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# VETERANS COURTS & Veterans Justice Outreach (VJO)

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### **What are we going to talk about?**

1. Veteran identification and uniqueness.
2. Challenges experienced by veterans
  - Readjustment to civilian life
  - PTSD, TBI, Substance Abuse, Suicide Risk
3. Veterans Justice Outreach Program
  - Mission and Goals
  - Key Components
  - Access and Resources
4. Veterans Courts
  - Origins, Benefits and Effectiveness
  - Concepts and Configurations
  - Authority and Funding Sources



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## WHO IS A VETERAN

- Anyone who has served in the Active Federal Armed Forces. (Varies by time periods)
- Had their own reason to be military.
- Have their own experience .  
and unique story.
- Have a strong sense of patriotism
- Have a strong sense of commitment to each other. A sense of “brotherhood”
- Have their own “language” vernacular riddled with Acronyms.





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- Since 9/11 over 2 million men and women have deployed many multiple tours
- More deployments=more significant need for treatment
- 1/3 returning have PTSD, only 20% seek treatment.
- National Center for PTSD reports a connection between trauma and subsequent contact with the legal system.
- OIF/OEF following this pattern.



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- Vietnam: 18.7 percent of Vietnam veterans suffer from a stress disorder
- Nearly one in three veteran returning from Iraq or Afghanistan will have mental and/or physical problem.
- Approx. 38% of soldiers and 31% of Marines report psychological symptoms.
- Among National Guard this increases to 49%.



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- Jail Population
  - 70% are veterans of a non-violent crime
  - 5% with prior arrest
  - 45% served 2 or more prison terms
  - Three in five have SUD
  - One in three with Serious Mental Illness
  - Trauma
    - 18% childhood
    - 20% combat



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To enter the current  
military you cannot have  
any significant legal/  
criminal history.

So, what happens when this guy  
meets....





..... this Guy ?



# MILITARY CULTURE

- Rank and Order
- Mission comes first
- Group interdependence
- Group identity over individual identity
- Team accomplishment over individual accomplishment
- Individual accountability to the group
- Esprit Corp.
- History, customs, ceremony, traditions
- Never Leave a comrade behind
- **Learn to do fight and kill.**



**AND WHAT IF HE/SHE DOES?**

**“Battle mind skills helped you survive in combat... but  
may cause problems when you get home...”**

- **Buddies (cohesion) vs. Withdrawal**
- **Accountability vs. Controlling**
- **Targeted Aggression vs. Inappropriate Aggression**
- **Tactical Awareness vs. Hypervigilance**
- **Lethally Armed vs. “Locked and Loaded” at Home**
- **Emotional Control vs. Anger/Detachment**
- **Mission Operational Security vs. Secretiveness**
- **Individual Responsibility vs. Guilt**
- **Non-Defensive (combat) Driving vs. Aggressive Driving**
- **Discipline and Ordering vs. Conflict**

# Battle mind Transitions Behaviors

- Risky behaviors to get the adrenaline rush
- Speeding/erratic driving/road rage (drive down middle of road/avoidance of objects on side of road, swerving under bridges, driving over curbs.)
- In traffic jam, may panic, feel “ambushed” if stuck in traffic.
- Alcohol abuse
- Domestic Violence/child abuse
- Relationship problems
- Addiction (various – work, alcohol, drugs, sex, food, adrenaline)

# Battle mind Transitions Problems

## The enemy:

- In a war zone, knowing the enemy is crucial to survival.
- When the enemy blends in with the population, everybody is viewed as suspicious.
- Back at home, the vet may continue to regard everyone as a potential enemy-and this can leave them isolated and separate from the world they are trying to return to.

## Response tactics:

- While “act first, think later” may be the best response in a war zone, .....
- most responses at home are better approached with a “think first, act later” strategy. Vets may have to re-learn how to regulate responses.

# Battle mind Transitions Problems

## Intelligence:

- Even what might seem like unimportant information can be put together and used as intelligence by the enemy.
- Vets may be very sensitive about giving out any information.

## Talking:

- Talking to someone who has not been in a war is difficult .  
because others cannot understand the context .
- Vets may resent questions that people ask, or, do not ask.
- They may be concerned that if they talk realistically about the war, people will become quickly overwhelmed.
- Being alone and not able to talk about war can keep the vet from feeling a part of life at home.



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# **Post Traumatic Stress Disorder (PTSD)**



# HISTORICAL ASPECTS OF DIAGNOSTIC TERMS

- Soldiers Heart (Civil War)
- SHELL SHOCK (WWI)
- COMBAT FATIGUE (WWII)
  - “traumatic war neurosis” (Kardiner & Spiegel, 1947)
  - “combat exhaustion” (Swank, 1949), and
  - “operational fatigue (Grinker et al., 1946, I., II.).
- COMBAT STRESS (Vietnam)
- PTSD and ASD (1980 in DSM III)



# Common Symptoms/Associated Features

- Re-Experiencing the event (flashbacks)
- Nightmares
- Emotional numbing and detachment
- Guilt
  - Survival
  - Remorse/shame
- Hyper-arousal
  - Irritability
  - Insomnia
  - Fearful
  - Anxious/anxiety
  - Increased startle response

# Common Symptoms (cont.)

- Behavioral Changes
  - Self destructive/ dangerous behaviors
  - Irritability/fights
  - Loss of interest in pleasurable activity (anhedonia)
- Substance Abuse

# Prevalence in Veteran Groups

- 30% in Vietnam Veterans
- 10% in Gulf War Veterans
- 6-11 % in OEF Veterans
- 12-20% in OIF Veterans
- WWII and Korea
  - Emerging group
  - Little research
    - Prevalence of 7-9 % in those who never sought tx.
    - As high as 84 % in certain groups. (i.e. battle, pow)

