



WRITTEN TESTIMONY

**SUBMITTED BY ERICA SURPRENANT, SPECIAL PROJECTS DIRECTOR
TEXAS CRIMINAL JUSTICE COALITION**

REGARDING INTERIM CHARGE 4

**HOUSE CRIMINAL JURISPRUDENCE COMMITTEE
AND SUBCOMMITTEE OF DEFENSE & VETERANS' AFFAIRS**

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TEXAS CRIMINAL JUSTICE COALITION

The Texas Criminal Justice Coalition is committed to identifying and advancing real solutions to the problems facing Texas' juvenile and criminal justice systems. We provide policy research and analysis, form effective partnerships, and educate key stakeholders to promote effective management, accountability, and best practices that increase public safety and preserve human and civil rights.

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Dear Members of the Committee,

My name is Erica Surprenant. I am the Special Projects Director of the Texas Criminal Justice Coalition. Thank you for allowing me this opportunity to present testimony on Charge 4: *“Monitor the implementation of SB 1940 (81R), which established veterans court programs in Texas, and examine the link between combat stress disorders of war veterans, including post-traumatic stress disorder and traumatic brain injury, and the onset of criminal behavior.”*

INTRODUCTION

It is no surprise that war can have a disastrous effect on both a person’s physical and mental state. The challenges faced by returning service members are numerous and difficult: reconnecting with family, adjusting to civilian life, and finding stable employment each can pose problems. An added burden on returning service members is the emotional and mental strain that accompanies combat and long periods of sustained stress, namely post-traumatic stress disorder (PTSD) and other mental health disorders. Sadly, substance abuse has become an issue for many returning service members seeking a way to cope with the stresses of combat and other feelings associated with their service.

The current wars in Iraq and Afghanistan have made this discussion especially timely. As of September 2008, 1.7 million troops had been deployed to Iraq and Afghanistan,¹ with another 34,000 troops deployed in 2009.² Additional data from 2009 shows that 35,000 individuals have been wounded in action,³ with an unparalleled 90 percent surviving their injuries.⁴ However, physical injuries are not these wars’ only concern. In fact, PTSD and Traumatic Brain Injury (TBI) caused by blasts are considered the ‘signature’ injuries of the wars in Iraq and Afghanistan:⁵ an estimated 30 percent of veterans report signs of PTSD, depression, and other mental health issues,⁶ which does not include those individuals who may experience other symptoms coupled with PTSD – such as depression and anxiety – that can contribute to aggressive behavior.⁷

One of the more alarming conclusions of studies on combat trauma is that brain injuries and PTSD are linked to the onset of criminal behavior in several ways. This testimony seeks to examine the link between mental health conditions and criminal behavior, as well as explore effective programs that address these issues and provide solutions to this looming problem.

POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder, or PTSD, is defined by the American Psychiatric Association (APA) as “a disorder characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma.”⁸ It is further defined by the Diagnostic and Statistical Manual of Mental Disorders as:

the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm,

or threat of death or injury experienced by a family member or other close associate.⁹

Although the official term “post-traumatic stress disorder” and its subsequent definition were not added to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) until 1980,¹⁰ the symptoms associated with the disorder have existed for as long as wars have been waged: known as “soldier’s heart” during the Civil War and “shell shock” during World War I, it became known as “combat fatigue” during World War II before PTSD was officially accepted after the end of the Vietnam War.¹¹

Certainly, the current conflicts in Iraq and Afghanistan have their own share of mental health concerns. The sheer amount of deployed troops contributes to the high amount of physical injuries and ensuing mental health disorders that are plaguing returning service members.

What is PTSD and What are its Symptoms?

As noted above, PTSD is an anxiety disorder that manifests itself after experiencing an event that caused or threatened to cause serious harm or death.¹² Symptoms associated with the disorder include feelings of numbness or detachment, nightmares and trouble sleeping, “hyper-arousal,”¹³ “hyper-vigilance,”¹⁴ and both avoidance¹⁵ and re-experiencing of the traumatic event.¹⁶ An event is considered traumatic if it involves serious death or injury and is typified by suddenness;¹⁷ research suggests that an individual’s perception of the event is “more important than the actual danger associated with the event.”¹⁸ Severity of the traumatic event has been linked with the intensity and duration of the event.¹⁹

There are three types of PTSD based on the manifestation of symptoms. Acute PTSD involves symptoms lasting less than three months; chronic PTSD symptoms last three months or longer; and delayed onset PTSD involves symptoms beginning at least 6 months after the traumatic event.²⁰ A diagnosis of PTSD requires that symptoms be present for at least one month and cause “significant distress or impairment” in a social or occupational setting.²¹

How is PTSD Acquired?

The most likely manner in which PTSD is acquired among veterans is exposure to combat and war-zone stress.²² Levels of exposure can range from direct combat – where an individual is in the direct line of imminent harm – to lower level combat where individuals are still subject to danger.²³ As such, killing an enemy combatant, handling dead bodies, or simply knowing someone who was killed in action have been known to lead to PTSD.²⁴

The onset of PTSD symptoms is likely to be positively influenced by the amount of combat exposure an individual has experienced.²⁵ Multiple deployments and extended tours of duty – common occurrences for soldiers in the wars in Iraq and Afghanistan – mean a greater risk for exposure to trauma and, thus, an increased risk of developing PTSD.²⁶ This theory was substantiated in a 2008 report made by the Army’s Fifth Mental Health Advisory Team, which found that the length of deployment, the number of deployments, and the time in between deployments contributed to the deleterious mental health condition of service members.²⁷

Exposure to combat and the onset of PTSD symptoms have additional demographic factors, including age, education, and substance abuse history.²⁸ In a national sample of Vietnam-era veterans, childhood antisocial behavior was also found to be an important factor in the development of PTSD: individuals with antisocial qualities may take increased risks in a war zone because they perceive less threat, thus exposing themselves to a greater risk of possible trauma.²⁹ Ultimately, while other elements may be relevant, five main factors are found to influence the development of PTSD: (1) biological factors, (2) development level, (3) severity of the traumatic experience, (4) social context, and (5) prior and subsequent life events.³⁰

Note: Developmental factors, including education level and cognitive and emotional maturity, play an important role in an individual's reaction to a traumatic situation.³¹ In general, the older, more mature, and more educated a person is, the more able (mentally) he or she will be to deal with traumatic events.³² It is for this reason that some professionals believe that "what an individual brings to a traumatic event"³³ is as important as the intensity of the traumatic event itself. Likewise, the environment to which a survivor of intense trauma returns is critical. A supportive community and family setting can help mitigate the symptoms associated with a traumatic event and lessen the symptoms of PTSD.³⁴

Rates of PTSD

A report published in 2007 by the U.S. Department of Veterans Affairs (VA) predicted that 30 to 40 percent of Iraq veterans would face "serious psychological problems" as a result of PTSD.³⁵ The high rate of injuries in the Iraq and Afghanistan wars may contribute to these high rates of PTSD, which are found to be substantially higher after a completed tour of duty than before deployment.³⁶

