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Whom Do They Serve? A National Examination of Veterans Treatment Court Participants and Their Challenges

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Abstract

The veterans treatment court (VTC) is a recently developed specialized court that targets the growing population of veterans in contact with the criminal justice system. Using data collected from the first national survey of VTCs in 2012, this study explores who VTC participants are by creating a descriptive portrait of their personal and military characteristics and the legal, extralegal, and programmatic challenges they face. This study also examines the perceived relationships between military service and legal and extralegal issues. This research produces the first early illustration of VTC participants on a national level, finding similarity and variability across VTCs, in comparison with the national veteran population, and between servicemen and servicewomen on a variety of factors. Furthermore, this study identifies recent changes in the VTC participant population. Recommendations for VTC programs and for research on justice-involved veterans and active-duty personnel are provided in light of the fluid VTC population.

Keywords

veterans and crime, justice-involved veterans, veterans treatment court, veterans court, national survey, veterans, military service, specialized court

Introduction

> We must consider the more sobering aspects of the consequences of war: the creation of the "veteran" role and the infliction of war wounds, physical, psychological, and "hidden." Despite a plethora of professionals whose occupational assignments direct their attention

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> to veterans, and despite some excellent scholarly work on policies toward veterans . . . little has been done to assess what kind of a difference it makes to the individual in his civilian capacity, or to the society of which he is a member, when he is a veteran (cf. Jennings & Markus 1977, Schreiber 1979, Janowitz & Wesbrook 1983) . . . If we move beyond attested disabilities to psychological wounds, we must recognize that we are dealing with an aspect of the way individuals understand themselves that is socially constructed, and that war is not something solidly in the past and influencing present behavior but is, rather, dialectically tied up with present concerns, and is something both highly personal and part of a very public debate. (Modell & Haggerty, 1991, pp. 220-221)

The public has called for criminal justice reform emanating from concern regarding repeat offenders and mass incarceration. Simultaneously, criminal justice personnel were frustrated by both the burgeoning court caseloads and incarcerated population that were resultant from repeat offenders and their processing within the system. In response to public demand and their own concerns, criminal justice personnel sought new solutions to these issues. To achieve both efficiency and effectiveness that would reduce the number of repeat offenders and, in turn, the large caseloads, population of inmates, and related costs, the criminal justice system created various types of specialized courts (e.g., drug courts, mental health courts).

The specialized court movement is based on the related ideas that specific groups demand particular sets of services/responses that may not be readily accessible and that specialized courts are a vehicle for connecting offenders to those services (Baldwin, 2015). These innovative courts aim to eliminate or reduce recidivism, and thus contact with the system, by addressing offenders' underlying causes and correlates of crime through services and treatment. Treating offenders within the community is more *efficient* than the traditional criminal justice procedure of incarceration (Peters & Belenko, 2011), and early intervention, *effective* treatment, and mandated treatment for substance-abusing behavior and mental health issues can reduce recidivism (e.g., drug use, crime, incarceration; National Institute of Justice, 2006; Peters & Belenko, 2011; Steadman, Relich, Callahan, Robbins, & Vesselinov, 2011). In this vein, more than 2,000 drug courts (American University, 2011), 250 mental health courts (Redlich, Steadman, Monahan, Robbins, & Petrilia, 2006; Steadman et al., 2011), and, most recently and of interest to this study, 114 veterans treatment courts (VTCs; Baldwin, 2015) have been implemented in the United States.

As a continuation of the specialized court movement, the criminal justice system created VTCs in light of the increased recognition of veterans[1] in contact with the criminal justice system and the constellation of issues challenging veterans (Baldwin, 2013, 2015).[2] Their goal is to divert veterans from the institutional correctional setting to mandated treatment/services to address any underlying issues that may be related to criminal behavior.[3] The development and national dissemination of VTCs are evidence of the growing concern for and interest in veterans in contact with the criminal justice system because of service-related issues (White, Mulvey, Fox, & Choate, 2012).

Given their recent development, VTCs are less researched than their more well-established specialized court counterparts, especially drug courts. It has been only a little more than a decade since the first VTCs were established, and less than a decade

since the concept disseminated nationally, gaining media attention (Baldwin, 2013, 2015; Baldwin & Rukus, 2015; DeMatteo et al., 2013). As such, there is still much to learn concerning these courts and their participants. Thus far, the current extant literature[4] has either provided an overview of VTC operation, including origins, criticism, and justifications for these courts (i.e., Cartwright, 2011; Cavanaugh, 2011; Hawkins, 2010; Russell, 2009; Smith, 2012; Totman, 2013; Walls, 2011); described a particular court (i.e., Hawkins, 2010; Smith, 2012); or discussed recidivism of veterans who have participated in a treatment court (i.e., Smith, 2012). In addition to these areas, research on theory (Baldwin & Rukus, 2015), national operation, structure, and implementation (Baldwin, 2013, 2015; Baldwin & Rukus, 2015), and recidivism (Smith, 2012) is beginning to emerge.[5]

To further add to the important and growing foundation of this area of research, this article documents the state of the veteran population currently being served by VTCs across the country, illustrating the first national portrait of this group. Specifically, this study focuses on the personal and military characteristics of veterans in VTCs nationwide, as well as their legal, extralegal, and program challenges. These results are further examined by sex and juxtaposed with the national veteran population. Finally, this study examines the perceptions of VTC personnel concerning the relationships between the military service and the legal and extralegal issues faced by the veterans. The findings of this study are intended to provide a national context for site-specific (single and multiple) studies examining veterans in VTCs, as well as studies focusing on participants in other specialized courts. To understand the contribution of this study, a review of the extant research on the following is first conducted: (a) the challenges that may face veterans and (b) veterans in contact with the criminal justice system in general.

Non-Legal Issues and Military Service/Training

Much research has examined relationships between military service and subsequent non-legal issues (e.g., mental illness) particularly among Vietnam-era veterans. Today, a large body of research spanning combat eras indicates that a distinct constellation of issues and needs (i.e., mental health, substance abuse, homelessness) exists within the veteran population.[6]

As a result of clinical research conducted after the Vietnam War, post-traumatic stress disorder (PTSD) is known to be prevalent among veterans, even those who have not had direct combat experience.[7] While causes vary, a strong relationship between combat experience, traumatic experience, and the development of PTSD has been consistently identified (e.g., Fontana & Rosenheck, 1994; Hoge et al., 2004; Seal et al., 2009; Veterans Health Administration Office of Public Health and Environmental Hazards, 2008). PTSD complicates numerous aspects of life, including reintegration into civilian life (Lee, Vaillant, Torrey, & Elder, 1995). Evidence also suggests that PTSD negatively impacts both mental and physical health. For veterans in post-Vietnam eras but prior to the 9/11 era, PTSD has worsened mental and physical health (Ren, Skinner, & Lee, 1999) and resulted in adjustment issues (Lee et al., 1995).

Beyond PTSD, medical science is now discovering the existence of, and identifying the symptoms associated with, traumatic brain injury (TBI),[8] which is becoming increasingly common among veterans from the more recent military era Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn (OIF/OEF/OND). The Defense and Veterans Brain Injury Center (DVBIC) reported that more than 300,000 TBI medical diagnoses occurred in the U.S. armed forces from 2000 through 2014 (DVBIC, 2014). The DVBIC also stated that TBI accounted for approximately 25% of OIF/OEF combat injuries, which is more than 2 times that of Vietnam (DVBIC, 2011). Approximately 20% of frontline infantry suffered concussions in combat (Associated Press, 2004; Hoge et al., 2008; Zoroya, 2006).

The National Council on Disability (2009) stated that TBI and PTSD have been named the "'signature injuries' of the Iraqi War" (p. 1). The council estimated that approximately 25% to 40% of recent era veterans have psychological and neurological injuries related to PTSD and TBI. Approximately 17% of OIF veterans who return home were diagnosed with a serious mental disorder, which constitutes a twofold increase over pre-deployment levels (Hoge et al., 2004). Although some increase in these mental injuries might be attributable to improved detection methods, it is likely that their prevalence is rising with the increase in survival rates as survival rates from the current theater are higher than previous engagements (Peake, 2005). More veterans are returning with physical trauma, chronic pain, and mental health issues to join the already wounded veteran population.

Onset of symptoms caused by PTSD or TBI can occur anytime from immediately after the traumatic experience to years after the event(s). In Vietnam-era veterans, Kulka et al. (1990) found PTSD to be prevalent in approximately one third of their sample within the first year of return from combat, while Schlenger and colleagues (1992) discovered that 15.2% of the males and 8.5% of females[9] had PTSD 15 or more years after service. Delayed onset has been documented as surfacing as late as 6 months—*Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000)—to 40 years (Aldwin, Levenson, & Spiro, 1994; Brunello et al., 2001; Spiro, Schnurr, & Aldwin, 1994) after the traumatic experience. Accordingly, the Institute of Medicine (2010) stated that the full need of the most recent era of veterans may not peak until 2040, suggesting that the full extent of PTSD, as well as other mental wounds, among veterans is not yet fully known.

In addition to these mental health issues, veterans have historically been at risk for substance-abusing behavior. For example, references to morphine addiction, then referred to as "soldier's disease," date as far back as the Civil War (Albin, 2001). Higher rates of alcohol consumption within the military and veteran populations are well-known, and this assertion has been scientifically supported (e.g., Bray et al., 2009a, 2009b). This most recent era's deployments and combat exposure may be associated with increased alcohol consumption, binge and heavy drinking, and alcohol-related problems (Jacobson et al., 2008; Spera, Thomas, Barlas, Szoc, & Cambridge; 2011). Although specific percentages vary with reports ranging from 40% of OIF/OEF veterans engaging in potentially dangerous alcohol use (Calhoun, Elter, Johnes,

Kudler, & Straits-Troster, 2008) to 43% of active-duty military personnel being classified as binge drinkers (Stahre, Brewer, Fonseca, Naimi, 2009), Bray, Brown, and Williams's (2013) decade-long examination of alcohol consumption trends (1998-2008) discovered steady and significant increases in heavy drinking (from 15% to 20%) and binge drinking (from 35% to 47%) among military personnel. Alcohol use among military personnel and veterans has become so prevalent that alcohol has been called one of the "signature substances" of OIF/OEF/OND veterans (Institute of Medicine, 2012).[10]

The co-occurrence of mental health issues and substance abuse is often examined. Mental health issues may intensify veterans' propensity for substance abuse and addiction as self-medication is often used as a means to cope with mental health symptoms.[11] For example, Vietnam veterans with PTSD have also experienced significant problems with substance addiction (Bremner, Southwick, Darnell, & Charney, 1996; Jordan et al., 1991; Kulka et al., 1990; McFall, Mackay, & Donovan, 1991; McGuire, Rosenheck, & Kasprow, 2003). Similarly, 75% of Vietnam combat veterans diagnosed with PTSD also had alcohol abuse or dependence issues (Kulka et al., 1990), and OIF/OEF veterans who had PTSD or depression were twice as likely than those without both disorders to abuse alcohol (Jakupcak et al., 2010).

