PRACTICE COMMENTARY

DEVELOPMENT OF VETERANS TREATMENT COURTS: LOCAL AND LEGISLATIVE INITIATIVES

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Veterans treatment courts are a recent but rapidly growing phenomenon in the judicial system, driven by a need for mental health and substance abuse treatment among justice-involved veterans. As of January, 2010, there were 24 operational veterans treatment courts in the United States, with another 40 in planning or development. This article examines how these courts have developed out of and been informed by existing treatment court theory and practice, and identifies the unique elements that characterize this new form of treatment court. An analysis of legislative initiatives targeting veterans in the courts finds that legislative proposals generally include more restrictive admission criteria than typical veteran court practice; a finding which may limit coverage of legislation-driven veterans treatment court dissemination. We conclude with a review of potential benefits of this collaboration between the courts and the U.S. Department of Veterans Affairs, and emphasize the importance of systematic evaluation of both veteran outcomes and policy effects of legislative initiatives that seek to influence development of the veterans treatment court model.

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INTRODUCTION

Since the 1989 advent of the first drug court, the concept of treatment as an alternative to incarceration has taken hold in the judicial system, as evidenced by the robust growth of treatment or problem solving courts (Huddleston, Marlowe, & Casebolt, 2008; National Institute of Justice, 2006). Treatment courts share the central premises that a) behaviors characteristic of mental illness and addiction are frequently present in encounters with law enforcement and can and do result in incarceration, and b) extended treatment monitored and reinforced by specially trained judges can diminish or end involvement with the justice system over time (Bureau of Justice Assistance, 2008; Huddleston, Marlowe, & Casebolt, 2008).

There is an abundance of news stories that have focused attention on the impact of various aspects of military experience, particularly combat, on the mental health of Service members returning to life in the U.S. from the wars in Iraq and Afghanistan (for example, Tempest, 2006). Combat exposure or injury and/or repeated deployments have been implicated in domestic or other interpersonal conflict and alcohol or drug abuse resulting in behavior that can trigger a law enforcement response. Post-traumatic stress disorder (PTSD) has been hypothesized to have links to criminal behavior (Baker & Alfonso, 2010).

In a landmark national study, Kulka (1990) described the relationship between military trauma and post-deployment mental health problems and criminal activity, citing the community readjustment experiences of Vietnam War veterans. Since then, military researchers have conducted population-wide mental health screening studies, the most recent of which found that, among American soldiers who had served in Iraq, 27% of active duty and 35% of reserve component members were at risk for mental health problems that included depression, PTSD, suicidal and

aggressive thoughts, and interpersonal conflict (Milliken, Auchterlonie, & Hoge, 2007). In addition to these findings is the as yet unclear extent and intensity of traumatic brain injury (TBI) which likely heightens mental health and readjustment risk (Tanelian & Jaycox, 2008).

Besides actual combat exposure, in recent years military researchers examining the training of American soldiers have begun to recognize and address the impact of acquisition of combat skills and of constant battle readiness upon civilian readjustment, and have coined the acronym "battlemind" to identify 10 skills adaptive for combat that require conscious modification for coping with civilian life (Walter Reed Army Institute of Research, 2010). These include constant awareness of one's surroundings, carrying weapons at all times, strict control of one's emotions during combat, unpredictable fast driving, absolute discipline and unquestioning obedience to orders. Although most soldiers and veterans appear to develop effective coping responses for the stressors experienced in the military and upon reentry to civilian life, research and media reports suggest that a significant proportion of Service members returning from current wars either as a result of mental health problems or as a result of their military training are at high risk for contact with the criminal justice system. While there is little national data, to date, on criminal involvement among veterans of the current wars, the most recent data from the U.S. Department of Justice, Bureau of Justice Statistics (BJS) *Survey of Inmates in Local Jails 2002* revealed that 9.3 percent of people incarcerated in American jails were veterans (Mumola & Noonan, 2008).

In summary, significant numbers of America's veterans are involved in the nation's justice system or are at risk for such involvement. Justice-involved veterans have been shown to have high rates of substance abuse, mental illness, homelessness, and other chronic and infectious medical diseases, and most are likely eligible for U.S.

Veterans Administration (VA) services (Mumola, 2000). The emerging veterans treatment court model represents a considered response to veterans' justice involvement that is due to stress, trauma, medical or psychiatric illness and social dysfunction. This article briefly describes veteran-specific modifications that have been made to established treatment court models, and reviews recent legislative efforts and their congruence with established and developing veterans treatment court practices. The article concludes with a consideration of the potential benefits of collaboration between veterans treatment courts and the U.S. Department of Veterans Affairs.

