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Serving those Who Served: Outcomes from the San Diego Veterans Treatment Review Calendar (SDVTRC) Pilot Program

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Abstract
Veterans Treatment Courts (VTCs) are a type of specialty treatment, problem-solving, criminal court. Though the number of VTCs has increased over the past decade, few research studies have examined their effectiveness. This paper examines the data collected concerning a particular VTC experience, the first 82 Veterans enrolled in the Veterans Treatment Review Calendar Pilot Program conducted by the California Superior Court of the county of San Diego from February 2011 until July 2014 (SDVTRC.) The evidence presented herein concerns the nature of this cohort's population, the SDVTRC program structure in which these Veterans participated, and the outcomes of participation. SDVTRC participants showed a significant decrease in symptoms on 11 of 12 clinical measures from baseline to 12 months. Particular outcomes of the SDVTRC program were related to factors of military service, such as length of service, number of awards, and discharge status. There were also significant relationships between symptom decrease and court process factors, such as length of time in program and sanctions imparted. This court has a 0% recidivism rate, which is believed to be related to its systematic data collection process that was used to inform individualized treatment plans for participants. Implications for other VTCs are provided.

Keywords Veteran treatment courts · Veterans · PTSD

With over a decade of war in Iraq (OIF) and Afghanistan (OEF), there is a growing body of evidence to support the provision of specialized services to Veterans who are involved in the criminal justice system (Tsai, Flatley, Kasprow, Clark, & Finlay, 2017; Baldwin, 2016; Slattery, Dugger, Lamb, & Williams, 2013; Smee, et al., 2013; Hawkins, 2010; McMichael, 2011; Russell, 2009). Among the growing consequences of the recent conflicts is the manifestation of trauma-related mental health issues as criminal behaviors (Slattery et al., 2013; McMichael, 2011; Hawkins, 2010). Veterans Treatment Courts (VTCs) are one method that has been gaining popularity since 2004, to address this issue. Often, as is the case with VTCs, specialty courts are initiated due to the perceived need or gap in the system when addressing the complex behavioral health needs of some justice-involved persons.

As of 2015, every state in the USA has at least one problem-solving court including drug courts, mental health courts, and more recently VTCs (NADCP.org). The popularity of problem-solving courts in the USA cannot be overstated. They have three main common characteristics: a problem-solving orientation, interdisciplinary collaboration, and a focus on accountability (Porter & Rempel, 2010) with a general goal of diverting defendants out of typical criminal justice processing and into community-based treatment. Currently, there are nearly 400 adult mental health courts (Goodale, Callahan, & Steadman, 2013), 2500 adult drug courts (www.NADCP.org), and over 350 VTCs (Tsai et al., 2017).

These specialty courts often operate within the theoretical framework of therapeutic jurisprudence, which attempts to apply the law in a therapeutic way, while still respecting the traditional values of law (Wexler, 2000; Perlin, 2013). Therapeutic jurisprudence does not advocate for favoring therapeutic outcomes over other goals of law. Rather, it encourages integrating therapeutic responses into existing

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applications of the law. One of the interpretive applications of therapeutic jurisprudence is to treat the underlying condition(s) that often contribute to criminal offending. Therapeutic jurisprudence focuses on the law in action, considering the impact that the law has on an individual's emotional life and psychological well-being (Wexler, 2008).

This paper reports on preliminary data from the San Diego Veterans Treatment Review Calendar (SDVTRC) Pilot Program to serve as a case study examining the VTRC population, court structure, and treatment outcomes among participants. This paper will address two specific research questions that will contribute to the existing limited literature exploring VTCs (Baldwin, 2015a, b; Baldwin, 2016; Tsai et al., 2017; Vaughan, Holleran, & Brooks, 2016). First, within the framework or therapeutic jurisprudence, whereby one of the overarching goals of the court is the treatment of the underlying condition(s) that contribute to offending, do VTRC participants experience a decrease in behavioral health symptoms and substance use during their involvement with the VTC? Second, which factors of the participants' military service or the court process are associated with changes in behavioral health symptoms and substance use?

Data that were analyzed in this study are ideal for two reasons. First, this discussion will focus attention on a cohort of recent Veterans who served during OIF/OEF. It is highly plausible that there will be an influx of OIF/OEF Veterans in the American justice system in the future (Baldwin, 2016), therefore supporting the need to better understand this population. Further, data were collected systematically from the establishment of the court. Baldwin (2016) highlighted the need to examine court operations and participant outcomes from the emergence of the court in order to facilitate a comprehensive study of change. This study will allow such an exploration.

In order to fully explore the research questions, a detailed overview of the court is provided, including the imposition of both incentives and sanctions. This overview of the court structure will demonstrate how the court incorporates therapeutic jurisprudence into its operation. Preliminary outcomes, specifically mental health and trauma-related behaviors, are presented to explore changes in behavior among VTRC participants. Finally, these changes are explored through the lens of military service history and court process to see which factors are related to behavior changes. The sum of all of these components provides an overview of one VTC that has implemented a systematic evaluation component, contributing lessons learned for other courts throughout the country.

Veterans Treatment Courts (VTCs)

There is some variation in VTCs, but most share similar structures and procedures with other specialty courts, especially with drug treatment courts. The overarching goals of VTCs include diversion from incarceration for justice-involved Veterans while utilizing a treatment-based approach to deal with the underlying issues that are likely contributing to or causing criminal behaviors (Baldwin, 2016). These courts subscribe to a collaborative model in lieu of a traditional adversarial model, and each court designates its own eligibility criteria. Many VTCs require a mental health or substance abuse diagnosis in participants. Some courts limit participation to combat Veterans (McMichael, 2011). These markers of the court are consistent with other specialty courts operating within the framework of therapeutic jurisprudence. Although the San Diego court reported on within this paper does not limit participation to combat Veterans, they do have eligibility criteria requiring the crime to be connected to a trauma-related mental health condition caused by military service, as determined by an LCSW at the Veterans Affairs (VA) hospital; this is often, though not always, combat.