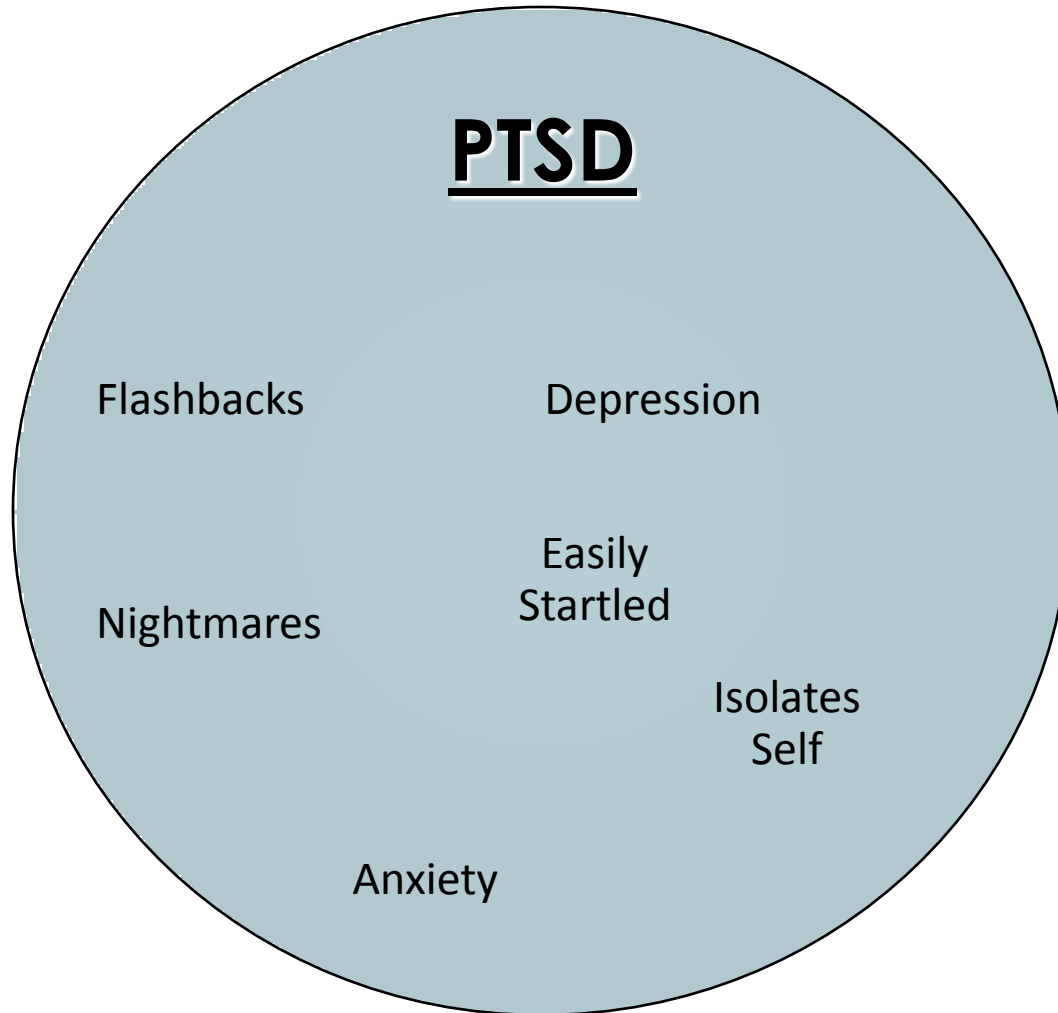
# Theoretical Psychological Effects

- Energy expended in defending against the trauma hinder further development of the ego.
- Ego Experience during critical life transitions, are more vulnerable to maladjustment
- (Silverstien, 1996)

# Suggestions of what to do

- Minimize environmental stimulation
- Be aware of personal space and proximity
- Be aware of potential triggers
  - Accommodate specific needs. (i.e. lights on at night)
- Focus on the here and now
  - Reinforce they are safe
- Be supportive
  - Offer help, but don't pry.
  - Be Empathic
    - Acknowledge difficulty, don't minimize it.
    - Be a good listener
- Refer for assessment and treatment
  - V.A
  - Mental Health Services

# PTSD Symptoms



# Traumatic Brain Injury (TBI)





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- Application to the brain of an external physical force or rapid acceleration and/or deceleration forces
  - not due to congenital, degenerative, vascular, hypoxic-ischemic, neoplastic, toxic-metabolic, infectious, or other causes
- Produces an immediately apparent physiological disruption of brain function manifested by cognitive or neurological impairments
- Results in partial or total functional disability (regardless of the duration of such disability)





# TBI SYMPTOMS

- **Cognitive:** Attention problems, memory difficulties, intellectual deficit.
- **Psychological:** Irritability, depression, poor anger control, anxiety.
- **Physical:** Headaches, Nausea/vomiting, sleep problems, dizziness, Tinnitus, hearing loss.



