2019

Veterans' Treatment Courts in Kentucky: Examining How Personal Characteristics and During-Program Occurrences Influence Program Completion and Criminal Recidivism

Monica Lynn Himes
University of Kentucky, mhimes74@gmail.com
Author ORCID Identifier:
https://orcid.org/0000-0001-9978-5327
Digital Object Identifier: https://doi.org/10.13023/etd.2019.135

STUDENT AGREEMENT:

I represent that my thesis or dissertation and abstract are my original work. Proper attribution has been given to all outside sources. I understand that I am solely responsible for obtaining any needed copyright permissions. I have obtained needed written permission statement(s) from the owner(s) of each third-party copyrighted matter to be included in my work, allowing electronic distribution (if such use is not permitted by the fair use doctrine) which will be submitted to UKnowledge as Additional File.

I hereby grant to The University of Kentucky and its agents the irrevocable, non-exclusive, and royalty-free license to archive and make accessible my work in whole or in part in all forms of media, now or hereafter known. I agree that the document mentioned above may be made available immediately for worldwide access unless an embargo applies.

I retain all other ownership rights to the copyright of my work. I also retain the right to use in future works (such as articles or books) all or part of my work. I understand that I am free to register the copyright to my work.

REVIEW, APPROVAL AND ACCEPTANCE

The document mentioned above has been reviewed and accepted by the student's advisor, on behalf of the advisory committee, and by the Director of Graduate Studies (DGS), on behalf of the program; we verify that this is the final, approved version of the student's thesis including all changes required by the advisory committee. The undersigned agree to abide by the statements above.

Monica Lynn Himes, Student

Dr. Melanie Otis, Major Professor

Dr. Julie Cerel, Director of Graduate Studies

VETERANS' TREATMENT COURTS IN KENTUCKY: EXAMINING HOW PERSONAL CHARACTERISTICS AND DURING-PROGRAM OCCURRENCES INFLUENCE PROGRAM COMPLETION AND CRIMINAL RECIDIVISM

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Social Work
at the University of Kentucky

By
Monica Himes, MSSW, LCSW

Lexington, Kentucky

Director: Dr. Melanie Otis, Professor of Social Work

Lexington, Kentucky

2019

https://orcid.org/0000-0001-9978-5327

ABSTRACT OF DISSERTATION

VETERANS' TREATMENT COURTS IN KENTUCKY: EXAMINING HOW PERSONAL CHARACTERISTICS AND DURING-PROGRAM OCCURRENCES INFLUENCE PROGRAM COMPLETION AND CRIMINAL RECIDIVISM

Military veterans are disproportionately represented in United States (U.S.) jails and prisons, with nearly 10% of current inmates being veterans. Veterans' criminal justice involvement is often precipitated by underlying mental health and substance abuse that are connected to their military service. Veterans' treatment courts are the judicial response to a need for more coordinated provision of mental health and substance abuse services to veterans involved in the criminal justice system. Modeled after drug courts and mental health courts, veterans treatment courts are a judicial innovation that aim to honor the service of veterans by providing them an alternative to incarceration. There are currently 551 veterans' treatment courts in 42 states throughout country, including five in Kentucky.

This exploratory descriptive study uses Andersen's healthcare utilization model and a social control theoretical perspective as a framework to examine veterans' treatment court outcomes from a sample of participants (N=58) in Kentucky. Univariate and bivariate analyses were used to provide a description of the sample and to examine relationships between personal characteristics and during-program occurrences and the outcomes of program completion and criminal recidivism. The findings of this study indicate that gender, sanctions, drug screens, and treatment sessions each have a significant association with program completion, and both age and housing status have a significant association with recidivism. Findings for each outcome variable are discussed, along with possible explanations, as well as limitations of the study, implications of this research for social work practice, and suggestions for future research.

KEYWORDS: veteran's treatment court, substance abuse, mental health, incarceration

Monica Himes
(Name of Student)

04/17/2019
Date

VETERANS' TREATMENT COURTS IN KENTUCKY: EXAMINING HOW PERSONAL CHARACTERISTICS AND DURING-PROGRAM OCCURRENCES INFLUENCE PROGRAM COMPLETION AND CRIMINAL RECIDIVISM

By

Monica Himes

Dr. Melanie Otis

Director of Dissertation

Dr. Julie Cerel

Director of Graduate Studies

04/17/2019

Date

DEDICATION

"This nation will remain the land of the free only so long as it is the home of the brave."
Elmer Davis

This work is dedicated to the brave men and women, past and present,
who have sacrificed and served to defend our way of life.
May we never forget that freedom is never free.

Acknowledgements

First and foremost, I want to give glory to God for seeing me through journey. For the past four years, I have prayed consistently for wisdom, courage, and for willingness to do hard things, and through it all, He has been faithful. I will not waste this opportunity to do good work and will always continue to *seek justice, love mercy, and walk humbly with my God* (Micah 6:8).

To my committee for their guidance, wisdom, constructive criticism, and support. Dr. Chris Flaherty, Dr. Karen Lawrence, Dr. Michelle Staton, and Dr. Laura Frey, thank you all for sharing your time and talents with me. And to my chair - Dr. Melanie Otis, you have been with me from day one in the program and have challenged me to seek knowledge, to challenge the status quo, and to think more critically than I ever have before. You have literally changed the way I think, and have inspired me to always continue learning. You believed in me, even when I struggled to believe in myself, and for that I am eternally grateful.

To my parents – from my dreams of being an aerospace engineer all the way until today, you have supported and encouraged every crazy endeavor I ever attempted. Your unconditional love and support are the foundation of who I am and have allowed me to always dream big. Dad, it is my hope that my work honors your military service and helps improve care for all veterans and service members.

To my life group – you ladies are a source of joy and inspiration in my life and your friendship and support throughout this process have been a constant. I truly appreciate all of the calls, texts, GIFs and memes of encouragement and support and I promise you won't have to endure me talking about the dissertation anymore!

To my cohort – you are the unexpected blessing of this PhD journey and I could not have made it through this without you. I can't believe that I actually miss our long Fridays spent together in POT, but I know the friendships we formed during this time will be for life. No matter where the road takes each of you, your Kentucky girl will always be here rooting for you!

To all of my colleagues at Morehead State University, thank you for believing in me, and for your support and guidance along the way. Latonya, Deirdra, and Becky have been my greatest cheerleaders, and I sincerely value your friendship and support. Lisa, thank you for entrusting me with the data from your project and for your wisdom, patience, and level-headedness while helping me navigate this process. I truly appreciate all of your help.

And lastly, but certainly not least – to my squad….Kevin, Candace, and Megan. Kevin, you have been my rock through all these years of schooling and have been my safe place to land in the midst of this chaos. You are always my biggest supporter and have sacrificed so much in order for me to pursue this dream. We've done this together, and I

look forward to enjoying some post-dissertation downtime with you in the coming months and years.

Candace and Megan – I can only hope you are half as proud of me as I am of you. Throughout the years, my schooling has often taken me away from you, but I hope that you have seen not just the value of being a learner and a thinker, but also the importance of persistence, overcoming fear, and dreaming big. The sky is the limit for you smart, strong girls, and I can't wait to see how each of you make your own waves in this world!

TABLE OF CONTENTS

LIST OF TABLES

Chapter One: Introduction

Specialized courts have grown significantly within the United States (U.S.) criminal justice system in the past three decades, including the implementation of drug, mental health, domestic violence, family, and gun courts (National Institute of Justice, 2019). There are currently 3,316 drug courts in operation nationwide (National Association of Drug Court Professionals, 2018b), along with 332 mental health courts (Marlow, Hardin, & Fox, 2016). Veterans' treatment courts (VTC), one of the newest iterations of the specialized court system, are a strategic combination of drug and mental health courts. VTCs were created to provide treatment, support, and accountability to military veterans who face legal troubles, and they utilize a multi-disciplinary, collaborative approach involving judges, lawyers, law enforcement, VA outreach staff, social workers and other mental health providers, case managers, and peer mentors (National Association of Drug Court Professionals, 2013). There are currently 551 VTCs in 42 states throughout the U.S. (United States Department of Veterans Affairs, 2018c), including five in Kentucky (Kentucky Court of Justice, 2018).

Kentucky launched its first VTC in 2012 in Jefferson County, and has since opened courts in Hardin, Fayette, and Christian Counties, and Northern KY (Boone, Kenton, and Campbell Counties). This current study analyzed secondary data from the first two VTCs implemented in Kentucky: Jefferson County VTC and Hardin County VTC. These two counties were chosen for this project, as their data collection was complete, while the research and data collection in the other counties is still ongoing. A research team led by Dr. Lisa Shannon from Morehead State University collected the data in conjunction with the Administrative Office of the Courts (AOC) and on behalf of

grants awarded by the Federal Bureau of Justice[1]. As part of that project, Dr. Shannon completed a process evaluation, including findings from interviews with key stakeholders (Shannon et al., 2017), rather than examining participant outcomes, as is the focus of this current study.

The current study is an exploratory descriptive study examining the participant characteristics and during-program occurrences associated with program completion and criminal recidivism among participants in these two Kentucky VTCs. Similarities and differences between program completers and non-completers, and between recidivists and non-recidivists are considered, as well as the relationship between program completion and recidivism. This was accomplished by analyzing the empirical outcome data from Jefferson and Hardin Counties at the end of their respective four-year grant periods, reviewing trends regarding demographic information, drug usage, and history of mental health treatment, as well as the importance of certain components of treatment such as sanctions, all as they relate to program completion and criminal recidivism. The body of literature regarding the effectiveness of drug court is robust and consistent (Belenko, 2001; Brown, 2011; Gottfredson, Najaka, & Kearley, 2003; Huddleston & Marlowe, 2011; Kalich & Evans, 2006; Sanford & Arrigo, 2005; Shaffer, Hartman, Listwan, Howell, & Latessa, 2011), but because of their relative newness, there is limited empirical research pertaining to veterans' treatment courts, although it is beginning to emerge (Hartley & Baldwin, 2019; Johnson et al., 2017; Knudsen & Wingenfeld, 2015; Slattery, Dugger, Lamb, & Williams, 2013; Smith, 2012; Tsai, Flatley, Kasprow, Clark,

[1] Bureau of Justice; BJA FY 12 Adult Drug Court Discretionary Grant Program: Implementation; Awarded to Kentucky Administrative Office of the Courts; Award Number 2012-DC-BX-0039 (Jefferson County). Bureau of Justice; BJA FY 13 Adult Drug Court Discretionary Grant Program: Implementation; Awarded to Kentucky Administrative Office of the Courts; Award Number 2013-VW-BX-0038 (Hardin County).

& Finlay, 2017; Tsai, Finlay, Flatley, Kasprow, & Clark, 2018). Specifically, there is scant research about how program components (e.g., sanctions, drug screens) and/or personal characteristics of the veteran participants (e.g., age, race, combat status) relate to likelihood of program completion and/or criminal recidivism. To date, the most relevant findings come from a recent study of 7,931 participants from VTCs across the country that examined participant characteristics in relation to recidivism (Tsai et al., 2018), and thus will provide some initial comparisons with the findings of this study. Due to the sparse literature regarding VTC outcomes, this study aims to add to the body of knowledge and provide further insight about this specialty court that can help shape policies and procedures to ensure veterans are receiving services that are evidence-based.

Scope of the Problem: Current Challenges for the U.S. Military

Since the attacks on the U.S. in September of 2001, the nation has been involved in continuous international conflict in the Middle East (Green, 2016; Hoge & Castro, 2012). This period of time is now referred to in military literature as "post-9/11"; indicating the significance of September 11, 2001 as a pivotal moment in U.S. and world history that has had a tremendous impact on the U.S. military. Since 2001, nearly three million American troops have been deployed in support of Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND) (United States Department of Veterans Affairs, 2016), resulting in more than 6,000 deaths and 48,000 injuries among U.S. service members (Institute of Medicine, 2013).

The gradual removal of troops from Iraq and Afghanistan began in 2011 and has resulted in a significant influx of soldiers separating from the military and reintegrating into their communities (Institute of Medicine, 2013). These new veterans need a variety

of ongoing physical and mental health services to assist in their reintegration, many of which they do not seek (Hoge et al., 2004; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Wang et al., 2005a) or which have extensive waiting periods (Shulkin, 2017). Subsequently, an estimated 700,000 veterans are currently in the U.S. criminal justice system, possibly due in part to untreated mental health and substance use disorders related to or exacerbated by their military service (McCaffrey, 2013).

Negative mental health symptoms as a result of military service have been a concern for service members and veterans for as long as wars have existed (Baldwin, 2013). Post-traumatic stress disorder (PTSD) is the "most common and conspicuous psychiatric problem" among OEF/OIF veterans (Yarvis, 2011, p. 51). From 2002-2015, nearly 379,000 veterans were diagnosed with PTSD at the Veterans Health Administration (VHA) (United States Department of Veterans Affairs, 2015). The VHA further reports that only 61% of those deemed eligible to receive VA healthcare services (i.e., physical and/or mental healthcare) since 2002 have actually accessed those services (United States Department of Veterans Affairs, 2015). PTSD and the typical accompanying symptoms – insomnia, nightmares, hypervigilance, anxiety, depression, and flashbacks -- adversely affect the daily functioning of the veteran and place him/her at higher risk for incarceration (Baldwin, 2013; Greenberg & Rosenheck, 2009; McGuire, Rosenheck, & Kasprow, 2003; Saxon et al., 2001).

Substance abuse and dependence are separate, but related, concerns for veterans. Approximately 345,000 Iraq and Afghanistan veterans have been officially diagnosed at the Veterans Health Administration with a substance use disorder (United States Department of Veterans Affairs, 2018a). Among those diagnosed with PTSD, 20% have

a co-occurring substance use disorder and combat veterans with PTSD are more likely to be binge drinkers (United States Department of Veterans Affairs, 2018b). Additionally, multiple studies of veterans with histories of incarceration have found that substance use disorders are a primary risk factor for incarceration (Ross, Waterhouse-Bradley, Contractor, & Armour, 2018; Sullivan & Elbogen, 2014; Tsai, Rosenheck, Kasprow, & McGuire, 2013; Weaver, Trafton, Kimerling, Timko, & Moos, 2013).

Some veterans do not qualify for VA healthcare due to their military service history (e.g., served in the National Guard but were never called to active duty), or their discharge status (e.g., other than honorable, bad conduct, or dishonorable discharge) (United States Veterans Administration, 2019a). Therefore, because some veterans do not qualify for VHA care and many others choose not to seek treatment, there are many veterans living with a variety of challenges that may be a result of undiagnosed mental health and/or substance abuse problems (Hoge et al., 2004; Pietrzak et al., 2009; Wang et al., 2005a).

There is extensive research indicating that veterans have a higher prevalence of mental illness, traumatic brain injuries, post-traumatic stress disorder, and substance use disorders that increase their risk of incarceration compared to the civilian population (Baldwin, 2013; Greenberg & Rosenheck, 2009; McGuire, Rosenheck, & Kasprow, 2003; Saxon et al., 2001). Additionally, these issues have often been shown to manifest into violent and illegal behaviors (Baldwin, 2013; Elbogen et al., 2010, Elbogen et al., 2014a, Elbogen et. al, 2014b, Greenberg & Rosenheck, 2009; Jakupcak, et al., 2007; Killgore et al., 2008). Left untreated, this complicated mix of mental health, physical health, violence, and substance abuse is likely to result in incarceration (Baldwin, 2013;

Beckerman & Fontana, 1989; Erickson, Rosenheck, Trestman, Ford, & Desai, 2008; Freeman & Roca, 2001; Sherman, Sauter, Jackson, Lyons, & Han, 2006).

In 2011, there were 181,500 veterans in U.S. prisons and local jails (Bronson, Carson, Noonan, & Berzofsky, 2015). Approximately one-third of those veterans in jail had never previously been incarcerated (Bronson et al., 2015), indicating that they were not delinquent during their teens years and the criminal behavior may be newly acquired. Compared with their incarcerated civilian counterparts, incarcerated veterans reported mental health issues at a higher rate (55% compared to 43%) and incarcerated veterans were twice as likely to report a prior diagnosis of PTSD than incarcerated civilians (Bronson et al., 2015).

The founding premise of the VTC is that the criminal behaviors of veterans are often directly attributed to or exacerbated by their military service experiences and thus the government has a moral obligation to provide assistance and treatment to them (Baldwin, 2013; Gansel, 2013)

> The United States military transformed these men and women into soldiers and placed them in especially traumatic situations. Consequently, the United States justice system must take responsibility and create paths to treatment for soldiers whose service-related PTSD lead them to commit crimes (Gansel, 2013, p. 158).

The goal of the VTC is to divert veterans out of jail and into appropriate treatment - treatment that they have earned through their military service. The VTC works to coordinate care between the court, community mental health providers, and the Veterans Health Administration, so that veterans are able to utilize their VA benefits and get the help they need.

Rationale and Purpose of the Study

As VTCs are relatively new with limited empirical evidence to support their claims of helping veterans, research is needed to ensure that the current practices in VTCs are producing the desired effect –reduced criminal behavior. In fact, it has been stated that the proliferation of the VTCs was "grounded in ideology rather than evidence" (Ahlin & Douds, 2016, p. 84). To date, what has been published in regards to VTCs are primarily white papers (e.g., Justice for Vets, 2018; McGuire, Clark, Blue-Howells, & Coe, 2013; Russell, 2009), preliminary outcome evaluations (e.g., Shannon et al., 2017), and two nationwide surveys of VTC programs (e.g., Baldwin, 2013; Tsai et al., 2018). Due to a lack of empirical research on the impact of various individual components of the VTC on the overall outcomes, the research questions in this study are exploratory in nature, and aim to add to the body of knowledge regarding who successfully completes VTC programs, what components of VTC programs have the biggest impact on program completion and/or recidivism, and who recidivates after entering the VTC. Specifically, this exploratory study examines a variety of demographic and programmatic variables to identify components of the VTC that influence program completion and/or whether they recidivate.

Relevance to Social Work

Nationwide, social workers have a significant role in the care and treatment of mental health disorders (National Association of Social Workers, 2019). The Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS) identifies clinical social workers as one of five critical categories of mental health professionals, along with clinical psychologists, marriage and family

therapists, psychiatrists, and advanced practice nurse practitioners (Heisler, 2018). A recent congressional research publication indicates there are nearly 300,000 mental health practitioners in the U.S. mental health workforce and the largest group is clinical social workers (Heisler, 2018). In 2017, there were 112,040 clinical social workers in the United States, which accounts for approximately 38% of the current mental health workforce (Heisler, 2018). With over 12,000 social workers, the U.S. Department of Veterans Affairs is the largest employer of clinical social workers in the country (United States Department of Veterans Affairs, 2019d) and social workers play a vital role in the treatment of the veteran and military population. Even outside of the VA, social workers are increasingly involved in the treatment of veterans in primary care settings with a nationwide push towards integrated behavioral health (American Psychiatric Association & Academy of Psychosomatic Medicine, 2016). Integrated behavioral health, also known as the Collaborative Care Model is a team-based approach for detecting and treating mental health issues within primary care settings and social workers work alongside medical doctors, nurse practitioners, psychologists, and psychiatrists to address the holistic needs of the patient (American Psychiatric Association & Academy of Psychosomatic Medicine, 2016). Additionally, social workers are involved in veterans' treatment courts in various capacities, potentially serving as clinicians, case managers, treatment providers, or as researchers and program evaluators (Getz, 2017). Therefore, this study is relevant to social workers, as social workers are integral players in the conversation about the mental healthcare of veterans. Furthermore, this study adds to the body of knowledge about veterans involved in the criminal justice system and possible ways in which social workers might intervene and assist in their successful reintegration.

Moreover, this study is relevant to the social work profession because the Code of Ethics challenges social workers to adhere to the core ethical principles of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (National Association of Social Workers, 2018). Social workers' involvement in veterans' treatment courts specifically relates to their call to seek social justice on behalf of veterans by educating others about the unique culture of the military and the ways in which military service might place a veteran at risk of being part of a vulnerable population due to mental health or substance use issues. The impetus for the development of VTCs was to provide rehabilitation instead of retribution, which aligns with the social work values of challenging social injustice and respecting the inherent dignity and worth of all people (National Association of Social Workers, 2018). Social workers involved in VTC honor the dignity and worth of every veteran, regardless of their mental health issues, addiction, or criminal behavior. Lastly, social workers serving in the VTC acknowledge and understand the critical element of human relationships. As per the code of ethics, and central to the VTC is the importance of human relationships as a vehicle for change.

In summary, this study is timely and relevant to the social work profession, as social workers are on the front lines of the nationwide initiatives to provide ethical, comprehensive, and evidence-based interventions to U.S. veterans.

Research Questions

The primary goal of this study is to examine initial outcome data for two Kentucky VTCs and examine how personal characteristics of the participants and during

program occurrences relate to program completion and criminal recidivism. To that regard, this exploratory study considers four primary research questions:

RQ1: Do individual characteristics of the participants (age, gender, race, marital status, combat status, drug of choice, history of mental health issues, housing status, and employment status) influence VTC completion?

RQ2: Do individual characteristics of the participants (age, gender, race, marital status, combat status, drug of choice, history of mental health issues, housing status, and employment status) influence criminal recidivism?

RQ3: Do during-program occurrences (sanctions, drug screens, judicial interaction, and treatment sessions) influence VTC completion?

RQ4: Do during-program occurrences (sanctions, drug screens, judicial interaction, and treatment sessions) influence criminal recidivism?

Chapter Overview

This dissertation will follow the traditional five-chapter format. Chapter two begins with a description of the model and theories that are the foundation of drug court and veterans' treatment courts and provide the theoretical orientation for this study. The chapter then moves into a review of the literature pertinent to this topic, focusing on three key areas: the issues currently facing veterans that are associated with increased risk for incarceration and which prompted the need for veterans' treatment courts, the history and structure of both drug court and mental health courts and the known research about their effectiveness, and lastly the formation of veterans' treatment courts and what is known to date about the outcomes thereof.

Chapter three describes the methodology used for this exploratory descriptive study, including the research design, who the participants in the study were and how the data were collected, as well as how access to the data set was gained for the purpose of this dissertation. Then each variable of interest from the data set are detailed and the analytic plan is described.

Chapter four presents the results of the data analysis. Univariate and bivariate analyses were completed and the results of these will be detailed in this chapter along with any accompanying data tables.

Lastly, chapter five is a discussion of the results of this study and the implications for future social work practice and research. The known weaknesses and limitations of the study are detailed as well, and a challenge is presented regarding future work with veterans and military service members.

Chapter Two: Literature Review

To gain perspective and understand the context within which the veterans' treatment courts operate, a comprehensive literature review was conducted to examine current veterans' issues and the judicial responses. The scope of this literature review is three-fold: 1) to examine the data and the literature regarding the primary issues experienced by today's veterans that increase their risk of incarceration and that supported the creation of veterans' treatment courts; 2) to review both the drug court and mental health court models upon which veterans' treatment courts are based, and examine the available data regarding their judicial innovation and effectiveness at reducing criminal behavior; and 3) to examine the bourgeoning body of literature surrounding veterans' treatment courts, including the conceptual framework on which they rest: therapeutic jurisprudence. After providing details on relevant theoretical perspectives, these three areas will be delineated below.

Theoretical Orientation

Three theoretical perspectives provide a guide for this study: the healthcare utilization model, social control theory, and the age-graded theory of informal social control. Each of these theories help explain the creation of drug court and VTCs and serve as a framework for understanding why these interventions are effective and with which populations they work best. Each of these perspectives will be discussed below, as they pertain to this study.

Andersen-Newman Healthcare Utilization Model. Although not formally tested in this exploratory study, the Andersen-Newman Healthcare Utilization Model offers some insight into potential factors that may influence if a veteran enters and

completes treatment in a VTC program. This model attempts to explain how individual characteristics and other factors might affect an individual seeking and following through with treatment (Andersen, 1995; Andersen & Newman, 1973). Developed over fifty years ago, this model is still widely used as a way to explain healthcare utilization behavior in a variety of settings (Alwahabi, Bhattacharya, & Sambamoorthi, 2015; Babitsch, Gohl, & Lengerke, 2012; Simo, Bamvita, Caron, & Fleury, 2018), including treatment for mental health and substance use disorders (Bruwer et al., 2011; Carragher, Adamson, Bunting, & McCann, 2010; Oser et al.,2011; Satre, DeLorenze, Quesenberry, Tsai, & Weisner, 2013; Wang et al., 2005b; Weisner, Matzger, Tam, & Schmidt, 2002).

Although the model has changed and evolved through research, debate, and discussion (Aday, Andersen, & Fleming, 1980; Aday, Andersen, Loevy, & Kremer, 1985; Gilbert, Branch, & Longmate, 1993; Mechanic, 1979; Rundall, 1981), at the core of the model are three sets of predictive factors: predisposing factors, enabling factors, and need factors (Andersen, 1995). Predisposing factors are the personal characteristics that precede the current illness, but which might influence one's likelihood of seeking healthcare services. These predisposing factors are typically operationalized in variables such as gender, age, race, marital status, education, occupation, and attitudes about healthcare (Aday & Andersen, 1974; Leukefeld, Logan, Martin, Purvis, & Farabee, 1998). In drug court research, multiple predisposing factors have been found to be associated with program completion. These include age (Devall & Lanier, 2012), race (Shah et al., 2013), marital status (Mateyoke-Scrivner, Webster, Staton, & Leukefeld, 2004), employment status (Devall & Lanier, 2012), substance use (Brown, 2010), mental

health (Mendoza, Trinidad, Nichajski, & Farrell, 2013) and criminal history (Shannon, Jackson, Perkins, & Neal, 2014; Wolf, Sowards, & Wolf, 2003).

In addition to predisposing factors that may influence whether or not a person seeks healthcare, there are also enabling factors that support or encumber a person's use of healthcare services. Enabling factors are often operationalized as income, health insurance, access to healthcare, and knowledge of available healthcare resources. Lastly, the need factors refer to the individual's own perceived need for treatment, along with the need for treatment, as assessed by professionals. Need factors include current symptoms and impairment due to the illness.

Leukefeld et al. (1998) adapted the healthcare utilization model for use with drug-abusing criminal offenders, looking at predisposing factors (e.g., social and demographic traits, drug use), enabling factors (e.g., income, health insurance), and needs factors (e.g., drug use severity, mental health status). Additionally, they amended the model to position historical health factors (e.g. history of substance abuse treatment) as a separate category from predisposing factors (Leukefeld et al., 1998).

In the current study, predisposing factors (e.g., age, gender, race, marital status, combat status, history of mental health treatment), and needs factors (e.g. drug of choice) will be examined through this healthcare utilization framework. Enabling factors such as income and health insurance were not collected consistently in the data set, and therefore cannot be used in this study. The utility of the Andersen-Newman model for this study is that it provides a lens through which to consider the impact of personal characteristics on the likelihood that a participant will take advantage of the services and resources provided to them through the VTC. Participants in the VTC are there voluntarily, and

once enrolled, they must choose to work the program that is made available to them. With completion rates in specialty courts typically hovering around the 50% mark (Marlowe, Hardin, & Fox, 2016), it is worthwhile to consider what factors might impede participation and completion of the treatment programs provided.

Phase II of Andersen's model, proposed in the 1970's, included aspects of the healthcare system, and how they interact with the individual to influence treatment utilization (Aday et al., 1985). This includes policy, resources, and organization as additional components to treatment utilization, in addition to the personal factors from phase I (Andersen, 1995). In their adapted model, Leukefeld et al. (1998) also included the role of the characteristics of the healthcare system in treatment utilization, which will be applied in this study as well. Again the utility of the Andersen model for this study is to examine and consider how VTC program components (e.g., sanctions, drug screens, interaction with judge, sessions) may influence someone's decision to enter and/or complete the treatment program offered by the VTC.

Social Control Theory. Social control theory is utilized in this study to offer insight into the behavior of VTC participants. Social control theory posits that people do not inherently conform to rules and that because rule violation is intrinsic to human nature, it is conformity that must be explained (Hirschi, 1969). Although the theory was initially developed using a sample of adolescents, it has endured as a tool to explain behaviors throughout the life course and in a variety of populations (Alston, Harley, & Lenhoff, 1995; Cohen & Land, 1987; Cretacci, Rivera, Gao, & Zheng, 2018; Kabiri et al., 2018; Koeppel & Chism, 2018). The theory asserts that individuals engage in rule-breaking behavior (e.g., criminal acts, illicit drug use) when they have a weak social bond

to society (Wiatrowski, Griswold, & Roberts, 1981). This social bond is comprised of four elements: attachment, commitment, involvement, and belief (Hirschi, 1969). Attachment refers to the individual's connection to others within society, such as family, friends, and community institutions (Hirschi, 1969). Someone with strong attachments to their family and friends is perceived to be less likely to violate social expectations. Commitment refers to the amount of investment an individual has made to social activities and institutions (Hirschi, 1969). Someone with a considerable amount of time and energy invested in their education or career is perceived to have more to lose and is therefore less likely to participate in deviant behavior. Involvement refers to how busy a person is and how that acts as a pragmatic deterrent for deviant behavior (Hirschi, 1969). Someone who volunteers, takes care of young children, works, or goes to school is perceived to have less free time to participate in deviant behavior. Belief is the last component of social control theory and refers to the amount of belief the individual espouses in the cultural norms (Hirschi, 1969). If a person believes strongly in their society's cultural values and norms, they are perceived to be less likely to deviate from the accepted behaviors (Hirschi, 1969).