Despite the attention given to veterans' issues that has come with this empirical knowledge, there are impediments preventing veterans from obtaining the appropriate treatments and services needed to address these issues. In particular, the Department of Defense Task Force on Mental Health (2007) identified two barriers to service in the current system: (a) the stigma (real or perceived) related to receiving mental health treatment and (b) insurance coverage. Military resistance to mental health care stems from the anticipation of negative perceptions by their peers and leaders. This stigma is disproportionately evident in those most in need of mental health services (Hoge et al., 2004). For example, of OIF/OEF soldiers with a mental health disorder (including major depression, generalized anxiety, and PTSD) after deployment, only 23% to 40% sought care for mental health. In comparison with veterans without these issues, afflicted veterans were twice as likely to have a higher concern about both stigmatization and the obstacles hindering access to mental health services (Hoge et al., 2004). Second, care may not be readily accessible or insured through the Department of Veterans Affairs (VA) due to specific eligibility requirements. To receive services such as mental health treatment from the Department of Veterans Affairs, the veteran cannot have a discharge status of *dishonorable* (U.S. Department of Veterans Affairs, 2010, 2014b). This requirement precludes VA aid to veterans who may be in need of such services.

As illustrated here, barriers to treatment and services currently exist for a population that is or is more likely to be in need of these services, and if these issues are not addressed, additional ramifications, such as contact with the criminal justice system, may result. Antisocial behavior, including aggression, violence, substance abuse, and even homelessness, that manifests as a consequence of combat-related mental health issues may further draw attention from law enforcement (Beckerman & Fontana, 1989; Drug Policy Alliance, 2009; Erickson, Rosenheck, Trestman, Ford, & Desai,

2008; Freeman & Roca, 2001; Lasko, Gurvits, Kuhne, Orr, & Pitman, 1994; Sherman, Sautter, Jackson, Lyons, & Han, 2006). When untreated and/or unresolved, these specific issues with symptoms of illegal, violent, or hostile behavior[12] (Elbogen et al., 2012; Greenberg & Rosenheck, 2009) may put veterans at a higher risk for incarceration than the general population (e.g., Greenberg & Rosenheck, 2009; McGuire et al., 2003; Saxon et al., 2001).

Veterans and the Criminal Justice System

Whereas the majority of U.S. military personnel return to civilian life without experiencing legal issues, a substantial subgroup of veterans comes into formal contact with the criminal justice system as a result of criminal or delinquent behavior. This subgroup of veterans has been recently referred to as "justice-involved veterans" (JIVs). Several organizations, including the Bureau of Justice Statistics (BJS), VA, and Substance Abuse and Mental Health Services Administration (SAMHSA), have mentioned the existence of this group.[13]

Researchers have explored the presence of veterans in the adult incarcerated population. Recently, Noonan and Mumola's (2007) policy review used data from the 2004 Survey of Inmates in State and Federal Correctional Facilities, while White and colleagues (2012) collected data on veterans in Maricopa County Jail (the fifth largest county jail in the country) in 2009. Although incarceration rates for veterans rose 46% from 1985 to 1998[14] (Mumola, 2000), the percentage of incarcerated veterans has declined nationally in recent years with an 8% decrease in state prisons from 1986 to 1997 and a 13,100-person decrease from 2000 to 2004 in federal prisons (Noonan & Mumola, 2007). Most recently, White et al. (2012) found that only 6.3% of their arrestee sample reported serving in the U.S. military, which is lower than the national average of 10% (Noonan & Mumola, 2007). These more recent results discovered by White and colleagues may be related to the decline of 3.5 million veterans in the general population (Noonan & Mumola, 2007; White et al., 2012). Although the incarcerated veteran population has decreased, it is anticipated to increase as soldiers continue to return from the current OIF/OEF/OND conflicts (Reger, Gahm, Swanson, & Duma, 2009; White et al., 2012).

Two of the first VTC judges (i.e., Judge Murphy of the Alaska VTC and Judge Russell of the Buffalo [New York] VTC) have explained their defendant populations, which served as the impetus for creating their respective VTCs. First, Judge Murphy (Alaska) witnessed many veterans repeatedly appearing in his court (Smith, 2012), which is reminiscent of the repeat drug offenders who served as partial provocation for the creation of drug courts. Second, Judge Russell (Buffalo) (2009) listed the following issues as the primary ones facing veterans on his docket: alcohol and drug abuse, homelessness, strained relationships, unemployment, and mental health.

Characteristics of incarcerated veterans. Several studies have documented the characteristics of incarcerated veteran samples. For example, more than three quarters (81%) of nationally incarcerated veterans had substance abuse issues prior to incarceration

(Mumola, 2000). Within White and colleagues' (2012) Maricopa County sample, more than half of the incarcerated veterans reported at least one combat-related problem, such as physical injury, mental health issues (including PTSD), or substance abuse. Both Noonan and Mumola (2007) and White et al. (2012) found fewer veterans from the OIF/OEF/OND era in comparison with other eras (i.e., in their national incarcerated state and federal prison veteran populations [5%] and their jail sample, respectively). Specifically, only 5% of the incarcerated veterans in Noonan and Mumola's 2004 national study of state and federal prisons and 16% of incarcerated veterans in White et al.'s Maricopa County study were OIF/OEF/OND veterans. However, Noonan and Mumola's (2007) research employed data from 2014, reporting this era as OIF/OEF from 2002 to 2004. Although a more recent study found a higher percentage of OIF/OEF/OND veterans, White and colleagues (2012) noted the historical context of their findings as their study was conducted on arrestees in 2009: "There will be a substantial influx of returning veterans of OIF/OEF in 2011-2012" (p. 278).

Some researchers have compared characteristics and predicted arrest within the JIV subgroup. In a convenience sample of incarcerated veterans located in two counties in Washington, those with PTSD had higher lifetime rates of substance use, more severe legal problems, and poorer health than veteran inmates without PTSD (Saxon et al., 2001). In a national survey of OIF/OEF/OND-era veterans, history of arrest was shown to be a strong predictor of future arrests (Elbogen et al., 2012), which is in line with statistically significant findings of arrest prediction models for most samples of any population. For example, history of arrest was a statistically significant predictor of future arrest for both veterans and non-veterans in opiate treatment programs (Rothbard et al., 1999).

Veterans: Incarcerated versus un-incarcerated. Research has compared the characteristics of incarcerated veteran samples with the national population of both incarcerated and un-incarcerated veterans. Findings show substantial differences between veterans who have and who have not been incarcerated on the basis of factors such as military branch, marriage, employment, family support, and legal and non-legal issues. Contrary to the total national veteran population, Army veterans were overrepresented while Air Force veterans were underrepresented in state prisons (Noonan & Mumola, 2007). Veterans who had never been incarcerated were more likely to be married than incarcerated veterans (Greenberg & Rosenheck, 2009), and incarcerated veterans who were married had been more dissatisfied in their marriages than un-incarcerated veterans (Shaw, Churchill, Noyes, & Loeffelhoz, 1987). Incarcerated veterans were also found to have significantly more employment instability and shorter employment histories (Shaw et al., 1987), more problems with their families (Benda, Rodell, & Rodell, 2003), less family support (Benda et al., 2003), and higher rates of spousal abuse (Gondolf & Foster, 1991), as well as report substance abuse or be diagnosed with substance abuse disorder (Elbogen et al., 2012; Erickson et al., 2008; Shaw et al., 1987), when compared with their un-incarcerated counterparts. Research also suggests that incarcerated veterans may have a higher risk for suicide than either veteran status

or incarceration alone (Frisman & Griffin-Fennell, 2009; Wortzel, Binswanger, Anderson, & Adler, 2009).

Inmates: Veterans versus non-veterans. Incarcerated veterans differ from inmates drawn from the civilian population in several notable ways. In general, incarcerated veterans are ordinarily older, less racially/ethnically diverse (more White), and more educated, more frequently employed full-time than their non-veteran incarcerated peers (Noonan & Mumola, 2007; White et al., 2012). In addition, more veterans were incarcerated for violent offenses than non-veteran inmates (Noonan & Mumola, 2007; White et al., 2012), and incarcerated veterans were more likely to report a recent history of receiving mental health services (i.e., overnight hospital stay, diagnosis, prescription, therapy; Noonan & Mumola, 2007). Fewer veterans reported past drug use (75%) and recent drug use (42%) than civilians (84% and 58%, respectively) in their national study (Noonan & Mumola, 2007).

VTCs and Their Participants

As noted above, research on VTCs is slowly beginning to emerge as these courts move from their infancy and integrate into the established system of criminal courts. To date, two studies have examined the veterans who are participating in VTCs: (a) Smith (2012) utilized the records of 133 Alaska VTC veterans who were eligible for participation and attended hearings between July 1994 and December 2010, and (b) Slattery, Dugger, Lamb, and Williams (2013) conducted an early impact evaluation of a VTC in Colorado, examining 83 participants over 3 years. The majority of participants in both studies were male and White (Slattery et al., 2013; Smith, 2012), which is consistent with the demographics of the armed services as a whole. The majority of Slattery et al.'s (2013) sample served in the Army, were OIF/OEF-era veterans (no longer enlisted), had an average of two tours of duty in combat, and had a mean age below 30 years. Conversely, Smith's (2012) sample was primarily older and, relatedly, from eras prior to OIF/OEF/OND. The majority of the Alaska VTC participants had assault charges. All of the Colorado VTC participants screened positive for PTSD, between one quarter to one half (depending on the screening tool) were positive for TBI (one third with PTSD had TBI), and half tested positive for a "strong potential" for substance abuse or dependence. At baseline, approximately three quarters of the Colorado VTC participants lived in their own home.[15]

The results from Smith (2012) and Slattery et al.'s (2013) studies must be viewed within the context of the eligibility requirements respective to their VTCs because not all veterans are eligible for participation in all VTCs. Many VTCs limit eligibility on the basis of various military, VA, criminal history, charge, or sentence statuses (Baldwin, 2013, 2015). Smith's Alaska VTC site only accepted veterans as defined by federal law and charged with misdemeanors in the Municipality of Anchorage. Furthermore, the Alaskan VTC's agreement with the prosecutor included "the right to refuse . . . otherwise eligible individuals entry . . . due to their current offense, criminal history, or history with the VA" (Smith, 2012, p. 97). The eligibility requirements of Slattery et al.'s Colorado VTC were not reported.

