HHS Public Access

Author manuscript

Sex Abuse. Author manuscript; available in PMC 2020 August 01.

Published in final edited form as:

Sex Abuse. 2019 August ; 31(5): 560–579. doi:10.1177/1079063218793633.

Veterans in Prison for Sexual offenses: Characteristics and Reentry Service Needs

Andrea K. Finlay[1], **Jim McGuire**[2], **Jennifer Bronson**[3], and **Shoba Sreenivasan**[4,5]

[1]Center for Innovation to Implementation (Ci2i) and National Center on Homelessness Among Veterans, Department of Veterans Affairs, VA Palo Alto Health Care System; 795 Willow Road (152-MPD), Menlo Park, CA 94025, USA

[2]Retired; formerly of the Veterans Justice Programs, US Department of Veterans Affairs; VA Greater Los Angeles, 11301 Wilshire Blvd., Los Angeles, CA 90073, USA

[3]Bureau of Justice Statistics, 810 Seventh Street, NW, Washington, DC 20531, USA

[4]VA Greater Los Angeles, 11301 Wilshire Blvd, Los Angeles, CA 90073, USA

[5]Keck USC School of Medicine, 1975 Zonal Ave., Los Angeles, CA 90033, USA

Abstract

Among prison incarcerated men in the United States, a higher percentage of veterans (35%) have a sexual offense conviction than non-veterans (23%; Bronson, Carson, Noonan, & Berzofsky, 2015); however, limited research has investigated factors explaining the link between military service and sexual offending. Nationally representative data from prison incarcerated men (n = 14,080) were used to examine veteran status associated with sexual offenses, adjusting for a variety of demographic, childhood, and clinical characteristics. Incarcerated veterans had 1.35 higher odds (95% confidence interval [1.12, 1.62], $p < .01$) of a sexual offense than incarcerated non-veterans. Among incarcerated veterans, those who were homeless or taking mental health medications at arrest had lower odds and veterans with a sexual trauma history had higher odds of a sexual offense compared to other offense types. Offering mental health services in correctional and health care settings to address trauma experiences and providing long-term housing options may help veterans with sexual offenses as they transition from prison to their communities.

Keywords

Sex Offenses; Prison; Criminal Behavior; Reentry

Corresponding author: Andrea Finlay, Center for Innovation to Implementation, 795 Willow Road (152-MPD), Menlo Park, CA 94025. Work phone 650-493-45000 × 23426. Andrea.Finlay@va.gov.
Author email addresses: Andrea Finlay – Andrea.Finlay@va.gov; Jim McGuire – jimfmcguire@yahoo.com; Jennifer Bronson – Jennifer.Bronson@usdog.gov; Shoba Sreenivasan – Shoba.Sreenivasan@va.gov.

Disclosures: All authors have no actual or potential conflicts of interest.

Introduction

In the United States, military veterans are over-represented among incarcerated adults with sexual offenses. Among the prison incarcerated population in 2011-2012, 35% of veterans were incarcerated for sexual offenses compared to 23% of non-veterans (Bronson et al., 2015). Among the jail incarcerated population, 12% of veterans were incarcerated for sexual offenses versus 8% of non-veterans. The higher rates of sexual offenses among incarcerated veterans were evident in two earlier U.S. reports (Mumola, 2000; Noonan & Mumola, 2007). Internationally, veterans were more likely to be incarcerated for a sexual offense than non-veterans in Britain and Canada (Defence Analytical Services and Advice, 2010; Derkzen & Wardop, 2015). Despite a higher rate of incarceration, military veterans with sexual offense convictions have received little investigation to date.

Research among non-veterans indicates that adults who commit sexual offenses are a highly stigmatized population subject to registries and residence restrictions (Levenson & Cotter, 2005; Levenson, D'Amora, & Hern, 2007; Mercado, Alvarez, & Levenson, 2008; Tewksbury, 2012). The U.S. Department of Veterans Affairs (VA) is tasked with meeting the treatment and housing needs of veterans; however, an understanding of veterans with sexual offense histories and how they differ from other veterans with criminal histories is needed to appropriately direct resources to this group of veterans.

Research Questions

The current study examined two research questions: (1) Do veterans have higher odds of incarceration for sexual offenses compared to non-veterans, after adjusting for sociodemographic, clinical, and childhood factors?; and (2) If so, are there factors that distinguish veterans with sexual offenses from veterans with other offenses that may help inform provision of treatment and housing for veterans with sexual offense histories?

Military Service and Violent Offending

A small body of literature suggests that military service since the all-volunteer force era is associated with violent offending. In a nationally representative sample of young adults born between 1957 to 1961 who were matched to a sample of individuals who served in the military in 1978, 13% of individuals with a military service history compared to 8% of non-military individuals had committed a violent offense (Bouffard, 2005). Even after adjusting for demographic factors such as sex, age, race, education, social class, and prior juvenile delinquency, military service was associated with a higher likelihood of reporting a violent offense. Military service was linked to violent offending by Hispanic individuals, those from a lower social class, and those with a history of juvenile delinquency. Military service for individuals in this study occurred at the end of the Vietnam draft era and at the start of the all-volunteer force, suggesting that observed results may be due to changes in military recruiting. Indeed, period specific differences have been noted in other research studies. Among adults during the end of the Vietnam War (post-1968), those with military experience had a lower average offending rate than their non-military counterparts in the same cohort (Bouffard, 2014). Veterans who entered the military in 1968 or earlier did not differ from non-military members of their cohorts on rates of offending. A study using four

time periods of nationally representative data from incarcerated and non-incarcerated persons found that veterans had 1.23 times higher odds of being incarcerated for a violent crime than non-veterans. However, when distinguished by era of service, veterans who served during the draft era have 0.66 lower odds and veterans who served during the all-volunteer force era had 2.26 times higher odds of being incarcerated for a violent offense (Culp, Youstin, Englander, & Lynch, 2013). Furthermore, veterans who served during wartime had 0.51 times lower odds of being incarcerated for a violent offense. Finally, a study that used the same data source and similar measures as Culp et al. (2013) found that veterans were more likely to have a violent offense conviction than non-veterans (Van Dyke & Orrick, 2017). These studies suggest that individuals who self-select into the military may be more likely to commit violent offenses.

Military Service and Sexual Offending

Research on sexual offending among veterans is scant with prior studies including sexual offenses as part of the violent offense category. Combining these types of offenses is problematic for two reasons. First, compared to adults with other types of criminal offenses different supervisory conditions and restrictions are applied to adults with sexual offenses histories, whether they are veterans or not. For example, adults with sexual offense histories have residence restrictions or sex offender registry requirements that impact where they can live and can make finding employment difficult (Levenson & Cotter, 2005; Mercado et al., 2008). Thus, combining sexual offenses with other violent offenses masks the challenges faced by people with sexual offense records once they exit prison. Second, the distinction between sexual offenses and violent non-sexual offenses is critical because when sexual offenses are excluded, veterans are less likely to be in prison for a violent offense (Noonan & Mumola, 2007).