Social control theory is helpful when examining VTC programs, as many of the elements of the program address the core elements of social bonding that are laid out in the theory. One of the issues that veterans experience as they reintegrate into society after their military service is the lack of rigid structure and accountability to which they have grown accustomed (Danish, 2013; Danish & Antonides, 2013; Spiro, Settersen, & Aldwin, 2016; Teachman & Tedrow, 2016). Early in their military service, new recruits go through basic training or "boot camp" in order to transform them from civilians into

soldiers, and from individuals into a cohesive unit (Bouffard & Laub, 2004; McGurk, Cotting, Britt, & Adler, 2006; Rossellini et al., 2017; U.S. Army, 2015). Throughout their service, soldiers are expected to adhere to very strict military rules and norms, and to sacrifice their own individuality for the sake of the cause (Bennett, 2018). The Supreme Court acknowledged this in Goldman v. Weinberger (1986), stating "The essence of military service is the subordination of the desires and interests of the individual to the needs of the service" (p. 507). Military service forges a brotherhood, a sense of family, belonging, commitment, and rigid loyalty that is unparalleled anywhere else in the world (Spence, Henderson, & Elder, 2012), and serves as a form of social control. Unfortunately, once they return home and no longer have the structure, security, and camaraderie that is synonymous with military service, many veterans struggle with unemployment, homelessness, substance use disorders, and mental health disorders (Sayer et al., 2010). A major focus of VTC programs is to re-build that trust, brotherhood, and community among the veterans, and between veterans and their VTC team members, including the judge, treatment providers, and peer support persons. VTC programming often includes a focus on education and career-readiness, which aligns with this theory as well, and provides a source of positive social control. By providing participants an opportunity to gain legal and productive employment, the VTC is helping to increase the participants' commitment. VTC programming can serve as a way for participants to be more involved in their community and to have less free time in which to commit crimes. Lastly, participation in the VTC program allows the veteran an opportunity to have small incremental successes, which bolster their self-esteem and their personal belief in their ability to live a drug/alcohol free life.

Although social control theory does provide a backdrop for understanding criminal behavior, critics argued its focus on explicating causes of delinquency did not account for behavior changes over time and throughout the life course. The age-graded theory of social control is another helpful theory to understanding the behaviors of the VTC participants and will be detailed next.

Age-Graded Theory of Informal Social Control. Spinning off from social control theory, Laub and Sampson (1993) developed a theory that uses the life course perspective to explain criminal behavior across the life span. The theory posits that while there is strong continuity of antisocial behavior stretching from childhood through adulthood, informal social controls can help explain desistance among many adults who exhibited prior delinquent behaviors (Laub & Sampson, 1993). Essentially, not all juveniles who break the law continue to offend once they enter adulthood and social controls can help explain why (Doherty, 2005). One key aspect of the age-graded theory of informal social control are events known as "turning points", which serve as transitional moments in a person's life that can change their trajectory (Sampson & Laub, 1993). Sampson and Laub (1993) theorized that "turning point" events that occur during adulthood, such as marriage or employment can mark a defining moment in an individual's path. Some researchers have suggested that military service is a negative turning point for many that leads to increased risk of substance use disorders and incarceration (Wright, Carter, & Cullen, 2005). Others have disagreed, asserting that military service serves as a positive turning point for many soldiers and deters them from criminal activity (Bouffard, 2014; Teachman & Tedrow, 2016). Military service is often seen as a great opportunity for teens who have a history of criminal behavior or

delinquency and who want to turn away from that and commence new behaviors in adulthood (Teachman & Tedrow, 2014). However, military veterans often exhibit criminal behaviors after their service, particularly during the challenging and often tumultuous reintegration period (Booth-Kewley, Highfill-McRoy, Larson, & Garland, 2010; Sreenivasan, Rosenthal, Smee, Wilson, & McGuire, 2018).

Laub and Sampson (2003) later examined more thoroughly how desistance from crime was related to strong social bonds with family, employment, and the military. They stated that "men who desisted from crime were embedded in structured routines, socially bonded to wives, children, and significant others, drew on resources and social support from their relationships, and were virtually and directly supervised and monitored" (Laub & Sampson, 2003, pp. 279-280). This theory will be applied to the current study about VTC as a way to better understand how not just military service but the VTC program itself can serve as a turning point to reduce future criminal behavior, and how personal characteristics of the participants (e.g., being married, being employed) can also serve as deterrents to criminal behavior.

Veterans' Issues that Increase Risk of Incarceration

To appreciate the reasoning for a specialized court specific to veterans, it is important to understand the scope of current issues facing this population. Due to the nature of their mission and their daily work while serving in the military, veterans often experience a complex assortment of residual physical and mental health concerns. Veterans frequently suffer from post-traumatic stress disorder (PTSD), traumatic brain injuries (TBI), significant physical disabilities, and other mental health concerns that often contribute to or exacerbate alcohol and drug abuse (Bjork & Grant, 2009; Bremner,

Southwick, Darnell, & Charney, 1996; Brunello et al., 2001; Calhoun, Elter, Johnes, Kudler, & Straits-Troster, 2008; Corrigan & Cole, 2008; Eggleston, Straits-Troster, & Kudler, 2009; Graham & Cardon, 2008; Hoge et al., 2004; Jacobson et al., 2008; Jorge et al., 2005; McFall & Cook, 2006; Ponsford, Whelan-Goodinson, & Bahar-Fuchs, 2007; Stahre, Brewer, Fonseca, & Naimi, 2009). Furthermore, drug and alcohol abuse and mental health issues among veterans are highly correlated with homelessness, criminal behavior, and incarceration (Drug Policy Alliance, 2012; Erickson et al., 2008). Three of the most prevalent issues that arose from the literature review and that correlate to increased risk of incarceration for veterans – mental health, substance abuse, and criminal behavior – are delineated here and the pertinent literature about each will be summarized.

Mental Health. Mental health has long been a primary concern for veterans. Although post-traumatic stress disorder did not become an official diagnosis until 1980, the phenomenon of soldiers having a collection of symptoms related to their wartime trauma has been a concern for as long as wars have existed (Baldwin, 2013).

> It is interesting to note that spending months of continuous exposure to the stresses of combat is a phenomenon found only on the battlefields of the twentieth century. Some psychiatric casualties have always been associated with war, but it was only in the twentieth century that our physical and logistical capability to sustain combat outstripped our psychological capacity to endure it (Grossman, 2009, p. 44-45).

According to the RAND Center for Military Health Policy Research, approximately one- third of returning OEF/OIF veterans reported symptoms of mental health issues (Tanielian & Jaycox, 2008; Tanielian et al., 2008). Furthermore,

approximately 15% of soldiers who have served in Afghanistan or Iraq have been diagnosed with post-traumatic stress disorder (Yarvis, 2011) and half of those who need treatment do not seek it (Tanielian et al., 2008). Additionally, the Veterans Health Administration reports that approximately 30% of Vietnam veterans have suffered from PTSD in their lifetime (United States Department of Veterans Affairs, 2018a). Another study showed that incarcerated veterans with PTSD had more serious legal problems, increased psychiatric symptoms, more extensive substance abuse histories, and worse overall health than those without PTSD (Saxon et al., 2001).

A recent systematic review of literature focusing on justice-involved veterans found that 13-62% of the veterans in the included studies self-reported having a mental health problem, with a mean prevalence rate of 34% (Blodgett et al., 2015). In this same study containing 13 samples of justice-involved veterans, the overall rates of self-reported PTSD ranged from 4% to 39% with a mean prevalence rate of 22.8% (Blodgett et al., 2015). This is consistent with the VA, which generally reports a prevalence rate of PTSD around 20% (United States Department of Veterans Affairs, 2018a). Blodgett found in this thorough review of literature that although there were differences in research design and sample make-up, research consistently finds that justice-involved veterans have higher rates of mental health concerns than other veterans (2015).

In addition to having mental health disorders related to their military service, several recent studies have also found that a significant number of active duty soldiers and veterans report having pre-enlistment onset of severe mental health disorders such as PTSD, major depressive disorder, borderline personality disorder, and generalized anxiety disorder (Kessler et al., 2014; Ursano et al, 2014; Varga, Haibach, Rowan, &

Haibach, 2018). The Army Study to Assess Risk and Resilience in Servicemembers (STARRS) found that nearly half (47%) of active duty soldiers reported having pre-enlistment suicidal ideations (Ursano et al., 2014), information that was likely not disclosed upon enlistment, as it may have disqualified them from serving.

Substance Abuse. According to the Veterans Health Administration, approximately 19% of OEF/OIF veterans receiving care at the VA have been diagnosed with a substance use disorder (United States Department of Veterans Affairs, 2014). In 2007 alone, the VA diagnosed more than 375,000 veterans with a substance use disorder (United States Department of Veterans Affairs, 2009). When compared with their age-equivalent civilian peers, combat veterans consistently have higher rates of problematic substance use (Larson, Wooten, Adams, & Merrick, 2012; Seal et al., 2011).

Low socioeconomic status, substance use disorders, and mental illnesses are all known to be risk factors for criminal justice involvement among veterans (Culp, Youstin, England, & Lynch, 2011; Erickson et al., 2008; Sparr, Reaves, & Atkinson, 1987). However, in many studies, substance abuse is the condition that presents the greatest risk for incarceration among veterans (Elbogen et al., 2012; Erickson et al., 2008). Both substance abuse and PTSD increase the likelihood of a serious or violent offense by a veteran that may result in his/her involvement with the criminal justice system (Elbogen et al., 2012; McCormick-Goodhart, 2013; Larson & Norman, 2014). Notably, incarcerated African American veterans are significantly more likely to have a substance use disorder and to be incarcerated for a drug-related offense than white veterans (Tsai et al., 2013).

Criminal Behavior and Criminal Justice Involvement. Currently in the United States, veterans are disproportionately represented in the prisons, as 10% of the prison population is veterans, while veterans only make up 7% of the overall U.S. population (Bialik, 2017). Numerous studies have shown that the majority of incarcerated veterans meet the criteria for a mental health and/or substance use disorder diagnosis (Fontana & Rosenheck, 2005; Greenberg, Rosenheck, & Desai, 2007; Tsai et al., 2013). Many veterans experience significant difficulty transitioning from military to civilian life, and encounter issues such as unemployment, underemployment, homelessness, and social isolation, all of which place them at increased risk of incarceration (Greenberg, Rosenheck, & Desai, 2007; Pentland & Scurfield, 1982).

Data collected by the Drug Policy Alliance assert that veteran incarceration increases after every major war (2012). For example, 34% of new admissions to U.S. prisons from 1946 to 1949 were WWII combat veterans returning home (Lunden, 1952). In 1985, approximately 22% of all men in prison were veterans, a direct correlation to the simultaneous end of the Vietnam War and the start of the "war on drugs" declared by President Richard Nixon (Drug Policy Alliance, 2012). In 2011, there were 181,500 incarcerated veterans and veterans were more likely to be sentenced for violent offenses than their civilian counterparts (64% and 48%, respectively) (Bureau of Justice, 2012). Studies of incarcerated veterans indicate that a mean of 41% report having an alcohol use disorder and a mean of 48% report having a drug use disorder prior to their arrest (Blodgett et al., 2015). Additionally, approximately 34% have a mental health issue prior to incarceration (Blodgett et al., 2015). Studies examining the differences between incarcerated and non-incarcerated veterans found that incarcerated vets were more likely

to report a mental health problem (Greenberg & Rosenheck, 2009). A recent study of 3,102 veterans examining how adverse childhood events and other traumas influence the likelihood of incarceration found that the lifetime prevalence of an alcohol use disorder increased chances of incarceration among veterans by 2.9 times, and a lifetime history of a drug use disorder increased the chances of incarceration among veterans by 4.6 times (Ross et al., 2018).

One theoretical perspective on the connection between military service and criminal behavior focuses on the personal characteristics and temperamental factors of those who choose to join the military (Snowden, Oh, Salas-Wright, Vaughn, & King, 2017). This suggests that it is not military involvement that explains behavior, but rather the choice to go into the military and the choice to engage in criminal behavior have a common cause. In the landmark Study to Assess Risk and Resiliency in Servicemembers (STARRS), researchers found that those who choose to join an all-volunteer Army are characterized by elevated impulsivity, sensation seeking, and aggressiveness (Rossellini et al., 2015). Notably, these traits have been highly correlated with increased risk of criminal behavior (Delisi & Vaughn, 2014; Raine, 2013), suggesting that those who choose to serve have personal traits that may lead to criminal behavior and incarceration regardless of their military service (Snowden et al., 2017). Blosnich et al. (2014) compared the differences in adverse childhood experiences (ACEs) between veterans who were drafted into service and veterans from the all-volunteer era and found that veterans who chose to join the military had significantly higher prevalence rates on every category of ACEs than their civilian counterparts, while veterans from the draft era only differed from their civilian counterparts on the ACEs scale in regards to household drug

use. Moreover, ACEs have been convincingly linked to numerous negative outcomes for adults including substance abuse (Choi, DiNitto, Marti, & Choi, 2017; Dube et al., 2003; Forster, Gower, Borowsky, & McMorris, 2017; Rothman, Edwards, Heeren, & Hingson, 2008), depression (Ege, Messias, Thapa, & Krain, 2015), suicidality (Dube et al., 2001; Merrick et al., 2017), and long-term physical health problems (Monnat & Chandler, 2015).

In summary, the past decade has seen an influx of U.S. veterans returning home and facing significant challenges reintegrating. Based on the literature review, mental health and substance abuse are two primary issues that place veterans at risk for incarceration. Veterans often cycle in and out of the traditional criminal justice system without being linked to the resources and support that are available to them through the VA and other veteran-focused community programs (Russell, 2009). Reflective of the healthcare utilization model, for a variety of reasons some veterans may choose not to utilize available VHA-provided mental health and substance abuse services. Collectively, these factors support the argument that veterans have unique needs and complex mental health and substance use issues that warrant an alternate judicial intervention, such as veterans' treatment court (Russell, 2009).

Model and Theoretical Foundation of Specialty Treatment Courts

Specialty courts such as drug courts, mental health courts, and veterans' treatment courts do not operate under the traditional courtroom models of justice, but employ a collaborative justice approach. Collaborative justice is a model in which all involved parties -- the judge, prosecutor, defense attorney, social worker, probation officer, and the participant all work collaboratively to focus on rehabilitation of the participant (Smee et

al., 2013). The emphasis of specialty courts is to divert offenders away from punitive solutions, such as jail, and into mental health or substance abuse treatment (Smee et al., 2013). The aim is to decriminalize mental illness and provide assistance and accountability to improve their quality of life and benefit society (Smee et al., 2013).

Treatment courts rest on a theoretical foundation of therapeutic jurisprudence (TJ), a term coined by David Wexler in 1990 to describe an approach to law that attempts to "reshape law and legal processes in ways that can improve the psychological functioning and emotional well-being of those affected" (Winick & Wexler, 2003, p. 479). Wexler asserted that the roles of judges, lawyers, and others in the courtroom, in combination with specified rules and legal procedures all work in unison to produce a therapeutic outcome for the participant (Wexler & Winick, 1991). The overarching goal of therapeutic jurisprudence is to "apply and incorporate insights and findings from the psychology, criminology, and social work literature to the legal system" (Wexler, 2016, p. 369). Therapeutic jurisprudence is at the core of the problem-solving courts, asserting that law should "be applied in a manner that benefits the individual while preserving social protection and justice" (Lucas & Hanrahan, 2016, p. 54). Although developed independently of problem-solving courts, the basic drug court model is viewed by legal scholars as a perfect example of applying the concepts of TJ (Hora, Schma, & Rosenthal, 1999; Saum & Gray, 2008). Wexler argues that judges and court staff must go beyond the procedural justice practices of voice, validation, and respectful treatment (Wexler, 2016). Although these are likely to be a part of the judicial interaction, therapeutic jurisprudence takes this process a bit further by borrowing from the techniques of relapse prevention. This involves having conversations with the individual about the details of

what happened before, during, and after the event, to identify and address the issues or situations that could be problematic for the participant and lead them to relapse or recidivate (Wexler, 2016). Wexler asserts that law is a social force that can result in positive (therapeutic) consequences or negative (anti-therapeutic) consequences (Wexler, Perline, Vols, Spencer, & Stobbs, 2016). In the spirit of therapeutic jurisprudence, proponents of VTC insist that instead of "being churned through the courts like any common criminal", veterans "need and deserve something much better" (Logsdon & Keogh, 2010, p. 24).

Drug Court Model

In 1971, President Richard Nixon declared the nation's "war on drugs", asserting that illegal drug use was "public enemy number one" (Nixon, 1971, p. 755). This included sizable funding increases for government-led initiatives to find, arrest, and incarcerate drug users and drug traffickers. The Drug Enforcement Agency (DEA) was created out of this push in 1973 and put nearly 1,500 new agents on the streets to fight drug use (Drug Enforcement Administration Museum and Visitors Center, 2019), resulting in a significant increase in drug-related arrests and convictions and a proliferation of the U.S. criminal justice system (Lucas & Hanrahan, 2016). Many saw this as more of a war on minorities and immigrants, as these groups quickly became disproportionately represented in the jails and prisons (Sirim, 2011). The height of the crack cocaine epidemic in the United States was in 1989, and not coincidentally, the first drug court also began that year in Miami, Florida (Marlowe et al., 2016). In 1991, state prison costs for low-level drug offenses topped $1.2 billion (Marlowe et al., 2016). A study completed in 2010 by the National Center on Addiction and Substance Abuse

found that 65% of U.S. inmates (2.3 million people) met the DSM criteria for alcohol or other drug abuse or dependence (National Center on Addiction and Substance Abuse, 2010). An additional 458,000 were sub-threshold for the official diagnosis, but were considered substance-involved, meaning they were actively using at the time of their crime (National Center on Addiction and Substance Abuse, 2010). As prisons and jails across the country subsequently faced significant overcrowding, and incarceration costs skyrocketed, drug courts became the judicial response to an outcry for a more treatment-focused approach when dealing with substance-using offenders in the criminal justice system (Marlowe et al., 2016).

Touted as the "most successful justice innovation in American history" (National Association of Drug Court Professionals, 2018a, 2:04), there are currently 3,316 drug courts in operation in the United States (National Association of Drug Court Professionals, 2018b), including one each in 113 of Kentucky's 120 counties (Administrative Office of the Courts, 2019). These courts served approximately 140,000 individuals in 2018 (National Association of Drug Court Professionals, 2018b), with 2,506 of those being in Kentucky (Administrative Office of the Courts, 2019).

Although there is some variance in policies and procedures by county and based on the presiding judge, drug courts are generally 18 to 24-month programs that follow a structured and rigorous evidence-based model that aims to provide treatment as an alternative to incarceration (Hiller et al., 2010). In Kentucky, participants work through four phases within the program (Kentucky Specialty Courts, 2016). Phase I is the Stabilization phase and lasts a minimum of 30 days. While in Phase I, participants submit to three random drug screens per week, attend a minimum of three clinical hours

of treatment per week, attend one court session per week, and have additional expectations and responsibilities. Phase II is the Education phase and lasts a minimum of 90 days. While in Phase II, participants submit to two random drug screens per week, attend a minimum of two clinical hours of treatment per week, and attend one court session every two weeks, in addition to having employment, stable housing, and other additional requirements. Phase III is the Self-Motivational phase and lasts a minimum of 90 days. While in Phase III, participants submit to one random drug screen per week, attend at least one clinical hour of treatment per week, and attend one court session every three weeks, while maintaining employment, stable housing, paying off court obligations, and attending self-help meetings. Aftercare is the final phase and the length of time spent in aftercare varies based on the participants' needs. Aftercare is much less structured but provides continued support and accountability for the participant as they work to maintain their sober lifestyle (Kentucky Specialty Courts, 2016).

Key Components of Drug Court. The key components of drug court, as outlined in *Defining Drug Courts: The Key Components*, are:

1) Drug courts integrate alcohol and other drug treatment services with justice system processing.
2) Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
3) Eligible participants are identified early and promptly placed in the drug court program.
4) Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

5) Abstinence is monitored by frequent alcohol and other drug testing.
6) A coordinated strategy governs drug court responses to participants' compliance.
7) Ongoing judicial interaction with each drug court participant is essential.
8) Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9) Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10) Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness (National Association of Drug Court Professionals, 1997, p. iii – iv).

One of the primary elements of drug courts is the referral and provision of a continuum of substance abuse treatment, as stipulated in Key Component #4 (National Association of Drug Court Professionals, 1997). This includes self-help meetings, individual therapy, family therapy, group therapy, and intensive outpatient treatment. Participants attend a minimum of 1-3 clinical hours of treatment weekly, depending on their phase, as well as actively participating in a self-help group such as Alcoholics Anonymous or Narcotics Anonymous.

Another primary element of drug courts is the use of sanctions and rewards, a result of Key Component #6 (National Association of Drug Court Professionals, 1997). Sanctions are not intended to be punishments. They are used in drug court to guide the individual through the ebbs and flows of the recovery process, with the understanding

that addiction is a chronic, relapsing disease and each relapse can be a teachable moment. However, sanctions are administered in increased severity, as drug use or other undesirable behaviors continue and are applied immediately when a relapse or undesirable behavior has occurred. Some examples of sanctions that might be used in drug court are: warning from the judge, demotion to an earlier phase, increased drug testing frequency, earlier curfew, jail time, or community service, but could include termination from the program if undesirable behaviors continue repeatedly. Drug courts use rewards to recognize progress and behavioral changes and to acknowledge even the most incremental of successes. Examples of rewards that are commonly used in drug courts are: encouragement and praise from the judge and the team, reduced fines, decreased frequency of drug tests, advancement to next phase, reduced or suspended sentences, and graduation ceremonies.

Lastly, another crucial element of drug courts is the relationship and interaction between the judge and the participant, a result of Key Component #7 (National Association of Drug Court Professionals, 1997). Participants attend regular court hearings where they are held accountable for their progress. If participants have a positive drug test or have failed to comply with any of the requirements or conditions of the court, they will have to answer for such to the judge in open court, and will likely face sanctions, as previously detailed. Judges and participants build rapport and judges play a central role in the course of the participant's treatment.

Clinical treatment, the use of sanctions, and judicial interaction are three of the key components of VTC, and will be examined within this study to determine the impact they have on program completion and criminal recidivism.

Reducing Criminal Recidivism. Reducing re-arrests is a primary concern for adult drug courts, and numerous research studies have shown that drug courts do reduce new charges and convictions (Belenko, 2001; Brown, 2011; Gottfredson et al., 2003; Huddleston & Marlowe, 2011; Kalich & Evans, 2006; Sanford & Arrigo, 2005; Shaffer et al., 2011). Criminal recidivism is broadly defined as a new charge or conviction received after entering the treatment court program (Latimer, Morton-Bourgon, Chrétien, 2006), and is often used interchangeably with the term "re-offending". In their *Best Practice Standards*, the National Association of Drug Court Professionals (2013) defines criminal recidivism in the context of drug courts as any new charge, arrest, or conviction that occurs after entry into the drug court program. Many empirical studies examining the effectiveness of drug courts use the term "recidivism", while others use the term "re-offending", and yet others specify even further by using the terms "In-Program Recidivism versus Post-Program Recidivism" (e.g. Mitchell, Wilson, Eggers, & MacKenzie, 2012; Shannon, Jones, Nash, Newell, & Payne, 2018). These inconsistencies in operationalization of recidivism can be problematic and lead to differing results and conclusions across studies. Dr. Belenko, one of the nation's foremost researchers on drug court programs stated, "A shortcoming of some drug court evaluations is a lack of specificity about data collection timeframes, especially in terms of recidivism outcomes" (2001, p. 29). Many studies provide data for a set time-period (such as 12 months), but there is often no clear distinction made between recidivism that occurred while the person was still enrolled in the program, and recidivism that occurred after completing the program (Belenko, 2001).

For clarity and consistency within this dissertation, the term criminal recidivism will be used to discuss the concept of acquiring new arrests, charges, or convictions after entering the VTC program. In this study, criminal recidivism does not include jail time that is a result of sanctions levied by the VTC.

In the past decade, studies have found that drug courts not only reduce drug using and criminal behavior during participation in the program, but also reduce criminal recidivism for a period of one to three years post completion (Belenko, 1998, 1999, 2001; General Accounting Office, 2005; Gottfredson, Najaka, Kearley, & Rocha, 2006; Henggeler, Halliday-Boykins, Cunningham, Randall, & Shapiro, 2006; Lowenkamp, Holsinger, & Latessa, 2005; Wilson, Mitchell, & MacKenzie, 2006). At least nine meta-analyses completed in the past decade have concluded that adult drug courts significantly reduce criminal recidivism by approximately 8-14% (Aos, Miller, & Drake, 2006; Carey, Mackin, & Finnigan, 2012; Latimer et al., 2006; Lowenkamp et al., 2005; Mitchell et al., 2012; Rossman et al., 2011; Shaffer, 2010; U.S. Government Accountability Office, 2011; Wilson et al., 2006).

In connection to reducing criminal recidivism, drug courts also have been found to be highly cost-effective (Belenko, Patapis, & French, 2005; Bhati, Roman, & Chalfin, 2008; U.S. Government Accountability Office, 2011). Not only does drug court result in direct reductions of spending for incarceration, but it also results in reductions to peripheral expenses such as healthcare and foster care (Marlowe, 2010). A seminal longitudinal study by the National Institute of Justice collected drug court data for 5 years and found that drug courts reduced criminal recidivism rates and lowered costs to states and counties related to incarceration (Marlowe, 2010). Recidivism rates varied

throughout the years based on changes in the programming and varying judge assignments, but the yearly reduction in criminal recidivism was between 17 and 26% (Marlowe, 2010; Rempel, Green, & Kralstein, 2012). Additionally, studies found reduced criminal recidivism and subsequent long-term positive outcomes resulted in a tax-payer savings of $3000 to $13,000 per drug court participant (Aos, Miller, & Drake, 2006; Barnoski & Aos, 2003; Carey, Finigan, Crumpton, & Waller, 2006; Finigan, Carey, & Cox, 2007; Logan et al., 2004). Research by the National Association of Drug Court Professionals (NADCP) asserts that every dollar of federal money invested into drug courts saves $27 in incarceration and other recidivism-based expenses (National Association of Drug Court Professionals, 2018b).

Other Mitigating Factors. Although many studies have found that drug court reduces overall criminal recidivism, there are still few studies that have explored the reasons why drug court works, and what elements of drug courts are most effective. One study of 302 drug court participants who abused alcohol, cocaine, or marijuana aimed to discern if their drug of choice influenced their rate of completion or likelihood of recidivism (Shaffer et al., 2011). Although the researchers hypothesized that cocaine users would be less likely to complete the program and more likely to recidivate, after following the participants for two years, they found that drug of choice was not a significant predictor in completion of drug court or criminal recidivism (Shaffer et al., 2011). A recent qualitative study of 42 drug court participants found that frequent drug testing and frequent interaction with the judge, key components of drug court, were both critical elements of their successful completion of the program (Gallagher, Nordberg, & Lefebvre, 2016). A study of 157 participants who were randomly assigned to control and

treatment groups did find that the number of hearings attended, the number of drug tests taken, and completing drug treatment were all significant predictors of reduced drug use (Gottfredson, Kearley, Najaka, & Rocha, 2007).

The consensus now is that drug courts are effective at reducing criminal recidivism, which subsequently reduces crime and cost to taxpayers (Belenko, 1998, 1999, 2001; General Accounting Office, 2005; Gottfredson et al., 2006; Henggeler et al., 2006; Lowenkamp et al., 2005; Wilson et al., 2006). The drug court model is a natural application of therapeutic jurisprudence (Winick & Wexler, 2001) and produces desired effects. The specifics of which components of the drug court model are most effective are still largely unknown, although some studies have indicated that strong judicial leadership plays a key role (Marlow & Meyer, 2011). As these courts gained attention and their efficacy was widely reported, the drug court model began to be emulated in other problem-solving courts, one of which is the veterans' treatment courts.

Mental Health Courts

Another division of the specialty court systems, mental health courts were developed to provide alternative interventions for persons in the criminal justice system with serious and persistent mental health disorders such as schizophrenia, bipolar disorder, and schizoaffective disorder, severe depression, and anxiety disorders (Council of State Governments, 2008a, 2008b, 2019). Additionally, courts can consider other cases that involve individuals with developmental disabilities, traumatic brain injuries, and dementias that may be the root cause of their criminal behavior (Council of State Governments, 2008b). Mental health courts also treat individuals with mental illness who have co-occurring substance use disorders. Without intervention and linkage to

appropriate community resources, these individuals often cycle through the criminal justice system repeatedly (Johnson et al., 2011; Mendoza et al., 2013; Skeem, Manchak, & Peterson, 2011). These courts typically serve individuals with nonviolent offenses and participants receive intensive case management and treatment services in lieu of incarceration. Similar to drug courts, mental health court participants meet regularly with the judge, take frequent drug and alcohol tests (when indicated, for those with co-occurring substance abuse), and receive incrementally increased sanctions for any program infractions (Marlowe et al., 2016).

It should be noted that "mental health courts are not merely drug courts for people with mental illnesses" (Council of State Governments, 2008b, p. 9). Participants come into the court with a wide variety of charges, and their treatment plans are individualized and flexible. Whereas drug courts can easily monitor basic program compliance with frequent drug screens, monitoring program adherence within mental health courts is much more complex. Additionally, drug courts often have requirements for participants to get an education and/or gain employment and secure self-sufficient housing, whereas mental health court participants might not be expected to achieve those same accomplishments in order to complete the program, and they may require more long-term case management and support (Council of State Governments, 2008b).