This Study

The current study addresses the understudied population of veterans in contact with VTCs using data collected through a national survey of VTCs. As such, this study is exploratory in nature, with the intention of determining the personal and military demographics, the legal and extralegal problems, and the programmatic challenges of veterans in VTCs across the country. Furthermore, the existence of sex-specific challenges is explored by comparing the legal, extralegal, and programmatic issues (both legal and treatment-oriented) between males and females. VTC case statuses (i.e., active, graduated, terminated, drop out, opt out, returned), as well as the reasons for dropping out, opting out, and being terminated, are ascertained. Finally, the VTC practitioners' perceptions of the relationships between military service, challenges, and crime within this population are examined.

In addition to being the first study to examine these VTC elements on a national level, close to the date of their national proliferation, this research serves several purposes for both academic scholarship and practitioner work in the area of VTCs. This study provides a national context for single- and multi-site VTC studies, allowing scholars and practitioners to view emerging studies within a time-relevant national context. This examination also allows for comprehensive studies of change because this research was conducted close to the time of the dissemination of VTCs across the country, which is a limitation of the few national surveys of various specialized courts (Baldwin, 2015). Furthermore, this study adds to the limited literature on participants in specialized courts in general at the national level.

Method

This study conducted a survey that was administered to the national population of VTCs. Qualtrics®, an online survey software program, was used to create and administer the survey.[16]

The guidelines set forth in Dillman, Smyth, and Christian (2009) were adhered to in the creation of the survey instrument. The survey included 70 hybrid,[17] closed, and open-ended items. Spacing and layout of surveys have been shown to bias responses (Dillman et al., 2009), but Qualtrics® standardizes both the spacing and layout of the survey instrument. Bipolar-scale items presented five response options;[18] the scales were also fully labeled to increase reliability and validity (Krosnick & Fabrigar, 1997). The 70 survey items were divided into eight sections, and the current study examines items from the following three sections: (a) Participant Demographics, (b) Veterans Court Dynamics and Outcomes, and (c) Outcomes, Opinions, and Other.

Population Frame: The National Compendium

Several steps were taken to identify the population frame because a list of VTCs across the country did not exist at the time this research was initiated. A Google Alert with the terms "veterans court," "veterans treatment court," and "veterans court legislation" was created in June 2010, which produced 528 media reports/Internet resources up to

May 2012. The VTCs discovered were listed to start the compendium. Justice for Vets (JFV), a nonprofit organization devoted to connecting veterans in contact with the criminal justice system to VTCs, posted a list of VTCs on its website in May 2012, and VTCs listed by JFV that were not already included in the list were incorporated.[19] In June 2012, administrative court offices in each state were contacted to identify VTCs that were either in operation or in the process of being established; any additional VTCs were added to the compendium. This third step was repeated in October 2012 to achieve the most up-to-date compendium.[20]

Contacts for each VTC were also obtained and included in the compendium. Contact information was procured from the Internet (e.g., specific VTC websites, court websites, names to search from media reports) and from telephone and email communication with personnel in numerous court systems and offices of court administration.[21] Based on these communications, it was possible to ascertain whether each VTC was in operation. As of November 1, 2012, the full compendium listed 114 VTCs in operation in 32 states. An additional 2 VTCs were in transition, and 1 was on hold due to the absence of current participants. Furthermore, 18 VTCs were in the planning stages in 9 states (Baldwin, 2015).

Data Collection

In the dissemination and administration of the survey, the guidelines set forth in Dillman et al. (2009) and several best practices (e.g., Nulty, 2008; Zúñiga, 2004) were followed to increase response rates. Specifically, the latter methods included the following: (1) assuring anonymity of responses, (2) frequent reminders, (3) persuading respondents their responses will be used, (4) providing rewards, (5) extending duration of availability, and (g) pushing the survey through easy access (URL provided directly via email). Similarly, the author utilized personalized and repeated contact (this strategy is referred to as "7" in subsequent paragraphs; Dillman et al., 2009; Nulty, 2008; Zúñiga, 2004). The implementation of each method (referred to numerically) is explained in the following paragraphs.

In June 2012, each VTC contact listed in the population frame at that time was called (7). They were informed that their responses would be used for both academic and practitioner purposes (3), responses would only be reported in aggregate and no one other than the principal investigator (PI) would have access to their identifying information (1), and an executive summary of the results would be sent in return for their participation (3,4). From Qualtrics®, a personalized email containing the aforementioned information, the survey link, a deadline, and the principal researcher's contact information was sent to all whom agreed to participate (1,3,4,6,7). Immediately after the Qualtrics® email was sent, the PI sent a follow-up email from her personal email address also containing this information (1,2,3,4,6,7). At the 3-week and 1-week dates preceding the deadline, reminder emails, which included the survey link, were sent from the PI's private email address to potential participants who either did not complete or start the survey (2,6).

If the survey was not completed by the original deadline, the PI called those potential participants to ask them whether they were still willing to participate (2,7). If they

were, the PI provided an extension (5); if they were not, the PI requested an alternate qualified contact.[22] For the newly provided contacts and additional VTC contacts obtained from the second round of phone calls to court administration, the procedure previously explained was repeated between August and October 2012 (1,2,3,4,5,6,7). The PI closed the survey on December 1, 2012, concluding the 6-month data collection effort.

Respondent Sample

The response rate was 69% of the population,[23] specifically 79 VTC contacts responded to the national survey. It is important to keep in mind that the responses to the items are the data provided by and perceptions of the respondents. Slightly more than half of the respondents (51.8%) are male, and the most reported VTC occupations (32.9%) were program or court coordinators, followed by VJOs (15.1%) and administrators/directors/superintendents (15.1%; see Baldwin, 2015: Table 1). Non-response trends were examined; however, the location was the only information available for both participating and nonparticipating VTCs. Based on the four regions defined by the U.S. Census Bureau (i.e., West, Midwest, South, Northeast), the West had the highest response rate (80%), and the Northeast had the lowest response rate (56%; Baldwin, 2015). No statistically significant difference emerged between regions (Baldwin, 2015).

Measures

Personal and military characteristics. In a previous survey by the PI, most VTCs stated that their quarterly reports consisted of percentages. Therefore, survey participants were asked to provide the "percentage of veterans with cases in your veterans court during its operation that are" of specific personal and military categories. The personal demographics requested were sex (i.e., women, men), race/ethnicity (i.e., White [non-Hispanic], African American [non-Hispanic], Hispanic, Asian/Pacific Islander), and age ranges (i.e., 18-20, 21-25, 26-30, 31-40, 41-50, 51-60, more than 60). The military characteristics included active-duty status, veterans from specific eras (i.e., OIF/OEF/OND, Vietnam, Gulf War), branches of service (i.e., Army, Navy, Marines, Air Force, Coast Guard, National Guard), and trauma experience. These items were "sliders" in Qualtrics® where the respondents could move the bar anywhere along a continuum between 0% and 100%. As the respondents move the bar, the respondent can see the actual percentage (e.g., "22%," "53%," "85%"). For the results, the percentages were averaged to produce an overall percentage across VTCs. In addition, standard deviations were calculated to show the differences between participant populations in VTCs across the United States.

Legal charges by sex. Separate hybrid items for males and females were used for legal charges. In the first item, survey participants were asked to provide "the percentages of the MALE VETERANS that have participated in veterans court" for the following offenses: drug (not driving under the influence [DUI] or driving while intoxicated

Table 1. Personal Characteristics of Veterans Ever in 79 VTCs.

Personal characteristics	Average %; *n* = 3,649 (*SD*)	National veteran population %[a] *N* = 21,854,374 (Age range)
Sex		
Male	91.7 (14.0)	93.2
Female[b]	5.6 (6.0)	6.8
Race/ethnicity		
White (non-Hispanic)	62.2 (24.9)	84.8
African American (non-Hispanic)	30.3 (25.3)	10.5
Hispanic	11.9 (13.7)	5.2
Asian/Pacific Islander (non-Hispanic)	0.7 (1.4)	1.2
Age		
18-20 years of age	3.4 (5.4)	<.1 (<20)
21-25 years of age	18.6 (17.6)	1.3 (20-24)
26-30 years of age	21.0 (15.0)	3.4 (25-29)
31-40 years of age	22.6 (15.3)	8.4 (30-39)
41-50 years of age	22.6 (15.1)	14.3 (40-49)
51-60 years of age	16.4 (14.5)	17.3 (50-59)
61+ years of age	11.8 (10.8)	49.1 (60-60+)

Note. VTC = veterans treatment court.
[a]U.S. Census Bureau (2010a, 2010b, 2010c) and Westat (2010).
[b]The majority of VTCs (61 VTCs, 77.2%) reported having female participants.

[DWI]), traffic (not DUI or DWI), DUI or DWI, domestic violence, violent (not domestic), weapons, theft/fraud, and prostitution. In addition, there were open-ended items ("other (specify)") provided for the participants type in charges not listed or that were more specific. The hybrid item for females listed the same response options as the male item and requested "the percentages of the FEMALE VETERANS that have participated in veterans court." Both sex-specific items employed the "slider" format described in the personal and military characteristics measure above. Results for legal charges were calculated in the same fashion as the personal and military characteristics: percentages were averaged for an overall percentage across VTCs and standard deviations were produce to determine whether charges (male and female) widely varied across VTC participant populations.

Extralegal challenges by sex. These items structurally mirrored those inquiring about legal challenges: separate items for males and females, "slider" response, and inclusion of the "other (specify)" response categories with the write-in component. In addition to the "other (specify)" response options provided, response options for both items included "homelessness, unstable housing," "substance abuse problem," "mental health problem," "family issues," and "anger management, violence issues." Average percentages and standard deviations were produced in the same ways and for the same reasons as the previous two measures.

VTC compliance issues by sex. VTCs can require veteran participants to complete various tasks (e.g., participate in substance abuse and/or mental health treatment, pay restitution, pass medication and/or drug screenings, obtain employment; Baldwin, 2015). Some requirements may be more difficult than others for participants, and the author wanted to also determine whether the levels of difficulty varied by sex. Thus, separate but identical items for males and females were created. The first item began with "For MALE VETERANS," and the second item began with "For FEMALE VETERANS." Both items continued with "please rank the items they have the hardest time complying with (1 = *hardest*, 11 = *easiest*). These items provided the following requirements for ranking "passing drug screens," "passing medication screens," "attending treatment sessions," "obtaining steady housing," "abiding by housing facility rules," "obtaining steady employment," "stop making money illegally (example: stop selling drugs or prostitution)," "reconciling with family/spouse," and "controlling anger/violence." Additional hybrid response options with write-in components were also provided: "following OTHER probation requirements NOT already listed, specify:" and "Other (specify)." For interpretation purposes, the results were reverse coded, resulting in 0 representing the easiest and 10 representing the most difficult requirements, and only the top 11 issues (0-10) are reported.

