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History & Approach to the Liminality of Combat Trauma**

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Chapter 12

Veterans' Courts and Criminal Responsibility:

A Problem Solving History & Approach to the Liminality of Combat Trauma

Justin Holbrook¹

Society felt no responsibility for the young men who filled the prisons before the [Civil War]. But when the prisoners of after-war days were the young 'veterans' of those grand armies of the Republic to whom a nation's gratitude was due, there was a genuine desire to get them out if possible

Edith Abbott, The Civil War and the Crime Wave of 1865-1870²

In January 2010, Britten Walker was arrested after assaulting a federal police officer and a doctor at the Department of Veterans Affairs (VA) Medical Facility in Buffalo, New York. A 32-year old veteran who had served three combat tours in Iraq and Afghanistan, Walker committed the assaults after threatening to kill a VA worker, bomb several television stations, and bomb cars on the New York State Thruway. "The VA is totally unequipped to handle all the soldiers who are coming back from Iraq and Afghanistan and need help," Walker angrily told reporters when he first appeared in court on federal charges stemming from the assault and threats. "This has been devastating on me and my family. . . . I'm sick of America right now."³ According to Walker's family, the young veteran had no intention of hurting anyone when he boiled over at the VA. "He suffers from [post-traumatic stress disorder], and he needs help," Walker's twin brother told

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² Edith Abbot, *The Civil War and the Crime Wave of 1865-1870*, SOC. SERV. REV., June 1927, at 233.

³ Dan Herbeck, *Arrest Raises Questions on Care at VA; Inadequate Counseling Blamed for Assaults*, BUFF. NEWS, Feb. 21, 2010, at B1, available at <http://bit.ly/bwEmgz>.

reporters. “For some reason, he hasn’t been able to make a connection with the counselors at the VA in Buffalo.”⁴

Facing federal felony charges, Walker’s case was assigned to U.S. Magistrate Judge Jeremiah McCarthy. Instead of immediately scheduling the case for trial, Judge McCarthy took the unusual step of appointing a psychiatrist to evaluate Walker for combat-related trauma.⁵ After reading the psychiatrist’s report, the judge released Walker from jail to attend a 30 day treatment program for veterans suffering from post-traumatic stress disorder (PTSD).⁶ Once Walker successfully completed the program, the judge turned Walker over to family members on the condition that he attend an outpatient mental health program until the conclusion of his case.⁷ “I’m sure you’re not going to let yourself or them down, is that correct?”⁸ McCarthy asked Walker. “That is correct, your honor,” Walker politely answered.⁹

Five months later, Walker’s case became the first of its kind in the country to be transferred from federal court to a local veteran’s treatment court for final adjudication. After carefully orchestrating the arrangement between the U.S. Attorney’s Office, the U.S. Office of Probation & Pretrial Services, the local veterans court, Walker’s defense attorney, and veterans advocates, Judge McCarthy dismissed Walker’s case without prejudice to allow it to be heard by the

⁴ *Id.*

⁵ Dan Herbeck, *Veteran to Undergo Psychiatric Evaluation; Judge Won’t Rule Until After Treatment*, BUFF. NEWS, Mar. 12, 2010, at B1, available at <http://bit.ly/dtaztg>.

⁶ *Id.*

⁷ Dan Herbeck, *Veteran Held in Assault at VA Wins Approval to Rejoin Family*, BUFF. NEWS, Apr. 18, 2010, at C8, available at <http://bit.ly/cSJ1B2>.

⁸ *Id.*

⁹ *Id.*

Buffalo Veterans Treatment Court, a division of Buffalo City Court.¹⁰ The focus of everyone involved, Walker’s defense attorney said, was to help the veteran receive the psychiatric counseling he needed.¹¹ The prosecuting attorney agreed, telling reporters, “We are seeking a better way to provide justice to those veterans who, despite the sacrifices they made for our country, sadly find that they have brought the war home with them.”¹²

For those involved in veterans’ advocacy and treatment, Walker’s case is significant for a number of reasons. First, his is the first criminal case nationwide to be transferred from federal court to a local veterans treatment court where the goal is to treat—rather than simply punish—those facing the liminal effects of military combat. Walker’s case may be seen as a key performance indicator of the broadening acceptance of veterans’ courts and the success with which they are viewed. Second, the case reignites the still unsettled controversy over whether problem-solving courts generally, and veterans courts specifically, unfairly shift the focus of justice away from the retributive interests of victims to the rehabilitative interests of perpetrators. One can imagine, for example, the victims whom Walker threatened objecting to dismissal of his case without a finding of guilty and imposition of an appropriate sentence. Third, Walker’s case serves as a signal reminder to all justice system stakeholders, including parties, judges, attorneys, and treatment professionals, of the potential benefits of sidestepping courtroom adversity in favor of a coordinated effort that seeks to ameliorate victim concerns while advancing treatment opportunities for veterans suffering from combat-related trauma.

¹⁰ Dan Herbeck, *Veteran Gets 2nd Chance from a Court with a Heart*, BUFF. NEWS, Sept. 14, 2010, at B1, available at <http://bit.ly/dve3vq>.

¹¹ *Id.*

¹² *Id.*

This chapter explores these issues in light of the development of veterans' treatment courts around the country. As a backdrop, attention is first given to the history of combat-related trauma as a medical and psychological condition requiring specialized diagnosis. The chapter then reviews combat-related trauma within the social context of criminal responsibility, exploring caselaw from the years following World War I through the Supreme Court's 2009 decision in *Porter v. McCollum*.¹³ The recent initiative to create specialized problem-solving courts for veterans is then discussed, as well as the tenet methodologies employed by most veterans courts. Drawing lessons from the long history of combat-related trauma in the United States, the chapter concludes by advocating for increased trial court use of treatment methodologies designed to assist traumatized veterans facing criminal prosecution.

COMBAT TRAUMA AND THE LIMINAL EFFECTS OF WAR: A HISTORY

Though known by various names, accounts of combat trauma extend into the mists of mythology, literature, and history.¹⁴ In Homer's *Odyssey*, Odysseus returns home from the Trojan wars to find himself in a country he does not recognize. Confused, he asks the goddess Athene, "What land is this, what neighborhood is it, what people live here?"¹⁵ In Shakespeare's *Henry IV*, Lady Percy worries over her husband's "thick-eyed musings and cursed melancholy" after he returns home from a bloody battle. "In thy faint slumbers I by thee have watch'd," she tells him, "and heard thee murmur tales of iron wars[.]"¹⁶ Psychologists reviewing historical

¹³ *Porter v. McCollum*, 558 U.S. ___, 130 S. Ct. 447 (2009) (per curiam).

¹⁴ See generally DARYL S. PAULSON & STANLEY KRIPPNER, HAUNTED BY COMBAT: UNDERSTANDING PTSD IN WAR VETERANS INCLUDING WOMEN, RESERVISTS, AND THOSE COMING BACK FROM IRAQ 8 (2007).

¹⁵ Note, *Post-Traumatic Stress Disorder—Opening Pandora's Box?*, 17 NEW ENG. L. REV. 91, 92 n. 6 (1982) [hereinafter *Pandora's Box*] (quoting R. LATTIMORE, THE ODYSSEY OF HOMER ¶ 230, at 204 (1965)). For a comparison of the psychological wounds inflicted on soldiers of the Trojan wars and Vietnam war, see generally JONATHAN SHAY, ACHILLES IN VIETNAM: COMBAT TRAUMA AND THE UNDOING OF CHARACTER (1994).

¹⁶ WILLIAM SHAKESPEARE, THE FIRST PART OF KING HENRY THE FOURTH act 2 sc. 3. See also SHAY, *supra* note 15, at 165-66 (reviewing the text of Shakespeare's *Henry IV* in light of PTSD symptomatology).

records have discovered PTSD-like symptoms in such historical figures as Alexander the Great (356-323 BC), Captain James Cook (1728-1779), and Florence Nightingale (1820-1910), each of whom was exposed to combat or death.¹⁷

In the modern era, serious inquiry into the relationship between post-combat behavior and combat trauma began in the late eighteenth century when Dr. Benjamin Rush, widely considered to be the father of American psychiatry, observed in 1786 that soldiers of the Revolutionary War “who enjoyed health during a campaign, were often seized with fevers upon return to the *Vita Mollis* at their respective homes.”¹⁸ Civil War-era physicians made similar observations, diagnosing what today arguably would be considered PTSD as “nostalgia” or “soldier’s heart” in a statistically significant number of cases.¹⁹ For example, during the first year of the civil war, doctors reported 5,213 cases of “nostalgia,” a rate of 2.34 cases per 1,000 soldiers.²⁰ During the second year of the war, the rate rose to 3.3 per 1,000.²¹ In the years after the Civil War’s conclusion, Dr. James Mendes DaCosta studied a group of veterans who presented as physically sound but nevertheless “complained of palpitations, increased pain in the cardiac region, tachycardia, cardiac uneasiness, headache, dimness of vision, and giddiness.”²² Describing the condition as a “disturbance of the sympathetic nervous system,” Dr. DaCosta labeled it “irritable

¹⁷ Philip A. Mackowiak & Sonja V. Batten, *Post-Traumatic Stress Reactions before the Advent of Post-Traumatic Stress Disorder*, MIL. MED., Dec. 2008, at 1158.

¹⁸ *Id.* (quoting Benjamin Rush, *Results of Observations*, 7 LONDON MED. J. 77, 99 (1786)).

¹⁹ See Louis F. Bishop, Jr., *Soldier’s Heart*, AM. J. OF NURSING, Apr. 1942, at 377-380 (describing “soldier’s heart” as a cardiac neurosis that “is more than fear—it is an emotional state linked with fear”); Joel D. Howell, *Soldier’s Heart: The Redefinition of Heart Disease and Specialty Formation in Early Twentieth-Century Great Britain*, MED. HIST., Supp. 5, 1985, available at <http://bit.ly/9twLJC>; PAULSON & KRIPPNER, *supra* note 14, at 9; *Pandora’s Box*, *supra* note 15, at 92-93. For in-depth treatment of combat trauma and the Civil War, see ERIC T. DEAN, JR., SHOOK OVER HELL: POST-TRAUMATIC STRESS, VIETNAM, AND THE CIVIL WAR (1997).

²⁰ Michael J. Davidson, *Post-Traumatic Stress Disorder: A Controversial Defense for Veterans of a Controversial War*, 29 WM. & MARY L. REV. 415, 418 n. 21 (1988) (citing P. BOURNE, MEN STRESS AND VIETNAM 9-10 (1970)).

²¹ *Id.*

²² C.B. SCRIGNAR, POST-TRAUMATIC STRESS DISORDER: DIAGNOSIS, TREATMENT, AND LEGAL ISSUES 2 (1984). See also John Talbott, *Combat Trauma in the Civil War*, HIST. TODAY, Mar. 1996, at 41 (providing numerous anecdotal accounts of combat trauma among Civil War soldiers).

heart,” a term later used interchangeably with the eponymous diagnosis “DaCosta syndrome.”²³

At the same time, European physicians were observing similar symptoms—called “Swiss disease”—among Swiss soldiers who had experienced combat conditions in Europe.²⁴

From Soldier’s Heart to Shell Shock

By World War I, doctors had begun drawing distinct connections between combat activity and post-combat behavior, though medical investigation remained largely focused on physiological symptoms. British physicians speculated that “muscular exertion” was the primary cause of “soldier’s heart,” and the cohort of conditions linked to “soldier’s heart” and “DaCosta syndrome” began to be called “effort syndrome” in the popular literature.²⁵ Others, noting both the psychological and physiological elements of the condition, labeled it “neurocirculatory asthenia.”²⁶ The genesis of the condition remained indeterminate, however, with one commentator admitting as late as 1942 that “it is generally agreed that the cause of soldier’s heart is obscure.”²⁷

Simultaneous with these developments, which primarily focused on physiological etiology, another branch of trauma-related inquiry arose as a result of the concussive explosions experienced by soldiers during World War I.²⁸ Experts initially believed the “shell shock” exhibited by such soldiers resulted from small cerebral hemorrhages.²⁹ As evidence, doctors

²³ SCRIGNAR, *supra* note 22, at 2.

²⁴ PAULSON & KRIPPNER, *supra* note 14, at 9

²⁵ See SCRIGNAR, *supra* note 22, at 2; Bishop, *supra* note 19, at 377.

²⁶ See SCRIGNAR, *supra* note 22, at 2-3; Bishop, *supra* note 19, at 377; Howell, *supra* note 19, at 43.

²⁷ Bishop, *supra* note 19, at 377.

²⁸ Perhaps the most thorough treatment of “shell shock” and psychiatry during World War I is BEN SHEPHARD, *A WAR OF NERVES* (2000).