Key Components of Mental Health Court. Based loosely on the key components of drug courts, the key elements of mental health court, as laid out in *The Essential Elements of Mental Health Court* are:

1) Planning and supervision – ensuring that a solid collaboration between the criminal justice, mental health, and substance abuse stakeholders within each community.
2) Target population – in order to be effective and sustainable, the target population must be clearly identified and eligibility criteria established that are fair and consistent.
3) Timely participant identification and linkage to services – by accepting referrals from an array of sources such as police officers, jail staff, judges, and family members, eligible participants are identified early in order to begin safe and effective treatment in lieu of incarceration.
4) Terms of participation – program rules and expectations are laid out clearly and enforced consistently in a way that provides the least restrictive supervision conditions, while keeping the participant and the community safe.
5) Informed choice – participants are given full disclosure about the program requirements and must be deemed competent to participate.
6) Treatment supports and services – at the core of the mental health court is an array of essential mental health treatment services and supports including counseling, medication, substance abuse treatment, housing, peer supports, and case management.
7) Confidentiality – policies and procedures are implemented that secure that safeguard the mental health information of all participants.
8) Court team – the court team is comprised of judges, case managers, mental health treatment providers, prosecutors, defense attorneys, and court

supervision agents. All team members are trained on the nontraditional setting of mental health court and agree to work collaboratively towards the best interest of the participant.

9) Monitoring adherence and court requirements – mechanisms are in place to ensure continuous monitoring of all participants and timely reporting of progress to all team members.
10) Sustainability – courts should collect and analyze performance and outcome data in order to assess effectiveness and to secure and maintain long-term funding (Council of State Governments, 2008a).

The number of mental health courts in the United States has grown consistently from four in 1997 to over 300 today in 38 states (Marlowe et al., 2016), including one in Kentucky (Kentucky Court of Justice, 2018). Studies have indicated that mental health courts are effective at reducing criminal recidivism (Sarteschi, Vaughn, & Kim, 2011) and that the effect lasts at least two years post-completion (Aldige Hiday, Ray, & Wales, 2015; Rossman et al., 2012). While mental health courts provide an important and needed service to those with severe and persistent mental illness, there remained a gap in the criminal justice system with substance abuse and/or mental health issues who are military veterans. Out of a need for a court system that values their military service while considering the unique nuances of their issues, and helping to ease the complexities involved with accessing VA care, veterans' treatment court was born.

Veterans' Treatment Courts

Recognizing the increase in veterans cycling through the criminal justice system, while also acknowledging the distinctiveness of military culture, retired U.S. Army

Brigadier General Judge Sigurd Murphy and retired U.S. Air Force Colonel Judge Jack Smith began offering special services to veterans within the Anchorage Alaska drug court system in 2004 (Alcorn, 2010; Garza, 2014; Hawkins, 2009; Smith, 2012). Judges Murphy and Smith worked diligently to implement a veterans-only court in their jurisdiction, building on the successes of the drug court model (Smith, 2012). One of the primary reasons they cited for investing in this endeavor was their belief in the value of the shared military experience as a mechanism to create change in the veterans' lives (Smith, 2012). They assert that soldiers are trained to perform difficult and unpleasant tasks, despite the challenges, in the name of teamwork and for the greater good of the group, and that this behavior is not "unlearned" once they return home. Judges Murphy and Smith saw an opportunity to capitalize on the group bonding and cohesion of veterans to facilitate "buy-in" and get them needed treatment (Smith, 2012). The creation of VTCs is in line with social control theory, and the need to keep rigorous controls, community, and accountability in place for veterans in order to reduce their likelihood of deviant behavior.

The first official veterans' treatment court (VTC) was established by Judge Robert Russell in Buffalo, New York in 2008 (Russell, 2009). Judge Russell had been presiding over drug court in that county and began noticing a trend of an increased presence of military veterans in criminal proceedings. Hearing about the successes in the Anchorage drug court with a veteran-specific docket, Judge Russell was compelled to implement a similar court in his jurisdiction (Russell, 2009). As leaders of the courtroom, judges are in a distinctive position to view the trends of recidivism and have the authority to "make demands that the door stop revolving" by developing innovative

solutions (Miller & Johnson, 2009, p. 125). Believing that veterans have distinct needs that are unique to their military service, Judge Russell leveraged his current position and influence to begin the work of implementing a special court to address the underlying issues that resulted in the veteran's involvement with the criminal justice system (Russell, 2009).

Judge Russell asserted that the veterans he was seeing in his court faced myriad of issues including mental health disorders, substance use and abuse, homelessness, strained relationships, unemployment, and challenges reintegrating into their communities (Russell, 2009). Veterans' treatment courts aim to provide treatment for substance use disorders and mental health disorders, along with linkages to job placement and housing resources, as needed (Baldwin, 2013). This is achieved by a network of professionals working collaboratively towards a common goal: to assist the justice-involved veterans in receiving the services they have earned that will facilitate their successful reintegration in the community. This group of professionals includes the judge, attorneys, law enforcement, VA outreach staff, social workers and other mental health providers, case managers, and peer mentors (National Association of Drug Court Professionals, 2013), and each court is established using the Key Components of Veterans' Treatment Court model.

Key Components of Veterans' Treatment Court. Veterans' treatment court modified the widely accepted ten key components of drug court, as were delineated in *Defining Drug Courts: The Key Components* and customized them to the veteran population (National Association of Drug Court Professionals, 1997). These key components are as follows:

1) Integrate alcohol, drug treatment, and mental health services with justice system case processing,

2) Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights,

3) Eligible participants are identified early and promptly placed in the veterans' treatment court program,

4) Provide access to a continuum of alcohol, drug, mental health and other related treatment and rehabilitation services,

5) Abstinence is monitored by frequent alcohol and other drug testing,

6) A coordinated strategy governs Veterans' Treatment Court responses to participants' compliance,

7) Ongoing judicial interaction with each Veteran is essential,

8) Monitoring and evaluation measure the achievement of program goals and gauge effectiveness,

9) Continuing interdisciplinary education promotes effective veterans' treatment court planning, implementation, and operations,

10) Forging partnerships among veterans' treatment court, Veterans Administration, public agencies, and community-based organizations generates local support and enhances Veterans' Treatment Court effectiveness (Justice for Vets, 2017, pp. 1-3)

The only differences between the key components for drug court and the key components for VTC are that it is a veteran population and they receive many of their clinical services at the VA, rather than from community mental health providers. The

expectations of participation, the progression through program phases, and the requirements for completion of the program are the same across both courts.

Uniqueness of Veterans' Treatment Court. When compared with other similar problem-solving courts, the VTC has a couple of important and unique factors that could impact the outcomes of the court. These are the eligibility requirements for admission into the program and the use of peer mentors, which are defined and described below.

Eligibility Requirements. Upon entry into the court system, defendants in counties where VTCs are located are identified for possible inclusion and are provided information about the program. Eligibility requirements vary across jurisdictions and are generally decided at a state level (Baldwin, 2016; McGuire et al., 2013). While the eligibility criteria may differ from state to state, the basic criteria are that the defendant is a United States veteran, who completed their service or was honorably discharged, and who is in court for a non-violent offense that can somehow be accredited to their military service (Tsai, Flatley, Kasprow, Clark, & Finlay, 2017). However, various jurisdictions have interpreted these loose guidelines differently and there are some counties where those with dishonorable discharges and/or lower-level violent offenses could be considered as well (Baldwin, 2016; Flatley, Clark, Rosenthal, & Blue-Howells, 2017; Tsai et al., 2017). Approximately 20% of VTCs nationwide will only accept veterans with military-related mental health diagnoses, and 5% will only accept combat veterans (Flatley et al., 2017).

Opponents of the development of VTCs argue that these courts perpetuate a "moral sorting" of defendants into differentiated courts, based on who deserves better treatment (Collins, 2017). Some opponents assert that VTCs "embody a judgement about

moral desert of these offenders" (Collins, 2017, p. 1504) and the practice of excluding those who were dishonorably discharged is unfair because we are not recognizing the trauma they may have experienced during their military service, regardless of discharge status (Collins, 2017).

Even within the veterans' treatment court community, there are differences in opinion and in the policies regarding who can be served. Some courts require that a veteran have been deployed to combat to be eligible. Supporting that premise, there is a significant body of literature indicating that deployment to a combat zone and subsequent exposure to combat are strongly associated with negative mental health outcomes, including PTSD, depression, and substance use disorders (Helzer, Robbins, & McEnvoy, 1987; Hoge et al., 2004; Hoge, Auchterlonie, & Milliken, 2006; Jordan et al., 1991; Kang, Natelson, Mahan, Lee, & Murphy, 2003; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Prigerson, Maciejewski, & Rosenheck, 2001, 2002; Sareen et al., 2007; Smith et al., 2008; Toomey et al., 2007). One such court is in Orange, California, where the only eligible vets are those who have committed offenses attributable to their combat-related post-traumatic stress disorder, substance abuse or other mental health issues (McMichael, 2011). Judge Wendy Lindley supports this policy, asserting that:

> What unites combat veterans is their combat. That experience ... resonates very deeply with them. I think that if they've been damaged as a result of their service ... in a combat zone, that ethically and morally, we need to respond by offering them special services to restore them to who they were (McMichael, 2011, p.1, para. 53).

Many other courts, such as the original one in Buffalo, New York, accept all veterans, regardless of their combat experience. This is based on the idea that military service looks differently for different soldiers, and also that traumas can occur during military service, even when the soldier is not on the front lines of combat (McNally & Frueh, 2013; Ursano et al., 2014). For instance, it is estimated that 16% of service members (4% of men and 38% of women) experience sexual trauma during their time of service (Allard, Nunnink, Gregory, Klest, & Platt, 2011; Wilson, 2016), although reporting statistics of sexual assault or mental illness within the military are thought to be low due to the stigma involved (Brown & Bruce, 2016; Conrad, Young, Hogan, & Armstrong, 2014; Green-Shortridge, Britt, & Castro, 2007; Valente & Wright, 2007). Although there is not an abundance of literature supporting this idea, some recent studies of OEF/OIF-era veterans have indicated that deployment status is less important and that those who serve but are never deployed are still at risk of negative mental health outcomes (LeardMann et al., 2013; Schoenbaum, Kessler, & Gilman, 2014; Ursano et al., 2014). One study of over 35,000 active duty soldiers indicates that 25.1% of non-deployed personnel met criteria for a DSM-IV anxiety, mood, disruptive behavior, or substance use disorder (Ursano et al., 2014). These concerns among non-deployed soldiers could be the result of the common experience of military training, but they could also be the result of pre-enlistment mental health or substance use issues.

Another potential explanation that has received some attention is phenomenon of survivor guilt, something experienced by soldiers who might feel they did not do their part, or have guilt about going home to their families when others did not make it out alive (Janssen, 2013; O'Connor, Berry, Weiss, Bush, and Sampson, 1997). Survivor guilt

is described as "the ever present feeling of guilt, as accompanied by conscious or unconscious dread of punishment, for having survived the very calamity to which their loved ones succumbed" (Niederland, 1961, p. 238). In relation to PTSD, the American Psychiatric Association defined survivor guilt as "guilt about surviving while others have not, or about behavior required for survival" (2000, p. 465). In their newest iteration of the manual, they acknowledged the critical role of guilt and shame in the diagnosis of PTSD, adding these constructs as new symptomological criteria (American Psychiatric Association, 2013). Empirical studies have shown a significant association between survivor guilt and depression, pessimism, perfectionism, and addiction (Niederland, 1961, 1980; O'Connor et al., 1997; O'Connor, Berry, Weiss, & Stiver, 2011), all of which could contribute to an individual's entry into the criminal justice system.

Judge Russell asserted that "all veterans deserve special consideration simply for their willingness to serve and defend their nation (McMichael, 2011, p.1, para. 54). "Status courts aim to honor the offender's experience and strengthen the offender's association with the characteristic used to sort him or her into court" (Collins, 2017, p. 1481). In Kentucky, the VTC accepts both combat and non-combat veterans, with priority given to combat veterans. They accept veterans with felony and misdemeanor charges, excluding violent felonies and sexual offenses. Individuals with domestic violence charges are considered, as long as the charge is a misdemeanor. The participant must have served in the U.S. military with an honorable or general discharge, although dishonorable discharges are considered on an individual basis. The participant must have a diagnosed substance use disorder or mental health disorder, and lastly, they must have the mental capacity to consent and participate in treatment (Shannon, 2016).

Peer Mentoring. Another aspect of veterans' treatment courts that is unique in comparison to drug court and other problem-solving courts is their use of peer mentors. Peer mentors are non-criminally involved veterans from the local community who serve as a mentor, guide, and friend to the participant, assisting them in navigating the court system and holding them accountable for their work in the program (Vaughn, Holleran, & Brooks, 2016). The goal of the peer mentor component of veterans' treatment court is to give the participant a healthy role model and help them feel they are not alone (Collins, 2017). Considering how brotherhood and camaraderie are woven into the fabric of U.S. military culture, this aspect of the VTCs demonstrates their awareness of the distinct differences of veterans from the general population. By using peer mentors, the VTCs are leveraging the sense of solidarity and esprit de corps of military culture to rehabilitate veterans in the criminal justice system (Easterly, 2017). A goal of veterans' treatment court is not simply to punish or change the veteran's behavior, but to focus on fostering a sense of respect for themselves and their military service (Collins, 2017), and peer mentors are an integral part of that process.

Gaps in the Literature

As VTCs are relatively new, there is a paucity of research that examines how individual characteristics of participants and specific components of VTC programs contribute to veterans' likelihood of program completion and criminal recidivism. There is not a consensus within the literature about how certain basic personal characteristics such as age, gender and marital status influence completion of the VTC program. There is also relatively no literature that speaks about characteristics specific to the military such as combat status and how that may influence program completion and recidivism.

While there is some research in drug court populations that examines the links between mental health and substance abuse issues and their impact on program completion and recidivism, there is no similar body of research in the VTC literature. Additionally, very few empirical studies specifically examine program components such as drug screens, judicial interaction, therapeutic sessions, and sanctions, and how those things contribute individually and collectively to the likelihood of program completion and criminal recidivism. While the use of sanctions and rewards is a key component of problem-solving courts like drug court, there is a lack of literature outlining how effective these tactics are with the veteran population. Having more research about specific components of the VTC program could help shape changes in the policies and procedures to ensure their ongoing and future practices are evidence-based.

This study aims to fill some of these gaps in the literature by adding to the body of knowledge surrounding VTCs, looking to provide insight about how personal characteristics of participants (e.g., age, gender, race, marital status, combat status, drug of choice, mental health issues) and during-program occurrences (e.g., sanctions, drug screens, interaction with judge, and sessions) may influence program completion and criminal recidivism.

Chapter Summary

This chapter began with a look at the healthcare utilization model and also explored social control theory and the age-graded theory of informal social control, to serve as a backdrop and foundation for this current study. Pertinent literature was reviewed and details of the veterans' treatment court model as well as its predecessors, drug court and mental health court provided. Based on this information, this study was

developed and carried out to fill the subsequent gaps in knowledge about the outcomes of veterans' treatment court. Chapter three will detail the methodology used to execute this study including the research plan, the data collection procedures, the variables of interest, and the research questions.

Chapter Three: Methodology

The purpose of this chapter is to introduce the research methodology employed in this exploratory study. The research plan, including the study design, data collection procedures, study participants, and how access to the data set was gained for the purpose of this dissertation will all be detailed. Next, each study variable of interest is listed and operationalized, and the research questions are presented. Lastly, the analytic plan for this study is described.

Research Design

This study involves secondary data analysis of Kentucky veterans' treatment court data collected as part of two Bureau of Justice Assistance grants awarded to the Kentucky Administrative Office of the Courts (AOC) for the implementation of the VTCs in Jefferson County and Hardin County, Kentucky. The grants provide financial assistance to county and state courts to implement and operate VTCs that utilize evidence-based substance abuse treatment and comprehensive wrap-around services designed to prevent criminal recidivism and support long-term recovery for veterans (Bureau of Justice Assistance, 2012). Dr. Lisa Shannon from Morehead State University was the Principal Investigator (PI) of a process evaluation titled Kentucky Specialty Court Veterans Treatment Court Evaluations that examined the implementation of the VTCs in Kentucky, based on quantitative and qualitative data collected from each site. The current study is an exploratory descriptive study looking at outcomes from the Kentucky VTC project.

Data Collection

The data for this study were collected from 10/01/12 until 09/30/16 in Jefferson County, and from 10/01/13 until 09/30/17 in Hardin County. The specific timeframes of data collection for each site were based on the respective start dates associated with the receipt of grant funding. AOC collected and managed the demographic, assessment, and process evaluation data in the Management Information System (MIS) as stipulated by the grant. These data were made available for the current study after approval of Institutional Review Board (IRB) protocols at both Morehead State University and the University of Kentucky. There are three separate types of data used in this study: assessment data, criminal history data, and performance indicator data. Each of these will be detailed below.

Assessment Data. Initial assessment data were collected on each participant upon their entry into drug court. Each participant completed either the Kentucky Drug Court Eligibility Assessment (KDCEA) form (see Appendix A) or the Kentucky Drug Court Risk and Needs Assessment (KDCRANA) (see Appendix B) via a face-to-face interview with that county's drug court program coordinator or case manager. The KDCEA was used until July 2015, and then was replaced by the KDCRANA. This change occurred due to program administrators within Kentucky's drug court system wanting to have a more holistic assessment tool that included assessment of the participants' risks and needs. The KDCRANA is a comprehensive assessment that includes scoring mechanisms for recidivism risk, social risk, and substance abuse risk. From a research standpoint, it is not ideal that the assessment instrument changed during

the data collection window, and this challenge is discussed further in the limitations section later in this chapter.

The KDCRANA utilizes the Addiction Severity Index (ASI), an instrument that has been widely used in both clinical settings and research studies for nearly four decades (McLellan, Luborsky, Woody, & O'Brien, 1980). The ASI is a self-reported instrument that gathers data in seven areas: physical health, employment and financial support, illegal or criminal activity, family and social relationships, psychiatric symptoms, and drug and alcohol use (McLellan et al., 1992). The ASI has been tested in a wide variety of clinical and research applications and has consistently been found to be a reliable and valid instrument (Carise et al., 2001; McLellan et al., 1985, Peters et al., 2000; Rosen, Henson, Finney, & Moss, 2000; Wertz, Cleveland, & Stephens, 1995).

Both assessments (the KDCEA and KDCRANA) collected basic demographic information, as well as information about the participant's medical history, education and employment history, drug and alcohol use, criminal justice history, family and social history, and mental health history. On this form, participants had the option to identify themselves as being veterans of the United States Armed Forces or the National Guard, which then triggers the interviewer to assess if the participant is potentially eligible for veterans' treatment court. Copies of the assessment for each participant were also made available for the current study and every collected data point was subsequently entered into SPSS for possible analysis. Assessments were de-identified by AOC and were labeled with a 5-digit MIS number to protect participant confidentiality.

Criminal History Data. Participant criminal history data came from CourtNet, Kentucky's official recording system, and captured every criminal conviction that

occurred after the participants' entry into the VTC. The AOC's CourtNet record includes all misdemeanor and felony convictions for each participant. The data were categorized into variables based on type of crime, such as property crime, drug trafficking, traffic crime (e.g. speeding, DUI), and violent crime. For each category of criminal behavior both an interval measure (how many times they were convicted of a specific type of crime) and a nominal measure that stipulates with a YES/NO response whether they have been convicted of that particular type of crime were computed. The CourtNet record was de-identified by AOC and participants were labeled with their 5-digit MIS number, so this data could be merged with the assessment data in the new SPSS data set.

Performance Indicator Data. Data were collected throughout the grant period by AOC staff regarding every aspect of the VTC process. The data include the results of every drug test taken while in the program, the dates of every judicial interaction, the dates and type of every treatment session (e.g. group, individual, self-help) attended, dates and reasons for every sanction given, as well as dates and comments for every accomplishment made while in the program. Additionally, the performance indicator data contains dates and reasons for phase and status changes, which includes whether or not a participant completed the program.

Program Participants

This data set is comprised of veterans' treatment court participants from Jefferson and Hardin County, Kentucky. The data set includes participants who entered the veterans' treatment court during the grant periods (October 1, 2012 to September 30, 2016 for Jefferson County and October 1, 2013 to September 30, 2017 for Hardin County), and whose complete assessment, MIS, and performance indicator data was

available for analyses. Every participant who entered the program signed a release to be included in the data collection by AOC. The final data set includes 58 participants -- 22 from Hardin County and 36 from Jefferson County.

Ethical Considerations

As this is a study of existing de-identified data, the study was approved by exempted review by the University of Kentucky Institutional Review Board (IRB). Additionally, Dr. Lisa Shannon added the author as study personnel to an existing IRB approval at Morehead State University. To protect their identities, study participants were assigned unique five-digit identification numbers. Data were processed in SPSS on a university-owned and password-protected computer, and were stored on an external hard drive, which was stored in a locked cabinet in the researcher's university office.

Power Analysis

A post-hoc power calculation utilizing G*Power 3.1.9.2 (Faul, Erdfelder, Lang, & Buchner, 2007) was conducted for the specific analyses (χ^2 and t-tests) and indicated that with the sample size of 58, the calculations could expect to have excellent power (.97 and .99, respectively) to detect large effect sizes, moderate power (.62 and .76) to detect medium effect sizes, and minimal power (.11 and .18) to detect small effect sizes (Cohen, 1988).

Measures

Due to the small sample size, as well as a review of the distribution of the data on each variable, the study variables were dichotomized for inclusion in the bivariate analyses. Each variable is detailed below, including a description of how the data were originally collected and coded, followed by a description of how the variables were

dichotomized, along with an explanation of why the categories were chosen, when applicable.

Outcome Variables.

Criminal Recidivism. The recidivism variable is a dichotomous variable that indicates if a participant has acquired any new misdemeanor or felony convictions since entering the VTC. This information comes from the criminal history data and the variable is coded as (0) for no (no new convictions) and (1) for yes (they have new convictions).

Program Completion. The completion category variable is a dichotomous variable that categorizes all participants as either (0) not completed or (1) completed. The not completed category includes all those who were terminated (serious or repeated rule infractions), administratively discharged (veteran no longer wants to participate), suspended (currently incarcerated), or who absconded (fled the court's jurisdiction). This information comes from the performance indicator data.

Independent Variables: Participant Characteristics

Age. Participant age was calculated using the birthdate provided by the participant in their initial assessment and their reported date of entry into the VTC. Age was recoded into age categories of: 20-39 (coded as 0) and 40-69 (1). Although not exact, the age variable was dichotomized in this way as a close approximation to dividing the participants by era of service with the 20-39 group representing OEF/OIF, and the 40-69 group representing the Gulf War and Vietnam.

Gender. Gender is a dichotomous nominal level variable coded as (0) male, and (1) female. This information is self-reported and comes from the assessment data.

Race. Race is a nominal level variable originally coded as (1) White, (2) Black, (3) Hispanic, (4) Asian / Pacific Islander, and (5) Other. This information is self-reported and comes from the assessment data. For the bivariate analyses, the race variable is coded as (0) for White and (1) for non-white (Black, Hispanic, Asian/Pacific Islander, and other combined).

Marital Status. Marital status is a nominal level variable originally coded as (0) never married, (1) single, (2) married, (3) separated, (4) divorced, and (5) widowed. This information is self-reported and comes from the assessment data. For the bivariate analyses, the marital status is recoded as (0) for Married and (1) for non-married (single, separated, divorced, widowed). Although not precise, this categorization aims to group the participants as either "attached" or "unattached" to a partner, a delineation that has been interpreted in line with social control and social support research.

Combat Status. The combat status variable is a dichotomous variable indicating any self-reported history of combat while in the military. This information is found in the assessment data and is coded (0) for no combat and (1) for a history of combat.

Drug of Choice. The drug of choice variable is a categorical variable indicating the primary drug of choice for each participant. The variable is originally coded as (1) Alcohol, (2) Amphetamine, (3) Benzodiazepine, (4) Cocaine, (5) Heroin, (6) Marijuana, (7) MDMA, (8)Methadone, (9) Methamphetamine, (10) Opiates, (11) Suboxone, (12) Synthetic, and (0) None. This information is self- reported and comes from the assessment data. For the bivariate analyses, the drug of choice variable is recoded as (0) for Alcohol and (1) for drugs.

Mental Health. As mental health is a serious concern for the veteran population, the intake assessment includes questions about prior treatment for mental health issues. The mental health variable is a dichotomous variable indicating any self-reported prior treatment for mental health issues upon admission to the VTC. The variable is coded (0) for no prior history of mental health treatment and (1) for a prior history of mental health treatment. On the KDCEA assessment tool, respondents were asked "Have you ever been treated as an outpatient for psychological or emotional problems?" and "How many times have you been treated for any psychological or emotional problems in a hospital?" A positive response to the first question and/or a response greater than zero on the second question resulted in the participant being coded as a (1), indicating a history of prior mental health treatment. On the KDCERNA assessment tool, respondents were asked "Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?" and "Have you ever been seen in in a psychiatric emergency room or been hospitalized for psychiatric reasons?" A positive response to ether question resulted in the participant being coded as a (1), indicating a history of prior mental health treatment.

Housing Status. Housing status is a dichotomous variable that captures if the participant was stably housed at the time of admission to the VTC. Stable housing is defined as having your own place (own or rented apartment or house). Not stably housed is defined as staying with others, staying in a halfway house or transitional living, staying in an institution (hospital, prison, or jail) or being homeless (outdoors, in a shelter, or in a car). This information is self-reported and comes from the assessment data. The variable is coded (0) for unstable housing and (1) for stable housing.

Employment Status. Employment status is a dichotomous variable that captures if the participant was employed at the time they entered the VTC. This information is self-reported and comes from the assessment data. The variable is coded (0) for unemployed and (1) for employed.

Independent Variables: During-Program Occurrences. During-program occurrences are defined as the programmatic components of the VTC, such as sanctions, drug screens, judicial interaction, and treatment sessions. These occurrences are the key elements of the VTC program that are a part of every participant's treatment plan, and will be detailed below.

Sanctions (total number). Sanctions are used in the VTC to provide swift accountability for rule infractions, and examples of sanctions used are verbal warnings from the judge, demotion to an earlier phase, jail time, or community service. Although there is not a set limit to the number of sanctions a participant can receive before being terminated from the program, sanctions increase incrementally in magnitude over successive infractions. The sanctions variable is a computed variable that sums the total number of sanctions the participant received while in the program. This information comes from the performance indicator data and was manually calculated and entered into SPSS.

Positive Drug Screens (percent positive). Frequent drug and alcohol testing is a critical component in the VTC to ensure substance use is detected and addressed quickly. Participants must submit regularly to random drug screening that is consistent with their program phase. Based on their current phase, participants can expect drug testing one to three times per week; however, they could be tested more often if deemed necessary by

the VTC team. A judge might order more frequent drug screens if there is specific concern about relapse, especially around celebrations, holidays, and anniversaries of events (both good and bad). Although there is no set number of positive drug screens that would automatically result in termination from the program, positive drug screens are addressed swiftly with incrementally increased sanctions and/or changes to the treatment plan. Judges may choose to increase the number of drug screens per week if a participant has a positive screen. The positive drug screen variable is an interval level variable that is calculated using the number of positive drug screens divided by the total number of screens they submitted while in the program. This information comes from the performance indicator data and was manually calculated and entered into SPSS by the researcher.

Judicial Interaction (per month). Judicial interaction is a core element of the VTC model and reinforces assertions within social control theory about the importance of accountability and rigid structure to promote abstention from criminal behavior. Based on their current program phase, participants must appear in court from one to four times per month. During the court sessions, they interact with the judge who inquires about their progress, makes any needed changes to their treatment plan, and administers any sanctions or rewards. The judicial interaction per month variable (Judge Month) is a continuous variable that is based on the total number of judicial interactions while in the program divided by the number of months in the program. This information comes from the performance indicator data and was manually calculated and entered into SPSS.

Treatment Sessions (per week). While in VTC, participants must attend clinical treatment sessions from two to six hours per week, based on their current phase and their

individual treatment plans. Sessions include individual therapy, group therapy, self-help groups, specialized treatment for substance abuse, traumatic brain injuries (TBI), PTSD, anger, and parenting, as well as other topical groups that may be assigned as deemed necessary by the VTC team. The number of treatment sessions assigned to each participant varies widely, based on an evaluation of his or her individual needs. The treatment sessions per week variable (SessionsWeek) is a continuous variable that is calculated based on the total number of treatment sessions while in the program divided by the number of weeks in the program. This information comes from the performance indicator data and was manually calculated and entered into SPSS.

Data Analysis

The analytic process included descriptive univariate and bivariate analyses. Univariate analyses provide descriptive information for each variable, including frequencies and percentages as applicable. Bivariate analyses examined the relationships between participant characteristics (e.g., age, gender, marital status) and program completion, participant characteristics and criminal recidivism, during-program occurrences (e.g., sanctions, drug screens) and program completion, and during-program occurrences and criminal recidivism. Due to the exploratory nature of this study, p-values of .05 and .10 are highlighted within the analyses, and chi-square will be reported without correction, an approach that is supported in the literature for this type of study (Bender & Lange, 2001; Oleson, Brown, & McCreery, 2019; Rothman, 1990).

Missing Data. The original sample contained 79 participants. Upon examination, the data for 13 participants were removed, as those participants were still active in the VTC at the time the data set was provided to the researcher, and therefore,

one of the primary outcome variables of interest - program completion, could not be examined. Of the remaining 66 participants, there were eight that had significant missing data (more than 50% of the variables of interest did not have responses), and therefore listwise deletion was utilized and they were removed from the sample.

All analyses were completed utilizing the Statistical Package for the Social Sciences (SPSS), version 23 (IBM, 2015).

Chapter Summary

The goal of this chapter was to outline the research methodology used in this study to answer the research questions. First, the research design was described, along with the data collection methods, and the study sample. Next, the variables of interest were detailed and operationalized, and lastly, the analytic plan was highlighted. The next chapter will provide the results of the data analyses.