With regard to Vietnam-era veterans, this population showed prevalence of PTSD at rates of 15 percent compared to the general population, where rates are 3 to 4 percent.³⁷ The National Vietnam Veterans Readjustment Study (NVVRS), which conducted interviews with over 3,000 American Vietnam War veterans, concluded that the lifetime prevalence of PTSD of the studied population was 30.9 percent,³⁸ with nearly half of those individuals having been arrested or been in jail at least one time, 34.2 percent having been arrested or in jail more than once, and 11.2 percent having been convicted of a felony.³⁹

Data from a June, 2010, survey of over 18,000 recent army and National Guard veterans conducted by psychiatrists from the Walter Reed Army Institute of Research, shows approximately "8 to 14 percent of infantry soldiers who served in Iraq and Afghanistan return seriously disabled by mental health problems. [...] About half the soldiers with either PTSD or depression also misused alcohol or had problems with aggressive behavior."⁴⁰

Problems Associated with PTSD

PTSD manifests numerous symptomatic behaviors and is often co-morbid (pertaining to two conditions that occur together)⁴¹ with other psychiatric disorders, including major depression, generalized anxiety disorder,⁴² acute stress disorder,⁴³ and alcohol abuse.⁴⁴ In fact, research shows 88 percent of males with PTSD have one or more co-morbid diagnoses.⁴⁵ Aside from co-morbidity,

other difficulties accompanying PTSD may include (1) symptoms of intrusion, (2) avoidance symptoms, (3) numbing, (4) difficulties with appraisal, (5) problems with allostasis (adapting to change),⁴⁶ and (6) physical manifestations of the disorder.⁴⁷ These difficulties often evolve into unsafe behaviors that can lead to relationship strain, unemployment issues, and substance abuse. Generally, such problematic behaviors can be attributed to four main impulses: overreacting to danger cues, behavioral re-experiencing (*discussed more fully on page 5*), pursuing stimulation-seeking behavior to surmount feelings of numbness, and engaging in dangerous behavior to ease survivor guilt.⁴⁸

Again, substance abuse presents a special problem for returning veterans. Research suggests that veterans diagnosed with PTSD have worse substance abuse issues than veterans who do not suffer from PTSD.⁴⁹ Specifically, veterans who screened “positive for PTSD had greater lifetime use of alcohol to the point of intoxication, of heroin, and of cocaine.”⁵⁰ Additionally, Vietnam veterans with combat-related PTSD who lack the proper treatment to address it have a high risk of dying from a drug overdose.⁵¹ Sadly, data indicates that younger veterans are even more vulnerable to substance abuse and co-occurring disorders.⁵²

The symptomatic behaviors of PTSD, as noted above, can create difficulties in an individual’s life, especially with regard to personal relationships and social interactions. These unhealthy behaviors can lead to social breakdowns, increase the chance of criminal activity, and may result in involvement in the criminal justice system. This is especially likely in the event of hyper-alertness, when an individual suffering from PTSD reacts more aggressively to situations than he or she did prior to the trauma.⁵³ Flashbacks, often triggered by something harmless,⁵⁴ are not uncommon and can be accompanied by “gaps in awareness or distortions in perception,”⁵⁵ which can lead to reckless behavior and sometimes violence. It is understandable that relationships for individuals with PTSD often suffer as a result. Marital strain, domestic abuse, and difficulties in parenting have all been unfortunate occurrences.⁵⁶

Difficulty in Getting Help

Although rates of PTSD among combat veterans remain high, only approximately 23 percent of studied samples seek treatment,⁵⁷ and on average women are less likely to utilize VA mental health services than men.⁵⁸ There are a few reasons why such a small percentage of veterans exhibiting symptoms of PTSD receive much-needed services. One study showed that more than 60 percent of veterans of Operation Iraqi Freedom and Operation Enduring Freedom (Afghanistan) feared stigmatization from peers and superiors,⁵⁹ and in another study, 49 percent felt that seeking treatment would damage their career in the military.⁶⁰ Stigmatization is linked with the feeling of appearing weak in front of others. Because military service members, coming from a “warrior culture,” usually have a great deal of pride, they often believe that admitting to having mental health problems, especially those associated with PTSD, is a an indication of weakness.⁶¹

Another reason veterans do not seek help for their mental health issues is the lack of quality care available through the military health care system. One recent report noted a 40 percent vacancy rate in the Army and Navy for psychologist positions, and also found that only 10 to 20 percent of military health care providers have training to deal with PTSD.⁶² Poor treatment and improper diagnoses have been ongoing problems for returning soldiers of the wars in Iraq and Afghanistan.

Soldiers reported being sent to Iraq despite having misdiagnosed brain injuries, and then being punished for their illness: out of a sample of 276 soldiers who were discharged for personality disorder, 56 actually had PTSD.⁶³ Misdiagnosis of PTSD could have several explanations. In one study, patients expressed concern that their providers did not believe them, while others expressed frustration in getting appointments and the short duration of those appointments.⁶⁴ A more alarming explanation comes in an email from the Department of Veterans Affairs, where a senior staff member encouraged staff members to (mis)diagnose patients with adjustment disorder instead of PTSD to avoid costs.⁶⁵

Incarcerated Veterans and PTSD

Given the nature of PTSD and its effect on a person's behavior, it becomes apparent how so many soldiers afflicted with the disorder have interactions with the criminal justice system. As noted above, veterans with PTSD exhibit high rates of violent outbursts, aggressive behavior, hostility, and poor anger control.⁶⁶ One study shows that 40 percent of veterans who had symptoms of PTSD committed violent crimes after their service.⁶⁷ The same study suggests that individuals with a diagnosis of PTSD are 4.6 times more likely to be "currently imprisoned for an expressive violent act."⁶⁸ Other difficulties facing incarcerated veterans with PTSD include substance abuse, psychiatric problems, and additional physical problems.⁶⁹

Many veterans who are incarcerated are young, pointing to the need for specialized treatment now to prevent long-term problems or escalating behavior. In fact, current estimates find that the majority of veterans serving time in prison are between the ages of 25 and 34.⁷⁰ We are seeing history repeat itself: approximately half of Vietnam-era combat veterans who have PTSD had been arrested or incarcerated at least once, and 11 percent had a felony conviction.⁷¹

PTSD's link to crime has several explanations. The National Center for PTSD suggests that its symptoms can predispose an individual to commit crimes, and that often the crimes that veterans commit are similar to the traumatic event they experienced.⁷² This is known as "behavioral re-experiencing," where the individual undergoes behavioral responses similar to the ones that occurred during the initial traumatic event.⁷³ Combat "addiction" can also lead an individual suffering from PTSD into toxic behaviors. In such cases, individuals will engage in repeated patterns of aggressive behavior in order to re-create a state that mirrors the original trauma.⁷⁴ Combat veterans' criminal behavior may also stem from their development of violent coping skills. Data collected from the NVVRS showed 40 percent of respondents had been involved in three or more violent acts in the preceding year, suggesting that combat-era veterans had developed violent coping skills and continued to employ those skills.⁷⁵ Brain injuries compound this problem: due to cognitive deficits, individuals with brain injuries resort to aggression and violence when they are unable to meet their needs in normal ways.⁷⁶