One of the key components credited with the success of VTCs is a strong collaborative partnership with the Department of Veterans Administration (VA). The VA has demonstrated a diligent initiative to improve mental health services for service members suffering from Post-Traumatic Stress Disorder (PTSD; Elbogen et al., 2012a, b) and has taken on the responsibility of providing a great amount of the treatment for service-related conditions, especially PTSD (Smee et al. 2013). The partnership with the VA facilitates a lesser burden on local and state monies, although most VTCs accept Veterans who are ineligible for VA benefits due to discharge status or length of service. The latter group comprises only about 14% of VTC participants (McGuire, Clark, Blue-Howells, & Coe, 2013). For those VTC participants who are VA-eligible, they are often assisted by a VA employee—the Veterans Justice Outreach Specialist (VJO)—to navigate the VA benefits and treatment system.

Another key element contributing to the widespread success of VTCs is the incorporation of a court peer mentor support component with over half (55%) having a program and more in the planning stages (McGuire et al., 2013). The principle underlying these programs is that Veterans respond well to other Veterans who can understand the unique challenges that are commonly faced by the population (McMichael, 2011; Russell, 2009; Slattery et al., 2013).

Despite the recent upsurge in support for VTCs following the return of over two million OIF/OEF service members, most VTCs (96%) accept Veterans from all service eras (McGuire et al., 2013). Few VTCs limit their eligibility criteria to military-related mental health disorders (14%), combat-related disorders (8%), or current wars and conflicts (1%); however, approximately 15% prioritize admission for OIF/OEF Veterans (McGuire et al., 2013). The majority (61%) of VTCs accept both felony and misdemeanor cases. The VA's survey of VTCs reports a 69% graduation/completion rate across all VTCs. Veterans can exit the

program prior to graduation for a number of reasons ranging from death to dismissal due to non-compliance.

In one published study of a VTC, Slattery et al. (2013) report that in the Colorado Springs' court, participants' mental health improved during the program, whereas their housing and employment did not. There were sustained improvements in PTSD, depression, self-harm, substance abuse, and emotional liability (Slattery et al., 2013). While it is not possible to ascertain the mechanism for the improvements exhibited by the VTC participants in Colorado, the authors propose that the felony arrest that led them to participation in the VTC may have been a "wake up" call for intervention. The "wake up" call combined with the support provided by the peers and the militaristic structure of the court program might have strongly contributed to participants' success in the program.

In contrast to the findings of Slattery et al. (2013), Tsai et al. found that Veterans who were enrolled in the VA VJO program and were participating in a VTC had better outcomes on independent housing and employment than those participating in a non-treatment court. The authors propose that the better outcomes experienced by VTC participants are likely related to the benefits of treatment court participation including reduction or dismissal of charges, peer mentor services, and trauma-informed justice practitioners, thus reducing subsequent stigma for housing and employment.

As the science and understanding of PTSD and other combat-related disorders develops, coupled with a national trend to divert persons with behavioral health disorders from the criminal justice system, VTCs offer the country an opportunity to respond to the justice consequences of military service in a more positive and supportive manner than was offered to Vietnam Veterans. The key to diverting Veterans from a path of homelessness and justice involvement is early intervention, which is exactly what VTCs strive to offer (McMichael, 2011).

Criminal Justice Involvement of Veterans

Some studies have observed a high incidence of justice involvement among Veterans, although the proportion of inmates in the USA who are Veterans has been declining since 2004 (Noonan & Mumola, 2004). Between 2004 and 2012, there was a 9% decrease in incarcerated Veterans (Bureau of Justice Statistics, 2015). A number of studies suggest that a relationship between combat trauma/PTSD and criminal behavior exists (Elbogen et al., 2012a, b; Noonan & Mumola, 2004; Sullivan & Elbogen, 2014; Wilson & Zigelbaum, 1983). Many researchers have linked PTSD with incarceration, aggression, alcohol misuse, and violence (Calhoun, Malesky, Bosworth, et al., 2005; Elbogen et al., 2014; Grafman et al., 1996; Greenberg & Rosenheck, 2009; Pandiani, Rosenheck, & Banks, 2003; Saxon et al., 2001; Shaw, Churchill, Noyes, & Loeffelholz, 1987). Whether diagnosed or un-diagnosed, those exhibiting symptoms of PTSD are at an increased risk of being arrested and incarcerated (Elbogen et al., 2012a, b).

Considering findings from previous studies regarding Veterans and justice involvement, we might expect an uptick in the number of justice-involved Veterans, as more OIF and OEF Veterans return with combat exposure and begin or continue to experience PTSD. In fact, there is ample support to estimate future justice involvement among recent Veterans. Maguen, Madden, Cohen, Bertenthal, and Seal (2012) found that there was median 5.5 year lag between the time that a service member or Veteran was diagnosed with a behavioral health condition and the time when he or she engaged in minimally adequate services to address that behavioral health condition. A lag of this amount of time directly increases risk of a variety of adverse life events, including justice involvement. Galea et al. (2014) propose that our society might not see the peak of service-connected mental disabilities, including PTSD, in recent service members until 2040. Further, Smee et al. (2013) argue that there is reason to believe that the future incarcerated OIF and OEF Veterans will share characteristics with other incarcerated conflict-era Veterans including high rates of violent offenses and prior use of drugs and alcohol. There is already support of this theory through the increased number of Veterans who are seeking mental health and substance abuse services at the VA in recent years. These findings bolster the need to examine and understand existing VTCs in order to create a legal and service system that is equipped to meet the needs of future justice-involved Veterans.

Research Setting

The Veterans Treatment Review Calendar (VTRC) Pilot Program is a specialized docket within the San Diego Superior Court that was created in February 2011, after approximately 4 years of preparation to implement a Veteran treatment model within the courts. There are two major military bases, over 50,000 active duty military members, just under 20,000 Reservists training at Camp Pendleton (Commander, Navy Installations Command , n.d.; Marines, , n.d.), and approximately 235,000 Veteran residents in San Diego County (U.S. Census Bureau, 2014), making San Diego a prime location for a VTC. The mission of the VTRC is to provide judicially supervised mental health treatment to justice involved Veterans whose criminal conduct likely resulted from a military-connected mental health condition. Judge Roger W. Krauel, Col. USAR (Ret.), presided over the VTRC from its development in February 2011 until the end of the pilot program in 2014. While the judge is a Veteran

himself, he did not present as a "battle buddy" to the defendant, favoring a proper commanding officer to subordinate relationship structure.