Number of veterans in VTC and status of VTC cases. In an open item, respondents were asked to indicate the number of individuals who "have EVER had cases in your veterans court (current and past cases)" (referred to as "total"), "have active cases in your veterans court (currently on docket)" (referred to as "open"), "have graduated from veterans court" (referred to as "graduates"), "were eligible . . . but opted to NOT have their case in veterans court" (referred to as "opt outs"), participated in veterans court "but then later decided to no longer have cases in the veterans court" (referred to as "drop outs"), had cases "terminated by the court" (referred to as "terminated"), and "have had more than one case in veterans course (. . . graduated from veterans court but then had another charge so was accepted back into veterans court)" (referred to as "returners"). Responses for each category (i.e., total, open, graduate, opt out, drop out, terminated, and returner) were summed, and the sums for each category are reported.

Reasons for dropping out, opting out, and being terminated. In two separate open-ended items, respondents were asked "What reasons did veterans provide for not wanting to participate in your veterans treatment court?" and "What reasons did veterans provide for dropping out (their choice) of your veterans treatment court program after agreeing to participate?" Respondents could provide as many reasons as necessary. For termination, a hybrid item asked, "For what reasons have veterans been terminated (kicked out) of your veterans treatment court program?" This item was not mutually exclusive, and response options included "violation of probation," "positive drug screen," "negative medication screen," "nonparticipation in treatment," "failure to appear in court," "commission of a new criminal offense," "re-arrest for same offense," and "re-arrest for different offense," as well as the "Other, please specify" option with the ability to write in the response(s). The write-in options for the former open-ended items (two)

and the latter hybrid item (one) underwent thematic coding (see "Analytic Strategy," next subsection). Once all responses of the three items were coded and subsequently quantified, they were summed and converted into the percentages that are reported.

Perceptions of relationships between military service, legal issues (crime), and extralegal issues. In three separate items, respondents were asked whether the relationship between the following existed: (a) military service and extralegal issues, (b) extralegal issues and legal issues (crime), (c) military service, extralegal issues, and legal issues (crime). All items utilized a 5-point Likert-type scale (i.e., *definitely yes, probably yes, maybe, probably not, definitely not*). The percentages of each response for each item are presented.

Analytic Strategy

Because the purpose of this study is to provide a comprehensive national portrait of veterans in VTCs across the country, the results are descriptive in nature. Whereas the majority of the items were closed, thematic coding was necessary for the open-ended items and the hybrid items' write-in portions (e.g., "other (specify)"). Thematic coding was utilized for three reasons:[24] (a) the survey was exploratory with the goal of determining categories, (b) the data came from survey research with multiple participants, and (c) the survey employed standardized and semi-structured items (Fowler, 2001; Saldaña, 2013; Wilkinson & Birmingham, 2003). In chronological order, the following steps were manually taken: data organization, initial reading and memoing (noting initial themes) within items, and thematic coding (using but expanding on initial themes; Creswell, 2013).

Furthermore, the open-ended responses and write-in responses in the hybrid items were exported. These were then stored and analyzed using MAXQDA 11, qualitative software that allows for pattern identification, thematic analysis, and visualization. Using MAXQDA 11, the author was able to systematically affirm the themes that emerged from the previously explained manual coding. These themes were then quantified for descriptive analysis (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 2003). The author only minimally collapsed themes (as she deemed necessary) to allow for a detailed portrait of these veterans. The final themes presented below were not further combined beyond what was previously described, and standard deviations are included in certain tables to illustrate the variations in VTC populations across the United States.

Results

All respondents (n = 79) provided average percentages of the personal characteristics and military characteristics of veterans who have ever been in their VTCs, and these results are presented in Tables 1 and 2, respectively. Most VTC participants are male (91.7%), White non-Hispanic (62.2%), and no more than 30 years of age (averages of 3.4% 20 and younger, 18.6% 21-25, 21.0% 26-30). Although the large majority of

Table 2. Military Characteristics of Veterans Ever in 79 VTCs.

Military characteristics	Average %; *n* = 3,649 (*SD*)	National veteran population %[a] (*N* = 21,854,374)
Active duty		
Active-duty reserves	7.6 (11.4)	—
Active-duty military	2.9 (5.2)	—
Era		
OIF/OEF/OND	38.5 (24.6)	11.7
Vietnam	25.3 (22.1)	33.5
Gulf War	15.1 (16.0)	25.3
Branch		
Army	47.6 (22.2)	44.0
Marine Corps	29.5 (21.1)	11.0
Navy	15.7 (14.8)	23.0
National Guard	13.2 (16.2)	
Air Force	13.0 (10.6)	18.0
Coast Guard	5.8 (9.6)	1.0
Trauma experience	71.1 (24.0)	

Note. OIF/OEF/OND = Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn; VTC = veterans treatment court.
[a]U.S. Census Bureau (2010a, 2010b, 2010c) and Westat (2010).

VTC veterans are male, more than three quarters of VTCs (77.2%) reported having female participants. Most participants are truly veterans (exited from military service) as few are active-duty military (2.9%) or reserves (7.6%). OIF/OEF/OND (38.5%) is the most represented era, and most VTC participants were in the Army (47.6%) and experienced trauma (71.1%). All VTCs reported having males, Whites, and veterans with trauma experience in their participant populations (not shown).[25] In addition, in open-ended items, VTCs reported recently seeing an increase in younger participants, female participants, and participants with substance abuse and/or mental health issues than previously.

Large standard deviations in Tables 1 and 2 indicate high variability in veteran participant demographics across VTCs in this national sample.[26] Across VTCs, the most variability exists regarding race, specifically for African American (non-Hispanic; *SD* = 25.3%) and White (non-Hispanic; *SD* = 24.9%), followed by era (*SD* for OIF/OEF/OND = 24.6% and Vietnam = 22.1%), trauma experience (*SD* = 24.0%), and branch (*SD* for Army = 22.2% and Marine Corps = 21.1%). The least variability is also related to race with a *SD* of 1.4% for Asian/Pacific Islander (non-Hispanic).

When comparing the responding VTCs' participants with the national population of veterans, several differences in characteristics exist, specifically with regard to race/ethnicity, age, and military era and branch. African Americans, Hispanic, younger, OIF/OEF/OND-era, and Marine Corps veterans are overrepresented in the VTC participant sample. Conversely, White, older (i.e., minimum of 60 years of age), Vietnam-and

Table 3. Offenses Bringing Veterans to VTC and Issues Faced by Sex in 79 VTCs *Not Mutually Exclusive*.

	Average % of males veterans; *n* = 3,357 (*SD*)	Average % of female veterans; *n* = 219 (*SD*)
Legal issues (criminal offenses)		
Drug (not DUI/DWI)	49.5 (30.6)	43.4 (42.9)
DUI or DWI	39.0 (23.6)	48.7 (44.6)
Theft or fraud	22.4 (20.4)	40.4 (34.5)
Domestic violence	20.7 (19.6)	9.8 (12.0)
Violent (not domestic)	17.6 (16.4)	27.0 (38.3)
Traffic (not DUI/DWI)	10.9 (16.0)	3.7 (6.6)
Weapons	8.6 (8.3)	0.6 (1.1)
Prostitution	5.5 (18.6)	6.5 (8.0)
Extralegal issues faced		
Substance abuse	81.1 (19.6)	67.6 (38.9)
Mental health	68.4 (25.4)	58.8 (40.0)
Family issues	55.7 (32.0)	53.6 (40.9)
Anger, aggression, violence	44.0 (26.5)	24.6 (33.1)
Homelessness	34.2 (27.0)	31.3 (33.5)

Note. VTC = veterans treatment court; DUI/DWI = driving under the influence/driving while intoxicated.

Gulf War-era, and Navy veterans are underrepresented in the VTC participant sample.

All responding VTCs (n = 79) reported average percentages by sex for both the legal issues (i.e., criminal offenses) that brought participants to VTCs and their extralegal issues. In Table 3, similarities and differences emerged between the sexes, and the standard deviations indicate both variability and consistency across courts. The most prevalent legal issues for both males and females are drug (49.5% of males, 43.4% of females) and DUI/DWI (39.0% of males, 48.7% of females), but theft/fraud is also highly reported for females (40.4%). On average, males are in VTCs more often for drug, traffic, domestic violence, and weapons charges than females, whereas female veterans are in VTCs for more DUI/DWI, violent (non-domestic), theft/fraud, and prostitution charges than their male counterparts.

Regarding extralegal issues, differences exist between the sexes after the top three primary challenges. Substance abuse (81.1% of males, 67.6% of females), mental health (68.4% of males, 58.8% of females), and family issues (55.7% of males, 53.6% of females) were the most reported challenges for both sexes on average. Beyond these similarities, the fourth most reported extralegal challenge is homelessness (31.3%) for females but is anger/aggressive/violent behavior for males (44.0%).

Overall, there was greater variability for both males and females in the extralegal issues in comparison with the variation of legal issues across VTCs. Specifically, variability across VTCs is high (cut point of 20%) for the following three legal issues of

males: drug (not DUI/DWI; *SD* = 30.6%), DUI/DWI (*SD* = 23.6%), and theft/fraud (*SD* = 20.4%). High variability across VTCs for females also emerged in the same three areas: DUI/DWI (*SD* = 44.6%), drug (non DUI/DWI; *SD* = 42.9%), and theft/fraud (*SD* = 34.5%). In addition, high variability across VTCs for females included a fourth offense type of violence (non-domestic; *SD* = 38.3%). However, the high variability across VTCs emerged in four extralegal categories for males (family *SD* = 32.0%, homelessness *SD* = 27%, anger/aggression/violence *SD* = 26.5%, mental health *SD* = 25.4%) and in five for females (family *SD* = 40.9%, mental health *SD* = 40.0%, substance abuse *SD* = 38.9%, homelessness *SD* = 33.5%, anger/aggression/violence *SD* = 33.1%).

The least amount of variation (cut point of 5%) across courts only emerged for females for weapons charges (*SD* = 1.1%). The standard deviation for females is higher than males for all issues faced with the exception of domestic violence, traffic, weapons, and prostitution charges. All standard deviations exceeded the cut point of 20% for both sexes with the exception of male substance abuse (19.6%). Aside from that exception, all standard deviations for males and females ranged from 25.4% (male mental health) to 40.9% (female mental health, female family issues). Although minimums and maximums were not included in Table 3 for either legal or extralegal issues, these values lend to a further understanding of the participant population across VTCs. The minimums for all legal and extralegal issues for males and females were 0% except for substance abuse and mental health for males, meaning male participants with substance abuse or mental health issues are prevalent in all of the VTCs sampled.