²⁹ See Howell, *supra* note 19, at 43; *Pandora's Box*, *supra* note 15, at 93 n. 11.

pointed to the presence of blood in the spinal fluid of some patients.³⁰ Opinions changed, however, when soldiers who had not been exposed to concussive airblasts presented with similar symptoms, and doctors ascribed a psychopathological cause rooted in identifiable personality predispositions.³¹ Both “soldier’s heart” and “shell shock” were “marked by breathlessness and nervous instability, were less common in men previously accustomed to active, outdoor work, and regularly called into question the possibility of malingering.”³² Even in light of these similar symptoms, the conditions remained diagnostically unique, as did the manner in which the diagnoses were received.³³ Perhaps because of the negative bias then existent toward psychology generally, diagnoses of “shell shock”—or “combat neurosis” as it also was called—were “often equated with malingering or cowardice,” while diagnoses of “soldier’s heart” received more sympathetic consideration due to their supposed physiological connection.³⁴ As with the Civil War, cases of “shell shock” among soldiers were significant. By 1916, an estimated 40 percent of British casualties were related to “shell shock,” with some 80,000 British

³⁰ See *id.*; DEAN, *supra* note 19, at 30. See also *Sorenson v. State*, 188 N.W. 622, 624 (Wis. 1922) (doctor testified “he has found as a result of shell shock and other nervous and mental disturbances originating in battle, actual changes in the central nervous system produced by continuous proximity to shock and concussion caused by heavy artillery, in some cases actually causing more or less permanent derangement of the central nervous system”).

³¹ See *Pandora's Box*, *supra* note 15, at 94. See also SHEPHARD, *supra* note 28, at 31 (observing by 1916 clinicians had concluded “shell shock” may be caused by “an emotional disturbance or mental strain”); Harold Merskey and August Piper, *Posttraumatic Stress Disorder is Overloaded*, CAN. J. OF PSYCHIATRY, Aug. 2008, at 499 (discussing the evolution of combat trauma diagnosis from shell shock to combat neuroses to PTSD); C. Peter Erlinder, *Paying the Price for Vietnam: Post-Traumatic Stress Disorder and Criminal Behavior*, 25 B.C. L. REV. 305, 313-14 (1984).

³² Howell, *supra* note 19, at 43

³³ See *id.*

³⁴ *Id.* See also DEAN, *supra* note 19, at 31 (“Attitudes toward the psychiatric casualties of the war varied widely over time; initially, many disoriented men at the front were treated as deserters and shot[.]”); Talbott, *supra* note 22, at 41 (“[M]en whom medical officers might have diagnosed for combat trauma in 1916, 1944, or 1968 were hauled before courts martial in 1864, and some of them probably wound up at the end of a noose or in front of a firing squad.”).

soldiers treated by the British Army Medical Service for the condition and nearly 200,000 soldiers discharged.³⁵

Despite the experience of World War I, by the onset of World War II neither medical practitioners nor military authorities had definitively linked the trauma of combat with the post-combat behaviors observed in veterans. Rather, experts remained convinced that “shell shock” and “soldier’s heart” stemmed from personality traits exacerbated by exposure to combat rather than combat itself.³⁶ Hoping to screen out enlistees exhibiting such traits, U.S. military authorities rejected 1.6 million of 20 million draftees during World War II for psychological reasons, a rejection rate 7.6 times that of World War I.³⁷ Similarly, soldiers who made it through the screening process but suffered from post-combat trauma were discharged at a rate five times that of World War I.³⁸

As the number of discharges exceeded the number of enlistees, the military revised its policy and, by 1943, attempted to treat men suffering from such “combat exhaustion” with rest, food, and sleep rather than discharge.³⁹ The goal was to return fatigued soldiers to the battlefield as quickly as possible.⁴⁰ Notably, the number of casualties reportedly associated with combat

³⁵ DEAN, *supra* note 19, at 30-31. Similar efforts to screen out “feeble-minded” and “neurotic” enlistees had been made toward the latter part of World War I. See SHEPHARD, *supra* note 28, at 126.

³⁶ DEAN, *supra* note 19, at 35.

³⁷ *Id.* See also *Pandora's Box*, *supra* note 15, at 95.

³⁸ DEAN, *supra* note 19, at 35.

³⁹ See *id.*; Erlinder, *supra* note 31, at 314.

⁴⁰ The “forward psychiatry” treatment methodologies employed on large scale by the U.S. Army in World War II, which brought psychiatrists to the front to treat soldiers immediately rather than return them rear asylums, had been pioneered in World War I by Dr. Tom Salmon. See SHEPHARD, *supra* note 28, at 125-32.

trauma escalated during World War II.⁴¹ In 1944, the rate of soldiers admitted to overseas hospitals for psychological conditions was 47 per 1000. Other estimates place the overall incident rate of psychological casualties at nearly 114 per 1000.⁴²

By the time of the Korean conflict, medical and military authorities had established a set of treatment protocols for “combat exhaustion” requiring temporary hospitalization with eventual return to combat conditions.⁴³ Under the Army’s diagnostic criteria, “combat exhaustion” was a type of “transient personality reaction” defined as an “acute psychiatric casual[t]y of combat.”⁴⁴ Investigators in the war zone undertook an intense study of the psychological and physiological effects of combat, and combat tours were shortened from the duration of the entire war (as had been the case in World War II) to a fixed term of nine months.⁴⁵ As a result of these measures, the incident rate of casualties attributed to psychological trauma dropped to 37 per 1000.⁴⁶

Although PTSD entered the popular lexicon in connection with the post-war experiences of Vietnam veterans, the wartime incident rates of psychological casualties during the Vietnam conflict were actually lower than prior conflicts involving U.S. soldiers.⁴⁷ One author places the incident rate at 12 per 1000, a significant reduction from both the Korean conflict and World War II.⁴⁸ Soldiers reportedly benefited from fixed duty tours of one year, frequent rest and relaxation opportunities, and “the application of modern military psychiatry” in the theater of

⁴¹ For a detailed review of the possible explanations for the increase in psychiatric casualties in World War II, see *Pandora's Box*, *supra* note 15, at 95 n. 25. Also, at least one expert has “concluded that over ninety percent of chronic war neuroses were both undiagnosed and untreated during World War I.” *Id.* at 94.

⁴² *Id.* at 95 n. 25, 97 n. 30.

⁴³ *Id.* at 97.

⁴⁴ *Id.* at 95 n. 25 (quoting War Dep’t Technical Medical Bulletin (TB MED) 203, issued Oct. 19 1945).

⁴⁵ *Id.* at 97-98.

⁴⁶ *Pandora's Box*, *supra* note 15, at 97 n. 30.

⁴⁷ *See id.* at 98.

⁴⁸ *See id.* *See also* DEAN, *supra* note 19, at 40

war.⁴⁹ Some commentators argue, however, that despite these advances, soldiers serving in Vietnam faced aggravating stressors distinct from those faced by earlier veterans.

Vietnam-era soldiers on average were 19.2 years old, compared to 26 years old in World War II.⁵⁰ Soldiers traveling to and from Vietnam traveled individually rather than as a unit, often arriving and departing on commercial aircraft.⁵¹ Some even returned home on the same day they departed the battlefield.⁵² Further, the war's shifting political and military objectives led to uncertainty and disillusionment among soldiers,⁵³ feelings exacerbated by a U.S. populace that was ambivalent at best and hostile at worst to the entire war effort.⁵⁴ With the benefit of historical hindsight, such aggravating factors caution against drawing a firm correlation between the incident rates of wartime psychological casualties and post-war episodes of combat-related trauma—a lesson to be remembered when calculating the potential psychological impact of the Iraq and Afghanistan wars on today's returning soldiers.⁵⁵

Post-Combat Behavior and PTSD

For purposes of this chapter, the critical question is whether and to what extent combat-related trauma suffered by wartime veterans lingers once they returned home from combat and reintegrated into society. Both anecdotal accounts and historical data are revealing. Jason Roberts, a Union soldier who had been a prisoner in Southern prisons during the Civil War,

⁴⁹ See *Pandora's Box*, *supra* note 15, at 98; DEAN, *supra* note 19, at 40. As a result of these advances, a leading psychiatrist concluded at the time, “[T]here is reason to be optimistic that psychiatric casualties need never again become a major cause of attrition in the United States military in a combat zone.” *Id.*

⁵⁰ Davidson, *supra* note 20, at 416 n. 11.

⁵¹ See *id.*; DEAN, *supra* note 19, at 41; Dennis McLellan, *PTSD-Shellshock Hit Vietnam Vets Hardest: 20 Years After the Fall*, L.A. TIMES, Apr. 27, 1995, at 4, available at <http://lat.ms/aEs0YL>.

⁵² See *Pandora's Box*, *supra* note 15, at 99.

⁵³ See Davidson, *supra* note 20, at 417.

⁵⁴ See *Pandora's Box*, *supra* note 15, at 99; DEAN, *supra* note 19, at 41.

⁵⁵ See *Pandora's Box*, *supra* note 15, at 99; DEAN, *supra* note 19, at 41.

returned home to his wife and children on a stretcher exhibiting “peculiar actions,” “curious” talk, and threatening behaviors.⁵⁶ “I kept him a little afraid of me, by threatening him with punishment,” his wife said. “He got so that he did not mind me, & I saw that he watched me very closely. He had a wild angry look in his eyes and I got afraid of him at last.” She eventually applied to have him committed for “chronic mania.”⁵⁷ In England, using language not altogether dissimilar from that used to describe today’s veterans, an article in the *London Times* from March 1, 1920 documented the haunting post-war experience of World War I veterans when they returned home:

*Of the many problems calling for solutions, one of the most urgent is that of the man disabled in the war or suffering from shell-shock or neurasthenia. There exists a great army of men suffering from varying degrees of mental instability, and in the ordinary labour market, and particularly in the employment bureaux, such men are at a serious disadvantage. Employers have come to look askance at them.*⁵⁸

Aside from these brief anecdotes, historical data support the conclusion that veterans of prior wars also suffered from both acute and delayed onset of PTSD.⁵⁹ In the United States in 1921, the number of U.S. veterans receiving care for psychiatric disorders was 7,499.⁶⁰ By 1931, the number had increased to 11,342.⁶¹ Similarly, from 1923 to 1932, benefits paid to World War I

⁵⁶ *Id.* at 84.

⁵⁷ *Id.* at 85.

⁵⁸ *Id.* at 39.

⁵⁹ *Id.* at 70.

⁶⁰ DEAN, *supra* note 19, at 39.

⁶¹ *Id.*

veterans for psychiatric disorders jumped from \$23,256 to \$67,916.⁶² Veterans of World War II exhibited similar post-war responses to combat stress. A cohort of veterans followed by researches for twenty years displayed “persistent symptoms of tension, irritability, depression, diffuse anxiety symptoms, headaches, insomnia, and nightmares.”⁶³ Labeling the condition “veteran’s chronic stress syndrome,” researchers concluded: “These particular veterans cannot blot out their painful memories.”⁶⁴ Significantly, one researcher observed in 1945 that “[the] majority of psychiatric admissions among returnees are not men who have returned with war neuroses, but those who develop signs of illness after completing a full term of duty.”⁶⁵

Like veterans before them, veterans of the Vietnam conflict also suffered from the trauma of war after returning home. Estimates in the 1980’s placed the number of Vietnam veterans with PTSD between 500,000 to 1,500,000.⁶⁶ Those with significant combat experience had incident rates of suicide, substance abuse, marriage problems, and unemployment higher than those of the general population.⁶⁷ Because psychiatrists and psychologists viewed Vietnam veterans’ combat and reintegration experiences as unique, however, they adopted new terminology to describe returning veterans’ symptomatology—“Vietnam Syndrome,” “Post-Vietnam Syndrome (PVS),” “Vietnam-Veteran Syndrome,” “Re-Entry Syndrome,” or “Post-Viet Nam Psychiatric Syndrome (PVNPS)” were all employed in the literature of the day.⁶⁸

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ DEAN, *supra* note 19, at 39.

⁶⁶ Erlinder, *supra* note 31, at 305.

⁶⁷ *Id.* at 311.

⁶⁸ DEAN, *supra* note 19, at 42.

Too often these labels were reinforced by negative media images of angry, distrustful veterans returning home to an unwelcoming public, scenes far different than the idealized cheery parades and welcoming banners heralding the return of veterans of earlier conflicts. While some commentators have recently disputed the uniqueness of the Vietnam combat experience, arguing that veterans of earlier conflicts similarly suffered from dislocation, unemployment, family disintegration, and recurring trauma after returning from war,⁶⁹ the portrayal of troubled Vietnam veterans during the 1970's generated the sympathy needed in both political and medical circles for the advancement of combat trauma as a subject of serious psychological study and treatment.