EVOLUTION OF TREATMENT COURTS

Drug Treatment Courts

In June of 1989, officials in Miami-Dade County, Florida established the nation's first dedicated treatment court, known at the time as the Drug Treatment and Diversion Program (Bureau of Justice Assistance, 1998). This small-scale, innovative effort (Brummer & Rodham, 1993) touched a nerve in the judicial system. There are over 1,100 adult drug courts out of 2,301 drug courts operating in the United States, and hundreds more problem-solving or treatment courts employing nontraditional court procedures to address specific problems (Huddleston, Marlowe, & Casebolt, 2008).

Initially, the Miami-Dade program's eligibility criteria were narrow: only first-time offenders could participate, and only those charged with possessory drug offenses (Brummer & Rodham, 1993). Over time, these criteria were expanded, and the court accepted defendants with a wider range of charges and criminal histories. Difficult as it may have been to design and implement, the program's basic philosophy and structure were simple. The court would approach defendants as individuals in need of treatment, rather than bad actors in need of punishment. In

practical terms, this meant suspending traditional criminal proceedings against a participating defendant, facilitating access to drug treatment services, supervising and encouraging the defendant's adherence to treatment requirements (with a combination of positive and negative reinforcement) and, upon successful completion, dismissing the instant charge and expunging the record. Potentially more problematic than organizing such a system was the profound attitudinal shift required of the judges, attorneys, and court personnel working with the new program. Rather than the adversarial orientation of a traditional court, the drug treatment court embodied a truly collaborative approach, offering support and encouragement to defendants undergoing court-supervised treatment, while holding them accountable. These basic structural and conceptual elements inform, to varying degrees, every drug treatment court in operation today.

Mental Health Treatment Courts

The success of the drug treatment court movement opened the door for other novel uses of the criminal justice system to address specific problems. Notable among these are the mental health courts. As noted by the Bureau of Justice Assistance: "Drug courts have been particularly instrumental in paving the way for mental health courts… Some of the earliest mental health courts arose from drug courts seeking a more targeted approach to defendants with co-occurring substance use and mental health disorders." (BJS, 2008, p. 3).

In addition to drug treatment court model standards involving ongoing monitoring of court participants and a focus on abstinence and sanctions that reinforce abstinence, a fully-realized, effective mental health court is more than an alternative track providing linkage to treatment services in lieu of prosecution. It is also a diagnostic tool that can identify the resource limitations of the public mental health

and substance abuse treatment systems. In this way, a mental health court is a flexible mechanism capable of connecting participants with treatment services tailored to meet their individual needs, in an environment that promotes adherence to treatment, recovery in the community, and hopefully, reduced contact with the justice system. Mental health courts are like drug courts in their mission and basic structure, but the wide variation of needs among mental health participants, coupled with what are often scattered and limited resources to meet those needs, means that mental health courts are tremendously diverse and, by necessity, creative in their efforts to work with participants. Mental health treatment courts require greater flexibility and patience from judges, as well as adjustable expectation levels (Bureau of Justice Assistance, 2008).

The Effectiveness of Treatment Courts

Treatment courts have multiplied rapidly in part because research has begun to demonstrate effectiveness in significantly reducing recidivism in a population which has consistently been unresponsive to treatment (Marlowe, DeMatteo, & Festinger, 2003). Four meta-analyses indicated that drug courts reduced crime by an average of 7 to 14 percentage points (Huddleston, Marlowe, & Casebolt, 2008). Outcome studies on mental health courts are promising, but to date based on limited data. These studies suggest fewer new bookings, greater numbers of mental health treatment episodes, lower likelihood of rearrest or new charges, and improvement of mental health functioning and reduction of substance use (Bureau of Justice Assistance, 2008).

Researchers who have conducted outcome studies have identified two significant factors inhibiting treatment courts' performance. The first is difficulty in securing both the full range and sufficient dosages of health and mental health services for treatment court clients, upon which the effectiveness of the court intervention crucially depends

(TAPA Center for Jail Diversion, 2004). More recently, local government mental health budgets under severe strain from the recession may further exacerbate service scarcity. The second inhibiting factor is treatment courts' inability to deliver the type of treatments indicated for participants. Researchers and policy analysts have begun suggesting that diversion clients, particularly those at highest risk for re-offending, should receive not only standard mental health treatments but evidence-based treatments that target underlying trauma, including combat trauma (Osher, 2009; Steadman, 2009), and criminogenic thinking (Cusack et al., 2008).