Only one study that we are aware of used nationally representative data and examined sexual offending separately from other types of offending – results indicated that military service was associated with 1.3 times higher odds of being incarcerated for sexual offending (Culp et al., 2013). However, wartime service was associated with 0.40 lower odds of sexual offending. The study adjusted for sociodemographic factors including age, sex, race, ethnicity, poverty, and education, but other known clinical factors such as mental health or substance use disorder conditions (Fazel, Sjostedt, Langstrom, & Grann, 2007) or childhood sexual abuse (Jespersen, Lalumiere, & Seto, 2009) were not available in their study. In addition to the nationally representative study, two studies with small samples of veterans with sexual offenses indicated that the majority of veterans had mental health and substance use disorder conditions as well as medical conditions that required treatment (Schaffer, 2011; Schaffer & Zarilla, 2018). It is necessary to examine veterans with sexual offense histories separately from other veterans to shed light on their treatment needs, housing challenges, and other addressable factors that impede their return to the community from prison.

Reasons for the higher representation of sexual offenses among incarcerated veterans compared to incarcerated civilians are unknown. Some possible factors may be effects of selection into the military, experiences of military service, or persistence of mental health or

substance use disorders that started during military service. Individuals who select into military services during the all-volunteer force era may have characteristics that are linked with sexual offending, such as experiencing adverse events while growing up. In a representative national sample, adults with military service had experienced a higher total number of adverse childhood experiences compared to adults without military service (Katon et al., 2015). One childhood adverse event, sexual abuse, has been linked with sexual offending in adulthood (Jespersen et al., 2009; Levenson, Willis, & Prescott, 2016). A study of all-volunteer service era men indicates that those with military service had higher odds of being forced to have sex with an adult or a person at least 5 years older than them before age 18 than men without military service (Blosnich, Dichter, Cerulli, Batten, & Bossarte, 2014). Although we do not know the extent to which the military draws from adults with sexual trauma histories, it is likely there is some overlap between these groups that may partially explain higher rates of sexual offending in this population.

Higher rates of sexual offending among veterans may also be due to military service, which can be traumatic in a variety of ways. Among veterans who served in the Iraq or Afghanistan wars and received services at VA facilities, 0.7% of men and 15% of women screened positive for military sexual trauma (Kimerling et al., 2010), which may increase their risk for sexual offending. Traumatic sexual experiences are even more common among a sample of veterans incarcerated in jail with 5% of men and 58% of women reporting sexual assault while in the military (Stainbrook, Hartwell, & James, 2016). Combat experience was also common among veterans in jail with over half of men (58%) in the sample and a third of women (38%) having served in a combat zone. Traumatic brain injury may be associated with sexual offending among non-veterans (DelBello et al., 1999). Levels of traumatic brain injury include mild, moderate, and severe brain injury. Mild traumatic brain injury – a signature injury of war for those who serve in combat zones – is defined as a disruption of brain functioning such as loss of consciousness, loss of memory of events immediately before or after injury, feeling dazed or confused, or focal problems (e.g., loss of vision without injury to the eye) (Snell & Halter, 2010). Untreated combat trauma and traumatic brain injury may also be linked to sexual offending for military veterans (Seamone, Brooks Holliday, & Sreenivasan, 2018). Lifetime traumatic events are common among veterans in jail, with 87% (Saxon et al., 2001) to 93% (Hartwell et al., 2014) of incarcerated veterans having experienced at least one traumatic event in their lives. The cumulative effect of traumatic experiences prior to military service and military sexual trauma or combat trauma during military service on risk for sexual offending is unknown.

Untreated mental health or substance use disorders during or after military service may heighten the risk for sexual offending. Sexual offenses have been linked with a history of psychiatric hospitalizations for serious mental illness and substance use disorders (Fazel et al., 2007); thus, ensuring treatment access and engagement may help attenuate this link. However, in some cases rather than treating mental health or substance use disorders, military personnel are discharged from the military with a status rendering them ineligible for VA treatment (Seamone et al., 2014). Others may experience delays in initiating treatment (Maguen, Madden, Cohen, Bertenthal, & Seal, 2012) or be uninterested or ambivalent about seeking mental health care (Hearne, 2013). Military veterans leaving prison also have inconsistent use of VA health care services: 44% of veterans who received

VA Health Care for Reentry Veterans outreach services in prison did not visit a VA facility in the following year (Finlay et al., 2017). Although it is unknown how many of these veterans have sexual offense convictions, there are likely some who have unmet mental health treatment needs that may put them at risk for criminal offending.

Housing and Treatment Needs of People with Sexual Offense Histories

Although there is scant literature on veterans with sexual offense histories, research on the general population of people with sexual offenses provides insight into the challenges they face. Housing restrictions can cause many difficulties for people with sexual offense histories. In two counties in New York, residence restrictions eliminated over 95% of available residential locations in urban areas and over 70% of residential locations in rural areas where people with sexual offenses could possibly live (Berenson & Appelbaum, 2011). Among a sample of people with sexual offenses in Florida who were surveyed, half were forced to move due to residence restrictions and a quarter could not return to their former residences after conviction due to restrictions (Levenson & Cotter, 2005). Community notification of their sex offender status or sex offender registries can compounded housing difficulties: 24% of people said they moved after their landlord learned about their criminal history and 20% said they moved after their neighbors found out (Mercado et al., 2008). Furthermore, some landlords will not rent to people on sex offender registries (Cubellis, Walfield, & Harris, 2018) further diminishing the already small stock of available housing options. Difficulties finding housing coupled with other market forces, such as increased rent prices and higher population density, can increase the likelihood that a person with a sexual offense history will become homeless (Socia, Levenson, Ackerman, & Harris, 2015). Homeless shelters are often not an option for people with sexual offense histories. Among homeless shelters in four states, 65% run a check on the sex offender registry and 82% deny access to registered sex offenders (Rolfe, Tewksbury, & Schroeder, 2017). Almost half of the shelters that denied people with sexual offenses had no other policies against criminal offenders. Only 12% of shelters made exceptions to their sexual offender rules, usually for women who were registered sex offenders or people with statutory rape charges.

Housing is also limited by the employment and financial means of people with sexual offenses. Among people with sexual offenses who responded to surveys about their experiences, half said they had lost jobs because of community notification for their crimes (Mercado et al., 2008) and half said they had suffered financially due to residence restrictions (Levenson & Cotter, 2005). In another study, 21% of people said they lost a job when it was discovered they were on a sex offender registry (Levenson et al., 2007). Among people living in a transitional housing facility, they reported difficulties finding and maintaining employment (Kras, Pleggenkuhle, & Huebner, 2016). They also struggled to save money because of lack of employment and because they had to pay fees for the facility, which limited their ability to find housing they could afford on their own. Residents in the transitional housing facility also reported lacking social support, which is an important element to returning to communities after prison and reintegrating into everyday life. Some individuals lost social support because of the notification requirements (Mercado et al., 2008), whereas for other people housing restrictions prevented them from living with supportive family members (Levenson & Cotter, 2005). Isolation was also heightened by

housing restrictions and being placed on a sex offender registry (Levenson & Cotter, 2005; Levenson et al., 2007). Consistent with reports by people with sexual offense histories, 70% of clinical practitioners and community correctional workers believe that people with sexual offense histories face difficulties due to residence restrictions and 77% believe they experience emotional or psychological problems (Call, 2016).