Considering PTSD's symptomatic behaviors, it is no surprise that some studies find a strong relationship between the disorder and domestic violence.⁷⁷ On a positive note, evidence suggests that treating PTSD symptoms can reduce aggressive behavior in subjects,⁷⁸ and anger management training has improved anger control among Vietnam-era veterans with PTSD.⁷⁹

TRAUMATIC BRAIN INJURY

Another injury affecting large percentages of soldiers serving in Iraq and Afghanistan is Traumatic Brain Injury (TBI). TBI is defined as “a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain.”⁸⁰ Necessary to any definition of TBI is the appearance of biomechanical force sufficient to cause injury, something that has been “difficult to precisely determine in the current military setting.”⁸¹ The most common cause of TBI during war is blasts,⁸² with 60 to 80 percent of soldiers who experienced a blast acquiring TBI.⁸³ Blasts can have damaging and lingering effects, especially on body parts with “air-fluid interfaces, such as lungs, bowels, and middle ear.”⁸⁴ At the very least, on the spectrum of mild to severe, approximately 80 percent of brain injuries have been classified as mild.⁸⁵

TBI and other brain injuries can be identified with the use of a magnetic resonance imaging (MRI) scan;⁸⁶ however, due to the subtlety of mild TBI and the manifestation of its symptoms, many head injuries go unreported and, thus, untreated.⁸⁷ Under ideal circumstances, soldiers who have experienced blasts or head injuries that could potentially result in an established TBI should not return to full duty until they remain symptom-free for several days.⁸⁸

Rates of TBI among Operations Iraqi Freedom and Enduring Freedom veterans have been estimated at 22 percent,⁸⁹ which is higher than any previous war due to the increased number of explosive and blast attacks resulting from the use of Improvised Explosive Devices (IED).⁹⁰ In April 2006, the Department of Defense reported that nearly 18,000 service members had been wounded, two-thirds of which had been injured by IED blasts.⁹¹ An article written two years later in 2008 states that 320,000 service members had been diagnosed with “symptoms related to traumatic brain injury.”⁹² That number can only be growing.

TBI and Links to Crime

Both short- and long-term problems can develop as a result of TBI, often affecting daily living by causing problems in thinking, behavior, and emotions.⁹³ As with PTSD, these problems can manifest into behavioral problems, as well as cause sleeplessness, headaches, anxiety, and depression.⁹⁴ Additionally, mild TBI has been found to result in job loss, relationship strain, and substance abuse, all of which can lead to increased interaction with the criminal justice system.⁹⁵

Studies of incarcerated veterans show a prevalence of TBI, and in a study of 279 Vietnam-era combat veterans, those with TBI exhibited higher rates of “violence, aggression, anger, and hostility” than those without TBI.⁹⁶ Among the incarcerated, 50 percent of a studied sample of individuals convicted of felony crimes reported TBI.⁹⁷ Another study showed that male inmates with a history of TBI had a record of violence, including domestic violence.⁹⁸

PTSD, TBI, AND CRIMINAL BEHAVIOR

According to the Bureau of Justice Statistics, the number of veterans currently incarcerated is estimated at 9.4 percent of the total prison population,⁹⁹ and this number continues to increase despite declines in the national population of veterans.¹⁰⁰ Like noted above, the NVVRS found that nearly half of Vietnam-era combat veterans studied had been arrested one or more times.¹⁰¹ Current

numbers show that veterans of the Iraq and Afghanistan wars represent 3.7 percent of veterans in state facilities and 4.5 percent in federal institutions.¹⁰²

Relying on punitive sanctions like incarceration – popular in the aftermath of the Vietnam War¹⁰³ – is not an effective method of addressing the root causes of some veterans’ criminal behavior. Veterans coming into contact with the criminal justice system may suffer from a neurological impairment; they should receive a proper diagnosis and individualized treatment so that they can better avoid the long-term impact of criminal and collateral consequences.

Below are various factors that may contribute to veterans’ criminal behavior.

Contributors to Criminal Behavior

- ***Neurological Impairment***

One of the main contributors to criminal behavior in individuals with TBI is neurological impairment – specifically, frontal lobe damage – caused by a blast or other head injury.¹⁰⁴ Frontal lobe injury and lesions are associated with a lack of self-control and poor judgment,¹⁰⁵ as well as violent and aggressive behavior.¹⁰⁶ Several studies have also demonstrated a specific link between brain injury and acts of domestic and spousal abuse.¹⁰⁷

- ***Combat-Related Trauma***

Trauma associated with combat can also be linked to criminal behavior, as symptoms of PTSD can inevitably lead to crime, and criminal acts can be linked to the actual traumatic event that the individual experienced.¹⁰⁸ Survivors of trauma may also experience emotional numbness among other symptoms that can result in sensation-seeking behavior verging on criminal conduct.¹⁰⁹ Other variables that have been known to contribute to criminal behavior include demographic variables,¹¹⁰ symptom severity,¹¹¹ underlying medical conditions,¹¹² environment,¹¹³ and combat training, which “breaks down the mind’s natural barriers to committing violent acts.”¹¹⁴

- ***Substance Abuse***

It is well documented that veterans, especially those with combat experience, use drugs and alcohol as a way of coping with the emotional consequences of war.¹¹⁵ In fact, data suggests that substance abuse is the leading cause of incarceration for veterans.¹¹⁶ The most commonly abused substance among active duty military and veterans is alcohol,¹¹⁷ with 75 percent of combat veterans exhibiting symptoms of lifetime PTSD also meeting criteria for alcohol abuse.¹¹⁸ Furthermore, more than “25 percent of veterans in prison were intoxicated at the time of their arrest.”¹¹⁹

Veterans returning from combat suffer from alcohol abuse: 15 percent of returning service members screened positive for alcohol dependence,¹²⁰ and an estimated 256,000 veterans are in substance abuse treatment, though data suggests that only about 20 percent of those needing treatment actually receive services.¹²¹

Veterans of the wars in Iraq and Afghanistan also struggle with drug dependence, specifically opioids like painkillers.¹²² Likewise, mood disorder medications – such as benzodiazepines – are also widely abused by veterans according to VA records.¹²³ It seems drug abuse is more prevalent among younger veterans, again highlighting the need for treatment at early stages to prevent long-term problems: survey data collected from National Household Surveys on Drug Abuse in 2000 and 2001 suggest that veterans aged 18 to 25 were more likely to engage in drug use than older veterans.¹²⁴

