Veterans and Criminal Justice

A REVIEW OF THE LITERATURE

INTRODUCTION

The policy analyst identified relevant studies from a computerized search of the following databases: ERIC, JSTOR, JAMA, PubMed, SOCIOFILE, the Law Library of Congress, WILEY, EBSCOHost, VioLit, VA (JRRD, NCPTSD), and the Department of Justice for articles published since 1990 which outlined a historical framework for psychological issues in veterans as well as treatment interventions for those exhibiting criminal behavior. Key words used in the search were veteran, military service, mental health, substance abuse, family violence, law enforcement, criminal justice, court, sentencing, prison, and treatment methodology. Four hundred and sixty abstracts were generated by the search and reviewed. Among them 140 articles met the criteria for the literature search and were reviewed in their entirety. Twenty-three additional articles were discovered and gleaned from the initial studies, and after full reading, 80 articles were determined not to be appropriate for the literature. In total, 83 articles are included in the following review.

Background


Mental Health and Substance Abuse

Gleaning the literature allows us to measure the magnitude of the effects of war on veterans and their families, notably rates of post traumatic stress (PTS), depression, traumatic brain injury (TBI), and substance abuse. Tanielian, Terri, et al. (2008) provided us with the first major national picture and estimated 300,000 Iraq and Afghanistan veterans are currently suffering from post traumatic stress or major depression. Institute for Operations Research and the Management Sciences (2009) noted shortly after that when factoring in delayed onset of PTS the latest research suggests rates of PTS as high as 35 percent (700,000 Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn [OIF/OEF/OND] veterans). Treatment models tell us that about half (53 percent) of Global War on Terror (GWOT) veterans who need treatment for major depression or post traumatic stress seek it, while half of those who seek treatment for mental health conditions receive “minimally adequate care” (Tanielian, Terri, et al. 2008). While jails and prisons screen for mental health, and claim that 64 percent of all jail inmates have mental health issues (James and Glaze, 2006), they do not specifically screen for PTS (McGuire and Clark, 2011). Evidence claims that incarcerated veterans can face “a level of suicide risk that exceeds that
attributable to either veteran status or incarceration alone,“ (Frisman and Griffin-Fennell, 2009; Wortzel, et al. 2009).

Literature shows that the single greatest predictive factor for the incarceration of veterans is substance abuse (Beckerman, et al. 2009; Erickson, et al. 2008). Young veterans and National Guard and Reservists in particular are at an increased risk of new-onset binge drinking and alcohol-related problems (Jacobson, et al. 2008). Substance abuse/dependence often becomes a primary means of self-medicating for underlying untreated mental health issues. The Institute of Medicine (2010) claimed, and our literature research confirmed that research on substance abuse behavior in the military is limited. They cite the difficulty in pinpointing the magnitude of substance abuse and dependence in the military because comprehensive data is lacking as the use and abuse of drugs often results in a less than honorable discharge status and these discharge statuses are omitted from many studies.

Sayer, Friedemann-Sanchez, et al. (2008) found, and the public has now taken notice that the ongoing wars in Iraq and Afghanistan have created an over-stretched armed forces experiencing multiple deployments and appear to have more complex emotional trauma than we’ve seen in past wars. Prior era veterans can also have untreated or undertreated mental health issues, and although there is less research and attention given to their mental health issues, we know many veterans have long been in and out of the justice system (Noonan and Mumola, 2007). Many prior era veterans are becoming casualties of the streets; they are overwhelmingly overrepresented in both the veteran homeless population and in prisons. For veterans who lack access to care for psychological conditions or economic support, their lives can quickly unravel into a cycle of poverty and homelessness. Many of these veterans give up on the system and take matters into their own hands—often through drug use, theft and property crimes. These veterans are engaging in illegal survival tactics which make them prone to arrest and conviction (Culhane, et al. 2011; Noonan, 2010).

Identifying Justice-Involved Veterans

But how do we know how many veterans have entered our jails and prisons? To put it simply, we don’t. Through the literature, we identified that the most recent national data on justice-involved veterans is from 2004, when the wars in Iraq and Afghanistan were just beginning to show their effects in our service members deploying to a combat theatre and coming home. With over two million personnel serving in OIF/OEF/OND, it is anticipated that the number of Iraq and Afghanistan veterans engaging with the criminal justice system has and certainly will continue to rise. Add to the current era veterans, a population of prior era veterans with untreated or undertreated issues stemming from their military service, and the numbers are around 10 percent (Noonan and Mumola, 2007).