The Role of the Department of Veterans Affairs

The VA is the primary agency responsible for the health and health care of veterans. Providers within VA who serve justice-involved veterans are grappling with how to address the treatment and housing needs of veterans with sexual offenses. Due to federal, state, or local laws or regulations prohibiting adults with sexual offense convictions from using some housing programs, housing for homeless veterans with sexual offenses remains the most intransigent unmet need (Abshire, Nakashima, & Kuhn, 2011; U.S. Department of Veterans Affairs, 2015). For example, the Housing and Urban Development (HUD) office excludes veterans with a sexual offense who are subject to lifetime sex offense registration from using the Veterans Affairs Supportive Housing (HUD-VASH) program, which provides housing vouchers to veterans (VA National Center on Homelessness Among Veterans, 2004). HUD-VASH is VA's largest homeless option with 78,000 beds nationally, followed by the VA's Grant and Per Diem (GPD) Program with 14,500 beds, which provides grant housing through community agencies (https://www.va.gov/HOMELESS/housing.asp). However, despite efforts by VA's homeless programs to increase housing access through the GPD Program, it is difficult to place veterans with sex offenses in housing due to a variety of factors including community distance and insurance provider restrictions. Currently, the extent to which housing is being provided to veterans with a sexual offense history is unknown, but there are only a few housing programs that we know of that accept a limited number of veterans with sexual offense histories. There may be other partnerships between VA and community programs that together meet the housing and treatment needs of veterans with sexual offenses (Schaffer & Zarilla, 2018), but we are unaware of a public source listing such partnerships and programs.

Very little is known about the treatment needs of veterans with sexual offenses and whether targeted services beyond what is provided to other justice-involved veterans are needed. One small study of 42 veterans with sexual offenses who received VA outreach services post-incarceration found the majority had drug (65%) and alcohol (32%) problems and mental health (54%) problems as well as medical problems, such as hypertension (47%) and heart problems (32%) (Schaffer, 2011). Although extant mental health and substance use disorder treatment programs at the VA may meet some of the treatment needs of veterans with sexual offenses, the VA does not provide treatment interventions designed specifically for sexual offenders. There may be existing psychologists or other providers with training on treatments for sexual offenders that may help address this gap. Difficulties obtaining employment is also documented among adults with sexual offense histories, but we have no information on employment challenges among veterans with sexual offenses or whether VA employment programs are meeting their needs. The current study sought to address these gaps in the literature and inform policy and practitioners about targeted complementary services that may be needed for veterans with sexual offenses.

Current Study

The current study used existing national Bureau of Justice Statistics (BJS) data of incarcerated adults in prison. Our primary research question was to examine whether veteran status was associated with incarceration for sexual offending, after adjusting for a variety of known and potential sociodemographic, clinical and childhood, and criminal history factors related to sexual offending. Our secondary research question was to examine veterans separately, comparing veterans with sexual offenses to veterans with other criminal offenses. The aim of the study is to understand characteristics related to sexual offenses that may help VA – and perhaps communities more generally – formulate treatment and overall care planning that may be needed for these veterans as they transition out of prison.

Method

Data Source and Description

This study uses data from the BJS Survey of Inmates in State and Federal Correctional Facilities, which was collected in 2004 (Noonan & Mumola, 2007; United States Department of Justice, Office of Justice Programs, & Bureau of Justice Statistics, 2016; Van Dyke & Orrick, 2017). This survey is the most recent data that is publicly available and contains the variables of interest. Interviews were conducted with incarcerated adults in state and federal prisons to provide information on their background, mental health and substance use history and treatment, and criminal history. A two-stage sample design selected prisons (first stage) and incarcerated adults (second stage) to generate nationally representative data. Refusal rates for participation in the survey were 11% for state prisons and 15% for federal prisons. The Stanford University Institutional Review Board and VA Palo Alto Research & Development Committee approved this study.

Sample

All incarcerated men (n = 14,080) who responded to the BJS survey were included in our study; 10% had a sexual offense as their controlling conviction and 90% had other controlling offenses including non-sexual violent offenses, property offenses, drug offenses, and other offenses. Descriptive statistics for the sample are reported in Table 1. Women were excluded (n = 3,888) from this study because of the very small number of women who were both veterans and had a sexual offense conviction.

Measures

Outcome Variable.—*Sexual offenses* were identified by a controlling offense code, generally the most serious crime associated with a person's current incarceration. Convictions indicating rape or other sexual assault (e.g., assault and battery with intent to commit rape, molestation) were coded as 1; all other offenses were coded as 0.

Sociodemographic Characteristics.—Incarcerated adults were identified as military *veterans* (no, yes) if they indicated they served in any branch of the U.S. Armed Forces. Sociodemographic characteristics included *race/ethnicity* (Hispanic, non-Hispanic: Black, American Indian/Alaskan Native, Asian/Pacific Islander/Native Hawaiian, White, Multi-racial), *age* (<35, 35-44, 45-54, 55-64, 65+), *education* (less than high school/GED, high

school/GED, some college, four-year college degree), and *marital status* (married, widowed, divorced, separated, never married). *Employment type at arrest* (full-time, part-time, occasional, unemployed, incarcerated or detained), and *during the month before arrest had a job or business* (no, yes); and *housing type at arrest* (house, apartment, trailer or mobile home, homeless/shelter), and *in the year prior to arrest ever homeless* (no, yes) were included.

Clinical and Childhood Characteristics.—Nine mental health treatment (no, yes) variables were included: (1) *received mental health counseling ever* and (2) *in year prior to arrest;* (3) *mental health hospitalization ever* and (4) *in year prior to arrest*; (5) *taken mental health medication ever*, (6) *in year prior to arrest*, and (7) *at the time of arrest*; and (8) *received other mental health treatment ever* and (9) *in year prior to arrest.* Seven variables measured whether the incarcerated individual had ever been told by a mental health professional they had (1) *a depressive disorder*, (2) *manic-depression, bipolar disorder, or mania*, (3) *schizophrenia or another psychotic disorder*, (4) *post-traumatic stress disorder (PTSD)*, (5) *another anxiety disorder*, (6) *a personality disorde*r, or (7) *any other mental or emotional condition* (all coded as no or yes). A screener to measure current mental health symptoms were coded as (1) *psychosis*, (2) *major depression*, and (3) *mania/persistent anger*, consistent with previous research using the same survey (Noonan & Mumola, 2007). One variable measured *current medical condition* (no, yes), including HIV, tuberculosis, sexually transmitted infection, hepatitis, cirrhosis, asthma, arthritis or rheumatism, kidney problems, heart problems, diabetes or high blood sugar, stroke or brain injury, high blood pressure, paralysis, and cancer.