Chapter 4: Results

In this chapter, the results of the statistical analyses are presented, along with corresponding tables. To review, the primary research questions in this study are: RQ1) Are individual characteristics of the participants (age, gender, race, marital status, combat status, drug of choice, history of mental health issues, housing status, and employment status) associated with VTC program completion?; RQ2) Are individual characteristics of the participants (age, gender, race, marital status, combat status, drug of choice, history of mental health issues, housing status, and employment status) associated with criminal recidivism?; RQ3) Are during-program occurrences (sanctions, drug screens, judicial interaction, and treatment sessions) associated with VTC program completion?; and RQ4) Are during-program occurrences (sanctions, drug screens, judicial interaction, and treatment sessions) associated with criminal recidivism? First, the descriptive statistics for personal characteristics, during-program occurrences, and program outcomes will be detailed. Many of the analyses are presented by county in order to identify any significant differences between the two programs. After presenting the descriptive analyses, bivariate analyses addressing each of the four research questions is delineated.

Descriptive Analyses

Independent Variables. The independent study variables are divided into two categories: participant characteristics and during-program occurrences. Participant characteristics include gender, age, race, marital status, combat status, drug of choice, and history of mental health treatment. During-program occurrences include sanctions, positive drug screens, judicial interactions, and treatment sessions.

Participant Characteristics. Participant characteristics are the individual demographic variables, such as age, gender, and marital status. This information was collected during the participants' initial VTC assessment. As outlined in Table 1, the participants in the study (Total N=58) were predominantly male (89.7%), ages 30-39 (36.2%), white (79.3%), and divorced (36.2%). The participants in Hardin County (n = 22) were predominantly younger with 81.8% being in the 20-39 years of age category, compared to only 50% in the 20-39 years category in Jefferson County (n = 36). Nearly 66% of the total sample reported a history of combat service; however, the percentage was much higher in Hardin County (86.4%) than in Jefferson County (52.8%). Over two-thirds of the participants (67.2%) reported a history of mental health treatment, but mental health treatment was much more likely in Jefferson County (75%) than Hardin County (54.5%). The drug of choice for the majority of the sample was alcohol (34.5%), methamphetamine (22.4%), or heroin (19.0%). Most of the drug categories were similar between the two counties, except for cocaine, which was the drug of choice for 11% of Jefferson County participants and was not the drug of choice for any Hardin County participants. Overall, 82.8% of participants (n=48) reported being stably housed upon admission to the VTC, with 90.9% of Hardin County participants stably housed and only 77.8% of Jefferson County participants stably housed. Upon admission to the VTC, 56.9% of participants (n=33) reported being unemployed. In Hardin County, 50% of participants (n=11) were unemployed, while in Jefferson County, 61.1% of participants (N=22) were unemployed.

During-Program Occurrences. During-program occurrences refer to the components of the program that are standardized from site to site and that are based on

Table 1

Characteristics of VTC Participants in Jefferson and Hardin Counties (N=58)

	Hardin (n=22)	% within Hardin	Jefferson (n=36)	% within Jefferson	Total (n=58)	% of Total
Gender						
Male	19	86.4%	33	91.7%	52	89.7%
Female	3	13.6%	3	8.3%	6	10.3%
Age						
20 - 29 years old	8	36.4%	7	19.4%	15	25.9%
30-39 years old	10	45.5%	11	30.6%	21	36.2%
40-49 years old	3	13.6%	5	13.9%	8	13.8%
50-59 years old	1	4.5%	10	27.8%	11	19.0%
60-69 years old	0	0.0%	3	8.3%	3	5.2%
70 and over	0	0.0%	0	0.0%	0	0.0%
Age (dichotomized)						
20-39 years old	18	81.8%	18	50.0%	36	62.1%
40 - 69 years old	4	18.2%	18	50.0%	22	37.9%
Race / Ethnicity						
White	19	86.4%	27	75.0%	46	79.3%
Black	2	9.1%	7	19.4%	9	15.5%
Hispanic	1	4.5%	0	0.0%	1	1.7%
Asian / Pacific Islander	0	0.0%	2	5.6%	2	3.4%
Race / Ethnicity (dichotomized)						
White	19	86.4%	27	75.0%	46	79.3%
Non-White	3	13.6%	9	25.0%	12	20.7%
Marital Status						
Never Been Married	1	4.5%	1	2.8%	2	3.4%
Single	2	9.1%	8	22.2%	10	17.2%
Married	6	27.3%	8	22.2%	14	24.1%
Separated	6	27.3%	5	13.9%	11	19.0%
Divorced	7	31.8%	14	38.9%	21	36.2%
Marital Status (dichotomized)						
Married	6	27.3%	8	22.2%	14	24.1%
Non-Married	16	72.7%	28	77.8%	44	75.9%
History of Combat Service						
Yes	19	86.4%	19	52.8%	38	65.5%
No	3	13.6%	17	47.2%	20	34.5%
Primary Drug of Choice						
Alcohol	7	31.8%	13	36.1%	20	34.5%
Methamphetamine	5	22.7%	8	22.2%	13	22.4%
Heroin	4	18.2%	7	19.4%	11	19.0%
Opiates	2	9.1%	2	5.6%	4	6.9%
Cocaine	0	0.0%	4	11.1%	4	6.9%
Marijuana	1	4.5%	1	2.8%	2	3.4%
Benzodiazepines	0	0.0%	1	2.8%	1	1.7%
None	3	13.6%	0	0.0%	3	5.2%
Primary Drug of Choice (simplified)						
Alcohol	7	31.8%	13	36.1%	20	34.5%
Drugs	12	54.5%	23	63.9%	35	60.3%
None	3	13.6%	0	0.0%	3	5.2%
Prior Treatment for Mental Health						
Yes	12	54.5%	27	75.0%	39	67.2%
No	10	45.5%	9	25.0%	19	32.8%
Housing Status						
Stably Housed	20	90.9%	28	77.8%	48	82.8%
Not Stably Housed	2	9.1%	8	22.2%	10	17.2%
Employment Status						
Employed	11	50.0%	14	38.9%	25	43.1%
Not Employed	11	50.0%	22	61.1%	33	56.9%

the Key Components of Veterans Treatment Court (Justice for Vets, 2017). This section will examine the during-program occurrences of drug screens, sanctions, judicial interaction, and treatment sessions.

Drug Screens. One primary element of the VTC structure is consistent drug testing throughout the program. Frequent drug testing allows the court team to monitor progress and provide quick intervention when a relapse occurs. Based on their phase within the program, all VTC participants submit to random drug screens from one to three times per week. Table 2 provides descriptive statistics for three categories of during-program occurrences: drug screens, sanctions, and treatment sessions. Jefferson County ordered 4,250 drug screens, an average of 118 per person, with 2.8% of those tests being positive. Hardin County ordered 1,742 drug screens, an average of 79 per person, with 2% of those being positive. While the percentage of all drug screens that resulted in a positive was low, approximately 62% of VTC participants tested positive for drugs or alcohol while in the program (64%, n=14 in Hardin County and 67%, n=24 in Jefferson County).

Sanctions. Another primary element of VTC drug courts is the use of sanctions, a result of Key Component #6 (Justice for Vets, 2017). Sanctions are not intended to be punishments, but rather are used as potential turning points to guide participants through the recovery process. Sanctions are meant to grab the participants' attention and encourage self-reflection about current behaviors that are not conducive to their long-term recovery. Some examples of possible sanctions include warnings from the judge, community service, earlier curfew, or jail time. Hardin County issued 103 sanctions, for

Table 2

Frequencies of During-Program Occurrences

	Hardin (n=22)	%	Jefferson (n=36)	%	Total (n=58)	%
Sanctions						
Additional Assignments	10	9.7%	17	13.0%	27	11.5%
Community Service	6	5.8%	20	15.3%	26	11.1%
Drug Test	2	1.9%	1	0.8%	3	1.3%
Home Incarceration	1	1.0%	4	3.1%	5	2.1%
Incarceration	54	52.4%	67	51.1%	122	51.7%
Increase level of treatment	2	1.9%	7	5.3%	9	3.8%
Phase Demotion	0	0.0%	1	0.8%	1	0.4%
Residential treatment	1	1.0%	1	0.8%	2	0.9%
Additional Self-Help	24	23.3%	13	9.9%	37	15.8%
Warrant	3	2.9%	0	0.0%	3	1.3%
Total	103		131		235	
Average # sanctions per participant	4.7		3.6		4.1	
Drug Testing						
Number of Drug Tests	1,742		4,250		5,992	
Number of Positive Drug Tests	34	2.0%	120	2.8%	154	2.6%
Number of participants who tested	14	64%	24	67%	36	62.1%
Average # of drug tests per participant	79.2		118.1		103.3	
Judicial Interaction						
Number of interactions with Judges	677		1,045		1,722	
Average # judicial interactions per participant	30.8		29.0		29.7	
Sessions Provided						
Aftercare	0	0.0%	28	0.3%	28	0.2%
Ancillary	3	0.1%	9	0.1%	12	0.1%
Enhanced Treatment	0	0.0%	1	0.0%	1	0.0%
Family	0	0.0%	1	0.0%	1	0.0%
Group	684	17.5%	1,923	17.3%	2,607	17.3%
Individual	671	17.2%	1,583	14.2%	2,254	15.0%
Intensive Outpatient	2	0.1%	28	0.3%	30	0.2%
Phone	60	1.5%	166	1.5%	226	1.5%
Self-Help	2,352	60.2%	6,776	60.8%	9,129	60.7%
VA	54	1.4%	424	3.8%	478	3.2%
Wrap-Around	2	0.1%	4	0.0%	6	0.0%
Other	76	1.9%	203	1.8%	279	1.9%
Total	3,904		11,146		15,050	
Average # sessions per participant	177		310		259	
Average months in the VTC	18.8		16.4			
Range of time in VTC (in months)	2 to 41		2 to 36			

an average of 4.7 sanctions per participant. Jefferson County issued 131 sanctions, for an average of 3.6 sanctions per participant. Looking at the sanctions that were utilized in the VTC, incarceration is the modal form of sanction for both counties, with 52.4% (n=54) of sanctions given in Hardin County being incarceration and 51.1% (n=67) of sanctions given in Jefferson County being incarceration. Additional self-help groups (n=37), additional assignments (n=27), and community service (n=26) were also common sanctions used.

Judicial Interaction. Consistent judicial interaction is a key component of the VTC model and the rapport built between the judge and participant is thought to play an important role in the overall outcomes. One element of the VTC that was similar between the two counties was the amount of judicial interaction, with each court providing an average of approximately 30 judicial interactions per participant.

Treatment Sessions. Treatment sessions are the clinical component of the VTC. All VTC participants attend from two to six hours of treatment sessions per week, based on their current phase and their individual treatment plans. Treatment sessions include individual therapy, group therapy, and self-help groups, as well as specialized treatment for substance abuse, traumatic brain injuries (TBI), PTSD, and parenting. Jefferson County's VTC provided 11,146 treatment sessions, an average of 309 per person, while Hardin County provided 3,904 treatment sessions, an average of 177 per person. Despite the participants in these two counties being in their respective programs for similar lengths of time, it is notable that Jefferson County participants were provided approximately 75% more treatment than Hardin County participants in a shorter period of time (average of 18.8 months in Hardin County and average of 16.45 months in Jefferson

County). Between the two sites, a total of 9,128 self-help sessions, 2,607 group sessions, and 2,254 individual sessions were attended during the 4-year grant period.

Outcome Variables. The dependent variables in this study are program completion and criminal recidivism. As outlined in Table 3, 46.6% (n=27) of the participants completed the VTC program. There was no statistically significant difference between program completers and non-completers, based on their county (χ^2 = 0.454; p=.501). In Jefferson County, 50% (n = 18) completed the program compared to 40.9% (n = 9) of participants in Hardin County. Looking at recidivism outcomes, 63.8% (n=37) of participants did not recidivate after entering the VTC program. There was no statistically significant difference between recidivists and non-recidivists, based on their county (χ^2 =0.339; p=.560). In Jefferson County, 33.3% (n=12) recidivated, while 40.9% (n=9) recidivated in Hardin County.

Table 3

Outcome Variables by VTC Location

	Hardin (n=22)	% within Hardin	Jefferson (n=36)	% within Jefferson	Total (n=58)	Total %
Program Completion						
Yes	9	40.9%	18	50.0%	27	46.6%
No	13	59.1%	18	50.0%	31	53.4%
Recidivism						
Yes	9	40.9%	12	33.3%	21	36.2%
No	13	59.1%	24	66.7%	37	63.8%

Answering the Research Questions

Next, the four research questions will be discussed individually and the results of the statistical analyses completed for each one will be delineated.

RQ #1: Do Personal Characteristics Influence Program Completion?

Characteristics of Program Completers versus Non-Completers. In relation to research question one, Table 4 provides a summary of the characteristics of those who completed the VTC program versus those who did not. Highlighting a few trends in the descriptive statistics, it is noted that of the six females in the sample, 83.3% (n=5) completed, compared to 42.3% (n = 22) of males who completed the program. In terms of age, the two greatest discrepancies between completers and non-completers was the 20-29 category, where only 33.3% (n=5) completed the program and ages 60-69 where 66.7% (n = 14) completed the program. The marital status category with the largest percentage of participants was also the group with the largest percentage completing the program (66.7% completing). When looking at history of combat service, 45% of those with a combat history completed the program, while 50% of those with no combat history completed. Data for primary drug of choice was distributed over eight distinct categories (including 3 participants in who did not endorse a drug of choice). With three categories (Alcohol, Methamphetamine, and Heroin) containing approximately 75% (n = 42) of the sample, it is notable that only one (9.1%) participant in the heroin category (n = 11) completed the program. Completion rates for those who did or did not acknowledge prior mental health treatment was similar, 48.7% and 42.1%, respectively. Although the majority of participants (84%) were stably housed, a higher percentage of non-stably housed (55.6%, n = 5) completed compared to stably housed completers (45.8%, n=22).

Table 4

Characteristics of Program Completers and Non-Completers

	Completers (n=27)	% within the IV	Non-Completers (n= 31)	% within the IV	Total (n=58)
Gender					
Male	22	42.3%	30	57.7%	52
Female	5	83.3%	1	16.7%	6
Age					
20 - 29 years old	5	33.3%	10	66.7%	15
30-39 years old	10	47.6%	11	52.4%	21
40-49 years old	4	50.0%	4	50.0%	8
50-59 years old	6	54.5%	5	45.5%	11
60-69 years old	2	66.7%	1	33.3%	3
Race / Ethnicity					
White	20	43.5%	26	56.5%	46
Black	5	55.6%	4	44.4%	9
Hispanic	0	0.0%	1	100.0%	1
Asian / Pacific Islander	2	100.0%	0	0.0%	2
Marital Status					
Never Been Married	0	0.0%	2	100.0%	2
Single	4	40.0%	6	60.0%	10
Married	6	42.9%	8	57.1%	14
Separated	3	27.3%	8	72.7%	11
Divorced	14	66.7%	7	33.3%	21
History of Combat Service					
Yes	17	44.7%	21	55.3%	38
No	10	50.0%	10	50.0%	20
Primary Drug of Choice					
Alcohol	11	55.0%	9	45.0%	20
Methamphetamine	9	69.2%	4	30.8%	13
Heroin	1	9.1%	10	90.9%	11
Opiates	1	25.0%	3	75.0%	4
Cocaine	2	50.0%	2	50.0%	4
Marijuana	0	0.0%	2	100.0%	2
Benzodiazepines	1	100.0%	0	0.0%	1
None	2	66.7%	1	33.3%	3
Prior Treatment for Mental Health					
Yes	19	48.7%	20	51.3%	39
No	8	42.1%	11	57.9%	19
Housing Status					
Stably Housed	22	45.8%	26	54.2%	48
Not Stably Housed	5	50.0%	5	50.0%	10
Employment Status					
Employed	14	56.0%	11	44.0%	25
Not Employed	13	39.4%	20	60.6%	33

Lastly, when considering employment status, non-completers had a higher rate of unemployment upon entry to the VTC (60.6%) than completers (39.4%).

Chi-Square Analysis. Bivariate relationships were examined between each categorical independent variable (gender, age, marital status, race, combat status, drug of choice, and mental health) and the program completion variable. Pearson Chi Square was calculated to determine if there were statistically significant associations between any of the categorical independent variables and the program completion variable (See Table 5). Only one personal characteristic was significantly associated with program completion, with female veterans being more likely to complete the program than male veterans ($p = .056$). Although significant (at $p > .10$), this finding should be considered carefully in light of the exploratory nature of this study and the small number of females in the sample.

RQ #2: Do Personal Characteristics Influence Criminal Recidivism?

Characteristics of Recidivists versus Non-Recidivists. In relation to research question 2, Table 6 provides a summary of the characteristics of those who recidivated after entering the VTC and those who did not. Highlighting a few of the trends in the descriptive statistics, it is noted that 63.8% of the sample (n=37) did not recidivate after entering the VTC program. In Hardin County, 59.1% (n=13) did not recidivate, while 66.7% (n=24) of those in Jefferson County did not recidivate. There were six females in the sample, and 83.3% of the females (n=5) did not recidivate, compared to 61.5% (n=32) of the male participants. In terms of age, the greatest discrepancy between recidivists and non-recidivists was the 20-29 age category, where 66.7% (n=10)

Table 5

Prevalence of Program Completion based on Participant Characteristics

	Completed (n=27)		Not Completed (n=31)					
	n	% within completed	n	% within non-completed	χ^2	OR	95% CI	*p*
Gender								
Males	22	81.5%	30	96.8%	3.639	6.818	[0.743, 62.551]	0.056
Females	5	18.5%	1	3.2%				
Age								
Ages 20-39	12	44.4%	10	32.3%	0.910	0.595	[0.204, 1.734]	0.340
Ages 40-69	15	55.6%	21	67.7%				
Race								
White	20	74.1%	26	83.9%	0.844	1.820	[0.502, 6.593]	0.358
Non-White	7	25.9%	5	16.1%				
Marital Status								
Married	6	22.2%	8	25.8%	0.101	1.217	[0.362, 4.093]	0.750
Non-married	21	77.8%	23	74.2%				
Combat Status								
Has been in combat	17	63.0%	21	67.7%	0.146	0.810	[0.274, 2.396]	0.702
Never in combat	10	37.0%	10	32.3%				
Drug of Choice								
Alcohol	11	40.7%	9	29.0%	1.665			0.435
Drugs	14	51.9%	21	67.7%				
None	2	7.4%	1	3.2%				
History of Mental Health Treatment								
No Prior Treatment	8	29.6%	11	35.5%	0.225	1.306	[0.432, 3.949]	0.636
Prior Treatment	19	70.4%	20	64.5%				
Housing Status								
Stably Housed	22	81.5%	26	83.9%	.058	0.846	[0.216, 3.308]	.810
Not Stably Housed	5	18.5%	5	16.1%				
Employment Status								
Employed	14	51.9%	11	35.5%	1.576	1.958	[0.682, 5.619]	0.209
Not Employed	13	48.1%	20	64.5%				

recidivated, while in all other age categories, the majority of participants did not recidivate. In the marital status category, there is not much variance between the recidivists and the non-recidivists, except in the divorced category, where 90.5% of divorced participants (n=19) did not recidivate. Among those with a history of combat (n=38), 63.2% did not recidivate and among those who reported having prior mental health treatment (n=39), 66.7% did not recidivate. In the stable housing category, 70.8% (n=34) of those who were stably housed were non-recidivists, while only 22.2% (n=2) of those who were unstably housed were non-recidivists. Lastly, among those who were employed at the time of entry into the VTC (n=25), 60% (n=15) recidivated.

Table 6

Characteristics of Recidivists and Non-Recidivists

	Non-Recidivists (n=37)	% within IV	Recidivists (n=21)	% within IV	Total (n=58)
VTC Location					
Hardin	13	59.1%	9	40.9%	22
Jefferson	24	66.7%	12	33.3%	36
Gender					
Male	32	61.5%	20	38.5%	52
Female	5	83.3%	1	16.7%	6
Age					
20 - 29 years old	5	33.3%	10	66.7%	15
30-39 years old	13	61.9%	8	38.1%	21
40-49 years old	7	87.5%	1	12.5%	8
50-59 years old	9	81.8%	2	18.2%	11
60-69 years old	3	100.0%	0	0.0%	3
Race / Ethnicity					
White	31	67.4%	15	32.6%	46
Black	5	55.6%	4	44.4%	9
Hispanic	0	0.0%	1	100.0%	1
Asian / Pacific Islander	1	50.0%	1	50.0%	2
Marital Status					
Never Been Married	1	50.0%	1	50.0%	2
Single	4	40.0%	6	60.0%	10
Married	9	64.3%	5	35.7%	14
Seperated	4	36.4%	7	63.6%	11
Divorced	19	90.5%	2	9.5%	21
History of Combat Service					
Yes	24	63.2%	14	36.8%	38
No	13	65.0%	7	35.0%	20
Primary Drug of Choice					
Alcohol	13	65.0%	7	35.0%	20
Methamphetamine	9	69.2%	4	30.8%	13
Heroin	7	63.6%	4	36.4%	11
Opiates	2	50.0%	2	50.0%	4
Cocaine	2	50.0%	2	50.0%	4
Marijuana	0	0.0%	2	100.0%	2
Benzodiazepines	1	100.0%	0	0.0%	1
None	3	100.0%	0	0.0%	3
Prior Treatment for Mental Health					
Yes	26	66.7%	13	33.3%	39
No	11	57.9%	8	42.1%	19
Housing Status					
Stably Housed	34	70.8%	14	29.2%	48
Not Stably Housed	2	22.2%	7	77.8%	9
Employment Status					
Employed	15	60.0%	10	40.0%	25
Not Employed	22	66.7%	11	33.3%	33

Chi-Square Analysis. Next, bivariate relationships were examined between individual characteristics (gender, age, marital status, race, combat status, drug of choice, and mental health) and the recidivism variable (See Table 7). Two independent variables had a statistically significant association with recidivism: Age and housing status. Specifically, younger participants (p = .005), and those who are unstably housed (p=0.016) are more likely to recidivate.

Table 7

Prevalence of Criminal Recidivism based on Participant Characteristics

	Non-Recidivists (n=37)		Recidivists (n=21)					
	n	% within non-recidivists	n	% within recidivists	χ2	OR	95% CI	*p*
Gender								
Males	32	86.5%	20	95.2%	1.106	0.320	[0.035, 2.942]	0.293
Females	5	13.5%	1	4.8%				
Age								
Ages 20-39	19	51.4%	3	14.3%	7.817	6.333	[1.590, 25.221]	**0.005**
Ages 40-69	18	48.6%	18	85.7%				
Race								
White	31	83.8%	15	71.4%	1.246	2.067	[0.570, 7.497]	0.264
Non-White	6	16.2%	6	28.6%				
Marital Status								
Married	9	24.3%	5	23.8%	0.002	1.029	0.294, 3.604]	0.965
Non-married	28	75.7%	16	76.2%				
Combat Status								
Has been in combat	24	64.9%	14	66.7%	0.019	1.083	[0.350, 3.356]	0.890
Never in combat	13	35.1%	17	81.0%				
Drug of Choice								
Alcohol	13	35.1%	7	33.3%	1.933			0.380
Drugs	21	56.8%	14	66.7%				
None	3	8.1%	0	0.0%				
History of Mental Health Treatment								
No Prior Treatment	11	29.7%	8	38.1%	0.426	0.688	[0.223, 2.124]	0.514
Prior Treatment	26	70.3%	3	14.3%				
Housing Status								
Stably Housed	34	91.9%	14	66.7%	5.974	0.176	[0.040, 0.782]	**0.015**
Not Stably Housed	3	8.1%	7	33.3%				
Employment Status								
Employed	15	40.5%	10	47.6%	0.274	1.333	[0.453, 3.922]	0.601
Not Employed	22	59.5%	11	52.4%				

RQ #3: Do During-Program Occurrences Influence Program Completion?

T-tests were run to examine the relationships between each continuous independent variable (sanctions, drug screen, judicial interaction and treatment sessions) and the program completion variable. These findings are delineated in Table 8.

An independent samples t-test was conducted to compare the number of sanctions between completers and non-completers. There was a significant difference in the number of sanctions between completers (M=2.00, SD=3.126) and non-completers (M=5.810, SD=7.631; t (56) =2.419, p = .019). The magnitude of the differences in the means (mean difference = 3.806, 95% CI: .654 to 6.959) was medium to large (d=.653).

An independent samples t-test was conducted to compare the percent of positive drugs screens between completers and non-completers. There was a significant difference in the percentage of positive drug screens between completers (M=1.606, SD=2.679) and non-completers (M=8.754, SD=14.448, t (32.358) =2.702, p = .011). The magnitude of the differences in the means (mean difference = 7.148, 95% CI: 1.761 to 12.534) was medium to large (d=.688).

An independent samples t-test was conducted to compare the number of judicial interactions per month between completers and non-completers. There was not a significant difference in the number of judicial interactions per month between completers (M=1.773, SD=0.629) and non-completers (M=1.858, SD=0.955; t (52.309) =0.404, p=.688). The magnitude of the differences in the means (mean difference = .0849, 95% CI: -0.337 to 0.506) was very small (d= 0.104).

Finally, an independent samples t-test was conducted to compare the number of treatment sessions per week between completers and non-completers. There was a

Table 8

Group Differences for Sanctions, Drug Screens, Judicial Interactions, and Treatment Sessions between Program Completers and Non-Completers

	Completers (n=27)		Non-Completers (n=31)				
Variables	M	SD	M	SD	t(x)	*p*	Cohen's d
Sanctions (total)	2.000	3.126	5.810	7.631	2.419	0.019	0.653
Drug Screens (% positive)	1.606	2.679	8.754	14.447	2.702	0.011	0.688
Judicial Interactions(per month)	1.773	0.629	1.858	0.956	52.309	0.688	0.104
Sessions (per week)	3.916	1.614	2.711	2.037	55.540	0.015	0.655

significant difference in the number of treatment sessions per week between completers (*M*=3.916, *SD*=1.614) and non-completers (*M*=2.711, *SD*=2.037; *t* (55.54) =-2.510, *p=.015*). The magnitude of the differences in the means (mean difference = -1.205, 95% *CI*: -2.167 to -0.243) was medium to large (*d*=0.655).

RQ #4: Do During-Program Occurrences Influence Criminal Recidivism?

To address the final research question, t-tests were run to examine the relationships between each continuous independent variable (sanctions, drug screen, judicial interaction, and treatment sessions) and the criminal recidivism variable (See Table 9).

An independent samples t-test was conducted to compare the number of sanctions between non-recidivists and recidivists. There was no significant difference in the number of sanctions between non-recidivists (*M*=3.380, *SD*=7.166) and recidivists (*M*=5.190, *SD*=3.983; *t* (56) =-1.066, *p*=.291). The magnitude of the differences in the means (mean difference = -1.812, 95% *CI*: -5.216 to 1.592) was small to medium (*d*=.312).

Table 9

Group Differences for Sanctions, Drug Screens, Judicial Interactions, and Sessions between Non-Recidivists and Recidivists

	Non-Recidivists (n=37)		Recidivists (n=21)				
Variables	M	SD	M	SD	t(x)	*p*	Cohen's d
Sanctions (total)	3.380	7.166	5.190	3.983	-1.066	0.291	0.312
Drug Screens (% positive)	3.975	9.653	7.985	13.447	-1.316	0.194	0.343
Judicial Interactions(per month)	1.839	0.883	1.781	0.697	0.258	0.798	0.073
Sessions (per week)	3.510	2.073	2.853	1.625	1.249	0.217	0.353

An independent samples t-test was conducted to compare the percent of positive drugs screens between non-recidivists and recidivists. There was no significant difference in the percentage of positive drug screens between non-recidivists (*M*=3.975, *SD*=9.653) and recidivists (*M*=7.985, *SD*=13.447; *t* (56) =-1.316, *p*=.194). The magnitude of the differences in the means (mean difference = -4.010, 95% *CI*: -10.116 to 2.096) was small to medium (*d*=.343).

An independent samples t-test was conducted to compare the number of judicial interactions per month between non-recidivists and recidivists. There was no significant difference in the number of judicial interactions per month between non-recidivists (*M*=1.839, *SD*=0.883) and recidivists (*M*=1.781, *SD*=0.697; *t* (56) = 0.258, *p*=0.798). The magnitude of the differences in the means (mean difference = 0.058, 95% *CI*: -0.392 to 0.507) was extremely small (*d*=0.073).

An independent samples t-test was conducted to compare the number of treatment sessions per week between non-recidivists and recidivists. There was no significant difference in the number of treatment sessions between non-recidivists (*M*=3.510, *SD*=2.073) and recidivists (*M*=2.853, *SD*=1.625; *t* (56) =1.249, *p*=.0.217). The

magnitude of the differences in the means (mean difference = 0.657, 95% *CI*: -0.397 to 1.710) was extremely small (*d*=0.353).

Program Completion and Criminal Recidivism

This exploratory study focused on addressing four identified research questions related to predictors of program completion and criminal recidivism among participants in two Kentucky VTCs. The bivariate analyses found gender, sanctions, drug screens, and treatment sessions were all significantly associated with program completion, and age and housing status were associated with recidivism. While sample size precluded a more in-depth analysis, a preliminary exploration of the association between program completion and criminal recidivism was conducted. This decision was guided by the recognition that if emphasis is going to be placed on whether or not a participant completes the program, it should be because the data indicates that program completion is actually important for reducing recidivism. An examination of the bivariate relationship between program completion and criminal recidivism found a statistically significant association (p=.039) (See Table 10). With reduced recidivism as one of the program's primary goals, it was a promising outcome that 77.7% (n=21) of those who completed the program did not recidivate. However, it is interesting that six individuals who recidivated, still completed the program.

