Catch, Treat, and Release: Veteran Treatment Courts Address the Challenges of Returning Home

Michelle Slattery¹,², Mallory Tascha Dugger¹, Theodore A. Lamb² and Laura Williams³

¹Trauma, Health & Hazards Center, UCCS, Colorado Springs, Colorado, USA; ²Peak Research, Colorado Springs, Colorado, USA; ³Office of Behavioral Health, Colorado Department of Human Services, Denver, Colorado, USA

After a decade of war, there is a great need for treatment and alternatives to incarceration for justice-involved veterans. U.S. military service members are returning from combat with substantial mental health challenges, which increase the potential for justice involvement. Veteran Treatment Courts are starting across the nation to meet this need for therapeutic justice. These problem solving courts provide access to treatment and motivation for engagement. Preliminary evidence from a Substance Abuse and Mental Health Services Administration-funded evaluation suggests that significant improvements in posttraumatic stress disorder and substance use are just a few of the positive outcomes that these courts may help veterans achieve.

Keywords  Veteran Treatment Court, substance use, PTSD, TBI, employment, housing, U.S. military, OEF/OIF, justice, SAMHSA

There is a great need for treatment and alternatives to incarceration for veterans. More than 2.2 million Americans have deployed to Iraq, Afghanistan, or both since October 2001 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012a). Research suggests that these veterans are returning with substantial mental health challenges including posttraumatic stress disorder (PTSD), increased risk of suicide, traumatic brain injury (TBI), and depression (ARMY Gold Book, 2012; Hoge et al., 2004; MSMR, 2010; Rand Report, 2008). All of these disorders have known links to other challenges, which pose an increased risk of justice involvement for veterans, including unemployment, homelessness, the use of illegal drugs, alcohol misuse (BLS Report, 2011; Institute of Medicine, 2010, 2012). A wide range of studies suggest a correlation between combat trauma and criminal behavior (Noonan & Mumola, 2004; Rand Report, 2008; Wilson & Zigelbaum, 1983). The National Vietnam Veterans Readjustment Study (Kulka et al., 1990), for example, found that nearly half of male combat veterans who suffered from PTSD had been incarcerated one or more times.

Veteran Treatment Courts (VTCs) offer a “circle the wagons” approach as they provide access to treatment for mental health challenges, linkage to services to help participants obtain housing and employment, peer mentors for guidance and encouragement, and intensive supervision and accountability to help justice-involved veterans transition back to useful and productive lives.

The VTCs may serve justice-involved veterans and active-duty military service members with misdemeanor and/or felony charges. Some VTCs require participants to plead guilty before beginning the program with intensive requirements of supervised probation, mental health treatment, substance use monitoring, and frequent court appearances. Veterans choose VTC participation over traditional paths to justice involving criminal trials and possible incarceration, with the intention of graduating, having their sentences deferred, their charges reduced, and/or records sealed. Sealing a felony conviction effectively...
erases it, allowing the participant a fresh start, as though the conviction never occurred.

The ability of VTCs to seal felony convictions provides substantial incentive to participate and engage in treatment. Evidence-based practices, such as prolonged exposure therapy and cognitive processing therapy for PTSD, are encouraged. If participants fail to engage in treatment, sanctions are recommended by the Court Team. A key feature of some VTCs is staffings attended prior to the docket each week by a Court Team that consists of a VA Veteran’s Justice Outreach specialist, private therapists, Army Behavioral Health team, the presiding Judge, District Attorney, Public Defender, Probation Officers, peer mentors, and an evaluator.

The VTCs are often modeled on other specialty courts, such as drug courts, with a wide range of methodologies, policies, and procedures. VTCs may feature different intercept points for participants and may allow different types of charges, but most follow the foundational tenets of drug courts to address risk factors for criminal behavior that might result in additional justice involvement (Russell, 2009b). When veterans succeed in these courts, communities also win as recidivism for these types of courts is expected to be lower than traditional paths to justice and equal to or better than drug courts (Holbrook & Anderson, 2011).

The VTCs are growing in number at three times the rate that Drug Courts grew 20 years ago (National Association of Drug Court Professionals [NADCP], 2010). The first was started in 2004 in Anchorage, Alaska (Holbrook & Anderson, 2011), but the court credited with providing the inspiration for the current surge of VTCs was started by Judge Robert Russell in 2008 in Buffalo, New York (Russell, 2009a). Today, there are more than 100 VTCs in America, with more than 200 in the planning stages (NADCP, 2012). Public support appears to be growing for the idea of a second chance for justice-involved veterans with mental health and substance use disorders resulting from military service trauma.

