

HB

313

<TARGET><BILL>HB 313</BILL><SUBJECT>HB
313</SUBJECT><COMM>HJUD28</COMM></TARGET>

ALASKA STATE LEGISLATURE



REPRESENTATIVE GARA

Sponsor Statement

House Bill 313

Creating a Mitigating Factor Related to Combat-Related Post-Traumatic Stress Disorder and Traumatic Brain Injury

Many veterans have served honorably under extreme hardship, and our nation has a long tradition of according honor to veterans in recognition of their service, especially for those who fought on the front lines. Upon being discharged, and after returning home, many former soldiers begin to suffer the symptoms of combat-related post-traumatic stress disorder (PTSD), including nightmares, hyper-vigilance, the inability to sleep, and depression, as well as combat-related traumatic brain injury (TBI). The symptoms of PTSD are pervasive and cause disruption in many phases of life. The condition can last for years unless treated.

Under Alaska's sentencing statute, a judge considering a sentence for a person convicted of a felony is allowed to consider certain statutorily-created mitigating factors to reduce a sentence below a mandatory or minimum required sentence. House Bill 313 would create a new mitigating factor allowing a judge to consider whether the offender's conduct was related to combat-related PTSD or combat-related traumatic brain injury. The offender would have the burden of proving that he or she suffers from combat-related PTSD or combat-related traumatic brain injury resulting from combat with an enemy of the United States while on active duty as a member of the armed forces. The mitigator specifically excludes cases that are crimes of serious injury, so it would not apply to assaultive conduct or sexual crimes.

Combat-related PTSD and substance abuse often go hand in hand. These soldiers sometimes self-medicate by abusing drugs. Many of them should be treated with anti-anxiety medications, but they rarely disclose that they are suffering. Many former soldiers who have committed offenses after serving overseas had no prior criminal record and no substance abuse problems prior to their service. Jail conditions exacerbate the symptoms of PTSD. The soldier becomes even more hyper-vigilant in a jail setting and his or her sleep becomes even more impaired. Thus, jail actively makes the soldier worse, and any rehabilitative function of a jail sentence tends to be ineffective. Allowing the offender to prove that his or her criminal conduct was related to PTSD or traumatic brain injury as a result of service while a member of the United States Armed Forces, would give the sentencing judge the flexibility to fashion a sentence that could require specific treatment for this specific condition.

28-LS1161\N
Strasbaugh
3/26/14

CS FOR HOUSE BILL NO. 313()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-EIGHTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES GARA, LeDoux, Foster

A BILL
FOR AN ACT ENTITLED

1 **"An Act relating to mitigation at sentencing in a criminal case for a defendant found by**
2 **the court to have been affected by combat-related post-traumatic stress disorder or**
3 **combat-related traumatic brain injury."**

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 *** Section 1. AS 12.55.155(d) is amended to read:**

6 (d) The following factors shall be considered by the sentencing court if proven
7 in accordance with this section, and may allow imposition of a sentence below the
8 presumptive range set out in AS 12.55.125:

9 (1) the offense was principally accomplished by another person, and
10 the defendant manifested extreme caution or sincere concern for the safety or well-
11 being of the victim;

12 (2) the defendant, although an accomplice, played only a minor role in
13 the commission of the offense;

14 (3) the defendant committed the offense under some degree of duress,

1 coercion, threat, or compulsion insufficient to constitute a complete defense, but that
2 significantly affected the defendant's conduct;

3 (4) the conduct of a youthful defendant was substantially influenced by
4 another person more mature than the defendant;

5 (5) the conduct of an aged defendant was substantially a product of
6 physical or mental infirmities resulting from the defendant's age;

7 (6) in a conviction for assault under AS 11.41.200 - 11.41.220, the
8 defendant acted with serious provocation from the victim;

9 (7) except in the case of a crime defined by AS 11.41.410 - 11.41.470,
10 the victim provoked the crime to a significant degree;

11 (8) before the defendant knew that the criminal conduct had been
12 discovered, the defendant fully compensated or made a good faith effort to fully
13 compensate the victim of the defendant's criminal conduct for any damage or injury
14 sustained;

15 (9) the conduct constituting the offense was among the least serious
16 conduct included in the definition of the offense;

17 (10) the defendant was motivated to commit the offense solely by an
18 overwhelming compulsion to provide for emergency necessities for the defendant's
19 immediate family;

20 (11) after commission of the offense for which the defendant is being
21 sentenced, the defendant assisted authorities to detect, apprehend, or prosecute other
22 persons who committed an offense;

23 (12) the facts surrounding the commission of the offense and any
24 previous offenses by the defendant establish that the harm caused by the defendant's
25 conduct is consistently minor and inconsistent with the imposition of a substantial
26 period of imprisonment;

27 (13) the defendant is convicted of an offense specified in AS 11.71 and
28 the offense involved small quantities of a controlled substance;

29 (14) the defendant is convicted of an offense specified in AS 11.71 and
30 the offense involved the distribution of a controlled substance, other than a schedule
31 IA controlled substance, to a personal acquaintance who is 19 years of age or older for

1 no profit;

2 (15) the defendant is convicted of an offense specified in AS 11.71 and
3 the offense involved the possession of a small amount of a controlled substance for
4 personal use in the defendant's home;

5 (16) in a conviction for assault or attempted assault or for homicide or
6 attempted homicide, the defendant acted in response to domestic violence perpetrated
7 by the victim against the defendant and the domestic violence consisted of aggravated
8 or repeated instances of assaultive behavior;

9 (17) except in the case of an offense defined by AS 11.41 or
10 AS 11.46.400, the defendant has been convicted of a class B or C felony, and, at the
11 time of sentencing, has successfully completed a court-ordered treatment program as
12 defined in AS 28.35.028 that was begun after the offense was committed;

13 (18) except in the case of an offense defined under AS 11.41 or
14 AS 11.46.400 or a defendant who has previously been convicted of a felony, the
15 defendant committed the offense while suffering from a mental disease or defect as
16 defined in AS 12.47.130 that was insufficient to constitute a complete defense but that
17 significantly affected the defendant's conduct;

18 (19) the defendant is convicted of an offense under AS 11.71, and the
19 defendant sought medical assistance for another person who was experiencing a drug
20 overdose contemporaneously with the commission of the offense;

21 (20) except in the case of an offense defined under AS 11.41 or
22 AS 11.46.400, the defendant committed the offense while suffering from a condition
23 diagnosed as a fetal alcohol spectrum disorder, the fetal alcohol spectrum disorder
24 substantially impaired the defendant's judgment, behavior, capacity to recognize
25 reality, or ability to cope with the ordinary demands of life, and the fetal alcohol
26 spectrum disorder, though insufficient to constitute a complete defense, significantly
27 affected the defendant's conduct; in this paragraph, "fetal alcohol spectrum disorder"
28 means a condition of impaired brain function in the range of permanent birth defects
29 caused by maternal consumption of alcohol during pregnancy;