Alcohol use variables included *in entire life had 12 drinks of any kind of alcohol* (yes, no), *age when first started drinking* (age <13, age 13-15, age 16-20, age 21+, never), *used alcohol in the year prior to arrest* (no, yes), and *drinking any alcohol at time of offense* (no, yes). Problematic drinking was measured by the *CAGE* screener, code as 0-4 positive responses. Another screener was used to measure current symptoms of *alcohol abuse* or *alcohol dependence* (no or yes for each variable). Other drug use variables included *ever used any illicit drugs* (no, yes), *used drugs in the month prior to arrest* (no, yes), *age when first used any illicit drugs* (age <13, age 13-15, age 16-20, age 21+, never), and *under the influence of drugs at the time of offense* (yes, no). A screener was used to measure current symptoms of *drug abuse* or *drug dependence* (no or yes for each variable).

Trauma history and childhood characteristics included *physically abused or assaulted* before admission to prison (no, yes), *ever forced to have sex* before admission to prison (no, yes), *caretakers were on welfare* (no, yes), *caretakers abused drugs and/or alcohol* (yes, no), *lived in public housing growing up* (yes, no), *living situation growing up* (family or friends, foster home/agency/institution), *any family members sentenced and served time in jail or prison* (yes, no), and *childhood friends were involved in illegal activities* (e.g., shoplifting, stole a motor vehicle; yes, no). Participants were also asked if anyone *shot a gun at them* (no, yes), or *used a knife or other sharp object against them* (no, yes).

Criminal History Characteristics.—Participants were asked about their prior history of criminal offenses, including *sexual offenses, violent offenses* (not including sexual offenses),

drug offenses, property offenses, and *other offenses.* These criminal history variables were not mutually exclusive – participants could have prior offenses of multiple types of crimes. Other criminal history variables included ever been under a *restraining order* (no, yes), ever *previously arrested* (no, yes), ever on *ever on probation* (no, yes), ever been charged with a *parole violation* (no, yes), and *prison type* (federal, state).

Results

Data Analysis

Due to the limited prior literature or theory related to veterans who committed sexual offenses, we used Homser & Lemeshow's (2000) exploratory model building method to build our logistic regression model examining whether veterans status was associated with sexual offenses. Our five step model building process was as follows: (1) We conducted univariate analyses by examining contingency tables of the outcome (sexual offense) versus each independent variable and used a chi-squared test to examine the p-value with $p < .25$ and variables of clinical importance retained. (2) Once variables were selected, we built our multivariate models using the stepwise procedure of forward selection using a p-value < .25 with a test for backward elimination using a p-value < .30. (3) We examined the Wald statistic and the estimated coefficient from the multivariable model with the coefficient from the univariate model for each variable. Variables that did not contribute to the model were eliminated. (4) We then examined how veteran status interacted with the other characteristics. The interaction variables were added one at a time to the main effects model, with checks for significance using a likelihood ratio test. Interactions at the level of p-value < .05 were retained. Due to significant interactions between veteran status and other characteristics in the multiple logistic regression model, we stratified by veteran status. (5) We then examined the variables among veterans with sexual offenses and veterans with other offenses and eliminated any non-significant variables from the logistic regression model using a p-value < .05.

To answer the first research question, descriptive statistics and results of the variables included logistic regression model of the full sample from step 3 were reported. To answer the second research question, descriptive statistics and results of the variables included in logistic regression model of the veteran only sample from step 5 were reported. Missing data was less than 5% among cases with responses to questions other than controlling offense and prison type and 8% among all cases; therefore, we did not conduct missing data analysis.

All Incarcerated Men

There were 14,080 incarcerated men who participated in the survey; 1,364 (10%) had a sexual offense as their controlling conviction and 12,716 (90%) had other controlling offenses, including non-sexual violent offenses, property offenses, drug offenses, and other offenses. Results of the regression model that included all incarcerated men indicated that veterans had 1.35 higher odds (95% confidence interval [CI] = 1.12, 1.62) of incarceration for a sexual offense compared to non-veterans ($p < .01$), adjusting for sociodemographic, clinical, childhood, and criminal justice history factors (Table 1). There were significant

interactions between veteran status and living situation growing up, previous history of a sexual offense, and parole violation. Therefore, we stratified the sample by veteran status.

Veterans

Of 1,569 male veterans in the sample, there were 303 (19%) who had a controlling sexual offense and 1,266 (81%) who had other controlling offenses (Table 2). Participants who had been homeless in the year prior to their arrest had lower odds (OR = 0.39, 95% CI [0.19, 0.81], $p < .01$) of having a sexual offense than those who had been housed. Taking mental health medications at the time of arrest (OR = 0.31, 95% CI [0.16, 0.61], $p < .05$) and ever being on probation (OR = 0.47, 95% CI [0.34, 0.66], $p < .001$) was also associated with lower odds of having a sexual offense. Older age, having a job or business at the time of arrest, ever having received mental health counseling, ever been forced to have sex, and a prior conviction of a sexual offense were associated with higher odds of having a sexual offense for the current incarceration.

Discussion

Results of this study indicate that veteran status is associated with higher odds of incarceration for sexual offenses. Veterans incarcerated for sexual offenses differ from veterans incarcerated for other offenses across several demographic, clinical and criminal justice factors. Examining veterans with sexual offenses separately from veterans with violent non-sexual or non-violent criminal offenses is critical to ensuring treatment is offered to address their unique needs. Although these results do not provide evidence of a causal link between military service and sexual offending, they do suggest that the VA has responsibility to address factors related to sexual offending to reduce veteran sexual offending. These results are also helpful in how to direct resources, notably in the direction of mental health treatment.

Mental Health Treatment

There were two results of immediate clinical value for VA practitioners and policymakers. First, receipt of mental health medications at the time of arrest was associated with lower odds of sexual offending, suggesting that medications can attenuate the association between mental health conditions and sexual offending (Fazel et al., 2007). Mental health medications are available at all VA facilities; however, the benefits of treatment are contingent upon patients using treatment services. Among veterans who are seen by VA Health Care for Reentry Veterans staff during outreach in prison, 44% did not visit a VA facility in the year after outreach (Finlay et al., 2017). Ensuring veterans with sexual offenses link to services is the first step in treatment utilization, but medications for disorders such as schizophrenia and bipolar disorder require long-term monitoring and management of patients. Mental health medications should be available and considered for all veterans with an indicated need, but more active case management of veterans with a history of sexual offenses may support management of their mental health symptoms. Releasing veterans with sexual offenses to re-entry courts may be one way to mandate and monitor their treatment utilization (Seamone et al., 2018).

