

AIR COMMAND AND STAFF COLLEGE

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VETERAN'S TREATMENT COURTS:
ALTERNATIVE JUSTICE FOR THE CRIMINAL VETERAN

by

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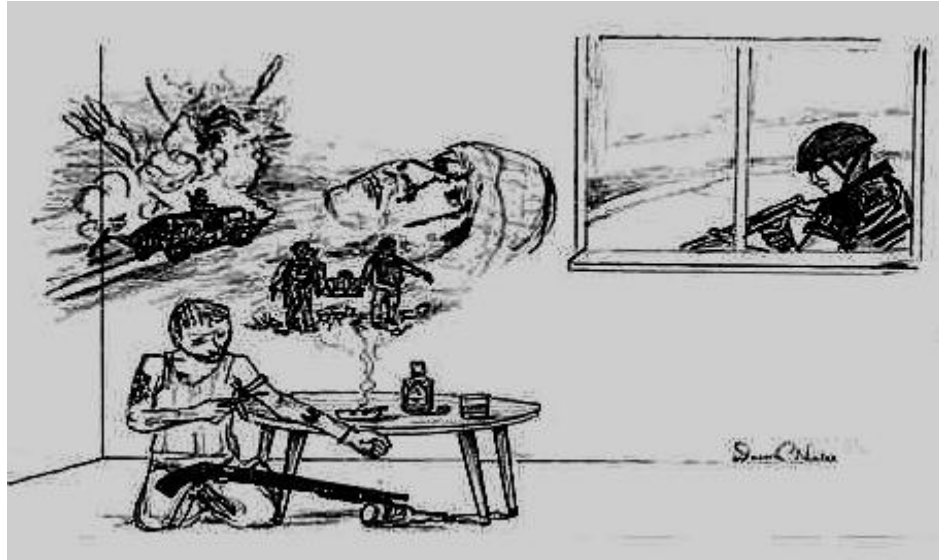
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Abstract

Throughout history, many civilizations asserted the need for a military, employed the military during conflict, and integrated the returning veteran into society. Some veterans require behavioral adjustment when returning from war to civilization. This can be a challenge for some veterans. Societal and economic burdens, along with physiological or psychological injuries, create challenges to assimilation. Studies, statistics and research also implicate the Department of Defense discharge from duty process, along with the Department of Veterans Affairs (VA) compensation and pension procedures as specific challenges to U.S. soldiers reentering society.

Some veterans who fail to adapt to societal norms are arrested and enter the criminal justice system. Judges and probation officers took notice of an increasing trend of ignored symptoms and treatment for these veterans; thus, judicial employees and the National Association of Drug Court Professionals established Veteran Treatment Courts (VTC) based on their existing drug court model. Working with local VA counselors, VTC attempt to transition military veteran offenders from the criminal justice system into VA treatment centers for care and rehabilitation. As most VTC are less than three years old, statistics for the courts are limited. Pending federal legislation can improve the measurement and operation of VTC. Evaluation of the initial assessments indicates a low recidivism rate among VTC graduates. New Jersey state courts' successful alternative, Veteran Assistance Program, proudly asserts a zero recidivism rate. Currently, VTC provide the best legal venue, as well as treatment and rehabilitation option for military veteran offenders.



(Nehls n.d.)

INTRODUCTION

Since the beginning of recorded history, mankind has engaged in conflict. Conflict has occurred between nations, between a nation and its citizens, and person against person. As a result of conflict, some people are killed, while others might become physiologically or psychologically injured, carrying these wounds back home. Civilizations created various forms of treatment to help the wounded warrior reintegrate, while others hid their injured, ignorant of their true needs. A greater understanding of the effects of conflict has led to an increased awareness of the needs of returning warriors.

While our government and society established an increased capability to provide for our wounded warrior's care and recuperation, some veterans ignored the proffered assistance. While some were forced to relinquish eligibility for benefits or care, others ignored or remained ignorant of resources available to assist them in their recovery. Some veterans experienced worsening symptoms then found themselves involved with the criminal justice system as a result of their unacceptable behavior. This awareness, along with the increased costs of the criminal justice system, led some in the judicial branch to establish separate proceedings called Veteran

Treatment Courts (VTC) for the military veteran offender. The VTC coordinates with various government agencies to refer a veteran for further counseling and treatment instead of incarceration. As will be discussed in Section 4, VTC judges and counselors work to retain veterans with underlying combat related issues who will benefit from treatment and counseling. The disposition of the remaining military veteran offenders depends on the circumstances of their individual case.

Whether the government's established processes and procedures fail the veteran, or the veteran ignores a proffered benefit, it is the individual who suffers the detrimental effects as shown in Section 3. It is the responsibility of the government to scrutinize and properly categorize military members for the appropriate administrative or punitive military discharge. Failure to adequately scrutinize each individual's circumstances prior to discharge may have serious consequences for the veteran, such as denial of educational, vocational, or medical benefits.

With the rise in unseen injuries such as traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD), some returning veterans find themselves discharged from the military and into their local criminal justice system. Did the military discharge a veteran, a criminal, or a person susceptible to criminal behavior? Military members likely to avoid psychological treatment while on active duty will also likely continue to avoid medical assistance once discharged.¹ When veterans shun rehabilitative assistance, they may have trouble adjusting to civilian life, even turning to drugs and alcohol to help cope. They avoid Department of Veterans Affairs (VA) education, job training and disability assistance programs.²

The VA has worked with a variety of outreach organizations to design programs to help returning veterans reintegrate to family and society more effectively. The programs give veterans

copied skills to help make the transition from acceptable combat behaviors and reactions to acceptable civilian behaviors and reactions. Absent a nation-wide mandate to enroll veterans in these programs, criminal justice personnel, in coordination with the National Drug Court Institute (NDCI) and the VA, established VTC to transition military veteran offenders to probation and VA treatment centers instead of jail. The NDCI, a professional organization with a charter to promote drug courts, based the VTC on their drug court model. An evaluation of the VTC performance through comparison of admittance, graduation, and recidivism rates would lend support to promote this as a nation-wide solution.

Militaries train individuals to be willing to perform behaviors and reactions considered acceptable in time of war. However, law enforcement agencies arrest military members and veterans when they perform those behaviors and reactions unacceptable in civil society. Should the VTC be the standard venue for a psychologically wounded criminal veteran?