In sum then, prior to the advent of the veterans treatment court model, almost two decades of experience had led to the identification of principles supporting treatment court practices, and the mental health court represents an important evolutionary step for the treatment court model. These developments, and the outcome studies that have examined them, set the stage for the arrival of the newest treatment court model, the veterans treatment court.

VETERANS TREATMENT COURTS[1]

At the most basic level, veterans treatment courts supervise veteran defendants by design, with structural features intended to enhance the provision of and adherence to treatment services for this population. These courts are usually formed within drug or mental health courts or

[1] The terms "Veterans treatment court," or "veterans court" as used in this article should not be confused with the United States Court of Appeals for Veterans Claims (http://www.uscourts.cavc.gov/) which "provides veterans an impartial judicial forum for review of administrative decisions by the Board of Veterans' Appeals that are adverse to the veteran-appellant's claim of entitlement to benefits for service-connected disabilities, survivor benefits and other benefits such as education payments and waiver of indebtedness."

according to drug and/or mental health court principles, seeking to cluster veteran defendants on a single, dedicated docket. An important element of a veterans court is access to veteran-specific resources. Many veterans have access to economic benefits and health services through the U.S. Department of Veterans Affairs (VA), State Departments of Veterans Affairs, County Departments of Veterans Affairs, and a variety of additional programs for veterans operated at federal, state and local levels.

There are currently 24 veterans courts that are actively overseeing veterans, with an additional 40 in various stages of planning. Table 1 presents data outlining elements of 9 of the 24 operational courts. An additional 15 veterans courts were started since March 2009 and the specifics of the court operations are still emerging. The best-known of its type is the veterans treatment court in Buffalo, New York, over which Judge Robert Russell presides. As the leading pioneer of the veterans court model, Judge Russell and his court serve as the model upon which many other operational and planned veterans courts are patterned (Russell, 2009). Planning groups typically consist of leaders in criminal justice and the judiciary, Veterans Service Organizations, political leaders, and treatment providers. The Veterans Health Administration (VHA) is involved in planning the development of a court as a treatment provider, and in treatment planning once veterans are accepted to participate in the court. The design and implementation of the legal and procedural aspects of the court program fall to members of the local judiciary and legal community, who employ their expertise in the jurisdiction's laws and rules of procedure.

Table 1: Characteristics of Veterans Courts Developed Through March 2009.

Court Type	Model	Veteran Eligibility	Charges Allowed	Pre/post conviction	Mentors	VA staff role
District Court	wellness court	eligible for VHA, MH or SA diagnosis	misdemeanor	post-conviction	no	• in court • linkage to VA • treatment
County Superior Court	combined MH and drug court	all veterans	felony or misdemeanor	post-conviction	in development (VA)	• in court • linkage to VA • treatment
County Superior Court	combined MH and drug court	combat veterans with military-related MH condition	felony or misdemeanor	post-conviction	in development (VA)	• in court • linkage to VA • treatment

Table 1 continues…

County Superior Court	collaborative court	all veterans	felony or misdemeanor	mixed	yes (VA)	• in court • linkage to VA
County Circuit Court	mental health court	all veterans	felony or misdemeanor, some exclusions of violent crimes	post-conviction	no; under consideration	• in court • linkage to VA
County Circuit Court	drug court	all veterans	misdemeanors and non-violent felonies (case-by-case for violent charges)	pre-plea	in development (court)	• telephone referral • linkage to VA
City Court	combined MH and drug court	all veterans	misdemeanor or felony	mixed	yes (court)	• in court • linkage to VA • treatment

Table 1 continues…

County Court	combined MH and drug court	all veterans	misdemeanors and non-violent felonies (case-by-case for violent charges)	mixed	yes (VA)	• in court • linkage to VA • treatment
County District Court	drug court	all veterans	non-violent alcohol or drug-related felonies	post-conviction	in development (community)	• in court • linkage to VA • treatment

Note: This table includes courts that were developed through March 2009. Since that time, 15 additional veterans courts have begun seeing clients. They are not included in the table as they are in very early developmental phases and have not defined all of the elements listed here.

In these courts, veterans are identified through a screening process, typically based on a question such as "have you ever served in the U.S. Armed Forces or U.S. military?" Those who have served in the military are referred to the court team for consideration. As in other types of treatment courts, the court team reviewing cases is overseen by the judge, and can include the court coordinator, prosecuting attorney, defense attorney, community health/mental health provider, probation officer, and U.S. Department of Veterans Affairs representative who can determine eligibility for VA services. If the prosecution consents and the court approves, the veteran can choose to participate in a judicially supervised treatment plan in lieu of traditional criminal case processing.