Observations of treatment courts such as the VTRC reveal that judges have considerable leeway in deciding to impose sanctions or set aside possible sanctions, in favor of allowing participants the opportunity to be accountable, or truthful about their violations (Callahan, Steadman, Tillman, & Vesselinov, 2013). In the San Diego VTRC, the judge made decisions after considering the law, the evidence, the facts, and the arguments of the attorneys and treatment providers. The statutory basis for the SDVTRC Pilot Program was the CA Penal Code §1170.9 (Appendix 1).

One of the common characteristics of all specialty or problem-solving treatment courts is the use of incentives and sanctions to encourage program compliance. In this court, legal incentives, such as a reduction in fines or probation, are proposed by the prosecutor to be approved by the court. Sanctions are relevant to treatment rather than traditional sanctions such as re-incarceration or public work service, unless the Veteran commits a severe violation or is believed to be a danger to him/herself or others. In such a case, probation may be revoked and the participant placed in custody until either they are removed from the VTRC program or an alternate, more appropriate treatment plan is developed. Sanctions could be implemented by the court for a variety of reasons including noncompliance with treatment (missing appointments, not engaging, being removed from a treatment program, etc.), positive toxicology screens, missed appointments with probation, and other VTRC program violations.

These dynamics are consistent with the therapeutic jurisprudence framework. Initially, the court attempts to integrate therapeutic responses to problem behavior, activating the law as a therapeutic agent. However, in the event that the therapeutic sanctions are not successful or appropriate in proportion to the violation, traditional punitive sanctions will be applied. The legitimacy of the court and the criminal proceedings are not sacrificed in favor of therapeutic goals.

The San Diego VTRC utilized peer mentors, believing that mentors are a necessary aspect and contribute greatly to the success of the participants. This belief was further strengthened by letters written to the judge by SDVTRC participants during advancement from one phase to another or at graduation that praised court mentors and cited their role as key to a participant's success.

Study Design and Methods

The VTRC screened 444 potential participants from February 2011 to July 11, 2014. Eighty two Veterans were accepted to the VTRC Pilot Program. Reasons for not being admitted into VTRC after submitting an application included, for example, that the defendant withdrew their application, was deemed to have a mental health condition requiring treatment beyond the scope of VTRC such as severe psychosis, or did not demonstrate the required causality nexus—the defendant suffered from a mental health conditions related to their military service that contributed to the commission of their crime. Other reasons were that defense counsel and the prosecutor, who were appointed by the local District Attorney and City Attorney offices to represent their respective offices on the team, were unable to reach a plea agreement that included VTRC; defendant pleaded guilty as part of a plea agreement that did not include treatment; defendant was sentenced traditionally without being evaluated for VTRC; or defendant's counsel did not follow up after the initial screening.

VTRC Participants

The eligibility criteria for the VTRC included a history of service in the US military, the presence of a mental health condition resulting from military service, and a connection between the current charge and a military-related mental health condition. In addition, the Veteran had to be eligible for probation, and there had to be an appropriate 12–18-month treatment plan available.

Most of the participants were male (90%) and white (49%). This cohort represents a highly formally educated group of offenders with only 3% having less than a high school diploma/GED; over half had some college (39%) or a college degree (13%). At the time of court participation, 44% were married, 43% were employed, and 51% lived in a private home. These demographics are consistent with Baldwin's (2015a, b) review of incarcerated Veterans and how they are vastly different than persons typically entering the criminal justice system. While this study was unable to compare this cohort to a general incarcerated population, Baldwin (2015a, b) states that incarcerated Veterans are more likely to be white, more highly educated, and employed fulltime compared to their non-Veteran counterparts. This might suggest that the cohort represented here has more social assets and resources to support recovery and re-entry into the community.

Of the 82 participants, 35 (43%) had graduated by the time data collection ended on July 25, 2014. As of that date, 33 (40%) of the original 82 were still in the program, 3 (4%) of the participants had voluntarily withdrawn, and 11 participants were involuntarily terminated from VTRC. With 49 participants having an "outcome," meaning that they either graduated from the program, voluntarily terminated, or were involuntarily terminated, the successful completion rate was 71%. Follow-up on the 35 graduates revealed no reported criminal recidivism with the follow-up period varying by participant. VTRC followed graduates for a period of 5 years after graduation to identify any new criminal convictions.

Marines (42%) comprised the largest proportion of participants, likely due to the close proximity of Camp Pendleton, the major west coast Marine base. Navy (29%) and Army (27%) comprised most of the remainder of the participants' military affiliations, with Air Force only representing 2% of participants. On average, the participants spent 7.6 years in the military, and the majority (82%) were eligible for VA benefits. Nearly all (93%) had at least one deployment. Many (43%) had two or more deployments, with the majority being deployed to Iraq (76%), Afghanistan (30%), other theaters (15%), Desert Storm/Shield (5%), and Bosnia/Serbia/Kosovo (4%) (see Table 1). Other theaters included classified (e.g., SEAL missions), Africa, Somalia, and the Persian Gulf. While many had multiple deployments, fewer than half of participants (43%) reported completing multiple combat deployments.

Most of the Veterans in this sample presented with a history of mental health conditions and or substance use, as expected given the nexus qualification of the court (Table 2). Their mental health histories appear complex with many having prior experience with treatment and one third having a history of suicidal ideation. It is important to note that while nearly three quarters admit to having a prescription for a mental health condition, none report having a prescription for anti-psychotic medications, likely due to the eligibility criteria of the court. Similarly, many report a long history of frequent, including daily for many, substance use. There is evidence of many combining drugs, alcohol, and prescription medication on a regular basis.

Some of the sample presents with a history of violent behaviors, including violence with a weapon and homicidal ideation. Only about a quarter of the sample report ever being on parole or probation prior to involvement with the VTRC.