30 (21) except in the case of an offense defined under AS 11.41 or
31 AS 11.46.400, the defendant committed the offense while suffering from a

1 condition diagnosed as combat-related post-traumatic stress disorder or combat-
2 related traumatic brain injury, the combat-related post-traumatic stress disorder
3 or combat-related traumatic brain injury substantially impaired the defendant's
4 judgment, behavior, capacity to recognize reality, or ability to cope with the
5 ordinary demands of life, and the combat-related post-traumatic stress disorder
6 or combat-related traumatic brain injury, though insufficient to constitute a
7 complete defense, significantly affected the defendant's conduct; in this
8 paragraph, "combat-related post-traumatic stress disorder or combat-related
9 traumatic brain injury" means post-traumatic stress disorder or traumatic brain
10 injury resulting from combat with an enemy of the United States in the line of
11 duty while on active duty as a member of the armed forces of the United States;
12 nothing in this paragraph is intended to limit the application of (18) of this
13 subsection.

Statutory Definition of Traumatic Brain Injury

Sec. 47.80.529. Definition. Article 07. GENERAL PROVISIONS In AS 47.80.500 - 47.80.529, "traumatic or acquired brain injury" means an insult from physical force or internal damage to the brain or its coverings, not of a degenerative or congenital nature, that produces an altered mental state and that results in a decrease in cognitive, behavioral, emotional, or physical functioning.

FISCAL NOTE

STATE OF ALASKA
2014 LEGISLATIVE SESSION

Bill Version HB 313
Fiscal Note Number _____
() Publish Date _____

Identifier (file name) HB313-LAW-CRIM-03-10-14 Dept. Affected LAW
Title MITIGATING FACTOR: COMBAT-RELATED PTSD Appropriation Criminal Division
Allocation Criminal Justice Litigation
Sponsor REP(S) GARA, LEDOUX
Requester HOUSE MILITARY AND VETERAN'S AFFAIRS OMB Component Number 2202

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY15 Appropriation Requested	Included in Governor's FY15 Request	Out-Year Cost Estimates					
			FY15	FY16	FY17	FY18	FY19	FY20
OPERATING EXPENDITURES								
Personal Services	***		***		***	***	***	***
Travel								
Services								
Commodities								
Capital Outlay								
Grants, Benefits								
Miscellaneous								
TOTAL OPERATING	***	0.0	***	***	***	***	***	***

FUND SOURCE (Thousands of Dollars)

1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1007	I/A Rcpts (Other)							
1156	Rcpt Svcs (DGF)							
		***	0.0	***	***	***	***	***

POSITIONS

Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES

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Estimated SUPPLEMENTAL (FY14) operating costs _____ (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY15) costs _____ (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended, or repealed? _____ Discuss details in analysis section.

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial version, not applicable.

Prepared by Loretta Withington, Division Operations Manager
Division Department of Law
Approved by Michael C. Geraghty, Attorney General
Division Department of Law

Phone 465-5427
Date/Time 3/7/14 12:00 AM
Date 3/10/2014

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2014 LEGISLATIVE SESSION

BILL NO. HB 313

Analysis

HB 313 would add a new mitigating factor for sentencing persons convicted of a felony. It would allow a mitigator if the defendant was affected by a combat-related post-traumatic stress disorder or combat-related traumatic brain injury that substantially affected the defendant's behavior. If proven, the court would have discretion to reduce the term of imprisonment below the presumptive range.

The proposed new factor would not apply to persons convicted of crimes against a person (AS 11.41) or arson in the first degree (AS 11.46.400). The fiscal impact for the Department of Law is indeterminate because it will require expert testimony on the issue of whether the person suffers from such a disorder and if so, did it substantially affect his or her behavior.

FISCAL NOTE

STATE OF ALASKA
2014 LEGISLATIVE SESSION

Bill Version HB 313
 Fiscal Note Number _____
 () Publish Date _____

Identifier (file name) HB313-DOA-OPA-03-07-2014 Dept. Affected Administration
 Title Mitigating Factor: Combat Related PTSD Appropriation Legal and Advocacy Services
 Allocation Office of Public Advocacy
 Sponsor Representative Gara
 Requester House Military and Veterans Affairs OMB Component Number 43

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY15 Appropriation Requested	Included in Governor's FY15 Request	Out-Year Cost Estimates				
			FY16	FY17	FY18	FY19	FY20
OPERATING EXPENDITURES	FY15	FY15	FY16	FY17	FY18	FY19	FY20
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE		(Thousands of Dollars)					
1002	Federal Receipts						
1003	GF Match						
1004	GF						
1005	GF/Prgm (DGF)						
1007	I/A Rcpts (Other)						
1156	Rcpt Svcs (DGF)						
		0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							
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Estimated SUPPLEMENTAL (FY14) operating costs 0.0 (separate supplemental appropriation required)
 (discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY15) costs 0.0 (separate capital appropriation required)
 (discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
 If yes, by what date are the regulations to be adopted, amended, or repealed? _____ Discuss details in analysis section.

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by Richard Allen, Director
 Division Office of Public Advocacy
 Approved by Curtis Thayer, Commissioner
 Division Department of Administration

Phone 907-269-3504
 Date/Time 03-06-14 12:05 P.M.
 Date 3/7/2014

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2014 LEGISLATIVE SESSION

BILL NO. HB 313

Analysis

HB313 would amend AS 12.55.155(d), concerning mitigating factors in sentencing for criminal offenses, by adding a new mitigating factor, at new paragraph (22). The new mitigator would allow for a sentencing court to mitigate an offender's sentence upon finding that the offense was committed while the offender suffered from combat-related brain injury or Post-traumatic Stress Disorder, while on active duty with the U.S. armed forces.

Therefore, OPA submits a zero fiscal note.

FISCAL NOTE

STATE OF ALASKA
2014 LEGISLATIVE SESSION

Bill Version HB 313
Fiscal Note Number _____
() Publish Date _____

Identifier (file name) HB313-DOA-PDA-03-07-14 Dept. Affected Administration
Title Mitigating Factor: Combat Related PTSD Appropriation Legal and Advocacy Services
Allocation Public Defender Agency
Sponsor Representative Gara
Requester House Military and Veterans Affairs OMB Component Number 1631

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY15 Appropriation Requested	Included in Governor's FY15 Request	Out-Year Cost Estimates				
			FY16	FY17	FY18	FY19	FY20
OPERATING EXPENDITURES	FY15	FY15	FY16	FY17	FY18	FY19	FY20
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE		(Thousands of Dollars)					
1002	Federal Receipts						
1003	GF Match						
1004	GF						
1005	GF/Prgm (DGF)						
1007	I/A Rcpts (Other)						
1156	Rcpt Svcs (DGF)						
		0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY14) operating costs 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY15) costs 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended, or repealed? _____ Discuss details in analysis section.