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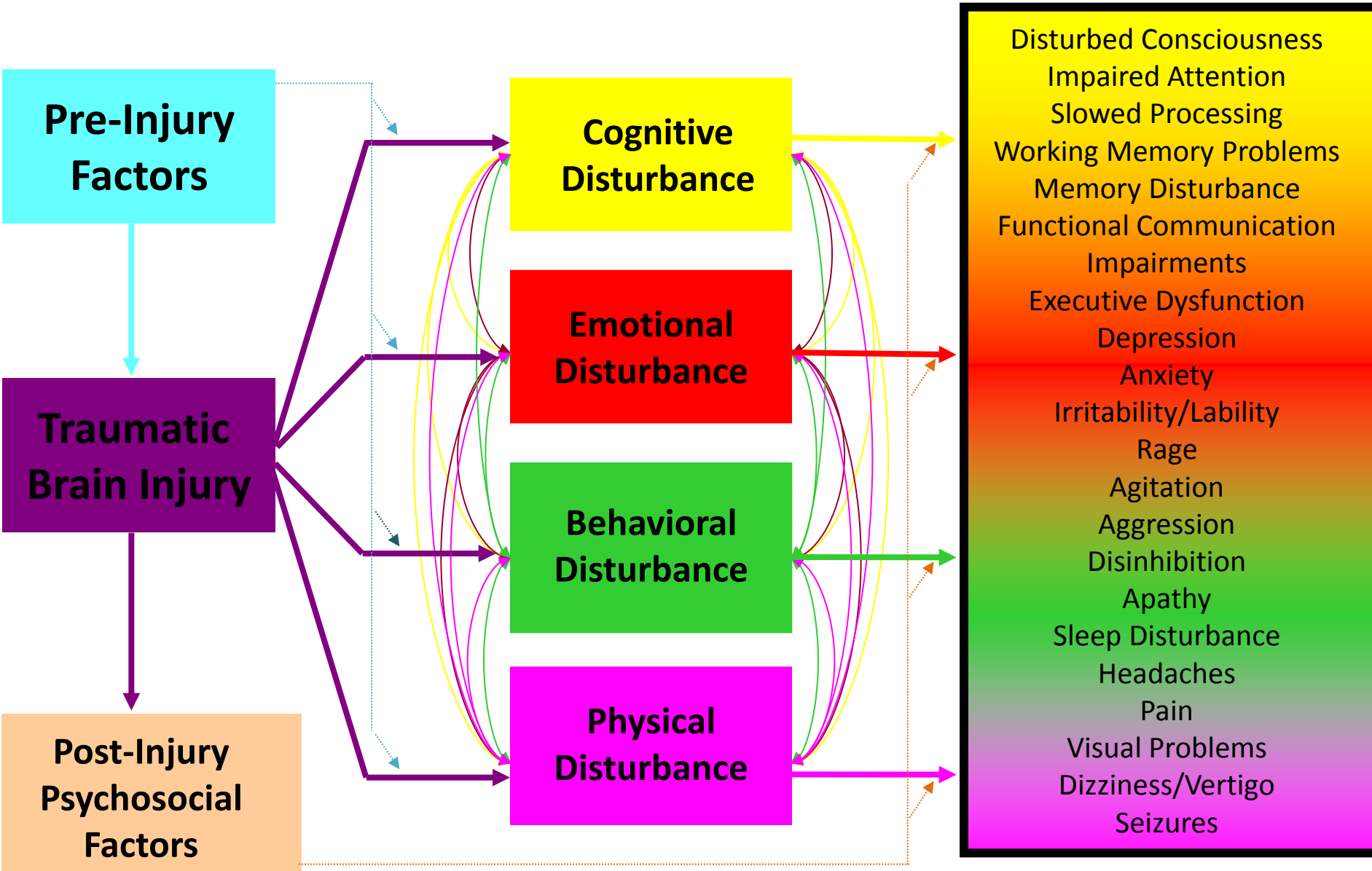
Immediately post-injury 80% to 100% describe one or more symptoms

Most individuals return to baseline functioning within a year



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- “Gold standard” for diagnosis of TBI remains self-report and requires caution:
  - under-reporting vs. over-reporting
  - poor understanding of TBI
  - misunderstanding symptoms as reflective of TBI when other diagnoses offer better explanations
  - stigma vs. secondary gains
- **Avoid missed opportunities to target other treatable conditions (PTSD, MDD, etc.)**



**Pre-Injury Factors**

**Traumatic Brain Injury**

**Post-Injury Psychosocial Factors**

**Cognitive Disturbance**

**Emotional Disturbance**

**Behavioral Disturbance**

**Physical Disturbance**

- Disturbed Consciousness
- Impaired Attention
- Slowed Processing
- Working Memory Problems
- Memory Disturbance
- Functional Communication Impairments
- Executive Dysfunction
- Depression
- Anxiety
- Irritability/Lability
- Rage
- Agitation
- Aggression
- Disinhibition
- Apathy
- Sleep Disturbance
- Headaches
- Pain
- Visual Problems
- Dizziness/Vertigo
- Seizures

(Adapted from Silver and Arciniegas 2006)

***”In order to understand the effects of brain injury, we must undertake full study of the individual’s constitution. In other words, it is not just the kind of injury that matters, but the kind of brain that is injured.”***

***Sir Charles Symonds, c. 1937***



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- Age and gender
- Baseline intellectual function
- Psychiatric problems & substance abuse
- Sociopathy
- “Risk-taking” and “novelty-seeking” behavior
- Premorbid behavioral problems
- Social circumstances
- Neurogenic