Second, veterans who had been forced to have sex had higher odds of incarceration for sexual offending. A third of veterans with sexual offenses had ever received mental health counseling, but it is unknown whether their counseling included evidence-based psychosocial treatment. Evidence-based treatments for PTSD is promoted at VA and trauma-informed care is widely practiced at VA facilities and promoted in the homeless programs, which include the justice programs (U.S. Department of Veterans Affairs, 2017). Trauma-informed care is a treatment framework that acknowledges the impact of trauma and integrates information about trauma into treatment practices, procedures and policies to facilitate recovery and avoid re-traumatization (Kelly, Boyd, Valente, & Czekanski, 2014). These mental health services may be necessary for any veteran with experiences of trauma, but more intensive or longer treatment periods may be needed for veterans with a history of sexual offenses to address cumulative traumatic experiences. In addition to mental health services, screening and treatment for traumatic brain injury may be necessary for veterans with sexual offenses exiting prison, given the link between traumatic brain injury and sexual offending found in a non-veteran sample (DelBello et al., 1999).

To the extent that traumatic sexual experiences occur during military service (Kimerling et al., 2010; Stainbrook et al., 2016), the health care of service members primarily occurs in the Department of Defense treatment system rather than the VA. Prior research suggests that the military attracts adults who have more traumatic experiences as children (Katon et al., 2015), and among men from the all-volunteer era childhood sexual abuse is more common among men with military experience than those without (Blosnich et al., 2014). Entry into military service may also be an ideal time to screen for adverse childhood events, especially sexual abuse, and deliver mental health services during boot camp or other periods of service. Prevention programs focused on rape and sexual assault prevention and bystander training for men to intervene when witnessing sexual assaults may also help prevent sexual offenses among this population. For example, a training program designed to lower men's likelihood of committing rape or sexual assault and increase their willingness to intervene as bystanders that was originally developed for college students has been tested among U.S. Army soldiers (Foubert & Masin, 2012). Other education and prevention programs, such as the U.S. Navy Sexual Assault Intervention Training program, have been developed specifically for military personnel (Rau et al., 2011). However, a recent review indicated the evidence base for the effectiveness of these programs with military populations is in the early stages (Orchowski, Berry-Caban, Prisock, Borsari, & Kazemi, 2018).

Homelessness

One surprising result of this study is that homelessness is associated with lower odds of sexual offending. There are several possible explanations for this finding. Homeless individuals may be focused on other competing needs such as food or shelter (Piat, Ricard, Sabetti, & Beauvais, 2008), or they may be arrested and incarcerated for non-violent crimes (Roy et al., 2016). They may be committing crimes against other homeless people who may not report sexual offense crimes due to fears of being arrested themselves or a lack of perceived credibility by the police. Finally, there may also be a lack privacy to commit a sexual offense – 67% sexual assaults occur in or near the victim's home or homes of their friends or acquaintances (Planty, Langton, Krebs, Berzofsky, & Smiley-McDonald, 2013).

Housing is the most challenging unmet need within the VA health care system for homeless veterans with sexual offenses (Abshire et al., 2011; U.S. Department of Veterans Affairs, 2015). Veterans who exit prison and are homeless or use homeless services at the VA have higher odds of entering and engaging in VA mental health and substance use disorder treatment services compared to veterans who are not homeless (Finlay et al., 2017). Thus, providing housing for veterans with sexual offenses may help support them in a variety of ways, including their utilization of mental health services, while also ensuring there is proper supervision to prevent recidivism. Research with adults with sexual offense histories suggest that housing is currently not ideal to support their transition to the community (Kras et al., 2016). More research is needed to understand the optimal housing environments to support veterans with sexual offenses who are returning to their communities.

Limitations

The current study has limitations that restrict the generalizability of the results. The first limitation is that we restricted our sample to adult males and then to military veterans. The sample size of women veterans was too small to conduct analyses. Also, we were unable to find any published articles on female veterans with sexual offenses. Nationally in the US, 2.3% of people on sex offender registries are female (Ackerman, Harris, Levenson, & Zgoba, 2011). A growing body of literature is examining females with sexual offenses (Lewis & Dwyer, 2017; Morgan & Long, 2018; Williams, Gillespie, Elliott, & Eldridge, 2017) and with time we may have a better understanding of female veterans who commit sexual offenses. We did not examine active duty military members nor are we able to determine if a veteran's sexual offense was committed after military service or during military service. It is possible that veterans in our sample committed a sexual offense while in the military and were discharged into the civilian prison system, but we are unable to determine the timing of events from our data, nor was this issue discussed in prior research on this topic. Future research examining sexual offending behavior while in military service and links with post-military sexual offending may provide additional insights into veterans with sexual offense histories (see Schaffer & Zarilla, 2018 for a discussion on this topic).

The second limitation is that the study data is of adult males who were caught and convicted of a crime, incarcerated in prison, and responded to the survey questionnaire. We are unable to estimate sexual offense rates among the general population of veterans and non-veterans or the likelihood of sexual offense conviction among veterans and non-veterans with these data (but see Culp et al., 2013). However, our results are geared towards policymakers and practitioners who serve justice-involved veterans; thus, these results are valuable to inform provision of treatment needed at VA facilities or other health care systems that serve veterans with a history of sexual offenses who are exiting prison. Although we included an extensive list of factors in the exploratory models, there may be other factors not captured in this study that would inform analyses, such as treatment use at VA facilities prior to being arrested. Also, we are unable to provide evidence of a causal relationship between military service and sexual offending, thus we can only speculate about mechanisms that explain our results. Finally, while the age of the data is a limitation, it is the most recent available on veteran sex offending, and use of the data permit a discussion on research and intervention on this important issue within VA.

Conclusion

The VA has an obligation to provide health care and other services to VA-eligible veterans. The VA already has capacity to provide many of the services that veterans with a history of sexual offenses may need, including trauma-informed care, PTSD treatment, and medication for mental health disorders, but sexual offending needs to first be recognized as a health care issue for the VA to galvanize their resources to help this population. Furthermore, without coupling treatment services with housing support the effectiveness of such mental health treatment may be diminished as veterans struggle to meet their basic shelter needs. This study indicates that mental health treatment is an important priority for the VA to address the treatment needs of veterans with a history of sexual offenses. More research and evaluation is needed to identify mechanisms that explain the link between veteran status, sexual offending, and homelessness and develop policies that meet the needs of veteran patients at the VA and ensure public safety.

Acknowledgments:

Dr. Finlay was supported by a VA Health Services Research & Development (HSR&D) Career Development Award (CDA 13-279). The authors take responsibility for the integrity of the data, the accuracy of the data analyses, and have made every effort to avoid inflating statistically significant results.

Role of the funding source: The funding source had no role in the research and/or in the preparation of the manuscript. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs (VA), the Department of Justice, the Bureau of Justice Statistics, or the United States government.