Figure 1 illustrates the levels of difficulty male and female veterans have in complying with VTC mandates, as perceived by 36 VTC respondents. Respondents reported that passing drug screens is the most difficult compliance requirement for both male and female participants (ranked as 10 for both sexes). Other requirements that are most challenging for both sexes (ranging from levels 9 to 6) include attending treatment (9 for males, 8 for females), maintaining housing (8 for males, 7 for females), and passing medication screening (6 for males, 9 for females). In addition, males often face obstacles in controlling aggression (ranked 7), and females reportedly have frequent difficulty following housing facility rules (ranked 6). The largest disparities in compliance difficulty between sexes are obtaining legal employment (5 for females, 0 for males), controlling aggression (7 for males, 2 for females), and passing medication screens (9 for males, 6 for females).

The majority (83.9%) of veterans who were offered participation accepted that offer (not shown).[27] Table 4 displays the VTC case statuses and the percentage of each status for the participants in VTCs sampled (*n* = 79). Most veterans were either current participants (51.2%) or graduates (33.6%) with active cases outnumbering all other categories. Whereas 81.0% of VTCs sampled terminated a veteran (not shown), termination numbers were lower (11.8%) in comparison with active participants (51.2%) and graduates (33.6%). As of the survey close date, no more than 2.0% of veterans returned to VTC after any type of participation (i.e., graduation, termination, drop out).

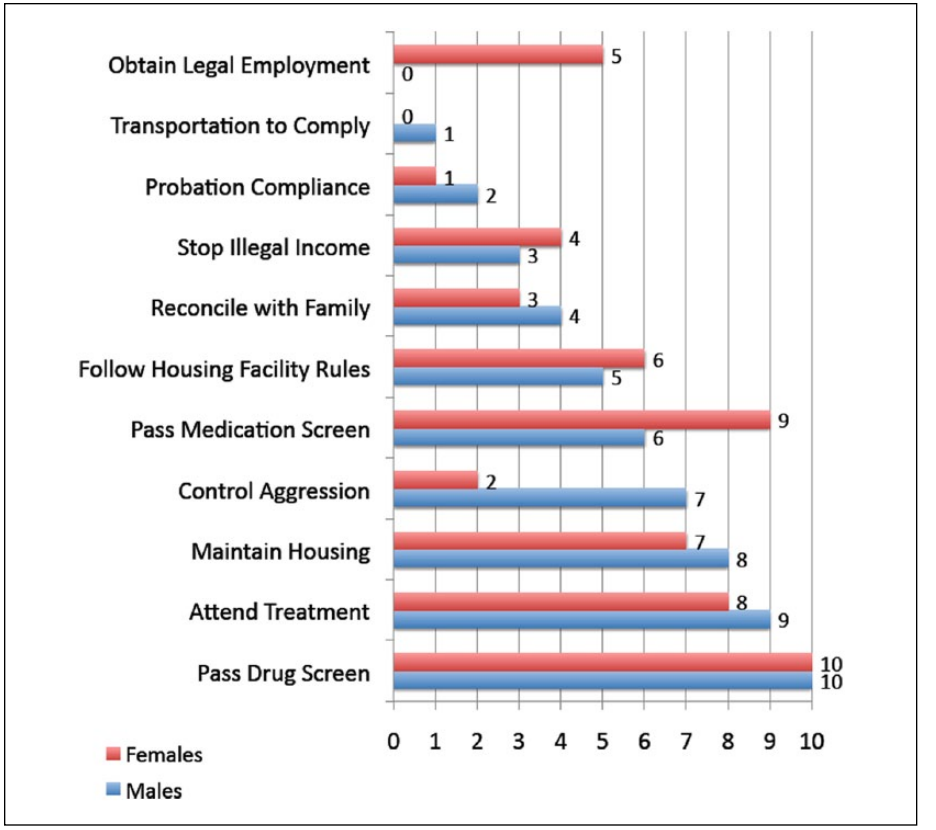

Figure 1. Rank of difficulty with VTC requirements by sex (10 = *most difficult*, 0 = *least difficult*).
Note. VTC = veterans treatment court.

Table 4. Status of Veteran Cases in 79 VTCs.

Status in VTC	% of total participants (n = 3,649)
Active Case	51.2
Graduate	33.6
Terminated	11.8
Drop Out	3.3
Returner[a]	*2.0*

Note. VTC = veterans treatment court.
[a]This returner group is not mutually exclusive of the three groups listed immediately above it because the returners had to have graduated, been terminated, or dropped out prior to returning to VTC.

Table 5. Reasons for Opt Out or Drop Out *Not Mutually Exclusive*.

Reasons for opting or dropping out	% reporting reason for initial opt out (n = 69 VTCs)[a]	% reporting reason for drop out (n = 44 VTCs)[b]
Program too rigorous	37.6	47.7
Not want treatment/want to continue use	15.9	25.0
Thought they could get a better deal in criminal court	8.6	11.3
Did not want to plead guilty	7.2	—
Residency: Change of residency during pending case, did not reside in jurisdiction	4.3	4.5
Transportation issues	2.8	4.5
Wanted to go to trial	2.8	—
Stigma	1.4	2.2
Charges nolle prossed	1.4	2.2
Plea offer	—	2.2
Eligible for other treatment courts	1.4	—
Previous negative experience with VA clinic	1.4	—
Do not know why	*27.5*	*13.6*
Refused to answer	—	*2.2*

Note. VTC = veterans treatment court; VA = Veterans Affairs.
[a]Ten VTCs did not have any veterans choose not to participate in VTC.
[b]Thirty-four VTCs have not had any veterans drop out to date, and one VTC reported that dropping out was not an option (participants either graduate or are terminated by the VTC).

Reasons behind veterans' decisions to initially opt out and later drop out after agreeing to participate are located in Table 5. Respondents could report as many reasons as necessary, making these results not mutually exclusive, and these samples are reduced because not all of the VTCs had veterans opt or drop out or had terminated veterans.[28] The most prevalent reasons for both opting out and dropping out include offenders believing the programs to be too rigorous (37.6% opt out, 47.7% drop out) followed by not wanting treatment (15.9% opt out, 25.0% drop out) and belief in obtaining a "better deal" in traditional court (8.6% opt out, 11.3% drop out).

The majority of the VTC sample terminated veterans from their programs (81.0%), and Table 6 illustrates the reported reasons for termination. The most prevalent reason for termination is nonparticipation in mandated services (60.9%). Nearly half also reported failure to appear in court (46.8%) or probation violations (42.1%). For termination, all VTCs reported that nonparticipation must be a *consistent* behavior. Although testing positive for substances was reported as a cause for termination by 32.8% of VTCs, a single positive substance test does not result in automatic termination, but termination results from continued noncompliance and non-responsivity to treatment,

Table 6. Reasons for Termination (n = 64) *Not Mutually Exclusive.*

Reasons for termination	% of VTCs that have terminated
Nonparticipation in treatment	60.9
Failure to appear in court	46.8
Violation of probation	42.1
Positive drug test	32.8
Re-arrest for different offense	29.6
Re-arrest for same offense	26.5
Other general noncompliance with program	4.6
Absconding	3.1
Negative medication screening	3.1
Issues to severe to be handled in VTC	3.1
Failure to pay restitution	1.5

Note. Fifteen VTCs have not terminated any veterans at the survey date, reducing the original sample of 79 VTC to 64 applicable VTCs. VTC = veterans treatment court.

evidenced in this case by multiple failed drug tests. A specific number of failed tests was not provided by any respondent.

Regarding relationships between military service, extralegal issues, and legal issues (crime), Figures 2 to 4 illustrate the respondents' perceptions of these various relationships. Most respondents felt that there is either a *probable* or *definite* relationship between military experience and extralegal issues (70%), extralegal and legal issues (82%), and all three (73%). Across Figures 2 to 4, the most popular response is "probably yes" (approximately 50%), meaning that the respondents believe that a relationship between these issues most likely exists; the fluctuation is minimal for this response category across relationships examined (highest differential across tables is 2% for "probably yes"). Across relationships presented, few believed there was no relationship (ranging from 0% to 1%) or probably not a relationship (ranging from 0% to 3%).

Overall, depending on which items are examined, the characteristics of VTC participant populations are both similar and varied across courts and as a whole in comparison with the national population of veterans. However, some clear trends across courts exist regarding reasons for dropping out, opting out, and being terminated; programmatic challenges; and practitioners' beliefs in the existence of relationships between military service, personal issues, and legal issues. In addition, male and female participants are both similar and dissimilar depending on which legal, extralegal, and program challenges are of focus.

Research Limitations

Specific Limitations of This Study

This study faces several limitations that must be addressed. First, when interpreting the findings, consumers must note that not all VTCs participated in the survey despite

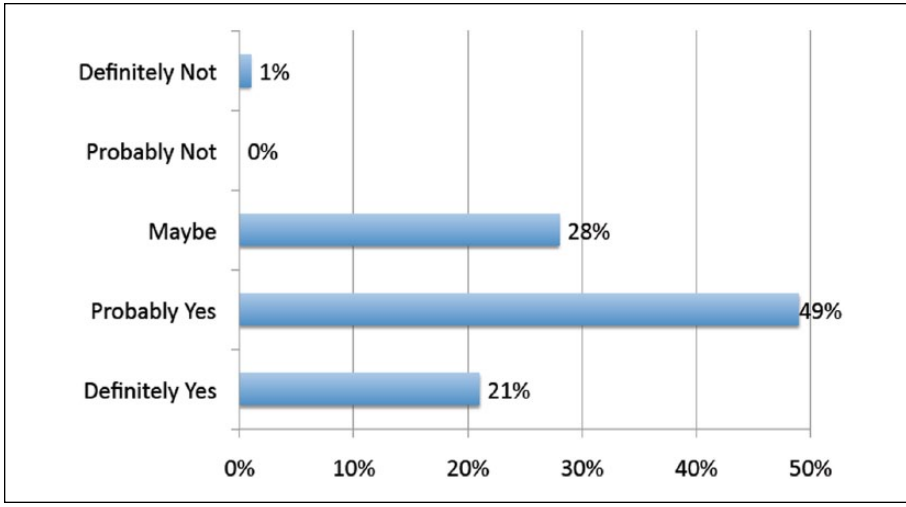

Figure 2. VTC respondent belief in relationship between military experience and extralegal issues (n = 71 VTCs).
Note. VTC = veterans treatment court.