As shown in Table 1, veterans courts vary in the way they define a court-eligible veteran. Most veterans courts consider all defendants with military service, while others treat only those who qualify for services at the VHA (http://www1.va.gov/opa/vadocs/current_benefits.asp). Still others admit only veterans with particular mental health or substance abuse diagnoses, such as drug addiction or PTSD. In one operational veterans court and a number of planned courts, the veteran's mental health diagnosis must be directly linked to his or her combat service (for example, PTSD related to military combat), a criterion which that court believes captures veterans with the most severe symptoms and readjustment problems. Perhaps the broadest admission criteria is employed by one newly developed veterans court, which admits active duty military personnel who have not yet been discharged from the service, as well as their spouses if the spouse also has criminal charges pending that meet court acceptance criteria.

Veterans courts also differ as to the nature and severity of charges that render a veteran defendant eligible to participate. One court focuses exclusively on misdemeanor charges, and eight other courts will admit defendants with

certain felony charges. Four courts consider only non-violent charges, while the other five will review cases with violent charges (for example, assault) to determine treatment court eligibility. In two courts, charge-based eligibility is defined by state statutes that regulate that state's drug court or mental health court operations. Since this is a newly emerging model, several courts have general criteria and accept all referrals for further review, rather than defining criteria in advance that might screen out potential participants.

Veterans courts admit defendants with cases in a variety of procedural postures. One court will accept a veteran prior to entering a plea, five courts require the veteran to plead guilty and be placed on probation as a condition of enrollment in the program, and three courts oversee defendants both pre- and post-plea.

On the treatment side, although there is some geographic variability in the VA system, the VHA generally provides a broad range of services and supports for veterans involved in the justice system. Services include inpatient and outpatient medical and psychiatric services; domiciliary; nursing home and community residential care; specialized healthcare for female veterans; and residential services designed for homeless veterans. Medical services include specialized assessment and treatment of TBI caused by closed or penetrating head trauma, which may cause veterans to behave in a manner consistent with mental health and substance abuse diagnoses. Mental health services include general psychiatry, substance abuse treatment, compensated work therapy and PTSD treatment. This full range of services means that veterans can access, through a single point of service, most or all of the components of a court-supervised treatment plan. Families of veterans involved in a veterans treatment court often have needs in addition to those of the veteran. VA medical centers and Vet Centers can provide some counseling services to family members in the context of direct treatment of the veteran, and some family

members can be eligible for health coverage benefits through the CHAMPVA program. However, in many cases, needs of family members who are not veterans are addressed through community services.

The addition of veteran-specific resources to the treatment court resource coalition and service continuum can mean significant enhancements to a treatment plan, not least of which is the efficiency of dealing with a single provider for a given case, or across much of an entire docket. VHA staff collaborate with existing veterans courts in a number of ways. As indicated in Table 1, VHA staff participation in the court ranges in intensity and can include presence in court, referral to and assistance with linkage to VHA services, and direct provision by the staff member of ongoing case management, substance use disorder and mental health treatment services. VHA's court involvement begins once a veteran has elected to participate. Veterans not eligible for access to or electing not to participate in a court program are still referred for services at VHA. With the veteran's consent, VHA can share assessment information with the court while the veteran is under consideration for treatment court.

VHA's contribution to the process is its provision of treatment services, not legal advocacy or representation. In the context of treatment court, the VHA does not extend to expert testimony or forensic assessments[2]. VHA does not operate formal diversion programs and cannot accept legal custody of a veteran (Perlin, 2006).

[2] Qualification to provide forensic evaluation services requires specialized training and certification. *See* American Board of Psychiatry and Neurology, Forensic Psychiatry Core Competencies Outline 2.1, available at: http://www.abpn.com/downloads/core_comp_outlines/core_FP_2.1.pdf (last visited Oct. 14, 2009).

In addition to VHA services, the Veterans Benefits Administration (VBA) of the U.S. Department of Veterans Affairs determines eligibility for services, offers benefits, and in some courts sends representatives to the court to educate veterans regarding their benefits and assist with applications to receive benefits. Some VBA benefits include disability compensation for veterans disabled by illness or injury incurred or aggravated during active military service, pensions for permanently and totally disabled veterans with low incomes, education and training benefits, home loans and life insurance. The addition of VBA to the court treatment team helps to ensure that veterans are able to access all benefits to which they are entitled and also provides an additional point of contact to help veterans stay engaged in the court treatment process.