Accordingly, in 1980, the American Psychological Association (APA) included post-traumatic stress disorder (PTSD) in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), the major diagnostic manual used by clinicians in treating mental disorders.⁷⁰ Earlier editions of the DSM had categorized combat trauma as “gross stress reaction” or “adjustment reactions of adult life,” diagnoses which failed to articulate a description of trauma-induced symptoms sufficient to either diagnose or treat veterans.⁷¹ In DSM-III, PTSD was characterized by the development of specific symptoms—including diminished responsiveness, hyperalertness, exaggerated startle response, insomnia, recurrent nightmares, aggressive behavior, depression, and anxiety—exhibited after a “psychologically

⁶⁹ For a comparison of the psychological casualties in Vietnam to those of the Civil War, see DEAN, *supra* note 19, at 181-209.

⁷⁰ AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (3rd ed. 1980) [hereinafter DSM-III]. See also Thomas L. Hafermeister & Nicole A. Stockey, *Last Stand? The Criminal Responsibility of War Veterans Returning from Iraq and Afghanistan with Posttraumatic Stress Disorder*, 85 IND. L.J. 87, 94 (2010).

⁷¹ Davidson, *supra* note 20, at 419-20. See also Erlinder, *supra* note 31, at 315. One of the shortfalls of “gross stress reaction” was that it assumed combat trauma was situational and “would abate with a reduction in exposure to the stressor.” *Id.* at 315.

traumatic event that is generally outside the range of usual human experience.”⁷² Both acute and delayed PTSD were recognized, and combat veterans were specifically referenced in the diagnostic description.⁷³ The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) modified the diagnostic criteria, but remained focused on symptoms resulting from traumatic events, including “military combat.”⁷⁴

COMBAT TRAUMA AND THE PROBLEM OF CRIMINAL RESPONSIBILITY

In an April 2008 study titled “Invisible Wounds of War,” the RAND Corporation approximated that 300,000, or nearly 20 percent, of the 1.64 million veterans who have served in Iraq and Afghanistan since 2001 suffer from PTSD.⁷⁵ These figures generally accord with a 2004 study which found that 15.6 to 17.1 percent of veterans of Iraq met the screening criteria for major depression, generalized anxiety, or PTSD.⁷⁶ Incident rates of PTSD were directly tied to the number of combat experiences, from a rate of 9.3 percent for soldiers involved in one or two firefights to 19.3 percent for those involved in five or more firefights.⁷⁷ More recently, the Department of Veterans Affairs (VA) disclosed that 44 percent of Iraq and Afghanistan war veterans seeking treatment at VA medical facilities had been diagnosed with mental health

⁷² DSM-III, *supra* note 70, at 236.

⁷³ *Id.*

⁷⁴ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 463-64 (4th ed. 2000) [hereinafter DSM-IV-TR].

⁷⁵ RAND CTR. FOR MILITARY HEALTH POLICY RESEARCH, INVISIBLE WOUNDS OF WAR: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY iii (Terri Tanielian & Lisa H. Jaycox eds., 2008) [hereinafter Rand Report]. See also Anthony E. Giardino, *Combat Veterans, Mental Health Issues, and the Death Penalty*, 77 FORDHAM L. REV. 2955, 2958. For a discussion of the possible over-diagnosis of PTSD, see Merskey and Piper, *supra* note 31, at 499. See also Hafermeister & Stockey, *supra* note 70, at 90 n. 12 (same). This chapter does not discuss Traumatic Brain Injury (TBI), a physiological injury estimated to have occurred in 300,000 combat veterans returning from Iraq and Afghanistan. See Giardino at 2598. Veterans suffering from TBI who commit criminal acts, however, also require sympathetic consideration and a problem-solving approach to rehabilitation. Accordingly, arguments supporting specialized courts for veterans with PTSD may be extended to veterans with TBI.

⁷⁶ Charles W. Hoge, et al, *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 NEW ENG. J. MED. 1, 13 (2004).

⁷⁷ *Id.* at 13.

disorders, with 23 percent diagnosed with possible PTSD.⁷⁸ In 2009, the National Center for PTSD published a bibliography of studies in which it found an overall PTSD rate of 10 to 18 percent for combat troops serving in Iraq and Afghanistan.⁷⁹

PTSD and Criminal Behavior

The relevance of PTSD rates for justice system stakeholders lies in their correlation to risk factors which, themselves, are routinely linked to incidents of criminal activity. Surveys from the 1980's suggested a measurable link between PTSD and criminal behavior in Vietnam-era veterans,⁸⁰ with one study finding a heightened disposition toward violent crimes in incarcerated Vietnam veterans compared to incarcerated non-veterans⁸¹ and another finding a relationship between PTSD and “self-reported aggression, hostility, and anger[.]”⁸² Researchers elsewhere estimated that 25 percent of veterans who experienced heavy combat had been charged with committing a criminal offense since returning home.⁸³ Perhaps the most comprehensive assessment comes from the National Vietnam Veterans Readjustment Study, which determined the rate of violent acts in Vietnam veterans with PTSD to be nearly four times that of veterans without PTSD.⁸⁴ Study results further showed nearly half (45.7 percent) of veterans suffering

⁷⁸ William H. McMichael, *VA Diagnosing Higher Rates of PTSD*, MARINE CORPS TIMES, Jan. 18, 2009, available at <http://bit.ly/cA8Qj5>.

⁷⁹ Brett T. Litz and William E. Schlenger, *PTSD in Service Members and New Veterans of the Iraq and Afghanistan Wars: A Bibliography and Critique*, PTSD RESEARCH QUARTERLY, Winter 2009, at 1-3. By contrast, historical studies on Vietnam veterans following conclusion of the conflict indicate PTSD rates of 30 percent. See Hafermeister & Stockey, *supra* note 70, at 100.

⁸⁰ *See id.* at 101; Elizabeth J. Delgado, *Vietnam Stress Syndrome and the Criminal Defendant*, 19 LOY. L.A. L. REV. 473, 478-82 (1985); John P. Wilson & Sheldon D. Zigelbaum, *The Vietnam Veteran on Trial: The Relation of Post-Traumatic Stress Disorder to Criminal Behavior*, 1 BEHAV. SCI. & L. 69 (1983).

⁸¹ Bruce Pentland & James Dwyer, *Incarcerated Viet Nam Veterans*, in THE TRAUMA OF WAR: STRESS AND RECOVERY IN VIET NAM VETERANS 406 (1985).

⁸² Lynne Peralme, *Predictors of Post-Combat Violent Behavior in Vietnam Veterans* 13 (1995) (unpublished Ph.D. Dissertation, The Florida State University College of Arts and Sciences).

⁸³ Erlinder, *supra* note 31, at 306 n. 5.

⁸⁴ Peralme, *supra* note 82, at 14. *See also* Ann R. Auberry, Comment, *PTSD: Effective Representation of a Vietnam Veteran in the Criminal Justice System*, 68 MAR. L. REV. 647, 650 (1985) (25 percent of Vietnam veterans involved

from PTSD had been arrested or imprisoned, compared to only 11.6 percent of veterans without PTSD.⁸⁵

Not surprisingly, emerging studies of Iraq and Afghanistan veterans show similar trends. A longitudinal study of Iraq and Afghanistan veterans six months after deployment revealed that “27 to 35 percent reported symptoms placing them at mental health risk, including symptoms of PTSD, depression, alcohol misuse, and suicidal ideation, as well as self-reported aggression.”⁸⁶ Other reports have suggested an increase in drug abuse by Iraq and Afghanistan veterans,⁸⁷ and noted that veterans between the ages of 20 to 24 years are reportedly four times more likely to commit suicide than their nonveteran counterparts.⁸⁸

Although environmental variables between Vietnam veterans and Iraq and Afghanistan veterans prevent direct comparison, current data indicate that Iraq and Afghanistan veterans who display PTSD hyperarousal symptomatology have greater difficulty—like their Vietnam veteran counterparts—in controlling aggressive impulses or urges, managing anger, and controlling violence.⁸⁹ These risk factors do not yet appear to have led to an increase in the percentage of

in heavy combat had been charged with a crime, a rate higher than that of veterans not in heavy combat or non-veterans).

⁸⁵ Peralme, *supra* note 82, at 14.

⁸⁶ Debra A. Pinals, *Veterans and the Justice System: The Next Forensic Frontier*, J. AM. ACAD. PSYCHIATRY AND L. (June 2010) at 164.

⁸⁷ See *Serious Psychological Distress and Substance Use Disorder among Veteran*, THE NATIONAL SURVEY ON DRUG USE AND HEALTH REPORT, U.S. DEP'T OF HEALTH & HUMAN SERVICES, Nov. 2007 [hereinafter NSDUH REPORT], available at <http://bit.ly/c1uxq9> (“One quarter of veterans age 18 to 25 met the criteria for [substance use disorder] in the past year compared with 11.3 percent of veterans aged 26 to 54 and 4.4 percent of veterans aged 55 or older.”).

⁸⁸ Rick Little & Stacy Garrick Zimmerman, *Helping Veterans Overcome Homelessness*, 43 CLEARINGHOUSE REV. 292, 295 (2009). *But see* Margaret E. Noonan & Christopher J. Mumola, *Veterans in State or Federal Prison, 2004*, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE 7, May 2007 (finding no link between combat service and mental health problems among incarcerated veteran inmates), available at <http://bit.ly/dxfBcc>.

⁸⁹ Eric B. Elbogen, et al., *Correlates of Anger and Hostility in Iraq and Afghanistan War Veterans*, Am. J. Psychiatry, Sep. 2010, at 1051. *See also* Wilson & Zigelbaum, *supra* note 80, at 73-74; Melissa Pratt, *New Courts*

veterans among prison populations, although the lack of recent data hinders firm conclusion. A 2004 study, the most recent available, found that 10 percent of state prisoners were veterans, a decline from 12 percent in 1997 and 20 percent in 1986.⁹⁰ During that same time period, veterans as a percentage of the U.S. population dropped to 11 percent in 2004 from 16 percent in 1985, suggesting that the downward trend of veterans in prison populations mirrors that of the decline of veterans among the populace generally.⁹¹

Of course, long before either the Vietnam conflict or the wars in Iraq and Afghanistan, writers, policy makers, and researchers recognized the potential connection between combat and post-war criminal behavior. Sir Thomas More, writing in *Utopia* in 1516, referred to individuals who, in war, “had so inured themselves to corrupt and wicked manners [] that they had taken a delight and pleasure in robbing and stealing[.]”⁹² In Machiavelli’s *Art of War*, published in 1521, the character Fabrizio similarly contends, “War makes thieves, and peace hangs them.”⁹³ Winston Churchill, in the aftermath of World War I, declared at a London dinner in 1919:

on the Block: Specialized Criminal Courts for Veterans in the United States, 15 *APPEAL* 39, 40 (2010); Deborah Sontag and Lizette Alvarez, *Across America, Deadly Echoes of Foreign Battles*, N. Y. TIMES, Jan. 13, 2008, available at <http://nyti.ms/9Mc3zV>. In January 2008, the New York Times uncovered 121 media stories involving veterans of the Iraq and Afghanistan wars who had been accused of committing manslaughter or murder. *Id.* See also Pratt, at 40 (discussing the New York Times story). Many of the accused veterans reportedly suffered from combat trauma or substance dependency. *Id.*

⁹⁰ Noonan & Mumola, *supra* note 88.

⁹¹ *Id.* at 2. In January 2000, the U.S. Department of Justice reported that “[m]ale military veterans are incarcerated in the nation’s prisons and jails at less than half the rate of non-veterans[.]” Press Release, Bureau of Justice Statistics, U.S. Department of Justice (Jan. 18, 2000), available at <http://bit.ly/aASjgn>. Notably, the U.S. Department of Justice also reported that “[v]eterans were more likely to be in a state prison for a violent offense (55 percent) . . . than the non-veteran inmate population (46 percent . . .).” *Id.* Non-veterans had a higher incident rate than veterans for drug offenses (22 percent and 14 percent, respectively). *Id.* A study released in 2007 found similar results, though it also noted the incarceration rate was due to the difference in age distribution because prisoners who were veterans were older. Noonan & Mumola, *supra* note 88, at 1-2. See also Press Release, Bureau of Justice Statistics, U.S. Department of Justice (Apr. 29, 2007), available at <http://bit.ly/acMCLf>.

⁹² Abbot, *supra* note 2, at 46 (quoting THOMAS MORE, *UTOPIA* (1516)).

⁹³ NICCOLO MACHIAVELLI, *THE ART OF WAR* 14 (Christopher Lynch trans., University of Chicago Press 2003) (1520).

