for what came to be known as "the great generation" and, thus, some meaningful efforts to support and address the difficulties experienced by returning troops, things changed when it was time to confront the aftermath of the Vietnam War and the soldiers it so profoundly impacted. Returning soldiers, who experienced myriad psychosocial stressors and a largely hostile public, struggled considerably to adapt to civilian life (MacPherson, 1993). According to Severo et al. (2016), upwards of 100,000 Vietnam veterans were addicted to opiates or alcohol and 80% of them were receiving no treatment at all; most didn't even know they were entitled to benefits. Unemployment was rampant and, once again, poverty and drug addiction were factors in the lives of veterans who found themselves ensnared by the criminal justice system. During the 70s, benefits provided through the Veterans Benefits Administration (VBA) were not

expanded to meet these emergent needs. Rather, Nixon prevented funding for more doctors and cut monies which had been allocated to vocational rehabilitation (Severo et al., 2016).

Troubles for incarcerated veterans continued. In 1977 hearings in congress on the *Veterans Education and Readjustment Act* addressed, in part, the provision of educational opportunities and services to veterans during prison sentences. One individual, Howard S. Steed, who was the president of a college interested in providing educational services, stated that he saw providing services to veterans in prison as one strategy for "attacking this high rate of recidivism" (United States Congress, 1977). Despite these efforts, educational resources and access to GI Bill and other student aid while incarcerated remained restricted at the time. Seamone (2016) referred to the commonly held belief that veterans who were incarcerated could not be trusted to use educational monies for their intended purpose, which could be one reason for why funding was denied again in 1991 when the *Incarcerated Veterans Rehabilitation and Readjustment Act*, which would have additionally held "the Federal Bureau of Prison… responsible for the psychological treatment of veterans incarcerated within their facilities," (Sigafoos, 1994, p. 118) failed to pass, in part due to opposition from the VA. That said, a number of important points were raised throughout hearings on this issue, including the idea that treating the "psychological readjustment" issues that led to incarceration would reduce recidivism.

The VA's role over time has not always been positive when it comes to the matter of incarcerated veterans. Seamone (2016) explained the timeline, beginning in the 50s, when some VHA medical centers refused to serve veterans with felony records. While this changed for a time, in 1986 the VHA's regulations shifted and they were no longer "required" to provide services to incarcerated veterans. Worse still, in 1999, the VHA was legally restricted from providing direct healthcare services to veterans due to duplication of services presumed to be the responsibility of departments of corrections (Glynn et al., 2016). This bar on providing services includes all healthcare and psychological services, which can mean that veterans, with their specific set of treatment needs, may not have access to adequately trained providers. Ultimately, Congress intervened to expand options for addressing incarcerated veterans' needs with attention to post-incarceration transition. According to Pinals (2010),

> Congress has recognized the critical importance of understanding the special needs of veterans in the criminal justice system and, in 2001, passed a law mandating the Veterans Health Administration (VHA) to develop a coordinated plan with the Under Secretary for Health for veterans at risk of homelessness who are released from incarceration. This mandate contributed to the development of the VHA Health Care for Re-entry Veterans (HCRV) program.

This program continues today and has provided incarcerated veterans with case management services toward the end of their sentences, such as linkages to medical, mental health, and financial resources, to aide in their re-entry to the community following incarceration.

All of this history is helpful to understanding contemporary efforts to support veterans while they are in prison through the development of specialized veterans

units within local, state, and federal correctional institutions. Since New York Department of Corrections (NYDOC) began their program, the longest running, in 1987, upwards of 24 states have implemented these units in some form. Seamone (2016) stated that there is a strong connection to VTCs, which are the subject of a subsequent chapter in this book. VTCs were essential in raising awareness of the issues facing veterans who are now returning home from Operation Enduring Freedom (IEF) and Operation Iraqi Freedom (OIF). Like VTCs, these units emphasize rehabilitation over punishment; utilization staff who are familiar with military culture and, often times, who have served in the US Military; involvement of the VHA for care coordination; the development of partnerships with other non-governmental organizations, such as counseling centers, universities, and Veterans Service Organizations (VSOs) in order to connect veterans to services which will address underlying issues which brought them into the criminal justice system; and use of peer mentors (Seamone et al., 2014).