All veterans courts in operation use or plan to use a mentoring program, matching veteran defendants with volunteer mentors from the community, all of whom are also veterans. The concept of the veteran mentoring component is to re-engage the veteran defendant with a positive sense of veteran identity, as well to offer practical advice and services in addition to what the veteran receives in the context of his or her treatment plan.

While veterans courts are a new model, there are identifiable lessons learned in the past year, often reflecting issues outlined in the National Association of Drug Court Professionals' flagship document, *Defining Drug Courts: The Key Components* (1997). Most important of these is the need for clearly-defined roles and managed expectations; that is, all parties must understand each others' roles, and any limits on the roles and services. This helps reduce confusion and frustration among court team members and reinforces understanding of the VA's nonsupervisory treatment role. Successful models of coordination have included the participation of the VHA staff member in court treatment team meetings, as well as holding regular administrative

meetings to ensure that all parties have an understanding of the mission of the court and each others' roles, and to review the progress of court development. Such meetings have helped identify important gaps in services (for example, transportation) and potential solutions. Administrative meetings also help reinforce the veteran's status as both a veteran eligible for VA services and a citizen eligible for community services.

Importantly, having written materials or handbooks defining the court structure and the expectations of participants is key to ensuring that roles are understood when there is staff turnover. In the absence of written materials, roles can be confused and veterans may not understand the type of program they have enrolled in. Clear communication among the parties involved in veterans courts has highlighted the need for a VHA staff person to act as a liaison to assist the veteran in accessing VHA resources. Although the VHA is a service-rich system, accessing the full range of services can be very difficult for outside providers to navigate. Finally, there is a clear need for leadership representation from all parties involved in the veterans court to ensure that resource commitments are honored.

LEGISLATIVE INITIATIVES

To date, development of veterans courts has been led by communities with established treatment courts that have strong coalitions of justice and community partners interested in the intersection of substance abuse, mental health, criminal justice, and veterans' issues. Legislation, both state and federal, that encourages or requires the creation of veterans courts is a recent development with significant implications for the future development of these courts.

Table 2 provides a snapshot of pending and enacted legislation focused on veteran defendants in criminal cases. Unlike a local decision made without legislative prompting to

launch a veterans court in response to observed local needs and with resource commitments secured, a legislative mandate for veterans courts, while a powerful driver for development broadly, can leave judges, attorneys, and treatment providers wondering how to get started. It is therefore worth considering the extent to which these legislative efforts mirror the structure and function of existing courts that preceded and informed their introduction.

At the federal level, a proposed law (H.R. 2138/S.902, 2009) has the potential to provide material support to a large number of veterans courts, as well as significantly heightened visibility for the veterans court model. As currently written, the Services, Education, and Rehabilitation for Veterans (SERV) Act (2009) would provide $25 million in grants to the courts for the creation of veteran-specific treatment court programs. Among veteran court-focused legislation, the SERV Act is unique in its requirement that courts include a veteran peer mentor component, often cited as a defining feature of the Buffalo model. The SERV Act's limitation to nonviolent offenders mirrors that found in the original drug court authorizing legislation, the Violent Crime Control and Law Enforcement Act of 1994 (1994), and is notable for its restrictiveness. Defendants are barred from participating not only if their current charges involve violence, but also if they have a prior conviction for a violent crime within the past five years.

Table 2. State and Federal Legislative Initiatives

State/Federal legislation	Underlying issue to be addressed	Other restrictions on participation	Program Duration	Court monitoring of treatment progress	Who screens/ initiates the process?	Pre-plea/ post-plea	Status of Legislation?
California (PC 1170.9)	PTSD, substance abuse, psychological problem stemming from combat	defendant asserts causal link between condition and instant offense	not longer than maximum sentence	not specified	defendant	post-plea	amended version signed by governor 9/29/06; original version 1982
California (AB 1925)	PTSD, TBI, military sexual trauma, substance abuse, or any mental health problem stemming from United States military service	no	not specified	yes; provides for veterans court teams, led by judges	not specified; requires submission of plan including operational details	not specified	introduced 2/16/10; amended and referred to Appropriations Committee 4/21/10

Table 2 continues…

Colorado (HB 1104)	"mental health injuries" resulting from military service	no	not specified	yes; authorizes veterans treatment courts	not specified	not specified	signed by governor 4/16/10
Connecticut (SB 211)	returning military veterans accused of committing crimes which may be related to mental illness or substance abuse problems suffered due to military service	not specified	not specified	not specified	not specified	not specified	referred to Judiciary Committee 3/5/10