Significance of the Study

The U.S. government has enacted numerous laws and programs designed to compensate and care for returning veterans, as well as the widows and orphans of those who do not. The DOD has strived to improve individual protective measures and provide enhanced patient care that allowed 40,000 wounded veterans to return to civilian society in the past ten years.³

For some veterans, the transition from military hospitals to VA or civilian treatment facilities is a matter of identifying the correct doctor or clinic for their injuries. Other veterans return to smaller, isolated communities without access to medical facilities and counselors who understand the needs of psychologically or physiologically wounded combat veterans assimilating back into society. Still other veterans flagrantly deny any mental or physical medical issue exists. They choose instead to ignore symptoms while their conditions worsen or they

consume alcohol and drugs in an effort to mask the pain. For whatever reason, this latter group does not seek nor receive the attention necessary to remedy their condition. They don't get help to cope with reintegration into family and society, or obtain access to rehabilitation programs to help with their transition to civilian life. It is this group of veterans that is more likely to have symptoms of mental disorders and experience alcohol or substance dependency.⁴ According to a 2008 RAND Corporation study, this group has a higher probability of experiencing psychological problems, being a suicide risk, or presenting other socially unacceptable behavior that may result in the veteran entering the criminal justice system.⁵

According to an American Journal of Public Health report on the health and health care of inmates, 10% of U.S. prisoners were military veterans in 2004. This percentage is verified by the most recent Bureau of Justice statistics published in 2007, which also revealed over 60% of the imprisoned veterans experienced mental health problems.⁶ There is no footnote or source to show if these people had the opportunity for counseling, treatment, or rehabilitation, it appears the legal system saw and treated them as criminals. However, a few judges and probation officers recognized the downward spiral that brought the military veteran offenders into their courtrooms. It was these judicial employees, working with the NDCI and the VA who established the initial VTC. The VTC attempt to transition veterans out of the criminal justice system into counseling, rehabilitation programs, and educational opportunities. Most importantly, successful candidates who graduate from the treatment program may apply to have their records expunged.

Research Methodology

This research paper will discuss the operation of VTC using the Ackerman evaluation methodology and advocate for the use of these courts as the standard venue for a psychologically

wounded criminal veteran. The background will provide a historical look at the growth and recognition of psychological injuries and the resultant behavioral changes. The next section will discuss the interaction between veterans with the criminal justice system. I will also present details on the creation, growth and effectiveness of the VTC and discuss New Jersey Veterans Assistance Project as an alternative to VTC. Finally, the recommendation and conclusion summarize the necessity to improve or revise DOD mental health treatment, unit manpower and military discharge requirements, as well as the continued role of VTC in transitioning military veteran offenders out of the criminal justice system.



BACKGROUND

Historical records of battles strive to capture and relay the horrific experiences of combat. These records help us improve on past performances and learn not to repeat the same mistakes. Fictional accounts of combat are also sometimes based upon real life experiences. They allow us to witness planning, conflict, and a return to a state of peace through the eyes of the characters portrayed. In his book, *Achilles in Vietnam*, Dr. Jonathan Shay, M.D., PH.D., uses the *Iliad* to illustrate how the effects of battle, betrayal and death may psychologically wound a person. As a psychiatrist with Vietnam veteran patients, he can compare and contrast Achilles' experience with modern Post Traumatic Stress Disorder (PTSD) diagnostic tools. The *Iliad* describes Achilles' actions and conduct as a psychologically wounded person whose family and contemporary society consider objectionable. It is this type of objectionable behavior that can force families and friends of identified psychologically wounded veterans to seek the assistance of civil and medical authorities.

The *Iliad* presents the story about the closing days of the Trojan War when Agamemnon refuses to return or ransom a war prize he has kept for himself, the daughter of a priest of Apollo. As a result, Apollo causes a plague to ravage the entire Greek army. Achilles speaks for the Greek coalition in demanding Agamemnon return his war prize and end the Greek's suffering brought about by the plague. Agamemnon relents, returning the daughter of the priest and lifting the plague from his army. When Agamemnon demands compensation, he publicly dishonors and shames Achilles by demanding Achilles' war prize in return.⁷

Dr Shay describes this betrayal of "what's right" by Agamemnon as being the first phase in developing symptoms of Post Traumatic Stress Disorder (PTSD). Whether being selected to

monitor the burn pit, serve guard duty, or walk point, superiors must be seen as assigning duties or ordering punitive actions in a fair and impartial manner.⁸

After this betrayal of “what’s right”, Dr. Shay describes Achilles’ reaction as entering a berserk state.⁹ Upon losing his war prize, Achilles speaks out against Agamemnon, his frustration developing into a desire to kill Agamemnon before being stopped by an unseen emissary of the Gods. Publically disgraced, Achilles retreats with his forces from the battle despite the desires expressed by fellow warriors and his family. While withdrawn from the battle, Achilles continues to speak against Agamemnon, has hallucinations and trouble sleeping. As days pass, he withdraws from his own forces, speaking only with his foster brother, Patroklos.¹⁰

When Achilles learns of Patroklos’ death at the hands of Hektor, he attacks and kills with fervor. Discarding honor, he ruthlessly slaughters Trojan leaders, soldiers and prisoners providing no quarter. Falling deeper into a berserk state, Achilles earns praise as a warrior but also earns blame for the senseless killing he committed. He horrifies Hekabe by cornering and slaying her son, Hektor. Achilles mutilates his body in full view of the Trojans in revenge for the death of Patroklos.¹¹ Achilles grief then consumes him. The Iliad describes, “. . . A black storm cloud of pain shrouded Akhilleus[sic] . . . he stretched his giant length and tore his hair with both hands.” His friend Antilokhos notices the impulsive behavior and grabs Achilles hands to prevent Achilles from killing himself.¹²

While in mourning, Achilles sees Patroklos ghost asking for burial with Achilles in their father’s house.¹³ Ravaged by guilt for his actions in battle and loss of Patroklos, Achilles thoughts again turn to suicide.¹⁴ In misery from depression, insomnia, avoidance, hallucination and attempted suicide, Achilles actions portray the symptoms of PTSD as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).¹⁵

American Civil War veterans are also documented as suffering from PTSD. Eric Dean published a study of the affects of the Civil War on a group of veterans from Indiana in his book “Shook Over Hell”.¹⁶ While not a true statistical random sample of Civil War Veterans, Dean used available service, pension, hospital admittance and family records to assemble enough data to draw meaningful conclusions from a sample of 291 veterans. The subjects of Deans’ research participated in numerous Civil War battles and included a number of deserters. They were admitted to the Indiana Hospital for the Insane in Indianapolis, IN, over 460 times after the war for psychological disorders related to combat service.¹⁷

This group of men were described as fearful and imagining they were still in the army, running away from the enemy to avoid being killed. Some would retreat from their homes into nearby woods, at times for many days, to hide from their imagined dangers. Others were unable to sleep, preferring to be in a constant state of motion to avoid those they perceived as trying to kill them, until sedatives were administered. These old soldiers would establish defensive fighting positions in their homes, cover windows and lock doors against intruders they felt were stalking them in order to kill them.¹⁸