The distinction between prisons and jails is also notable and worth exploring to better understand how these programs function. Jails house individuals who are awaiting trial or transfer to other facilities for shorter periods of time and it is therefore difficult to address any long-standing concerns and long-term needs; on average, jail inmates are only there for a few weeks and usually not longer than a month. Given this, our research indicates there are fewer jail-based veterans units with inmates taking on defined leadership roles. Their function is really to stabilize acute emergencies and provide support in a stressful time rather than to address the impact of service-related trauma. Jails are, however, uniquely poised to more quickly make changes, like specialized dorms. This is because prisons, part of complex state and federal systems, often take a great deal of time to coordinate and gain permission from various levels of administration before implementing new programs and initiatives. It is in the prisons where the greatest opportunity to address issues and needs in a more meaningful way and, theoretically, to obtain more long-lasting results. Veterans units can focus on creating institutional knowledge through the ongoing participation of those with longer or even life sentences.

Philosophy and Objectives of Specialized Veterans Units

As discussed, efforts to address the intersection of military service and incarceration have been made going back to the aftermath of WWI. They've included the Indiana State Farm at Green Castle in the 1940s (Virgil & Hawkins, 1946), the Veterans in Prison (VIP) program, launched by the Southern California Brentwood VHA healthcare center in 1977 (Pentland & Scurfield, 1982), the Second Tour Program at the federal prison in Phoenix (Sigafoos, 1994), and the Veterans Residential Therapeutic Program at Groveland Correctional Facility run by the NYDOC (1994), among others outside of our knowledge. These programs, among others in jails and prisons, have been a way to gather people with a similar set of needs together in one place so that resources can be provided in the most efficient way in order to address

underlying problems that may have led to incarceration in the first place. Prisons have not limited these types of programs to veterans alone. Rather, they have developed dorms for individuals who are committed to earning GEDs, have an interest in practicing a certain faith tradition while incarcerated, and for those who would benefit from support in developing fatherhood skills, among others. For veterans, supporters of this concept have suggested that the dorms may be able to meet any number of objectives and provide the unique, often only, opportunity to meaningfully engage with veteran-specific psychological and readjustment concerns.

First, it's important to note some unifying themes which exist in all or most units. Among the veterans dorms that we know of, certain common themes have emerged, many of which have been highlighted in the National Institute of Corrections' handbook (Vanek, Brown, Busby, Amos, & Crawford, 2018) on "veteran-specific housing units." Military culture is fostered in a number of ways: visually, units have murals on the walls; enforcement of strict rules with emphasis on good behavior; memorials and monuments to honor veterans; special uniforms to increase pride; or even through participation in military rituals, like color guard. The atmosphere in veterans units is consistently structured, as well, and veterans are encouraged to connect to one another and embrace the commonality of their experiences while holding a high standard for conduct, ideally by honoring confidentiality. Leadership training encourages personal responsibility and accountability, and veterans are given work duties, like service dog training, unit maintenance, peer support, and many more. Interaction with the community is also fairly consistent in terms of providing service and including veterans from the community, including placing staff with military experience on units, and inviting community members in to mentor and help with the transition out of prison. Units also aim to provide access to real resources to facilitate smoother and more productive transitions, hopefully permanent ones, back to the community and to offer programming that will be of particular benefit or interest to veterans.

Approaches to Veterans Units: Four Models

There are a variety of models which have been implemented around the country, so the attributes discussed thus far may not all come together in any given program due to some inherent contradictions. As an example, at the first and only veterans unit in Connecticut, many veterans reported feeling distressed by the military themes and emphasis on creating an environment reminiscent of the military. For those who expressed that opinion, it brought them back in the frame of mind they had during the military, which for many was traumatic. Randall Liberty, the sheriff who ran a veterans' dorm in Kennebec County, Maine, was sensitive to this tension in noting the inherent difficulty of creating a military environment while also expecting veterans to work through their trauma and difficulties when he said, "There is a culture of suffer in silence. You suck it up and take the pain. That's a behavior that serves us well in combat, but when you get out, that mentality unfortunately continues to be

adopted" (Schroeder, 2013). Liberty has advocated for something he calls 'purpose-driven incarceration' (Vanek et al., 2018, p. 11), which incorporates the principle of acknowledging service but also tailoring interventions to help veterans cope with the impact of combat-related trauma. For instance, he implemented a fly-fishing course to help with concentration difficulties secondary to trauma.