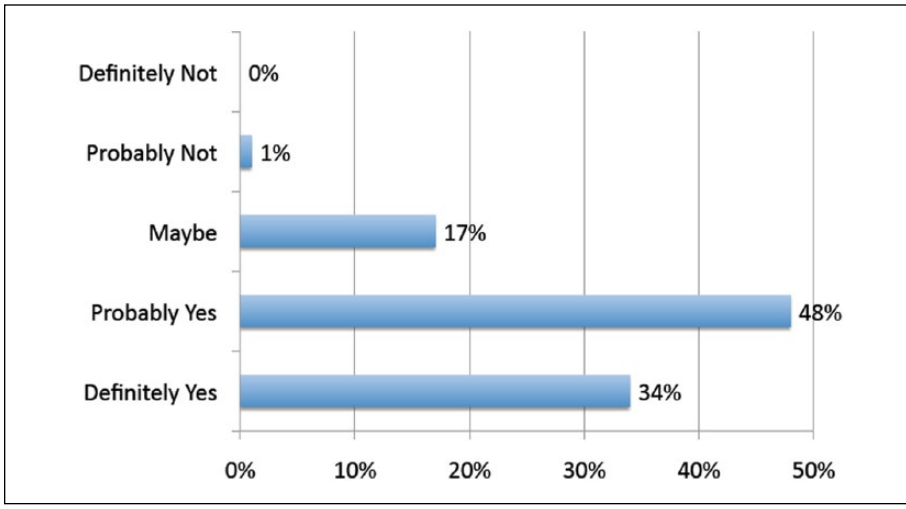

Figure 3. VTC respondent belief in relationship between extralegal issues and legal issues (crime; n = 71 VTCs).
Note. VTC = veterans treatment court.

multiple contacts via phone and email, reminders, and extensions. Whereas unit non-response bias has been explored, the data for comparison was limited to only location, and these results were not significant (Baldwin, 2015). However, the response rate was

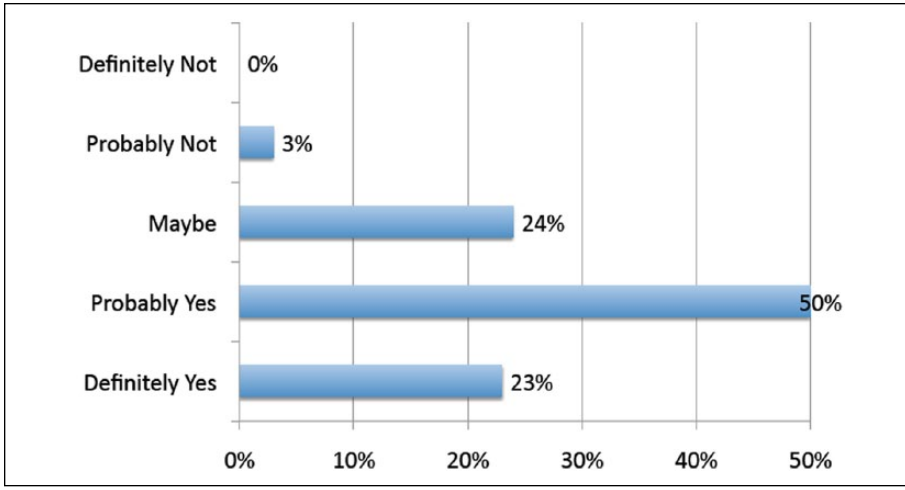

Figure 4. Respondent belief in relationship between military experience and extralegal and legal issues (crime; *n* = 70 VTCs).
Note. VTC = veterans treatment court.

high (69%) and was of the population, not a sample. Second, although the data were collected by the PI, all results presented are based on responses provided by the VTC practitioner respondents; the author did not directly collect this information from official records. Third, detailed substance abuse and mental health information was not obtained due to the information-sharing restrictions within VTCs. In addition, whereas information on why veterans chose not to participate in (opt out of) VTC was gathered, reasons why veterans chose to participate were not collected. Fourth, whereas this research gathered participant perceptions of the relationships between military service, extralegal challenges, and crime, assessing these relationships is outside the scope of the current study. Finally, this article focuses solely on veterans in contact with VTCs across the country. As such, these findings cannot be generalized to (a) those veterans who are in contact with the criminal justice system but not in contact with a VTC and (b) veterans not in contact with the criminal justice system.

Challenges Affecting Veterans Research

Although relationships between military service, non-legal issues, criminal behavior, and incarceration have been intermittently explored for more than 70 years, extant research has been unable to reach consensus in determining their relationship(s) (White et al., 2012). One challenge to this area of research is the issue of selection effects that makes experimental design impossible. Selection effects by both the individual and the military may contribute to—an unknown extent—the veteran population possessing different characteristics than the non-veteran population. Regardless,

this course of research has re-emerged due to the current influx of veterans returning from OIF/OEF/OND.

Challenges Facing JIV Research

Although some research has examined JIVs, there is reason to believe that the reports of veterans in the incarcerated population may actually be underestimates. First, not all individuals who serve(d) in the U.S. armed forces identify with the term *veteran* because various definitions exist.[29] Second, most criminal justice institutions do not ask offenders whether they are veterans or served in the U.S. armed forces, let alone systematically identify veterans. Third, some veterans may be reluctant to provide their veteran status if asked due to loss or reduction of VA benefits as a result of various contact with the criminal justice system.[30]

Discussion

All VTCs maintained eligibility requirements, which vary from VTC to VTC (see Baldwin, 2015), and these requirements may affect, to an unknown extent, all results related to the characteristics of veterans in VTCs. For example, if a VTC excludes participants with previous criminal histories, there is a high likelihood that more Vietnam-era veterans would be excluded than a veteran who has just returned from Iraq, which would contribute to the explanation of an overrepresentation of younger OIF/OEF/OND veterans in VTCs in comparison with the national veteran population. However, eligibility requirements are only one potential factor that may be contributing to the underrepresentation of older veterans in VTCs; additional factors may include, but are not limited to, the ability to offend, the age-crime curve, willingness of law enforcement to arrest, current influx of veterans from OIF/OEF/OND, and perceptions of treatment.[31] Regardless, the identification of related factors is beyond the scope of this study.

Findings of this study can only be compared with a few single-site VTC studies, as little research is currently available on veterans in VTCs, and to the few studies of veterans in the incarcerated population. For personal characteristics, VTCs in this study's national sample had primarily White and male participant populations, which is similar to the Colorado and Alaska VTCs. The percentage of female participants was also similar. Regarding age, this study's results were more similar to the Colorado VTC participants (mean age under 30, OIF/OEF/OND era) than the Alaska VTC participants (pre-OIF/OEF/OND era). This study's era results (average of 38.5% OIF/OEF/OND) support White and colleagues' (2012) prediction of an increase in recent era veterans.[32] In addition, similar to the Colorado VTC, White et al.'s (2012) single jail sample and Noonan and Mumola's (2007) national jail and prison samples, this study's VTC participants are also of veteran status (not active duty) and served in the Army. Finally, with the exception of branch, this study's findings on military characteristics support Slattery and colleagues' (2013) single-site results in Colorado.

Regarding legal and extralegal issues, this study is, again, both similar and different to the previous literature available for comparison (although none of these studies examined numerous VTCs across the country). Based on previous research, drug offenses, followed by violent offenses, should be the most reported types of crimes, and substance abuse and mental health issues should be the most reported extralegal challenges. This study does support previous literature in finding that drug offenses were the most reported legal issues for both male and female veterans. In further support of previous research, this study discovered that substance abuse was the first and mental health was the second most reported extralegal issues for both males and females.

Alternatively, differences were found for results involving violent offenses. Although White et al. (2012) and Noonan and Mumola (2007) found more incarcerated veterans with violent offenses in comparison with incarcerated non-veterans and most Alaska VTC participants had assault charges, violent crimes (domestic and non-domestic) were further down the list for both males and females, whereas theft/fraud was the third most reported crime type for both males and females. Specifically, non-domestic violent and violent crimes were the fourth and fifth most reported crimes for males, and non-domestic violent crimes were the fourth most reported crime type for females. However, these samples are not directly comparable, and as previously presented, eligibility requirements may be driving the differences found in this national VTC study. For example, nearly half (43%) of the VTCs that participated in the national survey excluded veterans charged with any type of felony charge, and only 1.3% of VTCs excluded any type of drug offenses (Baldwin, 2013, 2015).

Although homelessness has traditionally been the most publicized issue facing veterans, substance abuse and mental health issues were the most reported issues facing veterans in VTCs nationally in this study. This study revealed that homelessness was the least prevalent issue for male veterans and the second least for female veterans. Whereas some VTCs require a substance abuse and/or mental health diagnosis for participation or a relationship between these issues and the offense (Baldwin, 2015), which would increase the prevalence of these issues in their VTCs, not all VTCs that reported these issues as the most prevalent did. The VA has recently made strides in acknowledging and offering treatment for veterans' mental health issues. These efforts should continue, specifically by making mental health care—and substance abuse treatment—more accessible by reducing restrictions, including VA eligibility requirements, in an effort to adequately treat those in need. In addition, efforts to reduce perceptions of stigma associated with treatment should be undertaken in effort to reduce the second barrier to treatment.

Active cases were found to outnumber all other categories, which indicate that VTCs are actively operating with new members. The various legal and financial incentives (Baldwin, 2015) may be a reason why the majority of veterans (86%) have chosen to participate. Although the returner rate may appear to suggest low recidivism, "returner" does not refer to any subsequent contact with the criminal justice system or any other form of re-offending after initial contact with a VTC. The returner group *only* includes veterans that have returned to the VTC after a form of previous participation (i.e., graduation, termination, drop out). Veterans who have previously had contact with

the program may be returning to the criminal justice system but not necessarily to the VTC for various reasons, such as being arrested in another jurisdiction or not transferring to the original VTC due to ineligibility. Creating a system of communication between VTCs would improve the creation of treatment plans within VTCs and provide a more accurate picture of case statuses nationally. In addition, keeping record of veterans who may return to their original VTC but are deemed ineligible upon return would increase accuracy in documenting the existence of this subgroup.