Men from this sample would seclude themselves during their anxiety attacks, thinking their family members and friends were the enemy who were trying to kill them. For example, Lt. Allen Wiley was exposed to Confederate artillery fire while manning a defensive position south of Louisville, Kentucky. Fellow soldiers noticed their comrade was excited, frightened and unable to concentrate on his duties. After Lt. Wiley was discharged, family quickly noticed his reclusive tendencies, as well as trouble concentrating and sleeping. A sister noted her brother was prone to panic attacks during which he believed pursuers were attempting to shoot and kill him. His wife filed for divorce, claiming she could no longer stand her husband’s beatings and

menacing behavior. Allen's family briefly admitted him to the Indiana Hospital for the Insane for fits of violent behavior. During his stay, they built a strong room with barred windows and doors in their house. His parents wanted to protect and care for their son at home. The bars prevented their loved one from hurting himself and others. Even the family doctor would only administer to his illnesses through the bars.¹⁹

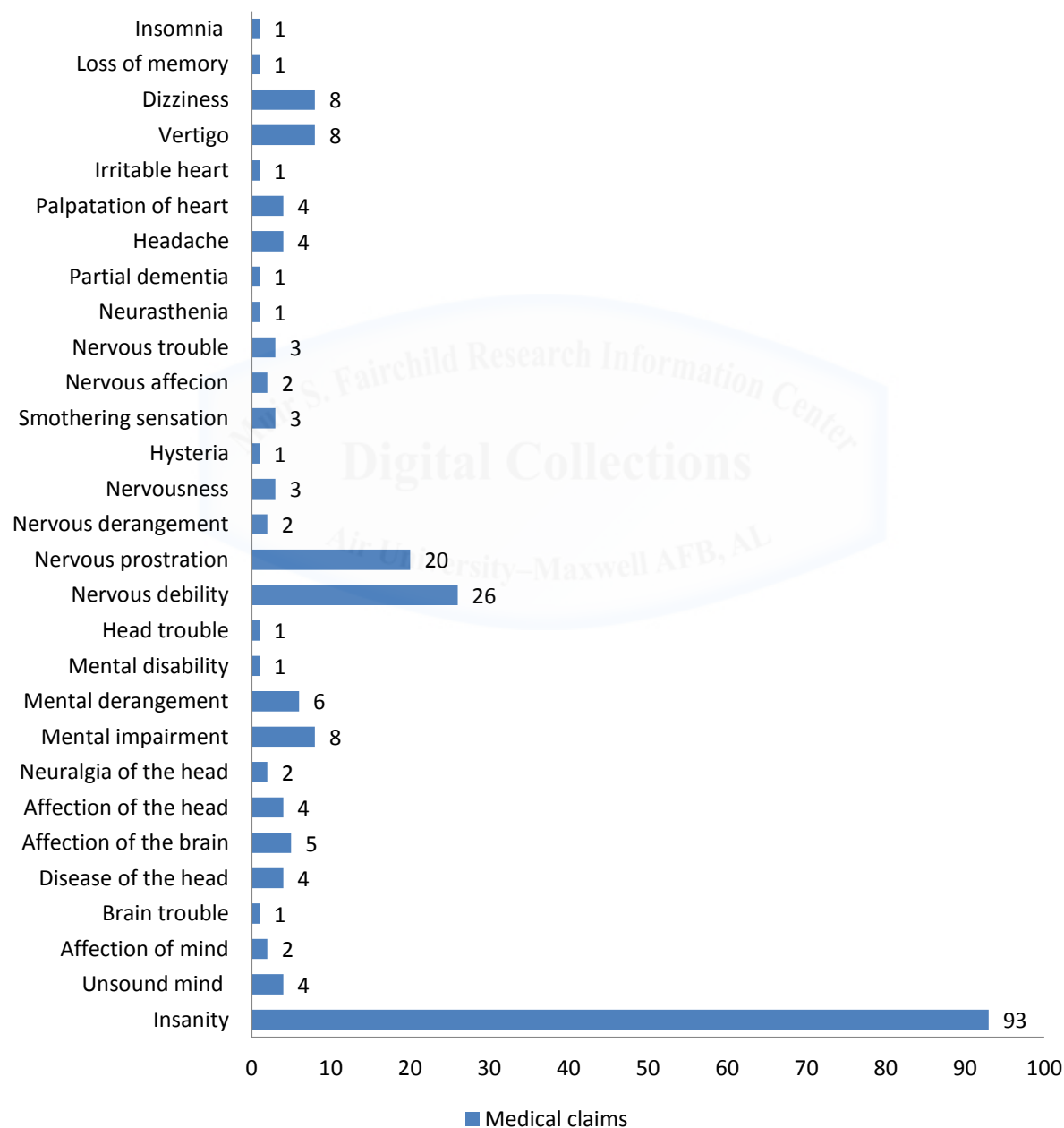
Beyond frequently threatening to kill others, members of this group attempted to take their own lives to relieve themselves of their constant fear and perceived situation. Two Union riflemen suffered gunshot wounds which left them partially paralyzed and with limited physical movement. After their discharge and return home, they were both eventually admitted to the Indiana Hospital for the Insane. Diagnosed with sleeplessness, recurrent mania, and suicidal tendencies, records indicate 149 of the 291 Indiana veterans attempted to commit suicide or had suicidal tendencies. Their actions required them to be placed under guard for their safety, as well as others.²⁰

The medical records document a history of psychological disorders such as depression, anxiety, fear and reliving experiences of killing and death.²¹ The periods of admission to the Indiana Hospital for the Insane for the 291 veterans lasted as short as 1.5 months to as long as 16 months.²² At the time, medical opinion was the veterans could be cured of their disorders and be returned to society and family. In actuality, the men were admitted when experiencing the extremes of behaviors related to their combat experience and beyond the control of their caregiver. Figure 1 reveals the variety of physiological ailments claimed by 226 veterans and their families during the federal military pension claims process.²³

With the onset of World War I (WWI), British medical officers diagnosed over 1,900 patients admitted to hospitals as suffering behavior disorder without physical cause as early as

1914. By 1915 that number had grown to over 20,000. During the first day of fighting for the Somme Valley in 1916, the British lost 60,000 soldiers killed or wounded. By the end of the year, much of the fighting had ceased, but not before claiming another half-million British casualties, 50 percent of whom were psychological patients.²⁴

Figure 1. Civil War Veteran Federal Pension Medical Claims



(Dean 1997)