Veterans may come with vastly different experiences and thus potentially divergent needs, and therefore institutions may adopt models which emphasize military culture on a spectrum ranging from very central to more of theme in the background. Sociologist William Brown has written about the possible harms of overdoing the military culture aspect of these dorms and pointed out that the most important thing should be to encourage assimilation to civilian life (Ferdman, 2018). While there may be some disagreement about this tension between military culture and trauma triggers, Rosenthal and McGuire (2013) noted, "Regardless of whether in combat or not, each incarcerated veteran carries with him or her a military history and a sense of service to the country" (p. 345). The models described in this section highlight the various ways in which prisons have taken this tension into consideration in working to address veterans' needs while incarcerated.

Readjustment Model: "Second Tour"

Dorms which have used this model have emphasized structure, organization, and reeducation on psychological impacts of military service and readjustment to civilian life. Seamone (2016) described the overarching objective of the model to be the development by veterans of an understanding of how the prison experience may overlap with experiences of confinement (taking orders, limited privacy, temporarily losing control of one's life, and being in the presence of danger and physical threat) and using that knowledge to prepare, in vivo, for community reintegration. Based on implementation at Indiana State Farm (Virgil & Hawkins, 1946) and the "Second Tour" program at FCI Phoenix (Sigafoos, 1994), the structure has been described as a "captive audience" and is thought to help retrain veterans to better understand how their military service impacted their psychology and behavior (Seamone, 2016). As Seamone notes elsewhere in this volume, one benefit of being a captive audience is "time to spare, [giving] incarcerated veterans … a competitive advantage over non-incarcerated veterans to effectively obtain discharge upgrades" (p. 30). Programs which have utilized this model differentiate between combat and non-combat veterans in order to tailor psychoeducational efforts to groups who may have been impacted differently while at the same time keeping the program open to veterans with any type of military service, including non-military contractors. The approach may vary for combat veterans given the understanding that they will need more assistance in understanding how extended time in fight or flight can cause significant legal and personal problems once out of the war zone. Readjustment-oriented units have also taken a longer-term vision, aiming to connect veterans with mentors in the community after their release. A last feature is the "squad orienta-

tion" through which veterans are offered mutual support and shared learning as they move through the program, in many ways replicating the brotherhood and comradery often associated with military service.

Trauma-Informed Approach: PTSD Model

Seamone (2016) outlined an approach which has focused on addressing combat trauma and PTSD in a more targeted way. For reference, this type of model was used by the FCI Phoenix and the Southern California VIP programs. Under this model, mental health providers offer trauma services in institutional settings, sometimes with the assistance of consultation from VHA. This consultation is important to note because it is the only way VHA can be involved given the 1999 bar on VHA services in prisons; it has meant that, despite the specialized training that VHA mental health providers receive, they are unable to directly assist with issues as they arise in a prison setting. For this reason, units which aim to tackle issues connected to trauma have collaborated extensively, at times, with VHA, even so far as to gain medical records, with the veteran's approval, to contextualize care. In addition, the VA may provide training to prison staff and providers on effective and evidence-based approaches to working with veterans (Seamone, 2016).

The PTSD treatment model, not surprisingly, is heavily reliant on the creation of therapeutic settings and both individual and group treatment. Stabilization of PTSD symptoms and the development coping skills are two objectives of the programs and veterans are encouraged to "make meaning" of their military service, in part through addressing beliefs about the campaigns in which they participated. Additionally, families are included where possible so that PTSD's impact on relationships can be explored and processed with the veteran's support system.