Table 1 Military experiences of San Diego. Pilot VTRC participants

	(n = 82)
% Enlisted	99%
Branch	
Army	27%
Navy	29%
Marines	42%
Air Force	2%
Total average time in service	7.6 years
Type of discharge	
Honorable	69%
General	13%
Other than honorable	8%
Active duty	11%
Total deployments	
0	2%
1	40%
2	31%
3 or more	26%
Total combat deployments	
0	7%
1	50%
2	29%
3 or more	14%
Deployments	
Afghanistan	30%
Iraq	76%
Desert Shield/Storm	5%
Bosnia/Serbia/Kosovo	4%
Non-combat	6%
Other theater	15%

Measures

In addition to the demographic information, military service, and history of behavioral health (mental health and substance use) disorders collected on all VTRC participants, the court staff maintained data on the participants' progress through the program such as the amount of time spent in each phase and the number and type of sanctions and/or incentives received.

As part of the program intake, all participants agreed to complete a number of measures at baseline, 6 months, and 12 months as an indicator of the impact of the treatment and other program interventions on their symptoms. This process was important to the court so that it could measure changes in underlying mental health and substance use disorders that contributed to the participant's criminal activity. After all, the goal of the court was to address the underlying conditions that related to military service and criminal behaviors. If the symptoms were reduced, it was hypothesized that the substance use would diminish and the criminal behavior end. We conducted internal validity analyses for all scales, and the alphas are included in the following list of measures:

1. PTSD Checklist (PCL) is a 17-item Likert-type checklist that measures post-traumatic stress disorder symptoms (Weathers, Litz, Herman, Huska, & Keane, 1993). In addition to a total trauma and stress measure (Cronbach's α = .954), subscales include re-experiencing (α = .919), avoidance (α = .898), and hyperarousal (α = .881).
2. Modified Overt Aggression Scale (MOAS) is a 16-item Likert-type scale (Cicerone & Kalmar, 1995). In addition to a total anger and aggression measure (α = .935), subscales include verbal aggression (α = .842), physical aggression toward objects (α = .898), physical aggression toward others (α = .951), and physical aggression toward self (α = .833).
3. Drug Abuse Screening Test (DAST-10) is a 10-item yes/no inventory to measure illegal drug use over the prior 4 weeks (α = .864).
4. Alcohol Use Disorders Identification Test (AUDIT-C) consists of three questions to measure frequency and volume of alcohol consumption over the prior 4 weeks.

Table 2 Behavioral health and criminal justice. Factors of San Diego pilot VTRC participants

	(*n* = 82)
Acknowledges having MH dx	87%
- Suicidal ideation	33%
Using any illegal drug	94%
Type of substances—overall	
- Alcohol	88%
- Marijuana	22%
- Meth/amphetamines	18%
- Heroin	11%
- Cocaine	10%
- Prescription opiates	7%
- Ecstasy	2%
- Anti-anxiety medications	2%
Frequency of use	
- Rarely	3%
- Monthly	5%
- Weekly	20%
- Semi-weekly	11%
- Daily	62%
Treatment history	
- Ever in hospital for MH tx	68%
- Ever in residential treatment program	33%
Has at least one prescription medication	71%
- Sleep	21%
- Depression/anxiety	57%
- Pain	21%
- Other	21%
History of violent behavior	
- History of violence	20%
- History of violence with weapons	13%
- Homicidal ideation	13%
Ever been on parole or probation	26%

5. Patient Health Questionnaire-9 (PHQ-9) is a 10-item Likert-type scale to measure symptoms of depressed mood over the prior 2 weeks ($\alpha = .913$) (http://www.ncbi.nlm.nih.gov/pubmed/11556941).

The first relationship of interest was whether symptoms were reduced for SDVTRC participants over time. Changes in clinical measures were calculated by examining the difference between means from admission to 12 months. To establish whether the change score was significant, a dependent sample *t* test was performed.

The next relationships of interest were the factors associated with the changes in symptoms. To this end, there were two types of factors selected for consideration: military service factors and court process factors. To explore relationships, correlations between the change scores from admission to 12 months on the scale measures and the service factors or court process were performed.

Findings

Prior to discussing clinical outcomes for VTRC participants, an overview of the court process is provided, focusing on imposition of rewards and sanctions. This overview is meant to provide a context for this court setting since there is much variation between VTCs and demonstrate the therapeutic application of the law that was employed by this court. Following the discussion of the court process, findings regarding changes in symptoms for VTRC participants and military factors or court process associated with symptom change are presented.

VTRC Court Process

In this program, a majority of participants (73%) received no program sanctions during their program participation (see Table 3) and were mostly compliant with judicial orders. Minor mistakes such as missing a treatment appointment or urine test were dealt with by our team probation officer or SDVTRC judge through motivational discussion more than formal program sanctions. These instances of imperfect compliance were generally understood in terms of the myriad requirements each participant had, understanding relapse as a learning opportunity. The court generally accepted "less harm" approaches rather than demands for absolutes, and most participants corrected the deficiency without needing a formal sanction.

Among the 27% of participants who ever received a sanction while participating in the court, there was a statistically significant reduction in verbal aggression ($p < .01$), physical aggression toward objects ($p < .01$), and total anger and aggression ($p < .01$) after imposition of the sanction.

Progressing through program phases is an indication that participants are meeting the requirements of their programs. The average time spent in phase 1 was 6 months; phase 2 was 6.3 months; and phase 3 was 4.3 months. On average, participants spent 15.3 months in the VTRC program.

Fifty-one Veterans were moved from phase 1 to phase 2, the first milestone accomplishment available to the Veterans. Phase goals, responsibilities during each phase, and requirements for advancing to the next phase as presented to participants in the SDVTRC Participant's Handbook can be found in Appendix 2. During phases 1 and 2, the most common incentives offered to Veterans were either to have their fines and fees forgiven or to receive a 6-month reduction in their probation sentence. The behaviors that were being incentivized at this phase are described in Appendix 2. Nearly 60% of Veterans had the financial responsibilities (e.g., fees and fines) associated with their crime forgiven, alleviating the financial burdens associated with their justice

Table 3 San Diego Pilot VTRC Program descriptions

	(*n* = 82)
Participant ever received a sanction	27%
Number of sanctions received	
0	73%
1	21%
2	5%
3	1%
Average time in program phases	
Phase 1	6 months
Phase 2	6.3 months
Phase 3	4.3 months
Total time in program	15.4 months

involvement. Approximately 43% were granted 6 months off of their probation term.