- ***Difficulties in Adjustment***

A veteran's transition back to American society can be extremely difficult and can complicate family and personal relationships, jeopardize employment prospects, create legal difficulties,¹²⁵ and increase the risk of contact with the criminal justice system. In one sample, 62 percent of veterans were separated or divorced, and 22 percent were homeless (itself a contributor to criminal behavior).¹²⁶ Many veterans report difficulties with maintaining employment, which can further strain finances, family relationships, and ultimately lead to homelessness.¹²⁷ Survey data shows that “47 percent of all homeless veterans served during the Vietnam War era.”¹²⁸ Veterans who have had dealings with the criminal justice system face additional barriers to housing and employment because of their criminal record.¹²⁹

TREATMENTS

Effective treatments for PTSD, TBI, and co-occurring disorders are currently available, and additional strategies are being investigated. Examples of effective treatments include cognitive behavior and exposure therapy, as well as medications.¹³⁰ Cognitive behavioral therapy focuses on re-programming an individual with regard to his or her stress response to a certain traumatic event. The therapy promotes the use of relaxation techniques in an effort to reduce the “physical reaction to PTSD triggers and overcom[e] avoidance symptoms.”¹³¹ Exposure therapy, a type of cognitive behavioral therapy, has been effective in treating symptoms associated with panic disorder and PTSD in combat veterans. The treatment involves exposing an individual to sounds, smells, and visual stimuli that trigger a fear response in the patient. The fear response can eventually be eliminated through gradual exposure and the use of calming techniques such as meditation.¹³² Virtual reality treatments have begun to be used in exposure therapies with recorded success.¹³³

Note: Treatments for combat-related mental health disorders are especially critical in light of high rates of suicide among veterans. The greatest risk factors associated with suicide among this population include difficulties with fellow military members, legal issues, and personal relationships.¹³⁴ Given the prevalence of these difficulties, as well as mental health and substance abuse issues among veterans,¹³⁵ suicide rates were reported in 2005 to be 20.8 per 100,000 among veterans, compared to a rate of 8.9 per 100,000 among non-veterans.¹³⁶ As of 2008, there had been 147 “recognized suicides in Iraq,” and a 2007 report from the Department of Veterans Affairs states that more than 1,000 veterans commit suicide each year.¹³⁷

VETERANS COURTS AND PROGRAMS

As noted throughout, veterans continue to become and stay involved with the criminal justice system. According to 2008 data from the Bureau of Justice Statistics, 229,000 veterans were incarcerated in local and state jails and state and federal prisons, 400,000 were on probation, and an additional 75,000 were on parole.¹³⁸ One approach gaining national attention for providing specialized assistance to this population is the veterans court program, ideally a treatment court option that offers diversion as an alternative to incarceration to non-violent defendants facing criminal charges resulting from their combat military service. These programs seek to provide services to veterans that will better enable them to manage their dependency and psychological issues outside of a traditional legal setting.¹³⁹ As an incentive, some veterans courts may offer defendants dismissal of their charges upon successful completion of the program.¹⁴⁰

According to West Huddleston of the National Association of Drug Court Professionals, 21 veterans courts have been established across the nation,¹⁴¹ and financial assistance from the federal government is available through the SERV Act.¹⁴² Under these guidelines, veterans courts must assist only non-violent defendants who have served in active duty and who do not have a dishonorable discharge.¹⁴³

Buffalo Veterans Court

The first veterans court was established in January 2008, in Buffalo, N.Y.¹⁴⁴ Currently, about 100 veterans are enrolled, and graduates of the program maintain a zero percent recidivism rate.¹⁴⁵ Buffalo's Veterans Court accepts veterans with a serious and persistent mental health disease, as well as those who struggle with substance abuse.¹⁴⁶ Screening of eligible participants uses evidence-based practices to best assess veterans who will successfully benefit from the program.¹⁴⁷

Texas-Specific Courts and Programs

Texas has a unique opportunity to address the needs of system-involved veterans throughout the state, as 1,634,000 veterans call Texas home.¹⁴⁸ Veterans courts are currently operational in Harris and Tarrant counties, and the newest court, established in Dallas County, currently serves seven participants.¹⁴⁹ Bexar, Denton, El Paso, Fanning, Hidalgo, Orange, and Travis counties are in the process of establishing courts as well.¹⁵⁰

- ***Harris County***

Harris County is home to the second-largest Operation Enduring Freedom and Operation Iraqi Freedom veteran populations,¹⁵¹ and “three hundred veterans are booked into the Harris County jail each month.¹⁵² To address the needs of this population, a veterans court pilot program has been established to assist criminal justice-involved veterans diagnosed with a mental illness/disorder, TBI, or substance abuse in their efforts to receive treatment and counseling.¹⁵³ The court has one docket currently serving a maximum of 20 veterans.¹⁵⁴

- ***Tarrant County***

Tarrant County has established the Veterans Court Diversion Program for Justice-Involved Veterans, designed to divert these individuals away from the traditional criminal justice system.¹⁵⁵ Participants must be a veteran or active duty service member, and they must be diagnosed with a brain injury or a mental illness/disorder such as PTSD. Furthermore, cases must be approved by the District Attorney's office.¹⁵⁶

- ***Bell County***

Bell County has established several programs, largely through the leadership of Todd Jermstad, Director of Bell and Lampasas Counties Community Supervision & Corrections Department, to assist veterans involved with the criminal justice system. The Substance Abuse/Post Traumatic Stress Disorder Program assists probationers who have served in a combat zone, helping them to cope with their PTSD-related symptoms and, especially, reduce their reliance on drugs and alcohol as a means of coping. As an added benefit, this program is available to any individual on probation who has served his or her country, regardless of discharge status.¹⁵⁷ In addition to PTSD and substance abuse counseling, participants receive acupuncture treatments designed to reduce stress and anxiety.¹⁵⁸

An additional PTSD program has been established in Bell County, with services provided by the VA and offered at the Veteran's Center in Harker Heights. The program provides 12 weeks of no-cost PTSD counseling to probationers who have served in a combat zone.¹⁵⁹

INCARCERATED VETERANS SURVEY PROJECT

To better understand the circumstances surrounding the service and crimes of incarcerated veterans, TCJC conducted an informal survey in May and June, 2010, whereby we collected information and anecdotal stories from 25 incarcerated veterans throughout Texas. Specifically, we compiled information related to age at enlistment, number of deployments, and type of service, as well as combat, substance abuse, and mental health history.

Findings:

➤ Army/Combat Experience Background

Branch of Service:

- 56% served in the Army.
- 16% served in the Navy.
- 16% served in the Marine Corps.

Age at Enlistment:

- The majority of respondents joined the service at ages 17 or 18.
 - 35% joined at 18 years of age.
 - 26% joined at 17 years of age.
- Overall, respondents' enlistment ages ranged from 15 years to 23 years of age.

Our sample represented a range of branches, including service with the following divisions or companies: 17th Engineer Battalion, 122 Signal Battalion, 2nd Infantry Division, 101st Military Police Company, 101st Airborne Division, 5th Marine Division, 25th Infantry Division, 3rd Marine Division, 335th Aviation Company, and others. Members of our sample served overwhelming in South Vietnam; others were stationed in Korea, Egypt, and Germany.