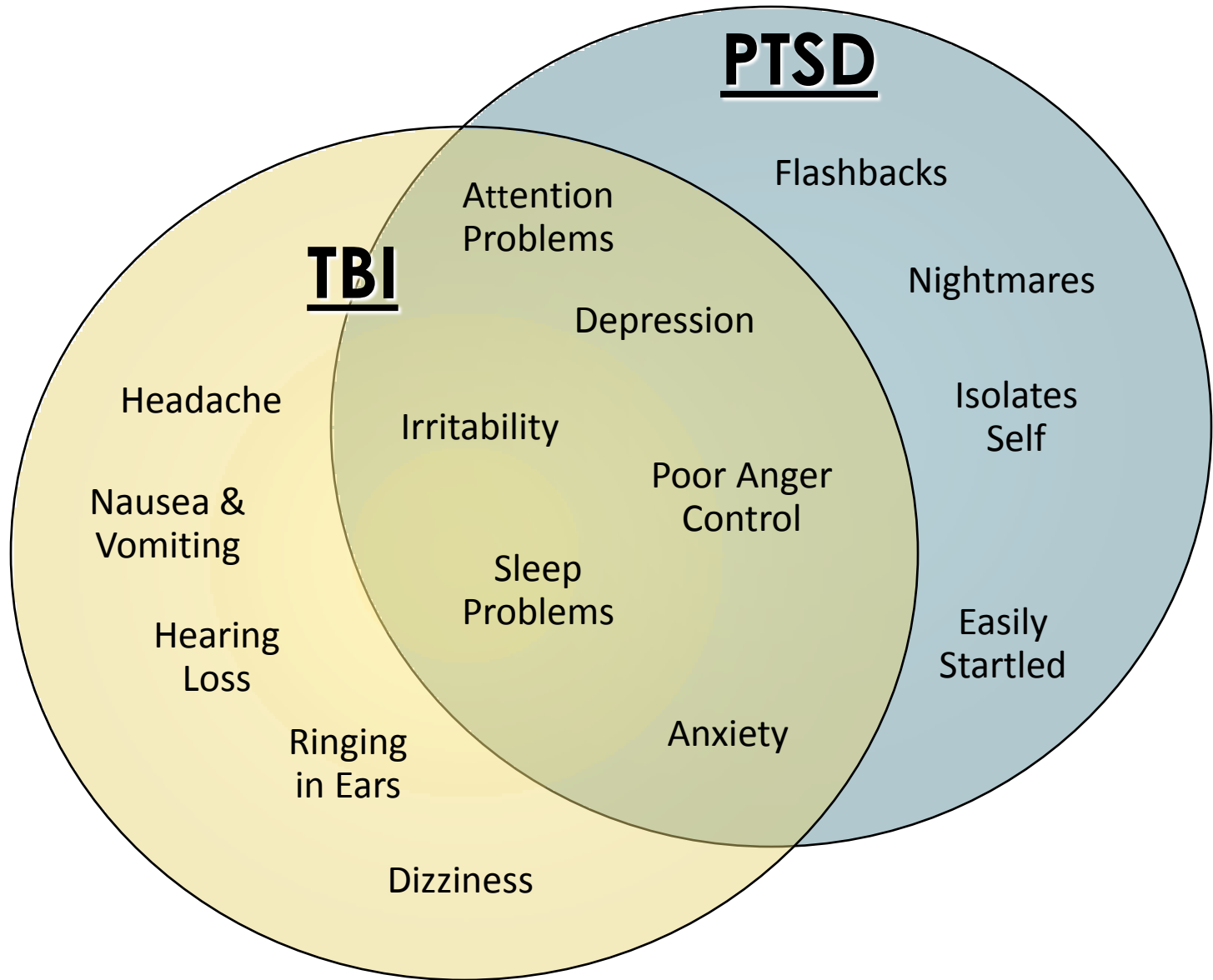
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## COMMON SYMPTOMS

- Depression
- Mania
- Pathological Laughing and Crying
- Anxiety
- Irritability or loss of temper (“rage episodes”)
- Disinhibition
- **Agitation/Aggression** (“socially inappropriate behavior”)
- Apathy (loss of drive to think, feel, and/or behave)
- Psychosis
- Sleep disturbance



# TBI- PTSD symptom overlap







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## SUBSTANCE ABUSE

- Generational/age related
- Secondary to other Mental Health Problems
  - PTSD, Anxiety, Depression, sleep disorders
- Secondary to physical health problems.
  - Pain killers, muscular skeletal injuries



## **Musculoskeletal Injuries**

Number one complaint for treatment at the V.A. from Iraq and Afghanistan Veterans (primarily joint and back disorders) second only to mental health problems.

The number of soldiers who medically retire from the Army with at least 1 musculoskeletal condition increased 10 fold from 2003-2009.

Annually, the Department of Veterans Affairs pays in excess of \$500 million for musculoskeletal injuries



Routinely carry up to 33 percent more than the suggested maximum weight and up to nearly 75 percent of a member's own body weight, routinely hefting combat gear that can exceed 120 pounds.



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- Prescription drug abuse has doubled among U.S. military personnel from 2002 to 2005 and has almost tripled between 2005 and 2008.
- Soldiers screened 3 to 4 months after returning from deployment to Iraq showed:
  - 27 % met criteria for alcohol abuse and were at increased risk for related harmful behaviors (e.g., drinking and driving, using illicit drugs).
  - Soldiers frequently reported alcohol concerns, but few are referred to alcohol treatment.

National Institute of Drug Abuse (April 2011)