Thirteen states, including Colorado, received 5-year SAMHSA grants in 2008 and 2009 to help fund the design, development, and implementation of pilot VTCs (SAMHSA, 2008). These grantees were also tasked with working with groups statewide on legislation, infrastructure, sustainability, training on trauma-informed care, and laying the groundwork to roll out VTCs statewide. Importantly, comprehensive evaluations of these courts were required and are now starting to yield results, like this study, which may help others understand the potential impact of VTCs in their communities.

The present study reports the preliminary results of participation in a pilot VTC on veterans with PTSD and/or TBI. The purpose of this study was threefold: (1) establish rates of PTSD, TBI, and substance use among VTC participants; (2) explore veteran experiences, comorbidity, and participation outcomes; and (3) discuss the VTC model, what works, why, and where it achieves its greatest impact. The remainder of this introduction describes the PTSD, TBI, and substance use problems many veterans are facing.

PTSD

According to the Department of Veterans Affairs (VA), one in five “Operation Enduring Freedom” (Afghanistan) and “Operation Iraqi Freedom” (OEF/OIF) veterans in their care has symptoms of a mental health disorder (SAMHSA, 2012a). PTSD was first classified as a mental health disorder in 1980 in the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., text rev.; DSM-III; American Psychiatric Association, 1980). It is defined as a mental disorder resulting from exposure to an extreme, traumatic stressor, and features symptoms of re-experiencing, avoidance and numbing, and/or increased arousal. Published rates of PTSD prevalence for OEF/OIF veterans vary in the literature (e.g., Hoge et al., 2004; Milliken, Auckterlonie, & Hoge, 2007; Ramchand et al., 2010; Rand Report, 2008), ranging from approximately 13% to 35%. PTSD is associated with cooccurring disorders, such as TBI, substance use disorders, and depression (Pietrzak, Goldstein, Southwick, & Grant, 2011). Research shows that veterans with PTSD suffer from poorer overall health, greater use of alcohol and drugs over their lifetimes, and more justice involvement than their peers without PTSD (Saxon et al., 2001). A PTSD diagnosis makes a veteran four times more likely to report thoughts of suicide than veterans without a PTSD diagnosis (Jakupcak et al., 2009) and 14.9 times more likely to attempt suicide than peers without a PTSD diagnosis (Davidson, Hughes, Blazer, & George, 1991).

Discharged and retired veterans of OEF/OIF have twice the risk of PTSD of active-duty warriors (Schell & Marshall, 2008), suggesting that there may be a lag in the time to trouble for the development of PTSD symptoms, as was found in research on Vietnam era veterans that took place 10–20 years after combat (Kulka et al., 1990). Rates of PTSD also seem to increase with time. Seal et al. (2011) used VA data to discover a more than 21% increase in PTSD from 2001 to 2008. Stigma surrounding care may also limit early diagnosis (cited in Friedman, 2004). It may be too early to understand the full magnitude of post-911 era combat experiences on veterans.

TBI

Traumatic brain injury is defined by the Centers for Disease Control and Prevention (CDC, 2003) as “an injury caused by a blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.” TBI has become a “signature injury” of the wars in Afghanistan and Iraq because of the large number of injuries sustained by contact with improvised explosive devices and also because the wounded are surviving their brain injuries.

Findings by the Committee on the Initial Assessment of Readjustment Needs of Military Personnel (2010, as cited in Army Gold Book, 2012) show that veterans of OEF/OIF have a “fatality to wounded ratio of 1:5.0 and 1:7.2 as of November 2009, compared with a Vietnam ratio of 1:2.6.” Veterans wounded in our most recent conflicts are surviving at a higher rate, creating additional...
challenges for diagnosis and treatment. The VA began screening procedures for mild TBI in 2007, consisting of questions that are required to be asked of all OEF/OIF veterans who seek care at VA medical facilities (GAO, 2008). This action may improve our understanding of the true rate of TBI among veterans in the future.

Estimates of the incidence of mild TBI vary from study to study, ranging from 10% (Stein and McAllister, 2009) to 19% (Rand Report, 2008). Severe brain trauma is reported in 25% of service members evacuated from Iraq & Afghanistan (NADCP, 2010).

According to Hoge et al. (2008), PTSD is strongly associated with TBI. They found that 43.9% of soldiers with a reported loss of consciousness met the criteria for PTSD, compared with 9.1% of soldiers with no injuries and 16.2% of soldiers with other injuries.