Combat experiences also varied: some respondents engaged in reconnaissance missions, others in hand-to-hand combat, and one served during the TET Offensive.

When asked about specific combat experience and deployments:

- 54% were exposed to combat during a tour of duty.
- 60% experienced blasts or open fire during their service.
- 20% were not sure if they had experienced blasts or open fire.
- 32% had one or more deployments.

➤ **Mental Health History and Background**

- 92% of our sample stated that they have a history of mental illness.

Our sample reported the following symptoms, both as prior history and current experience:

- 21% used or abused substances.
- 29% experienced recurring nightmares and/or had difficulty sleeping.
- 26% experienced symptoms of avoidance and/or felt numb and/or detached.
- 24% experienced flashbacks to traumatic events.

When asked when the onset of the above symptoms began, our sample reported as follows:

- 36% reported that symptoms began during deployment.
- 44% reported that symptoms began after returning from service.

For those that reported symptoms of PTSD prior to deployment:

- 40% reported that the symptoms increased in severity after service.
- 16% reported that their symptom severity remained the same.
- 44% chose not to answer.

Diagnoses:

- 84% had been diagnosed with a mental illness by a doctor. Of those, 52% were diagnosed with PTSD.
- 12% had not been diagnosed by a doctor.
- 4% were not sure if they had been diagnosed by a doctor.

For those that had experienced symptoms related to PTSD, the majority reported symptoms that manifested after they completed their service, although a fair percentage reported symptoms starting while they were still serving.

Additionally, respondents reported experiencing symptoms of multiple conditions:

- 32% experienced symptoms of manic depression.
- 28% experienced symptoms of anxiety or panic disorder.
- 20% experienced symptoms of depression.
- 16% experienced symptoms of schizophrenia.
- 16% experienced symptoms of substance/alcohol abuse.
- 8% experienced symptoms of bipolar disorder.

Of the 84% in our sample that were diagnosed with a mental illness:

- 72% received some form of treatment.
- 16% did not receive any treatment.
- 12% were not sure if they had received treatment.

Of those who indicated they received treatment, our sample reported receiving one or more of the following treatments:

- 80% received medications.
- 64% participated in group therapy.
- 64% participated in individual counseling.
- 32% received behavioral therapy treatments.

Our sample provided varied explanations for not having received treatment after being diagnosed with a mental illness. Some reported that they did try to access services through the VA but were not helped (they did not give details); one respondent stated that he believed at the time that people who received mental health treatment were mentally “weak”; one reported that the military was not “well informed” on PTSD and was not “able to treat [it] effectively”; one reported that he did not know where to go for assistance and did not have funds to cover the costs of treatment; and one mentioned that there is no therapy or counseling available inside TDCJ.

Additionally, respondents reported having various other symptoms, include the following:

- 80% experienced confusion.
- 80% experienced memory and/or concentration difficulties.
- 62% experienced frequent headaches.
- 32% experienced episodes of an inability to awaken from sleep.
- 32% experienced slurred speech.

➤ **Adjustment Difficulties**

Our sample reported experiencing one or more of the following obstacles in returning from service:

- 80% had trouble relating to other people.
- 76% faced mental health problems.
- 56% experienced financial strain.

- 48% experienced difficulty in accessing treatment services.
- 32% experienced housing difficulties.

When asked about assistance, 36% of our sample stated they received assistance from a community organization or agency upon returning, specifically identifying the VA.

When asked about the effect of military service on relationships:

- 92% experienced relationship strain after returning from service.
- 40% had been married once.
- 16% had been married twice.
- 16% had been married three times.
- 12% had been married four times.
- 12% had been married five or more times.
- 4% were not sure how many times they had been married.

When asked about experiences related to relationship strain, our sample reported that relating to other people was difficult, especially with regard to the events they had experienced during combat. One respondent stated that he “had a distrust of others,” another stated that he “avoided social situations,” yet another stated he experienced “trust issues, avoidance, and acceptance problems,” and one stated that he had “no compassion.” Many reported that their drug and/or alcohol abuse contributed to their relationship strain.

When asked about substance abuse:

- 88% had used alcohol or drugs at least one time.
- 12% have never used alcohol or drugs.

Of those who reported using drugs and/or alcohol:

- 56% use drugs and/or alcohol daily.
- 12% use drugs and/or alcohol 1 - 2 times per week.
- 4% use drugs and/or alcohol 3 - 4 times a week.
- 8% use drugs and/or alcohol 5 - 6 times a week.
- 8% reported “other.”
- 12% chose not to answer.

When asked about an increase in their substance usage:

- 84% of those who used drugs and/or alcohol said that their use increased after service;
- 4% were unsure if their drug and/or alcohol use increased after service; and
- 12% chose not to answer.

➤ **Criminal History Information**

Our sample population was incarcerated for the following criminal offenses:

- 64% for violent offenses.
- 18% for drug-related offenses.
- 18% for property-related offenses.

When asked about the impact of military service on criminal behavior:

- 88% believed that their military experience had an impact on their criminal behavior.
- 12% weren't sure if their military experience had an impact on their criminal behavior.

In the events leading up to their criminal actions, our sample showed that many were experiencing depression or marital stress, or were under the influence of an illegal substance or alcohol. When asked to describe how their military service had impacted their criminal behavior, one asserted that the traumatic events he had experienced during his service “deeply impacted [his] subconscious mind” and that the only solace he could find “was to drink...to calm the demons that [his] mind could not deal or cope with.” Another stated that when his drug use turned to abuse, he needed to find a way to afford his habit and began stealing.

POLICY RECOMMENDATIONS

➤ **Increase Availability and Access to Community-Based Treatment.**

Veterans with established cases of TBI and PTSD resulting from injuries sustained during service should receive care and treatment in a supportive environment – something they are not likely to receive in a correctional setting.¹⁶⁰ In fact, punitive sanctions may further compromise the physical and mental health of a veteran suffering from TBI or PTSD and, as such, should be considered as a last-resort option.¹⁶¹ Community-based treatment, which has proven to be effective in treating the root causes of criminal behavior (such as addiction), can reduce the risks of re-offending while saving the state money.¹⁶²

➤ **Expand Support for Veterans Courts that Incorporate Best Practices.**

Texas should increase incentives and support to counties to implement specialized veterans courts. Such courts should form partnerships with local VA offices, public agencies, community-based organizations, and mental health professionals to ensure adequate evaluation¹⁶³ and support for the veteran clients. Similarly, veterans courts should increase collaboration with law enforcement agencies to identify possible participants and increase opportunities for diversion of eligible veterans.

Identifying and incorporating best known practices is essential to a successful veterans court. One key component of a true diversion court would allow veterans to participate without having to plead guilty in order to receive treatment.¹⁶⁴ Additionally, although veterans courts typically accept only minor offenses, such as drug possession, past data suggests that most veterans are incarcerated for more serious felonies, such as assault.¹⁶⁵ Expanding eligibility for veterans courts would better serve those with the greatest needs.