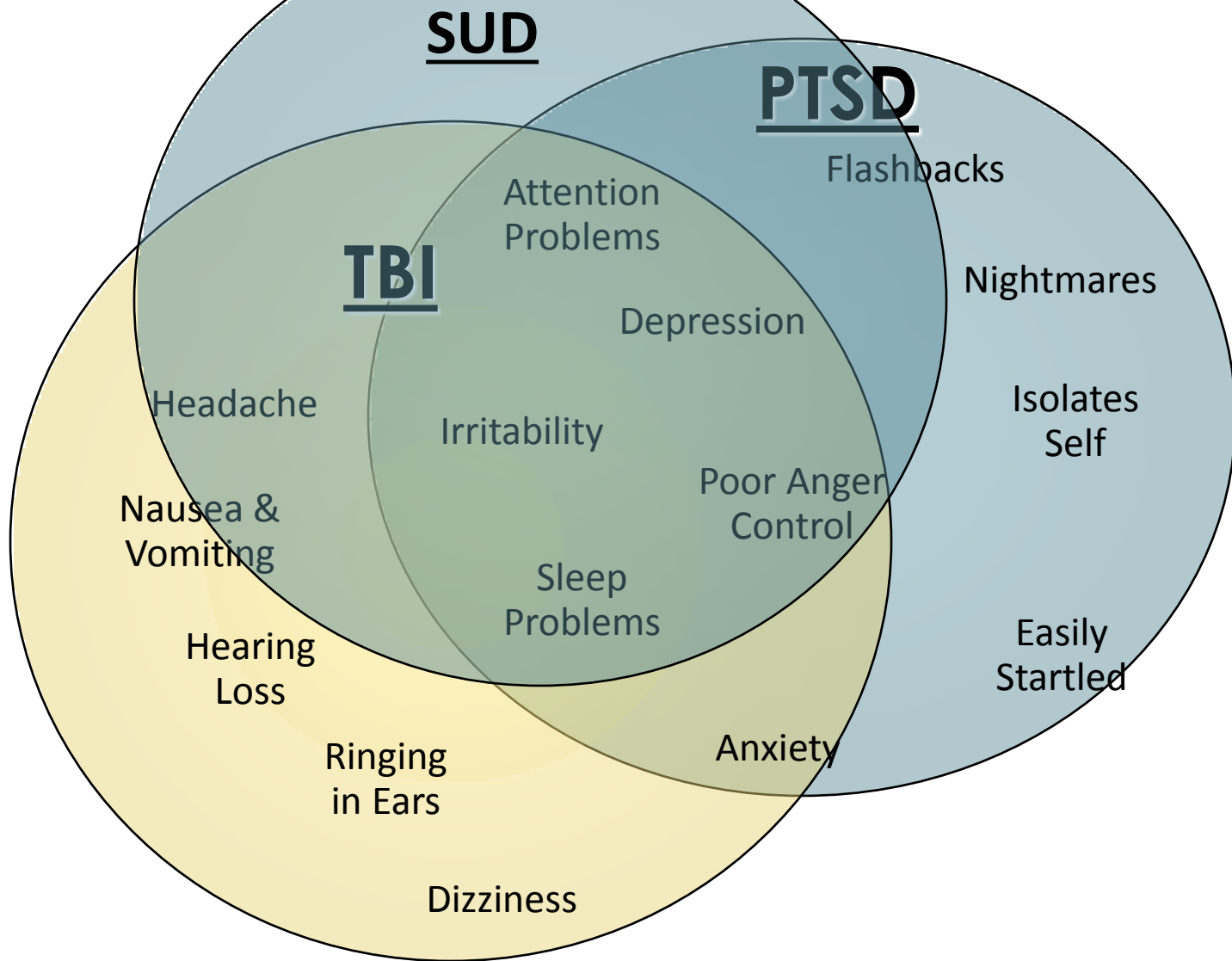


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- Drug or alcohol use frequently accompanies mental health problems.
- Involved in 30 percent of the Army's suicide deaths from 2003 to 2009
- More than 45 percent of non-fatal suicide attempts from 2005 to 2009.
- Reserve and National Guard personnel and younger service members who deploy with reported combat exposures are at increased risk of new-onset heavy weekly drinking, binge drinking, and other alcohol-related problems.

National Institute of Drug Abuse (April 2011)

# TBI- PTSD-Suicide Overlap



# Suicide



Plato

428-348 BC (approx.)

***“It is only the dead who have seen the end of war.”***



Emile Durkheim  
(1858-1917)

- **French Sociologist**
- **Concluded:**
  - **Social factors**  
contributed to suicide rather than only personal ones.
  - **Social Integration**
    - Tied to a social group
    - Basic theory still used today





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# Suicide in the Veteran Population

- 18 Veterans attempt suicide every day
- 7% are successful, 11% try again within 6 months.
- 4-5 veterans die by suicide each day.
- 60% suffer from depression
- Veteran's aged 20 through 24 had the highest suicide rates among all veterans. This rate is estimated to be between two and four times higher than civilians of the same age.
- The suicide rate for non-veterans is 8.3 per 100,000. while the rate for veterans was between 22.9 to 31.9 per 100,000.
- 32,000 people die by suicide each year; approximately 6,000 are veterans.

# Suicide Findings in the Veteran Population

- CDC data identified the following associated circumstances among a group of 1,622 former and current military personnel who died by suicide in 2005:
  1. Although almost half of them (**47.2%**) were depressed at the time of death, only about one forth (**26.7%**) were receiving mental health treatment.