Substance Use

Substance abuse is often described as “the single greatest predictive factor for the incarceration of veterans” (Drug Policy Alliance, 2009) because of recent studies (Erickson, Rosenheck, Trestman, Ford, & Desai 2010). According to the annual SAMHSA National Survey on Drug Use and Health (SAMHSA, 2012b), the rate of illicit drug use among Americans is 8.7%. For criminal justice populations, rates of illicit drug use increase to 26.5%. It is estimated that 60% of veterans in U.S. prisons have substance use disorders (NADCP, 2010). The Bureau of Justice Statistics (Mumola, 2000) reports that 81% of justice-involved veterans had a substance abuse problem prior to incarceration. The National Center for PTSD (2010) reports that many veterans use alcohol to self-medicate.

The PTSD and substance use disorders are often mutually diagnosed, with estimates ranging from 19% to 58% (cited in Reynolds et al., 2005). Research shows that when PTSD improves there are also better substance use outcomes; however, improvement in substance use disorders does not make PTSD better (Ouimette, Brown, & Najavits, 1998).

Other Challenges

The PTSD, TBI, and substance use disorders have known links to other challenges, which pose an increased risk of justice-involvement for veterans, including unemployment, homelessness, and suicide risk. The unemployment rate for OEF/OIF veterans was 12.1% in 2011 (BLS Report, 2011), compared with 7.8% for the general population today. The national rate of homelessness is 21 homeless people per 10,000 people in the general population, whereas for veterans it is 31 homeless veterans per 10,000 veterans in the general population for the period 2009–2011 (State of Homelessness in America, 2012).

A veteran commits suicide in this country about every 20 minutes (Army Times, 2010). According to “Invisible Wounds of War,” a report released in 2008 by the RAND Corporation, increasing numbers of veterans are returning from combat with mental health issues for which they do not seek treatment, placing them at a higher risk for justice involvement. Thoughts of suicide are more prevalent among veterans with PTSD (Jakupcak et al., 2009). Readjustment to civilian life may be challenging for all of the reasons previously cited, but dwindling news coverage and the fact that few Americans have served in the military during these conflicts has contributed to the perception by both post-9/11 veterans and the public that there is “little or no understanding” of the challenges faced by the military (Pew, 2011).

METHODS

Participants

Study participants are 83 individuals who agreed to participate in the evaluation of the VTC in Colorado Springs over a period of 3 years. Eighty percent are separated from service (veterans); 20% are still in the military (active duty) at Baseline. Participants are primarily White (76%), male (95%), U.S. Army (93%), OEF/OIF Era (88%) warriors who have served an average of two tours of duty in combat theater (95%). Mean age is just under 30 years. Educational level is high, with 63% reporting “some college” or more education. Just 2% of participants do not have at least a high school diploma or GED at Baseline.

Procedures

Participants completed lengthy, 200-item, private, in-person interviews with evaluation researchers at the Court House during scheduled VTC dockets. Interviews were completed at Baseline, 6 months, and 12 months. Participants were paid $20 cash after each completed interview, at each of the three-time intervals, for a total of $60. Informed consent for participation in the VTC, the evaluation of the VTC, and each of the three interviews was obtained. The University of Colorado Colorado Springs IRB approved the study.

Measures

Baseline, 6-month, and 12-month interview protocols were assembled by Advocates for Human Potential (AHP), the national evaluation team for Jail Diversion and Trauma Recovery–Priority to Veterans SAMHSA grantees. Interviews consisted of approximately 200 items each. Items were grouped into the following categories: demographics, education, employment, income, military service, military trauma, lifetime mental health/substance use service, drug and alcohol use, Cut down, Annoyed, Guilty, Eye-Opener (CAGE), criminal justice, functioning, social connectedness, traumatic events, Post-Traumatic Stress Disorder Checklist Civilians (PCL-C), the 24-item version of the Behavior and Symptom Identification Scale (BASIS-24), Recovery Markers - Revised, services used, and perception of care. Sixty-four of these items were created by and required for Government Performance and Results Act/National Outcomes Measurement System (GPRA/NOMS) compliance (GPRA, 1993).

Military Service/Combat Experience questions were adapted from several sources, including Rand Monograph items from Invisible Wounds of War (Tanielian &
Jaycox, 2008) and standard veteran questions from the United States Census Bureau (2010). The protocol included combat experience items provided in Hoge et al. (2008), which are tailored to the nature of combat in Iraq and Afghanistan.