The Bureau of Justice Statistics reports that in 2004 Iraq and Afghanistan veterans already comprised 4 percent of the total veteran population incarcerated in state and federal prison, when the war in Iraq had just recently begun. Anecdotal evidence points to an increasing trend in numbers and our literature research certainly shows this. Travis County, Texas, for example, show an average of 153 veterans arrested and booked into jail each month, comprising 5 percent of all arrests and bookings (Veterans Intervention Project, 2009). In El Paso County, Colorado, 180 veterans and 76 active duty military personnel are arrested each month, comprising 14 percent of all arrests (Equal Justice Foundation, 2011). Imagine what the national numbers could be now, with the wars in Iraq and Afghanistan approaching a decade of combat exposure, and prior era veterans going untreated for mental and cognitive health issues.
The data confirms that older veterans are overrepresented in prisons, with differences in incarceration rates among veterans and non-veterans driven heavily by age. In 2004, 65 percent of veteran males were 55 or older, compared to 17 percent of non-veteran men. The median age (45) of veterans in state prison was twelve years older than that of non-veterans (33). General demographics show veterans as typically older, better educated, and more likely to be Caucasian and formerly married than other prisoners (Noonan and Mumola, 2007).

**Diversion**

A recent movement to engage veterans with treatment over incarceration has developed as more and more evidence of criminality stemming from service-related mental or cognitive injuries is heard (Huddleston, Marlowe and Casebolt, 2008; Griffin and Munetz, 2006; National Institute of Justice, 2006; Patterson and Greifinger, 2007). PTS has seen a significant growth in forensic deliberations, and although PTS has been difficult to use in diminished capacity considerations or insanity pleas in civilian convictions (Sparr and Pitman, 2007); PTS linked to military service is increasingly being used in criminal defense.

The legislature has carved out exceptions to criminal law by treating offenders differently in similar circumstances, and in consideration of significant disadvantages or mitigating circumstances (AB 674, 111th Congress; Griffin and Munetz, 2006). Special courts are created to handle certain offenses; drug courts are one such example of similar efforts to veteran diversion. In addition, by recognizing defenses such as diminished capacity, California courts have

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**Violence**

There is enough research on both current and prior era veterans and violence to make a claim for the intersection of military service-related issues, particularly PTS, with violent criminality. Veterans that have been diagnosed with severe depression or PTS are at particularly high-risk of becoming perpetrators of domestic violence, and rates among veterans with PTS are higher than those of the general population (Marshall, et al. 2005; Sherman, et al. 2006; Tetan, Sherman and Han, 2009). One study found through the literature stated that 33 percent of veterans in their sample who had PTS had self-identified as perpetrators of domestic violence (Taft, et al. 2009). There is also a significant link between the severity of PTS and Inter-Partner Violence (IPV) severity (Finley, et al. 2010; Gerlock, 2004; Sayers, et al. 2009). Studies on prior era veterans are limited and outdated, but do explain the same correlation of PTS and domestic violence. A study of Vietnam era veterans showed that those with PTS are more likely to commit acts of domestic violence than those without PTS (Sherman, 1992). Research indicates that both departures to, and returns from operational deployment impose stresses on military families and likely increase the rate of child maltreatment. Transition phases and multiple deployments are significantly linked (Gibbs, et al. 2007; Sogomonyan and Cooper, 2010).

Rentz, et al. (2006) noted there is a lack of consistency in policies and practices between military and civilian agencies which makes comparing rates of domestic abuse among military families with non-military families a challenge. In addition to the lack of interchange between civilian and military agencies found in the literature, we also found that veterans who have committed domestic violent crimes are not given an individualized treatment plan that addresses the intersection of violence with service-related issues; but instead are given the standard 52-week Batterer Intervention Program (Healey, Smith, and O’Sullivan, 1998). We found no current legislation in the literature that addresses the need for a unique treatment plan for violent veteran offenders (in lieu of diversion models which they are excluded from) which makes note of their service history and subsequent issues.
taken notice of an offender’s particular circumstances in determining punishment. In both examples, the law has carved out alternative standards or sentencing applicable to the unique needs of at-risk groups.