➤ **Establish Judicial Authority for Sentence Mitigation for Some Veterans.**

Judges in all courts should have the discretion to consider mitigating factors when sentencing veterans suffering from combat-related mental health disorders. Often, specialized veterans courts will not accept participants charged with serious and/or violent offenses. Other states, such as Minnesota and California,¹⁶⁶ have taken an individual's combat experience into account when deciding an appropriate sentence.¹⁶⁷

➤ **Ensure All Veterans have Access to Diversion and Treatment Programs.**

Often, veterans who have been dishonorably discharged from the military are not eligible for services through the VA, or diversionary programs such as veterans courts. Because injuries such as PTSD and TBI could have potentially contributed to the behavior that caused veterans to be dishonorably discharged, Texas should increase incentives, opportunities, and coordination to ensure that every community can appropriately address the needs of this vulnerable population.

➤ **Encourage the Establishment of Family Violence Prevention Councils (FVPC).**

In an effort to address the growing incidences of family violence among military service members, the Hampton Roads Domestic Violence Prevention Task Force, based in Norfolk, Virginia, established the Military and Civilian FVPC. A collaboration between the Task Force, five military branches, and other stakeholders, FVPC seeks to reduce family violence in the Hampton Roads area through coordinated prevention, intervention, treatment, and rehabilitative measures.¹⁶⁸ A similar program could be established in Texas counties with large military populations, such as Bell County where Fort Hood is based.

➤ **Encourage Law Enforcement to Implement Pre-Booking Diversion Strategies.**

Pre-booking strategies specific to veterans should be established by law enforcement agencies: officers who, at the initial point of contact, identify an individual as requiring mental health assistance should divert him or her to VA hospital care.¹⁶⁹ Or, agencies could create a mental health task force with specialized care providers to better address the needs of veterans experiencing a mental health issue.

➤ **Increase Training of Criminal Justice Professionals to Identify Combat-Related Trauma.**

Criminal justice professionals in local county jails and state correctional facilities, as well as probation and parole officers, should be trained to recognize the symptoms related to PTSD and TBI, and they should screen individuals for military service and traumatic experiences during the intake process.¹⁷⁰

➤ **Expand Treatment Options and Improve Standards for Medication-Assisted Therapy.**¹⁷¹

Community health providers and the VA should focus on counseling and behavioral therapies – rather than rely solely on medication – to treat veterans exhibiting symptoms of PTSD and other mental health issues. Anti-psychotic medication should be used cautiously due to its potential to increase negative behavioral symptoms¹⁷² and risk of overdose. On the other hand, by expanding treatment options, mental health providers can meet the needs of more veterans and increase their likelihood of a successful rehabilitation.

➤ **Provide Overdose- and Suicide-Prevention Educational Materials to Veterans.**

Veterans, especially those suffering from PTSD and co-occurring disorders, are at a high risk of suicide and lethal overdose – especially once they are released from incarceration.¹⁷³ State and federal correctional facilities, in partnership with the VA, should make available comprehensive educational materials regarding overdose and suicide prevention.

➤ **Provide Veteran-Specific Re-Entry Services to Veterans Leaving Incarceration.**

Re-entry is especially difficult for veterans who are leaving incarceration while struggling with PTSD and/or other trauma-related conditions. It is likely that a period of incarceration will exacerbate symptoms of PTSD and, worse, it can re-traumatize an individual.¹⁷⁴ Veterans desperately need re-entry support to connect them with mental health services, VA healthcare services (if eligible), peer support services, employment and vocational training, and substance abuse treatment.¹⁷⁵ Because failure to secure housing and employment can lead to homelessness, it is crucial that an adequate support system exists for these veterans, particularly with regard to housing.¹⁷⁶ The VA provides assistance through the Homeless Veterans Coordinator, but it is important that correctional facilities and community organizations partner with the VA in efforts to ensure a smooth transition for veterans.

➤ **Provide PTSD and Trauma-Related Counseling to Incarcerated Veterans.**

Incarcerated veterans have an estimated PTSD rate of 39 percent, compared to a rate of 7.8 percent among the general population.¹⁷⁷ As PTSD is linked with anger, hostility, and aggressive acts,¹⁷⁸ it makes sense to provide PTSD counseling and therapy inside the correctional setting. This would not only help combat-era veterans deal with their own traumatic experiences, but may also mitigate aggressive behaviors and potentially violent behavior inside prison walls, thereby increasing safety for guards and prisoners alike.

* * *

Thank you for allowing me the opportunity to provide information about this critical issue. As many Texans continue to face combat situations where their mental health can be compromised, we must prepare for the consequences and establish assistive infrastructures that will address the needs of those who serve in the armed forces, thus increasing the health and stability of their families and communities.

NOTES

- ¹ Dan Heilman, "Veterans with post-traumatic stress disorder present challenges for the criminal justice system," *Minnesota Lawyer*, October 24, 2008, <http://www.minnlawyer.com/article.cfm?recid=79487>.
- ² Ann Scott Tyson, "Support Troops Swelling U.S. Force in Afghanistan: Additional Deployments Not Announced and Rarely Noted," *The Washington Post*, October 13, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/12/AR2009101203142.html>
- ³ Heidi Golding and others, "Understanding recent estimates of PTSD and TBI from operations Iraqi Freedom and Enduring Freedom," *Journal of Rehabilitation Research and Development* 46, no. 5 (2009): vii-xiii.
- ⁴ Constantina Aprilakis, "The Warrior Returns: Struggling to Address Criminal Behavior by Veterans with PTSD," *The Georgetown Journal of Law and Public Policy*, Vol. 3 (2006): 547.
- ⁵ Hillary S. Burke, Charles E. Degeneffe, and Marjorie F. Olney, "A New Disability for Rehabilitation Counselors: Iraq War Veterans with Traumatic Brain Injury and Post-Traumatic Stress Disorder." *Journal of Rehabilitation* 75, no. 3 (2009): 5.
- ⁶ Drug Policy Alliance. *Healing a Broken System: Veterans Battling Addiction and Incarceration*. (Issue Brief: November 4, 2009), 2.
- ⁷ Matthew Jakupcak and others, "Anger, Hostility, and Aggression Among Iraq and Afghanistan War Veterans Reporting PTSD and Subthreshold PTSD," *Journal of Traumatic Stress* 20, no. 6 (2007): 950.
- ⁸ Michael McCrea, PhD. and others, "Official Position of the Military TBI Task Force on the Role of Neuropsychology and Rehabilitation Psychology in the Evaluation Management and Research of Military Veterans with Traumatic Brain Injury," *The Clinical Neuropsychologist*, 22 (2008): 22.
- ⁹ William B. Brown, "Another Emerging 'Storm': Iraq and Afghanistan veterans with PTSD in the Criminal Justice System," *Justice Policy Journal* 5, no. 2 (2008): 11-12.
- ¹⁰ Natalie Bogle, "Post-Traumatic Stress Disorder Among Veterans," *Chrestomathy: Annual Review of Undergraduate Research* 7, (2008): 2.
- ¹¹ Drug Policy Alliance, 3.
- ¹² National Institutes of Health. *Post-Traumatic Stress Disorder (PTSD) Fact Sheet*. (July 2007), <http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-research-fact-sheet/index.shtml>, accessed June 29, 2010.
- ¹³ Drug Policy Alliance, 3.
- ¹⁴ *Ibid.*
- ¹⁵ Hillary S. Burke, 6.
- ¹⁶ Claudia Baker, MSW, MPH. *PTSD and Criminal Behavior*. National Center for PTSD, http://ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_legal.html?opm=1&rr=rr91&srt=d&echorr=true, accessed June 29, 2010.
- ¹⁷ Constantina Aprilakis, 542.
- ¹⁸ *Ibid.*
- ¹⁹ *Ibid.*, 546.
- ²⁰ Natalie Bogle, 2.
- ²¹ Andrea Friel, 67.
- ²² Andrew J. Saxon, M.D. and others, "Trauma, Symptoms of Posttraumatic Stress Disorder, and Associated Problems among Incarcerated Veterans," *Psychiatric Services*, 52, no. 7 (2001): 962.
- ²³ Major David L. Daniel, "Post-traumatic Stress Disorder and the Casual Link to Crime: A Looming National Tragedy," School of Advanced Military Studies, United States Army Command and General Staff College (AY 2007-2008): 23.
- ²⁴ Charles W. Hoge, M.D. and others, "Combat Duty in Iraq and Afghanistan, Mental Health Problems and Barriers to Care," *The New England Journal of Medicine* 351, no. 1 (2004): 16.
- ²⁵ Constantina Aprilakis, 545.
- ²⁶ *Ibid.*
- ²⁷ The CMHS National GAINS Center. *Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions: A Consensus Report of the CMHS National GAINS Center's Forum on Combat Veterans, Trauma, and the Justice System*. (August, 2008), http://www.gainscenter.samhsa.gov/text/veterans/Responding_to_Needs_8_08.asp, accessed June 29, 2010.
- ²⁸ Denise Dillard and others, "Conduct Disorder, War Zone Stress, and War-Related Posttraumatic Stress Disorder Symptoms in American Indian Vietnam Veterans," *Journal of Traumatic Stress* 20, no. 1 (2007): 54.