Traumatic Event items were designed to capture early life (before age 18), adult life (18 or older), and past 6-month trauma histories. Items were adapted from the Post-traumatic Diagnostic Scale (Foa, 1995). This instrument is descriptive only, providing trauma history and information about timing.

The Cut down, Annoyed, Guilty, Eye-Opener instrument is widely used in criminal justice as a quick, easy to remember screen for alcohol dependence or misuse (Ewing, 1984). The CAGE has four items with a “have you ever” format. Two positive responses indicate strong potential for substance dependency or abuse (CAGE, 1984).

The VTC participants were also asked to rate the frequency at which they experienced problems related to substance abuse—hiding drug or alcohol use, having the urge to use, and experiencing problems from use. Ratings were provided for the past 30 days at 6-month interview and 12-month interview. Ratings were provided on a 5-point Likert scale from “never” (0), “rarely” (1), “sometimes” (2), and “often” (3) to “always” (4).

The 24-item version of the Behavior and Symptom Identification Scale is a widely used, well validated, “measure of self-reported difficulty” of full scale functioning on six functioning domains, developed at McLean Hospital in Belmont, MA (Idiculla, Speredelozzi, & Miller, 2005). The six subscales have 24 weighted items that yield subscale scores and an overall 24 item score. Subscales include depression/functioning, relationships, self-harm, emotional lability, psychosis, and substance abuse. The responses to the items vary from zero to four. There are five response options augmented by “Don’t Know” or “Refuse to Answer.” The answer options vary from “No difficulty” to “Extreme difficulty,” “None of the time” to “All of the time,” and “Never” to “Always.”

The PTSD was measured with the PCL-C, a widely used, well-validated instrument, which consists of 17 items representing three categories of symptoms: “reliving,” “avoidance,” and “arousal.” Response options include “Not at all,” “A little bit,” “Moderately,” “Quite a bit,” or “Extremely.” Items are rated on a scale from 1 to 5. The scores are summed to determine symptom severity. The clinical cutoff for PTSD diagnosis is a score of 50 or above. (Weathers, Litz, Herman, Huska, & Keane, 1993).

Criminal Justice items were adapted from previous cross-site evaluations of SAMSHA grants by AHP. Six items address age of first arrest, previous incarcerations, history of protection orders, and probation history.

Arrest data were accessed from probation Eclipse databases for prior, target, and one-year post arrest record tracking.

The 4-Question PTSD Screen was used as a quick screen for PTSD diagnosis for participants to determine program eligibility for the District Attorney prior to program start and clinical engagement (Prins et al., 2003). The Lead Peer Mentor administers this instrument.

The Defense and Veterans Brain Injury Center 3-Question TBI Screen (DVUSIC-Q) was used as a quick screen for TBI diagnosis for participants to determine program eligibility prior to program start. The DVUSIC-Q is widely used by military organizations as a starting point to recommend additional testing (Schwab et al., 2006). The Lead Peer Mentor also administers this instrument.

**Limitations of the Study**

This analysis presents a longitudinal evaluation of the experiences of one group of veterans. The study does not include a comparison group to measure what might have happened had veterans remained within the judicial system. The study is also limited to a single veterans court in one city, which does not allow for comparisons that would identify the most effective features of a VTC. Lastly, the sample size is fairly modest, which restricted identification of smaller effects and the specification of more complex statistical models.

**Statistical Analyses**

Personal interview data were collected with a mix of paper instruments and QDS (Questionnaire Development System) computer-assisted personal interview software loaded onto a laptop computer with PGP Encryption. SPSS software (version 19.0) was used for data analysis. Descriptive statistics (proportions, means, standard deviations) were used to describe the overall population and subgroups on demographic variables. Chi-square tests were used to assess when differences between groups were statistically significant. One-way analysis of variance (ANOVA) with repeated measures was used to compare means between the groups and across three-time intervals on the BASIS-24 and the PCL-C.

**RESULTS**

This section first examines the mental health problems presented at Baseline and then examines improvement over time in mental health, substance use, and various measures of social integration.

**Participant Characteristics—PTSD**

At Baseline, all study participants (100%) had positive screens for PTSD on the 4-Question PTSD quick screen to determine program eligibility. A majority of study participants (80.7%) also met criteria for clinical diagnosis of PTSD on the PCL-C at Baseline. PCL-C scores that met the clinical level for diagnosis declined from 80.7% at Baseline to 66.7% at 6-month interview, and to 57.8% at 12-month interview (Table 1). PTSD improved

| TABLE 1. Percentage of VTC participants with PCL-C DSM-IV diagnosis for PTSD |
|----------------|----------------|----------------|
| Baseline       | 6 months       | 12 months      |
| 80.7%          | 66.7%*         | 57.8%*         |

*Significant reductions from Baseline to 6-month interview and Baseline to 12-month interview, p < .05.
significantly \((p < .05)\) from Baseline to 6-month interview. This improvement was sustained after 12 months, although no further declines were noted between 6 and 12 months.