The Sequential Intercept Model is broadly used by those engaging with justice-involved veterans, including the VA and veteran courts (Clark and Blue-Howells, 2010). It predicts a series of points of interception during which a treatment alternative can be delivered to prevent veterans who have committed crimes from entering or penetrating deeper into the criminal justice system. Using the model, a community can develop targeted strategies that evolve over time to increase diversion and linkage to community services (Griffin and Munetz, 2006). The various points of interception are important indicators of a community’s resources and effectiveness in responding to the treatment needs of veterans committing crimes. Depending on which intercept is chosen, the community can prevent initial involvement of veterans in the criminal justice system, decrease admissions to jail, engage individuals in treatment as soon as possible, minimize time spent moving through the criminal justice system, link individuals to community treatment upon release from incarceration, and decrease the rate of return to the criminal justice system (Clark and Blue-Howells, 2010; Griffin and Munetz, 2006; Holbrook, 2010).

Effective mental health and drug treatment intervention has been shown to decrease recidivism over the long-term. Tailored treatment approaches allow veterans to reintegrate into society, lessening reliance on state-funded healthcare, public assistance, and law enforcement (Washington State Institute for Public Policy, 2006). The literature also shows that providing veterans an alternative process is likely to save the state money. In the short-term, diversionary programs cost less because there is a reduction in the number of offenders entering prison and parole supervision programs (CA LAO, 2000). In addition, placing a veteran offender in a diversion program in place of incarceration will have a significant impact on the veteran’s status within the VA. Alternative sentencing allows veterans to continue receiving benefits and mental health/substance abuse support that they rely on and greatly need. Preventing the withdrawal of benefits as a result of incarceration allows for a smoother readjustment process after sentencing requirements are met by avoiding the complex and frustrating uphill battle of reinstating benefits through the VA (§§ 5307, 5313; § 3.665, 21.276[h]).

Over 30 states have legislative efforts in progress which would provide alternative treatment for veterans experiencing psychological trauma and/or substance abuse issues as a result of their military service (Gambill, 2010). California has PC §1170.9 for veterans convicted of crimes when a sentence would result in jail or prison time for an offense in which the veteran alleges is as a result of post traumatic stress (PTS), substance abuse, or other psychological problems stemming from service in U.S. military combat. The court, prior to sentencing, determines the merits of the allegation and refers the veteran defendant to a local, state, federal, or private non-profit treatment program for a period not to exceed that which the defendant would have served in state prison or county jail. However, as the literature suggests and our findings have confirmed, the penal code is not well-known and very little literature exists which provides information to public defenders and courts on the procedure (Tozer, 2008). Further, the court must determine that an appropriate treatment program exists (CA PC §1170.9).

To further complicate the process, the literature claims that not only do very few jurisdictions inquire about veteran status either at the point of booking or by a public defender, but many veterans may be discouraged from reporting veteran status for fear of losing federal benefits (Gambill, 2010). Although federal law states benefits will not be reduced if the veteran has been incarcerated less than 60 day, and for a non-felony conviction (39 U.S.C. Sections 1114(a), 5313(a), 1505; 38 C.F.R. Sections 3.665, 3.666), service providers
and advocates have noted that some veterans’ benefits are suspended or reduced even though they spent less than 60 days incarcerated, and even if the incarceration was not for a felony conviction (Coalition for Iraq and Afghanistan Veterans Conference, May 2010).

**Veteran Treatment Courts**

Veteran treatment courts have emerged as models for veteran diversion in the judicial system and address the need for a specialized system-of-care for veteran offenders (Russell, 2009). Currently, there are 70 courts throughout the country (McGuire and Clark, 2011) and the courts are built on an existing drug court model developed and disseminated by the National Association of Drug Court Professionals (Russell, 2009). Legal and procedural components of the court program are determined members of the local judiciary and legal community who decide a formula for the court by examining said jurisdiction’s laws and rules of procedure.

Unfortunately, legislative and regulatory rulings often restrict admission criteria to the court. Some jurisdictions currently operating veteran courts are limited by state statutes which govern their treatment court operations and limit their charge-based eligibility (Clark and Blue-Howells, 2010). In addition, many veteran courts process veterans on their docket by limiting eligibility; for instance, to only combat veterans or non-violent offenders, as a way to prioritize the procedures (Corry, 2010). Current plans for curriculum development to replicate the veterans court model throughout the country calls for providing descriptions of the target population of veteran offenders, but precludes explicit recommendations for eligibility requirements (Clubb, 2010). Therefore, eligibility determination is left up to the decisions of the individual courts and is subject to interpretation and resources (Russell, 2009). This often rules out veterans charged with violent crimes, veterans with no prior PTS diagnosis, and veterans with less than honorable discharge (Clark and Blue-Howells, 2010; Clubb, 2010; CIAV, 2010; Gambill, 2010).