Table 10

Prevalence of Criminal Recidivism based on Program Completion

	Non-Recidivists (n=37)		Recidivists (n=21)			
	n	% wtihin IV	n	% within IV	$\chi 2$ (1)	*p*
Completed Program	21	77.8	6	22.2	4.277	0.039
Did Not Complete	16	51.6	15	48.4		

Participants who Completed and Recidivated

Out of the bivariate analyses emerged one interesting group of participants, and those are the six individuals who completed the program and recidivated. These six warranted a further examination, as it might be helpful to understand how they persisted to program completion, despite having a legal setback during the program (See Table 11). The six were primarily from Jefferson County (83.3%), between 20 and 40 years of age, male, (83.3%), white (66.6%), non-married (83.3%), had experienced combat (66.6%), had a history of mental health treatment (83.3%), and identified their drug of choice as methamphetamine (50%). Among the six, 50% were stably housed and 50% were employed upon admission to the VTC.

The length of time these participants were in the program ranged from 19 months to 25 months, with the mean time being 23 months. These participants attended an average of 520 treatment sessions each, which is over twice the average of number attended by the full sample (259). On average, they had 43 judicial interactions, which is higher than the average of 29.7 for the full sample. These participants had an average of 2.3% positive drug screens, with a range from 0% to 8%. This is in line with the remainder of the sample, whose average is 2.6%. Lastly, these participants received an average of six sanctions, with a range from two to 16. The average for the full sample was 7.4 sanctions. The convictions that accounted for their recidivism were primarily misdemeanors (83.3%) that ranged from alcohol-related misdemeanors (n=2), property crimes (n=1), and "other" misdemeanors (n=2). One of these participants was convicted of felony drug trafficking. One element of the program that these participants all have in common is that they all received a jail sanction at least once during their program. The

number of incarceration sanctions these participants received ranged from one to eight, with the average being 3.2, which is higher than the full sample average of 2.1. The length of incarceration ranged from one day to 14 days, with the average time being four days. This seems to indicate that while rehabilitation is the long-term goal of VTC, as opposed to incarceration, short-term jail time can serve as a necessary impetus or "turning point" moment to get some participants back on track.

Summary of Findings

The findings of this study indicate that gender, sanctions, drug screens, and treatment sessions each have a significant association with program completion, and both age and housing status have a significant association with recidivism. Additionally, program completion has a significant association with recidivism. Each of these findings and their respective implications will be discussed in further detail in the following chapter.

Table 11

Characteristics of the Participants who Completed and Recidivated (n=6)

	n	%
Location		
Hardin	1	16.7%
Jefferson	5	83.3%
Gender		
Male	5	83.3%
Female	1	16.7%
Age		
20 - 39 years old	6	100.0%
40-69 years old	0	0.0%
Race		
White	4	66.7%
Non-White	2	33.3%
Marital Status		
Married	1	16.7%
Non-Married	5	83.3%
History of Combat Service		
Yes	4	66.7%
No	2	33.3%
Prior Treatment for Mental Health		
Yes	5	83.3%
No	1	16.7%
Primary Drug of Choice		
Alcohol	2	33.3%
Drugs	4	66.7%
None	0	0.0%
Housing Status		
Stably Housed	3	50.0%
Not Stably Housed	3	50.0%
Employment Status		
Employed	3	50.0%
Not Employed	3	50.0%

Chapter 5: Discussion

The primary goal of this exploratory study was to examine relationships between veterans' treatment court program participant characteristics, during-program occurrences and two program outcomes -- program completion and criminal recidivism. As VTCs are a relatively new iteration of the growing specialty court system, there is a lack of empirical evidence supporting the contention that VTCs are effective in reducing criminal recidivism. Despite the small sample size, the findings are important and relevant to the broader conversation about how to best address the needs of justice-involved veterans facing the challenges of transitioning to civilian life. Aside from providing demographic information about the VTC program participants, the results indicate some key relationships between participant characteristics, during-program occurrences, and outcomes that will be delineated in the following sections. As reducing recidivism is such a primary outcome of interest from the VTC, it will be discussed first.

Reducing Recidivism

Reducing criminal recidivism is one of the primary goals of the VTC. In the Kentucky sample, approximately 36% of the participants recidivated after entering the VTC, which is over twice the average from a recent national VTC sample, where only 14% of participants experienced new incarcerations after entering the program (Tsai, 2018). Due to inconsistencies in the operationalization of recidivism in many studies, it is important to note that the national study defined recidivism in the same way as the current study: any new arrest or incarceration that occurred after entering the VTC. According to the Bureau of Justice, the average 1-year recidivism rate for civilian prisoners (not involved in a treatment court program) is 56.7% (2019). This indicates

that although the Kentucky sample recidivated at a higher level than the national VTC sample, they did recidivate at a lower rate than civilians who go to jail and receive no treatment.

Comparing the Kentucky VTC Sample to the National VTC Survey Findings

Although there are relatively few empirical studies of VTCs examining outcomes and possible predictors, there is one recent national study that can provide relevant context for consideration of the findings of this study. The national study contains the data from 7,931 veterans in the Veterans Justice Outreach (VJO) programs throughout 115 VA sites (Tsai et al., 2018). VJO specialists are team members within the VTC program, and they collect and maintain their own database of information about justice-involved veterans enrolled in VTC programs. VJO specialists conduct their own in-person assessment, separate from the one completed by the VTC program coordinator. They collect information on a variety of sociodemographic characteristics, in addition to military service history, as well as physical and mental health information (Tsai et al., 2018). This VJO data is stored in the VA's Homeless Operations Management and Evaluation System (HOMES). The data for the national survey were extracted from the HOMES in a point-in-time snapshot, and included all veterans who entered the VJO system from 2011 through 2015, who were enrolled in a VTC, and who had exited the VTC at the time of the data extraction (Tsai et al., 2018). Considering the time frame of the data collection for the national sample coincides with the timeframe of the Kentucky sample, there is likely some overlap of data.

When considering the similarities and differences between the national sample and the Kentucky sample, it is important to remember that the participants in the national

sample come from a variety of VTCs that all have their own set of criteria for admission, which could vary from the admissions criteria in Kentucky. In Kentucky, the VTC accepts both combat and non-combat veterans, and they accept veterans with felony and misdemeanor charges, excluding violent felonies and sexual offenses. The participant must have served in the U.S. military with an honorable or general discharge and must have a diagnosed substance use disorder or mental health disorder (Shannon, 2016).

Upon examining the demographic statistics, there are several interesting distinctions to point out between the national survey of VTCs and the current sample that provide some insight about how the Kentucky sample may differ from the national sample. First, the national sample was 94.8% male, while the Kentucky sample was 89.7% male. The overall veteran population in the country is about 91% male and 9% female (United States Department of Veterans Affairs, 2019c).

The national sample of VTC participants was more racially diverse, with 65.7% being white, while 79.3% of the Kentucky sample was white. This difference is not surprising, as 87.8 % of the state's population is white, while only 8.4% are black, and 3.7% are Hispanic. What is noteworthy though, is that while black individuals only make up 11.9% of the total veteran population in the country (United States Department of Veterans Affairs, 2019c), 26% of the VTC participants in the national study were black, indicating a significant overrepresentation of black veterans in the criminal justice system. Research has consistently shown disparities in the criminal justice system based on race and black individuals are jailed at higher rates and for longer periods of time than their white counterparts (Alexander, 2012; American Civil Liberties Union, 2014; Nellis, 2016; Starr & Rehavi, 2014; The Sentencing Project, 2018; United States Sentencing

Commission, 2017). This intersectionality is concerning because while their military service may predispose them to criminal issues related to mental health and substance use, their minority status may unfairly work to increase the likelihood that those issues will lead to incarceration.

In the Kentucky sample, 65.5% reported a history of combat, much higher than the reported 47% in the national sample. Considering the preponderance of research that points to the negative mental health and substance use outcomes associated with combat (e.g. Hoge et al., 2004; Kang, Natelson, Mahan, Lee, & Murphy, 2003; Kessler, Prigerson, Maciejewski, & Rosenheck, 2001, 2002; Smith et al., 2008; Toomey et al., 2007), it would not be surprising that in a sample that includes nearly 20% more combat veterans, the outcomes would be poorer. However, while the overall Kentucky sample recidivated at a much higher rate than the national sample, it is notable that in the Kentucky sample there was not a significant difference in recidivism between those who had combat history and those who did not. Therefore, it would seem that among Kentucky VTC-involved veterans, other factors contribute to the likelihood of recidivism more than combat history. One of those possible factors could be the high rates of substance abuse within the state, which will be detailed next.

Lastly, the national sample predominantly reported their primary substance to be alcohol (55%), with drugs being secondary (38%). Conversely, the Kentucky sample reported drugs as the primary issue (60%) and alcohol secondary (35%). This disparate rate of drug use in Kentucky when compared to the national average is likely attributed to the drug epidemic plaguing the state, resulting in opioid-related deaths at the rate of 23 per 100,000 persons, double the national rate (National Institutes of Health, 2018).

Jefferson County has the highest number of heroin-related deaths in the state, totaling 426 deaths in 2017, tripling the rate of the next highest county (Kentucky Office of Drug Control Policy, 2019). Prescription painkillers are also still a serious issue for Kentucky, with over 250 million doses prescribed in 2018 (Kentucky Office of Drug Control Policy, 2019). Finally, methamphetamine use persists in the state, and although measures have been implemented to reduce the manufacturing of methamphetamines, throughout Kentucky there has been a rise in the use of methamphetamines produced in Mexico and South America (Kentucky Office of Drug Control Policy, 2019). In a recent Substance Abuse and Mental Health Services Administration (SAMHSA) one-day count of Kentuckians in substance abuse treatment, 44.1% reported having a drug problem only, 18.2% reported having an alcohol problem only, and 37.7% reported having both alcohol and drug use issues (2017). Due to the addictive properties of these drugs and the physiological changes the drugs make in the brain that perpetuate the chronic, relapsing nature of substance use disorders (Doweiko, 2019), it is not surprising that there are poorer outcomes among samples comprised predominantly of drug users.

Personal Characteristics Associated with Program Completion

The first study research question focused on the relationships between personal characteristics and program completion. Based on a series of bivariate analyses, only one significant association was identified – female participants were more likely to complete the program than male participants. Although this is a small total sample including a small number of females, this is an interesting finding because prior research findings about the relationship between program completion (drug court and VTC) and gender has be inconsistent and inconclusive at this point. For instance, one nationwide study of drug

courts indicated that women graduate at lower rates (39%) than the overall completion rates for drug court (58%) (Marlowe, Hardin, & Fox, 2016). In studies of Kentucky's drug courts, women have graduated at rates of approximately 35-40% (Marlowe, Hardin, & Fox, 2016; Shannon, Jackson Jones, Perkins, Newell, & Neal, 2016; Shannon, Jackson Jones, Perkins, Newell, & Payne, 2018), so although this study included a small number of females, the results are promising. This would be an interesting topic for future research – to examine the association between gender and program completion with a larger sample to see if the results are similar, and to consider how military service might influence a female's interaction with the criminal justice system. The national sample that is being used for comparative purposes did not use program completion as an outcome variable (their outcome variables were related to housing, employment, income, and recidivism); therefore, further comparisons between that sample and the current study in regards to program completion are not possible.

Personal Characteristics Associated with Criminal Recidivism

The data in the current study indicated that there is a significant association between recidivism and age. Among those in the 20-39 age category, 50% recidivated. However, among the 40-69 age category, only 13.6% (n=3) recidivated. These findings are consistent with the recent national study, where older participants were less likely to recidivate (Tsai, 2018). The mean age in the national sample was 44, while the mean age in the Kentucky sample was 39 (33 in Hardin County, 42 in Jefferson County). In the national veteran population, 20-39 year olds only account for 14.4% of veterans, while in the study sample, 20-39 year olds make up over half of the study sample (62.1%). Conversely, veterans aged 70 and over make up 32.7% of the national veteran population,

while there are zero veterans in that age category in the study sample. These findings are all supported by social control theory and overwhelming criminological literature showing a significant correlation between age and crime, whereas criminal behavior tends to peak in the late teen years and gradually decrease over time (Farrington 1986; Braithwaite 1989; Hirschi and Gottfredson 1983; Moffitt 1993; Piquero, Farrington, & Blumstein, 2003). This indicates that VTCs need consider younger veterans to be higher risk for recidivism and implement additional services and supports to help counterbalance that risk.

In the national study risk of recidivism was significantly associated with level of education, housing status, and employment status. Specifically, those with higher levels of education, those who had stable housing upon admission to the VTC, and those who were employed upon admission to the VTC were all less likely to recidivate (Tsai, 2018). In line with the national sample, in the Kentucky sample, there was a significant association between stable housing and recidivism, with those who were in stable housing upon admission to the program being less likely to recidivate. Conversely, in the Kentucky sample, employment status upon VTC entry was not significantly associated with recidivism. Lastly, the Kentucky sample did not collect level of education in a similar format as the national sample. Rather, the data set has a variable that captures whether or not the participants' educational status improved while they were in the VTC, and this variable is not significantly associated with recidivism.

During-Program Occurrences Associated with Program Completion

The third research question in the current study focused on the relationships between during-program occurrences and program completion and the analyses found

that sanctions, drug screens, and treatment sessions were all associated with program completion. Those participants who had fewer sanctions, fewer positive drug screens, and more treatment sessions were more likely to complete the program. All of these results are intuitive and as would be expected, which begs the question – how is this helpful information? It is useful information for future program planning and evaluation, as program administrators could examine their current practices and look for ways in which to better intervene when participants derail from their course of treatment. VTCs do currently have policies in place to demote participants to a lower phase when they have multiple infractions, but in light of this information, they could examine more closely if phase demotions are effective, and if not, what treatments are evidence-based for addressing these specific rule-breaking behaviors. These participants – the ones who have more positive drug tests and who experience the most sanctions (sometimes due to their positive drug screens) are in need of escalated intervention from the treatment team in order to increase their likelihood of completing the program, but VTCs will need to be flexible and responsive to each participant's individual treatment needs.

Program Completion is Significant to Reducing Recidivism

Although not a central focus of this current study, a preliminary examination of the intersection between program completion and criminal recidivism was conducted. It is noteworthy to report that program completion had a significant association with criminal recidivism in the Kentucky sample, with nearly three out of four (71.4%) recidivists not completing the treatment program. This finding is consistent with Tsai's recent study of all VTCs, where program completion was significantly associated with reduced recidivism (2018).

Implications for Practice

As this was primarily an exploratory descriptive study, the practice implications are limited. However, there are some findings within the data that merit further discussion as possible implications for practice and research. The primary practice implication for this study is that the findings inform us about what influences success in veterans' treatment courts in Kentucky, as defined by completing the program and/or not recidivating. This study found that age was significantly associated with recidivism, with younger participants being more likely to recidivate. This indicates that measures need to be implemented within VTCs to recognize and counteract this additional risk associated with younger age. Although this current study was not able to look at the role of peer mentors within the program, other studies have found that the peer/mentor bond is significant to the treatment process (Slattery et al., 2013). Younger veterans likely could benefit from a strong mentor relationship, and getting younger participants connected to the mentor program quickly upon entry into the VTC could be vital.

This study found that housing status upon entry to the VTC was significantly associated with recidivism, with those who are unstably housed being more like to recidivate. Prior research in drug courts has indicated that unstable housing can negatively impact the participant's outcomes in the program (Wolf & Colyer, 2001). This is a demographic factor that is easy to assess upon entry to the VTC and underscores the need to implement measures to offset this risk factor quickly upon their entry in the program by connecting the participant to resources and/or programs that can facilitate their transition to stable housing.

This study found, and other studies agree, that program completion is essential and is significantly associated with criminal recidivism. Participating in a VTC has been found to improve overall functioning and particularly social connection (Knudsen & Wingenfeld, 2015), a key element of social control theory. VTC participation provides veterans with rigorous accountability, and continuous treatment in a setting that honors and encourages community and brotherhood. As these are important elements to helping veterans reintegrate into civilian life and away from the criminal justice system, these findings suggest that program completion plays a meaningful role in assuring participants receive the full benefits available. Therefore, program administrators should work to quickly identify any potential barriers that may prevent veterans from persisting through the program and staying in treatment. Although relapse is likely a cause for dropping out and/or being terminated from the program, there are many other psychosocial factors that could result in a veteran not completing the program. These include financial strains, employment/scheduling conflicts, health issues, and family responsibilities, to name a few, all of which could be represented as predisposing and/or enabling factors in the Andersen-Newman Healthcare Utilization Model. Future research could aim to pinpoint reasons for program termination that are not drug/alcohol related, and then VTCs can strive to provide programmatic solutions that will decrease attrition.

One suggestion for future policy change consideration is in regards to eligibility criteria of the VTC. To be eligible for the VTC in Kentucky, the veteran has to have completed his/her service or be honorably discharged. Therefore, it is likely that a veteran who develops a substance use disorder while in the service that leads to criminal behavior and/or dishonorable discharge, will not be eligible for the VTC – the exact

services they need. After reviewing the VTC literature and the program requirements in Kentucky, one concern is that court administrators may not have a full understanding of the various types of military discharge. When talking about the eligibility requirements of the VTC, most of the current literature refers to discharge status as a dichotomy – honorable discharge and dishonorable discharge, when in fact, there are five types of military discharge. There are three types of administrative discharge: Honorable Discharge, General Discharge (under honorable conditions), and Other Than Honorable Discharge. There are two types of punitive discharges: Bad conduct discharge and dishonorable discharge (United States Department of Veterans Affairs, 2019b). Therefore, it is important for VTCs to understand the differences in discharge status and to be clear in the language they use regarding how discharge status impacts eligibility for VTC services in order to prevent eligible veterans from being inadvertently disqualified.

Additionally, another eligibility requirement is that the crime that brings them into court must be a non-violent offense, although the literature indicates that both substance abuse and PTSD increase the likelihood of a violent offense by a veteran that could result in them having contact with the criminal justice system (Elbogen et al., 2012; McCormick-Goodhart, 2013; Larson & Norman, 2014). This represents a gap in services for those veterans who could likely benefit the most from the intervention and treatment. The social work profession's stance concerning valuing the inherent dignity and worth of all people would support consideration of providing access to the VTC program to all veterans. Providing this service could benefit the veteran and potentially address the underlying mental health and/or substance abuse issues that less to their less than honorable discharge.

Suggestions for Future Research

As stated previously, the VTCs are relatively new and research is limited, so there are many avenues that could be taken when examining VTCs in the future. First, the usefulness of the healthcare utilization model will be discussed and how future studies could more effectively utilize the model as a guide. Then, some specific research questions for future examination will be presented.

Utility of the Andersen-Newman Healthcare Utilization Model. The Andersen-Newman Healthcare Utilization Model is a framework that can be used to explain factors that influence people's decision-making related to accessing available healthcare treatment. This framework is useful when thinking about VTCs, as the VTC provides a service and participants can choose to enter or not enter the program. Even among those who choose to enter the program, not all choose to continue in the program, for a variety of reasons. Therefore, they are choosing not to access services available to them. The model helps to explain possible reasons why a person would not utilize healthcare services that they need.

Central to the model are three sets of predictive factors: predisposing factors, enabling factors, and need factors (Andersen, 1995). Predisposing factors are the personal characteristics of individuals that precede their current illness, but which might influence their likelihood to seek healthcare services (Aday & Andersen, 1974; Leukefeld, Logan, Martin, Purvis, & Farabee, 1998). In the current study, the predisposing factors are operationalized in the gender, age, race, marital status, combat status and history of mental health treatment variables. The predisposing factors of age and gender were both associated with outcomes in this study. Age was a significant

predictor of recidivism and gender was a significant predictor of program completion. The model indicates that age is a predisposing factor and prior criminological research supports the finding that age is a strong predictor of recidivism, with older participants being less likely to recidivate (Farrington 1986; Braithwaite 1989; Hirschi and Gottfredson 1983; Moffitt 1993; Piquero, Farrington, & Blumstein, 2003). The model also indicates that gender is a predisposing factor and although the model doesn't make assertions about which gender is more likely to utilize healthcare, prior research within drug courts and VTCs has indicated that males complete the program at a higher rate than females (Marlowe, Hardin, & Fox, 2016). However, this current sample is the reverse, indicating that the participants in Kentucky were somehow different than participants in other studies.

Need factors refer to the individual's own perceived need for treatment, along with the need for treatment, as assessed by professionals. In the current study, all participants were assessed by a VTC professional and deemed eligible and in need of treatment, therefore the variable acts as a constant. Future research in the VTC could utilize the assessment to ascertain more details about participants' own perceived need for treatment, in order to further examine how need factors play a role in program completion and recidivism.

Lastly, in addition to predisposing and need factors, there are also enabling factors that support or encumber a person's use of healthcare services. Enabling factors are often operationalized as income, health insurance, access to healthcare, and knowledge of available healthcare resources. Enabling factors such as income and health insurance were not collected consistently in the data set, and therefore were not used in this study.

In this current study, the healthcare utilization model did not provide a clear set of factors for predicting if a veteran would complete the program. However, it remains a useful framework for thinking about all of the personal and environmental factors that go into a person's decision to seek care. Future researchers could work to collect data that more closely matches the predisposing factors, needs factors, and enabling factors identified in the model, in order to further test the utility of the model in this setting with this population.

Future Research Questions. Using this study of the Kentucky VTCs as a starting point, there is valuable research that can be done in the future, as the VTCs continue to grow. Future studies could ask important research questions that are significant to the veteran population and some suggestions for those will be highlighted below.

One of the limitations of this current study involved the changes made to the assessment form during the data collection process, resulting in some variables of interest not being included in the analyses. The KDCERNA is the assessment tool now being used by the Kentucky VTC, and with the consistent use of this new form, future research could include many important variables that were precluded from this current study, such as recidivism risk scores, social risk scores, PTSD, ASI scores, and suicidality.

Recidivism Risk and Social Risk Scores. On the KDCERNA, there are scales for assessing recidivism risk and social risk upon entry to the VTC. The scales includes questions about prior criminal history, employment, education, housing stability and neighborhood environment, drug and alcohol use, and social support. Participants are scored and categorized for both recidivism risk and social risk as low risk, medium risk,

or high risk based on their answers to these questions. In future research, these risk scores could be examined to determine if they are valid measurements and if they are significantly associated with actual recidivism. These findings could lead to changes in practice, as those who are identified early as high risk could receive additional resources and supports.

Post-Traumatic Stress Disorder. As PTSD is such a critical issue for veterans, it is important for future research in the Kentucky VTCs to examine the PTSD variable and its possible association with program completion and criminal recidivism. PTSD is an issue within the military community that warrants further research and exploration, as the symptoms associated with the disorder often coexist with other mental health disorders and substance use disorders, and cause significant impairment in daily functioning (Yarvis, 2011). In the KDCERNA, PTSD is captured through a series of questions that ask about specific symptoms of PTSD such as nightmares, flashbacks, strong fears, and hypervigilance. In future research, each of these symptoms could be examined for its potential association with program completion and recidivism. Furthermore, the new form would allow for further delineation of various mental health disorders and examination of which ones are more likely to be associated with program completion and recidivism.

Addiction Severity Index Scores. The KDCERNA assesses substance use using the Addiction Severity Index, a standardized measure that is valid and reliable. Using this measure will allow future researchers to assign an ASI score to all participants upon entry to the VTC in seven important risk areas related to substance use disorders such as medical status, employment and support, alcohol use, drug use, legal problems,

family/social status, and psychiatric status. Upon collecting this data, subsequent analyses could be run to examine the association of ASI scores within the various domains, with program completion and criminal recidivism.

Suicidality. The KDCERNA assesses suicidality by asking specific questions about suicidal thoughts and prior suicide attempts. Suicide among veterans is an issue that has received much attention from the media and from the VA, with a reported 20 veterans dying by suicide every day (United States Department of Veterans Affairs, 2018c). Given this data and the importance being placed on this issue by the VA (CITE), it is imperative for future researchers to include suicide measures in their studies in order to ascertain the impact of suicidal thoughts on their overall risk for recidivism as well as their ability to participate in and complete the program.

Peer Mentoring. Lastly, the use of peer mentoring is an important aspect of the VTC that warrants further research and comparison. Early VTC research has indicated that peer mentoring is an important component of the process and that participants who actively engaged with their peer mentors had positive clinical outcomes (Knudsen & Wingenfeld, 2016). Future research in the Kentucky VTC should collect data about this unique point of contact for the participants to ascertain how beneficial it is to the recovery process and if in fact, this unique aspect of the program is as helpful in Kentucky as it has been in other studies.

Limitations of Study

This study of the first two Kentucky VTCs had some notable accomplishments, in terms of the quantitative data offered regarding the outcomes of program completion and recidivism. This data offers valuable insight about the outcomes of the first cohorts of

participants in these two courts and can be used as a starting point for future research. Despite the valuable contribution this study makes to what is known about Kentucky VTCs, this research was an exploratory study of secondary data, and therefore is not without limitations, which will be delineated here.

One limitation is the type of data used in the study and the pre-experimental design of the study, which allows for threats to internal validity such as selection bias, maturation, and mortality. Using a quasi-experimental design and a control group in future research would be ideal, but identifying a well-matched comparison group in this type of research is challenging.

A second limitation of this study is the sample size, which is a threat to the external validity, and makes it challenging to conduct meaningful multivariate analyses. Additionally, one of the likely outcomes of a small sample size would be an increased likelihood of a Type II error. While the current study is not conducting hypothesis testing, the small sample size does increase the chance that significant associations between variables will not be detectable. Furthermore, some of the effects may be important, yet too small to identify with a sample size of 58 participants. As the Kentucky VTCs continue to grow and expand to new sites, future studies might include larger sample sizes and longitudinal research designs that allow for greater statistical power and reduced margin of error.

A third limitation within this study was the VTC's use of two different assessment tools, allowing for a threat to internal validity based on instrumentation. The program coordinators made a decision halfway through their grant period to change and improve their assessment tool, but from a research standpoint, this was problematic. The

improved and more thorough assessment tool has been adopted and so future research in the Kentucky VTCs should not have this issue.

Another limitation of the study is that some of the variables of interest were not collected or operationalized in a way that allowed for meaningful interpretation. Specifically, the mental health variable used in the current study is only an indicator of whether or not the participant had previously seen a provider for mental health treatment. Considering what is known about the reluctance for many military service members and veterans to seek mental health treatment, this is likely not the best measure for mental health, and questions about specific mental health symptomatology would be more accurate and meaningful measures of this concept.

Another limitation of the study is that no data were collected regarding the participants' contact with peer mentors. One aspect of the veterans' treatment court that is touted as being a unique and innovative component of their treatment is the use of veteran mentors. Although there is qualitative data from interviews with peer mentors, this quantitative data set does not include any data points related to the use of mentors. While there is information about every treatment contact participants had with the recovery coordinator, individual and group therapists, VA treatment providers, and self-help groups, no data were collected regarding the number and frequency of contacts the participants in this study had with their peer mentor. Therefore, no analyses can be run related to the amount of contact the mentor had with the participant and what impact that may have had on the participant's outcome. Qualitative interviews with VTC team members indicated that building a strong mentor program had proven to be challenging and that further efforts to recruit quality mentors were needed (Shannon, 2016).

The self-reporting nature of this data is also a potential weakness of this study. Several of the primary variables of interest regarding combat status, mental health, and substance abuse were self-reported, and therefore their accuracy is vulnerable to response bias. Social desirability response bias is the tendency of individuals to respond to a survey in a way that presents a favorable image of themselves (Johnson & Fendrich, 2002; King & Brunner, 2000), and could account for veterans underreporting their history of mental health and substance abuse. Moreover, researchers have found that fear and social stigma often result in underreporting of mental health and substance abuse symptoms by military personnel and veterans (Colpe et al., 2015; Hourani, Bender, Weimer, & Larson, 2012; Warner et al., 2011), further compounding the possibility of response bias. The prior statements notwithstanding, self-report instruments have long been used effectively in social science research. Some of the most common measures for PTSD (PCL-5), depression (PHQ-9), and substance use (ASI), are self-report instruments that have all been found to be valid and reliable research tools (Blevins, Weathers, Davis, Witte, & Domino, 2015; Kroenke, Spitzer, & Williams, 2001; Snow & Tipton, 2009).

Lastly, one issue within the arena of research is the operationalization of the concept of recidivism, which is defined inconsistently throughout the literature. Although approximately 36% of this sample recidivated during the grant period, it is important to consider that the longer the follow-up period is after treatment, the more likely someone is to recidivate, simply due to time and opportunity (Emigh, 2017). Therefore, longitudinal studies are needed with VTC participants to determine if the VTC provides temporary or long-lasting positive outcomes. This dissertation clearly identified

what is meant by recidivism within the current study, thus making it easier for future research to consider findings in relation to this work.

Conclusion

Veterans' treatment courts have been developed to provide services to justice-involved veterans who may benefit from a program that is attentive to their needs – some of which are similar to non-veterans and others of which are unique to their military background. Limitations notwithstanding, the study presents an early picture of two Kentucky VTCs. In the context of some national data that provides a starting point, this exploratory study begins to consider one state's approach to the implementation of VTCs. However, there is much more work to be done as we work to provide Kentucky veterans with holistic treatment and wrap-around services that are evidence-based, and that adequately honors their service and sacrifice.

Appendix A

Kentucky Drug Court Eligibility Assessment (KDCEA)

Kentucky Drug Court Eligibility Assessment

Date of Assessment: ☐ -- *mm/dd/yy*
Interviewer: ☐
Drug Court Site: ☐ *county*

Have you ever been in a Kentucky Drug Court Program? ☐

Section 1: Locator Information

This first section asks about your contact information.