References

Abshire C, Nakashima N, & Kuhn J (2011). The Eighteenth Annual Progress Report: Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) for veterans, Fiscal Year (FY) 2011, services for homeless veterans assessment and coordination. Retrieved from Veterans Health Administration, Homeless Program Office website: http://www.va.gov/HOMELESS/docs/chaleng/2011_CHALENG_Report_FINAL.pdf

Ackerman AR, Harris AJ, Levenson JS, & Zgoba K (2011). Who are the people in your neighborhood? A descriptive analysis of individuals on public sex offender registries. International Journal of Law and Psychiatry, 34(3), 149–159. doi:10.1016/j.ijlp.2011.04.001 [PubMed: 21529945]

Berenson JA, & Appelbaum PS (2011). A geospatial analysis of the impact of sex offender residency restrictions in two New York counties. Law and Human Behavior, 35(3), 235–246. doi:10.1007/s10979-010-9235-3 [PubMed: 20549319]

Blosnich JR, Dichter ME, Cerulli C, Batten SV, & Bossarte RM (2014). Disparities in adverse childhood experiences among individuals with a history of military service. JAMA Psychiatry, 71(9), 1041–1048. doi:10.1001/jamapsychiatry.2014.724 [PubMed: 25054690]

Bouffard LA (2005). The military as a bridging environment in criminal careers: Differential outcomes of the military. Armed Forces & Society, 31(2), 273–295. doi:10.1177/0095327X0503100206

Bouffard LA (2014). Period effects in the impact of Vietnam-era military service on crime over the life course. Crime & Delinquency, 60(6), 859–883. doi:10.1177/0011128710372455

Bronson J, Carson EA, Noonan M, & Berzofsky M (2015). Veterans in prison and jail, 2011-12 (NCJ 249144). Retrieved from U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics website: https://www.bjs.gov/content/pub/pdf/vpj1112.pdf

Cubellis MA, Walfield SM, & Harris AJ (2018). Collateral consequences and effectiveness of sex offender registration and notification: Law enforcement perspectives. International Journal of Offender Therapy and Comparative Criminology, 62(4), 1080–1106. doi:10.1177/0306624X16667574 [PubMed: 27634816]

Culp R, Youstin TJ, Englander K, & Lynch J (2013). From war to prison: Examining the relationship between military service and criminal activity. Justice Quarterly, 30(4), 651–680. doi: 10.1080/07418825.2011.615755

Defence Analytical Services and Advice. (2010). Estimating the proportion of prisoners in England and Wales who are ex-Armed Forces - further analysis. Retrieved from Office of Health Research Network: http://www.ohrn.nhs.uk/resource/policy/ProportionofPrisonVets.pdf

DelBello MP, Soutullo CA, Zimmerman ME, Sax KW, Williams JR, McElroy SL, & Strakowski SM (1999). Traumatic brain injury in individuals convicted of sexual offenses with and without bipolar disorder. Psychiatry Research, 89(3), 281–286. [PubMed: 10708275]

Derkzen D, & Wardop K (2015). A profile of veterans within the correctional service of Canada. Retrieved from Correctional Service, Government of Canada website: http://www.csc-scc.gc.ca/research/005008-rb-15-09-eng.shtml

Fazel S, Sjostedt G, Langstrom N, & Grann M (2007). Severe mental illness and risk of sexual offending in men: A case-control study based on Swedish national registers. Journal of Clinical Psychiatry, 68(4), 588–596. [PubMed: 17474815]

Finlay AK, Stimmel M, Blue-Howells J, Rosenthal J, McGuire J, Binswanger I, … Timko C (2017). Use of Veterans Health Administration mental health and substance use disorder treatment after exiting prison: The Health Care for Reentry Veterans program. Administration and Policy in Mental Health and Mental Health Services Research, 44(2), 177–187. doi:10.1007/s10488-015-0708-z [PubMed: 26687114]

Foubert JD, & Masin RC (2012). Effects of the men's program on U.S. Army soldiers' intentions to commit and willingness to intervene to prevent rape: A pretest posttest study. Violence & Victims, 27(6), 911–921. [PubMed: 23393953]

Hartwell SW, James A, Chen J, Pinals DA, Marin MC, & Smelson D (2014). Trauma among justice-involved veterans. Professional Psychology: Research and Practice, 45(6), 425–432. doi:10.1037/a0037725

Hearne CR (2013). Predictors of Operation Enduring Freedom/Operation Iraqi Freedom veterans' engagement in mental health treatment. Military Medicine, 178(11), 1183–1187. doi:10.7205/MILMED-D-13-00245 [PubMed: 24183763]

Hosmer DW, & Lemeshow S (2000). Applied logistic regression, second edition New York: John Wiley and Sons.

Jespersen AF, Lalumiere ML, & Seto MC (2009). Sexual abuse history among adult sex offenders and non-sex offenders: A meta-analysis. Child Abuse & Neglect, 33(3), 179–192. doi:10.1016/j.chiabu.2008.07.004 [PubMed: 19327831]

Katon JG, Lehavot K, Simpson TL, Williams EC, Barnett SB, Grossbard JR, … Reiber GE (2015). Adverse childhood experiences, military service, and adult health. American Journal of Preventive Medicine, 49(4), 573–582. doi:10.1016/j.amepre.2015.03.020 [PubMed: 26091925]

Kelly U, Boyd MA, Valente SM, & Czekanski E (2014). Trauma-informed care: Keeping mental health settings safe for veterans. Issues in Mental Health Nursing, 35(6), 413–419. doi: 10.3109/01612840.2014.881941 [PubMed: 24857525]

Kimerling R, Street AE, Pavao J, Smith MW, Cronkite RC, Holmes TH, & Frayne SM (2010). Military-related sexual trauma among Veterans Health Administration patients returning from Afghanistan and Iraq. American Journal of Public Health, 100(8), 1409–1412. doi:10.2105/AJPH.2009.171793 [PubMed: 20558808]

Kras KR, Pleggenkuhle B, & Huebner BM (2016). A new way of doing time on the outside: Sex offenders' pathways in and out of a transitional housing facility. International Journal of Offender Therapy and Comparative Criminology, 60(5), 512–534. doi:10.1177/0306624X14554194 [PubMed: 25326464]

Levenson JS, & Cotter LP (2005). The impact of sex offender residence restrictions: 1,000 feet from danger or one step from absurd? International Journal of Offender Therapy and Comparative Criminology, 49(2), 168–178. doi:10.1177/0306624X04271304 [PubMed: 15746268]

Levenson JS, D'Amora DA, & Hern AL (2007). Megan's Law and its impact on community re-entry for sex offenders. Behavioral Sciences and the Law, 25(4), 587–602. doi:10.1002/bsl.770 [PubMed: 17620324]

Levenson JS, Willis GM, & Prescott DS (2016). Adverse childhood experiences in the lives of male sex offenders: Implications for trauma-informed care. Sexual Abuse, 28(4), 340–359. doi: 10.1177/1079063214535819 [PubMed: 24872347]