Whereas the majority of eligible veterans opted to participate, this study found that veterans do opt and drop and are terminated. The qualitative data revealed that a common conversation between attorneys and veterans revolved around what the actual time spent incarcerated would be if the veteran chose not to participate because, hypothetically, serving half of a sentence, at most, due to jail overcrowding and being released without probation may be more attractive than a lengthy and rigorous program. This supports Morris and Tonry's (1990) proposition that community-based sentences can be equivalent to incarceration, as well as previous findings where offenders chose prison over an intensive supervision program one third of the time (Petersilia, 1990), preferred prison to probation because probation was stricter (Crouch, 1993), and believed intermediate sanctions to be just as punitive as prison (Petersilia & Deschenes, 1994). Regarding termination, qualitative data also revealed the nonparticipation and noncompliance must be ongoing. The need for consistent nonparticipation in treatment and/or positive drug screens (and not a one time deviation) suggests that VTCs appear to embody the medical model of addiction, which views addiction as a disease and relapse as part of the process. Gathering data on the number of noncompliance instances is necessary for both implementation and impact studies, which should be undertaken in the future.

"Not wanting treatment" was the second most popular response for dropping and opting out of VTC. It should be noted that the more specific responses of the desire for continued legal use of substances such as alcohol and also marijuana under state medical marijuana programs were included in this category. The changing legal acceptance of certain behaviors is an issue facing policymakers and program creators, which challenges the balance between logical inclusion of participants, program integrity, and internal and external legitimacy. This is not to suggest that any legally permissible behavior should be allowed by the VTC. However, program creators should keep in mind the legal status of behaviors when creating and evaluating eligibility and participation requirements. For example, participants in substance abuse treatment need to remain sober and should be required to do so and participate in treatment by the VTC per its general mission regardless of the substance's legality (e.g., legal access to alcohol or marijuana). However, if a participant is not diagnosed with a substance abuse issue or issues related to the use of legal substances by the doctor or qualified treatment counselor, banning the veteran from legal use of a publicly available substance presents a challenge as it excludes veterans based on lawful behavior unrelated to their legal and extralegal issues.

Retention rates appear high to date, but this survey did not address why participants continued to participate. Future research should explore the motivation for initially

opting in and remaining in the program as this knowledge may allow programs to highlight and stress the attractive reasons to increase participation. Increasing time in treatment positively affects VTC impact outcomes. Although it is too early to know VTC efficacy, drug court research indicates that more time in treatment is related to longer time to recidivism and lower recidivism rates (Banks & Gottfredson, 2004; Dickie, 2000; Goldkamp, 2003; Gottfredson, Kearley, Najaka, & Rocha, 2005; Gottfredson, Najaka, & Kearley, 2003; Peters & Murrin, 2000; Wilson, Mitchell, & MacKenzie, 2006), and VTC impact may emulate those of drug courts.

More than one quarter of respondents were not attempting to track, in some form, participants' outcomes and progress (26.6%; Baldwin, 2013). For more complete data, subsequent research, and resultant recommendations, all VTCs should attempt to track progress and outcomes of not only those in their programs, but also those who opt and drop out, were not eligible for participation, and have graduated. Tracking outcomes for all in contact with VTC programs, not just participants, allows for use of comparison groups in intermediate and long-term outcome evaluations. Because VTC programs are still emerging, this is the opportune time to implement these data collection practices so they become routine.

Most respondents believed, to some extent, the relationships between military service, legal issues, and extralegal issues existed. The belief in these relationships is important when thinking about implementation. When individuals do not believe in the existence of an issue or a policy or do not believe the program achieves the intended impact or impact desired by the individual, they are more likely to deviate from procedure and act according to their personal beliefs. Future research, beyond the scope of this survey, should examine reasons behind whether personnel believe in these relationships, determine whether varying beliefs affect implementation of the program, and assess implementation of these programs, which is often ignored (Dane & Schneider, 1998; Durlak, 1997; Dusenbury et al., 2003). The level of implementation achieved affects program outcomes (Durlak & DuPre, 2008). Achieving "good" implementation statistically increases program success and results in stronger positive results for participants (Durlak & DuPre, 2008). Although VTC program outcomes are extremely important, implementation must be ascertained before outcomes can be fully assessed.

VTCs nationally have reported recent shifts in their populations in the areas of era of service (and age), emergence of issues, and sex. Although veterans from many eras have been in the population for several decades and the VTC concept is based on the understanding and research focusing on those veterans, VTCs have emerged during the OIF/OEF/OND era. Much research on Vietnam veterans has informed our understanding of service-related problems, but nationally, VTCs reported a decrease in the age of veterans in contact with the criminal justice system with the increase of veterans from the most recent era of service. Although some VTCs have an older sample of veterans that is more congruent with the national veteran population and not the national VTC participant population, which is younger, eventually, the standard deviations for service eras and age will decrease as more OIF/OEF/OND return to the area and older veterans phase out. Time and future research will determine whether different services will be required for this new era of veterans.

VTCs nationally have reported an increase in the number of veterans they see with substance abuse issues. VTCs nationally may continue to see an increase in the number of substance abuse and mental health issues in their participant population based upon the current anticipated influx of veterans from the OIF/OEF/OND era and the literature on the delayed onset of these issues. Because mental health and substance abuse issues may not surface immediately, sometimes decades after service, VTCs may provide early intervention by being less exclusive in their eligibility requirements. For VTCs that allow veterans charged with innocuous offenses (e.g., traffic offense) to participate, they may be unknowingly providing early intervention to many veterans whose issues may not have surfaced yet.

VTCs across the country have also reported increases in their female veteran population. Whereas female veterans have participated in combat for decades, it should be noted that many injuries are not combat related, and more females are serving in the military today than previously. In addition, in January 2013, the ban on females serving in combat was removed. Due to these recent changes, further supported by the first two females graduating from Army Ranger School, combat experience and its related injuries are anticipated to increase in the female veteran population. As a result, VTCs, as well as the criminal justice system, may come in contact with more female veterans and military personnel as the years pass, and VTCs will need to adapt to servicing more female veterans. Because this study discovered variance in legal, extralegal, and program challenges by sex, future research should explore why there are differences in legal, extralegal, and programmatic challenges between males and females. With the increased percentage of females in the military (regardless of combat classification), the needs of the female veterans need to be further assessed for appropriate service and treatment application.

In summation, VTCs were created and are disseminating in a time when their populations were and continue to be fluid; therefore, these courts must continually adapt to the changes in their populations, requiring them to be ready to deal with a wide variety of veterans and their range of legal and extralegal issues. In effort to do so, research focusing on the active-duty population should continue, and VTC researchers and practitioners should take note of those findings in anticipation of whom their VTCs may encounter in the future. For example, Noonan and Mumola (2007) examined offenses for active-duty personnel in Department of Defense custody and found that nearly half of the offenses were violent (46%; drug and military offenses followed at 46% and 22%, respectively) and that rape or sexual assault was the most common type of violent offense at 29%. These active-duty personnel will eventually be veterans in society full-time and may have future contact with VTCs. Future research will also need to determine whether the most recent era of veterans faces similar issues and challenges to those of the Vietnam-era veterans, and a research focus on female veterans will become increasingly important.

Conclusion

Responding to war's impact on those whom served in the military has gained a renewed salience, and continued research on VTCs is necessitated as the expansion of these

courts is anticipated to continue, if not increase, for several reasons. First, public, and resultant political, support for these courts will likely persist. Some research suggests that the public supports more rehabilitative policies over punitive (e.g., Applegate et al., 1996; Maruna & King, 2004; Monterosso, 2009). In addition, it has been argued that the target population of "veterans" and "military personnel" may be viewed more favorably than those of other specialty courts, such as "drug users/addicts/abusers" and "domestic violence offenders" (Baldwin, 2015). The combination of these events indicates that the public will continue to support the creation of VTCs as the criminal justice system's response to the population of veterans in contact with the criminal justice system.

Second, the return of these veterans and military personnel and the emergence of issues related to contact with the criminal justice system is also expected to persist and potentially compound. Since the Vietnam War, OIF/OEF/OND is the longest sustained operation by the military; more than 1.9 million U.S. military personnel have been deployed in 3 million duty tours, lasting more than 30 days (Institute of Medicine, 2010). With survival rates higher than previous engagements (Peake, 2005), more veterans are currently returning with lasting issues from the physical to mental. The current essence of recent combat endeavors has increased mental stress (Bongar, Brown, Beutler, Breckenridge, & Zimbardo, 2007),[33] and their return increases the existing veteran population (Baker et al., 2009; Grieger et al., 2006; Hoge et al., 2004, 2008; Milliken, Auchterlonie, & Hoge, 2007; Seal, Bertenthal, Miner, Sen, & Marmar, 2007; Seal et al., 2009; Tanielian & Jaycox, 2008; Veterans for America, 2007).

Third, the growth of the VTC is currently following that of drug courts where national expansion and implementation have begun without a foundation in sound research (see Baldwin, 2015). They have quickly disseminated in the absence of intermediate and longer term impact studies. Thus, VTCs are "treating" VTC participants without an understanding of their impact. Furthermore, these courts have done so without extensive knowledge of population's issues. This study discovered that VTCs have been created and spread rapidly in a time when their overall and target populations have been fluid, specifically in regard to service (and age), sex, and emergence of issues. Although the signature injuries and substances of abuse for the most recent era veterans have already been declared, this era's veterans and their families' issues may not be fully realized until 2040 or later (Institute of Medicine, 2010). This fluidity in population is similar to the drug court movement's changing addict populations during their creation and dissemination, which consistently presented new challenges, and drug courts had to address these shifts in available substances, use, and population. As such, VTCs will have to adapt to the fluidity in their populations, as well. In light of these facts, policymakers, practitioners, and scholars should anticipate an increase in veterans from the Wars in the Middle East in VTCs, as well as in other specialty courts and the criminal justice system as a whole, and track current trends in their issues.

The current study created a comprehensive look at the national VTC population, providing the first glimpse into the current trends in VTC participant populations. Specifically, the findings of this study not only provide a national context for current

and future examinations of specific VTCs and their populations, but also have identified current shifts in population characteristics and allowed the ability to discern aggregate changes through follow-up national studies. Because this specific area of research is unprecedented, future research should examine all aspects VTC participants, the impact VTC policies and implementation have on the participants, and the growing and evolving veteran population, as well as active-duty military personnel.