-
- ²⁹ *Ibid.*
- ³⁰ Constantina Aprilakis, 544.
- ³¹ *Ibid.*, 545-6.
- ³² *Ibid.*, 546.
- ³³ *Ibid.*, 548.
- ³⁴ *Ibid.*, 547.
- ³⁵ William B. Brown, 13.
- ³⁶ Charles W. Hoge, M.D., 16.
- ³⁷ *Ibid.*, 20.
- ³⁸ Andrea Friel, 65.
- ³⁹ *Ibid.*, 72.
- ⁴⁰ Scott Hensley, "PTSD And Depression Common In Returning Combat Soldiers," *NPR*, June 7, 2010.
- ⁴¹ Casey T. Taft and others, "Aggression Among Combat Veterans: Relationships with Combat Exposure and Symptoms of Posttraumatic Stress Disorder, Dysphoria, and Anxiety," *Journal of Traumatic Stress* 20, no. 2 (2007): 136.
- ⁴² Charles W. Hoge, M.D., 13.
- ⁴³ Constantina Aprilakis, 543.
- ⁴⁴ *Ibid.*, 522.
- ⁴⁵ *Ibid.*
- ⁴⁶ The process of achieving stability through physiological or behavioral change, <http://en.wikipedia.org/wiki/Allostasis>, accessed June 29, 2010.
- ⁴⁷ Constantina Aprilakis, 549.
- ⁴⁸ *Ibid.*, 553.
- ⁴⁹ Andrew J. Saxon, M.D., 963.
- ⁵⁰ *Ibid.*, 961.
- ⁵¹ Drug Policy Alliance, 3.
- ⁵² National Survey on Drug Use and Health. *The NSDUH Report: Serious Psychological Distress and Substance Use Disorder among Veterans*. (Substance Abuse and Mental Health Services Administration, November, 1, 2007).
- ⁵³ *Ibid.*, 551.
- ⁵⁴ *Ibid.*, 554.
- ⁵⁵ *Ibid.*, 550.
- ⁵⁶ William B. Brown, 16.
- ⁵⁷ Charles W. Hoge, M.D., 13.
- ⁵⁸ Natalie Bogle, 4.
- ⁵⁹ William B. Brown, 17.
- ⁶⁰ Natalie Bogle, 6.
- ⁶¹ Dan Heilman.
- ⁶² Natalie Bogle, 7.
- ⁶³ *Ibid.*, 11.
- ⁶⁴ *Ibid.*, 7.
- ⁶⁵ William B. Brown, 15.
- ⁶⁶ Casey T. Taft, 135.
- ⁶⁷ Major David L. Daniel, 30.
- ⁶⁸ *Ibid.*, 44.
- ⁶⁹ Andrew J. Saxon, M.D., 962.
- ⁷⁰ Cara Tabachnick, "From the Battlefield to Prison," *The Crime Report*, November 10, 2009, <http://thecrimereport.org/2009/11/10/from-the-battlefield-to-prison-troubled-soldiers-and-the-u-s-justice-system/>, accessed June 29, 2010.
- ⁷¹ Drug Policy Alliance, 3.
- ⁷² Major David L. Daniel, 29.
- ⁷³ Constantina Aprilakis, 549.
- ⁷⁴ Andrea Friel, 74.
- ⁷⁵ Major David L. Daniel, 30.