Lewis ET 3rd, & Dwyer RG (2017). Psychosis and sexual offending: A review of current literature. International Journal of Offender Therapy and Comparative Criminology, 306624X17740016. doi: 10.1177/0306624X17740016

Maguen S, Madden E, Cohen BE, Bertenthal D, & Seal KH (2012). Time to treatment among veterans of conflicts in Iraq and Afghanistan with psychiatric diagnoses. Psychiatric Services, 63(12), 1206–1212. doi:10.1176/appi.ps.201200051 [PubMed: 23070131]

Mercado CC, Alvarez S, & Levenson J (2008). The impact of specialized sex offender legislation on community reentry. Sexual Abuse, 20(2), 188–205. doi:10.1177/1079063208317540 [PubMed: 18490481]

Morgan L, & Long L (2018). Female perpetrated sexual offences reported to a London sexual assault referral centre. Journal of Forensic and Legal Medicine, 54, 130–135. doi:10.1016/j.jflm.2018.02.001 [PubMed: 29453158]

Mumola CJ (2000). Veterans in prison or jail (NCJ 178888). Retrieved from U.S. Department of Justice, Office of Justice Programs website: https://bjs.gov/content/pub/pdf/vpj.pdf

Noonan ME, & Mumola CJ (2007). Veterans in state and federal prison, 2004 (NCJ 217199). Retrieved from Bureau of Justice Statistics website: http://bjs.gov/content/pub/pdf/vsfp04.pdf

Orchowski LM, Berry-Caban CS, Prisock K, Borsari B, & Kazemi DM (2018). Evaluations of sexual assault prevention programs in military settings: A synthesis of the research literature. Military Medicine, 183(suppl_1), 421–428. doi:10.1093/milmed/usx212 [PubMed: 29635603]

Piat M, Ricard N, Sabetti J, & Beauvais L (2008). Building life around foster home versus moving on: The competing needs of people living in foster homes. Psychiatric Rehabilitation Journal, 32(1), 32–39. doi:10.2975/32.1.2008.32.39 [PubMed: 18614447]

Planty M, Langton L, Krebs C, Berzofsky M, & Smiley-McDonald H (2013). Female victims of sexual violence, 1994-2010 (NCJ 240655). Retrieved from U.S. Department of Justice, Office of Justice Programs website: https://www.bjs.gov/content/pub/pdf/fvsv9410.pdf

Rau TJ, Merrill LL, McWhorter SK, Stander VA, Thomsen CJ, Dyslin CW, … Milner JS (2011). Evaluation of a sexual assault education/prevention program for female U.S. Navy personnel. Military Medicine, 176(10), 1178–1183. [PubMed: 22128655]

Rolfe SM, Tewksbury R, & Schroeder RD (2017). Homeless shelters' policies on sex offenders: Is this another collateral consequence? International Journal of Offender Therapy and Comparative Criminology, 61(6), 1833–1849. doi:10.1177/0306624X16638463 [PubMed: 27000141]

Roy L, Crocker AG, Nicholls TL, Latimer E, Gozdzik A, O'Campo P, & Rae J (2016). Profiles of criminal justice system involvement of mentally ill homeless adults. International Journal of Law and Psychiatry, 45, 75–88. doi:10.1016/j.ijlp.2016.02.013 [PubMed: 26922410]

Saxon AJ, Davis TM, Sloan KL, McKnight KM, McFall ME, & Kivlahan DR (2001). Trauma, symptoms of posttraumatic stress disorder, and associated problems among incarcerated veterans. Psychiatric Services, 52(7), 959–964. [PubMed: 11433115]

Schaffer BJ (2011). Veteran sex offenders and reentry problems. Journal of Correctional Health Care, 17(3), 266–270. doi:10.1177/1078345811401355 [PubMed: 21474531]

Schaffer BJ, & Zarilla L (2018). Military veteran sex offenders: Visible and on the radar. Journal of Human Behavior in the Social Environment, 28(1), 109–124. doi: 10.1080/10911359.2017.1377135

Seamone ER, Brooks Holliday S, & Sreenivasan S (2018). Veteran non grata: Veteran sex offenders with service-related mental health conditions and the need to mitigate risk. Virginia Journal of Criminal Law, 6(1), 182–237.

Seamone ER, McGuire J, Sreenivasan S, Clark S, Smee D, & Dow D (2014). Moving upstream: Why rehabilitative justice in military discharge proceedings serves a public health interest. American Journal of Public Health, 104(10), 1805–1811. doi:10.2105/AJPH.2014.302117 [PubMed: 25122020]

Snell FI, & Halter MJ (2010). A signature wound of war: Mild traumatic brain injury. Journal of Psychosocial Nursing and Mental Health Services, 48(2), 22–28. doi: 10.3928/02793695-20100107-01

Socia KM, Levenson JS, Ackerman AR, & Harris AJ (2015). "Brothers under the bridge": Factors influencing the transience of registered sex offenders in Florida. Sexual Abuse, 27(6), 559–586. doi:10.1177/1079063214521472 [PubMed: 24501210]

Stainbrook K, Hartwell S, & James A (2016). Female veterans in jail diversion programs: differences from and similarities to their male peers. Psychiatric Services, 67(1), 133–136. doi:10.1176/appi.ps.201400442 [PubMed: 26234331]

Tewksbury R (2012). Stigmatization of sex offenders. Deviant Behavior, 33(8), 606–623. doi: 10.1080/01639625.2011.636690

U.S. Department of Veterans Affairs. (2015). Veterans Health Administration Fact Sheet: Project CHALENG - Community Homelessness Assessment, Local Education and Networking Groups. Retrieved from Veterans Health Administration website: http://www.va.gov/homeless/docs/chaleng/52015_CHALENG_2015_Fact_Sheet.pdf.

U.S. Department of Veterans Affairs. (2017). Fact sheet: Trauma-informed care for working with homeless veterans. Retrieved from VA National Center on Homelessness Among Veterans website: https://www.va.gov/homeless/nchav/docs/Trauma-Informed-Care-Fact-Sheet.pdf.

United States Department of Justice, Office of Justice Programs, & Bureau of Justice Statistics. (2016). Survey of Inmates in State and Federal Correctional Facilities, 2004. ICPSR04572-v2 Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor].

VA National Center on Homelessness Among Veterans. (2004). HUD-VASH resource guide for permanent housing and clinical care. Retrieved from U.S. Department of Veterans Affairs website: https://www.va.gov/homeless/docs/center/144_hud-vash_book_web_high_res_final.pdf.

Van Dyke K, & Orrick EA (2017). An examination of the influence of veteran status on offense type among an inmate sample. American Journal of Criminal Justice, 42(2), 426–442. doi:10.1007/s12103-016-9373-3

Williams R, Gillespie SM, Elliott IA, & Eldridge HJ (2017). Characteristics of Female Solo and Female Co-Offenders and Male Solo Sexual Offenders Against Children. Sexual Abuse, 1079063217724767. doi:10.1177/1079063217724767

Table 1.