1. Defendant Information:
   First Name: ☐
   Last Name: ☐
   Middle Initial: ☐
1a. Maiden name/alias: ☐
1b. Date of Birth: ☐ Social Security Number: ☐ (please verify)
2. Gender: ☐ Male ☐ Female

* * * * * * * * *

Please state the following to the defendant: The next two questions are for statistical purposes only and will not be considered in the decision of entry/non-entry into Drug Court.

3. Race:
   - ☐ Alaskan Native
   - ☐ Asian or Pacific Islander
   - ☐ Black/African American
   - ☐ Bi-Racial
   - ☐ Hispanic-Mexican
   - ☐ Hispanic-Other
   - ☐ Native American
   - ☐ Other
   - ☐ Unknown
   - ☐ White
4. Ethnicity: ☐ Hispanic ☐ Non-Hispanic

* * * * * * * * *

5. What is your current address? ☐
6. How long have you lived at this address? ☐ years
6a. Who else resides in your household? (List name, age, and relation of those residing in the household) ☐
7. Are you single, married, divorced, separated, never married, or other? ☐
8. What is the best phone number to reach you? ☐ Home or Cell? ☐
9. What is your cell phone number? ☐ What is your landline #? ☐
10. Emergency Contact – Name, Address, Phone #, Relationship ☐
11. Do you have a valid driver's license?
    ☐ NO If NO, why not? ☐
    ☐ YES If YES, what is your driver's license number? ☐ (please verify)
12. Do you have an automobile available for use? ☐ NO ☐ YES

If yes, please provide the year, make, and model. ☐

13. Have you served in the National Guard or the United States Armed Forces? ☐
14. While in the service, were you ever in combat? ☐
15. **Interviewer comments on contact information:** ☐

Section 2: Medical Health Information

The following questions ask about your medical history.

1. How many times in your life have you been hospitalized for medical problems? (Include ODs and DTs; exclude birth of a child) ☐ times (If 0, skip to Question #3)
2. How long ago was your last hospitalization for a physical problem? (Exclude child birth)
   ☐ less than 6 months ☐ 6-12 months ☐ 1-2 years ago
   ☐ 2-3 years ago ☐ more than 3 years ☐ Other
3. Do you have any medical problems that affect your activities of daily living or your ability to work? ☐ NO ☐ YES If YES, please describe: ☐

3a. Indicate degree of severity: ☐ minimal ☐ moderate ☐ severe

4. Have you ever had any of the following health problems? If yes, explain in comments.
   ☐ None ☐ Hepatitis (B,C) ☐ Chlamydia (NGU) ☐ Syphilis
   ☐ Gonorrhea (GC, clap, dose) ☐ Pelvic Inflammatory Disease (PID)
   ☐ Genital Warts (HPV, venereal warts) ☐ HIV+ ☐ AIDS
   ☐ TB ☐ MRSA ☐ Herpes Comments ☐
5. Have you ever had a fit or seizure?
   ☐ NO ☐ YES If YES, what caused the seizure? ☐
   How long ago was your last seizure? ☐
6. Are you taking any prescribed medication on a regular basis for a physical problem?
   ☐ NO ☐ YES If YES, what? ☐

6a. Do you have a regular physician?
   ☐ (name, address, phone number)

7. Do you receive a pension for a physical disability? (Exclude psychiatric disability)
   ☐ NO ☐ YES If YES, what? ☐
8. How many days have you experienced medical problems in the past 30? (Not pregnancy related) ☐
9. **Interviewer comments on medical health information:** ☐

Section 3: Education and Employment Information

The following questions ask about your education and employment history.

1. How many years of education have you completed? ☐

1a. If 12 years, did you obtain a diploma or GED? ☐

2. Are you currently employed?
   ☐ NO ☐ YES If YES, Name of Employer: ☐

3a. How long have you worked at your current job? ☐ years

3b. What type of work is this job? ☐

3c. Is this job: ☐

4. How long was your last job? ☐ years ☐ months
5. Have you ever lost or left a job due to substance abuse issues?
   ☐ NO ☐ YES
6. How many days have you experienced employment problems in the past 30 days?

☐

7. Does someone contribute to your support in any way? ☐ NO ☐ YES
8. Who is the person who contributes the most to your support? ☐
9. Does the support from [insert answer to Question # 8] constitute the majority of your support? ☐ NO ☐ YES

10. **Interviewer comments on employment and education information:** ☐

Section 4: Drug and Alcohol Information

Drug/Alcohol Information	History of Use Ever Used	Frequency of Use # Days used in the past 30 days (not including jail time)	Duration of Use # Years used in Lifetime	Intensity of Use How has your use changed since you began?	Method of Use (Select all that apply)
Alcohol, any use	☐ NO ☐ YES	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Amphetamines (Adderall, Desoxyn) Uppers, Speed, Blue Boy, Blacks, Ecstasy	☐ NO ☐ YES	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Barbituates (Fiorinal, Seconal) Downers, Barbs, Barbies	☐ NO ☐ YES	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Benzodiazepines (Ativan, Halcion, Klonopin, Librium, Prosom, Valium, Xanax)Forget Pills, Roofies	☐ NO ☐ YES	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Cocaine Crack, Coke, Blow, Snow, Flake	☐ NO ☐ YES	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort

Club Drugs (Ecstasy/MDMA, GHB, Ketamine, Rohypnol) Love Drug, Roofies, Soap, Special K, Vitamin K, X, XTC	☐ NO ☐ YES				☐ IV ☐ Oral ☐ Smoke ☐ Snort
Hallucinogens (Ketamine, LSD, PCP) Acid, Angel, Angel Dust, Blotter, Dots, Ozone, Trip	☐ NO ☐ YES				☐ IV ☐ Oral ☐ Smoke ☐ Snort
Heroin H, Junk, Ska, Smack	☐ NO ☐ YES				☐ IV ☐ Oral ☐ Smoke ☐ Snort
Inhalants (Glue, Gas, Paint, Nitrous Oxide)Poppers, snappers, Whippets	☐ NO ☐ YES				☐ IV ☐ Oral ☐ Smoke ☐ Snort
Marijuana (THC) Ganga, Grass, Pot, Weed	☐ NO ☐ YES				☐ IV ☐ Oral ☐ Smoke ☐ Snort
Methadone (Amidone, Dolophine)Fizzies	☐ NO ☐ YES				☐ IV ☐ Oral ☐ Smoke ☐ Snort
Methamphetamine Chalk, Crank, Crystal, Glass, Ice, Meth, Speed	☐ NO ☐ YES				☐ IV ☐ Oral ☐ Smoke ☐ Snort
Opiates (Darvon, Demerol, Dilaudid, Lortab, Morphine, Oxycontin, Percoset, Vicodin) Antifreeze, Aunt Hazel, Horse	☐ NO ☐ YES				☐ IV ☐ Oral ☐ Smoke ☐ Snort
Stimulants (Adderal, Concerta, Dexedrine, Ritalin)	☐ NO ☐ YES				☐ IV ☐ Oral ☐ Smoke ☐ Snort
Suboxone (Buprenorphine)	☐ NO ☐ YES				☐ IV ☐ Oral ☐ Smoke ☐ Snort

1. Which substance is the major problem? ☐ None ☐ Alcohol
☐ Amphetamines ☐ Barbiturates ☐ Benzos ☐ Cocaine
☐ Club Drugs ☐ Hallucinogens ☐ Heroin ☐ Inhalants
☐ Marijuana ☐ Methadone ☐ Meth ☐ Opiates
☐ Stimulants ☐ Suboxone
2. How many days in the past 30 days (not including jail time) have you experienced any life problems that were a direct result of your alcohol or drug use?
Alcohol problems? ☐ days **Drug problems?** ☐ days
3. How many months long was your last period of voluntary abstinence from alcohol or other drugs? ☐ months **IF NEVER ABSTINENT, Skip to Question # 7**
4. When did this abstinence end? ☐
5. How many times have you had:
DT's (horrors)? ☐ times
Overdosed on drugs? ☐ times
Experienced Withdrawal symptoms? ☐ times Describe symptoms: ☐
6. How many times in the last 30 days, or the last 30 days on the street did you stay up past 4 a.m. because of drug or alcohol use? ☐
7. Have you ever been treated for alcohol or other drugs of abuse?
☐ NO ☐ YES
8. Please tell me how many times, not including AA/NA you have been treated for alcohol or other drugs of abuse:

	LIFETIME	PAST YEAR
How many times were you treated for drug abuse in an outpatient treatment program? *(not AA/NA)*	☐	☐
How many times were you treated for drug abuse in a residential or in-patient program?	☐	☐
How many of those were Detox only?	☐	☐

9. Have you ever completed in-patient treatment?
☐ NO ☐ YES If YES, when and where ☐

10. **Interviewer comments on drug and alcohol information**: ☐

Section 5: Criminal Justice History Information

The following questions ask about your criminal justice history.

1. Are your currently on probation or parole? ☐ NO ☐ YES
If Yes, what county and state? ☐
1a. Have you ever been on probation or parole? ☐ NO ☐ YES
If YES, what county and state? ☐
2. Have you ever been arrested in a state other than Kentucky? ☐ NO ☐ YES
If YES, what state? ☐ What were you charged with? ☐
If convicted, what charge(s) were you convicted of? ☐
3. How long have you been incarcerated in your life?
County Jail: ☐ (please enter number of days, months, or years)

Prison: ☐ (please enter number of days, months, or years)

4. How long was your last incarceration?
   ☐ less than 1 month ☐ 1-3 months ☐ 3-6 months
   ☐ 6 months to 1 year ☐ 1-3 years ☐ More than 3 years
5. Are you presently awaiting charges, trial, or sentence in this county or any other?
   ☐ NO ☐ YES
6. Reason(s) for awaiting charges? ☐
7. **Interviewer comments on criminal justice involvement information**: ☐

Section 6: Family/Social History Information

The following questions ask about your family and social history.

1. Do you have children? ☐ NO ☐ YES Name/Age ☐
1a. Which children are in your custody? ☐
1b. Who has custody of the other children? ☐
1c. Do you owe child support or arrearage? ☐
2. Are you expecting a child? ☐ NO ☐ YES
3. What has your usual living arrangements been in the past 12 months (past year)? ☐
4. Are you satisfied with these living arrangements?
   ☐ NO ☐ YES ☐ INDIFFERENT
5. Do you live with anyone that has a drug and/or alcohol problem?
   ☐ NO ☐ YES
6. Have the majority of your romantic relationships been with partners who use or abuse substances? ☐ NO ☐ YES
7. How many close friends do you have? ☐ friends
8. Do you believe that your family and social relationships negatively impact your life?
   ☐ NO ☐ YES If YES, please describe: ☐
9. **Interviewer comments on family and/or social history information**: ☐

Section 7: Mental Health Information

The next set of questions ask about your mental health.

1. Have you ever been treated as an outpatient for psychological or emotional problems? ☐ NO ☐ YES
2. How many times have you been treated for any psychological or emotional problems in a hospital? ☐ times
3. Have you ever been prescribed medication for any psychological or emotional problems:
   ☐ NO ☐ YES If YES, what? ☐
4. Have you been prescribed medication (or taken any prescribed medication) for any psychological or emotional problem in the past 30 days?
   ☐ NO ☐ YES If YES, what? ☐
5. Do you receive a pension for a psychiatric disability?
   ☐ NO ☐ YES
6. Have you had a significant period (that was not a direct result of drug or alcohol use) in which you:

	PAST 30 DAYS (NOT INCLUDING JAIL TIME)	IN LIFETIME
Experienced serious depression?	☐NO ☐YES	☐NO ☐YES
Comments: ☐		
Experienced serious anxiety or tension?	☐NO ☐YES	☐NO ☐YES
Comments: ☐		
Experienced hallucinations?	☐NO ☐YES	☐NO ☐YES
Comments: ☐		
Experienced trouble understanding, concentrating, or remembering?	☐NO ☐YES	☐NO ☐YES
Comments: ☐		
Experienced trouble controlling violent behavior?	☐NO ☐YES	☐NO ☐YES
Comments: ☐		
Experienced thoughts of suicide?	☐NO ☐YES	☐NO ☐YES
Comments: ☐		
Attempted suicide?	☐NO ☐YES	☐NO ☐YES
Comments: ☐		
Experienced anorexia, bulimia, or other eating disorders?	☐NO ☐YES	☐NO ☐YES
Comments: ☐		

7. Have any family members or any others such as strangers, acquaintances, intimate partners ever abused you:
   a. Emotionally (made to feel bad through harsh words, humiliation, manipulation)? (Do not include verbal abuse by strangers.)
   ☐ NO ☐ YES
   b. Physically (cause or threaten to cause physical harm such as: slapping, punching, kicking, hitting with an object, assaulting with a knife or other weapon, etc.) ?
   ☐ NO ☐ YES

c. Sexually (rape, forced sexual advances or non-consensual sexual acts)?
☐ NO ☐ YES

d. Has anyone ever sexually harassed you (inappropriate physical contact, stalking, using threats to secure sexual contact, etc.)?
☐ NO ☐ YES

e. If YES to any of the above, please describe the treatment or counseling services you received: ☐

8. How many days in the past 30 have you experienced psychological problems?
☐ days

9. **Interviewer comments on mental health information**: ☐

Please record any final comments you have about this defendant and/or this defendant's interview: ☐

Appendix B

Kentucky Drug Court Risk and Needs Assessment (KDCRNA)

Kentucky Drug Court Risk and Needs Assessment

Date of Interview (m/d/yyyy): ☐ Current Age: ☐

Interviewer: ☐ Drug Court Site (county):

Have you ever been in a Kentucky Drug Court Program?

A. CONTACT INFORMATION

This first section asks about your contact information.

1. Referral Information:
   - First Name: ☐
   - Last Name: ☐
   - Middle Initial: ☐

   1a. Maiden name/alias: ☐

   1b. Date of Birth:(m/d/yyyy) ☐ Social Security Number: ☐ (please verify)

2. Gender: ☐ (select one)

* * * * * * * * *

Please state the following to the defendant: The next two questions are for statistical purposes only and will not be considered in the decision of entry/non-entry into Drug Court.

3. Race: (select one)
4. Ethnicity: (select one)

* * * * * * * * *

5. What is your current address?

☐

Rev. 5/27/2015

*Items in Section B © Center for Criminal Justice Research. Used by permission.

** Items in Section C © TCU Institute of Behavioral Research. Used by permission.

*** Items in Section D © Project Return Foundation. Used by permission.

Page | 1

6. Who else resides in your household? (List name, age, and relationship of all those residing in the household)
7. What is your marital status? (select one)
8. What is the best phone number to reach you? Home or Cell? (select one)
9. What is your cell phone number? What is your landline #?
10. Do you have an email address? If so, what is it?
11. Emergency Contact – Name, Address, Phone #, Relationship

12. Do you have a valid driver's license?

NO If NO, why not?

YES If YES, what is your driver's license number? (please verify) 12a. Do you have an automobile available for use? (select one) 12b. If yes, please provide the year, make, and model.

12c. If you do not have a car to use and do not have a license, how will you get to drug court activities?

13. Have you served in the National Guard or the United States Armed Forces? (select one)

13a. While in the service, were you ever in combat? (select one)

14. Comments on contact information:

B. RISK SCREENING

Tell the participant: "We need to get some information about you in order to make a decision about whether drug court is a good fit for you and to find out what services you might need."

1. Do you have any prior arrests or convictions? (select one)

Rev. 5/27/2015

*Items in Section B © Center for Criminal Justice Research. Used by permission.

** Items in Section C © TCU Institute of Behavioral Research. Used by permission.

*** Items in Section D © Project Return Foundation. Used by permission.

**2. How many times have you been convicted of a felony (not counting the current offense)?

* 3. How old were you when you were arrested for the first time?

3a. What was your first arrest for?

4. As an adult, have you ever had a warrant filed for failure-to-appear to court? (select one)

4a. How many times?

* 4b. How many times during the past two years?

4c. What happened as a result?

5. Have you ever been incarcerated in jail or prison as a result of a conviction? (Probe to make sure that incarceration was a result of sentencing and not simply pretrial detention). (select one) 5a. How many times in jail?

5b. How many times in prison?

*(total for questions 5a and 5b): 0

**6. Are you currently employed? (select one) If yes, name of employer:

6a. If you are employed, is your work temporary, seasonal, or permanent? (select one)

6b. If employed, how long have you worked at your current job? (number) (select one) (days/weeks/months/years)

6c. What type of work is this job?

6d. How long did you work at your last job? (number) (select one)

Comments:

* 6e. Were you employed at the time of this arrest? (select one)

6f. Have you ever lost or left a job due to substance abuse issues? (select one) 6g. How many days have you experienced employment problems in the past 30 days (or past 30 days prior to incarceration?)

7. Are you in school? (select one)

7a. How many years of education have you completed?

7b. If 12 years, did you obtain a diploma or GED? (select one)

* 8. How long have you lived at your current residence? (number) ___ (select one) 8a. Is this your primary residence? (select one) If no, please explain:

8b. Do you own or rent? (select one)

8c. If you have moved within the past six months, what was the reason?

9. Have you ever had a problem with drugs or alcohol? (select one) 9a. If yes, please explain:

9b. How old were you when you first used any drug or alcohol?

10. Have you ever been arrested for drug use? (select one) 10a. If yes, please explain:

10b. When?

11. What drugs have you ___ used?

12. How often on average do ___ you use?

13. When was the last time you used drugs (prior to incarceration)?

* 13a. Have you used within the past 6 months (prior to incarceration)? (select one)

14. How has your drug use affected other parts of your life?

14a. For example, has a doctor ever told you to quit using drugs? (select one)

14b. Have you ever had problems at work because of drug use? (select one) 14c. How does your family feel about your drug use?

14d. (Probe further if needed about problems with health, relationships (family and social), legal, etc. related to substance abuse)

* 15. If I asked you to rate the severity of your drug use problem on a scale from 1 to 5, with 1 being few or no problems and 5 being many problems, what score would you give yourself? (select one)

16. Tell me about the neighborhood you live in.

**16a. How easy would you say it is to acquire drugs in your neighborhood? (select one)

17. How many close friends would you say that you have?

17a. Have any of your close friends been involved with criminal behavior? (select one)

**17b. How many of your close friends have been in trouble with the law? (select one)

17c. What kinds of _____ things have they been involved with?

Comments on Risk Screening:

Recidivism Risk Score:	Recidivism Risk Level:

Social Risk Score:	Social Risk Level:

C. SUBSTANCE ABUSE SCREENING

Tell the client: "Now I am going to ask you more specific questions related to your drug or alcohol use"

During the last 12 months (before being incarcerated, if applicable):

1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	(select one)
2. Did you try to control or cut down on your drug use but were unable to do it?	(select one)
3. Did you spend a lot of time getting drugs, using them, or recovering from their use?	(select one)
4. Did you have a strong desire or urge to use drugs?	(select one)
5. Did you get so high or sick from using drugs that it kept you from working, going to school, or caring for children?	(select one)
6. Did you continue using drugs even when it led to social or interpersonal problems?	(select one)
7. Did you spend less time at work, school, or with friends because of your drug use?	(select one)
8. Did you use drugs that put you or others in physical danger?	(select one)
9. Did you continue using drugs even when it was causing you physical or psychological problems?	(select one)
10a. Did you need to increase the amount of a drug you were taking so that you could get the same effects as before?	(select one) *(Yes to either question is a yes)*

Alcohol, any use	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Amphetamines (Adderall, Desoxyn) Uppers, Speed, Blue Boy, Blacks, Ecstasy	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Barbiturates (Fiorinal, Seconal) Downers, Barbs, Barbies	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Benzodiazepines (Ativan, Halcion, Klonopin, Librium, Prosom, Valium, Xanax)Forget Pills, Roofies	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Cocaine Crack, Coke, Blow, Snow, Flake	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Club Drugs (Ecstasy/MDMA, GHB, Ketamine, Rohypnol) Love Drug, Roofies, Soap, Special K, Vitamin K, X, XTC	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Designer Drugs K-2, Spice, Kratom, Salvia, Bath Salts	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort

Rev. 5/27/2015

Hallucinogens (Ketamine, LSD, PCP) Acid, Angel, Angel Dust, Blotter, Dots, Ozone, Trip	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Heroin H, Junk, Ska, Smack	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Inhalants (Glue, Gas, Paint, Nitrous Oxide)Poppers, snappers, Whippets	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Marijuana (THC) Ganga, Grass, Pot, Weed	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Methadone (Amidone, Dolophine)Fizzies	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Methamphetamine Chalk, Crank, Crystal, Glass, Ice, Meth, Speed	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Opiates (Darvon, Demerol, Dilaudid, Lortab, Morphine, Oxycontin, Percoset, Vicodin) Antifreeze, Aunt Hazel, Horse	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort

Stimulants (Adderal, Concerta, Dexedrine, Ritalin)	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Suboxone (Buprenorphine)	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort
Other Medications Neurontin, Ultram, Soma	☐ NO ☐ YES Age of first use: ☐	☐	☐	☐	☐ IV ☐ Oral ☐ Smoke ☐ Snort

15. Which substance is the major problem? (select one)

    15a. (if other, please specify): ☐

16. How many days in the past 30 days (not including jail time) have you experienced any life problems that were a direct result of your alcohol or drug use?

    16a. Alcohol problems? ☐ days

    16b. Drug problems? ☐ days

17. How long was your last period of voluntary abstinence from alcohol or other drugs? (number) ☐ (select one)

    17a. When did this abstinence end? ☐

18. How many times have you had:

    DT's (horrors)? ☐ times

    Overdosed on drugs? ☐ times

    Experienced Withdrawal symptoms? ☐ times Describe symptoms: ☐

19. How many times in the last 30 days, or the last 30 days on the street, did you stay up past 4 a.m. because of drug or alcohol use? ☐

20. Have you ever been treated for alcohol or other drugs of abuse? (select one)

20a. How many times, not including AA/NA, have you have been treated for alcohol or other drugs of abuse:

	LIFETIME	PAST YEAR
How many times were you treated for drug abuse in an outpatient treatment program? *(not AA/NA)*		
How many times were you treated for drug abuse in a residential or in-patient program?		
How many of those were Detox only?		

20b. Have you ever completed in-patient treatment? (select one) If YES, when and where

Comments on drug and alcohol information:

D. MENTAL HEALTH SCREENING***

Say to the defendant: "In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask me for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins –"Have you ever…"

Question	Yes/No	Details: (for yes answers in Questions 5-17, ask the questions in this column)
1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?	(select one)	Please explain:

Rev. 5/27/2015

*Items in Section B © Center for Criminal Justice Research. Used by permission.

** Items in Section C © TCU Institute of Behavioral Research. Used by permission.

*** Items in Section D © Project Return Foundation. Used by permission.

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?	(select one)	Please explain:
3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?	(select one)	If yes, what medications have you been prescribed? Have you been prescribed medication (or taken any prescribed medication) for any psychological or emotional problem in the past 30 days? (select one) If Yes, what?
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?	(select one)	Please explain: If yes, how many times?
5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?	(select one)	If yes, When did the problem first develop? How long did it last? Did the problem develop before, during, or after you started using the substances?) Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling services for this? (select one) If so, please describe

6a. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling services for this? (select one) If so, please describe ☐
6b. Did you ever attempt to kill yourself?	(select one)	If yes, When did the problem first develop? ☐ How long did it last? Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling services for this? (select one) If so, please describe ☐
7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? (*For example, warfare, gang fights, fire, domestic violence, rape, sexual abuse, emotional abuse, physical abuse, incest, a car accident, being shot or stabbed, witnessing these things happening to others, etc?*)	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling services for this? (select one) If so, please describe ☐

8. Have you ever experienced any strong fears? (*For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?*)	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling for this? (select one) If so, please describe ☐
9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property?	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling for this? (select one) If so, please describe ☐
10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling for this? (select one) If so, please describe ☐

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling for this? (select one) If so, please describe ☐
12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? (*For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?*))	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling for this? (select one) If so, please describe ☐
13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling for this? (select one) If so, please describe ☐

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling for this? (select one) If so, please describe ☐
15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? (*Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate*).	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling for this? (select one) If so, please describe ☐
16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling for this? (select one) If so, please describe ☐

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?	(select one)	If yes, When did the problem first develop? ☐ How long did it last? ☐ Did the problem develop before, during, or after you started using the substances?) ☐ Have you had these symptoms in the past 30 days? (select one) Have you ever received any treatment or counseling for this? (select one) If so, please describe ☐

Do you receive a pension for a psychiatric disability? (select one)

Comments on mental health information: ☐

It is recommended that a mental health professional be consulted about any "yes" response to questions 3 through 17. This person can help determine if there are issues that could affect the client's ability to successfully participate in drug court, and may suggest a diagnostic interview prior to admission to drug court. A "yes" response to any of questions 5 through 17 does not, by itself, ensure that a mental health problems exists now. A "yes" response raises only the possibility of a current problem, which is why talking with a mental health specialist is recommended.

Note: Scoring for Sections B, C, and D can be found on the last page of this document. If the referral does not score as having a substance abuse disorder or does not score as high or medium high risk on either of the risk scales, the interview can be terminated at this point, as drug court may not an appropriate recommendation.

E. Medical Health Information

The following questions ask about your medical history.

1. How many times in your life have you been hospitalized for medical problems? (Include ODs and DTs; exclude birth of a child) ☐ times (If 0, skip to Question #2)

1a. How long ago was your last hospitalization for a physical problem? (Exclude child birth) (select one)

2. Do you have any medical problems that affect your activities of daily living or your ability to work? (select one) If YES, please describe: ☐

2a. Indicate degree of severity: (select one)

3. Have you ever had any of the following health problems? If yes, explain in comments.

☐ None ☐ Hepatitis (B,C) ☐ Chlamydia (NGU) ☐ Syphilis
☐ Gonorrhea (GC, clap, dose) ☐ Pelvic Inflammatory Disease (PID)
☐ Genital Warts (HPV, venereal warts) ☐ HIV+ ☐ AIDS
☐ TB ☐ MRSA ☐ Herpes Comments ☐

4. Have you ever had a fit or seizure? (select one)

4a. If YES, what caused the seizure? ☐

4b. How long ago was your last seizure? ☐

5. Are you taking any prescribed medication on a regular basis for a physical problem?

(select one) If YES, what? ☐

5a. Do you have any allergies? (select one)

If so, what?

5b. Do you have a regular physician?

☐ (name, address, phone number)

6. Do you have health insurance? (select one)

6a. If yes, what type? (select one) If other, please explain:

7. Do you receive a pension for a physical disability? (Exclude psychiatric disability) (select one) If YES, what? ☐

8. How many days have you experienced medical problems in the past 30? (Not pregnancy related) ☐

Comments on medical health information:

F. Criminal Justice History Information

The following questions ask about your criminal justice history.

1. Are your currently on probation or parole? (select one)
   - 1a. If Yes, what county and state?
   - 1b. Have you ever been on probation or parole? (select one)
   - 1c. If YES, what county and state?
2. Have you ever been arrested in a state other than Kentucky? (select one)
   - 2a. If YES, what state?
   - 2b. What were you charged with?
   - 2c. If convicted, what charge(s) were you convicted of?
3. How long have you been incarcerated in your life?
   - County Jail: (number) (select one)
   - Prison: (number) (select one)
4. How long was your last incarceration? (select one)
5. Are you presently awaiting charges, trial, or sentence in this county or any other? (select one)
   - 5a. Reason(s) for awaiting charges?

Interviewer comments on criminal justice involvement information:

G. Family/Social/ History Information

The following questions ask about your family and social history.

1. Do you have children? (select one) (if no, skip to #2)
   - 1a. Name/Age of all children
   - 1b. Which children are in your custody?
   - 1c. Who has custody of the other children?

1d. Do you owe child support or arrearage? (select one) Amount

2. Are you expecting a child? (select one)
3. What has your usual living arrangements been in the past 12 months (past year)?
   3a. Are you satisfied with these living arrangements? (select one)
   3b. Do you live with anyone that has a drug and/or alcohol problem? (select one)
4. Have the majority of your romantic relationships been with partners who use or abuse substances? (select one)
5. Do you believe that your family relationships negatively impact your life? (select one)
   5a. If YES, please describe:
6. Do you believe that your social relationships negatively impact your life? (select one)
   6a. If Yes, please describe:
7. Does someone contribute to your support in any way? (select one)
   7a. Who is the person who contributes the most to your support? (select one)
   7b. Does the support from [insert answer to Question #7) constitute the majority of your support? (select one)

Comments on family and/or social history information:

Please record any final comments you have about this defendant and/or this defendant's interview:

References

Aday, L. A., & Andersen, R. (1974). A framework for the study of access to medical care. *Health Services Research, 9*, 208-220.

Aday, L. A., Andersen, R., & Fleming, G. (1980). *Healthcare in the U.S.: Equitable for whom?* Beverly Hills, CA: Sage Publishing.

Aday, L. A., Andersen, R., Loevy, S., & Kremer, B. (1985). *Hospital- physician sponsored primary care: Marketing and impact.* Ann Arbor, MI: Health Administration Press.

Administrative Office of the Courts. (2019). *Kentucky specialty courts*. Retrieved from https://courts.ky.gov/resources/publicationsresources/Publications/P134_SpecialtyCourtsBrochure.pdf

Ahlin, E., & Douds, A. (2016). Military socialization: A motivation factor for seeking treatment in a veterans' treatment court. *American Journal of Criminal Justice, 41*, 83-96.