The PTSD model does not restrict access only to those who meet criterion outlined in DSM-5 for PTSD due to a need for flexibility and acknowledgement of the various ways trauma responses can manifest behaviorally and psychologically. Rosenthal and McGuire (2013) referred to an acronym, BATTLEMIND, to define some of the specific ways that veterans suffer in civilian life for having adapted to an entirely different context through their military training and service. What may have been adaptive and necessary during war time or military training can manifest quite differently in day-to-day life back home. For example, the ability and need to make split-second decisions about whether or not to act is something that would help a soldier in combat to maintain a protective stance but may appear more like impulsivity, anger, and disproportionate response outside of the conditions of war. Similarly, a soldier is trained to have a weapon at all times in combat, which may pose additional challenges when back home and struggling with hypervigilance and a reduced threshold for anger. Given this, specialized veterans' units have a role to play in acknowledging and providing additional services to those who may not have had effective reentry counseling, if any at all, especially as more and more soldiers return from OIF and OEF.

Community Re-entry

Reentry models purposefully select veterans who are near to the end of their sentences, generally 3 years or less, because appropriate time to prepare for transition and to make linkages to community resources. The transition from prison to the community is known to be rife with material and emotional pitfalls, which often contribute to recidivism. This model is also seen as valuable because veterans may have to wait to gain residence on such units while serving out their sentences in general population, which is seen as incentive for good behavior. Veterans in community re-entry dorms are not expected to be engaged in long term treatment or trained in leadership roles on the unit. Rather, this model is based on the incentive of obtaining mental and physical healthcare and potentially vocational or economic resources, including housing for homeless veterans (Seamone, 2016). This makes it an ideal setting for HCRV, the VHA's program for connecting incarcerated veterans to VHA services upon release from prison, to perform outreach and provide this type of case management. Given the short time frame of these programs, it can be difficult to apply and determine eligibility for VHA services and VBA benefits. Per Seamone (2016) reentry dorms could potentially be less useful for those who are not VA-eligible. Possible solutions could include prioritizing the connection to VSOs who work with those who aren't eligible; building and maintaining ongoing relationships non-profits to help with employment and housing; and utilization of prison staff to assist with applications for state benefits, like Medicaid and SNAP, along with Social Security.

"Espirit De Corps" Model

Seamone (2016) called the *espirit de corps* model the equivalent of "barracks behind bars." These units and those that run them foster discipline, reward for military experience, and tend to be friendlier to those that both had honorable discharges and who are not dealing with significant trauma issues, as this type of military environment can be triggering for many, as previously noted. In such dorms, like those in Florida and Virginia's state prisons, military murals are prominent, as they may be in other dorm styles, as well; special uniforms are worn; clear roles are assigned; and military ceremonies and rituals are enacted with regularity. The value of this model is in its capacity to energize, foster pride, and encourage a sense of purpose for those veterans who live there.

Possible benefits of participation in any of these units are hard to ignore and correctional systems around the country are increasingly seeing the potential they offer. Seamone (2016) cited cost-savings through the provision of resources in one place; the improvement behavior through therapeutic approach, which could increase officer safety and ultimately public safety should veterans improve the conditions that brought them to prison; a decrease in officer stress by fostering a more respectful environment; and the ability to observe behavioral changes more quickly in a communal atmosphere. Seamone and Albright (2017) also pointed out the intense

experience of shame given that "Service members and veterans typically hold themselves to extremely high standards in recognition of the responsibility for safeguarding the nation" (p. 486). These units are able to address this shame by offering some sense of pride and belonging among veterans. While public sentiment toward those labeled criminals and felons has long been hardened in the United States, this notable interest in rehabilitation promises potentially different results as outcomes are studied. Veterans units are, for now, a test subject in uncovering improvements that may truly benefit both those that have served their country as well as the general public.

Existence of Specialized Veterans Units Nationally

While increasingly prevalent, there are relatively few veterans dorms considering the need and promise they present. Based on research by Jessica Blue-Howells and incorporated by Seamone (2016) there were 24 states with veterans units in either a local, state, or federal jail or prison in 2016 with only two in federal facilities, Florida and West Virginia. According to the National Institute of Corrections (2018), there are at least 84 units around the country. While they are sometimes called "specialized housing units," other times "pods," "wings," "blocks," "units," "dorms," and other labels, they have been developed at a steady pace as word has spread about their benefits. For our purposes, we will highlight a small percentage of programs around the country where many of the themes and practices described above are taking place in real time.