Thirty-five Veterans (43%) were accepted into phase 3 of the program (see Appendix 2 for advancement requirements). The most common incentives applied during the third phase again centered on a reduction in the length of their probation sentence. At this phase of the program, there are three opportunities for probation reduction. Thirty-seven percent of Veterans who reached phase 3 received 6 months off the term of their probation, while 26% received a 12-month reduction. The other probation-focused incentive, which was much less common, was a reduction to summary probation. This usually occurred when the prosecutor requested the court to reduce the participant's felony charge. Summary probation (supervision by the court instead of a probation officer) was also awarded to accommodate a participant's job or out-of-county treatment where traditional probation supervision was not possible. Only about 15% of Veterans were granted this incentive.

The highest accomplishment in the SDVTRC is the recommendation for graduation, and 35 Veterans were recommended for graduation by the SDVTRC team and recognized as a graduate by the SDVTRC judge. At the final phase of the program, it was highly unlikely to receive a reduction of either 6 or 12 months in the terms of probation. However, the majority of Veterans who made it this far, nearly 60%, were granted a reduction to summary probation. Including those who had been reduced to summary at phase 3 and those who were on summary probation during the entirety of the program, all Veterans who graduated the VTRC Pilot Program were then monitored only by the court and not a probation officer.

Outcomes

It is critical to remember that this court program was designed with a focus on clinical goals for VTRC participants, including symptom reduction. The program founder believed that focusing on clinical goals to treat underlying conditions would lead to reduced criminality and recidivism. The outcomes discussed below will relate to the clinical progress of VTRC participants.

Of the 82 VTRC participants included in this study, there are 52 for whom we have both baseline and 12-month measures. The following difference between means analysis is based on those 52 Veterans. As shown in Table 4, program participants, as a group, showed improvements on all measures with significant decrease in symptoms in 11 of 12 scales during their program participation. Overall, participants reported a decline in drug use ($p < .01$); depressed mood ($p < .001$); total trauma and stress and all three subscales ($p < .001$); total anger and aggression ($p < .001$); physical aggression toward objects ($p < .05$); and physical aggression toward self ($p = .052$). There was no statistically significant reduction in physical aggression toward others.

Military-related factors were associated with differences in VTRC outcomes among participants (see Table 5). Length of military service affects trauma and stress symptoms in that the longer someone served, the worse their outcomes on total trauma and stress ($p < .05$) as well as avoidance ($p < .01$). There was also a relationship approaching significance for re-experiencing ($p = .08$). Another military factor demonstrated to be significant was whether the service member or Veteran had received military awards. Those who had received military awards were significantly more likely to experience hyperarousal ($p < .05$) and physical aggression toward objects ($p = .05$) than those who had not received military awards. The relationship between military awards and verbal aggression was approaching significance ($p = .08$). Veterans who had received an honorable discharge were significantly more likely to experience a reduction in drug use ($p < .05$) than those who had received an other-than-honorable discharge. Interestingly, this analysis did not reveal any

Table 4 Reduction in symptoms over 1 year (*n* = 52)

	Mean (SD)	Significance
Drug scale	− 0.51 (1.3)	.009
Depressed mood	− 2.9 (5.3)	< .001
Trauma and stress subscales		
Re-experiencing	− 2.2 (4.1)	< .001
Avoidance	− 3.4 (6.9)	< .001
Hyper-arousal	− 2.7 (5.0)	< .001
Total trauma and stress scale	− 8.3 (14.2)	< .001
Anger and aggression subscales		
Verbal aggression	− 1.5 (2.7)	< .001
Physical aggression toward objects	− 0.5 (1.6)	.015
Physical aggression toward others	− 0.2 (1.1)	.161
Physical aggression toward self	− 0.5 (1.9)	.052
Total anger and aggression scale	− 2.8 (5.5)	.001

Data were available for 52 of 82 participants at both baseline and 12 months

Table 5 Factors associated with changes in symptoms

	r	Significance
Length of military service on		
Avoidance (trauma and stress)	.297	.03
Total trauma and stress scale	.291	.04
Re-experiencing (trauma and stress)	.245	.08
Receiving military awards on		
Hyper-arousal (trauma and stress)	.313	.03
Physical aggression toward object (anger and aggression)	.270	.05
Verbal aggression (anger and aggression)	.247	.08
Honorable discharge on		
Improvement in drug use	5.38	.02
Number of sanctions on		
Verbal aggression (anger and aggression)	− .374	.006
Physical aggression toward objects (anger and Aggression)	− .402	.003
Total anger and aggression scale	− .353	.01
Length of time in phase 1 on		
Verbal aggression (anger and aggression)	− .267	.056
Length of time in phase 3 on		
Physical aggression toward objects (anger and aggression)	− .470	.004
Total anger and aggression scale	− .391	.02
Verbal aggression (anger and aggression)	− .326	.056

statistically significant relationships between number of deployments and measures of trauma and stress or anger and aggression.

Finally, the time in program phases are also related to changes in symptoms (see Table 5). The average amount of time spent on phase 3 was 4.3 months. Data indicate that the more time a Veteran spent on phase 3 was significantly related to reduction in two components of anger and aggression: physical aggression toward objects ($p < .01$) and total aggression and anger ($p < .05$). These data cannot determine if this result is due to the treatment intervention during phase 3 or simply being in the phase for longer. The relationship between amount of time spent in phases 1 ($p = .06$) and 3 ($p = .056$) and reduction in verbal aggression was approaching significance.

Discussion

Many SDVTRC participants initially presented to the court with sordid mental health and substance use histories, marked by previous attempts at treatment. This study found statistically significant reduction in clinical measures, including measures of depression, drug use, and PTSD among participants. Further, there was a statistically significant reduction in aggressive behaviors among this justice involved population. This analysis suggests that there were successful components of the VTRC to address the underlying needs of the Veterans. Additionally, there were differences in treatment outcomes based on factors of military service, underscoring the importance of considering an individual's service history when developing their treatment plan, in lieu of a one size fits all approach for participants. This court has effectively achieved a 0% recidivism rate among its participants.