Many courts only allow veterans who are eligible for VA services (Clark and Blue-Howells, 2010) to qualify as a veteran, the U.S. Department of Veterans Affairs (VA) generally requires that the veteran must have served on active duty and must have been discharged on conditions other than dishonorable. However, to qualify for most VA benefits, the veteran must have at least received a minimum discharge of general under honorable conditions. Veterans with less than honorable discharge—general, other than honorable, bad conduct or dishonorable discharge—may be barred from access to VA mental health and dental care, hospitalization and domiciliary care, G.I. Bill benefits, home loans, and disability compensation and pension (VA, 2009). To qualify as a veteran in California, the service member need not have served on active duty but must have been discharged at least as other than dishonorable. However, for most state benefits the veteran must have an honorable discharge or release from active duty under honorable conditions (California Code § 18540.4; California Military and Veterans Code, § 980-980.5). Thirty-eight percent of incarcerated veterans were given a less than honorable discharge and many are not eligible for supportive services from the VA (Noonan and Mumola, 2007). These veterans are left to be processed through the traditional court system without access to VA services and dependent on community resources post-incarceration.

Violent offenders are largely excluded from diversion models and veterans courts throughout the country. The SERV Act, proposed legislation from the 111th Congress which never became law but is assumed to be reintroduced in 112th Congress, authorizes the attorney general to make grants to states and other entities: (1) to develop, implement, or enhance veteran treatment courts or to expand operational drug courts to serve veterans; and (2) for programs that involve continuing judicial supervision over non-violent offenders with substance abuse or mental health problems who have served in the U.S. military. Unfortunately, this will rule
out veterans involved in violent crimes in all of the jurisdictions which receive funding through this proposed model; which represent at least half of veteran offenses (Noonan and Mumola, 2007). Veterans whose mental health issues may manifest into aggressiveness and impulsivity are particularly vulnerable and often left to be processed through the traditional court system (Gambill, 2010).

Very little existing literature proposes an eligibility protocol in the veteran treatment courts which will be based on the service-related mental health issue at the root of the offense rather than the category of the crime committed or the veteran’s character of service (Gambill, 2010).

**Reentry**

The literature cites most veteran treatment courts operate a post-conviction program, and completing treatment does not always result in dismissal of charges (Clark and Blue-Howells, 2010; GAINS Center, 2008). Veterans convicted of criminal offenses face punitive policies which limit their access to reentry services (Love, 2005; Legal Action Center, 2004). The collateral consequences of post-conviction treatment programs as well as traditional incarceration can be damaging and can include limitations such as disenfranchisement, restrictions on licensure and employment, restrictions on housing, denial of public benefits, disqualification for financial aid, inability to adopt or foster a child, a forfeiture of one’s assets and/or property, as well as the use of arrest data in background checks for employment, housing, and credit access (Council of State Governments, 2005). These factors can limit the veteran’s ability to become self-sufficient post-treatment or post-incarceration, and may potentially lead to cyclical homelessness and recidivism (Washington State Institute for Public Policy, 2006).

Further, the literature overwhelmingly indicates that incarcerated veterans are highly vulnerable to death by overdose after release if they do not receive effective treatment (Binswanger, et al. 2007; Farrell and Marsden, 2007; Kariminia, Azar, et al. 2007; Strang, et al. 2003; Seaman, et al. 1998). Literature shows that veterans entering the community who are not receiving veteran-specific reentry services are part of the pool of overall parolees, 80 percent of whom do not receive adequate substance abuse, mental health, medical illness, family dysfunction, or domestic violence services (Taxman, et al. 2007).