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Notes

1. The term *veteran* is used in this article to refer to anyone who has served or is serving in the military, regardless of drafted or volunteer service, combat or non-combat, service era of war or peace, type of discharge, and Veterans Affairs benefit eligibility. The broad use of "veteran" is utilized because the focus of this study is various types of "veterans" in veterans treatment courts (VTCs), which vary widely in their eligibility requirements (Baldwin, 2015).
2. Although VTCs target veterans and/or current military personnel, VTCs exist within the public court system, not the military system.
3. It is well documented that despite their need, many veterans do not actually receive needed physical and mental health treatment. There are a variety of reasons for this failure, which VTCs attempt to redress. For a detailed explanation of the operation of VTCs, see Baldwin (2015), Baldwin and Rukus (2015), and Cartwright (2011).
4. As noted in Baldwin (2015).
5. See Baldwin (2015) for the list of paper presentations at the annual meetings of the American Society of Criminology, Academy of Criminal Justice Sciences (ACJS), and ACJS regional associations.
6. For recent research, see Baker et al. (2009); Bjork and Grant (2009); Calhoun, Elter, Johnes, Kudler, and Straits-Troster (2008); Corrigan and Cole (2008); Drug Policy Alliance (2009); Eggleston, Straits-Troster, and Kudler (2009); Graham and Cardon (2008); Grieger et al. (2006); Hoge et al. (2004, 2008); Jacobson et al. (2008); Jorge et al. (2005); Milliken, Auchterlonie, and Hoge (2007); Seal, Bertenthal, Miner, Sen, and Marmar (2007); Seal et al. (2009); Stahre, Brewer, Fonseca, and Naimi (2009); Tanielian and Jaycox (2008); and Veterans for America (2007). Research on military service and the life course is extensive (see such authors as Elder, Sampson, and Laub).
7. Post-traumatic stress disorder (PTSD), formally known as "shell shock," was finally included in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM-III*; American Psychiatric Association [APA], 1980; Kulka et al., 1990; Trimble, 1985) and is currently considered a serious health concern. The criteria for PTSD have been recently revised in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; APA, 2013):

> Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition. Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to *DSM-5*. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted. (U.S. Department of Veterans Affairs, 2014a, http://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp)

8. Traumatic brain injury (TBI) is brain injury caused by sudden trauma. Symptom severity (mild, medium, moderate) is dependent upon the extent of the injury. Symptoms include loss of consciousness, confusion, headache, lightheadedness, dizziness, tired eyes or blurred vision, fatigue or lethargy, change in sleep patterns, change in behavior or mood, bad taste in mouth, ears ringing, and trouble with concentration, memory, thinking, or attention (National Institute of Neurological Disorders and Stroke, 2011).
9. Vietnam theater veterans include those "who served on active duty in the U.S. Armed Forces during the Vietnam era (August 5, 1964, through May 7, 1975) in Vietnam, Laos, Cambodia, or the waters or air-space surrounding these countries" (Schlenger et al., 1992, p. 335).
10. Prescription opioids (e.g., OxyContin, Percocet, Vicodin) constitute the other "signature substance" (Institute of Medicine, 2012). In contrast, use of marijuana (Bachman, Freedman-Doan, O'Malley, Johnston, & Segal, 1999), cocaine (Bachman et al., 1999), and hallucinogens (Meich, London, Wilmoth, & Koester, 2013) among young military personnel has declined in comparison with their civilian counterparts. These declines have been linked to the military's antidrug policy (Bachman et al., 1999; Meich et al., 2013).
11. For example, Brunello et al. (2001); Corrigan and Cole (2008); Department of Defense Task Force on Mental Health (2007); Hoge et al. (2004); Jacobson et al. (2008); McFall and Cook (2006); Ponsford, Whelan-Goodinson, and Bahar-Fuchs (2007); and Stahre et al. (2009). It is important to note that the relationship between the co-occurrence of substance use and mental health is complicated, and various hypotheses for the co-occurrence of substance use and mental health issues have been expounded. Direct causal relationships, indirect causal relationships, and common risk factor relationships have been theorized in the general population (e.g., see Brady, Back, & Coffey, 2004; Degenhardt, Hall, & Lynskey, 2003). In addition, social practice or coping mechanisms can evolve into addictions (Eggleston et al., 2009). The self-medication of symptoms related to mental health disorders has been well established in the literature regardless of veteran status.
12. Anger and aggression are symptoms of PTSD and TBI (the signature injuries of Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn [OIF/OEF/OND] veterans; Sreenivasan et al., 2013), and combat exposure and PTSD are strong correlates for aggression and violence (e.g., Taft et al., 2007).
13. This justice-involved veterans (JIV) subgroup overlaps with another identified subgroup: adults involved with the criminal justice system who have mental health illnesses (Blue-Howells, Clark, van den Berk-Clark, & McGuire, 2013; Noonan & Mumola, 2007; Substance Abuse and Mental Health Services Administration [SAMHSA] National GAINS Center, 2008). The general population of incarcerated adults has higher rates of traumatic

experiences and mental health issues than the general un-incarcerated population, and veterans may be at greater risk due to stressors of military service and/or training (e.g., SAMHSA National GAINS Center, 2008; Tanielian & Jaycox, 2008).

14. Note, this is far less than increase experienced by non-veterans (172%; Mumola, 2000).
15. Others who lived in institutions such as jail or inpatient treatment facilities (13%), had "unstable" housing (13%), or were homeless (4%).
16. Whereas the general population widely varies in the ability to use and access the Internet, the author confirmed, when contacting potential participants, that all VTC contacts in the compendium (with the exception of one) were able to use and had access to the Internet. This one VTC did not participate in the study but was included in this study's population and all response rate calculations.
17. Hybrid items presented participants with both predetermined answers to choose from and an "other: specify" box where they could type in their own responses.
18. Five-item response options were utilized because five- and seven-item response options have been determined to be optimal (Dillman, Smyth, & Christian, 2009).
19. The initial compendium was more comprehensive than the Justice for Vets list. For the comparison, see Baldwin (2013).
20. The second round of calls to court administration offices produced an additional 23 VTCs to add to the compendium.
21. Although court personnel never simultaneously provided multiple VTC contacts, Internet searches occasionally produced multiple potential contacts. In these cases, the author vetted all options to determine each potential contact's position within the VTC. If contact information for the judge was provided, he or she was the first point of contact. Often, the judge would then refer the author to the veterans justice outreach specialist (VJO) or court coordinator and instruct the individual to participate in the survey. If contact information for the judge was not readily available but it was for the VJO or court coordinator, the VJO or coordinator would then become the first point of contact. In instances where judicial, VJO, and/or coordinator information was unavailable but attorney names were available, the attorneys became the first point of contact.
22. Because they were either no longer interested or felt unqualified to complete the survey, five contacts provided an alternative contact.
23. Cooperation, refusal, and contact rates were also calculated using the American Association for Public Opinion Research's (AAPOR) Response Rate Calculator, which differentiates between response, cooperation, refusal, and noncontact rates. This calculation standardizes response and non-response rates, allowing for rate comparison across research surveys of varying topics and administration modes (AAPOR, 2011). Because this was an Internet survey, the AAPOR's Standard Definitions Response Rate Calculator V3.1 for surveys conducted via Internet, telephone, and mail was employed (AAPOR, 2011). Using this method, the response rate remains at 69%. Cooperation rates are 86% (COOP1) and 90% (COOP3). The refusal rate for this study is 8%, and the contact rate is 81%. For a detailed explanation of these rates, see Baldwin (2013).
24. Each item was numbered with the respective responses corresponding to each item number, making structural coding unnecessary.
25. Although not included in Tables 1 and 2, the minimum values were 0 for all categories except male veteran participants (minimum of 16%), White veteran participants (minimum of 14%), and veteran participants with trauma experience (minimum of 15%).
26. Based on the results, 20% or more was considered "high variability," whereas 5.0% and below was considered "low variability."

27. The total number of veterans reported to have been offered participation is 4,347 in the VTCs sampled. Of those, 3,649 agreed to participate, producing a participation rate of 83.9% (an opt out rate of 16.1%).
28. Sixty-nine of the 79 VTCs (87.3%) had veterans choose not to join their programs, and only 44 of the 79 VTCs (55.6%) had veterans drop out of their programs. Some VTCs did not know why veterans opted out (27.5%) or dropped out (13.6%), but they are included because they did report veterans had dropped and/or opted out of their programs. Finally, one VTC refused to provide reason(s) why veterans had dropped out of its program, and, again, this court remained in the sample because it did have veterans drop out of its program.
29. Examples include but are not limited to the following: (a) "A person who has served in the military, someone who fought in a war as a soldier, sailor, etc., an old soldier of long service, a former member of the armed forces" (Merriam-Webster, 2014). (b) "Veterans are men and women who have served (even for a short time), but are not currently serving, on active duty in the U.S. Army, Navy, Air Force, Marine Corps, or the Coast Guard, or who served in the U.S. Merchant Marine during World War II. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps. While it is possible for 17 year olds to be veterans of the Armed Forces, ACS data products are restricted to the population 18 years and older" (U.S. Census Bureau, 2014). (c) "Served in the active military, naval or air service, and was discharged or released under conditions other than dishonorable" (U.S. Code Title 38 § 101 (2)).
30. "Dishonorable and bad conduct discharges issued by general courts-martial may bar VA benefits. Veterans in prison must contact VA to determine eligibility. VA benefits will not be provided to any Veteran or dependent wanted for an outstanding felony warrant" (U.S. Department of Veterans Affairs, 2014b, p. 5).

> Incarcerated Veterans: VA benefits are affected if a beneficiary is convicted of a felony and imprisoned for more than 60 days. Disability or death pension paid to an incarcerated beneficiary must be discontinued. Disability compensation paid to an incarcerated Veteran rated 20 percent or more disabled is limited to the 10 percent rate. For a Veteran whose disability rating is 10 percent, the payment is reduced to half of the rate payable to a Veteran evaluated as 10 percent disabled. Any amounts not paid to the Veteran while incarcerated may be apportioned to eligible dependents. Payments are not reduced for participants in work-release programs, residing in halfway houses, or under community control. Failure to notify VA of a Veteran's incarceration can result in overpayment of benefits and the subsequent loss of all VA financial benefits until the overpayment is recovered. VA benefits will not be provided to any Veteran or dependent wanted for an outstanding felony warrant. (U.S. Department of Veterans Affairs, 2014b, p. 109)

31. Although a limitation of this comparison includes differing dates these populations were recorded (i.e., the VTC population in 2011-2012 and the national veteran population in 2010), the percentages are still of interest because the disparities are so large. For example, the average percentage of OIF/OEF/OND-era veterans in VTCs is more than six times that of the general veteran population.
32. For incarcerated veterans, White, Mulvey, Fox, and Choate (2012) found 16% in their 2009 county sample, and Noonan and Mumola (2007) found 5% in their 2004 national prison and jail sample. Overall, both studies found more veterans from pre-OIF/OEF/OND eras but predicted an increase in OIF/OEF/OND-era veterans.

33. Specifically, repeated and extended deployment has been related to physical and mental health issues, which is characteristic of OIF/OEF where 75% of these troops have been deployed at least twice (Hoge et al., 2004).

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