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by Quinlan Steiner, Public Defender
Division Public Defender Agency
Approved by Curtis Thayer, Commissioner
Division Department of Administration

Phone 907-334-4414
Date/Time 3/6/14 3:00 PM
Date 3/7/2014

FISCAL NOTE ANALYSIS

**STATE OF ALASKA
2014 LEGISLATIVE SESSION**

BILL NO. HB 313

Analysis

HB313 creates a new mitigating factor that allows for a sentencing court to mitigate an offender's sentence upon finding that the offense was committed while the offender suffered from combat-related brain injury or Post-traumatic Stress Disorder, while on active duty with the U.S. armed forces.

HB313 is not expected to have a fiscal impact on the Public Defender Agency; the agency, therefore, submits a zero fiscal note.

FISCAL NOTE

STATE OF ALASKA
2014 LEGISLATIVE SESSION

Bill Version HB 313
Fiscal Note Number _____
() Publish Date _____

Identifier (file name) HB313-DOC-OC-03-07-14 Dept. Affected Corrections
Title MITIGATING FACTOR: COMBAT-RELATED PTSD Appropriation Admin and Support
Sponsor GARA Allocation Office of the Commissioner
Requester House Military and Veterans Affairs OMB Component Number 694

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY15 Appropriation Requested	Included in Governor's FY15 Request	Out-Year Cost Estimates				
			FY16	FY17	FY18	FY19	FY20
OPERATING EXPENDITURES	FY15	FY15	FY16	FY17	FY18	FY19	FY20
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE		(Thousands of Dollars)					
1002	Federal Receipts						
1003	GF Match						
1004	GF						
1005	GF/Prgm (DGF)						
1007	I/A Rcpts (Other)						
1156	Rcpt Svcs (DGF)						
		0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY14) operating costs 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY15) costs 0.0 (separate capital appropriation required)
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended, or repealed? _____ Discuss details in analysis section.

Why this fiscal note differs from previous version (if initial version, please note as such)

This is the original version of the bill.

Prepared by April Wilkerson, Director
Division Administrative Services - Department of Corrections
Approved by Leslie Houston, Deputy Commissioner
Division Department of Corrections

Phone 907-465-3460
Date/Time 3/7/14 11:00 AM
Date 3/7/2014

FISCAL NOTE ANALYSIS

**STATE OF ALASKA
2014 LEGISLATIVE SESSION**

BILL NO. HB 313

Analysis

This legislation provides for a mitigator at sentencing if, at the time of the offense, the defendant suffered from combat-related post-traumatic stress disorder or combat-related traumatic brain injury which significantly affected the defendant's behavior. This mitigator only applies to non-violent crimes.

This legislation could impact a number of offenders incarcerated for non-violent crimes. However, at this time, data is not available for the Department to calculate the number of defendants who would be able to take advantage of this mitigator. The Department will continue to monitor the potential impacts of this legislation.

Anchorage Veterans Court

What is the Anchorage Veterans Court?

The Anchorage Veterans Court is a specialized court designed to facilitate the rehabilitation of eligible veterans who are charged with criminal offenses. The court provides judicial monitoring coupled with alternative sentencing plea agreements to help eligible veterans succeed with their own rehabilitation and return to a productive law-abiding lifestyle, thereby reducing crime and its costs to society.

What are the objectives of the Anchorage Veterans Court?

- Promote public safety.
- Reduce incarceration of offenders who are veterans and promote their well being in the community.
- Reduce repeated contacts with the criminal justice system among our nations's veterans.
- Facilitate access to VA resources to aid the veteran with addressing problems that led to criminal justice contact.
- Promote treatment adherence for the veteran through ongoing judicial monitoring.

Who is eligible?

- The veteran must reside in the Municipality of Anchorage.
- The veteran must be eligible for VA services, as defined by federal law and confirmed by the Veterans Administration.
- The veteran must be charged with a criminal offense. A veteran charged with a felony offense will be considered on a case by case basis at this time to ensure public safety. Considerations will include the seriousness of the current offense, class of current offense, and offender's previous criminal history.
- The veteran must voluntarily agree to waive his or her right to a speedy trial during the time they participate in Anchorage Veterans Court.
- The veteran must have no other pending cases in district or superior court. All open cases must be heard at Anchorage Veterans Court hearings unless the parties decide otherwise.

...

Admission to the Anchorage Veterans Court is not automatic. The Anchorage Veterans Court, Prosecutor's Office and the VA must all agree that you and your criminal case qualify.

How does the Anchorage Veterans Court work?

Collaboration

The Anchorage Veterans Court provides a single and consistent point of contact for eligible veterans in the criminal justice system. Together the court team and the VA behavioral health system work to create a therapeutic court process that promotes behavioral change for the veteran.

Treatment

Eligible veterans receive assistance in developing, coordinating and monitoring an individualized treatment plan through the Department of Veterans Affairs. The court then orders the plan as conditions of bail or probation.

Alternative Sentencing

The veteran “opts-in” to the Anchorage Veterans Court by entering into a plea agreement. The veteran must agree to plead Guilty or No Contest to a least one charge, and agree to receive one of two sentences: a regular court sentence if the participant does not complete his or her VA treatment plan or a lesser sentence if the participant completes his or her treatment plan.

Monitoring by the Court

The court monitors the veteran’s treatment plan through regularly held status hearings during which reports are given by the VA, the prosecutor, the veteran’s attorney and the veteran.

Invitation

The Alaska Veterans Court hearings are open to the public and are held on alternate Tuesdays at 1:00 P.M. in the Nesbett Courthouse, 825 W. 4th Avenue, Anchorage, Alaska 99501.

**A Court that Assists Those
Who Have Served
in Our Armed Forces**



The Anchorage Veterans Court is a cooperative effort of:

- The Alaska Court System
- Department of Veterans Affairs (VA)
- State of Alaska Department of Law
- State of Alaska Public Defender Agency, Office of Public Advocacy
- Municipality of Anchorage Prosecutor’s Office (MOA)
- Law firm of Gorton & Logue (indigent defense contractor for the MOA)

For more information:

Alaska Veterans Court
907-264-0466
dsang@courts.state.ak.us

For more information about this publication, please call the
Alaska Court System Administrative Office at
(907) 264-8240
820 West Fourth Avenue
Anchorage, Alaska 99501

California Penal Code Section 1170.9

California has a specific statute designed for veterans suffering from post-traumatic stress disorder who become involved in criminal activity.

California Penal Code Section 1170.9 is an alternative sentencing scheme that allows judges to sentence military veterans to treatment instead of prison or jail in cases where those veterans committed their crimes as result of sexual trauma, traumatic brain injury, post-traumatic stress disorder, substance abuse, or mental health problems stemming from service in the United States military.