**PTSD Symptoms, Subscales, and Clinical Diagnoses**
The PCL-C Sum Severity Scores (Weathers et al., 1993) were analyzed with a one-way ANOVA for repeated measures. The results were significant, \(F(2) = 9.720, p < .001, n = 40.\) In addition, pairwise comparisons between means for the different measurement intervals show that scores dropped significantly from Baseline to 6-month interview, with continued, although not significant, improvement from 6- to 12-month interview. Figure 1 plots Sum Severity Score means across three-time intervals.

**Participant Characteristics—TBI**
The TBI quick screens were not clear for all participants. More than a quarter (26.5%) confirmed TBI on the quick screen at Baseline. Forty-seven percent of participants did not have positive tests for TBI on the DVBIC quick screen. More than a quarter (27.4%) had unknown, inconclusive, or missing results. Screens for TBI were administered only at Baseline. One third of participants (32.8%) with PTSD diagnoses at Baseline also had positive TBI screens. Twenty-seven percent of veterans and 24% of active-duty service members had positive TBI screens at Baseline.

**Participant Characteristics—Trauma**
Fifty-seven percent of VTC participants had drug or alcohol-related charges in the arrests that brought them to the program. Drug- and alcohol-related charges were not necessarily the most serious charges in the arrests of participants. This finding is likely an artifact of the selection criteria for the VTC. Fifty-two percent of participants answered two or more CAGE questions positively, indicating “strong potential” for substance abuse or dependence.

Twenty-seven percent reported being engaged in outpatient treatment for alcohol and substance abuse within the past 30 days at Baseline. Sixteen percent reported inpatient treatment for substance abuse or detox within the past 30 days at Baseline. No emergency room visits for alcohol or substance abuse were reported within the past 30 days at Baseline.

**Substance Use and Related Behaviors**
Ratings show that participants are not hiding drinking or drug use at 6 or 12 months (Figure 2). They have slightly more problems from drinking or drug use at 12 months than at 6 months, but ratings are very low. Participants struggle most with the urge to drink alcohol or take street drugs, with the urge slightly greater at 6 months than at 12 months.

Participants were also asked to report the frequency of usage for 10 substances, including alcohol, illegal street drugs, and prescription drugs not prescribed to them. Alcohol was the #1 substance choice followed by cannabis, methamphetamine, prescription opioids and sedatives not prescribed to the individual surveyed, cocaine, and street opioids (Table 2).

Participants reported substantial declines in use of alcohol and illegal drugs (Table 3). Alcohol use was
TABLE 2. Usage and frequency of substances at baseline

<table>
<thead>
<tr>
<th>Usage &amp; frequency of substances at baseline (past 30 days)</th>
<th>Never</th>
<th>Once or twice</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic beverages</td>
<td>57%</td>
<td>26%</td>
<td>14%</td>
<td>3%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>76%</td>
<td>11%</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>97%</td>
<td>1%</td>
<td>1%</td>
<td>0</td>
</tr>
<tr>
<td>RX stimulants not prescribed to you</td>
<td>99%</td>
<td>1%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>94%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Inhalants</td>
<td>100%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sedatives not prescribed to you</td>
<td>96%</td>
<td>3%</td>
<td>1%</td>
<td>0</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>99%</td>
<td>1%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Street opioids</td>
<td>97%</td>
<td>3%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RX opioids not prescribed to you</td>
<td>96%</td>
<td>4%</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: Totals may not equal 100% due to rounding.

TABLE 3. Alcohol and substance use

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any alcohol use—past 30 days</td>
<td>44.6%</td>
<td>26.7%*</td>
<td>20%</td>
</tr>
<tr>
<td>Any illegal substance use—past 30 days</td>
<td>26.5%</td>
<td>11.9%*</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

*Significant reductions from Baseline to 6-month interview, p < .05.

reported by more than 44% at Baseline but declined significantly by 6 months. This decline in use was sustained at 12 months. The modest decrease in use between 6 and 12 months was not significant. The same pattern was true for use of illegal substances, as well, with a steep, significant decline in the first 6 months and then those improvements were sustained. Just 5% of participants reported binge drinking in the past 30 days of five or more drinks in 1 day for males or four or more drinks in 1 day for females.