The British Director General of medical services ordered casualties not be evacuated “unless there are definite lesions and symptoms which require prolonged hospital treatment”.²⁵ During the war, 306 soldiers were summarily shot for “. . . desertion, cowardice, quitting their post and casting away their arms. . .” without a diagnosis of psychiatric disorder.²⁶ 90 years later, a review of their case history resulted in an after the fact diagnosis of PTSD, earning them a full pardon from the British government.²⁷ While looking for physical evidence to explain psychiatric issues, British Army Dr. Charles Myers originated the diagnosis of shell shock. He thought the constant and random concussion of bursting shells caused lesions in the brain. Shell shock remained an identifiable diagnosis through the end of the war, even though autopsies would prove no lesions were caused by explosions.²⁸

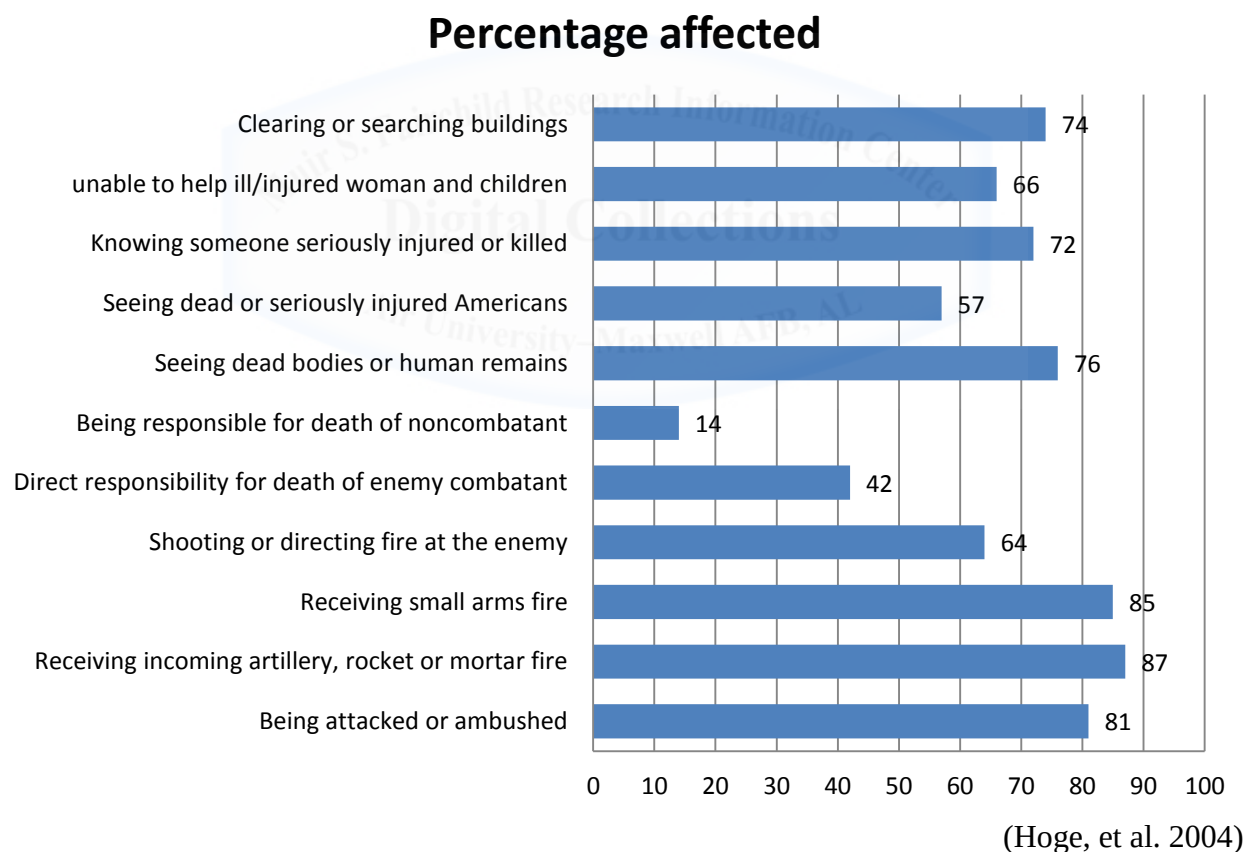
Once Dr. Myers theory was disproved, the British military returned to the terms malingerer, shirker and coward to describe a soldier suffering psychological injuries. Leaving the service, Dr. Myers became a psychiatric consultant with the British Army, focusing entirely on the effect of battle on the mind. He developed and received approval to institute procedures to counter the effects of shell shock: prompt care for affected soldiers as forward to their comrades as feasible and as simply as possible. No longer were soldiers restrained and subjected to electrocution therapy or a variety of medications to treat their symptoms. Patients instead received a few hot meals, hot showers and a good night’s rest before being returned to their unit.²⁹

By the end of WWI, the British army had over 80,000 soldiers diagnosed with shell shock.³⁰ As for the U.S., over 50,000 of the total 300,000 disabled WWI veterans were still hospitalized for psychiatric illness in 1938. Total cost for care provided was almost a billion in 1938 dollars.³¹ After the end of WWII, the VA filled 102,000 beds and had a 20,700 patient

waiting list for admission. 60% of those VA patients were diagnosed with psychological wounds.³²

In 2004, Walter Reed Medical Center conducted medical research of over 3,500 Army soldiers and Marines in an effort to determine the mental health of returning Operation Enduring Freedom (OEF) and Iraqi Freedom (OIF) veterans. The results, published in the July 2004 New England Journal of Medicine, revealed numerous experiences which can negatively affect the mental health of combat veterans.³³ As presented in this paper, some veterans with experiences such as those shown in Figure 2 suffer from psychological illness or injury while others do not.

Figure 2. Experiences of Army and Marine Combat Veterans



By 2006, over 1,000,000 service members were deployed in support of OEF and OIF, with almost half serving additional deployments.³⁴ Data collected from the Defense Health Board, Post-Deployment Health Re-Assessment (PDHRA) revealed 38% of Army soldiers, 31%

of Marines and 49% of deployed National Guard members expressed concerns about their psychological health after their deployment.³⁵ A 2008 analysis of patients who use VA health care, revealed 130,000 OEF and OIF veterans diagnosed with a psychological illness by the VA mental health services.³⁶

The U. S. Army completed a medical review of Fort Carson soldiers in 2007 discovering 18% of their 13,400 soldiers returning from a OEF or OIF deployment had symptoms of TBI.³⁷ According to George Zitney, cofounder of the Defense and Veterans Brain Injury Center located in Washington DC, 10% of Iraq and Afghanistan veterans with TBI had actual severe and penetrating wounds to the head and neck. According to the Fort Carson study, other soldiers suffer undiagnosed TBI with symptoms ranging from headaches to memory loss, irritability, difficulty sleeping and balance problems. The onset of symptoms may not occur for weeks or months. Without identified, visible indicators of TBI, soldiers may not be aware of an injury. Some of the Fort Carson military members were redeployed to combat environments with an expectation to continue to perform their duties as before.³⁸ These soldiers may develop additional symptoms like depression, anxiety, and emotional problems which can lead to disciplinary problems within a military organization.