The statute used to be limited to combat veterans, but it was amended in 2010 to eliminate the "combat theater" requirement.

The way Penal Code Section 1170.9 works is that if a defendant alleges that he or she falls within it, the court must hold a hearing to determine eligibility. Then, if the judge determines that the defendant is eligible for alternative sentencing, the judge can sentence the veteran-defendant to treatment instead of jail or prison for a period not to exceed that which the defendant would have served in custody.

To be eligible for California Penal Code Section 1170.9, the defendant must plead guilty to the crime and must be otherwise eligible for probation.

Source: <http://www.shouselaw.com/veterans-ptsd.html#2.2>

Minnesota becomes second state to offer treatment to veterans who commit crimes

Legislators say it makes more sense to rehabilitate
Comments (0) By **Beth Walton** Wednesday, May 21 2008

Last week, Minnesota became the second state in the nation to pass a sentence-mitigation bill for veterans facing criminal prosecution who suffer from combat related mental health disorders. Gov. Tim Pawlenty signed the bill into law the evening of May 12, meaning courts will now be allowed to consider treatment over incarceration. California passed a similar law in 2007.

The legislation, tucked into the Reentry Omnibus Bill, requires the courts to inquire whether a defendant facing criminal proceedings is a veteran. By establishing military service, attorneys can then order a psychological evaluation. If a veteran is found to be suffering from a combat related mental illness such as post-traumatic stress disorder, the courts will work with the Department of Veterans Affairs so that treatment can be considered as part of the sentencing.

"I really do believe the judges will consider this, and use it as a condition of probation," says Brockton Hunter, a veteran and current legislative chair of the Minnesota Association of Criminal Defense Lawyers. "Military veterans have a heck of a time asking for help. They're proud and they're trained to believe that they can handle anything."



Nick Vicek
"It would have made all the difference in the world for many men I know who are now quite lost or dead," says Guy Gambill, a formerly homeless veteran

Instead of seeking therapy, many veterans suffering from mental disorders like post-traumatic stress disorder turn to alcohol and drugs to deal with their problems, says Hunter, who authored the bill with the help of local veteran activist Guy Gambill.

According to a recent RAND report, one in five veterans suffers from psychological problems and many are not getting adequate care. The guerilla insurgency in Iraq and the increased stress of serving multiple tours has led to higher incidents of mental disorders.

"This is just the tip of the iceberg," says Hunter. "We need to prepare for the rest as they continue to come home."

In the last three years, Hunter estimates he's defended at least 25 veterans whose military service can be linked to their crime, including Shoreview resident Tony Klecker, a veteran of the Iraq and Afghanistan wars who is now in jail for killing a 16-year-old while driving drunk in South St. Paul.

"This is not the kind of disease that is just going to go away," says Hunter. "Without proper treatment and care this stuff can linger for decades.... Until we get them help, they will continue to present the same problem, the same danger to public safety."

In 1998, the U.S. Department of Justice reported that veterans accounted for 13 percent of state prisoners and 12 percent of jail inmates, with some 225,700 veterans of the U.S. Military incarcerated.

In 2006, 25 percent of Minnesota's male homeless population were veterans, more than half of them deemed to have a serious mental illness.

"The memories of the Vietnam era haunt us all," says state Sen. Linda Higgins-DFL, who was instrumental in the bill's passing. "Everyone my age can remember at least one veteran of that war who came back and was never quite right again. We can't repeat that."

Besides the personal and often devastating social repercussions untreated mental illness can have on soldiers and their families, the RAND report also warns of the economic costs to society associated with veterans suffering from untreated mental health disorders. "Billions of dollars" of government spending can be avoided with appropriate treatment, its authors argued.

"It makes a lot more sense to give them a break now, rather than just throwing them in the slammer and dealing with it on the other end," says Gambill, a former homeless veteran himself. "I can tell you it would have made all the difference in the world for many men I know who are now quite lost or dead."

Gambill is hoping to get a national version of the bill passed by Congress. He has spent the last few weeks in Washington, D.C., lobbying Sen. Amy Klobuchar's and Congressman Keith Ellison's offices for a congressional resolution drawing attention to the nexus between veterans, mental health, and crime.

"We are creating a permanent underclass here in the United States, bagged, tagged, and set on the shelf to stumble along until the lights go out," he wrote in an email from D.C. "For many, this [legislation] is a welcome respite from the piecemeal, haphazard existence we are forced to live."

Source: <http://www.citypages.com/2008-05-21/news/minnesota-becomes-second-state-to-offer-treatment-to-veterans-who-commit-crimes/full/>



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VA » Health Care » PTSD: National Center for PTSD » Public » PTSD and Substance Abuse in Veterans

PTSD: National Center for PTSD

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PTSD and Substance Abuse in Veterans

Some people try to cope with their Posttraumatic Stress Disorder (PTSD) symptoms by drinking heavily, using drugs, or smoking too much. People with PTSD have more problems with drugs and alcohol both before and after getting PTSD. Also, even if someone does not have a problem with alcohol before a traumatic event, getting PTSD increases the risk that he or she will develop a drinking or drug problem.

Eventually, the overuse of these substances can develop into Substance Use Disorder (SUD), and treatment should be given for both PTSD and SUD to lead to successful recovery. The good news is that treatment of co-occurring (happening at the same time) PTSD and SUD works.

How common is co-occurring PTSD and SUD in Veterans?

Studies show that there is a strong relationship between PTSD and SUD, in both civilian and military populations, as well as for both men and women.

Specific to Veterans:

- More than 2 of 10 Veterans with PTSD also have SUD
- War Veterans with PTSD and alcohol problems tend to be binge drinkers. Binges may be in response to bad memories of combat trauma.
- Almost 1 out of every 3 Veterans seeking treatment for SUD also has PTSD
- The number of Veterans who smoke (nicotine) is almost double for those with PTSD (about 6 of 10) versus those without a PTSD diagnosis (3 of 10).
- In the wars in Iraq and Afghanistan, about 1 in 10 returning soldiers seen in VA have a problem with alcohol or other drugs.

How can co-occurring PTSD and SUD create problems?

If someone has both PTSD and SUD, it is likely that he or she also has other health problems (such as physical pain), relationship problems (with family and/or friends), or problems in functioning (like keeping a job or staying in school). Using drugs and/or alcohol can make PTSD symptoms worse.

For example:

- PTSD may create sleep problems (trouble falling asleep or waking up during the night). You might "medicate" yourself with alcohol or drugs because you think it helps your sleep, but drugs and alcohol change the quality of your sleep and make you feel less refreshed.
- PTSD makes you feel "numb," like being cut off from others, angry and irritable, or depressed. PTSD also makes you feel like you are always "on guard." All of these feelings can get worse when you use drugs and alcohol.
- Drug and alcohol use allows you to continue the cycle of "avoidance" found in PTSD. Avoiding bad memories and dreams or people and places can actually make PTSD last longer. You cannot make as much progress in treatment if you avoid your problems.