Social Functioning

Figure 3 presents the BASIS-24 Scale scores. A substantial overall improvement occurred between Baseline and 6-month interview. The results were significant, \( F(2) = 7.315, p < .001, n = 38 \). In addition, pairwise comparisons between means for the different measurements and the plot below show that Full Scale scores dropped significantly \( p < .05 \) from Baseline to 6-month interview and were sustained at 12 months.

The BASIS-24 subscale scores were also analyzed with one-way ANOVAs. Only 2 of the 6 subscale scores, relationships and psychosis, did not show significant improvement \( p < .05 \). Table 4 includes the results of these analyses.

Social Integration

Participants experienced some improvement in employment and stability of housing during the study period, but gains were modest and not significant (Table 5). Thirty-four percent reported that they were “unemployed—looking for work” at Baseline, compared with 28% at 6-month interview and 20% at 12-month interview.

Seventy percent reported that they lived in their own homes most of the time in the past 30 days at Baseline. Thirteen percent reported that they lived in institutions, such as a jail or inpatient treatment facility. Thirteen percent reported “unstable” housing. Four percent were homeless. Approximately 17% of participants were homeless or unstably housed at Baseline, compared with 15.3% at 6-month interview and 15.6% at 12-Month interview. Rates of unstable housing were not significantly different \( p < .05 \) at Baseline and 6-month interview, Baseline and 12-month interview, or 6- and 12-month interview.

VTC Program Compliance

The average time to graduate from the VTC for the first 32 graduates of the program was 67 weeks, or approximately 17 months. During that time, participants averaged 2.5 treatment appointments per month. The mean number of total appointments related to VTC participation, however, was 16 per month during Phase 1, called Engagement, which typically lasted 120–180 days. These appointments included court appearances, meetings with Probation Officers, treatment appointments, substance use monitoring such as Urinalysis (UA), Breath Alcohol (BA), and

![BASIS-24](image-url)
TABLE 4. BASIS-24 subscale score means baseline to 12 months

<table>
<thead>
<tr>
<th>BASIS-24 subscale</th>
<th>Baseline mean</th>
<th>6 month mean</th>
<th>12-month mean</th>
<th>One-way ANOVA repeated measures results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression/functioning</td>
<td>1.8</td>
<td>1.4</td>
<td>1.4</td>
<td>( F(2, 39) = 3.877, \ p &lt; .05, n = 41^* )</td>
</tr>
<tr>
<td>2. Relationships</td>
<td>1.7</td>
<td>1.6</td>
<td>1.5</td>
<td>( F(2, 38) = 1.786, \ p &gt; .05, n = 40 )</td>
</tr>
<tr>
<td>3. Self-harm</td>
<td>0.39</td>
<td>0.27</td>
<td>0.08</td>
<td>( F(2, 37) = 4.339, \ p &lt; .05, n = 39^* )</td>
</tr>
<tr>
<td>4. Emotional lability</td>
<td>2.5</td>
<td>2.1</td>
<td>1.9</td>
<td>( F(2, 40) = 6.613, \ p &lt; .05, n = 42^* )</td>
</tr>
<tr>
<td>5. Psychosis</td>
<td>1.2</td>
<td>0.96</td>
<td>0.94</td>
<td>( F(2, 40) = 2.055, \ p &gt; .05, n = 42 )</td>
</tr>
<tr>
<td>6. Substance abuse</td>
<td>0.82</td>
<td>0.49</td>
<td>0.53</td>
<td>( F(2, 40) = 4.330, \ p &lt; .05, n = 42^* )</td>
</tr>
</tbody>
</table>

*Significant at the .05 level, two-tailed.

80-hour alcohol testing (EtG) appointments, as well as meetings with peer mentors and service providers.

The VTC participants report that they “like the services” they received from the VTC (86%), “would recommend” the VTC to others (81%), and the Court Team believes that they can “grow and change” (91%). When asked about the impact of peer mentors on their success in the program, 87% of participants attributed “some” or “all” of their success to the help they received from peer mentors. To date, 32% of VTC participants have graduated from the program and 11% have failed. Prerelease recidivism is 11%. Postrelease recidivism, defined as new charges within 1 year of graduation, is zero. It may be premature to report recidivism as just 10 individuals have been graduated from the VTC for a period of 1 year or more.

DISCUSSION

This study explored the preliminary results of participation in a pilot VTC on veterans with PTSD and/or TBI. The purpose of this study was to establish mental health and substance use challenges among participants and increase understanding of the VTC model.