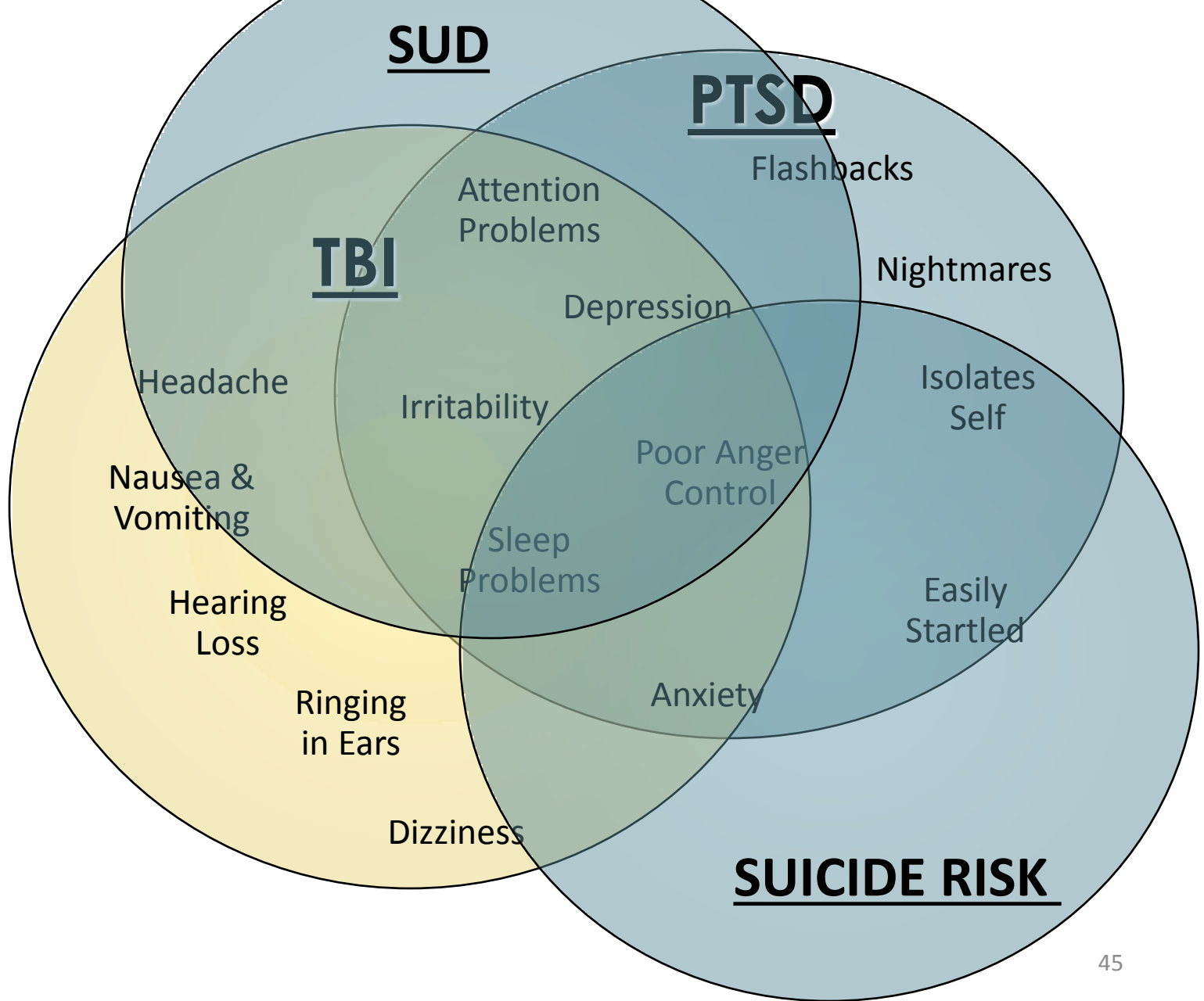
# CDC Findings Continued

2. **17.2%** had an alcohol problem and **7.7%** had a problem with other substances.
3. **24.5%** had a problem with an intimate partner.
4. **38.4%** had a physical health problem.
5. **28.0%** had experienced an acute crisis during the prior two weeks.
6. **33.9%** had left a suicide note.
7. **33.3%** had made a previous suicide attempt.
8. **29.0%** had verbalized their intent to commit suicide with enough time for someone to have intervened.

# What do these statistics mean?

- Veterans are at greater risk for suicide.
- We need to do more to reduce this risk.
- Suicides are preventable in most cases.

# TBI- PTSD-Suicide-SUD Overlap





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“It takes a village to raise a child” (African proverb)

End Result= Untreated veterans have a greater risk of contact with the justice system, homelessness incarcerations and community service agencies.





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- **90,000 of the 9 million “unique” inmates released annually are Vets.**
  - **65% qualify for V.A. services**

Historically:

- Association of Vietnam and Post Vietnam era veterans with histories of civilian and/or military trauma suggest an association between the trauma and subsequent contact with the legal system.
- Half of homeless have encounters with legal system.
- OIF/OEF Vets appear to be following this pattern
- **The VA’s national Center for PTSD reports that PTSD symptoms can indirectly lead to criminal behavior** (for example, self medication or acts related to hyper-vigilance) or through direct linkage of a traumatic incident to a specific crime.



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## VJO Mission

The VJO Project's mission is to **successfully habilitate veterans through Court approved treatment programs** that allow alternatives to the traditional criminal justice system while providing the veteran with the tools s/he will need in order to lead a productive and law-abiding lifestyle. **AVOID UNNECESSARY CRIMINALIZATION OF MENTALLY ILL VETERANS**

## VJO Goal

The VJO goal is to **reduce criminal behavior** in veterans by providing the kinds of assistance that helps them turn their lives around through an evidenced-based assessment of individualized needs utilizing directive case management and problem solving techniques. **PREVENT EXTENDED INCARCERATION BY ASSURING VETERANS ACCESS TO VA SERVICES AND BENEFITS AS APPROPRIATE**





- **VHA handbook 1160.1, Uniform Mental Health Services in V.A. Medical Centers and Clinics:**
  - “ VA is committed to the principal that when veteran’s non violent offenses are products of mental illness, veterans and their communities are often better served by mental health treatment rather than incarceration.”