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GET HELP FOR PTSD

LEARN FROM VETERANS HOW PTSD TREATMENT CAN TURN YOUR LIFE AROUND

ABOUT FACE



- You may drink or use drugs because it distracts you from your problems for a short time, but drugs and alcohol make it harder to concentrate, be productive, and enjoy all parts of your life.

VA has made it easier to get help. It is important to know that treatment can help and you are not alone.

What treatments are offered for co-occurring PTSD and SUD?

Evidence shows that in general people have improved PTSD and SUD symptoms when they are provided treatment that addresses both conditions. This can involve any of the following (alone or together):

- Individual or group cognitive behavioral treatments (CBT)
- Specific psychological treatments for PTSD, such as Cognitive Processing Therapy (CPT) (en Español) or Prolonged Exposure (PE) (en Español)
- Behavioral couples therapy with your spouse or significant other
- Medications that may help you manage the PTSD or SUD symptoms

Talk with your provider about treatment for specific symptoms like pain, anger, or sleep problems.

What should I do if I think I have co-occurring PTSD and SUD?

The first step is to talk to a health professional and ask for more information about treatment options. Each VA medical center has an SUD-PTSD Specialist trained in treating both conditions to reach the best health outcomes. If there are signals you are at risk for both disorders, you will be encouraged to talk with a provider about how to best support your recovery. There are treatment resources at every VA medical center. The VA wants you to have the best possible care for co-occurring PTSD and SUD.

- Find a VA PTSD Program
- Find a VA SUD Program

If you continue to be troubled or distracted by your experiences for more than three months or have questions about your drinking or drug use, learn more about treatment options. Life can be better! Talk to a VA or other health professional to discuss choices for getting started.

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The National Center for PTSD does not provide direct clinical care, individual referrals or benefits information.

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LAST UPDATED JANUARY 3, 2014

**Cynthia Strout
Attorney at Law
745 West Fourth Ave. Suite 250
Anchorage, Alaska 99501
(907) 276-0377**

February 21st, 2014

Member of the House Military
and Veterans Affairs Committee of the
Alaska Legislature

Dear Committee Members:

I am writing to urge you to support HB 313, which would create a new statutory sentencing mitigator relating to former soldiers suffering from combat-related Post Traumatic Stress Syndrome who have committed non-violent crimes. Under Alaska's sentencing statute, a judge considering a sentence for a persons convicted of a felony is allowed to consider certain statutorily created mitigating factors to reduce a sentence below a mandatory or minimum required sentence. HB 313 would create a new mitigator allowing a judge to consider whether the offender's conduct was related to combat created PTSD. The offender would have the burden of proving that he or she suffers from combat related PTSD resulting from combat with an enemy of the Unites States while on active duty as a member of the armed forces.

I am a criminal defense attorney based in Anchorage. I have been practicing primarily criminal defense for over thirty years. In the last several years

I have both represented former soldiers who have committed drug offenses after serving in Iraq, and consulted on similar cases. These clients had no prior criminal record and no substance abuse problems prior to their service. The client I have had most experience with served in Fallujah as a medic when he was 19 and 20 years old. His experiences were horrific. He saw children blown up. His best friend, also a medic, was killed in a Humvee-IED explosion and my client picked up his body parts. He had men die in his arms and saw men who had been blown to pieces.

This client was honorably discharged; when he came home he began to suffer the symptoms of combat-related PTSD—nightmares; hyper-vigilance, the inability to sleep, depression and intruding thoughts regarding his experiences. Until I began to educate myself about PTSD, I believed it was a condition that caused some nightmares but that people quickly recovered with the passage of a little time. This not true, especially for combat-related PTSD. The symptoms are pervasive and cause disruption in all phases of life functioning; the condition lasts for years unless treated.

Combat PTSD and substance abuse go hand in hand. It is rare to see a PTSD case where drugs or alcohol are not also involved. These soldiers self-medicate by abusing drugs. Many of them should legitimately be treated with anti-anxiety medications. But they rarely disclose that they are suffering; it seems

almost symptomatic that they do not want to talk about their experiences or burden their loved ones with their suffering.

The proposed mitigator would allow a sentencing judge to consider whether the offender's non-violent criminal behavior was related to combat-related PTSD. The mitigator specifically excludes cases that are crimes of violence, so it would not apply to assaultive conduct or sexual crimes. It is my belief that the primary application of the mitigator would be for drug-related offenses, and would permit a sentencing judge to reduce jail time for certain offenders and substitute treatment instead. For example, currently a first offender charged with possessing any amount of heroin with the intention of giving it to someone else would face a required sentence of five to eight years in jail. A soldier with combat-related PTSD who trades with someone to obtain the drug to ease his symptoms could be guilty of this offense and face this sentence. If the legislature adopts this mitigator, a judge could instead suspend some of this jail time and require the offender to get treatment.

The experts I have consulted regarding PTSD tell me that jail conditions exacerbate the symptoms of PTSD—the soldier becomes even more hyper-vigilant in a jail setting, his sleep becomes even more impaired etc. Thus, jail actively makes the soldier worse, and any rehabilitative function of a jail sentence doesn't really work. Allowing the offender to prove that his criminal conduct was related

to his PTSD would give the sentencing judge the flexibility to fashion a sentence that could require specific treatment for this specific condition.

In handling these types of cases I once had a district attorney ask me why these soldiers should be treated differently than any other offenders. My response is that these young people served their country at great physical and emotional risk of harm and that when they are harmed we, as a society, should recognize that they do deserve special treatment. They went to war for us; they were damaged while protecting us and we should treat them differently. There is a difference between a young person with no record who serves his country and is traumatized and the drug dealer who is just out on the streets making money. Right now our soldiers and these drug dealers are treated exactly the same. This is not right. HB 313 will allow a court to recognize and adjust for these soldiers. I urge to you adopt the bill. I would be happy to speak further with any of your regarding this issue.

Sincerely,

Cynthia Strout

Cynthia Strout

What Is PTSD?