The SDVTRC engaged in a pre-sentencing assessment[1] process whereby the Veteran received an application, thorough clinical assessment with an individualized treatment plan, and recommendations provided by the VTRC team, including treatment of the trauma-related condition(s) connected to the Veteran's criminal behavior. This process combined with the systematic data collection procedure implemented by this court is credited with the success of the court to effectively address the mental health needs of its participants, resulting in significant symptom reduction. The treatment plans that were developed by the court were flexible and could be adjusted as necessary to achieve maximum symptom reduction based on the information provided to the court by both providers and the participants themselves. Further, this court used a careful calculation, which was largely informed by the systematic data collection process, to determine the appropriate amount of time a Veteran spent on a phase based on his or her ability to demonstrate significant improvement of behavioral factors. The ability of this program to be successful at reducing measures of trauma and stress, anger and aggression, drug use, and depression suggests that this approach to treating Veterans in VTCs was successful. Other courts should consider engaging in such a calculated process in lieu of a "one size fits all" approach.

This cohort of Veterans was mostly compliant with the judicial conditions of the court, evidenced by the fact that only a little over

[1] Usually, the defense counsel (a designated Public Defender) or the SDVTRC Team Coordinator were contacted by either defense counsel or sometimes a pro per defendant inquiring about SDVTRC participation. They were sent the application and told to complete it and return it to the Coordinator. Once received, the Coordinator reviewed it according to the eligibility criteria established by the SDVTRC team and judge. If qualified, the application was sent to the VJO who contacted the Veteran to do the assessment. If ineligible, the Coordinator notified the defense counsel of the reason the client was ineligible. For eligible defendants, the VJO provided their defense counsel with the assessment and recommended treatment plan and notified the defense counsel that the SDVTRC team would hold staffing of the matter if desired. The SDVTRC team then met with the defense counsel to ascertain whether the defendant should be recommended for admission. If recommended, a report of recommendation was prepared for the sentencing judge and sent by the Coordinator. The defense counsel then used that documentation to negotiate with the sentencing court and prosecutor on the matter to have the defendant plead guilty and then be referred to the SDVTRC. If the sentencing judge agreed to accept the plea and send the offender to SDVTRC as part of their probation, the SDVTRC Coordinator prepared a written team recommendation for the SDVTRC judge and set the matter on a calendar after the sentencing occurred. The defendant was ordered to attend the admissions hearing at SDVTRC, and the recommendation was presented at that hearing. The final admission was up to the SDVTRC judge who heard from the defendant and his/her counsel and the SDVTRC prosecutor (if the team recommendation was not unanimous) before deciding whether or not the defendant should be admitted. If admitted, the defense counsel was given an option of attending all review hearings with their client or being relieved and the SDVTRC defense counsel was appointed to represent the participant henceforth.

a quarter of participants received any sanctions during their participation in court. Further, the sanctions that were applied were therapeutic in nature such as writing a letter to the court and volunteering with a Veteran service agency. The evidence suggests that tailoring sanctions to offer a therapeutic recourse, in lieu of a punitive recourse, for problem behaviors may be a good strategy for symptom reduction. However, it is important to note that this court did apply punitive sanctions when therapeutic sanctions either failed or were deemed inappropriate. The statistically significant clinical improvements made by this cohort of Veterans suggest that there might be value and efficacy in integrating such an approach into the court process. While it was beyond the scope of this analysis to compare clinical outcomes among this group to a control group, this does not diminish the finding that this process showed great promise for the Veterans and service members who participated in this program.

This study found that characteristics of service can be important predictors of mental health consequences and therefore should be considered when developing treatment plans for court participants. Service members and Veterans who spent longer in the service were at increased risk for negative measures of trauma and stress. This is likely due to more exposure to high-stress situations through deployment or training. Those who received military awards were more likely to experience symptoms of trauma and stress as well as anger and aggression. While it was beyond the scope of this analysis to examine the nature of awards received, it is important to consider that military awards are often, though not always, awarded for exemplary behaviors in high-stress situations. Veterans who had received an honorable discharge were more likely to demonstrate improvement on the drug use scale throughout participation in the treatment court. One possible explanation for this difference is that Veterans who received an other-than-honorable (OTH) discharge were already experiencing symptoms of mental health or substance use that contributed to their discharge. The simple fact is that honorably discharged Veterans have access to the full range of health care at the VA while Veterans with an OTH discharge do not. Knowing that Veterans with OTH discharge did worse in this court could suggest that they need to be referred to treatment upon discharge, especially when behavioral health-related behaviors underlie the severance. The strong reverence toward and understanding of military culture and experiences within this court allowed for custom treatment plans that considered factors of military service. Other courts should consider the implication of service factors on aspects of behavioral health and tailor responses to the differing experiences that might manifest in dissimilar ways among Veterans.

Conclusion

Future research on VTCs is needed to determine what works best for whom, in addition to the overall effectiveness of VTCs on symptom reduction and recidivism prevention. As stated, there is much variation across VTCs throughout the country and little is known about their effectiveness thus far. It is imperative to establish the best practices for VTCs by examining a wide array of practices, services, and outcomes. This particular court was tailored to meet the needs of combat Veterans who demonstrated a nexus between their service, mental health, and crime. It also mainly catered to OIF/OEF Veterans. As a result, the findings might have limited application for courts serving non-combat Veterans, older Veterans from previous conflicts, and Veterans without a requisite nexus.

Another limitation of these data is that this study examined a small sample of participants. This limits the ability to perform and interpret statistical testing. Therefore, relationships approaching significance were also presented in this paper, and caution was applied to interpreting the findings. While this study should be replicated with a larger sample to increase statistical power, it is noteworthy that at the time of submission, there was a 0% recidivism rate for all 82 Veterans represented here. The fact that this pilot program produced 0% recidivism suggests effectiveness of the structure of this court program to rehabilitate offenders. Therefore, other programs should consider the lessons learned from this court and its components of the court structure when designing their own program.