*People talk about the world on the morrow of the Great War as if somehow or other we had all been transported into a higher form. We have been transported into a sphere which is definitely lower from almost every point of view than that which we had attained in the days before Armageddon. Never was there a time when people were more disposed to turn to courses of violence, to show scant respect for law and country and tradition and procedure than the present.*⁹⁴

Edith Abbott, an early 20th century American economist and social worker, noted reports of “crime epidemics” in France after the Revolution of 1848, in France and Germany after the Franco-Prussian War (1870-1871), and in England after the Second Boer War (1899-1902).⁹⁵ In a detailed study of post-Civil War data, Abbott found “[a] marked increase occurred . . . in the number of commitments of men to prison during the years following the war.”⁹⁶ One prison warden of the time concluded that 90 percent of his new prisoners “had been more or less incapacitated and demoralized by an apprenticeship to the trade of war.”⁹⁷ Following World War I, both France and the United States feared an increase in crime as battle-hardened veterans returned to the homefront, with one French criminologist commenting that “[p]ersonal morality . . . has deteriorated during the years of war with the breaking-up of homes and the

⁹⁴ Abbot, *supra* note 2, at 212-13 (quoting MANCHESTER GUARDIAN, Nov. 28, 1919). Modern commentators parallel Churchill’s remarks. Robert Jay Lifton, a Harvard researcher who has studied PTSD, recently observed: “When they’ve been in combat, you have to suspect immediately that combat has some effect, especially with people who haven’t shown these [criminal] tendencies in the past.” Sontag & Alvarez, *supra* note 89. Similarly, William Gentry, an Army reservist and prosecutor in California, remarked: “You are unleashing certain things in a human being we don’t allow in civic society, and getting it all back in the box can be difficult for some people.” *Id.*

⁹⁵ Abbott, *supra* note 2, at 212-13.

⁹⁶ *Id.* at 216.

⁹⁷ *Id.* at 228.

perpetual vision of death, and has brought about a state of moral vertigo[.]”⁹⁸ After the conclusion of World War II, researchers in New York City found a substantial increase in violent personal crime, though they disputed whether it was attributable to the effect of combat on returning veterans, or simply the great volume of returning veterans themselves.⁹⁹ It should be noted that these historical studies rarely distinguish between the psychological and behavioral aspects of war, generally ascribing increased criminal activity to the “lost morality” of soldiers brutalized by war. Nevertheless, they provide an insightful connection between war and crime, and support the conclusion that present-day discussions about veterans and criminal behavior are trodding well-worn ground.

PTSD as a Defense Before 1980

While it may be well-settled that PTSD increases the risk factors for certain types of criminal behavior, the extent to which PTSD either excuses or mitigates associated criminal conduct as a matter of law remains a subject of lively concern. One of the earliest cases on point, *People v. Gilberg* (1925), addressed whether a World War I veteran accused of child molestation sufficiently raised insanity as a defense by introducing evidence of “shell shock” incurred during the war.¹⁰⁰ Testifying on the defendant’s behalf, experts explained “with minute detail the symptoms of ‘shell-shock’ and epilepsy and the effect of each upon the nervous organism[.]”¹⁰¹

⁹⁸ Edith Abbot, *Crime and the War*, J. OF AM. INST. OF CRIM. L. & CRIMINOLOGY, May 1918, at 40 (summarizing the arguments of M. Roux, professor of criminal law at the University of Dijon). See also Milton H. Erickson, *Some Aspects of Abandonment, Feeble-Mindedness, and Crime*, AM. J. OF SOC., Mar. 1931 (finding a statistical correlation between military service and the commission of criminal offenses following World War I); SHAY, *supra* note 15, at 23-28 (discussing impact of war on soldiers’ “Social and Moral Horizon”).

⁹⁹ Harry Willbach, *Recent Crimes and the Veterans*, J. CRIM. L. AND CRIMINOLOGY, Jan.-Feb. 1948, at 508.

¹⁰⁰ *People v. Gilberg*, 240 P. 1000 (Cal. 1925). Prior to *People v. Gilberg*, several defendants elsewhere also had raised “shell shock” as part of an insanity defense, all without success. See *State v. Thronson*, 191 N.W. 628, 634 (N.D. 1922) (defendant argued mental incapacitation due to shell shock from World War I); *Sorenson v. State*, 188 N.W. 622, 624 (Wis. 1922) (same); *State v. Shobe*, 268 S.W. 81 (Mo. 1924) (same).

¹⁰¹ *Gilberg*, 240 P. at 1002.

The Supreme Court of California, in language reflective of the prevailing view of the time, commented:

*[The soldier] received no battlefield wounds, but claims to have suffered an injury by falling into a “funk-hole.” It appears that he spent considerable time during his enlistment, both overseas and in this country, as a patient in hospitals, under treatment for “shell-shock.” “Shell-shock” is not a distinct type of nervous disorder, but a condition produced upon certain organisms by sudden fear or by highly exciting causes. It is a form of neurosis. It is not settled, general insanity, but, according to the testimony of the expert offered by the defense, a functional nervous disease, and not due to organic changes.*¹⁰²

Perhaps because of the nature of the alleged crime, or perhaps because the defendant’s in-court antics made his condition appear contrived, the Court upheld the trial court’s determination not to submit the matter of insanity to the jury.¹⁰³

In *People v. Danielly* (1949), a World War II veteran attempted to introduce evidence that his conviction for murder should be reduced to manslaughter because he had no recollection of the incident due to his combat-related “nervous” disability.¹⁰⁴ The trial court denied introduction of the evidence and the defendant was convicted of first degree murder. Although the Supreme Court of California upheld the trial court’s ruling, it noted that the defendant had been in the Navy 11 years, was wounded on August 18, 1944 “by the explosion of an enemy anti-personnel

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *People v. Danielly*, 202 P.2d 18 (Cal. 1949).

bomb,” and was diagnosed and ultimately discharged from the military for “psychoneurosis neurasthenia.”¹⁰⁵ Among other things, the defendant’s symptoms included nervousness, tremors, sweating, irritability, insomnia, “easy startle”, “battle dreams”, and anxiousness.¹⁰⁶ While not rendering the defendant legally insane, the Court found that such symptoms nevertheless warranted sympathy: “[T]hat he is a victim of war in the sense that his original emotional stability and related ability to cope with the vicissitudes and demands of living in normal society have been to some extent impaired seems . . . reasonably certain.”¹⁰⁷ At the conclusion of its ruling, the Court specifically commented on the governor’s ability to commute sentences for such compassionate purposes.¹⁰⁸

Finally, in the 1973 case of *Kemp v. State*, a Vietnam veteran pled not guilty by reason of insanity when he shot his wife in bed while dreaming “that he was in Viet Nam and being attacked by the Vietcong[.]”¹⁰⁹ The defendant, who had witnessed multiple companions killed by a land mine in Vietnam, developed “battle fatigue” and “battle neurosis” during his combat tour. He began to drink heavily, experienced amnesia, and had recurring nightmares about the Vietcong. After being discharged from the military, he drifted in and out of VA hospitals and took to sleeping with a weapon beneath his pillow. Five days after being released from outpatient care, he turned up armed and intoxicated at a VA hospital with no recollection of recent events. Later that day, police discovered his wife’s body in the couple’s bed, the bullets in her body matching the gun the defendant carried into the VA. At trial, six psychiatrists testified. The defendant’s psychiatrist and two court-appointed psychiatrists testified the defendant was

¹⁰⁵ *Id.* at 38-39.

¹⁰⁶ *Id.* at 40.40.

¹⁰⁷ *Id.* at 41.

¹⁰⁸ *Id.*

¹⁰⁹ *Kemp v. State*, 211 N.W. 2d 793 (Wis. 1973).

legally insane. Two state psychiatrists testified they could not give an opinion. One additional state psychiatrist testified the defendant might be legally insane. Despite their testimony, the jury found the defendant mentally competent and he was convicted of murder. The Supreme Court of Wisconsin disagreed, however, stating, “We believe the weight of the testimony is such that justice has probably miscarried and that it is possible a new trial will result in a contrary finding.”¹¹⁰ Accordingly, the Court ordered a new trial on the issue of the defendant’s sanity.¹¹¹

As these cases anecdotally suggest, veterans who relied on combat trauma to prove insanity met with mixed results prior to the recognition of PTSD as a formal diagnostic category in DSM-III. Partly this may be a function of the skepticism with which combat trauma was generally viewed by the public prior to 1980. A more significant reason, however, seems to lay in the fact that clinicians had few diagnostic tools with which to diagnose chronic, delayed onset of combat-related trauma. “Gross Stress Reaction,” the diagnostic category in DSM-I recognizing combat stress, was “seen as a situational disorder that would abate with reduction in exposure to the stressor.”¹¹² The more generalized category of “transient situational disturbances” contained in DSM-II offered even less assistance.¹¹³ Without adequate diagnostic tools, veterans facing criminal charges—and psychiatrists testifying on their behalf—had understandable difficulty in establishing the foundational requirement for any insanity defense: the presence of a “mental disease.”¹¹⁴

¹¹⁰ *Id.* at 797. See also Erlinder, *supra* note 31, at 308 n. 21 (discussing *Kemp*).

¹¹¹ *Kemp*, 211 N.W. 2d at 799.

¹¹² Erlinder, *supra* note 31, at 315-16.

¹¹³ *Id.*

¹¹⁴ See Hafermeister & Stockey, *supra* note 70, at 113.

With the exception of four states without an insanity defense, states generally employ one of four tests in determining a defendant’s insanity, all of which require an initial showing of a “mental disease.”¹¹⁵ Most states have adopted a strain of the *M’Naghten* rule, which articulates two alternative prongs for establishing insanity:¹¹⁶

*[T]o establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.*¹¹⁷

The U.S. Supreme Court has described these two prongs in terms of a defendant’s cognitive capacity (the ability to know the nature and quality of the act) and moral capacity (the ability to know that an act is wrong).¹¹⁸ Although most states follow the *M’Naghten* rule, other states have recognized that some defendants’ mental disorders may prevent them from controlling their actions even if they are aware their actions are wrong. Accordingly, these states utilize an alternative test—often called the Irresistible Impulse Test—based on a defendant’s volitional incapacity.¹¹⁹ Some of these states also follow the Model Penal Code, which combines elements of the Irresistible Impulse Test and the *M’Naghten* rule to obviate criminal responsibility when a defendant, as a result of mental illness, “lacks substantial capacity to appreciate the

¹¹⁵ See *Clark v. Arizona*, 548 U.S. 735, 747 (2006); Hafermeister & Stockey, *supra* note 70, at 113.

¹¹⁶ See *Clark*, 548 U.S. at 747; Hafermeister & Stockey, *supra* note 70, at 109.

¹¹⁷ *Clark*, 548 U.S. at 747 (quoting *M’Naghten’s Case*, 8 Eng. Rep. 718, 722 (H.L.) (1843)).

¹¹⁸ *Id.* See also Hafermeister & Stockey, *supra* note 70, at 109 n. 130.

¹¹⁹ See *Clark*, 548 U.S. at 750; Hafermeister & Stockey, *supra* note 70, at 109..

criminality . . . of his conduct or to confirm his conduct to the requirements of [the] law.”¹²⁰ In addition to these tests, the state of New Hampshire employs a final variant called the Product-Of-Mental-Illness Test, which “simply asks whether a person’s action was a product of a mental disease or defect.”¹²¹

PTSD as a Defense After 1980

After PTSD was added to DSM-III, veterans and legal practitioners had substantially more success in raising PTSD as an affirmative or mitigating defense in state and federal court.¹²² Literature from the mid-1980s discussed the application of PTSD in defenses of insanity, diminished capacity, automatism (involuntary action), and self-defense.¹²³ One commentator identified PTSD’s successful use in the early to mid-1980s in cases of “murder, attempted murder, kidnapping, and drug smuggling.”¹²⁴ When offered in mitigation, PTSD similarly proved helpful “for crimes such as drug dealing, manslaughter, assault with intent to commit murder, and even tax fraud.”¹²⁵ By 1985, the introduction of PTSD evidence at trial was credited

¹²⁰ Hafermeister & Stockey, *supra* note 70, at 110 (quoting MODEL PENAL CODE § 4.01(1) (2001)). Interestingly, this was the test primarily used by federal courts until John Hinkley, Jr. was acquitted on grounds of insanity in the attempted assassination of President Ronald Reagan in 1981. Davidson, *supra* note 20, at 422 n. 53, 427. In the ensuing public firestorm, Congress passed the Insanity Defense Reform Act of 1984, 18 U.S.C. § 20 (Supp. II 1985), which eliminated the volitional component of the Model Penal Code test and returned the *M’Naghten* rule to federal court practice. *Id.* at 427.

¹²¹ Clark v. Arizona, 548 U.S. 735, 750 (2006).

¹²² See, e.g., Erin M. Gover, *Iraq as a Psychological Quagmire: The Implications of Using Post-Traumatic Stress Disorder as a Defense for Iraq War Veterans*, 28 PACE L. REV. 561, 562 (2008) (“PTSD has been used to prove existing criminal law defenses since 1978. Its use as a defense rose dramatically when the American Psychiatric Association officially recognized it as a mental disorder in 1980.”) (citations omitted).