Dr. Gene Bolles, former chief of Neurosurgery at Landstuhl Regional Medical Center, identified damage to brain fibers due to shaking or the concussive affect from experiences such as roadside bombs can cause psychological conditions such as PTSD, which makes treating and coping with the physical ailments more difficult. There is no test to determine the extent of TBI damage following an incident. Not until an individual was required to function outside a medical setting when symptoms such as headaches, dizziness, and cognitive dysfunction appeared.³⁹

The RAND Corporation conducted a study of 1,965 military members in 2008 to determine the severity of psychological injury that they suffered and the barriers preventing them from seeking mental health assistance. 31% of the respondents reported some form of psychological condition or TBI caused by combat. Only approximately one half of those reporting psychological or physiological issues sought assistance for their condition. Reasons for not seeking treatment ranged from concern over careers and security clearances, to medication side effects and the loss of confidence from fellow service members.⁴⁰

WHAT WENT WRONG

A major focus of almost every war is on maintaining manpower levels of front line combat units. In order to maintain troop levels of combat units during the Civil War, additional reviews and approvals were required to obtain a military discharge from the service. Unit commanders and the medical officers had to agree there was a physical ailment then approve the discharge. Discharge from the service for psychological disorder required recognition of insanity or imbecility severe enough to warrant evacuation to the Washington D.C. Government Hospital for the Insane. Evacuation was approved by the Adjutant General rather than anyone in the medical services. Once evacuated and admitted only government asylum doctors could then analyze, diagnose, and recommend discharge for insane soldiers.⁴¹ Only about 1,231 of all Union soldiers were sent to the Government Hospital for the Insane for treatment during the Civil War.⁴²

Following the failed diagnosis of lesions on the brain as a cause for shell shock during WWI, military leadership used courts martial and dishonorable discharge to remove psychologically injured soldiers from the front lines. This only caused greater social issues since both of these actions denied the soldier access to a military or veteran benefit of care. Denis

Winter, writing in *Death's Men*, cites a WWI British commander who, at the first signs of fear or shell shock, would order the affected soldier be tied to the front line barbed wire fence for 30 seconds. 30 seconds was adequate time for a sniper to transition a psychological patient to a physiologically wounded, or dead, soldier.

To end overcrowding in VA facilities and the fiscal drain of treating psychologically wounded veterans in the late 1940s, doctors were authorized to conduct lobotomies.⁴³ Dr. Walter Freeman, a neurology professor at George Washington University, discovered how to isolate the nerve connections in the brain responsible for certain psychoses related to combat psychiatric problems. Under local anesthesia, his procedure required tapping a modified ice pick through the patient's eye socket, into the prefrontal lobe and severing it from the rest of the brain. For \$250 the patient would be less aggressive but reduced to a body devoid of its former self. The VA authorized the use of lobotomy as an acceptable practice to treat mental health disorders, but the practice was ended in the 1950s with the introduction of antipsychotic drugs, such as Thorazine and Chlorpromazine.⁴⁴

In 2007, the Army completed pre-deployment behavioral health screening for 10,678 3rd Infantry Division Brigade combat team soldiers. Medical personnel asked the soldiers an additional 15 questions regarding their behavioral health. They discovered 347 soldiers on psychotropic drugs and 96 soldiers previously identified as unfit for deployment.⁴⁵ CENTCOM subsequently issued a waiver for all 443 soldiers to deploy as they were identified as essential to the mission.⁴⁶

A U.S. Central Command (CENTCOM) policy allows deploying military members to have 90-180 day supply of more than one psychotropic drug. Individual soldiers can carry Valium, Xanax and Seroquel with them at their time of deployment, without tracking or follow

up medical care requirements for the first 90-180 days with pre-approval for prescription refill.⁴⁷

The results of a June 2010 Defense Department Pharmacoeconomic Center survey of over 1,000,000 active duty military members discovered 20% were taking an antidepressant, antipsychotic, sedative, or other controlled substances.⁴⁸

Between 30 September 2001 and 30 September 2007, over 11,400 OEF and OIF soldiers were discharged for drug abuse; 6,159 discharged for discreditable incidents; 6,436 discharged for commission of a serious offense; and 2,246 discharged for the good of the service.⁴⁹ In September 2007, a GAO study reported DOD and VA care for OEF and OIF wounded warriors suffering from PTSD and TBI was “inadequate” and “with significant shortfalls”.⁵⁰ They identified 46 percent of the Army’s returning members who were eligible to be assigned to medical units, who were not assigned due to staffing shortages. Audits revealed various Wounded Warrior Transition Units experienced staffing shortfalls of over 50% and an 8% drop in mental health providers Army wide.⁵¹ From 2003-2007, the number of active duty Air Force mental health professionals dropped by 20%. During the same period, the active duty Navy mental health staff lost 15% of their personnel. When seeking replacements for psychology internships in 2007, the Army filled 13 of 36 slots, while the Air Force was only able to fill 13 of 24 slots.⁵² This data suggests that individual service members may not have been afforded adequate screening for their physiological or psychological problems which existed prior to their discharge.

A lack of psychologists, psychiatrists and other mental health professionals potentially leaves service members without adequate care and working in units to maintain a state of deployment readiness. Army Commanders were given a tool to manage those members categorized as not deployable but could not be identified as having a combat related injury.

Individuals could be separated for a personality disorder. Army regulations require a commander refer soldiers to psychologist for assessment of “deeply ingrained maladaptive pattern of behavior of long duration that interferes with the Soldier’s ability to perform duty.”⁵³ Once the mental health staff agreed with the assessment, a Commander could separate the member with a dishonorable discharge allegedly for lying about their mental health at accession. This action was allowed despite a lack of accession mental health screening as required by 1998 Defense Authorization Act and DOD policy issued 6 October 1998.⁵⁴ The personality disorder clause allowed all services to dishonorably discharge more than 23,275 people from 2001 through 2007.⁵⁵ A 2008 GAO study revealed the personality disorder diagnosis requirement, along with any associated counseling, was not always determined before the discharge process was complete.⁵⁶ This left many discharged individuals without access to VA medical services for treatment of physiological or psychological injuries received during their service.⁵⁷

Even if a person manages to survive an injury, recover, and receive an honorable discharge, they must still file for compensation and pension disability from the VA. As a result of the Iraq war, the backlog of initial disability claims rose to 600,000. The average wait to hear the results of the initial claim was 6 months. If their initial claim is disapproved, a veteran can wait up to four years for an appeal to be reviewed and a decision announced.⁵⁸ If fortunate enough to live through this period, they may be awarded a disability rating for their injuries. However, according to VA records from 1 Oct 2007 to 31 Mar 2008, 1,467 veterans died while awaiting a response on their disability claim.⁵⁹ It is unknown if the approval of the veteran’s claims would have improved their condition or saved their lives.