PTSD

Posttraumatic stress disorder, or PTSD, can occur after someone goes through, sees, or learns about a traumatic event like:

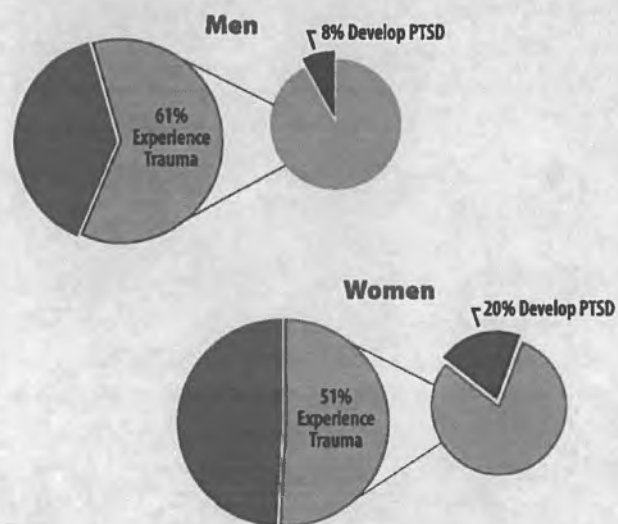
- Combat exposure
- Child sexual or physical abuse
- Terrorist attack
- Sexual/physical assault
- Serious accident
- Natural disaster

Most people have some stress-related reactions after a traumatic event. If your reactions don't go away over time and they disrupt your life, you may have PTSD.

See the next few pages for common reactions to trauma and PTSD symptoms.

How Common Is PTSD?

Many Americans have had a trauma. About 60% of men and 50% of women experience at least one traumatic event. Of those who do, about 8% of men and 20% of women will develop PTSD. For some events, like combat and sexual assault, more people develop PTSD.



What Are Some Common Stress Reactions after a Trauma?

It is normal to have stress reactions after a traumatic event. Your emotions and behavior can change in ways that are troubling to you.

Fear or anxiety

In moments of danger, our bodies prepare to fight our enemy, flee the situation, or freeze in the hope that the danger will move past us. But those feelings of alertness may stay even after the danger has passed. You may:

- feel tense or afraid
- be agitated and jumpy
- feel on alert

Sadness or depression

Sadness after a trauma may come from a sense of loss---of a loved one, of trust in the world, faith, or a previous way of life. You may:

- have crying spells
- lose interest in things you used to enjoy
- want to be alone all the time
- feel tired, empty, and numb

Guilt and shame

You may feel guilty that you did not do more to prevent the trauma. You may feel ashamed because during the trauma you acted in ways that you would not otherwise have done. You may:

- feel responsible for what happened
- feel guilty because others were injured or killed and you survived

Anger and irritability

Anger may result from feeling you have been unfairly treated. Anger can make you feel irritated and cause you to be easily set off. You may:

- lash out at your partner or spouse
- have less patience with your children
- overreact to small misunderstandings

Behavior changes

You may act in unhealthy ways. You may:

- drink, use drugs, or smoke too much
- drive aggressively
- neglect your health
- avoid certain people or situations

Most people will have some of these reactions at first, but they will get better at some time. If symptoms last longer than three months, cause you great distress, or disrupt your work or home life, you should seek help.



Real Stories: Frank



“It was nice to know there was a reason for what I was doing.”

Frank served our country in Vietnam. Before the war, he had been a happy person, but he rarely smiled once he came home.

For many years, Frank didn't talk about Vietnam, thinking he would spare people. He started drinking more. He had a short temper, and had to have his back to the wall in restaurants because he kept thinking someone was after him. He couldn't hold a job or have a successful relationship. He just felt that something was wrong. Frank didn't realize it, but he was having many of the symptoms of PTSD.

Frank went to the VA, where he was diagnosed with PTSD and given treatment and support. He's doing much better now.

“I would definitely recommend any Veteran go and get help.”

What Other Problems Do People with PTSD Experience?

People with PTSD may feel hopelessness, shame, or despair. Employment and relationship problems are also common. Depression, anxiety, and alcohol or drug use often occur at the same time as PTSD. In many cases, the PTSD treatments described in the Getting Help section will also help these other disorders, because the problems are often related and the coping skills you learn work for all of them.

How Likely Is a Person to Develop PTSD after a Trauma?

How likely you are to get PTSD can depend on things like:

- How intense the trauma was or how long it lasted
- If you lost someone you were close to or if you were hurt
- How close you were to the event
- How strong your reaction was
- How much you felt in control of events
- How much help and support you got after the event

Some groups of people may be more likely than others to develop PTSD. You are more likely to develop PTSD if you:

- Are female or a minority
- Have little education
- Had an earlier life-threatening event or trauma
- Have another mental health problem
- Have family members who have had mental health problems
- Have little support from family and friends
- Have had recent, stressful life changes



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Traumatic Brain Injury and PTSD

E. Lanier Sumnerall, MD, MPH

Background Information

The conflicts in Iraq and Afghanistan have resulted in increased numbers of Veterans who have experienced traumatic brain injuries (TBI). The Department of Defense and the Defense and Veteran's Brain Injury Center estimate that 22% of all combat casualties from these conflicts are brain injuries, compared to 12% of Vietnam related combat casualties. 60% to 80% of soldiers who have other blast injuries may also have traumatic brain injuries. This fact sheet provides information on the classification and natural history of traumatic brain injury; comorbidities in the Veteran population; challenges in the diagnosis and treatment of these disorders; and special issues for families living with traumatic brain injury.

Classification and Natural History of Traumatic Brain Injuries (TBI)

Severity

Many patients and clinicians assume that the terms mild, moderate and severe TBI refer to the severity of symptoms associated with the injury. In fact these terms refer to the nature of the injury itself. Here are the accepted definitions:

- Mild traumatic brain injury is defined as a loss or alteration of consciousness < 30 minutes, post-traumatic amnesia < 24 hours, focal neurologic deficits that may or may not be transient, and/or Glasgow Coma Score (GCS) of 13-15.
- Moderate traumatic brain injuries entail loss of consciousness > 30 minutes, post-traumatic amnesia > 24 hours, and an initial GCS 9-12.
- Severe brain injuries entail all of the moderate criteria listed above, but with a GCS < 9.

Mild TBI

About 80% of all TBIs in the civilian population are mild traumatic brain injuries (mTBI). The primary causes of TBI's in the civilian population are falls, motor vehicle accidents, being struck by an object, and assaults. Immediately subsequent to the initial insult, 80% to 100% of patients with mTBI will experience one or more symptoms related to their injury, such as headache, dizziness, insomnia, impaired memory and/or lowered tolerance for noise and light. In most cases of mTBI the patient returns to their previous level of function within three to six months, and it is important to reassure patients about this fact. However, some 10% to 15% of patients may go on to develop chronic post-concussive symptoms. These symptoms can be grouped into three categories: somatic (headache, tinnitus, insomnia, etc.), cognitive (memory, attention and concentration difficulties and emotional/behavioral (irritability, depression, anxiety, behavioral dyscontrol). Patients who have experienced mTBI are also at increased risk for psychiatric disorders compared to the general population, including depression and PTSD.

In the military population, the emerging picture is somewhat different. The primary causes of TBI in Veterans of Iraq and Afghanistan are blasts, blast plus motor vehicle accidents (MVA's), MVA's alone, and gunshot wounds. Exposure

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to blasts is unlike other causes of mTBI and may produce different symptoms and natural history. For example, Veterans seem to experience the post-concussive symptoms described above for longer than the civilian population; some studies show most will still have residual symptoms 18-24 months after the injury. In addition, many Veterans have multiple medical problems. The comorbidity of PTSD, history of mild TBI, chronic pain and substance abuse is common and may complicate recovery from any single diagnosis. Given these special considerations, it is especially important to reassure Veterans that their symptoms are time-limited and, with appropriate treatment and healthy behaviors, likely to improve.