¹²³ *Id.* (citation omitted). See also Hafermeister & Stockey, *supra* note 70, at 123; Adam Caine, *Fallen from Grace: Why Treatment Should Be Considered for Convicted Combat Veterans Suffering From Post Traumatic Stress Disorder*, 78 UMKC L. REV. 215, 222-23 (2009) (discussing insanity, automatism, and mitigation).

¹²⁴ Davidson, *supra* note 20, at 422-23 (citations omitted).

¹²⁵ *Id.* at 423 (citations omitted). See also Comment, *PTSD: Effective Representation of a Vietnam Veteran in the Criminal Justice System*, 68 MARQ. L. REV. 647, 670 (generally discussing use of PTSD in mitigation).

with helping some 250 Vietnam veterans obtain sentence reductions, treatment opportunities, or outright acquittals at trial.¹²⁶

One representative case is *State v. Heads*, in which a Louisiana jury found the defendant not guilty of murder by reason of insanity due to his PTSD.¹²⁷ Charles Heads had served as a Marine in Vietnam, performing 38 reconnaissance missions deep into enemy territory. On his first patrol, he witnessed his platoon commander killed by a land mine. Nine months later, with seven conformed “kills” himself, Heads was shot twice in the stomach and evacuated from the jungle by helicopter.¹²⁸ Seven years after returning home and marrying, Heads drove to his brother-in-law’s home late one night in search of his wife. He rang the bell and shouted, but no one answered. Walking away, something “hit” Heads and he immediately returned to the house, crashing through the door with a gun in his hand. After firing multiple shots, he returned to his car for a rifle, continued firing, and eventually killed his brother-in-law, who also was holding a gun.¹²⁹ When the police arrived moments later, Heads surrendered quietly.¹³⁰

Heads was tried by a Louisiana jury twice. The first trial, in 1977, led to a conviction for first-degree murder. That case was overturned on appeal when the appellate court determined the jury had been improperly instructed.¹³¹ The second trial, in 1981, led to an acquittal by reason of insanity after numerous lay and expert witnesses recreated the horrors of Vietnam and the reality

¹²⁶ See Christopher Hawthorne, *Bringing Baghdad Into the Courtroom*, 24 CRIM. JUST. 4, 7 (2009) (citing David Margolick, *New Vietnam Debate: Trauma as Legal Defense*, N.Y. TIMES, May 11, 1985, at A11); Davidson, *supra* note 20, at 422 n. 55.

¹²⁷ *State v. Heads*, No. 106, 126 (1st Jud. Dist. Ct. Caddo Parrish, La. Oct. 10, 1981). For an account of the *Heads* case, see Erlinder, *supra* note 31, at 319-320; MYRA MCPHERSON, *LONG TIME PASSING: VIETNAM AND THE HAUNTED GENERATION* 219-24 (2002).

¹²⁸ See MCPHERSON, *supra* note 127, at 219.

¹²⁹ See Erlinder, *supra* note 31, at 320.

¹³⁰ See MCPHERSON, *supra* note 127, at 219.

¹³¹ See *id.* at 219-20; Erlinder, *supra* note 31, at 320.

of PTSD for jurors. According to Heads' attorney, the difference in the two trials resulted from the addition of PTSD to DSM-III in 1980:

I represented Heads the first time when they found him guilty. I was unable to prove that he was suffering from insanity; psychiatrists never found any evidence of any recognized mental disorder. In 1980, after the American Psychiatric Association recognized PTSD, I knew that's what it was—and I had what I needed.

Relying on the diagnostic criteria of PTSD in DSM-III, Heads' attorney successfully argued the relevance of Heads' military service, combat trauma, and troubled childhood in establishing the presence of a "mental disease." The jury then applied a modified version of the *M'Naghten* rule and, in acquitting Heads, apparently believed his PTSD had caused him to enter a dissociative state in which he could not distinguish right and wrong.¹³²

In arguing the range of criminal offenses PTSD arguably could induce, legal practitioners and clinicians of the early 1980s were assisted by a key study presented by John P. Wilson, Ph.D., and Sheldon D. Zigelbaum, M.D., in 1983. Over a period of two years, Wilson and Zigelbaum assessed the relationship between PTSD and criminal behavior in 114 combat veterans.¹³³ Study results revealed three distinct ways in which PTSD could motivate criminal behavior.

¹³² Erlinder, *supra* note 31, at 320-21.

¹³³ Wilson & Zigelbaum, *supra* note 80, at 70.

First, a veteran could enter a *dissociative state* in which he “is likely to function predominately in the survivor mode by behaving as he did in combat in Vietnam.”¹³⁴ Dissociative states are most commonly linked to violent criminal behavior.¹³⁵ Second, a veteran could display a *sensation seeking syndrome*, characterized by attempts to seek out the same level of excitement, exhilaration, and stimulation as that experienced in combat.¹³⁶ Sensation seeking syndrome often manifests itself in risk-filled activities, such as motorcycle riding, sky diving, and gambling.¹³⁷ Third, a veteran could experience *depression-suicide syndrome*, which is accompanied by feelings of hopelessness, painful imagery, survivor guilt, and psychic numbing.¹³⁸ In an effort to end psychic pain, veterans with depression-suicide syndrome sometimes act out violently or recklessly knowing they will be caught or killed as a result of their actions.¹³⁹ Though based on limited data obtained nearly 30 years ago, the Wilson & Zigelbaum study continues to influence discussions of PTSD and criminal responsibility by providing a useful framework in which to connect particular criminal behaviors with specific PTSD symptoms.¹⁴⁰

PTSD in Today’s Courtroom

By 1985, the success of PTSD as an affirmative defense had begun to wane, as “juries . . . rejected an increasing percentage of stress-related defenses.”¹⁴¹ “It seems there was more receptivity five years ago,” Dr. Wilson (of the Wilson and Zigelbaum study) said at the

¹³⁴ *Id.* at 73.

¹³⁵ *Id.*

¹³⁶ *Id.* at 74.

¹³⁷ *Id.*

¹³⁸ Wilson & Zigelbaum, *supra* note 80, at 74-75.

¹³⁹ *Id.*

¹⁴⁰ See, e.g., Peralme, *supra* note 82, at 11-12; Gover, *supra* note 122, at 567; Hafermeister & Stockey, *supra* note 70, at 101 n. 77.

¹⁴¹ David Margolick, *New Vietnam Debate: Trauma As Legal Defense*, N.Y. TIMES, May 11, 1985, at A1.

time. “My batting average [as an expert witness] was once about .900 but now it’s dropped.”¹⁴² Commentators ascribed the decline to shifting public attitudes over Vietnam,¹⁴³ overuse of the defense by defense counsel,¹⁴⁴ continued public resentment of the acquittal of John Hinkley, Jr., who had been acquitted on grounds of insanity in the attempted assassination of President Ronald Reagan in 1981,¹⁴⁵ and the public’s fear of potentially false PTSD claims.¹⁴⁶

More recently, however, PTSD as both an affirmative and mitigating defense has re-emerged, largely as a result of a growing national consciousness of the problems faced by veterans returning from the wars in Iraq and Afghanistan.¹⁴⁷ In one of the first successful PTSD cases involving a veteran of the war in Iraq, for example, an Oregon jury in 2009 found a veteran accused of murder “guilty but insane” due to the combat trauma he suffered as a result of his deployment.¹⁴⁸ At trial, the prosecutor argued the 26-year old former Army National Guard soldier had “hunted down and killed” the victim, a man who allegedly raped the defendant’s fiancée.¹⁴⁹ In response, the defense attorney put on evidence that the defendant had returned from Iraq a changed man, living in the woods for days at a time patrolling with an assault rifle and unable to stay employed due to his explosive anger. Doctors at the VA had first rejected the defendant’s claim of PTSD, then later awarded him a disability rating of 70 percent and then 100 percent. At the time of the shooting, the defendant told his attorney, it was like he was back in

¹⁴² *Id.*

¹⁴³ See Hawthorne, *supra* note 126, at 7-8.

¹⁴⁴ See Margolick, *supra* note 141; Hafermeister & Stockey, *supra* note 70, at 119.

¹⁴⁵ See Davidson, *supra* note 20, at 422 n. 53.

¹⁴⁶ See Margolick, *supra* note 141; Hawthorne, *supra* note 126, at 7-8; Gover, *supra* note 122, at 582-83 (discussing *People v. Lockett*, 121 Misc. 2d 549 (N.Y. Crim. Term. 1983), in which a defendant who had never been in Vietnam misled both defense and state psychiatrists into diagnosing him with PTSD).

¹⁴⁷ See, e.g., Sontag & Alvarez, *supra* note 89; Hafermeister & Stockey, *supra* note 70.

¹⁴⁸ For a discussion of the trial, see Melody Finnemore, *Firestorm on the Horizon*, 70 OR. ST. B. BULL. 19 (2009); Kim Murphy, *Did the War Make Him Do It?*, L.A. TIMES, Nov. 28, 2009, available at <http://lat.ms/ckTQua>; Sarah Jane Rothenfluch, *Guilty But Insane Due to PTSD* (Or. Public Broadcasting radio broadcast Dec. 11, 2009), transcript available at <http://bit.ly/cUs3ri>.

¹⁴⁹ Murphy, *supra* note 148.

Kirkuk, “watching murderous events unfold around him. He saw somebody shooting [the victim], emptying all 10 rounds from the clip. [The victim’s] 14-year-old nephew was shouting from the front porch, and [the defendant] saw him as an Iraqi woman screaming.”¹⁵⁰ Believing the defendant needed treatment—not prison—the jury found him “guilty but insane” under Oregon law, and the defendant eventually was sentenced and moved from county jail to an Oregon state hospital.¹⁵¹

Of course, not all cases are as successful,¹⁵² and questions have been raised about the fairness of allowing veterans to sidestep criminal responsibility by placing blame on their combat trauma.¹⁵³ The Oregon decision does suggest, however, that judges and juries remain sympathetic to receiving and considering evidence of defendants’ combat trauma in determining the scope of criminal responsibility.¹⁵⁴

A 2009 Supreme Court case, *Porter v. McCollum*, underscores this point.¹⁵⁵ In *Porter*, the Supreme Court addressed whether the defendant’s Sixth Amendment right to counsel had been violated when his attorney failed to uncover or introduce at sentencing evidence of his significant combat experience.¹⁵⁶ In 1986, George Porter, a Korean war veteran, shot and killed his former girlfriend and her boyfriend. With standby counsel, he represented himself through most of the prosecution’s case, then decided to plead guilty with representation by counsel. The defense attorney put on one sentencing witness. Other than a passing reference, the attorney made no

¹⁵⁰ *Id.*

¹⁵¹ See Rothenfluch, *supra* note 148.

¹⁵² See Hawthorne, *supra* note 126, at 5-6 (comparing two recent cases involving traumatized veterans).

¹⁵³ See *infra* text accompanying notes 240-243.

¹⁵⁴ See Pratt, *supra* note 89, at 47 (discussing 2009 California case in which a court found a veteran accused of robbing a pharmacy not guilty by reason of insanity based on his PTSD).

¹⁵⁵ *Porter v. McCollum*, 558 U.S. ___, 130 S. Ct. 447 (2009) (per curiam).

¹⁵⁶ *Id.*

mention of Porter's mental health. After being convicted and sentenced to death, Porter filed a petition for post-conviction relief in 1995 and argued his defense counsel had been deficient in introducing mitigating evidence.

At a subsequent two-day hearing, Porter presented extensive evidence of his troubled childhood, history of substance abuse, and, in the Supreme Court's words, "his heroic military service and the trauma he suffered because of it."¹⁵⁷ Evidence from Porter and his former commander established that Porter's unit had been involved in two ferocious battles in Korea. In the first, Porter was shot as his unit protected the withdrawing Eighth Army from the advancing Chinese at Kunuri. In the second, less than three months later, at Chip-yong-ni, Porter's company was ordered to charge a hill under heavy fire. Porter again was wounded, and his unit sustained casualties of more than 50 percent.¹⁵⁸ The battles were "very trying, horrifying experiences," Porter's commander testified.¹⁵⁹ Porter's unit received the Presidential Unit Citation for their heroism at Chip-yong-ni, and Porter personally received two Purple Hearts and the Combat Infantryman Badge.¹⁶⁰ In addition to this evidence, Porter also introduced the testimony of a neuropsychologist who "concluded that Porter suffered from brain damage that could manifest in impulsive, violent behavior."¹⁶¹ The neuropsychologist further testified that "Porter was substantially impaired in his ability to conform his conduct to the law and suffered from an extreme mental or emotional disturbance," both of which warranted mitigation under Florida law.¹⁶²

¹⁵⁷ *Id.* at 449.