Research cites up to 56,000 veterans are released from state and federal prisons each year, and at least 90,000 veterans are released each year from city and county jails (Noonan, 2010). There are 71 Health Care for Re-entry Veterans Services (HCRV) specialists nationally assigned to 146,000 veterans (Veterans Health Administration, 2010), which is a colossal caseload. VA
statistics show that as of June 2010, only 16,000 reentry veterans had been contacted and 32 percent of state and federal correctional facilities had not been contacted by the HCRV Program (Clark, 2010). Moreover, current VA policy does not allow the Veteran Justice Outreach (VJO) and HCRV specialists to provide outpatient care for veterans who are inmates in an institution of another government agency, if that agency has a duty to give that care or services (38 C.F.R. § 17.38). The HCRV specialist's rehabilitative care is limited to outreach, psychosocial assessment and no case management until post-release (Veterans Health Administration, 2010).

In California, prior offenders who violate parole or commit new low-level offenses are placed on a “parole hold” and must file procedural paperwork full of a rigid sets of rules. Often offenders will waive their rights to a formal hearing and will return to prison (California Department of Corrections and Rehabilitation, 2007; Manley, 2009). Overall, 70 percent of parolees in California return to prison within one year, and California recidivism is higher than other states (Lin and Jannetta, 2006; Little Hoover Commission, 2007). No research was found that specifically shows veteran recidivism rates.

The literature states that efforts to address veterans and criminality must be collaborative and must occur throughout the entry, court, incarceration, and reentry process (GAINS, 2008; Manley, 2009; Petersilia, 2006). However, treatment providers are often not educated in cultural competency of veterans and their unique issues. There is also very little literature which provides a practical framework for educating providers in veteran cultural competency, including mental health, traumatic brain injury, substance abuse, domestic violence, and criminality (Combat to Community, 2011; Savitsky, Illingworth, and Dulaney, 2009; Sayer et al. 2009). The Honorable Judge Manley, presiding judge over the Santa Clara County Veteran Treatment Court, cites that responsibility for supervising offenders through the incarceration and reentry process is fragmented and states that there is a lack of continuity in treatment and supervision of offenders (Manley, 2009). When there is no cohesion or assessment plan for the offender, those left without close monitoring or support are often in non-compliance with treatment, with 75 percent of probationers and parolees dropping out of treatment prematurely or attending treatment irregularly (Marlow, 2002). Taxman (2008) found that evidence-based community corrections based on cognitive behavioral and social learning principles significantly lowered recidivism rates of participants in her study. Petersilia (2006) states that California should follow models from other states with interagency collaborative efforts. States such as Michigan, Missouri and Indiana are recognized as models with a multiple level interagency collaboration in at least three phases: institutional, re-entry and community.

Conclusion

Overall, the literature provides us with a framework for addressing the complex needs of justice-involved veterans. It is overwhelmingly clear that a collaborative framework is needed at all levels to ensure the well-being and adjustment of the veteran from criminal to member of the community, and that federal systems need help and input from the community level. Veteran cultural competency, knowledge of diversion programs and treatment protocol, and overall understanding is needed in order for criminal justice professionals and providers to properly engage veterans. Legislative and regulatory change is also needed in order to address the unique and complex rehabilitative needs of veterans.
REFERENCE LIST

38 C.F.R. § 17.38 Medical Benefits Package. Title 38—Pensions, Bonuses, and Veterans’ Relief.

39 U.S.C. Sections 1114(a), 5313(a), 1505; 38 C.F.R. Sections 3.665, 3.666.

Assembly Bill Committee Analysis, for AB 674. Assembly Committee on Public Safety. leginfo.ca.gov/pub/09-10/bill/asm/ab_0651_700/ab_674_cfa_20090420_114153_asm_comm.html.


CA Penal Code §1170.9.

California Penal Code § 18540.4. Also see: California Military and Veterans Code § 980-980.5 for limitations on benefits due to discharge status.


Lin, PhD, Jeffrey and Jesse Janeteta, MPP. The Scope of Correctional Control in California. UC Irvine Center for Evidence-Based Corrections. September 2006.


Services, Education, and Rehabilitation for Veterans Act, HR 7149, 110th Congress. § 1 [2008]; S. 3379, 110th Congress. § 2 (2008). (These Bills, with modifications, were reintroduced in Congress in April 2009 and are now identified as HR 2138, 111th Congress. § 1 [2009]; S 902, 111th Congress. § 1 [2009]). thomas.loc.gov/cgi


Title 38 United States Code §§ 5307, 5313; Title 38 Code of Federal Regulations § 3.665, 21.276(h).


Usher, Laura. CIT and Veterans: A natural partnership. nami.org/Template.cfm?Section=CIT&Template=/ContentManagement/ContentDisplay.cfm&ContentID=83094.