We want to first draw attention the program in Connecticut at Cybulski Correctional Institution because it is the basis for much of our interest in and knowledge of veterans dorms, having assisted with the development of the unit and ongoing implementation of programming and structure. The dorm, the product of collaboration among state and federal agencies, opened in the fall of 2015 and was developed in an effort to not only help veterans be successful following incarceration by streamlining and consolidating service. In line with the re-entry model described above, the Veterans Service Unit at Cybulski is made up primarily of veterans who are close to the end of their sentences or who had short sentences to begin with. This is partly because the unit is located in a minimum-security prison where individuals with more serious charges or intensive treatment needs are restricted entirely. The program itself, however, is largely based on the idea of providing community resources so that veterans can connect with the VHA, BVA, and other services in order to be more successful when they are released. It is the primary function of the unit to assist with and execute re-entry plans, which are facilitated by both VHA social workers and DOC staff, depending on whether or not the veteran is eligible for VHA benefits. The unit also has a strong emphasis on educational and vocational development and partnered with the Connecticut Department of Labor to provide employment services and with local schools to enroll veterans in training courses.

While the Cybulski program does offer ongoing group treatment, primarily for substance use disorders, it would not be considered a treatment-specific program. This is in part because the facility is not equipped to deal with complex and intensive mental health treatment for trauma or other disorders and in part because of the short-term nature of the program. A recent news report on a veterans dorm called HUMV in a county jail in Billerica, Massachusetts highlighted the two primary components of that program, which were described to be a "hyper-structured setting" and the provision of mandatory group and individual treatment for underlying mental health and substance use issues (Ferdman, 2018). The program, like Cybulski, is operated at very little cost with most additional services provided on a voluntary basis. For instance, it costs no additional money to have professionals from the VHA come in as a consultant or to provide case management services, nor would funding be required to integrate veteran mentors from the community. It should be remembered that VHA is barred by federal regulation from offering direct healthcare to incarcerated veterans, which imposes several limitations on service delivery.

Perhaps because of its early adoption of veterans prison units in 1987, the New York corrections system has a comprehensive system to address the needs of veterans tailored to meet veterans at a number of levels of need. Based on the DOC website, all New York State facilities coordinate with the VHA for connection to services and obtain copies of Certificates of Release or Discharges from Active Duty (DD 214s) for veteran inmates. At 14 prisons, there are veterans organizations that foster that "squad mentality" identified by Sigafoos (1994) as extremely helpful in adjusting to prison, treatment, and, ultimately, assimilation to civilian life. Veterans gather, participate in educational groups, and take part in military ceremonies and memorials. The system also has three prisons with veterans dorms, Veterans Residential Therapeutic Programs, in which veterans spend 6 months addressing readjustment issues and getting treatment for substance use, anger, aggression, and PTSD. Veterans are also connected with community providers to help counteract the inhibiting factor of power dynamics which exist in the prison setting and may preclude the "therapeutic" aspect of programming, at times. Of note, the Albany unit is known to avoid the use of military rituals and ceremonies in favor of a more assimilation-based model.

The task of describing the entire scope of operational veterans units is a large one, so we offer some final observations on noteworthy aspects of a smaller selection. For instance, the Stafford Creek Corrections Center Veteran Unit in Washington State has provided veterans an opportunity to train abandoned dogs so that they can become adoptable pets. The program has trained dozens of dogs and has been met with praise from veterans, the prison staff, and the families who are getting well-trained dogs. This is another example of a trauma-informed intervention given what is known about the therapeutic elements of animal therapy for individuals with PTSD. The San Bruno veterans unit in San Diego has provided veterans with extra perks, like the ability to obtain more comfortable bedding and the provision of televisions. There, veterans are able to take yoga classes, participate in a program to videotape themselves reading so they can connect with their children, and, like

other units, mandates participation in treatment. Units in Erie, Pennsylvania, and Kennebec, Maine, among others, are connected directly with VTCs so that those whose treatment options don't adequately address the problem have a plan once incarcerated.

In all of the programs we have reached out to or read about in the process of researching this phenomenon, we have found a deep personal connection to the military among those who spent their time and energy advocating for incarcerated veterans to have a more treatment-focused experience. In Kennebec, Warden Randall Liberty, a veteran himself, experienced personal loss and sought to fulfill a "moral duty" to provide veterans with care after they have returned from deployments (Schroeder, 2013). In Connecticut, many of the staff, including a critically involved deputy warden, had personal ties to the military and had their own experiences with the grief and loss suffered by veterans and their families in the aftermath of war. In each unit, there are staff who have themselves served in the military and are now working to view veterans in the justice system in a more holistic, healing way.