Alcorn, W. (2010, November 10). Veterans treatment court to handle unique problems. *The Vindicator*. Retrieved from http://www.vindy.com/news/2010/nov/10/veterans-treatment-court-to-handle-uniqu/

Aldigé Hiday, V., Ray, B., & Wales, H. (2015). Longer-term impacts of mental health courts: Recidivism two years after exit. *Psychiatric Services, 67*(4), 378–383.

Allard, C. B., Nunnink, S., Gregory, A. M., Klest, B., & Platt, M. (2011). Military sexual trauma research: A proposed agenda. *Journal of Trauma & Dissociation, 12*, 324–345.

Alexander, M. (2012). *The new Jim Crow: Mass incarceration in the age of colorblindness.* New York, NY: The New Press.

Alston, R., Harley, D., & Lenhoff, K. (1995). Hirschi's social control theory: A sociological perspective on drug abuse among persons with disabilities. *Journal of Rehabilitation, 61*(4), 31-35.

Alwhaibi, M., Bhattacharya, R., & Sambamoorthi, U. (2015). Type of multimorbidity and complementary and alternative medicine use among adults. *Evidence-Based Complementary and Alternative Medicine, 2015*, 1-9.

American Civil Liberties Union. (2014). *Racial disparities in sentencing: Hearing on reports of racism in the justice system of the United States*. Retrieved from https://www.aclu.org/sites/default/files/assets/141027_iachr_racial_disparities_aclu_submission_0.pdf

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM IV-TR*. Washington, DC.: American Psychiatric Association Publishing Incorporated.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM 5*. Washington, DC: American Psychiatric Association Publishing Incorporated.

American Psychiatric Association & Academy of Psychosomatic Medicine. (2016). *Dissemination of integrated care within adult primary care settings: The collaborative care model.* Retrieved from https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn

Andersen, R. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*, 1-10.

Andersen, R., & Newman, J. (1973). Societal and individual determinants of medical care utilization in the United States. *Milbank Memorial Fund Quarterly Journal, 51*, 95-124.

Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates.* Olympia, WA: Washington State Institute for Public Policy.

Babitsch, B., Gohl, D., & von Lengerke, T. (2012). Re-visiting Andersen's behavioral model of health services use: A systematic review of studies from 1998 to 2011. *GMS Psycho-Social Medicine, 9*, 1-15.

Baldwin, J. (2013). *Veteran's treatment courts: Studying dissemination, implementation, and impact of treatment-oriented criminal courts* (Doctoral dissertation). Retrieved from University of Florida Digital Collections, http://ufdc.ufl.edu/UFE0045314/00001

Baldwin, J. (2016). Investigating the programmatic attack: A national survey of veterans treatment courts. *The Journal of Criminal Law and Criminology, 105*(3), 705-751.

Barnoski, R,. & Aos, S. (2003). *Washington State's drug courts for adult defendants: Outcome evaluation and cost-benefit analysis.* Olympia, WA: Washington State Institute for Public Policy.

Beckerman, A., & Fontana, L. (1989). Vietnam veterans and the criminal justice systems: A selected review. *Criminal Justice and Behavior, 16*, 412.

Belenko, S. (1998). Research on drug courts: A critical review. *National Drug Court Institute Review, 1*, 1-42.

Belenko, S. (1999). Research on drug courts: A critical review 1999 update. *National Drug Court Institute Review, 2*, 1-58.

Belenko, S. (2001). *Research on drug courts: A critical review 2001 update*. Retrieved from the National Center on Addiction and Substance Abuse website: https://www.centeronaddiction.org/addiction-research/reports/research-drug-courts-critical-review-2001

Belenko, S., Patapis, N., & French, M. T. (2005). *Economic benefits of drug treatment: A critical review of the evidence for policy makers.* Alcohol and Drug Problem Association of North America.

Bender, R., & Lange, S. (2001). Adjusting for multiple testing: When and how. *Journal of Clinical Epidemiology, 54*(4), 343-349.

Bennett, J. (2018). Combating sexual assault with the military ethic: Exploring culture, military institutions, and norms-based preventative policy. *Armed Forces & Society, 44*(4), 707-730.

Bhati, A. S., Roman, J. K., & Chalfin, A. (2008). *To treat or not to treat: Evidence on the prospects of expanding treatment to drug-involved offenders*. Washington, DC: The Urban Institute.

Bialik, K. (2017). *The changing face of America's veteran population*. Retrieved from http://www.pewresearch.org/fact-tank/2017/11/10/the-changing-face-of-americas-veteran-population/

Bjork, J., & Grant, S. (2009). Does traumatic brain injury increase risk for substance

abuse? *Journal of Neurotrauma, 26*, 1077-1082.

Blevins, C., Weathers, F., Davis, M., Witte, T., & Domino, J. (2015). The Posttraumatic Stress Disorder Checklist for DSM-5(PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress, 28*, 489-498.

Blodgett, J., Avoundjian, T., Finlay, A., Rosenthal, J., Asch, S., Maisel, N., & Modboe, A. (2015). Prevalence of mental health disorders among justice-involved veterans. *Epidemiologic Reviews, 37*, 163-176.

Blosnich, J., Dichter, M., Cerulli, C., Batten, S., & Bossarte, R. (2014). Disparities in adverse childhood experiences among individuals with a history of military service. *JAMA Psychiatry, 71*(9), 1041-1048.

Booth-Kewley S., Highfill-McRoy R. M., Larson G. E., & Garland C. F. (2010). Psychosocial predictors of military misconduct. *Journal of Nervous and Mental Disease, 198*, 91-98.

Bouffard, L. A. (2014). Period effects in the impact of Vietnam-era military service on crime over the life course. *Crime & Delinquency, 60*(6), 859–883.

Bouffard, L.A., & Laub, J.H. (2004). Jail or the Army: Does military service facilitate desistance from crime. In S. Maruna & R. Immarigeon (Eds.), *After crime and punishment: Pathways to offender reintegration* (pp. 129-151).

Braithwaite, J. (1989). *Crime, shame and reintegration*. Cambridge University Press: Cambridge, MA.

Bremner, J. D., Southwick, S. M., Darnell, A., & Charney, D. S. (1996). Chronic PTSD in Vietnam combat veterans: Course of illness and substance abuse. *American Journal of Psychiatry, 153,* 369-375.

Bronson, J., Carson, A., Noonan, M., & Berzofsky, M. (2015). *Veterans in prison and jail.* Washington, DC: Office of Justice Programs. Retrieved from https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5479

Brown, N., & Bruce, S. (2016). Stigma, career worry, and mental illness symptomatology: Factors influencing treatment-seeking for Operation Enduring Freedom and Operation Iraqi freedom soldiers. *Psychological Trauma: Theory, research, Practice, and Policy, 8*(3), 276-283.

Brown, R. (2010). Associations with substance abuse treatment completion among drug court participants. *Substance Use & Misuse, 45*, 1874–1891.

Brown, R. (2011). Drug court effectiveness: A matched cohort study in the Dane County drug treatment court. *Journal of Offender Rehabilitation, 50*(4), 191-201.

Brunello, N., Davidson, J., Deahl, M., Kessler, R., Mendlewicz, J., Racagni, G., Shalev, A., & Zohar, J. (2001). Posttraumatic stress disorder: Diagnosis and epidemiology, comorbidity and social consequences, biology and treatment. *Neuropsychobiology, 43,* 150-162.

Bruwer, B., Sorsdahl, K., Harrison, J., Stein, D., Williams, D., & Seedat, S. (2011). Barriers to mental health care and predictors of treatment dropout in the South African Stress and Health Study. *Psychiatric Services, 62*(7), 774-781.

Bureau of Justice Assistance. (2012). Detailed information for award 2012-DC-BX-0039. Retrieved from https://external.ojp.usdoj.gov/selector/awardDetail?awardNumber=2012-DC-BX-0039&fiscalYear=2012&applicationNumber=2012-H0859-KY-DC&programOffice=BJA&po=BJA

Calhoun, P., Elter, J., Johnes, E., Kudler, H., & Straits-Troster, K. (2008). Hazardous

alcohol use and receipt of risk-reduction counseling among U.S. veterans of the wars in Iraq and Afghanistan. *Journal of Clinical Psychiatry, 69,* 1686-1693.

Carey, S. M., Finigan, M., Crumpton, D., & Waller, M. (2006). California drug courts: Outcomes, costs and promising practices: An overview of phase II in a statewide study. *Journal of Psychoactive Drugs*, SARC Supplement 3, 345-356.

Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review, 8*(1), 6–42.

Carise, D., McLellan, A. T., Cacciola, J., Love, M., Cook, T., Bovasso, G. & Lam, V. (2001). Suggested specifications for a standardized Addiction Severity Index database. *Journal of Substance Abuse Treatment, 20*, 239–244.

Carragher, N., Adamson, G., Bunting, B., & McCann, S. (2011). Treatment-seeking behaviours for depression in the general population: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Affective Disorders, 12*(1-2), 59-67.

Choi, N. G., DiNitto, D. M., Marti, C. N., & Choi, B. Y. (2017). Association of adverse childhood experiences with lifetime mental and substance use disorders among men and women aged 50+ years. *International Psychogeriatrics, 29*(3), 359–372.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences (Second edition).* New York, NY: Psychology Press.

Cohen, L., & Land, K. (1987). Sociological positivism and the explanation of criminality. In M. Gottfredson and T. Hirschi (Eds.), *Positive criminology*. Beverly Hills, CA: Sage.

Collins, E. (2017). Status courts. *The Georgetown Law Journal, 105*, 1481-1527.

Colpe, L., Naifeh, J., Aliaga, P., Sampson, N., Heeringa, S., Stein, M., Ursano, R., Fullerton, C., Nock, M., Schoenboem, M., Zaslavsky, A., & Kessler, R. (2015). Mental health treatment among soldiers with current mental health disorders in the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *Military Medicine, 180*(10), 1041-1051.

Conrad, P.L., Young, C., Hogan, L., & Armstrong, M.L. (2014). Encountering women veterans with military sexual trauma. *Perspectives in Psychiatric Care, 50*, 280-286.

Corrigan, J., & Cole, T. (2008). Substance use disorders and clinical management of traumatic brain injury and posttraumatic stress disorder. *Journal of the American Medical Association, 300*, 720-721.

Council of State Governments. (2008a). *Improving responses to people with mental illnesses: The essential elements of a mental health court*. Washington, DC: Bureau of Justice Assistance, U.S. Department of Justice. Retrieved from https://www.bja.gov/Publications/MHC_Essential_Elements.pdf

Council of State Governments. (2008b). *Mental health courts: A primer for policymakers and practitioners*. Washington, DC: Bureau of Justice Assistance, U.S. Department. of Justice. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-primer.pdf

Council of State Governments. (2019). *Mental health court*. Retrieved from https://csgjusticecenter.org/mental-health-court-project/

Cretacci, M., Rivera, C., Gao, Y., & Zheng, L. (2018). Bonding to bamboo: A social

control explanation of Chinese crime. *International Journal of Criminal Justice Sciences, 13*(1), 122-136.

Culp, R., Youstin, T., Englander, K., & Lynch, J. (2011). From war to prison: Examining the relationship between military service and criminal activity. *Justice Quarterly, 30*, 651-680.

Danish, S. (2013). A life skills, community-based approach for helping returning service members and their families. In E. Vera (Ed.), *Oxford handbook of prevention in counseling psychology* (pp. 393– 408). New York, NY: Oxford University Press.

Danish, S., & Antonides, B. (2013). The challenges of reintegration for service Members and their families. *American Journal of Orthopsychiatry, 83*(4), 550-558.

Delisi, M., & Vaughn, M.G. (2014). Foundation for a temperament based theory of antisocial behavior and criminal justice system involvement. *Journal of Criminal Justice, 42*(1), 10-25.

DeVall, K. E., & Lanier, C. L. (2012). Successful completion: An examination of factors influencing drug court completion for white and non-white male participants. *Substance Use & Misuse, 47*, 1106–1116.

Doherty, E. (2005). *Assessing an age-graded theory of informal social control: Are there conditional effects of life events in the desistance process?* (Doctoral dissertation). Retrieved from https://drum.lib.umd.edu/handle/1903/2680

Doweiko, H. (2018). *Concepts of chemical dependency, 10th edition*. Boston, MA: Cengage.

Drug Enforcement Administration Museum and Visitors Center. (2019). A *tradition of*

excellence: A history of the DEA. Retrieved from https://www.deamuseum.org/deahistorybook/.

Drug Policy Alliance. (2012). Healing *a broken system: Veterans and the war on drugs*. Retrieved from http://www.drugpolicy.org/resource/healing-broken-system-veterans-and-war-drugs.

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., Giles, W. H. (2001). Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. *JAMA, 286*(24), 3089–3096.

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics, 111*(3), 564–572.

Easterly, B. (2017). The ties that bind beyond the battlefield: An examination of the diffusion patterns of veteran's treatment courts. *Social Science Quarterly, 98*(5), 1622 – 1641.

Ege, M. A., Messias, E., Thapa, P., & Krain, L. P. (2015). Adverse childhood experiences and geriatric depression: Results from the 2010 BRFSS. *American Journal of Geriatric Psychiatry 23*(1), 110–114

Eggleston, A., Straits-Troster, K., & Kudler, H. (2009). Substance use treatment needs among recent veterans. *North Carolina Medical Journal, 71*, 54-58.

Elbogen, E.B., Wagner, H.R., Calhoun, P.S., Fuller, S.R., Kinneer, P.M., Midatlantic Mental Illness Research Education and Clinical Center Workgroup, & Beckham, J.C. (2010). Correlates of anger and hostility among Iraq and Afghanistan war

veterans. *American Journal of Psychiatry, 167*(9), 1051-1058.

Elbogen, E.B., Johnson, S.C., Newton, V.M. Straits-Troster, K., Vasterling, J.J., Wagner, H.R., & Beckham, J.C. (2012). Criminal justice involvement, trauma, and negative affect in Iraq and Afghanistan war era veterans. *Journal of Consulting and Clinical Psychology, 80*(6), 1097-1102.

Elbogen, E.B., Johnson, S.C., Newton, V.M., Timko, C., Vaserling, J.J., Van Male, L.M., Wagner, H.R., & Beckham, J.C. (2014a). Protective mechanisms and prevention of violence and aggression in veterans. *Psychological Services, 11*(2), 220-228.

Elbogen, E.B., Johnson, S.C., Wagner, H.R., Sullivan, C., Taft, C.T., & Beckham, J.C. (2014b). Violent behavior and post-traumatic stress disorder in US Iraq and Afghanistan veterans. *British Journal of Psychiatry, 204*, 368-375.

Erickson, S., Rosenheck, R., Trestman, R., Ford, J., & Desai, R. (2008). Risk of incarceration between cohorts of veterans with and without mental illness discharged form inpatient units. *Psychiatric Services, 59*(2), 178-183.

Farrington, D. P. (1986). Age and crime. *Crime and Justice, 7*, 189-250.

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*, 175-191.

Flatley, B., Clark, S., Rosenthal, J., & Blue-Howells, J. (2017). *Veterans court inventory 2016 update: Characteristics of and VA involvement in veterans treatment courts and other veteran-focused court programs from the veterans justice outreach specialist perspective.* Washington, DC: US Department of Veterans Affairs, Veterans Health Administration.

Finigan, M., Carey, S. M., & Cox, A. (2007). *The impact of a mature Drug Court over 10 years of operation: Recidivism and costs.* Portland, OR: NPC Research.

Fontana, A., & Rosenheck, R. (2005). The role of war-zone trauma and PTSD in the etiology of antisocial behavior. *Journal of Nervous and Mental Disease, 193*, 203-209.

Forster, M., Gower, A. L., Borowsky, I. W., & McMorris, B. J. (2017). Associations between adverse childhood experiences, student-teacher relationships, and non-medical use of prescription medications among adolescents. *Addictive Behaviors 68*, 30–34.

Freeman, T., & Roca, V. (2001). Gun use, attitudes toward violence, and aggression among combat veterans with chronic posttraumatic stress disorder. *The Journal of Nervous and Mental Disease, 189, 317*-320.

Gallagher, J., Nordberg, A., & Lefebvre, E. (2016). Improving graduation rates in drug court: A qualitative study of lived experiences. *Criminology & Criminal Justice, 17*(4), 468-484.

Gansel, E. (2013). Military service-related PTSD and the criminal justice system: Treatment as an alternative to incarceration. *Southern California Interdisciplinary Law Review, 23*, 147-184.

Garza, R. (2014). The soldier bears the deepest wounds and scars of war: Mobilizing Connecticut to implement a veteran's treatment court. *Connecticut Law Review, 46*, 1937-1974.

General Accounting Office. (2005). *Adult drug courts: Evidence indicates recidivism*

reductions and mixed results for other outcomes (GAO Publication No. 05-219). Washington, DC: U.S. Government Printing Office.

Getz, L. (2017). Veterans treatment courts: Helping vets seek justice. *Social Work Today, 17*(5), 22.

Gilbert, G., Branch, L., & Longmate, J. (1993). Dental care use by U.S. veterans eligible for VA care. *Social Science and Medicine, 36*, 361-370.

Goldman v. Weinberger, 475 U.S. 503 (1986).

Gottfredson, D.C., Najaka, S.S., & Kearley, B.W. (2003). Effectiveness of drug treatment courts: Evidence from a randomized trial. *Criminology & Public Policy*, *2*(2), 171-196.

Gottfredson, D. C., Najaka, S. S., Kearley, B. W., & Rocha, C. M. (2006). Long-term effects of participation in the Baltimore City drug treatment court: Results from an experimental study. *Journal of Experimental Criminology, 2*, 67-98.

Gottfredson, D. C., Najaka, S. S., Kearley, B. W., & Rocha, C. M. (2007). How drug treatment courts work: An analysis of mediators. *Journal of Research in Crime and Delinquency, 44*(1), 3-35.

Graham, D., & Cardon, A. (2008). An update on substance use and treatment following traumatic brain injury. *Annals of the New York Academy of Sciences, 1141*, 148-162.

Green, M. (2016). *How 9/11 changed America: Four major lasting impacts*. Retrieved from https://ww2.kqed.org/lowdown/2014/09/10/13-years-later-four-major-lasting-impacts-of-911/

Greene-Shortridge, T.M., Britt, T.W., & Castro, C.A. (2007). The stigma of mental

health problems in the military. *Military Medicine, 172*(2), 157-161.

Greenberg, G., & Rosenheck, R. (2009). Mental health and other risk factors for jail incarceration among male veterans. *Psychiatric Quarterly, 80*, 41-53.

Greenberg, G., Rosenheck, R., & Desai, R. (2007). Risk of incarceration among male veterans and nonveterans: Are veterans of the all volunteer force at greater risk? *Armed Forces and Society, 33*(3), 337-350.

Grossman, D. (2009). *On killing: The psychological cost of learning to kill in war and society.* New York, NY: Bay Back Books.

Hartley, R., & Baldwin, J. (2019). Waging war on recidivism among justice-involved veterans: An impact evaluation of a large urban veterans treatment court. *Criminal Justice Policy Review, 30*(1), 52-78.

Hawkins, M. (2009). Coming home: Accommodating the special needs of military veterans in the criminal justice system. *Ohio State Journal of Criminal Law, 7*, 563-573.

Heisler, E. (2018). The *Mental Health Workforce: A Primer*. Washington, DC: Congressional Research Service.

Helzer, J., Robins, L., and McEnvoy, L. (1987). Post-traumatic stress disorder in the general population: Findings of the epidemiologic catchment area survey. *New England Journal of Medicine, 317*(26), 1630-1634.

Henggeler, S. W., Halliday-Boykins, C. A., Cunningham, P. B., Randall, J., & Shapiro, S. B. (2006). Juvenile drug court: Enhancing outcomes by integrating evidence-based treatments. *Journal of Consulting and Clinical Psychology, 74*, 42-54.

Hiller, M., Belenko, S., Taxman, F., Young, D., Perdoni, M., & Saum, C. (2010).

Measuring drug court structure and operations: Key components and beyond. *Criminal Justice and Behavior, 37*, 933-950.

Hirschi, T. (1969). Causes *of delinquency*. Berkeley: University of California Press.

History.com. (2018). War on drugs. Retrieved at https://www.history.com/topics/the-war-on-drugs.

Hirschi, T., & Gottfredson, M. (1983). Age and the explanation of crime. *American Journal of Sociology, 90*, 1330-1333.

Hoge, C., Auchterlonie, J., & Milliken, C. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association, 295* (9), 1023-1032.

Hoge, C., & Castro, C. (2012). Preventing suicides in US service members and veterans: Concerns after a decade of war. *Journal of the American Medical Association, 308*, 671-672.

Hoge, C., Castro, C., Messer, S., McGurk, D., Cotting, D., & Koffman, R. (2004). Combat duty, mental health problems and barriers to care. *New England Journal of Medicine, 351,* 13-22.

Hora, P., Schma, W., & Rosenthal, J. (1999). Therapeutic jurisprudence and the drug treatment court movement: Revolutionizing the criminal justice system's response to drug abuse and crime in America. *Notre Dame Law Review, 74*, 439-538.

Hourani, L., Bender, R., Weimer, B., & Larson, G. (2012). Comparative analysis of mandated versus voluntary administrations of post-deployment health assessments among Marines. *Military Medicine, 177*(6), 643–8.

Huddleston, W., & Marlowe, D.B. (2011). *Painting the current picture: A national report on drug courts and other problem-solving court programs in the United States.* Alexandria, VA: National Drug Court Institute.

IBM Corp. Released 2015. IBM SPSS Statistics for Windows, Version 23.0. Armonk, NY: IBM Corp.

Institute of Medicine. (2013). *Returning home from Iraq and Afghanistan: Assessment of readjustment needs of veterans, service members, and their families*. Washington DC: The National Academies Press.

Jacobson, I., Ryan, M., Hooper, T., Smith, T., Amoroso, P., Boyko, E., Gackstetter, G., Wells, T., & Bell, N. (2008). Alcohol use and alcohol-related problems before and after military combat deployment. *Journal of the American Medical Association, 300*, 663-675.

Jakupcak, M., Conybeare, D., Phelps, L., Hunt, S., Holmes, H.A., Felker, B., & McFall, M.E. (2007). Anger, hostility, and aggression among Iraq and Afghanistan war veterans reporting PTSD and subthreshold PTSD. *Journal of Traumatic Stress, 20*(6), 945–954.

Janssen, J.S. (2013). Locked in the vault: Survivor guilt in combat veterans. *Social Work Today.* Retrieved from https://www.socialworktoday.com/news/enews_0713_1.shtml

Johnson, J.E., O'Leary, C.C., Striley, C.W., Abdallah, A.B., Bradford, S., & Cottler, L.B.

(2011). Effects of major depression on crack use and arrests among women in drug court. *Addiction, 106*(7), 1279–1286.

Johnson, R.S., Stolar, A.G., McGuire, J.F., Mittakanti, K., Clark, S., Coonan, L.A., & Graham, D.P. (2017). Predictors of incarceration of veterans participating in U.S. veterans' courts. *Psychiatric Services, 68*(2), 144-150.

Johnson, T., & Fendrich, M. (2002). *A validation of the Crowne-Marlowe Social Desirability Scale.* Retrieved from http://www.srl.uic.edu/publist/Conference/crownemarlowe.pdf

Jordan, B., Schlenger, W., Hough, R., Kulka, R., Weiss, D., Fairbank, J., & Marmar, C. (1991). Lifetime and current prevalence of specific psychiatric disorders among Vietnam veterans and controls. *Archives of General Psychiatry, 48*(3), 207-215.

Jorge, R., Starkstein, S., Arndt, S., Moser, D., Crespo-Facorro, B., & Robinson, R. (2005). Alcohol misuse and mood disorders following traumatic brain injury. *Archives of General Psychiatry, 62*, 747-748.

Justice for Vets. (2017). *The ten key components of veterans treatment courts.* Retrieved from https://justiceforvets.org/wp-content/uploads/2017/02/The-Ten-Key-Components-of-Veterans-Treatment-Courts.pdf

Justice for Vets. (2018). *Veteran's treatment court fact sheet.* Retrieved from https://justiceforvets.org/

Kabiri, S., Cochran, J., Severson, R., Shadmanfaat, S., Rahmati, M., & Sharepou, M. (2018). Social and personal controls and performance enhancing drug use: Toward an explanation of doping activity among professional athletes in Rasht, Iran. *Deviant Behavior, 39*(11), 1483-1496.

Kalich, D.M. & Evans, R.D. (2006). Drug court: An effective alternative to incarceration. *Deviant Behavior, 27*(6), 569-590.

Kang, H., Natelson, B., Mahan, C., Lee, K., & Murphy, F. (2003). Post-traumatic stress disorder and chronic fatigue syndrome-like illnesses among Gulf War veterans: A population based study of 30,000 veterans. *American Journal of Epidemiology, 157*(2), 141-148.

Kentucky Court of Justice. (2018). *Veteran's treatment court programs.* Retrieved from https://courts.ky.gov/courtprograms/vtc/Pages/vtcprograms.aspx.

Kentucky Office of Drug Control Policy. (2019). *2018 combined annual report of Kentucky Office of Drug Control Policy and Kentucky Agency for Substance Abuse Policy*. Retrieved from https://odcp.ky.gov/Reports/2018%20KYODCP%20KYASAP%20Combined%20Annual%20Report%20(Final).pdf

Kentucky Specialty Courts. (2016). *Paving the road to recovery: Handbook for Kentucky drug court participants.* Frankfort, KY: Administrative Office of the Courts.

Kessler, R., Heeringa, S., Stein, M., Colpe, L., Fullerton, C., Hwang, I.…Ursano, R. (2014). Thirty-day prevalence of DSM IV mental disorders among nondeployed soldiers in the US Army: Results from the Army Study to Assess Risk and Resilience Among Servicemembers (Army STARRS). *JAMA Psychiatry, 71*(5), 501-513.

Kessler, R., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048-1060.

Killgore, W., Cotting, D., Thomas, J., Cox, A., McGurk, D., Vo, A., & Hoge, C. (2008). Post-combat invincibility: Violent combat experiences are associated with increased risk-taking propensity following deployment. *Journal of Psychiatric Research, 42*(13), 1112–1121.

King, M., & Brunner, G. (2000). Social desirability bias: A neglected aspect of validity testing. *Psychology & Marketing, 17*(2), 79-103.

Knudsen, K., & Wingenfeld, S. (2015). A specialized treatment court for veterans with trauma exposure: Implications for the field. *Community Mental Health Journal, 52*, 127-135.

Koeppel, M., & Chism, K. (2018). Substance use and sexual orientation: A test of Hirschi's social bonds theory. *American Journal of Criminal Justice, 43*(2), 278-293.

Kroenke, K., Spitzer, R., & Williams, J. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606-613.

Larson G, & Norman, S. (2014). Prospective prediction of functional difficulties among recently separated veterans. *Journal of Rehabilitation Research and Development, 51*, 415–427.

Larson, M., Wooten, N., Adams, R., & Merrick, E. (2012). Military combat deployments and substance use: Review and future directions. *Journal of Social Work Practice in the Addictions, 12* (1), 6-27.

Latimer, J., Morton-Bourgon, K., & Chrétien, J.-A. (2006). *A meta-analytic examination*

of drug treatment courts: Do they reduce recidivism? Ottawa, Ontario, Canada: Research and Statistics Division, Canada Department of Justice.

Laub, J., & Sampson, R. (1993). Turning points in the life course: Why change matters to the study of crime. *Criminology, 31*(3), 301-325.

Laub, J. & Sampson, R. (2003). *Shared beginnings, divergent lives: Delinquent boys to age 70*. Cambridge, MA: Harvard University Press.

LeardMann, C., Powell, T., Smith, T., Bell, M., Smith, B., Boyko, J., …Hoge, C. (2013). Risk factors associated with suicide in current and former US military personnel. *Journal of the American Medical Association, 310*(5), 496-506.

Leukefeld, C., Logan, T.K., Martin, S., Purvis, R., & Farabee, D. (1998). A health services use framework for drug-abusing offenders. *American Behavioral Scientist, 41*(8), 1044-1049.

Logan, T. K., Hoyt, W., McCollister, K. E., French, M. T., Leukefeld, C., & Minton, L. (2004). Economic evaluation of drug court: Methodology, results, and policy implications. *Evaluation & Program Planning, 27*, 381-396.

Logsdon, C., & Keogh, M. (2010). Uncommon criminals: Why veterans need their own treatment court. *Arizona Attorney, 47*, 14-24.

Lowenkamp, C., Holsinger, A., & Latessa, E. (2005). Are drug courts effective: A meta-analytic review. *Journal of Community Corrections, 15*(1), 5-11.

Lucas, P., & Hanrahan, K. (2016). No soldier left behind: The veteran's court solution. *International Journal of Law and Psychiatry, 45*, 52-59.

Lunden, W. (1952). Military service and criminality. *The Journal of Criminal Law, Criminology, and Political Science, 42* (6), 766-776.

Marlowe, D. (2010). *Research update on adult drug courts.* Retrieved from https://www.nadcp.org/sites/default/files/nadcp/Research%20Update%20on%20Adult%20 Drug%20Courts%20-%20NADCP_1.pdf

Marlowe, D., Hardin, C., & Fox, C. (2016). *Painting the current picture: A national report on drug courts and other problem-solving courts in the United States.* Alexandria, VA: National Drug Court Institute.

Marlowe, D., & Meyer, W. (2011). *The drug court judicial benchbook.* Alexandria VA: National Drug Court Institute.

Mateyoke-Scrivner, A., Webster, J. M., Staton, M., & Leukefeld, C. (2004). Treatment retention predictors of drug court participants in a rural state. *The American Journal of Drug and Alcohol Abuse, 30*, 605–625.

McCaffrey, B. (2013). Opening comments. *Presented at the Vet Court Con, December 2, 2013*, Washington, DC.