Rates of PTSD and substance use among justice-involved veterans were substantial at program start. Participants also faced other challenges, including high rates of unemployment and unstable housing or homelessness. Although VTCs participation did not significantly improve unstable housing or unemployment, mental health did improve. Improvements in PTSD, depression, self-harm, emotional lability, and substance use were significant from Baseline to 6-month interview and sustained from 6- to 12-month interview. The impact of mental health and substance use improvements on long-term justice-involvement should continue to be tracked.

Improvement in PTSD symptoms and severity shows that the VTC model was both effective and quick in helping veterans on the path to recovery. The high rate of clinical PTSD diagnosis at Baseline far exceeded estimates obtained from a review of the literature, suggesting that justice-involvement may be more likely for people with PTSD. This finding makes a strong argument for the existence of VTC as well as the need for their expansion to provide therapeutic justice to help heal veterans who have served our country.

The TBI was difficult to assess in a meaningful way. Quick screens must be replaced by valid and comprehensive clinical assessments before understanding of the role of TBI on veterans, and cooccurring challenges may be possible.

More than half of VTC participants had substantial substance use disorders as measured by the presence of illegal drugs or alcohol in target arrest reports, results on CAGE items, self-reports of use, and BASIS-24 subscale scores. The use of alcohol and cannabis to “self-medicate” may explain the prevalence of use at Baseline. Once connected to treatment, which may include prescription medications, use of all substances dropped significantly and was sustained through the first year of participation. Again, the VTC model was effective at providing alternatives to alcohol and illegal substance use.

What happened to veterans during the 6-month window from Baseline interview to 6-month interview that allowed them to start healing and begin to curtail behaviors that may have been negatively impacting their lives?

One possibility is that felony charges with the possibility of incarceration may have provided the wake-up call needed for veterans to become motivated to address mental health issues and engage in treatment. Veterans who met VTC eligibility requirements received a second chance—access to treatment, no drug or alcohol use, and the opportunity to seal their records if they successfully completed the intensive requirements of the program.

Another possible reason for VTC success may be that participation restored access to peers—at court, in treatment, and in the community in the form of peer mentors. For some veterans, the sudden loss of military structure, stability, and support may have impacted their overall health and everyday coping skills. Restoration of access to their peers, linkage to VA services, and opportunities to file for changes in discharge status and disability benefits may have contributed to participant success. The role of peer mentors in veteran success is believed to be significant but requires further study.

Significant reduction on the Self-Harm Subscale of the BASIS-24 suggests that suicidality declines with
participation in a VTC. Again, the team approach of the
VTC has helped provide many insights into the challenges
and needs of each individual and to develop custom solu-
tions for each. The relationship between PTSD, substance
use disorders, and suicide risk was not explored in this
study, but it is clear that all three improved significantly
in the first 6 months of VTC participation and that im-
provements were sustained to 1 year.

Families already stressed by justice involvement be-
come more stressed when housing and employment are
unstable. The benefits achieved by VTC participation by 6
months did not include significant improvements in hous-
ing and employment. The requirements of VTC participa-
tion are intensive and may have made it difficult for partic-
ipants to hold down a full time job. Justice involvement is
another possible obstacle to both employment and hous-
ing. VTCs that have employment and housing stability as
goals would benefit from policies that promote, support,
and partner with their communities to overcome such bar-
rriers for justice-involved veterans as they recover.

Successful VTCs must identify the fine line between
motivation and punishment in their compliance require-
ments and create standards that help and heal the most
people. Taking a broad view, mental health, physical
health, financial stability, and family stability are all im-
portant elements in the overall health of individuals and
their possible contributions as productive members of
society.

Comprehensive evaluations of problem solving courts
must become standard to track program activities, goals,
measures, methods, and outcomes. Understanding the el-
ements of VTCs that heal veterans and those that need to
be tweaked to avoid harm is an ongoing process. VTCs are
unique, like the individuals and communities they serve,
and there is no one-size-fits-all. Depending on the level
of exposure to trauma, and other challenges, such as sub-
stance use and TBI, the requirements that will be achiev-
able and simultaneously heal individuals are best defined
with good data from a process evaluation.

Veterans showed improvement in mental health, sub-
stance use, and social reintegration after 6 months, which
was sustained at 12 months. These findings are consistent
with the possibility that VTCs are having a broad and sub-
stantial impact in the lives of troubled veterans. Further
research is clearly needed to better understand these po-
tentially important institutions, evaluate their long-term
impact, and guide their widespread use. Initial evidence
suggests that VTCs work and may save lives.