Participant Characteristics and Preliminary Outcomes

While the percentage of veterans in prison has vastly declined since the Vietnam era along with the reduction in troops, the most recent reports estimated that 8% of inmates in state and federal prisons and local jails are veterans (Bronson, Carson, Noonan, & Berzofsky, 2015), many of whom have significant trauma histories; one study in two states found that 93% of their incarcerated veterans reported a history of trauma (Hartwell et al., 2014), and the Bureau of Justice Statistics has also reported that nearly all justice-involved veterans have experienced some type of trauma, including military and non-military related trauma (Noonan & Mumola, 2007). According to Bronson et al. (2015), in 2011–2012, nearly half of all incarcerated veterans reported that they were either told they had a mental health disorder by a professional or formally diagnosed with one, and nearly twice as many veterans, 23%, reported they had been told they had PTSD compared to non-veterans. In addition, 64% of incarcerated veterans were serving time for violent crimes compared to 48% in the nonveteran population (Bronson et al., 2015). Estimates of the prevalence of mental disorders have been far from exact. For example, one review estimated that 13–62% reported having a mental health problem of any kind, 21–71% for alcohol, and 26–65% for drug use (Blodgett et al., 2015).

Incarcerated veterans were "more likely… to be white, older, more educated, and to have been married" (Bronson et al., 2015). The majority were discharged between 1974 and 2000, had served in the army (55% compared to roughly 20% in Marine Corps and Navy), and had done so for less than 3 years. Most veterans reported that they had not experienced combat (75% in prison and 69% in jail) (Bronson et al., 2015). Records have also indicated that the vast majority of veterans in prison were discharged with honorable or general under honorable conditions military discharges, which has been surprising to some who assume deviant behavior in the

military was a precursor to involvement in the criminal justice system. The minority of veterans with less-than-honorable conditions discharges is still substantial at 20% posing special considerations for discharge upgrading during the course of confinement (Seamone, this volume).

Additionally, it should be noted that veterans are often prepared with job training and skills during their time in the military, as well as the minimum requirement of a high school diploma or GED, which are strengths when considering opportunities for vocational development. With ever-changing statistics on who is impacted by PTSD and depression following service and with the wars in Iraq and Afghanistan still going on, it is essential to continue work to understand the complex set of issues that are related to combat exposure, PTSD, and the criminal justice system. Rosenthal and McGuire (2013) noted, according to the Institute for Operations Research and the Management Sciences in 2009, "it is estimated that veterans of the Iraq and Afghanistan wars will have a rate of PTSD as high as 35%." It has also been understood that veterans service longer prison sentences overall than their nonveteran counterparts (Rosenthal & McGuire, 2013).

It is more difficult to know the demographics of the veterans who have participated in veterans dorms, although, in 2017, Tsai and Goggin asked veterans living in the unit at Cybulski about their perceptions of needs and their particular challenges, as well as demographics. Compared to the national statistics, there were higher rates of substance use and mental health issues reported with 45% reporting a substance use disorder and 30% reporting PTSD. The Connecticut DOC's own numbers based on their intake assessments had the rates of mental health diagnosis at 63% and substance use diagnosis of any kind at 84% within months of administering the survey. While this data is far from generalizable, it does point to a least a very high prevalence of psychological issues in one veterans' unit. From this research a picture of individuals struggling under the weight of poverty also emerged. Out of the 87 who participated, 52% said they needed help with obtaining housing and 57% reported that they had needed help to pay utilities prior to incarceration. Even larger numbers (72% and 64%, respectively) reported that they needed access to healthcare and dental care. Perhaps most disturbing, roughly 70% of respondents said they had been unable to afford food and basic clothing. This snapshot of the impact of poverty on veterans is widely replicated among all prison populations nationally and here we can see veterans are no exception.