¹⁵⁸ *Id.* at 449-50.

¹⁵⁹ *Id.* at 450.

¹⁶⁰ *Porter v. McCollum*, 558 U.S. ___, 130 S. Ct. 447, 450 (2009) (per curiam).

¹⁶¹ *Id.* at 451.

¹⁶² *Id.*

In holding that Porter’s Sixth Amendment rights had been violated, the Supreme Court strongly chided the defense attorney for failing “to uncover and present any evidence of Porter’s mental health or mental impairment, his family background, or his military service,”¹⁶³ finding that such evidence could have been offered as both statutory and non-statutory mitigation.¹⁶⁴ The Court then remanded the case for rehearing on sentence.¹⁶⁵

Two key points readily emerge from the Court’s opinion in *Porter v. McCollum*. First, *Porter* reminds both defense counsel and courts of the necessity of introducing and considering evidence of military service—especially when it involves combat—as a mitigating factor in criminal trials. Aside from its success as an affirmative defense, PTSD remains critically relevant in mitigation.¹⁶⁶ Second, far from being averse to PTSD-related evidence, the Court favorably embraced both lay and expert testimony regarding Porter’s combat trauma, a point underscored by the language of the decision itself. In an opinion notable for its marked sympathy, the Court began the opinion with these words:

Petitioner George Porter is a veteran who was both wounded and decorated for his active participation in two major engagements during the Korean war; his combat service unfortunately left him a traumatized, changed man. His

¹⁶³ *Id.* at 453.

¹⁶⁴ *Id.* at 454-55.

¹⁶⁵ *Porter v. McCollum*, 558 U.S. ___, 130 S. Ct. 447, 456 (2009) (per curiam).

¹⁶⁶ For a discussion of military service as a mitigating factor in caselaw, see Pratt, *supra* note 89, at 45-46 (discussing *United States v. Pipich*, 688 F. Supp. 191 (D.Md. 1988) (district court judge relied on exemplary military record to lower sentence under sentencing guidelines)). Note, however, that the Sentencing Commission has determined that “military, civic, charitable, or public service; employment-related contributions; and similar good works are not ordinarily relevant” in deciding whether a sentence should deviate from the guidelines. *Id.* (citing U.S. SENTENCING GUIDELINES MANUAL § 5H1.11 (2007)).

*commanding officer's moving description of those two battles was only a fraction of the mitigating evidence that his counsel failed to discover or present during the penalty phase of his trial in 1988.*¹⁶⁷

In its conclusion, the Court adopted a similarly moving tone in explaining the leniency traditionally shown veterans:

*Our Nation has a long tradition of according leniency to veterans in recognition of their service, especially for those who fought on the front lines as Porter did. Moreover, the relevance of Porter's extensive combat experience is not only that he served honorably under extreme hardship and gruesome conditions, but also that the jury might find mitigating the intense stress and mental and emotional toll that combat took on Porter.*¹⁶⁸

It is this historic leniency, coupled with the data linking combat trauma to criminal behavior, which serves as the historical underpinnings to the veterans court movement today.

THE TREND TOWARD VETERANS COURTS

In January 2008, Judge Robert T. Russell presided over the first session of the Buffalo Veterans Treatment Court, the first court of its kind in the country “that specialized and adapted to meet the specific needs of veterans.”¹⁶⁹ The idea for the veterans court grew out of Judge Russell’s

¹⁶⁷ Porter v. McCollum, 558 U.S. ___, 130 S. Ct. 447, 448 (2009) (per curiam).

¹⁶⁸ *Id.* at 455.

¹⁶⁹ Robert T. Russell, *Veterans Treatment Court: A Proactive Approach*, 35 NEW ENG. J. ON CRIM. AND CIV. CONFINEMENT 357, 364 (2009). While the veterans court in Buffalo is often considered the “first” veterans treatment court, a less-well known veterans court had been established by two judges in Anchorage, Alaska four

experience as a sitting judge in the Buffalo, New York city court, where he observed that a rising number of defendants on his docket were military veterans.¹⁷⁰ Having seen that veterans in both the Buffalo Drug Treatment Court and the Buffalo Mental Health Court responded more favorably to other veterans, Judge Russell developed a court model designed to pair veteran-defendants with veteran-mentors and directly link defendants with service providers who understood veterans' unique challenges and needs.¹⁷¹ As Judge Russell explained, the Veterans Treatment Court adopted a comprehensive approach to treatment:

*The mission driving the Veterans Treatment Court is to successfully habilitate veterans by diverting them from the traditional criminal justice system and providing them with the tools they need in order to lead a productive and law-abiding lifestyle. In hopes of achieving this goal, the program provides veterans suffering from substance abuse issues, alcoholism, mental health issues, and emotional disabilities with treatment, academic and vocational training, job skills, and placement services. The program provides further ancillary services to meet the distinctive needs of each individual participant, such as housing, transportation, medical, dental, and other supportive services.*¹⁷²

years earlier. See Michael Daly Hawkins, *Coming Home: Accommodating the Special Needs of Military Veterans to the Criminal Justice System*, 7 OHIO ST. J. CRIM. L. 563 (2009) (discussing creation of court for veterans in Alaska in 2004); Steven Berenson, *The Movement Toward Veterans Courts*, 44 CLEARINGHOUSE REV. 37, 39 (2010) (“The first small-scale effort at starting a veterans court took place in Anchorage, Alaska, in 2004, but most commentators locate the beginning of the current movement toward specialty courts for veterans in Buffalo, New York.”).

¹⁷⁰ Russell, *supra* note 169, at 363.

¹⁷¹ *Id.* at 364.

¹⁷² *Id.* at 364.

Implicit in the Veterans Treatment Court’s initial methodology was an understanding that the risk factors for criminal behavior exhibited by some veterans—including alcohol and substance use, homelessness, broken relationships, unemployment, and mental health—would, if left unaddressed, likely result in future involvement with the criminal justice system.¹⁷³

*The Buffalo Veterans Treatment Court:
A Model of Therapeutic Justice*

From an operational perspective, the Buffalo Veterans Treatment Court diverts veterans with substance dependency or mental disorders to its docket by employing a court-initiated screening process.¹⁷⁴ Participation is voluntary, and typical offenders are facing either felony or misdemeanor charges for non-violent crimes.¹⁷⁵ Under the direction of the judge, veterans participating in the program receive a tailored package of cooperative assistance from community partners, including “the VA Health Care Network, the Veterans Benefits Administration, the Western New York Veterans Project, the Veterans Treatment Court teams, volunteer mentors, and a coalition of community health care providers.”¹⁷⁶ A VA employee attends every session of court, with a secure laptop allowing immediate access to veterans’ VA records.¹⁷⁷ Veterans not already receiving services from the VA may register in court.¹⁷⁸ One-on-one mentoring by a veteran mentor is key. Some forty veterans of the Korean war, the Vietnam war, Operation Desert Shield, Operation Enduring Freedom, and Operation Iraqi Freedom volunteer as mentors, listening, coaching, and helping defendants set and reach

¹⁷³ *See id.* at 357-63.

¹⁷⁴ *Id.* at 367-68.

¹⁷⁵ Russell, *supra* note 169, at 368.

¹⁷⁶ *Id.* at 368-69.

¹⁷⁷ Caine, *supra* note 123, at 233.

¹⁷⁸ *Id.*

goals.¹⁷⁹ The environment is therapeutic, but accountability is required. Veterans in the program must “attend regular status hearings, participate in the development of their treatment plans, and engage in community groups.”¹⁸⁰ After completion of the program, which generally lasts at least one year,¹⁸¹ “not only are veterans sober and stable, many also have their charges reduced or dismissed, or receive a commitment of non-incarceration.”¹⁸²

Methodologically, the Buffalo Veterans Treatment Court has adopted a modified version of the ten key components the Department of Justice described in its publication, *Defining Drug Courts: The Key Components*.¹⁸³ Now a model for other veterans courts, these components serve as guideposts in developing comprehensive treatment plans for veterans throughout the country:

1. Key Component One: Veterans Treatment Court integrates alcohol, drug treatment, and mental health services with justice system case processing
2. Key Component Two: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights
3. Key Component Three: Eligible participants are identified early and promptly placed in the Veterans Treatment Court program

¹⁷⁹ Russell, *supra* note 169, at 369-70. See also BUFFALO VETERANS COURT VETERANS MENTOR HANDBOOK § 2.1, available at <http://bit.ly/duWdf9>; Sergio R. Rodriguez, VA Secretary Eric K Shinseki Visits the Buffalo Veterans Treatment Court, Erie County Veterans' Services: The Buffalo Veterans Treatment Court, <http://bit.ly/dc2C8t> (last visited Oct. 28, 2010).

¹⁸⁰ Russell, *supra* note 169, at 369.

¹⁸¹ Caine, *supra* note 123, at 233.

¹⁸² Russell, *supra* note 169, at 369.

¹⁸³ *Id.* at 364 (citing NAT'L ASS'N OF DRUG COURT PROF., U.S. DEP'T OF JUSTICE, *DEFINING DRUG COURTS: THE KEY COMPONENTS* (1997), available at <http://bit.ly/drBEyz>).

4. Key Component Four: The Veterans Treatment Court provides access to a continuum of alcohol, drug, mental health and other related treatment and rehabilitation services
5. Key Component Five: Abstinence is monitored by frequent alcohol and other drug testing
6. Key Component Six: A coordinated strategy governs Veterans Treatment Court responses to participants' compliance
7. Key Component Seven: Ongoing judicial interaction with each veteran is essential
8. Key Component Eight: Monitoring and evaluation measures the achievement of program goals and gauges effectiveness
9. Key Component Nine: Continuing interdisciplinary education promotes effective Veterans Treatment Court planning, implementation, and operation
10. Key Component Ten: Forging partnerships among the Veterans Treatment Court, the VA, public agencies, and community-based organizations generates local support and enhances the Veterans Treatment Court's effectiveness¹⁸⁴

While data on the Buffalo Treatment Court's success is necessarily limited, initial results are promising. Judge Russell reported in 2009 that only 2 of more than 100 veterans who had

¹⁸⁴ Russell, *supra* note 169, at 365-67.

participated in the program had been returned to regular criminal court.¹⁸⁵ Of the 30 veterans who had graduated as of May 2010, none had been re-arrested.¹⁸⁶ Graduates from the program were free from substance abuse, had obtained adequate housing, and were either employed or were pursuing educational training.¹⁸⁷

Veterans Courts Across the Country

Seeing the Buffalo Veterans Treatment Court's initial success, approximately 21 states have established more than 40 veterans courts across the country, with courts currently operating or under development in Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Illinois, Michigan, Minnesota, Missouri, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Texas, Washington, and Wisconsin.¹⁸⁸ The vast majority of these follow the Buffalo Veterans Treatment Court treatment methodology by using the tenets of drug courts to build comprehensive, community-based treatment plans. Some differences, however, exist. For example, some veterans courts operate as pre-conviction diversion programs, while others only accept veterans who already have pled guilty.¹⁸⁹ Most hear only non-violent criminal cases,¹⁹⁰ though a few hear low-level violent criminal cases as well.¹⁹¹ The veterans court in Tarrant

¹⁸⁵ Berenson, *supra* note 169, at 30 (citing Nicholas Riccardi, *These Courts Give Wayward Veterans a Chance: The First Veterans Court Opened Last Year in Buffalo, N.Y.: Its Success Stories Have Led to More Across the Country*, L.A. TIMES, Mar. 10, 1009, available at <http://bit.ly/UiRJr>).

¹⁸⁶ Trauma Courts for Vets, The World (PRI radio broadcast May 10, 2010), transcript available at <http://bit.ly/a5xCII>.

¹⁸⁷ Russell, *supra* note 169, at 370. *See also* Pratt, *supra* note 89, at 52-53 (discussing the successful experiences of two Buffalo Veterans Treatment Court participants).

¹⁸⁸ Nat'l Assoc. of Drug Court Prof., Justice for Vets: The Nat'l Clearinghouse for Veterans Treatment Courts, <http://bit.ly/bK67tT> (last visited Oct. 28, 2010).

¹⁸⁹ For example, the Veterans Court Diversion Program in Tarrant County, Texas, requires admission of guilt before entry to the program. Conditions for Veterans Court Diversion Program, Veterans Court Diversion Program, Tarrant County, Texas, <http://bit.ly/9iMKrr> (last visited Oct. 28, 2010).

¹⁹⁰ *See, e.g.*, LA Opens New Criminal Court for Troubled Veterans, BBC News (Sept. 19, 2010), <http://bbc.in/9BI3I2> (last visited Oct. 28, 2010).