Moderate and Severe TBI

Patients with moderate and severe brain injuries often have focal deficits and occasionally profound brain damage. However, it should be noted that the severity of the initial injury does not correlate in a linear fashion with the severity of the brain damage, and that some of these patients can make remarkable recoveries. They may need ongoing cognitive and vocational rehabilitation, case management, and pharmacological intervention to return to their highest level of function.

Diagnosis

The diagnosis of TBI, associated post-concussive symptoms and other comorbidities such as PTSD, presents unique challenges for diagnosticians. No screening instruments available can reliably make the diagnosis; the gold standard remains an interview by a skilled clinician. The current VA screening tool is intended to initiate the evaluation process, not to definitively make a diagnosis.

Details of the original injury can be elusive. Patients with moderate and severe brain injuries often, though not always, have unequivocal evidence of the relationship of their symptoms to their injury. Patients who have experienced mTBI can be more difficult to diagnose. The brevity of the initial alteration of consciousness may cause the initial injury to go unnoticed and the patient may present some time after the original injury when details are unclear. Another factor is that these injuries can occur in chaotic circumstances, such as combat, and may be ignored in the heat of events. Clinicians may be presented with vague concerns and little relevant detail about the original injury; whenever possible, clinicians and patients should attempt to obtain supporting documentation. At minimum clinicians should elicit as detailed an injury history as possible.

Once the injury history has been established, the patient's course of recovery and remaining post-concussive symptoms should be documented. Because of the considerable symptom overlap between post-concussive symptoms and symptoms of many psychiatric and neurologic disorders, this process can be challenging. Clinicians should have a low threshold to consult available expertise when making these diagnoses.

Patients with TBI often meet criteria for PTSD on screening instruments for TBI and vice versa. Some of these positive screens may represent false positives, but many OEF/OIF Veterans have experienced a mild traumatic brain injury AND ALSO have PTSD related to their combat experience.

Treatment

To manage this new injury profile, the VA has initiated the Polytrauma System of Care, which treats patients with traumatic brain injury who also have experienced musculoskeletal, neurologic and psychological trauma. Many of the most severely injured Polytrauma patients are already receiving treatment at one of the 4 Polytrauma Rehabilitation Centers or one of the 21 Polytrauma Network Sites. Patients with milder injuries may present for treatment at other locales, including their local VA's or in their communities. Regardless of where a patient engages in treatment initially, there is no "wrong door" for treatment and the VA is working to ensure that any barriers to access are minimized.

Randomized controlled trials have demonstrated that education for the patient and family early in the course of recovery can improve outcomes in patients with TBI and help to prevent the development of other psychological problems.

Unfortunately, for reasons outlined above, many patients and their families do not receive education early in the course of illness and may require intervention after symptoms have become well established. Currently, the VA encourages a recovery message when prognosis is discussed, and inclusion of the family in treatment planning.

Treatments for PTSD, mTBI and other comorbidities should be symptom-focused and evidence based in concurrence with current practice guidelines (available at VA/DoD Clinical Practice Guidelines). For example, early data shows that the treatments that have worked well in Veterans with PTSD alone, such as cognitive processing therapy, prolonged exposure or SSRIs, can also work well for Veterans who have suffered a mild traumatic brain injury as well as emotional trauma. Memory aids can also be useful in this population. Patients can also benefit from occupational rehabilitation and case management, depending on the severity of their injuries. Patient should be referred to consultants, such as neurologists, neuropsychologists, and substance abuse or other specialized treatment as needed.

Given the complexity of treatment plans for these Veterans, careful collaboration and coordination of care between all providers is a critical element of treatment success. The VA is exploring ways to enhance this collaboration, particularly in more community-based outpatient clinics and more rural environments.

Family Issues

TBI of any severity can disrupt families, in no small part because of family members' changing roles in response to the patient's difficulties, even if these problems ultimately improve. Immediate family involvement and education about the course of illness is crucial, and ongoing attention should be paid to family needs as time passes. Supporting families can improve outcomes by ensuring that the patient's recovery is not hampered by a deteriorating family situation. Many providers will not have the time or expertise to include families in all phases of treatment, again, clinicians should not hesitate to seek out available expertise and support groups early in the course of illness.

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U.S. Department of Veterans Affairs | 810 Vermont Avenue, NW Washington DC 20420
 LAST UPDATED JANUARY 3, 2014



February 21, 2014

Representative Les Gara
Alaska State House
REF: HB 313

Les,

I was very pleased to receive your bill, HB 313 An Act relating to mitigation at sentencing in a criminal case for a defendant found by the court to have been affected by combat-related post-traumatic stress disorder or combat-related traumatic brain injury.

This is the first I've heard of this notion and I'm very pleased to support it.

As most of you know we have been researching the problem of veteran homelessness now for six years in our effort to end veteran homelessness in Anchorage and then Alaska. Believe me, lots to read and think about. One of the determining factors significantly contributing to veteran homelessness is combat related PTSD and minor TBI. I make a specific note to "minor" TBI as serious TBI is usually very obvious and severely disabling. But we are just beginning to understand, and technology is just beginning to help see minor TBI and how it changes behavior.

In addition to PTSD and minor TBI the abrupt separation of a service member from the camaraderie they experienced in service, often for the first time in their lives, and very much so in a combat theatre, the transition back into civil society is very difficult especially when you don't have family or friends as your support group. This often manifests itself in anger and violent behavior towards others and themselves. Often not out of malice but out of a sense of survival under stress.

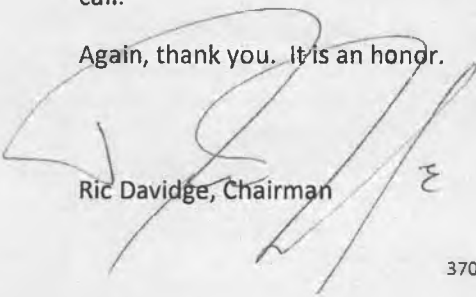
The best work on combat PTSD is *Once a Warrior Always a Warrior* written by the Department of Defense colonel responsible for understanding this challenge. Anyone who works with combat veterans must read this book if they are to truly understand the challenge. This is not a curable it is only a treatable, but we are making significant progress in that area.

Allowing a judge and hopefully a prosecutor to consider combat related PTSD and minor TBI in relationship to a violent act that may be criminal is an important step in helping these men and women navigate their way home – even with missteps. Thank you. This is truly a compassionate consideration.