-
- ⁷⁶ José León-Carrión, 213.
- ⁷⁷ Natalie Bogle, 8.
- ⁷⁸ Andrew J. Saxon, M.D., 142.
- ⁷⁹ Matthew Jakupcak, 951.
- ⁸⁰ Department of Health and Human Services Center, Center for Disease Control, *Traumatic Brain Injury: A Guide for Criminal Justice Professionals*, <http://www.cdc.gov/traumaticbraininjury/>
- ⁸¹ Michael McCrea, PhD., 13.
- ⁸² Department of Health and Human Services Center, Center for Disease Control.
- ⁸³ Hillary S. Burke, 6.
- ⁸⁴ *Ibid.*
- ⁸⁵ *Ibid.*
- ⁸⁶ Hillary S. Burke, 8.
- ⁸⁷ Michael McCrea, PhD., 18.
- ⁸⁸ *Ibid.*, 19.
- ⁸⁹ *Ibid.*, 5.
- ⁹⁰ Michael McCrea, PhD., 11.
- ⁹¹ Neville, Ruby V. TBI and the Provision of Substance Abuse and Other Behavioral Health Care Services for Returning Veterans and Their Families. Presentation given at the 19th Annual State of the States Head Injury Conference, September 10, 2008.
- ⁹² Dan Heilman.
- ⁹³ Department of Health and Human Services Center, Center for Disease Control.
- ⁹⁴ Hillary S. Burke, 6.
- ⁹⁵ Neville, Ruby V.
- ⁹⁶ L. Turkstra. D. Jones, and Hon. L. Toler, “Brain Injury and Violent Crime,” *Brain Injury* 17, no. 1 (2003): 39.
- ⁹⁷ *Ibid.*
- ⁹⁸ Department of Health and Human Services Center, Center for Disease Control.
- ⁹⁹ The CMHS National GAINS Center.
- ¹⁰⁰ Andrew J. Saxon, M.D., 959.
- ¹⁰¹ The CMHS National GAINS Center.
- ¹⁰² Major David L. Daniel, 45.
- ¹⁰³ William B. Brown, 8.
- ¹⁰⁴ L. Turkstra. D. Jones, 39.
- ¹⁰⁵ *Ibid.*
- ¹⁰⁶ José León-Carrión and Francisco Javier Chacartegui Ramons, “Blows to the head during development can predispose to violent criminal behavior: rehabilitation of consequences of head injury is a measure for crime prevention,” *Brain Injury* 17, no. 3 (2003): 208.
- ¹⁰⁷ Neville, Ruby V.
- ¹⁰⁸ Dan Heilman.
- ¹⁰⁹ Claudia Baker.
- ¹¹⁰ L. Turkstra. D. Jones, 40.
- ¹¹¹ *Ibid.*, 44.
- ¹¹² Drug Policy Alliance, 2.
- ¹¹³ Claudia Baker.
- ¹¹⁴ Chris Rohlfs, “Does Military Service Make You a More Violent Person?: Evidence from the Vietnam Draft Lottery,” University of Chicago (November 3, 2005), 1.
- ¹¹⁵ Constantina Aprilakis, 555.
- ¹¹⁶ Drug Policy Alliance, 2.
- ¹¹⁷ *Ibid.*, 4.
- ¹¹⁸ Neville, Ruby V.
- ¹¹⁹ Drug Policy Alliance, 3.
- ¹²⁰ The CMHS National GAINS Center.

-
- 121 National Household Survey on Drug Abuse.
- 122 *Ibid*, 5.
- 123 *Ibid*, 4.
- 124 National Household Survey on Drug Abuse. *The NHSDA Report: Illicit Drug Use among Veterans (2000 and 2001)*. (Substance Abuse and Mental Health Services Administration, November, 11, 2002).
- 125 Hillary S. Burke, 7.
- 126 Andrew J. Saxon, M.D., 960.
- 127 Hillary S. Burke, 7.
- 128 William B. Brown, 6.
- 129 Drug Policy Alliance, 7.
- 130 National Institutes of Health.
- 131 Hillary S. Burke, 8.
- 132 *Ibid*.
- 133 *Ibid*, 9.
- 134 Hillary S. Burke, 7.
- 135 National Survey on Drug Use and Health.
- 136 *Ibid*.
- 137 William B. Brown, 13-14.
- 138 Texas Association of Drug Court Professionals, "Veteran Courts," TADCP March 2010 Newsletter, <https://www.tadcp.org/files/TADCP%20Newsletter-March%202010.pdf>, accessed June 29, 2010.
- 139 Hon. Robert T. Russell, "Veterans Treatment Courts Developing Throughout the Nation," <http://contentdm.ncsconline.org/cgi-bin/showfile.exe?CISOROOT=/spcts&CISOPTR=204>, accessed June 29, 2010.
- 140 Buffalo Veteran's Court: Mentoring and Veterans Hospital Program Policy and Procedure Manual, [http://inghambar.org/files/Buffalos%20veterans%20court%20manual%20\(model%20used%20for%20IC-VTC\).pdf](http://inghambar.org/files/Buffalos%20veterans%20court%20manual%20(model%20used%20for%20IC-VTC).pdf), accessed June 29, 2010.
- 141 Texas Association of Drug Court Professionals.
- 142 Hon. Robert T. Russell.
- 143 Drug Policy Alliance, 7.
- 144 Hon. Robert T. Russell.
- 145 *Ibid*.
- 146 *Ibid*.
- 147 *Ibid*.
- 148 Hon. Robert T. Russell.
- 149 John Council, "Even Heroes Make Mistakes: Veterans Courts Give Those Who Served in Combat a Second Chance," *Texas Lawyer*, June 21, 2010, <http://www.law.com/jsp/tx/PubArticleFriendlyTX.jsp?id=1202462812351>, accessed June 24, 2010.
- 150 *Ibid*.
- 151 Mimi Swartz, "Home Front Lines: Will Iraq and Afghanistan be the wars that teach us how to take better care of our returning warriors?", *Texas Monthly*, January 2010, <http://www.texasmonthly.com/2010-01-01/btl.php>, accessed June 29, 2010.
- 152 *Ibid*.
- 153 Bobby Cervantes, "Courts for Accused Veterans Prioritize Treatment," *The Texas Tribune*, May 17, 2010, <http://www.texastribune.org/texas-newspaper/texas-news/courts-for-accused-veterans-prioritize-treatment/>, accessed June 29, 2010.
- 154 *Ibid*.
- 155 Veterans' Court Diversion Program, Tarrant County, <http://www.tarrantcounty.com/eccc9/lib/eccc9/TCVetctbrochure.pdf>, accessed June 29, 2010.
- 156 *Ibid*.
- 157 Substance Abuse/Post Traumatic Stress Disorder Program, established by Todd Jermstad in Killeen.
- 158 *Ibid*.
- 159 Bell/Lampasas Counties Veterans PTSD Program, Memo from Todd Jermstad.
- 160 Hillary S. Burke, 10.

-
- ¹⁶¹ *Ibid*, 8.
- ¹⁶² Drug Policy Alliance, 6.
- ¹⁶³ Constantina Aprilakis, 566.
- ¹⁶⁴ Buffalo Veteran’s Court.
- ¹⁶⁵ Cara Tabachnick.
- ¹⁶⁶ Beth Walton, “Minnesota becomes second state to offer treatment to veterans who commit crimes: Legislators say it makes more sense to rehabilitate,” May 21, 2008, <http://files.meetup.com/487275/Sentence%20Mitigation.pdf>, accessed June 29, 2010.
- ¹⁶⁷ Drug Policy Alliance, 6.
- ¹⁶⁸ “Military and Civilian Family Violence Prevention Council (FVPC),” PowerPoint Presentation, <http://hrfvpc.org/PresentationWebpageHistory.pdf>, accessed June 29, 2010.
- ¹⁶⁹ *Ibid*, 9.
- ¹⁷⁰ The CMHS National GAINS Center.
- ¹⁷¹ Drug Policy Alliance, 7.
- ¹⁷² Hillary S. Burke, 8.
- ¹⁷³ Drug Policy Alliance, 5.
- ¹⁷⁴ Claudia Baker.
- ¹⁷⁵ The CMHS National GAINS Center.
- ¹⁷⁶ Hillary S. Burke, 7.
- ¹⁷⁷ Andrew J. Saxon, M.D., 962.
- ¹⁷⁸ Matthew Jakupcak, 946.