Table 2 continues…

Illinois (HB 5214; SB 902)	PTSD, TBI, depression, substance use disorder, co-occurring conditions	defendant not charged with certain violent crimes; defendant not convicted of certain violent crimes within past 10 years; defendant has not participated in veterans court program within past three years	not specified	yes	court	pre-plea and post-plea	passed House and Senate 4/27/10

Table 2 continues…

Minnesota (Minn. Stat. § 609.115, Subd. 10)	PTSD resulting from military service	no	not specified	not specified	court, prosecutor, defense counsel, other court personnel - "as early as practicable" in the process	pre-plea and post-plea	signed by governor 5/12/08
Nevada (AB 187)	PTSD, Substance Abuse, mental illness - "appear to be" related to military service, including readjustment	defendant not charged with violent crime; no convictions for violent crime - unless prosecutor consents	not specified	yes; court to receive regular progress reports	court, prior to sentencing	post-plea; records sealed after three years	signed by governor; took effect 7/1/09

Table 2 continues…

New Hampshire (HB 295)	"mental illness"		not specified	not specified	court	not specified	signed by governor 7/13/09; took effect 1/1/10
New Mexico (SM 074)	feasibility of veterans' courts	n/a	n/a	n/a	n/a	n/a	approved 3/10/09; report due 10/1/09
Texas (SB 1940)	"service-related disabilities]" contributing to veterans' criminal justice involvement (PTSD, TBI)	defendant suffers from brain injury or mental illness resulting from military service	at least six months	yes; "ongoing interaction with program participants"	unclear; court is responsible	not specified	signed by governor 6/19/09

Table 2 continues…

Virginia (HB 663)	PTSD, TBI, mental illness, alcohol or drug abuse, "any of which appear to be related to military service," including readjustment to civilian life	defendant not charged with violent crime; no convictions for violent crime within past 10 years	not specified	yes	not specified	not specified	referred to Committee for Courts of Justice 2/16/10
SERV Act (S.902; H.R. 2138)	funding for veterans courts and drug courts serving veterans	defendant not charged with violent crime; no convictions for violent crime	not specified	yes	not specified	not specified	referred to the House Committee on the Judiciary 4/28/2009. referred to Subcommittee on Courts and Competition Policy 5/26/2009.

As shown in Table 2, there is considerable variation among states in the requirements for veteran defendants' participation in the treatment courts. One significant point of departure is whether defendants must enter a guilty plea to participate in the treatment court program. When a defendant in a court following the pre-plea model successfully completes treatment, the charge is dismissed. In a post-plea court, successful completion may earn the defendant the chance to withdraw his or her guilty plea, and to have the charge(s) dismissed[3]. This distinction also affects the amount of leverage courts have over defendants. Presented with a persistently noncompliant defendant, a judge sitting in a post-plea treatment court could enter a finding of guilt based on the plea[4]. That judge's pre-plea counterpart, having exhausted any available sanctions, would likely transfer the case back to the docket where it originated. The defendant would then be free to plead not guilty and contest the charge(s) as if the treatment court episode never happened. Several legislatures have not explicitly addressed the pre- versus post-plea issue.

Because the potential benefit to the diverted defendant is so significant, participation as defined in pending and enacted legislation is often restricted based on the nature and severity of the pending charge, as well as the defendant's criminal history. For example, California's PC 1170.9, which provides for post-plea diversion for veteran defendants with psychological problems stemming from combat exposure,

[3] Completing a post-plea treatment court program does not always result in dismissal of the charges. Some courts supervise individuals in treatment as a condition of probation. For these participants, successful completion will not alter the charges.

[4] The judge in a post-plea court could also allow the noncompliant defendant to withdraw his or her guilty plea, and transfer the case to its original docket. The important point is that this judge has more options for the disposition of the case than does the pre-plea judge.

does not limit participation to defendants with nonviolent charges or criminal histories[5]. In contrast, Nevada's recently passed AB 187, which promotes a pre-plea model for veterans courts, does limit participation to nonviolent offenders. The pre-plea model, by limiting the type of offense that can be overseen by the court, may generate lower numbers of participants for these treatment courts, although successful participants will emerge with fewer encumbrances (e.g., convictions, periods of incarceration), notably on efforts to gain and maintain employment (Bazelon Center for Mental Health Law, 2003).