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## COMPONENTS

### ▶ Outreach to veterans who are in contact with the justice system.

- Police
- Courts
  - Function as a court team member
- Jail

### ▶ Refer and link Vets with services

### ▶ Education

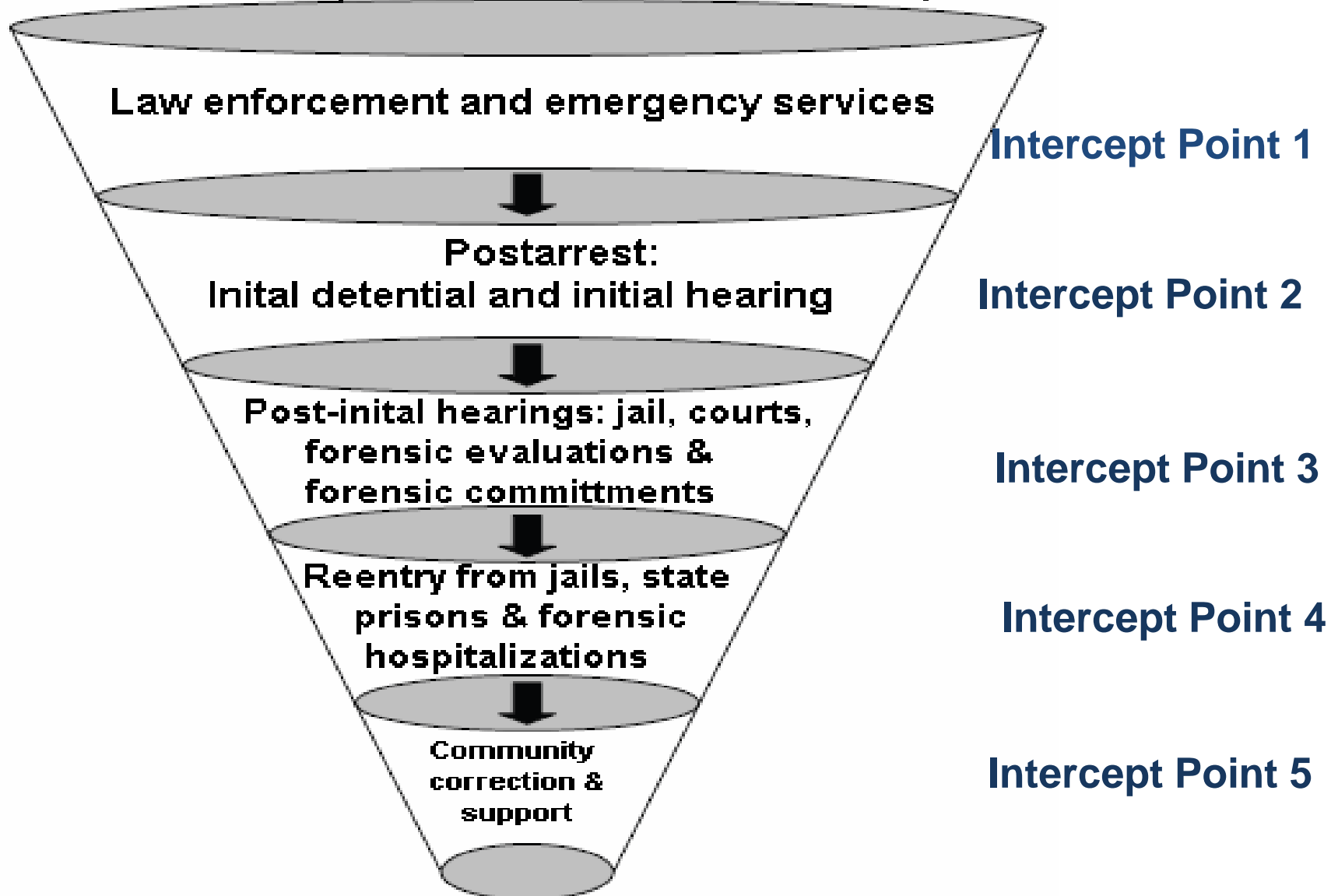
- PTSD
- TBI
- Etc.

Integration with current jail diversion programs

- CMH, Mental Health Courts, etc.

# Sequential Intercept Model

Best clinical practices: the ultimate intercept



# **6 KEY COMPONENTS**

- 1. Develop partnerships with intercept points: law enforcement agencies, jails and courts.**
- 2. Early identification and referral of eligible veterans to the VJOS.**
  - Provide information to judges/courts, law enforcement and jails on how to identify a Veteran.
  - Intervene at contact-intercept points to move veterans away from the justice system into appropriate treatment.

# KEY COMPONENTS

(CONTINUED)

## **3. Ensure the eligibility of Veterans and provide assistance in accessing and enrollment for VA services.**

- This process usually takes no more than 7 calendar days.
- A veterans discharge status can often be upgraded, usually with the assistance of a Veterans Service Officer

## **4. Assess the Veteran's mental health care needs, identify appropriate VA and non-VA services. Refer and link the Veteran to proper services.**

- Ensure that eligible veterans in contact with the criminal justice system have access to VA mental Health and substance use disorder services when clinically indicated and approved by the contact-intercept point.
- The VJOS provides the contact-intercept point with access to a continuum of VA and non-VA treatment, rehabilitative, vocational and homeless program services.

# KEY COMPONENTS

(CONTINUED)

## **5. Functions as a ready resource to Justice system contact-intercept agents: acquire veteran consent (ROI). Communicate necessary information; (e.g. -- attendance, progress, treatment, testing and discharge plan).**

- In order for the VJOS to communicate with the justice system, the Veteran must sign a Release of Information specifying the type of information to be communicated and the duration of course of treatment for which the information is to be provided. (VA form 10-5345, Request for and Authorization to Release Medical Records or Health Information).

## **6. Work with contact-intercept agencies providing information, training and education of VJO related personnel**

Court, Law enforcement and jailer training to help identify combat related trauma – i.e.. PTSD and TBI.



## ACCESS TO RESOURCES

Shift treatment expenses from local and state resources to the Federal V.A. Health Care system for eligible veterans.