VETERAN TREATMENT COURTS

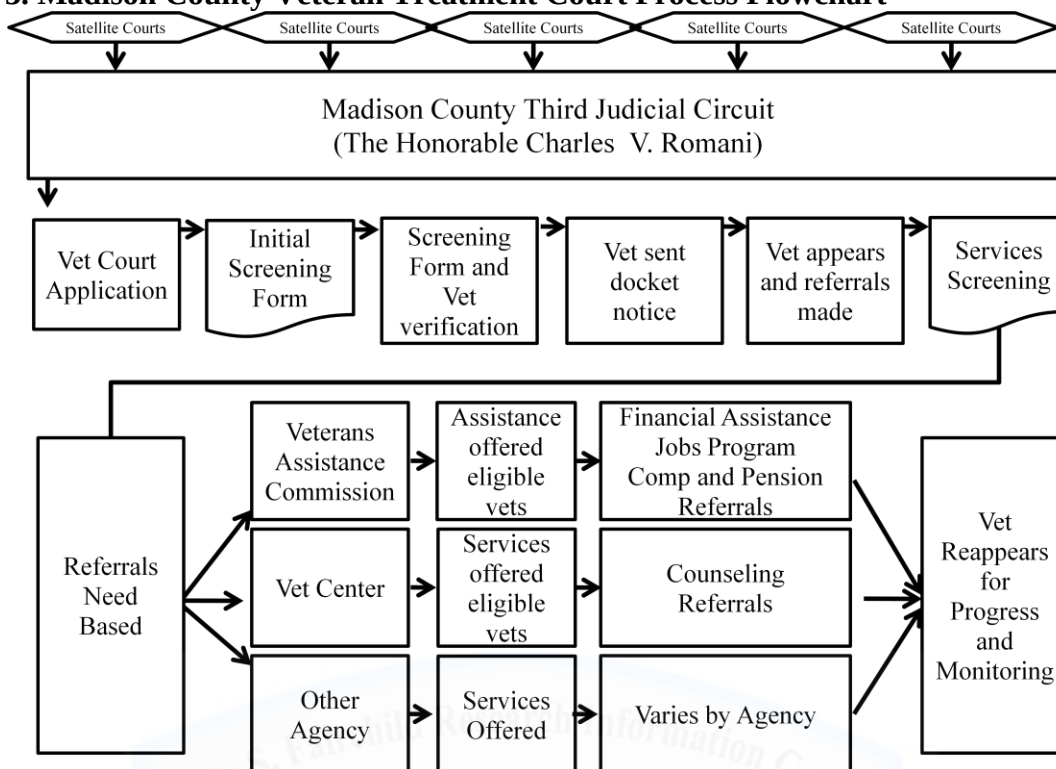
Judge Robert T. Russell, Erie County Court, Buffalo, New York, was surprised to learn there were over 300 veterans who appeared in Erie County Court in 2008. With many of the offenders suffering substance abuse or mental health issues, it was easy to use the NDCI drug court model to formally establish a separate court session to meet, listen to, and counsel non-violent criminal veterans.⁶⁰ As of September 2010, Judge Russell was proud to report graduates from his VTC had zero recidivism in his jurisdiction.⁶¹ Since the establishment of the Buffalo VTC in 2008, Judge Russell reports his process has successfully returned rehabilitated veterans to society, while saving the State of New York an estimated \$12,000,000 in social service costs.⁶²

In response to the success of the Erie County VTC, there was an increased demand by jurists to establish additional VTCs. National Association of Drug Court Professionals (NADCP) reports over 62 U.S. major metropolitan areas in 29 states have established or expressed a desire to create a VTC in their community.⁶³ Using their drug court model, NDCI and NADCP staffs created a VTC model which allows courts to retain individuals in probation long enough to coordinate treatment and allow rehabilitation to work.

NADCP created a six month planning initiative, application process, and training course. During the six months, court personnel complete various worksheets, attend a training session, complete and submit their VTC implementation plan. This same staff must then draft a policy and procedure manual for the operation of their court. Applicant court personnel then attend a NADCP training session hosted by a mentor court, such as Judge Russell's Erie County Court. The NADCP identified several VTC, along with their staff and supporting agency counselors, as mentor courts who host training sessions and offer assistance based upon their experience.

Mentor court staff work to apply lessons learned in seeking treatment, rehabilitation, and housing for the military veteran offenders. Mentor court staff, VA counselors, volunteers, NADCP personnel, as well as veterans provide presentations to assist the attendees in understanding their roles and responsibilities. These training sessions are held annually with periodic webinar series and annual NDCI conferences to relay updates and recommendations to court operations.⁶⁴

After the arrest and processing of a non-violent military veteran offender by the local law enforcement agency, the next step is an arraignment hearing during which the court determines the offender's veteran status. The original court can divert veterans to VTC in an effort to remedy their circumstances initially causing their appearance in court. The military veteran offender must then apply for their case to be transferred to the VTC, as shown in the Madison County process flowchart in Figure 3. Although the existing courts may not operate in a standardized configuration, the desire is to successfully progress a veteran through the process to graduation.

Figure 3. Madison County Veteran Treatment Court Process Flowchart

(Kammerer, Coordinator, Cook County Veterans Treatment Court System 2011)

Criteria for diversion to VTC can vary from court to court, with each judge instituting unique admittance standards using such conditions as listed in Figure 4. Each military veteran offender requires a personalized individual service plan for referral to appropriate services based on their circumstances and the legal charges which led to their arrest. During the screening process, the court staff attempts to determine the underlying cause of the crime to help prepare the court and veteran for success. Judges, lawyers, and probation officers attempt to link the criminal act to the veteran's military service, injury, or combat experience. While attempting to link the crime to military service, they also consider impact statements from victims. The presiding judge is the final approval authority for acceptance into the VTC program or remanding the military veteran offender to the original criminal court.

Figure 4. Veteran Treatment Court Sample Admittance Criteria

General Discharge	Residency in jurisdiction of VTC
Honorable Discharge	Substance abuse problem
Other Than Honorable Discharge	Combat related injuries
2 or more years of active service	Combat related mental health issue
Non-violent offender	Enter Guilty plea to charges
Violent offender with recommendations	Agree to seek treatment/counseling

(National Association of Drug Court Professionals n.d.)

The military veteran offenders sign a contract, similar to Figure 5, which outlines responsibilities of all signatories prior to their case being diverted to the VTC program. The military veteran offenders then become clients or participants of the process and are typically placed on probation during the 12 to 36 month VTC program. Prosecution and sentencing are deferred while the client successfully meets all conditions of their probation. The client is referred to appropriate VA or VA funded treatment centers for a variety of services, such as, anger management, substance abuse rehabilitation, or medical treatment. Other required agencies consulted by the veteran and their family can include counseling, education, and employment or housing assistance.