Declaration of Interest
The authors report no conflicts of interest. The authors
alone are responsible for the content and writing of the
article. The contents are solely the responsibility of the
authors and do not necessarily represent the official views
of SAMHSA.

Funding support for the study was provided by the
Jail Diversion and Trauma Recovery—Priority to Veter-
ans Grant awarded to the Colorado Department of Human
Services, Division of Behavioral Health from the Sub-
stance Abuse and Mental Health Services Administration,
Grant #SM58806.

RÉSUMÉ

La prise, le Plaisir et la Libération: L’Adresse de Cours
de justice de Traitement Chevonnée les Défis de Retour à la maison

Après une décennie de guerre, il y a un grand besoin
pour le traitement et les alternatives à l’incarcération pour
les vétérans de justice-impliqué. Les membres de ser-
vice militaires américains retournent du combat avec les
defis de santé mentale substantiels qui augmentent le po-
tentiel pour l’engagement de justice. Les Tribunaux de
Traitement de vétérans commencent à travers la nation
pour rencontrer ce besoin pour la justice thérapeutique.
Ces problème qui résout des tribunaux fournit l’accès
au traitement et la motivation pour l’engagement. La
preuve préliminaire d’une évaluation de SAMHSA-
SUBVENTIONNE suggère que l’amélioration signifi-
cative dans l’usage de PTSD et substance soit juste peu
d’entre les issues positives que ces tribunaux peuvent
aider des vétérans atteignent.

RESUMEN

Agarre, Trate, y Liberación: Dirección de Tribunales de
Tratamiento Veterana los Desafíos de Volver a Casa

Después de una década de guerra, hay una gran necesi-
dad de tratamiento y alternativas al encarcelamiento para
veteranos complicados de justicia. Los miembros de ser-
vice militares estadounidenses vuelven del combate con
desafíos de salud mental sustanciales que aumentan el po-
tencial para la participación de justicia. Los Tribunales de
Tratamiento Veteranos comienzan a través de la nación
para encontrar la necesidad de la justicia terapéutica. Es-
tos tribunales de solución de problema proporcionan
el acceso a tratamiento y motivación para el compromi-
so. Pruebas preliminares de una evaluación SAMHSA-
financiada sugieren que la mejora significativa de PTSD
y uso de sustancia sea sólo algunos de los resultados pos-
itivos que estos tribunales pueden ayudar a veterans a
conseguir.

THE AUTHORS

Michelle Slattery is the Lead
Evaluator for the Jail Diversion
and Trauma Recovery–Priority
Vets Grant at the UCCS
Trauma, Health & Hazards
Center as well as the President
of Peak Research, LLC. She
has an MA degree in human
factors Psychology. Her research
interests include the evaluation
of problem solving courts
and public health initiatives,
secondary trauma, trauma and
personality type, and STEM education.
change.

Laure Williams is the Project Director for the Jail Diversion and Trauma Recovery - Priority to Veterans Grant at the Colorado Department of Human Services, Division of Behavioral Health. She has an MA degree and an MBA and is also a Licensed Professional Counselor. Her research interests include the nexus between early childhood trauma, abuse, and loss and adult functioning, resiliencies and vulnerabilities.

GLOSSARY

PTSD: Posttraumatic stress disorder is a mental health condition that may develop after experiencing traumatic events.
Substance abuse: Excessive use of alcohol or drugs.
TBI: Traumatic brain injury is a temporary or permanent injury to brain cells caused by a blow to the head or penetration of the skull.

REFERENCES


Mallory Natasha Dugger is the Professional Research Assistant for the Jail Diversion and Trauma Recovery –Priority to Veterans Grant at the UCCS Trauma, Health & Hazards Center. She has a BA degree in psychology and a BA degree in sociology. Her current research interests include trauma and personality type.

Theodore A. Lamb is a Senior Consultant with Peak Research, LLC, and an Assistant Dean of Curriculum & Assessment at Naropa University in Boulder, CO, USA. His PhD is in sociology and he is a combat veteran of Viet Nam. His research focus is on developing predictive models of surviving trauma and understanding the role of contemplative education practices in healing and social change.

Laura Williams is the Project Director for the Jail Diversion and Trauma Recovery - Priority to Veterans Grant at the Colorado Department of Human Services, Division of Behavioral Health. She has an MA degree and an MBA and is also a Licensed Professional Counselor. Her research interests include the nexus between early childhood trauma, abuse, and loss and adult functioning.