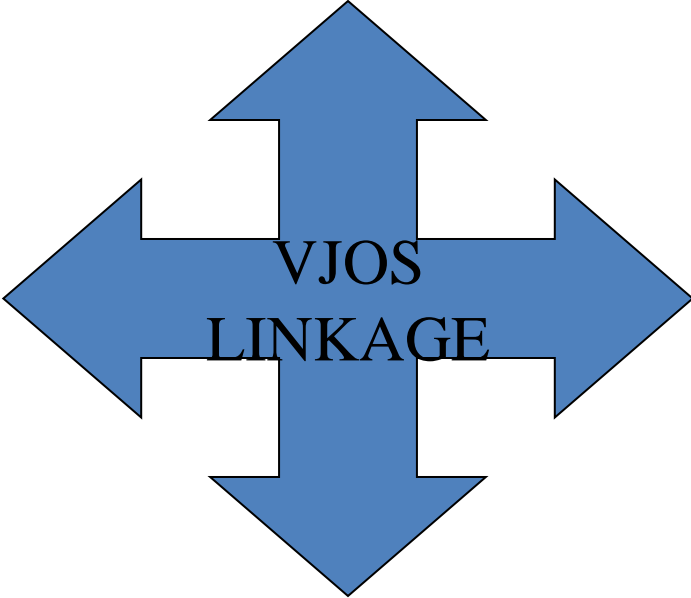
Obtain treatment that is specialized in the areas related to veterans.

Shift medical expense to the V.A. system for eligible veterans.

**COURTS/JUDGES  
LAW ENFORCEMENT  
JAILS/PAROLE**

**VA TREATMENT  
FEE BASED  
SERVICES**

**VETERANS  
HEALTH  
ADMIN**



**COMMUNITY**





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V.A. Resources:

Mentor network and peer support.

VJO Specialist

V.A. inpatient

Medical, SUD, PTSD, Mental Health, TBI programs,  
Women's specialized programs, Poly-trauma programs.

V.A. outpatient treatment resources:

Medical, SUD, PTSD, General Mental Health, Psychiatric,  
Peer Support, Homelessness, Community Training,  
OIF/OEF Coordinator, Women's Health.



# VETERANS TREATMENT COURT BENEFITS (Why should veterans be given special consideration?)

- Expedite access to Veteran-Specific resources.
- Ease burden on Community Resources
- Distinctive Process/similar people
- Promote Veteran Accountability.
- Coordinated response and judicial monitoring.



# VETERAN COURT EFFECTIVENESS

- 75% REMAIN ARREST FREE TWO YEARS AFTER LEAVING PROGRAM
- 3-14 YEARS LONG TERM OUTCOMES
  - REDUCE CRIMES BY AS MUCH AS 35% MORE THEN OTHER SENTENCING OPTIONS.



## VETERANS TREATMENT COURTS AUTHORITY

**MCL 600.1201 Veterans treatment court; compliance; characteristics; memorandum of understanding; training; participants from other jurisdiction; validity of transfer.**

Sec. 1201.

- (1) A veterans court shall comply with the modified version of the 10 key components of drug treatment courts as promulgated by the **Buffalo veterans treatment court**, which include all of the following essential characteristics:



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- (1) Integration of alcohol, drug treatment, and mental health services with justice system case processing.
- (2) Use of a non adversarial approach; prosecution and defense counsel promote public safety while protecting participants' due process rights.
- (3) Early and prompt identification and placement of eligible participants in the veterans treatment court program.
- (4) Provision of access to a continuum of alcohol, drug, mental health, and related treatment and rehabilitation services.



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- (5) Monitoring of abstinence by frequent alcohol and other drug testing.
- (6) A coordinated strategy that governs veterans treatment court responses to participants' compliance.
- (7) Ongoing judicial interaction with each veteran is essential.
- (8) Monitoring and evaluation to measure the achievement of program goals and gauge effectiveness.



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- (9) Continuing interdisciplinary education promotes effective veterans treatment court planning, implementation, and operations.
- (10) Forging of partnerships among veterans treatment court, veterans administration, public agencies, and community-based organizations generates local support and enhances veteran treatment court effectiveness.



## Sources of Funding

- State Level: Implementation: \$1,000,000 will be made available for awards to trial courts. No grant match is required. Any amount can be requested, awards are based on merit of the proposed program.
- Federal Level: Implementation: \$350,000 for 36 months (grant maximum); Enhancement of current programming: \$200,000





Courts are encouraged to apply for both Federal and State funding. Whichever application receives the higher reward, the remaining application would be rescinded



# COURT CONCEPTS AND CONFIGURATIONS

- INDIVIDUAL TRACKS
- DOCKETS
- REGIONALIZATIONS
- MOU'S

# Resources

- VA Share Point Library
  - <http://vaww.national.cmop.va.gov/MentalHealth/Veterans%20Justice%20Outreach/Forms/AllItems.aspx>
  
- VA - VJO Initiative homepage:
  - <http://www1.va.gov/homeless/page.cfm?pg=49>
  
- Veterans Justice Outreach Specialists by medical center:
  - <http://www1.va.gov/HOMELESS/VJO.asp>
  
- Health Care for Reentry Veterans Specialists:
  - <http://www1.va.gov/HOMELESS/Reentry.asp>
  - State point of contact list
  
- Some material used for this presentation were obtained from the National, White Cloud, MN VAMC and Fort Harrison, MO. V.A.M.C. JVO programs.

# Veteran's Courts Sources

- Michigan State Court Administrators Office
  - <http://courts.mi.gov/Administration/admin/Pages/Grant-Opportunities.aspx>
- Justice for Vets
  - <http://www.justiceforvets.org/>
- Michael Matwyuk, LMSW
  - [Michael.Matwyuk@va.gov](mailto:Michael.Matwyuk@va.gov)