Finally, the examination of the participants, structure and outcomes of this court adds to a growing body of literature examining VTCs throughout the country. Further, the discussion of findings and lessons learned by this court might prove beneficial to other VTCs in existence or in planning phases. There are components of this court that other courts might want to consider integrating into their own court programs.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Appendix 1 CA Penal Code §1170.9

CA Penal Code §1170.9 was the statutory basis for the SDVTRC Pilot Program. That law allows a judge to sentence an eligible veteran to court monitored treatment in lieu of incarceration if certain findings are made. To admit a veteran to SDVTRC, the Judge had to find:

1. the defendant was, or currently is, a member of the United States military; and
2. the defendant is suffering from sexual trauma, traumatic brain injury, post-traumatic stress disorder, substance abuse, or mental health problems as a result of that service; and
3. the criminal conduct is related to that mental health condition.

The statute allows that the court may request, through existing resources, an assessment to aid in that determination.

The process was that the defendant presented evidence that he/she was eligible for admission. The SDVTRC Team evaluated the evidence and made a collective recommendation to the judge regarding eligibility and the proposed treatment plan for the defendant. No team member possessed veto power over any admission.

Appendix 2 SDVTRC Participant's Handbook

Phase I – Goal: Demonstrating Accountability

Lasts minimum of 4 months and maximum of 8 months

During Phase I, you will sign all entry documents and begin the most intensive part of your treatment plan therapy. You will make contact with your mentor and begin to share about your life and recovery. You will get to know the SDVTRC Team and Judge while they also get to know you. You will develop a dedication to taking care of the things you are assigned to do. You will learn how to approach any problems that arise while using the resources of the treatment program and SDVTRC program available to help you with them. You will be required to make all treatment appointments and court appearances and be on time and prepared for them.

Phase I will usually include these components:

1.Satisfactory progress in your designated treatment program including a minimum of two hours of individual or group therapy sessions weekly that directly address your assessed condition.

2.Chemical testing on a random basis and/or alcohol monitoring if assigned.

3.Taking medication as directed by medical and mental health professionals.

4.Attendance at Veterans recovery support/self-help meetings if assigned (a minimum of one per week).

5.Actively keeping contact and engaging in discussions and activities with your SDVTRC mentor.

6. Reporting to your Probation Officer as directed (formal probation only).

7. Any additional case management services as determined by you and the treatment team. (For example, 12 step program meetings; domestic violence counseling; vocational or educational counseling; family counseling; specialized psychotherapy; nutrition or weight loss; exercise; anger management, parenting skills, etc.)

8. Bi-weekly or monthly court appearances as determined by the Judge.

9. Curfew as directed by the Court, probation or treatment team.

Advancement Criteria

In order to advance to Phase II, you must ask to be advanced. Your request will need to be written and honestly address what you have learned in the SDVTRC program thus far, and why you feel you have earned advancement. The SDVTRC team will then address the specific items below to make sure you have done them and then recommend your advancement to the SDVTRC Judge. The SDVTRC Judge will decide if you will be advanced. The SDVTRC Team and Judge will review your progress to date and your written request in making their recommendation or decision. Your request may be read by you to the SDVTRC Judge in court. Specific items you must demonstrate in order to advance are as follows:

- Completion of the most intense portion of your counseling and therapy program (as directed);
- Be in full compliance with all terms and conditions of your probation;
- Work with your treatment providers to set your personal goals and activities plan for Phase II;
- Demonstrate awareness of how your response to your traumatic condition led to your criminal activity;
- Demonstrate mastery of the tools you can use to prevent future crime;
- Have no positive chemical test results (including missed, tampered or dilute tests) for 90 consecutive days;
- Have no unexcused absences from scheduled services for 21 consecutive days
- Demonstrate you have used medication as directed by your medical staff for a minimum of 60 days.
- Documentation of required minimum attendance at recovery support/self- help meetings for a minimum of 90 days.
- Complete and return monthly symptom checklists consistently;
- Have the endorsement of the SDVTRC team.
- Have your request granted by the SDVTRC Judge.

Phase II – Goal: Demonstrating Responsibility

Lasts minimum of 4 months and maximum of 8 months

During Phase II, you will focus on completing the structured part of your treatment plan and prepare yourself for independent recovery. If you are in a residential program, the program will begin to prepare you to leave by assisting you in increasing your coping skills, building job skills or income sustainability, seeking information about college or vocational training, and obtaining a stable living environment. If you are in a non- residential program, these goals will be addressed by working with your case manager and mentor. The most intense part of therapy will end, and therapy sessions will happen less frequently or cease. You will continue to make regular contact with your mentor and share about your life and recovery. You will know the SDVTRC Team and Judge and they will know you. You will demonstrate that you are

responsible by taking care of the things you are assigned to do without reminders or missed appointments or meetings.

Additionally, you will devise a "Give Back" project in consultation with your treatment provider and SDVTRC Team that will give back to the community in a meaningful way. The purpose of this project is to reconnect you with the community in a positive and helpful manner. Work at non-profits (designated under IRS Code §501(c)3), speaking or writing engagements, teaching youth, using your military skills to improve the non-profit's facilities are all examples, but are not the only ways to do a Give Back project. You should think in terms of your leading role in the project rather than merely joining others in an already organized activity. This project should be individually planned by you, demonstrate a significant accomplishment; emphasize your strengths, show creativity and personal initiative to make a contribution to your community. Give Back project planning should begin on your first day of Phase II and should be discussed in the planning stage with your treatment providers and mentor. It must be presented in writing to the SDVTRC team for approval at team staffing at least two weeks prior to when it will be accomplished.

Your confidence in your ability to handle common problems will grow in Phase II and minor challenges will not overwhelm you. You will reach out to other participants and offer your experience, strength and encouragement to help them. You will continue to be on time for appointments, court appearances and be prepared for them.