At the operational court level, not all existing veterans courts accept defendants with felony charges, but those that do tend to admit these defendants post-plea. The felony-accepting courts reflect the growing interest in an expanded offense model and in examining the effectiveness of such treatment courts that admit defendants with felony (Broner et al., 2003; Fisler, 2005) and violent offenses (Bazelon Center for Mental Health Law, 2003), a practice usually conducted in consultation with the defendant's victim.

Most of the veterans court-focused legislation defines veteran participants by requiring that clinical issues be traceable to their military service or combat exposure. In addition to being at odds with the broader criteria used by most existing veterans courts, this approach may have consequences worth considering before program implementation. Limiting eligibility to veteran defendants whose clinical conditions stem from their service may result in the rejection of veterans who, because of identified clinical needs, diversion-eligible charges, and eligibility for and

[5] California's proposed AB 1925 would allow jurisdictions significant discretion in establishing veterans courts, including on the pre-plea/post-plea issue and the admission of defendants charged with crimes of violence.

access to VA health care, might seem ideal candidates for such programs. The most current BJS data (Mumola, 2000) on veterans in the justice system indicate that only 20% of veterans reported seeing combat during military service, and an analysis of more recent BJS data on veterans in prison concluded there was no relationship between recent mental health problems and combat exposure (Noonan & Mumola, 2007). Turning veterans away whose problems are not related to combat or military service may open the door to criticism that the rejection comes not because the veterans lack the requisite clinical needs to benefit from treatment court, or because their charges are too severe, but because they came by their mental health or substance use problems the "wrong" way (i.e. outside the military). Such exclusion could limit the impact of veteran peer support, which as indicated in Table 1 is a key feature of almost all of the developing courts. Finally, while requiring that veterans *only* be seen in veterans courts is unlikely for a host of reasons, it is quite possible that veterans themselves, imbued with a camaraderie found in few other social groupings, might be unlikely to support any exclusion of otherwise eligible veterans.

Requiring that clinical issues be traceable to military service further appears to create a barrier to participation in veterans treatment courts that has no parallel in the drug and mental health courts on whose models they are to be built. Drug and mental health courts make no inquiry and draw no distinctions as to how their participants developed the need for substance use or mental health treatment. Defining veterans courts as vehicles of treatment for veterans with service-related substance use and mental health needs, and no others, would thus be a significant departure from the longstanding practice of drug and mental health courts, and one that could exclude many participants.

A recent *Wall Street Journal* commentary (Efrati, 2009) has referenced the American Civil Liberties Union (ACLU) of Nevada's testimony before the Nevada State

Legislature regarding veterans courts. The Nevada ACLU raised the concern that the legislation, by including language that exempted veterans court participants from certain of Nevada's mandatory minimum sentencing laws, provided preferential treatment for veterans since similar exemptions do not apply in mental health or drug treatment courts for non-veterans. By contrast, the Illinois ACLU voiced support for the Cook County Veterans Court, in part because participants receive the same legal treatment as those in existing drug or mental health courts (Walberg, 2009). In establishing an automatic veterans court exemption from mandatory minimum sentencing laws, the Nevada legislation raises a potential Equal Protection issue not present in other legislative initiatives and runs counter to current practice in existing veterans courts.

There has also been some limited media suggestion that veterans courts may be offering preferential treatment based solely on defendants' veteran status, rather than the reality which is operating a differently-resourced (with VHA as the primary provider) but otherwise equivalent treatment court for veteran defendants with identified, treatable pathologies. Veteran status is never the sole criterion for an individual's participation in a treatment court program. For such diversion to make sense, that individual must first be determined to have a substance use or mental health problem. Defendants eligible for veterans treatment court are also eligible to participate in local drug and/or mental health courts.

A final point on which legislative efforts differ from each other is the responsibility for screening potential participants into these programs. Some rest this function with the court, others with the prosecutor, and at least one with the defendant him or herself. The earlier and more consistently screening is performed, the larger the pool of potential participants, and the greater the number of veterans the court will be able to accept. Screening later in the process or

screening applied without clear responsibility for who identifies or screens veterans is likely to result in lower numbers of veterans being admitted, potentially resulting in eligible defendants losing the benefit of treatment court participation. Operational veterans courts also vary widely in how the screening process occurs. Some have a formal process where the pre-trial officer or all judges ask about military service, whereas others receive referrals through word of mouth, self referral or referrals from attorneys who know of the court.