McCormick-Goodhart, M. (2013). Leaving no veteran behind: Policies and perspectives on combat trauma, veterans courts, and the rehabilitative approach to criminal behavior. *Penn State Law Review, 117*(3), 895-926.

McFall, M., & Cook, J. (2006). PTSD and health risk behavior. *PTSD Quarterly, 17,* 1-2.

McGuire, J., Rosenheck, R., & Kasprow, W. (2003). Health status, service use, and costs among veterans receiving outreach services in jail or community settings. *Psychiatric Services, 42,* 201-207.

McGuire, J., Clark, S., Blue-Howells, J., & Coe, C. (2013). *An inventory of VA*

involvement in veterans courts, dockets, and tracks. Retrieved from http://www.justiceforvets.org/sites/default/files/files/An%20Inventory%20of%20VA%20inv olvement%20in%20Veterans%20Courts.pdf.

McGurk, D., Cotting, D. I., Britt, T. W., & Adler, A. B. (2006). Joining the ranks: The role of indoctrination in transforming civilians to service members. In A. B. Adler, C. A. Castro, & T. W. Britt (Eds.), *Military life: The psychology of serving in peace and combat: Operational stress* (pp. 13-31). Westport, CT,: Praeger Security International.

McLellan, A., Luborsky, L., Cacciola, J., Griffith, J., Evans, F., Barr, H. L., & O'Brien, C. P. (1985). New data from the Addiction Severity Index: Reliability and validity in three centers. *Journal of Nervous and Mental Disease, 173*(7), 412-423.

McLellan, A., Luborsky, L., Woody, G., & O'Brien, C. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous and Mental Disease, 168*(1), 26-33.

McLellan, A., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., Pettinati, H. & Argeriou, M. (1992). The 5th edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment, 9*, 199–213.

McMichael, W. (2011). The battle on the home front: Special courts turn to vets to help other vets. *ABA Journal*. Retrieved from http://www.abajournal.com/magazine/article/the_battle_on_the_home_front_special_courts_turn_to_vets_to_help_other_vets

McNally, R., & Frueh, B.C. (2013). Why are Iraq and Afghanistan War veterans

seeking PTSD disability compensation at unprecedented rates? *Journal of Anxiety Disorders, 27*, 520-526.

Mechanic, D. (1979). Correlates of physician utilization: Why do multivariate studies of physician utilization find trivial psychosocial and organizational effects? *Journal of Health and Social Behavior, 20*, 387-396.

Mendoza, N. S., Trinidad, J. R., Nochajski, T. H., & Farrell, M. C. (2013). Symptoms of depression and successful drug court completion. *Community Mental Health Journal, 49*, 787–792.

Merrick, M. T., Ports, K. A., Ford, D. C., Afifi, T. O., Gershoff, E. T., & Grogan-Kaylor, A. (2017). Unpacking the impact of adverse childhood experiences on adult mental health. *Child Abuse & Neglect, 69*, 10–19.

Miller, J., & Johnson, D. (2009). *Problem solving courts: A measure of justice.* Lanham MD: Rowan & Littlefield Publishers.

Mitchell, O., Wilson, D.B., Eggers, A., & MacKenzie, D. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice, 40*(1), 60-71.

Moffitt, T. E. (1993). Life-course persistent and adolescence-limited antisocial behavior: A developmental taxonomy. *Psychological Review, 100*, 674-701.

Monnat, S. M., & Chandler, R. F. (2015). Long term physical health consequences of adverse childhood experiences. *The Sociology Quarterly 56*(4), 723–752.

National Association of Drug Court Professionals. (1997). *Defining drug courts: The key components.* Retrieved from https://www.ncjrs.gov/pdffiles1/bja/205621.pdf.

National Association of Drug Court Professionals. (2013). *Adult drug court best*

practices standards. Alexandria, VA: Author. Retrieved from https://justiceforvets.org/wp-content/uploads/2017/03/Best-Practice-Standards-Vol.-I.pdf

National Association of Drug Court Professionals. (2018a). Treatment courts are advancing justice. Video retrieved from http://www.nadcp.org/about/, 2:04.

National Association of Drug Court Professionals. (2018b). *Treatment courts in the U.S.: Cutting crime, saving money.* Retrieved from http://www.nadcp.org/wp-content/uploads/2018/03/US-Drug-Court-Fact-Sheet.pdf

National Association of Social Workers. (2018). *Code of ethics.* Washington DC: NASW Press.

National Association of Social Workers. (2019). *About Social Workers*. Retrieved from https://www.socialworkers.org/News/Facts/Social-Workers.

National Center on Addiction and Substance Abuse. (2010). *Behind bars II: Substance Abuse and America's prison population.* New York, NY: Columbia University.

National Institute of Justice. (2019). *Courts.* Retrieved from https://www.nij.gov/topics/courts/drug-courts/Pages/welcome.aspx

National Institute of Justice. (2019). *National statistics on recidivism.* Retrieved from https://www.nij.gov/topics/corrections/recidivism/pages/welcome.aspx#statistics

National Institutes of Health. (2018). *Opioid-related overdose deaths.* Retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/kentucky-opioid-summary

Nellis, A. (2016). *The color of injustice: Racial and ethnic disparity in state prisons.*

Retrieved from the Sentencing Project website: https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/

Niederland, W.G. (1961). The problem of the survivor. *Journal of Hillside Hospital, 10*, 233-247.

Niederland, W.G. (1980). The survivor syndrome: Further observations and dimensions. *Journal of American Psychoanalytic Society, 29*(2), 413-425.

Nixon, R. (1971). *Public papers of the presidents of the United States: Richard Nixon.* Retrieved from https://quod.lib.umich.edu/p/ppotpus/4731800.1971.001/821?page=root;rgn=full +text;size=100;view=image

O'Connor, L., Berry, J., Lewis, T., & Stiver, D. (2011). Empathy-based pathogenic guilt, pathological altruism, and psychopathology. In: B. Oakley, A. Knafo, G. Madhavan, & D. Wilson, (Eds.), *Pathological altruism*. Oxford, England: Oxford University Press.

O'Connor, L., Berry, J., Weiss, J., Bush, M., & Sampson, H. (1997). Interpersonal guilt: The development of a new measure. *Journal of Clinical Psychology, 53*(1), 73–89.

Oleson, J. J., Brown, G.D., & McCreery, R. (2019). Essential statistical concepts for research in speech, language, and hearing sciences. *Journal of Speech, Language, and Hearing Research, 62*(3), 489-497.

Oser, C., Leukefeld, C., Staton-Tindall, M., Garrity, T., Carlson, R., Falck, R., Wang, J.,

& Booth, B. (2011). Rural drug users: Factors associated with substance abuse treatment utilization. *International Journal of Offender Therapy and Comparative Criminology, 55*(4), 567-586.

Pentland, B., & Scurfield, R. (1982). Inreach counseling and advocacy with veterans in prison. *Federal Probation, 46*(1), 21-28.

Peters, R. H., Greenbaum, P. E., Steinberg, M. L., Carter, C. R., Ortiz, M. M., Fry, B. C. & Valle, S. K. (2000) Effectiveness of screening instruments in detecting substance use disorders among prisoners. *Journal of Substance Abuse Treatment*, 18, 349–358.

Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2009). Perceived stigma and barriers to mental health care utilization among OEF-OIF veterans. *Psychiatric Services, 60*(8), 1118–1122

Piquero, A. R., Farrington, D. P., & Blumstein, A. (2003). The criminal career paradigm. In M. Tonry (Ed.), Crime *and justice: A review of the research, volume 30* (pp. 359-506). Chicago, IL: University of Chicago Press.

Ponsford, J., Whelan-Goodinson, R., & Bahar-Fuchs, A. (2007). Alcohol and drug use following traumatic brain injury: A prospective study. *Brain Injury, 21*, 1385-1392.

Prigerson, H., Maciejewski, P., & Rosenheck, R. (2001). Combat trauma: Trauma with highest risk of delayed onset and unresolved posttraumatic stress disorder symptoms, unemployment, and abuse among men. *Journal of Nervous Mental Disorders, 189*(2), 99-108.

Prigerson, H., Maciejewski, P., & Rosenheck, R. (2002). Population attributable

fractions of psychiatric disorders and behavioral outcomes associated with combat exposure among US men. *American Journal of Public Health, 92*(1), 59-63.

Raine, A. (2013*). The psychopathology of crime: Criminal behavior as a clinical disorder.* San Diego, CA: Elsevier.

Rempel, M., Green, M., & Kralstein, D. (2012). The impact of adult drug courts on crime and incarceration: Findings from a multi-site quasi-experimental design. *Journal of Experimental Criminology, 8*(2), 165–192.

Rosen, C. S., Henson, B. R., Finney, J. W. &Moos, R. H. (2000) Consistency of self-administered and interview-based Addiction Severity Index composite scores. *Addiction*, 95, 419–425.

Ross, J., Waterhouse-Bradley, B., Contractor, A., & Armour, C. (2018). Typologies of adverse childhood experiences and their relationship to incarceration in U.S. military veterans. *Child Abuse & Neglect, 79*, 74-84.

Rossellini, A., Heeringa, S., Stein, M., Ursano, R., Chiu, W., Colpe, L. & Naifeh, J. (2015). Lifetime prevalence of DSM-IV mental disorders among new soldiers in the US Army: Results from the Army Study to Assess Risk and Resilience in Servicemembers (STARRS). *Depression and Anxiety, 32*(1), 13-24.

Rossellini, A., Stein, M., Benedek, D., Bliese, P., Chiu, W., Hwang, I., …Kessler, R. (2017). Using self-report surveys at the beginning of service to develop multi-outcome risk models for new soldiers in the U.S. Army. *Psychological Medicine, 47*(13), 2275-2287.

Rossman, S.B., Rempel, M., Roman, J.K., Zweig, J.M., Lindquist, C.H., Green, M., … Farole, D. J. (2011). *The Multi-Site Adult Drug Court Evaluation: The impact of*

drug courts, volume 4. Washington, DC: Urban Institute Justice Policy Center.

Rossman, S.B., Willison, J.B., Mallik-Kane, K., Kim, K., Debus-Sherill, S., & Downey, P.M. (2012). *Criminal justice interventions for offenders with mental illness: Evaluation of mental health courts in Bronx and Brooklyn, New York: Final report.* Washington, DC: The Urban Institute. Retrieved from http://www.courtinnovation.org/sites/default/files/documents/Criminal_Justice_Interventions.pdf

Rothman, E. F., Edwards, E. M., Heeren, T., & Hingson, R. W. (2008). Adverse childhood experiences predict earlier age of drinking onset: results from a representative US sample of current or former drinkers. *Pediatrics 122*(2), 298–304.

Rothman, K. (1990). No adjustments are needed for multiple comparisons. *Epidemiology, 1*(1), 43-46.

Rundall, T. (1981). A suggestion for improving the behavioral model of physician utilization. *Journal of Health and Social Behavior, 22*, 103-104.

Russell, R. (2009). Veteran's treatment court: A proactive approach. New England *Journal on Criminal and Civil Confinement, 35*, 357-372.

Sampson, R., & Laub, J. (1993). *Crime in the making: Pathways and turning points through life.* Cambridge, MA: Harvard University Press.

Sanford, J.S., & Arrigo, B.A. (2005). Lifting the cover on drug courts: Evaluation findings and policy concerns. *International Journal of Offender Therapy and Comparative Criminology, 49*, 239-259.

Sareen, J., Cox, B., Afifi, T., Stein, M., Belik, S., Meadows, G., & Asmundon, G.

(2007). Combat and peacekeeping operations in relation to prevalence of mental disorders and perceived need for mental health care: Findings from a large representative sample of military personnel. *Archives of General Psychiatry, 64*(7), 843-852.

Sarteschi, C., Vaughn, M., & Kim, K. (2011). Assessing the effectiveness of mental health courts: A quantitative review. *Journal of Criminal Justice, 39*(1), 12-20.

Satre, D., DeLorenze, G., Quesenberry, C., Tsai, A., & Weisner, C. (2013). Factors associated with treatment initiation for psychiatric and substance use disorders among persons with HIV. *Psychiatric Services, 64*(8), 745-753.

Saum, C. A., & Gray, A. R. (2008). Facilitating change for women? Exploring the role of therapeutic jurisprudence in drug court. In T. Anderson (Ed.), *Neither villain nor victim* (pp. 102-116). Piscataway, NJ: Rutgers University Press

Sayer, N., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., Murdoch, M. (2010). Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatric Services, 61*(6), 589-597.

Saxon, A., Davis, T., Sloan, K., McKnight, K., McFall, M., & Kivlahan, D. (2001). Trauma, symptoms of PTSD and associated problems among incarcerated veterans. *Psychiatric Services, 52*, 959-962.

Seal, K., Cohen, G., Waldrop, A., Cohen, B., Maguen, S., & Ren L. (2011). Substance use disorders in Iraq and Afghanistan veterans in VA healthcare, 2001-2010: Implications for screening, diagnosis, and treatment. *Drug and Alcohol Dependence, 116*(1-3), 93-101.

Schoenbaum, M., Kessler, R., & Gilman, S. (2014). Predictors of suicide and accident

death in the Army Study to Assess Risk and resilience in Servicemembers (Army STARRS). *JAMA Psychiatry, 74*(5), 493-503.

Shaffer, D.K. (2010). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly, 28*(3), 493–521.

Shaffer, D.K., Hartman, J.L., Listwan, S.J., Howell, T., & Latessa, E.J. (2011). Outcomes among drug court participants: Does drug of choice matter? *International Journal of Offender Therapy and Comparative Criminology, 55*(1), 155-174.

Shah, S., DeMatteo, D., Keesler, M., Davis, J., Heilbrun, K., & Festinger, D. S. (2013). Addiction Severity Index scores and urine drug screens at baseline as predictors of graduation from drug court. *Crime & Delinquency, 61*, 1257–1277.

Shannon, L. (2016). *Jefferson County veterans treatment court: Project implementation and evaluation overview.* Morehead State University.

Shannon, L., Birdwhistell, S., Hulbig, S., Jackson Jones, A., Newell, J., & Payne, C. (2017). Examining implementation and preliminary performance indicators of veterans treatment courts: The Kentucky experience. *Evaluation and Program Planning, 63*, 54-66.

Shannon, L., Jackson Jones, A., Nash, S., Newell, J., & Payne, C. (2018). Examining racial disparities for program completion and post-program recidivism rates: Comparing Caucasian and non-Caucasian treatment court participants. *Journal for Advancing Justice, 1*, 63-79.

Shannon, L., Jackson, A., Perkins, E., & Neal, C. (2014). Examining gender differences in substance use, participant characteristics, and treatment outcomes among individuals in drug court. *Journal of Offender Rehabilitation, 53*, 455–477.

Shannon, L., Jackson Jones, A., Perkins, E., Newell, J., & Neal, C. (2016). Examining individual factors and during program performance to understand drug court completion. *Journal of Offender Rehabilitation, 55*, 271–292.

Shannon, L., Jackson Jones, A., Perkins, E., Newell, J., & Payne, C. (2018). Examining factors associated with program completion among women participants in a statewide drug court program. *Journal of Social Work Practice in the Addictions, 18*, 1-24.

Sherman, M., Sautter, F., Jackson, H., Lyons, J., & Han, X. (2006). Domestic violence in veterans with posttraumatic stress disorder who seek couples therapy. Journal of *Marital and Family Therapy, 32*, 479-490.

Shulkin, D. (2017). Understanding veteran wait times. *Annals of Internal Medicine, 167*(1), 52-54.

Simo, B., Bamvita, J., Caron, J., & Fleury, M. (2018). Predictors of mental health service use among individuals with high psychological distress and mental disorders. *Psychiatry Research, 270*, 1122-1130.

Sirim, C. (2011). From Nixon's war on drugs to Obama's drug policies today: Presidential progress in addressing racial injustices and disparities. *Race, Gender & Class, 18*(3/4), 82-89.

Skeem, J.L., Manchak, S., & Peterson, J.K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law and Human Behavior, 35*(2), 110–126.

Slattery, M., Dugger, M., Lamb, T., & Williams, L. (2013). Catch, treat, and release:

Veterans treatment courts address the challenges of returning home. *Substance Use and Misuse, 48*, 922-932.

Smee, D., McGuire, J., Garrick, T., Sreenivasan, S., Dow, D., & Woehl, D. (2013). Critical concerns in Iraq / Afghanistan war veteran forensic interface: Veterans treatment court as diversion in rural communities. *Journal of the American Academy of Psychiatry and the Law, 41*(2), 256-261.

Smith, J. (2012). The Anchorage, Alaska veterans court and recidivism: July 6, 2004 – December 31, 2010. *Alaska Law Review, 29*, 93-111.

Smith, T., Ryan, M., Wingard, D., Slymen, D., Sallis, J., & Kritz-Silverstein, D. (2008). New onset and persistent symptoms of post-traumatic stress disorder self reported after deployment and combat exposures: prospective population based US military cohort study. *BMJ, 336* (7640), 1737-1744.

Snow, D., & Tipton, P. (2009). Evaluation of psychometric properties of variations of the Addiction Severity Index. *Journal of Addictions Nursing, 20*, 52-54.

Snowden, D., Oh, S., Salas-Wright, C., Vaughn, M., & King, E. (2017). Military service and crime: New evidence. *Social Psychiatry and Psychiatric Epidemiology, 52*(5), 605-615.

Sparr, L., Reaves, M., & Atkinson, R. (1987). Military combat, posttraumatic stress disorder, and criminal behavior in Vietnam veterans. *Journal of the American Academy of Psychiatry and the Law, 15*, 141-162.

Spence, N., Henderson, K., & Elder, G. (2012). Does adolescent family structure predict military enlistment? A comparison of post high school activities. *Journal of Family Issues, 34*(9), 1194-1216.

Spiro A., Settersten R., & Aldwin, C. (2016). Long-term outcomes of military service in aging and the life course: A positive reenvisioning. *Gerontologist, 56*(1), 5–13.

Sreenivasan, S., Rosenthal, J., Smee, D., Wilson, K., & McGuire, J. (2018). Coming home from prison: Adapting military resilience training to enhance successful community reintegration for justice-involved Iraq-Afghanistan veterans. *Psychological Services, 15*(2), 163-171.

Stahre, M., Brewer, R., Fonseca, V., & Naimi, T. (2009). Binge drinking among U.S. active-duty military personnel. *American Journal of Preventative Medicine, 36*, 208-217.

Starr, S., & Rehavi, M. (2014). Racial disparity in federal criminal sentences. *Journal of Political Economy, 122*(6), 1320-1354.

Substance Abuse and Mental Health Services Administration. (2017). *Behavioral health barometer, Kentucky volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System.* HHS Publication No. SMA–17–Baro– 16–States–KY. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sullivan, C.P., & Elbogen, E.B. (2014). PTSD symptoms and family versus stranger violence in Iraq and Afghanistan veterans. *Law and Human Behavior, 38*(1), 1-9.

Tanielian, T., & Jaycox, L. (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery.* Washington DC: RAND Center for Military Health Policy and Research.

Tanielian, T., Jaycox, L., Schell, T., Marshall, G., Burnam, M., Eibner, C., Karney, B.,

Meredith, L., Ringel, J., & Vaiana, M. (2008). *Summary and recommendations for addressing psychological and cognitive Injuries*. Santa Monica, Calif.: RAND Corporation. Retrieved from http://veterans.rand.org

Teachman, J., & Tedrow, L. (2014). Delinquent behavior, the transition to adulthood, and the likelihood of military service. *Social Science Research, 45*, 46-55.

Teachman, J., & Tedrow, L. (2016). Altering the life course: Military service and contact with the criminal justice system. *Social Science Research, 60*, 74–87

The Sentencing Project. (2018). *Report of the Sentencing Project to the United Nations special rapporteur on contemporary forms of racism, racial discrimination, xenophobia, and related intolerance.* Retrieved from https://www.sentencingproject.org/wp-content/uploads/2018/04/UN-Report-on-Racial-Disparities.pdf

Toomey, R., Hang, H., Karlinsky, J., Baker, D., Vasterling, J., Alpern, R., …Eisen, S. (2007). Mental health of US Gulf War veterans 10 years after the war. *British Journal of Psychiatry, 190*(5), 385-393.

Tsai, J., Finlay, A., Flatley, B., Kasprow, W., & Clark, S. (2018). A national study of veterans treatment court participants: Who benefits and who recidivates. *Administration and Policy in Mental Health and Mental Health Services Research, 45*(2), 236-244.

Tsai, J., Flatley, B., Kasprow, W., Clark, S., & Finlay, A. (2017). Diversion of veterans with criminal justice involvement to treatment courts: Participant characteristics and outcomes. *Psychiatric Services, 68*(4), 375-383.

Tsai, J., Rosenheck, R., Kasprow, W., & McGuire, J. (2013). Risk of incarceration and

other characteristics of Iraq and Afghanistan era veterans in state and federal prisons. *Psychiatric Services, 64*(1), 36-43.

United States Army. (2015). *Basic combat training*. Retrieved from https://www.goarmy.com/soldier-life/becoming-a-soldier/basic-combat-training.html

United States Department of Veterans Affairs. (2009). *VA/DoD clinical practice guideline for management of substance use disorders.* Washington, DC: Department of Veterans Affairs and Department of Defense.

United States Department of Veterans Affairs. (2015). *Analysis of VA health care utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) veterans*. Office of Public Health. Retrieved from https://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2015-qtr1.pdf

United States Department of Veterans Affairs. (2016). *National Center for Veterans Analysis and Statistics: Veteran population.* Retrieved from http://www.va.gov/vetdata/veteran_population.asp

United States Department of Veterans Affairs. (2018a). *How common is PTSD?* Retrieved from https://www.ptsd.va.gov/understand/common/index.asp

United States Department of Veterans Affairs. (2018b). *PTSD and substance abuse in veterans.* Retrieved from https://www.ptsd.va.gov/understand/related/substance_misuse.asp

United States Department of Veterans Affairs. (2018c). *VA national suicide data report,*

2005-2016. Retrieved from https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2016_508.pdf

United States Department of Veterans Affairs. (2018d). *Veterans treatment courts and other veteran-focused courts served by VA veterans justice outreach specialists.* Retrieved from https://www.va.gov/HOMELESS/docs/VJO/2018-Veterans-Treatment-Courts-FactSheet-508.pdf

United States Department of Veterans Affairs. (2019a). *About VA health benefits*. Retrieved from https://www.va.gov/health-care/about-va-health-benefits/.

United States Department of Veterans Affairs. (2019b). *VA benefits*. Retrieved from https://www.va.gov/records/.

United States Department of Veterans Affairs. (2019c). *Veteran population.* Retrieved from https://www.va.gov/vetdata/Veteran_Population.asp

United States Department of Veterans Affairs. (2019d). *VHA social work.* Retrieved from https://www.socialwork.va.gov.

United States Government Accountability Office. (2011). *Adult drug courts: Studies show courts reduce recidivism, but DOJ could enhance future performance measure revision efforts* (GAO-12-53). Washington, DC: Author.

United States Sentencing Commission. (2017). *Demographic differences in sentencing: An update to the 2012 Booker report.* Retrieved from https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20171114_Demographics.pdf

Ursano, R., Colpe, L., Herringa, S., Kessler, R., Schoenbaum, M., & Stein, M. (2014).

The Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *Psychiatry, 77*(2), 107 – 119.

Valente, S., & Wright, C. (2007). Military sexual trauma: violence and sexual abuse. *Military Medicine, 172*(3), 259-265.

Varga, C., Haibach, M., Rowan, A., & Haibach, J. (2018). Psychiatric history, deployments, and potential impacts of mental health care in a combat theater. *Military Medicine, 183*(1-2), 77-82.

Vaughan, T.J., Holleran, L.B., & Brooks, R. (2016). Exploring therapeutic and militaristic contexts in a veteran treatment court. *Criminal Justice Policy Review, 30*(1), 79-101.

Wang, P.S., Berglund, P., Olfson, M., Pincus, H.A., Wells, K.B., & Kessler, R.C. (2005a). Failure and delay in initial treatment contact after first onset of mental disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*(6), 603–613.

Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., & Kessler, R.C. (2005b). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 629-640.

Warner, C., Appenzeller, G., Grieger, T., Belenkiy, S., Breitbach, J., Parker, J., Warner, C., & Hoge, C. (2011). Importance of anonymity to encourage honest reporting in mental health screening after combat deployment. *Archives of General Psychiatry, 68*(10), 1065-1071.

Weaver, C.M., Trafton, J.A., Kimerling, R., Timko, C., & Moos, R. (2013). Prevalence

and nature of criminal offending in a national sample of veterans in VA substance use treatment prior to the Operation Enduring Freedom/Operation Iraqi Freedom conflicts. *Psychological Services, 10*(1), 54-65

Weisner, C., Matzger, H., Tam, T., & Schmidt, L. (2002). Who goes to alcohol and drug treatment? Understanding utilization within the context of insurance. *Journal of Studies on Alcohol, 63*(6), 673-672.

Wertz, J. S., Cleaveland, B. L. & Stephens, R. S. (1995) Problems in the application of the Addiction Severity Index (ASI) in rural substance abuse services. *Journal of Substance Abuse*, 7, 175–188.

Wexler, D.B. (2016). Guiding court conversations long pathways conductive to rehabilitation: Integrating procedural justice and therapeutic jurisprudence. *International Journal of Therapeutic Jurisprudence, 1*, 367-372.

Wexler, D.B., Perline, M., Vols, M., Spencer, P., & Stobbs, N. (2016). Guest Editorial: Current issues in therapeutic jurisprudence. *QUT Law Review, 16* (3), 1 – 3.

Wexler, D.B., & Winick, B.J. (1991). Therapeutic jurisprudence as a new approach to mental health law policy analysis and research. *University of Miami Law Review, 45* (5), 979 – 1004.

Wiatrowski, M., Griswold, D., & Roberts, M. (1981). Social control theory and delinquency. *American Sociological Review, 46*, 525-541.

Wilson, D.B., Mitchell, O., & MacKenzie, D. L. (2006). A systematic review of drug Court effects on recidivism. *Journal of Experimental Criminology, 2*, 459-487.

Wilson, L. (2016). The prevalence of military sexual trauma: A meta-analysis. *Trauma, Violence, & Abuse, 19*(5), 584-597.

Winick, B.J., & Wexler, D.B. (2001*).* Drug treatment court: Therapeutic jurisprudence applied. *Touro Law Review, 18*, 479.

Winick, B.J., & Wexler, D.B. (2003*). Judging in a therapeutic key: Therapeutic jurisprudence and the courts.* Durham: Carolina Academic Press.

Wolf, E., & Colyer, C. (2001). Everyday hassles: Barriers to recovery in drug court. *Journal of Drug Issues, 31*(1), 233-258.

Wolf, E. M., Sowards, K. A., & Wolf, D. A. (2003). Predicting retention of drug court participants using event history analysis. In N. Pallone (Ed.), *Treating substance users in correctional contexts: New understandings, new modalities* (pp. 139–162). Haworth Press: Binghamton, NY.

Wright, J. P., Carter, D. E., & Cullen, F. T. (2005). A life-course analysis of military service in Vietnam. *Journal of Research in Crime and Delinquency, 42*(1), 55–83.

Yarvis, J. (2011). A civilian social worker's guide to the treatment of war-induced PTSD. *Social Work in Health Care, 50*, 51-72.

Vita

MONICA LYNN HIMES

Education

Master of Science in Social Work **May 2009**
University of Louisville, Kent School of Social Work

Bachelor of Arts in Social Work **May 2006**
University of Kentucky College of Social Work

Teaching Experience

Assistant Professor of Social Work **Aug 2018 – present**
Morehead State University

Teaching Assistant **Aug 2017 - present**
University of Kentucky

Instructor / Program Facilitator **Jul 2013 – Aug 2018**
Morehead State University

Adjunct Faculty **Aug 2012 – Jul 2013**
Morehead State University

Clinical Experience

Assessment Counselor **Apr 2014 – Jan 2016**
Ridge Behavioral Health Systems

Clinical Director **May 2010 – Jun 2013**
Recovery Works Drug & Alcohol Treatment Center

Therapist **Jun 2009 – May 2013**
Recovery Works Drug & Alcohol Treatment Center

Social Service Worker II **Oct 2006 – Jun 2009**
Morehead State University

Publications

Himes, M. (2016). Clients and students: Reflections on the parallels found between direct social work practice and social work education. *Perspectives in Social Work, 12*(2), 22-28.

Presentations

From Soldier to Student: The Transition Experiences of Student Veterans in Higher Education, Presented at University of Texas Military Social Work Conference, Austin, TX. September 6, 2018.

Gender Differences in Predictors of Suicidality Among United States Veterans, Poster Presentation at Society for Social Work and Research Conference, Washington, D.C. January 14, 2018.

From Soldier to Student: The Transition Experiences of Student Veterans in Higher Education, Presented at Kentucky Association of Social Work Educators Conference, Lexington, KY. November 10, 2017.

Recognizing and Responding to Signs of Substance Abuse and Suicidality in College Students, Co-Presented at Kentucky Association of Social Work Educators Conference with Dr. Carol Barnett, PhD, LCSW. November 21, 2014.

Faculty Roles and Responsibilities: Striking a Balance, Panel Member at New Faculty Institute, Morehead, KY. August 11, 2014.

Addiction and Child Abuse: How to Keep Children Safe and Support Recovering Parents, Continuing Education Course, taught at Morehead State University, Ashland, KY. May 16, 2014.

Substance Abuse and Child Welfare: How Communities Can Work Together to Keep Children Safe, Presented to community child abuse prevention luncheon, Mount Sterling, KY. April 24, 2014.