Phase II will usually include these components:

1. Satisfactory progress in your designated treatment program including individual or group therapy sessions that directly address your assessed condition.
2. Completion of your residential treatment program and transition to independent living arrangement.
3. Substantially complete your therapeutic and personal goals and activities plan;
4. Chemical testing on a random basis and/or alcohol monitoring (if assigned).
5. Demonstrating initiative by proposing, obtaining SDVTRC Team approval and completing your "Give Back" project.
6. Taking medication as directed by medical and mental health professionals.
7. Attendance at Veterans recovery support/self-help meetings (a minimum of one per week as directed).
8. Actively keeping contact and engaging in discussions and activities with your SDVTRC mentor.
9. Reporting to your Probation Officer (as directed).
10. Progress on any additional case management services and court required programs as determined by you and the SDVTRC team/judge. (For example, 12 step program meetings; domestic violence counseling; vocational or educational counseling; family counseling; specialized psychotherapy; nutrition or weight loss; DUI courses; exercise; anger management, parenting skills, etc.)
11. Bi-weekly or monthly court appearances as determined by the Judge.
12. Curfew as directed by the Court, probation or SDVTRC team.

Advancement Criteria

In order to advance to Phase III, you must ask to be advanced. Your request will need to be written and honestly address what you have learned in the SDVTRC program thus far, and why you feel you have earned advancement. The SDVTRC team will then address the specific items below to make sure you have done them and then recommend your advancement to the SDVTRC Judge. The SDVTRC Judge will decide if you will be advanced. The SDVTRC Team and Judge will review your progress to date and your written request in making their recommendation or decision. Your request may be read by you to the SDVTRC Judge in court. Specific items you must demonstrate in order to advance are as follows:

- Progress in learning coping skills and useful tools in your counseling and therapy program;
- Be in full compliance with all terms and conditions of your probation;
- Work with your Case Manager or treatment provider to create your personal goals and activities plan for Phase III;
- Demonstrate understanding of how your trauma condition can hurt you, your family, and the community;

– Completion of your pre-approved "Give Back" project;

- Demonstrate mastery of the tools and coping skills you can use to prevent future crime in yourself and others in the SDVTRC program;
- Have no positive chemical test results (including missed, tampered or dilute tests) for 120 consecutive days;
- Have no unexcused absences from scheduled services for 60 consecutive days;
- Demonstrate you have used medication as directed by your medical staff for a minimum of 120 days.
- Documentation of required minimum attendance at recovery support/self- help meetings for a minimum of 32 meetings.
- Complete and return monthly symptom checklists consistently;
- Have the endorsement of the SDVTRC team.
- Have your request granted by the SDVTRC Judge.

Phase III – Goal: Demonstrating Independence and Productivity

Lasts minimum of 4 months and maximum of 8 months

During Phase III, the last phase of the SDVTRC program, you will focus on completing your treatment plan and move toward being an independent and productive citizen. You will have a support system in place to help you and skills/tools that you can use to manage your traumatic condition and be a survivor. You will be crime free and maintain stable housing, employment or school. You will initiate contacts with your mentor as needed and develop other supportive and healthy relationships. You will make greater contributions in serving your fellow veterans and the community. The SDVTRC Team and Judge will encourage and support you as you move toward your own plan for life goals and activities. You will demonstrate that you are a responsible leader by helping others in recovery from traumatic conditions. Your confidence in your ability to handle common problems will be evident even when challenges arise. You will continue to be on time for appointments, court appearances and be prepared for them.

Phase III will usually include these components:

1. Substantial completion of any remaining court requirements.
2. Maintain an independent living arrangement for 60 consecutive days.
3. Substantial completion of your personal goals and activities plan;
4. Chemical testing on a random basis and/or alcohol monitoring as directed.
5. Being a leader by demonstrating your assistance to other veterans with traumatic conditions.
6. Taking medication as directed by medical and mental health professionals.
7. Leadership in Veterans recovery support/self-help meetings (as directed).
8. Actively initiating contact and engaging in discussions and activities with your SDVTRC mentor.
9. Actively developing support relationships to support you when the court releases you from the SDVTRC program.
10. Reporting to your Probation Officer as directed.
11. Complete any outstanding case management services as determined by you and the treatment team/judge and substantially complete all court requirements. (For example, 12 step program meetings; domestic violence counseling; vocational or educational counseling; family counseling; specialized psychotherapy; nutrition or weight loss; exercise; anger management, parenting skills, etc.)
12. Monthly court appearances or less often if determined by the Judge.
13. Curfew as directed by the Court, probation or SDVTRC team.

Advancement Criteria

In order to graduate from the SDVTRC Program you must ask to be recognized for graduation. Your request will need to be written and honestly address what you have learned in the SDVTRC program thus far, and why you feel you have earned graduation. The SDVTRC team will then address the specific items below to make sure you have done them and then recommend your graduation to the SDVTRC Judge. The SDVTRC Judge will decide if you will graduate. The SDVTRC Team and Judge will review your progress to date and your written request in making their recommendation or decision. Your request may be read by you to the SDVTRC Judge in court. Specific items you must include in your request and demonstrate in order to graduate are as follows:

- Cite specific examples that show you can use the coping skills and useful tools you have learned in your counseling and therapy program;
- Confirmation that you are in full compliance with all terms and conditions of your probation;
- Demonstrate independent living, employment or full-time school, and that you make a productive use of your time by engaging in positive, chemical- free social activities;
- With help from your treatment provider and mentor, write your plan for aftercare for the next two years including counseling; relapse plans; ways you will connect positively with sponsors and significant others; support group meetings; and hobbies/training.
- State your new personal goals and activities plan for the next few years of your life;
- Demonstrate remorse for your crimes, make amends to your crime victims, and a dedication to remain law abiding;
- Make a commitment to help someone else in recovery;
- Have no positive chemical test results (including missed, tampered or dilute tests) for 180 consecutive days;
- Have no unexcused absences from scheduled services for 90 consecutive days;
- Demonstrate you have used medication as directed by your medical staff for a minimum of 180 days.
- Documentation of required minimum attendance at recovery support/self- help meetings for a minimum of 50 meetings.
- Complete and return monthly symptom checklist consistently.
- Have the endorsement of the SDVTRC team.
- Have your request granted by the SDVTRC Judge.

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