Descriptive Statistics of Individual Characteristics and Logistic Regression Analyses of Men Incarcerated in State and Federal Prisons Stratified by Sex Offense or Other Conviction

Sociodemographics	**Sex offense conviction (n = 1,364)**	**Other conviction (n = 12,716)**	**AOR**	**[95% CI]**
Veteran status	303 (22%)	1,266 (10%)	1.35**	[1.12, 1.62]
Race				
Black non-Hispanic	344 (25%)	5,496 (43%)	0.49***	[0.41, 0.58]
Hispanic	182 (13%)	2,520 (20%)	0.55***	[0.45, 0.68]
American Indian/Alaskan				
Native non-Hispanic	48 (4%)	203 (2%)	1.96***	[1.30, 2.96]
Asian/Pacific Islander/Native				
Hawaiian non-Hispanic	16 (1%)	149 (1%)	0.76	[0.41, 1.38]
White non-Hispanic	718 (53%)	3,981 (31%)	ref	
Multi-racial	51 (4%)	347 (3%)	0.84	[0.58, 1.23]
Age				
< 35	430 (32%)	6,633 (52%)	ref	
35-44	454 (33%)	3,730 (29%)	1.82***	[1.54, 2.16]
45-54	289 (21%)	1,777 (14%)	2.29***	[1.87, 2.79]
55-64	142 (10%)	485 (4%)	2.68***	[2.03, 3.53]
65+	49 (4%)	91 (1%)	3.95***	[2.48, 6.29]
Had job or business at arrest	1,122 (83%)	8,884 (70%)	1.51***	[1.25, 1.81]
Housing type				
House	786 (58%)	6,939 (55%)	ref	
Apartment	346 (25%)	3,912 (31%)	0.79***	[0.67, 0.93]
Trailer or mobile home	162 (12%)	798 (6%)	1.20	[0.96, 1.51]
Homeless shelter, car, homeless	40 (3%)	622 (5%)	0.50***	[0.32, 0.76]
Incarcerated or detained	25 (2%)	346 (3%)	1.01	[0.59, 1.72]
Homeless in year prior to arrest	84 (6%)	1,149 (9%)	0.63**	[0.46, 0.85]
Clinical and Childhood				
Ever had MH counseling	372 (28%)	2,221 (17%)	1.47***	[1.23, 1.76]
Taken MH medication at arrest	73 (5%)	637 (5%)	0.55***	[0.39, 0.76]
Ever been told by a mental health professional you had				
Post-traumatic stress disorder	72 (5%)	575 (5%)	0.60**	[0.43, 0.84]
Use drugs in month prior to arrest	433 (32%)	7,162 (58%)	0.47***	[0.40, 0.55]
Ever forced to have sex	245 (18%)	533 (4%)	4.43***	[3.55, 5.54]
Caretakers were on welfare	450 (34%)	4,411 (36%)	1.40***	[1.20, 1.63]
Living situation growing up	42 (3%)	213 (2%)	1.77*	[1.12, 2.81]
Shot at with gun	474 (35%)	6,319 (50%)	0.78**	[0.68, 0.91]

Sociodemographics	**Sex offense conviction (n = 1,364)**	**Other conviction (n = 12,716)**	**AOR**	**[95% CI]**
Criminal history				
Prior conviction				
Sex offense	221 (16%)	261 (2%)	8.51***	[6.59, 11.00]
Violent offense (non-sex offense)	265 (19%)	3,967 (31%)	0.69***	[0.58, 0.83]
Drug offense	136 (10%)	4,028 (32%)	0.53***	[0.42, 0.66]
Previous arrests	974 (71%)	10,995 (87%)	0.58***	[0.48, 0.71]
Restraining order	250 (18%)	1,633 (13%)	1.32**	[1.10, 1.60]
Probation ever	651 (48%)	8,113 (64%)	0.78**	[0.65, 0.92]
Parole violation	139 (11%)	2,955 (25%)	0.43***	[0.35, 0.54]
Federal prison (versus state)	39 (3%)	2,644 (21%)	0.09***	[0.06, 0.12]

* $p < .05$,

** $p < .01$,

*** $p < .001$.

Table 2

Descriptive Statistics and Logistic Regression Analyses of Male Veterans Incarcerated in State and Federal Prisons in 2004, Stratified by Sexual Offense or Other Offense Conviction

Sociodemographics	**Sexual offense conviction (n = 303)**	**Othrer offense conviction (n = 1,266)**	**AOR**	**[95% CI]**
Race				
Black non-Hispanic	54 (18%)	469 (37%)	0.41***	[0.28, 0.60]
Hispanic	10 (3%)	81 (6%)	0.36*	[0.16, 0.82]
American Indian/Alaskan				
Native non-Hispanic	12 (4%)	25 (2%)	1.19	[0.49, 2.87]
Asian/Pacific Islander/Native				
Hawaiian non-Hispanic	-	-	2.12	[0.23, 19.31]
White non-Hispanic	209 (69%)	630 (50%)	ref	
Multi-racial	16 (5%)	56 (4%)	1.14	[0.56, 2.32]
Age				
< 35	30 (10%)	200 (16%)	ref	
35-44	95 (31%)	425 (34%)	2.09**	[1.21, 3.61]
45-54	86 (28%)	427 (34%)	2.11**	[1.21, 3.68]
55-64	62 (20%)	172 (14%)	2.24**	[1.21, 4.14]
65+	30 (10%)	42 (3%)	5.29***	[2.41, 11.57]
Had job or business at arrest	264 (87%)	971 (77%)	2.06**	[1.31, 3.25]
Homeless in year prior to arrest	13 (4%)	116 (9%)	0.39*	[0.19, 0.81]
Clinical and Childhood				
MH counseling ever	98 (32%)	294(24%)	1.52*	[1.05, 2.21]
Taking MH medication at arrest	18 (6%)	124 (10%)	0.31***	[0.16, 0.61]
Use drugs in month prior to arrest	69 (23%)	588 (46%)	0.40***	[0.28, 0.58]
Ever forced to have sex	58 (19%)	75 (6%)	3.86***	[2.31, 6.47]
Caretakers were on welfare	73 (24%)	275 (22%)	1.59*	[1.08, 2.33]
Criminal history				
Prior conviction of sexual offense	45 (15%)	42 (3%)	4.94***	[2.81, 8.81]
Restraining order	59 (19%)	176 (14%)	1.71*	[1.12, 2.60]
Probation ever	117 (39%)	715 (57%)	0.47***	[0.34, 0.66]
Parole violation	16 (5%)	295 (23%)	0.19***	[0.10, 0.35]
Federal prison (versus state)	15 (5%)	307 (24%)	0.12***	[0.07, 0.22]

AOR = adjusted odds ratio. CI = confidence interval. MH = mental health.

* $p < .05$.

** $p < .01$.

*** $p < .001$.