CONCLUSION

The veterans treatment court has developed as a model which is an outgrowth of drug and mental health treatment courts and which organizes veteran-specific healthcare and mentoring services at a time when resources supporting programs that seek to provide an alternative to incarceration are dwindling. The nature of problems which veterans present, encompassing both mental illness and substance use, will likely require elements of both drug treatment and mental health treatment court models, a challenging blend of principles for judicial management in a single court model. Access to a comprehensive package of medical and mental health resources and the addition of peer support services designed to motivate and ensure access for justice-involved veterans represent significant enhancements of the treatment court model, which may explain in part why courts and judges, even those who do not preside over treatment courts, have been so receptive and energetic in developing the veterans court model.

In addition to grassroots/local development of the veterans courts, there is much legislative interest and activity in development of this model, emphasizing procedures similar to how the early veterans court pilots have been operationalized. Yet legislative proposals are generally much narrower in specification of which group or groups of

veterans would be eligible to participate. Some of the more restrictive legislative efforts may keep larger populations of veterans out of veterans courts, thus defeating the goal of getting veterans to federally-funded VA services and minimizing the impact on county health care budgets. While there are clearly factors that would limit veteran participation from both judicial (for example, severity of offense) and VA (for example, eligibility as a veteran for healthcare benefits) perspectives, discretionary review by judges and VA eligibility and upgrading procedures are such that practice may continue to be at odds with legislation.

An important implementation challenge is that heretofore the VA as a system has not reached out to justice-involved veterans. Thus, despite increased interest, judges often have little understanding of the range of services the VA can provide, and VA staff is often unaware how little community and justice system professionals know about the VA. There is a frequently-encountered perception in the community that VA health services are of poor quality, and that veterans do not either use or like to use the VA for healthcare. The facts are quite different: A recent RAND study found that the quality of VA services across a spectrum of 294 measures of quality in disease prevention and medical treatment outperformed all other sectors of American health care (Asch et al., 2004). Veterans have rated their satisfaction with VA services as high or higher than other American healthcare consumers rate their healthcare providers (Kussman, 2007; National Quality Research Center, 2006). A 2004 Institute of Medicine report indicated that, for all American veterans who use mental health services, 41% used VA mental health services almost exclusively (Rosenheck, 2004). Finally, the importance of the VA as a resource for returning military is underscored by the fact that approximately half (48%) of soldiers discharged since 9/11 have used VA services (Veterans Health Administration Office of Public Health and Environmental Hazards, 2009).

VHA's Office of Mental Health Services has over the last four years set population-based services and evidence-based treatment standards, which are now codified in the Uniform Mental Health Services in VA Medical Centers and Clinics (Veterans Health Administration, 2008). For three years, services have been enhanced system-wide through supplemental funding from Congress, and these enhancements are being monitored through a system of performance measures to assure implementation. Perhaps most importantly, the VHA in 2009 authorized staff to work with not only treatment courts, but with law enforcement, jails, and courts broadly to provide healthcare services where the criminal justice system makes the determination that public safety allows for treatment (Kussman, 2009), and now has a requirement that every VA Medical Center have a Veterans Justice Outreach Specialist to address the needs of justice-involved veterans (Veterans Health Administration, 2008). In identifying services and resources, it is important to note that there is literature which suggests that veterans have better outcomes when services are provided in a veteran-specific environment, in which military training, combat experience, and military cultural norms and values are understood and accepted; where VA staff are specifically trained in assisting veterans in managing these experiences; and where other veterans are present to provide the peer support that is often needed to cope effectively (Burnette, Williams, & Law, 1987; Shatan, 1973; Williams, 1980).

Relatedly, in its efforts to facilitate community readjustment, the military has been proactive in screening for TBI and mental health problems and has mandated and begun to provide battlemind debriefing training to diminish the impact of combat training and stress on community readjustment. Early results of this prevention approach are promising but show limited efficacy (Adler et al., 2009). Research on the Vietnam experience indicates that military and VA resources in collaboration with community and justice system resources are likely to be necessary over an

extended period of time to assist veterans in making effective readjustments to family and community life.

This review summarizes initial elements of the veterans courts in a rapidly growing arena. Limitations of the review are the limited number of courts and legislative proposals examined and the unanswered question of whether the presence of specialized veterans healthcare and peer support does in fact have a significant positive effect on outcome for justice-involved veterans. Future research needs to collect and analyze both process and outcome data that can determine the effectiveness of this strategy of diversion. In addition, at the systems level, it will be important to examine the policy effects of legislation that seeks to address this important area of societal concern. In contrast to a general neglect of post-war readjustment problems following the Vietnam War, veterans court policy and practice will provide useful lessons in reintegrating those soldiers from recent wars whose maladaptive coping may be improved through VA-justice system collaboration.

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