¹⁹¹ *See, e.g.*, Kevin Graman, *Special Courts Divert Wash. Veterans from Jail*, TRI-CITY HERALD, Sept. 19, 2010, available at <http://bit.ly/aD4NAB> (cases of domestic violence and fourth-degree assault heard by veterans court

County, Texas limits program participants to veterans with brain trauma, mental illness, or a mental disorder such as PTSD.¹⁹² The Buffalo Veterans Treatment Court, by contrast, accepts veterans with either substance dependency or mental illness.¹⁹³ In a third iteration, the veterans court in Orange County, California accepts only combat veterans eligible for probation.¹⁹⁴

Despite these differences, the goals of veterans courts to date have been similar—to provide at risk veterans, especially those with PTSD, with an opportunity to receive individualized help and treatment instead of incarceration. Two examples suffice.¹⁹⁵ In Harris County, Texas, one of the first veterans court participants was a veteran who served a combat tour in Iraq and, after returning, was diagnosed with PTSD.¹⁹⁶ He was “arrested for evading arrest after a small auto accident when he panicked after seeing the police lights.”¹⁹⁷ Because his PTSD was a contributing factor to his offense, he was accepted into the veterans court program with the possibility of having his indictment dismissed and his arrest record expunged upon successful completion of the program.¹⁹⁸ In Rochester, New York, a former Marine who fought in Iraq returned home and was arrested for drug use and writing forged checks.¹⁹⁹ Struggling with combat trauma, he had self-medicated with Oxycontin, which in turn led to drug dependency and financial turmoil. By electing to have his case heard in veterans court, he agreed to plead guilty

judge); Amy Gillentine, *4th Judicial District Creating Special Court for Veterans*, CO. SPRINGS BUS. J., Feb. 2, 2010, available at <http://bit.ly/cLYdul> (same); Lewis Griswold, *Valley Vets Get Court of Their Own: Tulare County Offers Victims of PTSD a Second Chance*, FRESNO BEE, June 19, 2010, available at <http://bit.ly/d0dKQI> (same).

¹⁹² Veterans Court Diversion Program, Tarrant County, Texas, <http://bit.ly/axkMDY> (last visited Oct. 28, 2010).

¹⁹³ See Russell, *supra* note 169, at 364.

¹⁹⁴ See Pratt, *supra* note 89, at 54.

¹⁹⁵ In addition to these examples, news outlets have reported many others. See, e.g., John Schwartz, *Defendants Fresh from War Find Service Courts in Court*, N.Y. TIMES, Mar. 15, 2010, available at <http://nyti.ms/9q9gpf>; Jessica Mador, *New Minn. Court Handles Vets Accused of Crimes*, National Public Radio, May 12, 2010, <http://n.pr/bWSkSG>; Griswold, *supra* note 191.

¹⁹⁶ Rodney Ellis, *Veterans Court Is a Dose of Good News*, HOUSTON CHRON., Dec. 20, 2009, available at <http://bit.ly/9vqbnf>.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ Lindsay Goldwert, *Tough-Love Judge a Veteran’s Lifesaver*, CBS News (Mar. 1, 2010), <http://bit.ly/8ZjmtL>.

and sign a contract with the judge to stay out of trouble for one year.²⁰⁰ “This isn’t a get-out-of-jail-free card,” the veterans court judge said when speaking about the court’s program. “It’s a ‘Who are you? What are you doing? What can we do to provide you with the type of treatment to make you a citizen again?’”²⁰¹

Community, State and Federal Action

Paralleling developments at the local level, policy makers at the community, state and federal levels have taken proactive steps toward encouraging the establishment of veterans treatment courts. The National Association for Drug Court Professionals has created Justice for Vets, a clearinghouse for information related to veterans treatment courts, and launched a cooperative training program between the National Drug Court Institute (NDCI), the Bureau of Justice Assistance (BJA), the U.S. Department of Veterans Affairs (VA), the GAINS Center, the Battered Women’s Justice Project, and numerous existing veterans courts to assist additional locales in establishing their own veterans treatment court programs.²⁰² The VA has placed Veterans Justice Outreach officers in each of its regional medical facilities to work with courts in providing frontline mental health and substance services to veteran-defendants in the criminal justice system.²⁰³ Embracing a community-based approach, the American Bar Association House of Delegates adopted a policy in February 2010 supporting veterans courts and setting forth key principles for their establishment.²⁰⁴ Central among the outcomes proposed by the

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² See Nat’l Assoc. of Drug Court Prof., Justice for Vets: The Nat’l Clearinghouse for Veterans Treatment Courts, <http://bit.ly/bK67tT> (last visited Oct. 28, 2010).

²⁰³ See Veterans Justice Outreach Initiative, U.S. Dep’t of Veterans Affairs, <http://bit.ly/beCyd0> (last visited Oct. 28, 2010).

²⁰⁴ Policy 105A, House of Delegates, American Bar Association, House of Delegates (February 8-9, 2010) [hereinafter ABA Policy], <http://bit.ly/bygdsz>. See also Rhonda McMillion, *Lingering Wounds: The ABA Enlists In Efforts to Help Homeless Veterans Deal with their Burdens*, A.B.A. J., Oct. 2010, at 66.

ABA are decreased recidivism, addiction recovery, veteran self-sufficiency, judiciary cost savings, and connection to local and federal service providers.²⁰⁵

In addition to these actions, both state and federal legislatures have considered or enacted legislation relating to veterans' courts. At the state level, five states—California, Colorado, Illinois, Nevada, and Texas—have passed legislation establishing veterans courts or requiring existing courts to considering military-connected factors, such as PTSD, in adjudicating criminal cases.²⁰⁶ In California, for example, legislation enacted in 2006 (modifying earlier legislation applying to Vietnam veterans) authorizes criminal courts to place veteran-defendants facing prison terms into treatment programs if the veteran suffers from “post-traumatic stress disorder, substance abuse, or psychological problems as a result of [military] service” and “alleges that he or she committed the offense as a result of post-traumatic stress disorder, substance abuse, or psychological problems stemming from service in a combat theater in the United States military[.]”²⁰⁷ Legislation passed in Texas in 2009 authorizes local establishment of veterans courts and dismissal of criminal charges following completion of a treatment program of at least six months.²⁰⁸ Focusing on rehabilitation and community coordination, the jurisdiction of such courts is tailored to veterans accused charged with either a misdemeanor or felony who (1) suffer “from brain injury, mental illness, or mental disorder, including post-traumatic stress disorder”, (2) that “resulted from the defendant’s military service in combat,” and (3) “materially affected the defendant’s criminal conduct at issue in the case.”²⁰⁹

²⁰⁵ *Id.*

²⁰⁶ See Griswold, *supra* note 191; Marc A. Levin, *Policy Brief: Veterans' Court*, TX. PUB. POL. FOUND., Nov. 2009, available at <http://bit.ly/b6jQTr>; Pratt, *supra* note 89, at 50-51 (discussing California’s statute requiring consideration of PTSD in mitigation).

²⁰⁷ CA. PENAL CODE §1170.9 (2010). See also Pratt, *supra* note 90, at 50 (discussing California legislation).

²⁰⁸ S.B. 1940, 81st Leg. (Tx. 2009) (enacted), available at <http://bit.ly/beOR0R>.

²⁰⁹ *Id.*

At the national level, legislators in both the U.S. House of Representatives and the Senate have introduced legislation to support the creation of additional veterans courts throughout the country.²¹⁰ Entitled the Services, Education, and Rehabilitation for Veterans (SERV) Act, the proposed legislation authorizes grants to states, state courts, and local courts “for the purpose of developing, implementing, or enhancing veterans’ treatment courts or expanding operational drug courts to serve veterans.”²¹¹

Predicting Outcomes for Veterans Treatment Courts

While the lack of available data prevents present analysis of veterans court outcomes, two analogical measures give hope for success. First, veterans convicted of criminal activity appear generally to have lower recidivism rates than non-veterans convicted of criminal activity.²¹² A 1993 study reviewing recidivism rates for veterans who were released from two New York correctional facilities after participating in an on-site veterans treatment program found that “[v]eterans who participated in one of the programs for a minimum of 6 months had a significantly lower rate of return to custody than veterans with less than 6 months program experience and those veterans with no program experience.”²¹³ The same study found that “veterans . . . return to the [correctional] system at less than 80 percent of the rate at which similarly situated non-veterans return.”²¹⁴ In 2000, a report released by the Bureau of Justice

²¹⁰ See Services, Education, and Rehabilitation for Veterans Act, H.R. 2138, 111th Cong. (2009), available at <http://bit.ly/cXT1eW>; Services, Education, and Rehabilitation for Veterans Act, S. 902, 111th Cong. (2009), available at <http://bit.ly/chSGWZ>. See also Pratt, *supra* note 89, at 50 (discussing congressional legislation).

²¹¹ H.R. 2138, 111th Cong. § 2(b)(2009), available at <http://bit.ly/cXT1eW>.

²¹² See generally, Pratt, *supra* note 89, at 40.

²¹³ K. Canestrini, *Veterans’ Program Follow-up July 1993*, N.Y. DEP’T OF CORRECTIONAL SERV., available at <http://bit.ly/cwKu11>.

²¹⁴ Pratt, *supra* note 89, at 40 (quoting K. Canestrini, *Veterans’ Program Follow-up July 1993*, N.Y. DEP’T OF CORRECTIONAL SERV., available at <http://bit.ly/cwKu11>).

Statistics from the U.S. Department comparing criminal history rates of incarcerated veterans to incarcerated non-veterans concluded that “[v]eterans in State prison were less likely than nonveterans to be recidivists.”²¹⁵ A 2007 follow-up report by the Bureau of Justice Statistics similarly concluded “[v]eterans in State prison had shorter criminal histories than their nonveteran counterparts,”²¹⁶ indicating that convicted veterans are less likely than non-veterans to re-offend following release. Other studies also have shown that veterans—especially those who complete treatment programs—have lower recidivism rates than non-veterans.²¹⁷ Taken together, these studies suggest that veterans participating in veterans court treatment programs, who are paired with a veteran-mentor and connected with specialized service providers, are less likely to engage in future criminal behavior than those convicted by traditional courts.

Data from drug courts provide a second positive predictor of veterans court outcomes. The initiative to create drug courts, which were the first specialized problem-solving courts in the country, began in 1989 when the first drug court opened in Miami, Florida.²¹⁸ Momentum built rapidly, and, by 1995, the number of drug courts had climbed to 75, joined by a variety of other specialized problem-solving courts: a women’s drug court in Michigan; a community court in New York; a DWI court in New Mexico; a juvenile drug court in California; and a family drug court in Nevada.²¹⁹ By 2007, some 2,147 drug courts were in existence, as well as 1,057 other

²¹⁵ Christopher J. Mumola, *Veterans in Prison or Jail, Jan. 2000*, BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE 7, Sept. 2000, available at <http://bit.ly/8ZSEXL>.

²¹⁶ Noonan & Mumola, *supra* note 88, at 4.

²¹⁷ *See, e.g.*, Pratt, *supra* note 89, at 41 (citing additional studies in Buffalo, New York and King County, Washington).

²¹⁸ C. West Huddleston, et al, *Painting the Picture: A National Report Card on Drug Courts and Other Problem-Solving Court Programs in the United States*, NATIONAL DRUG COURT INSTITUTE 1, May 2008, available at <http://bit.ly/bNhOI9>.

²¹⁹ *Id.*

problem-solving courts.²²⁰ Both independent and state researchers have consistently concluded that drug courts reduce future criminal activity for participants and deliver measurable savings for states. A study in California reported re-arrest rates of 41 percent for drug offenders who did not participate in drug court and 29 percent for offenders who did participate in drug court.²²¹ A similar study in Massachusetts reported that drug court participants “were 13 % less likely to be re-arrested, 34% less likely to be re-convicted, and 24% less likely to be re-incarcerated” than those on probation for similar offenses.²²² In four different “meta-analysis” studies, independent researchers have found “that drug courts significantly reduce crime rates an average of approximately 7 to 14 percentage points.”²²³ Further, researchers have found that while drug courts have significant start-up costs, they are more cost-effective in the long-run. An analysis of drug courts in Washington State found an average cost of \$4,333 per client, but an average savings per client of \$4,705 for taxpayers and \$4,395 for potential future victims.²²⁴ A study in California found an average cost of \$3,000 per client, with an average savings of \$11,000 per client.²²⁵ Nationally, drug courts are estimated to save taxpayers \$90 million annually.²²⁶ Other studies reveal similar savings.²²⁷

Given that drug courts utilize the same tenet methodologies as those now employed by veterans courts, drug court outcomes provide a useful comparator in estimating veterans courts’ recidivism rates and community savings. Additionally, several commentators have postulated

²²⁰ *Id.* at 1, 18.

²²¹ *Id.* at 6 (citation omitted).