Figure 5. Cook County Veteran Treatment Court Contract

**STATE OF ILLINOIS
CIRCUIT COURT OF COOK COUNTY
VETERANS TREATMENT COURT CONTRACT**

Defendant's Name: _____

Case Number(s): _____ Date: _____

• I agree to participate in and fully satisfy all conditions and requirements of a veteran treatment court, including, but not limited to, medical, mental health, and/or, where indicated, substance abuse treatment program(s) and to submit to any other evaluation recommended by the veterans court team, which consists of the judge, public defender, state's attorney, TASC, probation officer, Veterans Administration case manager or Illinois Department of Veterans Affairs case manager, and other treatment provider(s).

• I will consistently adhere to all components of my treatment, including, but not limited to, attending all counseling sessions, treatment programs (including residential placements), vocational and/or educational programs, taking my medication as prescribed, and engaging in structured daily activities as recommended by the team.

• I will remain drug and alcohol free for the duration of my sentence. I agree to submit to random urinalysis and/or breathalyzer tests, as required by the court, probation officer/case manager, or treatment provider and to the disclosure of said test results to the team members in open court or otherwise.

• I understand that I may be asked to participate in self-help groups and other support systems as recommended by the team.

• I will appear in court as required.

• I agree to keep the team informed of my current address, employment status, and any new arrests at all times during the program, especially any changes.

• I understand that it is essential that all members of the team communicate and share information regarding my participation in treatment and current treatment status and I agree to them doing so.

• I understand that based upon any report (written or oral) of my violation of this agreement, the court may issue a warrant for my arrest, impose any sanctions, including jail time, or otherwise extend, modify, or revoke my treatment plan, or the conditions of my probation.

Defendant Assistant State's Attorney

Attorney for Defendant Judge

(Kammerer, Coordinator, Cook County Veterans Treatment Court System 2011)

The program may require mentor counseling, group discussion forums, court appearances, home inspections, and random drug tests. Missing appointments for treatment, benefits or mentoring are grounds for dismissal from VTC, remanding the participant to the original criminal court for hearings, sentencing, and possible confinement. The client can also

voluntarily withdraw from the program and return to the original court for further criminal proceedings. Successful completion of the programs appointments, court appearances, and drug tests allows a client to graduate from the VTC program. After graduation, the court has various options from reduction in sentence to expunging the criminal record.

Recently, several VTC began to consider the plight of violent offenders. Judge Wendy Lindley's Orange County VTC was one of the first courts willing to consider acceptance of violent offenders into the program. With PTSD and TBI patients displaying aggressive behavior which caused their arrest, she could not deny violent military veteran offenders an opportunity to apply for access to her court.⁶⁵ Magistrate Judge Paul Warner, presiding judge for the United States District Court for the District of Utah, also witnessed this increase in violent offenders. His court became the first federal VTC to consent to acceptance of violent and non-violent military veteran offenders.⁶⁶ Both want to prevent the possibility of a continued cycle of criminal behavior by providing an incentive to seek treatment and rehabilitation.

Since Buffalo NY started their first VTC in 2008, over 60 communities across the U.S. established or are creating their own VTC.⁶⁷ With the assistance of NADCP, these additional courts are now working with various organizations to refer their clients for required assistance. The compilation of metrics is hindered by the lack of formal nationwide recognition and age of the VTC process. There is no established Justice Department statistical collection standard or repository assigned to gather or disseminate court data limiting analysis and further study. The only means available to assemble data was to email individual VTC Judges and coordinators asking for permission to use their statistics. Figure 6 displays the common metrics made available by judges and court coordinators for this paper. The 14 VTC had 22% of their clientele graduate with additional eligible military veteran offenders awaiting admittance from a satellite

court. VTC experienced a 22% discharge rate. Court staff members provided various reasons for participant discharge, such as death, failure to meet court appointed standards, or voluntary withdrawal from the court. While numerous courts did not collect recidivism data, the responding court personnel reported 24% of their graduates were repeat offenders.

Figure 6. Veteran Treatment Court Statistics

		enrolled	graduated	discharged	recidivism
Allegheny CO PA 2010	35	2	0	0	
Anchorage CO AK 2004-07	92	52	0	0*	
Anchorage CO AK 2009	24	0	0	0*	
Anchorage CO AK 2010	14	13	0	0*	
Buffalo NY 2009-10	180	40	25	0	
Colorado Springs CO 2011	3	0	0	0	
Cook CO IL 2010**	69	24	6	4	
Cook CO IL 2011**	79	29	11	20	
Mansfield OH 2010	36	8	1	2	
Mansfield OH 2011	36	14	1	0	
Orange CO CA 2009	15	0	0	0	
Orange CO CA 2010	28	7	4	0	
Rochester NY 2009-11	203	24	114	0*	
Rock CO WI 2009	1	0	0	0	
Rock CO WI 2010	8	0	1	0	
Rock CO WI 2011	0	2	0	0	
Youngstown OH 2010	6	0	0	0	
Sample Total	484	108	138	26	

*no recidivism rates are available

**6 Veteran Treatment Courts in Cook County

(Bibliography) n.d.)

Alternative to Veterans Treatment Courts

In December 2008, New Jersey began an alternative project with the same broad goals as the VTC, entitled the Veterans Assistance Project (VAP). The program starts with police asking about military veteran status at time of arrest. Violent and nonviolent veteran criminal offenders are eligible to participate in the VAP on a voluntary basis. The veteran can be referred to a veterans' service organization to assist with VA or VA funded mental health or addiction center

appointments while proceeding within the existing court system. If requested and approved, the Department of Military and Veteran Affairs can assign a military veteran mentor to help the military veteran offender better understand benefits, entitlements, and criminal trial proceedings. The VAP holds the offender solely responsible for their recovery as there is no special treatment court or staff. There are no reduced sentences or intervention programs to keep the military veteran offender out of criminal court. The goal is to prevent the veteran from repeating the behavior which resulted in their initial arrest. A total of 350 veterans in 11 New Jersey counties have voluntarily participated in VAP, with 34 involved in Bergen County alone, which has had zero recidivism as of the date of the source.⁶⁸ This alternative retains the traditional court process while providing a problem solving environment. While less costly, VAP lacks the liaison officers and collaborative relationships with non-judicial agencies available to assist the client of a VTC. Anticipating an end to an involvement by U. S. forces in any major combat operations, the VAP could serve as a model court when funding and the anticipated need for VTC subsidies.