Again, because of our familiarity with the veterans unit in Connecticut, we believe it may be helpful to offer a brief overview of qualitative feedback, obtained from quality-improvement questionnaires completed by those residing in the unit. Individuals shared that they considered physical fitness and "fresh air" primary needs given the sedentary nature of prison life. In this particular program, veterans wanted to be able to have assurances that they would be able to get outside, even if the weather was not cooperative. On the survey, one veteran wrote, "Fitness has always been a big part of my life. It keeps me level-headed and balanced. Helps with combat related stress and PTSD. This is a must for future success. I would like to see more weight room implemented." Responses about fitness and activity frequently focused on the mental and physical challenges of inactivity, such as bore-

dom, ill health, and possible negative impacts on mental health. Veterans also expressed strong desires to receive mental health and substance use treatment that they hadn't received on the outside and stressed the importance of vocation in their recoveries. With great frequency, veterans mentioned the cleanliness, order, and "brotherhood" that the dorm offered to them while numerous others reported feeling that the gathering of VA eligible and non-eligible, as well as combat and non-combat, veterans together was problematic because of resentments and ensuing divisions. This seemed to be an area of disagreement among respondents. Altogether, 60.5% of veterans said this unit was preferable to other units and over 50% said they felt safer and more prepared for reentry having participated in the program.

Early longitudinal data on recidivism points to successes among these fledgling veterans units, perhaps in large part due to the emphasis on connecting veterans to healthcare, housing, vocational training and other basic resources. Preliminary outcomes data revealed that out of the 117 veterans who had been released after spending at least a month in the program, only 5 were rearrested since 2016. For the rest of the state, the recidivism rate is closer to 70% over a 3-year period (Ferdman, 2018). Similarly, in Albany, in the first 2 years of the program, 195 veterans went through the unit and only 10 had returned. Back in 1994 when the Groveland unit was evaluated, it was determined that the recidivism rate among the veterans who completed the program was at 6.1% compared to 40.57% for veterans who didn't participate and 51.85% in the general population. We also know that the HCRV program run by the VHA, which is interactive with most veterans units in some form, has demonstrated its value; connecting veterans to VHA services post release "has been shown to be associated with a reduction in the risk of death for veterans when they are released from prison" (Blodgett et al., 2015). While this may seem dramatic, we believe it sets the stage for the high stakes nature of this endeavor with this population and the importance of bringing veterans together to best serve them and facilitate their healing. Anecdotally, those professionals, including ourselves, who have been engaged with veterans units have overwhelmingly been enthusiastic about the impact it has on veterans who engage with programming.

Topics for Further Exploration

There is much we still do not know about the outcomes and benefits of veterans units. Most importantly, longitudinal data is needed to track outcomes and rates of recidivism. If the goal is rehabilitation and improvement of the lives of participants, this is crucial information to gather. While all signs point to the effectiveness of the model, which prioritizes treatment, training, and resource gathering over punishment, it needs to be explored and documented in well-designed studies. It would also be essential to understand the experiences and needs of women veterans in prison since this has not been well-documented or studied. Seamone (2016) had posited that there may be cost-savings associated with this model and though that isn't the primary issue at hand, it may be a way to motivate policy-makers and

bureaucratic institutions to embrace this model of incarceration all the more and to continue on the path toward better care and treatment for our veterans.

The limitations of the model could also be better understood. There seems to be some level of disagreement about whether or not to treat these units as replicas of military experience or to get away from that in favor of a more purely therapeutic approach. The question of who benefits from which approach will likely reveal that different veterans require different things. This is to be expected, given the diversity of veterans themselves as well as their roles in the military. In fact, tensions among DOC employees and veterans, as well as among veterans with such differing experiences, is another potential limitation or important aspect to understand. There is also the problem, which was raised in the 70s and again in the early 90s, about the way VBA benefits, especially for education, are withheld during incarceration and the 1999 decision that the VHA could not provide direct healthcare services, a problem given the concentration of expertise on veterans issues and trauma-informed treatment at VHA.

We are hopeful that the historical context of specialized veterans units, coupled with the philosophy behind them, will provide insight to those in positions to help incarcerated veterans and perhaps inspire similar programs for all of those who are likely to have a complex set of issues that the typical prison experience isn't able to meaningfully address. Units around the country are continuing to develop and those that have been in existence are demonstrating positive results in terms of recidivism and veterans' reports of satisfaction.

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