²²² *Id.* (citation omitted).

²²³ Huddleston, *supra* note 218, at 6 (citations omitted).

²²⁴ *Id.*

²²⁵ *Id.*

²²⁶ Russell, *supra* note 169, at 371.

²²⁷ See, e.g., Berenson, *supra* note 169, at 40 (noting financial savings of drug courts and citing Dwight Vick & Jennifer Lamb Keating, *Community-Based Drug Courts. Empirical Success: Will South Dakota Follow Suit?*, 52 S.D. L. REV. 288, 304 (2007)).

that savings generated by veterans courts should outpace those of drug courts because the Department of Veterans Affairs offers at federal expense many of the support services participants in other problem-solving courts can obtain only at state or community expense.²²⁸

Advocates and Critics

Proponents of veterans courts primarily base their support of specialized problem-solving courts for veterans on one of three grounds. First, veterans are “a niche population with unique needs.”²²⁹ Service-members share experiences which are not common among members of the general public, including the trauma of combat, the strain of deployment, and the discipline inherent in military service. These experiences, proponents argue, can only be leveraged when the justice system both acknowledges and builds upon them.²³⁰ Second, veterans courts equip judges with rehabilitative tools beyond those available in a traditional criminal justice setting, where probation or incarceration are too often the only alternatives following conviction.²³¹ By including community partners in the process, veterans courts connect troubled veterans to service providers offering a range of veterans benefits, such as the Department of Veterans Affairs,²³² which veterans otherwise may not access.²³³ Third, veterans hold a unique position in society because of the patriotic service they have rendered. As a result, they deserve both assistance and leniency whenever possible.²³⁴ This mirrors the “grateful nation” language of earlier eras, most recently echoed by the Supreme Court in *Porter v. McCollum* when it stated, “Our Nation has a

²²⁸ See, e.g., Graman, *supra* note 191 (discussing cost savings of veterans courts).

²²⁹ Russell, *supra* note 169, at 363.

²³⁰ See *id.* at 363.

²³¹ See Berenson, *supra* note 169, at 38.

²³² See Russell, *supra* note 169, at 361; Pratt, *supra* note 89, at 51.

²³³ See Russell, *supra* note 169, at 361 (veterans reluctant to seek mental health assistance); *id.* at 363 (only 41 percent of soldiers involved in alcohol-related incidents referred to an alcohol program).

²³⁴ See Berenson, *supra* note 169, at 40 (arguing veterans deserve special treatment because they “were willing to sacrifice life and limb in service to their country”).

long tradition of according leniency to veterans in recognition of their service, especially for those who fought on the front lines as Porter did.”²³⁵ Veterans courts, advocates argue, are the best and most appropriate manifestation of that leniency.

Although muted, some critics have expressed concern that veterans courts unfairly benefit veterans by singling them out as a discrete population.²³⁶ Unlike drug or DWI courts, critics might argue, participation in veterans court is not based on commission of a particular offense, but on membership in a particular group. Should states also create courts for individuals of other like-minded interest groups, such as those sharing similarities in income, religion, or life experience? The ACLU of Nevada made an argument similar to this when it challenged legislation in Nevada creating a court specifically for veterans. According to one ACLU of Nevada representative, the proposed legislation would have provided “an automatic free-pass based on military status to certain criminal-defense rights that others don’t have.”²³⁷ A representative of ACLU of Colorado agreed, arguing “that the legal category of ‘veteran’ is both too broad and too narrow, sweeping in both Vietnam and World War II veterans who have very different experiences, but excluding non-veterans who also suffer from PTSD and aren’t eligible for any special courts.”²³⁸ The national arm of the ACLU avoided weighing in on the issue, but a spokesman for the ACLU in Illinois stated the ACLU had no concern with veterans courts that

²³⁵ *Porter v. McCollum*, 558 U.S. ___, 130 S. Ct. 447, 448 (2009) (per curiam). See also Pratt, *supra* note 89, at 45 (quoting *United States v. Pipich*, 688 F. Supp. 191 (D. Md. 1988) (“An exemplary military record, such as that possessed by the defendant, demonstrates that the person has displayed attributes of courage, loyalty, and personal sacrifice that others in society have not.”)).

²³⁶ See Graman, *supra* note 191 (observing “[c]ritics of veterans courts argue that the American justice system should single no one out for special treatment”); Hawkins, *supra* note 169, at 570-71 (“Of particular concern to civil libertarians is the disparity in treatment between non-violent drug offenders who are not veterans and those who are.” (citation omitted)).

²³⁷ Dahlia Lithwick, *A Separate Peace: Why Veterans Deserve Special Courts*, NEWSWEEK, Feb. 11, 2010, available at <http://bit.ly/chHEMT>.

²³⁸ *Id.*

model drug treatment courts. The objections in Nevada, the spokesman said, were that the legislation “automatically” transferred veterans into a special court and “provided some options for lower-level sentences.”²³⁹

Another objection centers on the perception that veterans courts allow veteran-defendants to avoid criminal responsibility by blaming their actions on their PTSD. TESSA, an advocacy group for domestic violence victims, voiced concern on precisely these grounds when a Colorado veterans court included on its docket low-level domestic violence cases. “We know that veterans who serve in combat have some unique, serious mental health issues as a result of that trauma,” the group’s Executive Director said, but “using PTSD or traumatic brain injury as the reason for violence is wrong[.]”²⁴⁰ In objecting, TESSA’s Executive Director noted that domestic violence victims routinely suffer from PTSD without resorting to violence.²⁴¹

In the 2009 Oregon case discussed earlier, the victim’s family objected to the trial’s result on similar grounds. as unfair. “We understand he has PTSD,” the victim’s brother told reporters, “But does that give him the right to just go murder somebody?”²⁴² At the heart of the family’s complaint is a concern that criminal justice system lacks fairness when the perpetrator’s rehabilitative interests are placed above the victim’s retributive interests. Aside from the relative merits of these arguments, which have been discussed in broader contexts elsewhere,²⁴³ the point

²³⁹ Debra Cassens Weiss, ACLU Likes Veterans Court—If It Doesn’t Include Special Sentencing Deals, A.B.A. J., Jul. 15, 2009, <http://bit.ly/aCeb5v>.

²⁴⁰ Amy Gillentine, *4th Judicial District Creating Special Court for Veterans*, CO. SPRINGS. BUS. J., Feb. 2, 2010, available at <http://bit.ly/cLYdul>.

²⁴¹ *Id.*

²⁴² Murphy, *supra* note 148.

²⁴³ See, e.g., *The Law of Mental Illness: Mental Health Courts and the Trend Toward a Rehabilitative Justice System*, 121 HARV. L. REV. 1168, 1174-75 (2008) (discussing swing of justice system pendulum between rehabilitative model of treatment and retributive model of punishment for criminal offenses).

they impress on those involved in developing veterans courts is that the interests of *all* justice system stakeholders require consideration in establishing a sustainable treatment program.

CONCLUSION

Drawing on the history of combat-related trauma and its evolving reception in both the medical and legal communities, several lessons relevant to the establishment of veterans courts present themselves. First, combat-related trauma is neither new nor unique. Three hundred years of military history in the United States provides more than sufficient evidence to conclude that a significant percentage of veterans from the Revolutionary War to the Iraq war (a) have suffered from combat-related trauma, and (b) had difficulty with social reintegration once they returned from combat. In light of this history, medical and social service providers should be proactively engaged in preparing for and treating returning combat veterans whose mental wounds, though invisible, exact an individual and social price no less than real than the physical wounds of war.

Second, combat-related trauma increases the risk that veterans will engage in criminal behavior. As the Wilson and Zigelbaum study suggests, veterans suffering from PTSD may respond by engaging in behaviors that, if left unattended, sometimes lead to criminal activity, including anger, violence, alcoholism, drug dependency, thrill-seeking, and despondency. Knowing this, justice system stakeholders should design criminal court procedures that emphasize treatment and rehabilitation over punishment whenever possible—a course that would result in fiscal benefits by reducing incarceration costs and, more importantly, social benefits by returning to society those members who arguably are among its most valuable and productive.

Third, judicial leniency toward veterans is part of the United States' historical tradition. Though perhaps not always shown, courts have long displayed sympathy for veterans whose military heroism in behalf of their country results in personal sacrifice and suffering, especially when that suffering later contributes to criminal misdeeds. Recognizing the liminal effects of combat in military veterans is thus a judicially appropriate response when the misconduct at issue arises from combat-related trauma.

Fourth, treatment methodologies employed by most problem-solving courts are well-suited to the needs of veterans facing prosecution in veterans courts. Most operating veterans courts adjudge misdemeanor and felony offenses committed by veterans with either substance abuse or mental illness concerns, both of which have been treated with marked success by drug and mental health courts. The ten key components of drug courts emphasize a voluntary, community-based approach to treatment. Coupled with involvement by a caring veteran-mentor and the Department of Veterans Affairs, the success of veterans courts should parallel—if not exceed—that of other problem-solving courts.

Fifth, veterans courts that hear violent offenses should seek to ameliorate victim concerns while advancing treatment opportunities for veterans suffering from combat-related trauma. As a matter of law, combat trauma may provide an affirmative or mitigating defense to criminal responsibility, a matter of concern to critics who view it as an escape hatch for veterans. In veterans courts, therefore, where courtroom adversity is sidestepped in favor of a collaborative, therapeutic approach to rehabilitation, victims' rights should be reconciled with veterans'

interests to the fullest extent possible. Veterans courts rely on community involvement and support. Harmonizing the retributive interests of victims with the rehabilitative interests of veterans provides a pathway for public acceptance of veterans courts' existence and outcomes.

Writing in 1918, Edith Abbott summarized the debt due service members returning from war. “[T]he country is agreed,” she wrote, “that no effort shall be spared to make the transition from war to peace as little onerous as possible to the great numbers of young men from whom we are already asking such heavy sacrifices.”²⁴⁴ Continuing, she stated:

Great pity, kindness, toleration, and infinite patience will be needed on all sides when the men go back from the excitement of war to beat their bayonets into ploughshares, and adequate plans for reconstruction should be got under way if the new peace is to be worthy of those who have sacrificed their youth to secure it.²⁴⁵

In many ways, the language Abbott uses echoes from a bygone era. The lessons she urges, however, do not. Within the context of the criminal justice system, the establishment of veterans courts is, perhaps, the best means yet of helping those who sacrificed so much “beat their bayonets into ploughshares”—a necessary repayment from the society that handed veterans their bayonets in the first place.

²⁴⁴ Abbott, *supra* note 98, at 45.

²⁴⁵ *Id.*

Table 1
Key Principles to Veterans Courts
Policy 105A
American Bar Association, House of Delegates,
February 8-9, 2010,

The American Bar Association House of Delegates adopted a policy in February 2010 supporting veterans courts and setting forth key principles for their establishment.²⁴⁶ The principles identified by the ABA list specific outcomes for measuring veterans courts' success, including decreased recidivism, addiction recovery, veteran self-sufficiency, judiciary cost savings, and connection to local and federal service providers.²⁴⁷

- 1) Participation is voluntary and the constitutional rights of participants are retained.
- 2) Veterans Treatment Courts or the resources devoted to veterans within existing civil and criminal court models will utilize the participation of a caseworker and legal representative with coordination from federal Veterans Affairs employees, veteran service agencies, community-based service providers, and local agencies to assess the needs of and provide veterans with appropriate housing, treatment, services, job training, and benefits.

²⁴⁶ ABA Policy, *supra* note 204.

²⁴⁷ *Id.*

- 3) Veterans Treatment Courts or the resources devoted to veterans within existing civil and criminal court models include mentoring sessions with other veterans.
- 4) In the criminal court context, participants in the program have all qualifying charges reduced or dismissed, or traditional sanctions waived, including where appropriate and feasible, more serious charges, commensurate with completion of appropriate treatment and services. Where charges are dismissed, public access to the record is limited, where appropriate and feasible as provided by state or local law, including through expungement.
- 5) The Veterans Treatment Courts shall address those criminal matters that involve serious violent felonies only at the discretion of local courts.
- 6) The success of Veterans Treatment Courts or additional resources devoted to veterans within existing civil and criminal court models is measured through the following outcomes:
 - a) prevention and reduction of homelessness among veterans;
 - b) reduction of recidivism;
 - c) recovery achieved through compliance with the individual treatment plan of the veteran;
 - d) improved communication and reunification with family members, when appropriate;
 - e) successful elimination of legal barriers to self-sufficiency;
 - f) reentry to the workforce, enhanced job opportunities, and reintegration with the community;

- g) economic savings to the courts, criminal justice and public health systems, and the community;
- h) connection to VA benefits, long term supportive housing, and other benefits for participants whose service related disabilities are so severe as to prevent their return to the workforce.²⁴⁸

²⁴⁸ *Id.*