Federal and State Support

During the 111th session of Congress in 2009, Senators Kerry (D-MA), Murkowski (R-AK), and Inouye (D-HI) introduced the Services, Education and Rehabilitation for Veteran's (SERV) Bill. That same year Representative Kennedy (D-RI) introduced H.R. 2138, SERV Bill, supporting the passage of the Senate version. Both versions direct the U.S. Attorney General to award grants to any jurisdictions establishing VTC with budget appropriation through the end of 2015. The authors included an eligibility requirement that military veterans be discharged under conditions other than dishonorable. Also included is guidance to consider admittance for violent offenders. The Senate and House documents were introduced to the appropriate Congressional judiciary committee and still await approval at the time of this writing.⁶⁹

The U.S. Justice Department and Substance Abuse and Mental Health Service Administration (SAMHSA) provide grants to fund VTC and suicide prevention services. For example, Clark County, Oregon received a \$350,000 U.S. Justice Department grant to fund a VTC in the fall of 2010. This amount will provide the support necessary for up to 50 veterans over three years.⁷⁰ Colorado Springs VTC is funded by grants from SAMHSA as a means to provide therapy to prevent suicide and rehabilitation from further substance abuse.⁷¹

The VA and Housing and Urban Development (HUD) work with all VTC to provide counselors and appropriate assistance to VTC participants. The VA provides liaison officers to verify veteran eligibility status to the court. The liaison helps the veteran obtain appointments for treatment of their physiological and psychological wounds.⁷² HUD-VA Prevention Pilot is a program designed to provide housing to eligible veterans. Staff from HUD and VA work with local VTC mentors, veteran organizations and homeless shelters to identify eligible veterans. The \$1.5 billion program will fund approximately 318,000 households to provide temporary housing for up to 24 months.⁷³ The HUD and VA also provide eligible veterans with permanent housing under the HUD-Veterans Affairs Supportive Housing (HUD-VASH) voucher program.⁷⁴

Colorado, Illinois, Nevada and Texas enacted legislation to establish and provide funding support to their VTC. California, Minnesota, and New Hampshire law allow judges the discretion to order treatment for a criminal veteran with a diagnosis of a combat related mental health disorder. Other states are considering various forms of legislation to provision for VTC or assistance programs to avoid the incarceration of affected veterans.⁷⁵

RECOMMENDATION

The DOD should implement pre-accession screening as required by the 1998 Defense Authorization Act and DOD policy. Identification of existing mental health issues during

military entrance processing can preclude enlistment of personnel with conditions not conducive to military service.

The DOD should maintain and increase funding to attract and retain mental health professionals. Mental health professionals should be assigned to forward operating combat operational stress clinics, combat surgical hospitals, wounded warrior transition units, and major military medical facilities treating combat casualties. Immediate treatment of combat stress related symptoms can help patients cope with combat operations and possibly prevent a diagnosis of mental health disorder. Mental health professionals can also provide care and oversight for forward deployed service members with previously diagnosed disorders and medication.

The DOD should assign injured service members to a wounded warrior transition unit when they require continued evaluation, rehabilitation, or treatment. These individuals should not be assigned to active military units where they occupy unit manpower positions and affect readiness standards. If adjudicated as fit to return to service, then DOD should provide the service member an opportunity to rejoin their old unit if vacancies exist or be assigned to other organizations suitable for their career field. If designated as unfit for service, the transition unit can help with the transfer of care to a local VA treatment facility where the veteran will reside. Caregivers and family members should receive continued counseling, training and medical information related to their injured veteran's condition in order to help with the crossover from the DOD to the VA.

The DOD, NADCP, and veteran service organizations should petition Congress to pass, and the President to approve, the SERV Bill with VTC funding while U.S. forces are engaged in combat operations. Passage can publicize the role of the court which may compel future military

veteran offenders to seek assistance offered by VTC. NADCP and veteran service organizations can adapt SERV Bill language to draft a standard legislative document for introduction to state legislatures. State legislation can assist the creation of VTC in their court systems to promote rehabilitation over incarceration of military veteran offenders. Using NADCP drug court model financial data, every \$1.00 invested in a drug court saves taxpayers \$3.36 in avoided Criminal Justice costs, such as reduced prison costs, a reduction in recidivism and retrial, as well as reduced victimization.⁷⁶ A nationwide mandate would standardize roles and responsibilities while supporting data collection for criminal justice studies to improve VTC operations.

An end to major combat operations may well reduce the need to provide treatment courts specifically for veterans. Combining the non-judicial agency liaison relationships of the VTC program and the New Jersey VAP can serve NADCP as a future court model. Converting to the New Jersey VAP model allows VTC judges to transition to customary operations and still identify military veteran offenders for treatment, rehabilitation and other assistance as necessary.

CONCLUSION

In response to returning psychologically wounded OEF and OIF veterans being arrested, the judicial system created programs to provide treatment as opposed to incarceration. HUD, VA, other government agencies, and private organizations also participate in outreach programs to give necessary support to veterans and their families. Working together in a VTC, or similar program, they provide a venue for a veteran to admit their guilt and obtain assistance to overcome their individual circumstance.

Despite a significant gap in literature and statistics, as well as standard operating procedures, the VTC process may provide the best option for the military veteran offender to obtain treatment, rehabilitation and other assistance needed. VTC transform the courts' role as a

partner with other agencies to rehabilitate an offender while holding the veteran accountable for their crime. This paper is relevant considering the current world situation which demands U.S. and other countries military members participate in combat operations. However, an end to combat operations may significantly reduce the causation of combat induced psychological injuries. This reduction should diminish the need for treatment courts specifically for military veteran offenders with combat related mental health issues. After cessation of combat operations and eventual elimination of VTC funding, the New Jersey VAP model remains a viable, no cost option. The VAP allows for the identification, referral, and treatment of veterans with physiological or psychological wounds related to their military service while keeping the veteran answerable to a criminal court.



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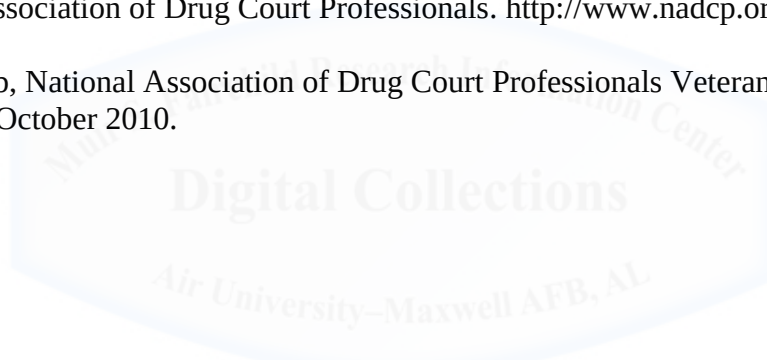
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