We at the Alaska Veterans Foundation, Inc. are strongly in support of this bill. We have forwarded it to 49 other states through the National Conference of State Council Presidents of Vietnam Veterans of America in hope that other states will consider similar legislation.

If I or our team can be of any further assistance in looking at this legislation or similar bills of concern, please call.

Again, thank you. It is an honor.


Ric Davidge, Chairman

Toby Smith

From: Schroeder, Kaci K (DOC) <kaci.schroeder@alaska.gov>
Sent: Thursday, March 13, 2014 2:17 PM
To: Toby Smith
Subject: PTSD and TBI in DOC

Toby,

Our diagnostic process starts at remand. We ask about FASD and about a history of TBI and our medical staff make clinical observations as well. If indicated, the inmate is then referred to mental health for a confirming diagnosis and possibly treatment. There is not a lot of treatment for TBI – sometimes medications can help with impulsivity, chronic pain, etc. There are some medications that we prescribe for PTSD when it is significant enough that the inmate has night terrors, flashbacks or other symptoms that interfere with their ability to function in DOC or participate in rehabilitative programming. We might also see the individual one on one or refer to a coping skills group. And if they have functional impairments, we work with them to secure appropriate resources in the community upon release.

Hope this helps. Please let me know as soon as you know when the bill is up again and I will have someone from our medical team available for questions. Thanks!



KACI SCHROEDER
Special Assistant to the Commissioner II

Alaska Department of Corrections
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Fax: (907) 485-3390 • kaci.schroeder@alaska.gov

★ CHOOSE RESPECT ★

March 13, 2014

To: Rick Davidge

From: TP Hubert, Veterans Incarcerated (VIC) National Chair

Re: Veterans Justice

- What Veterans benefits apply to Veterans while incarcerated?

Veterans Administration (VA) benefits are almost non-existent for veterans incarcerated and payments for retirement/disabilities are reduced to 10% after 60 days of incarceration. However, veterans can file a VA form to have their retirement/disability checks sent to their immediate family.

- What opportunities exist for diagnosis of PTSD and TBI while incarcerated in Alaska?
- What opportunities exist for treatment of PTSD and TBI while incarcerated in Alaska?
- Is treatment for PTSD better in or out of jail?

Post-traumatic stress disorder/Traumatic Brain Injury (PTSD/TBI) treatment during incarceration is almost non-existent. Vietnam Veterans of America (VVA) through the PTSD/VIC committees maintain the VA is the "sole source provider" for PTSD/TBI treatment services.

Note: The Vet Centers in the 1990's used to send outreach counselors into the prisons and conduct group sessions.

Many state prisons allow or permit incarcerated veteran groups or VVA chapters to organize and deal with PTSD themselves often with staff and outside volunteers to assist them. The BOP (Bureau of Prisons), the largest prison system with 220,000 prisoners, do not permit prisoner self-help programs per the NFP Act (No Frill Prisons Act 1996) and many states adopted the model which severely limits prison programming opportunities.

Generally speaking, prison administrators have two overriding concerns when it comes to transporting prisoners outside their perimeters first and foremost, security. It takes two officers with one being armed to escort them in the community. Secondly, budgetary and staffing restraints associated with taking prisoners into the community for any reason. So they are reluctant to make any unnecessary prisoner transports short of court orders or emergencies. Furthermore, they are really reluctant to turn prisoners over to other authorities, like the VA police.....

VA does not provide medical, dental or mental health services to incarcerated veterans because it is assumed prisons and jails are obligated to meet Constitutional minimum standards for these services. It is a duplication of services thus a budgetary concern of the VA.

Per the 2012 ACA (American Correctional Association) Directory, Alaska had almost 3,000 prisoners in 2011. Does the Alaska DOC identify veterans? Do the jails?

The VVA (VIC) has long urged the Department of Justice (DOJ) to hold the states and jails accountable for identifying veterans confined in their institutions as required if they receive DOJ funds and grants. The DOJ is negligent in assuring compliance with this mandate which makes it difficult to get adequate data and statistics about incarcerated veterans.

Earliest DOJ/BJS (Bureau of Justice Statistics) data is from 1985 reflects that 21% of the prisoners were veterans....1987 NVVRS (National Vietnam Veteran Readjustment Study) indicated that 36% of Vietnam veterans were arrested (justice challenged) upon their return and 11% convicted of felonies.... Both of these sources were behind the VA/DOD support for Veteran Courts with the NADCP (National Association of Drug Court Professionals) for the new generation of veterans. More recently, *Vets For Justice*, 1st Annual Veteran Court Conference- VA Secretary Shinseki: Since 2004, VA increase of 38% for MH/AOD and he estimated 700,000 veterans in jail or prison. Although I am skeptical about 700,000 and I generally support the notion that about 10% of our country are veterans and extrapolate that approximately a quarter million of our country's 2.3 million prisoners are veterans.

- What other states have implemented similar legislation?

California and Minnesota have veteran specific legislation similar to your House Bill No. 313.

- What is the official definition of PTSD?

See the newly revised DSM V replacing the DSM IV which listed PTSD and identified its symptoms for the first time in 1985, fully 10 years after Vietnam.

- What VA rehabilitation services are offered that a sentencing judge could impose as part of a mitigated sentence?
- Can we include in the mitigating factor options that would provide the judge the ability to assign rehabilitation responsibilities to the VA?

Simply put, the reason Veteran Courts are successful rest on the fact the VA provides a variety of mental health, medical and substance abuse (AOD) services and treatment as long as the veteran is not incarcerated.....

- If Veteran benefits do not apply during treatment, and an offender is sentenced to state-mandated treatment, must the state pay for the rehabilitation services, and would that create a fiscal note?

The VA is obligated to provide these services anyway and will do so again as long as they are not incarcerated.....The VA implemented the HCRV (Health Care for Reentry Veterans) in 2007 and hired Reentry Specialists who go to the prisons to identify those who are within 6 months of release to assist and develop reentry plans and VA services. I have included their summary statistics in their report, "Risk of Incarceration and Other Characteristics of Iraq and Afghanistan Veterans in State and Federal Prisons".

The VA does reinstate benefits and provides services and funds for prisoners in transitional programs such as work release, half-way houses and residential programs. These community based correctional programs allow veterans full access to VA benefits and resources.

- If Veteran benefits do not apply during treatment, and an offender is sentenced to state-mandated treatment, must the state pay for the rehabilitation services, and would that create a fiscal note?

If a judge mandates treatment, who pays? The VA will provide these services with no cost to the state or county. It is an "earned benefit" and only withdrawn after 60 days of continuous confinement. The reason Veteran Courts works so well and are cropping up all over the country is this fact; the most expensive part of court supervision is associated with treatment of offenders by mental health and AOD providers. Most jurisdictions are fiscally strapped to provide these services thus the VA's almost limitless resources are available at no cost to state and counties.



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DSM-5 Criteria for PTSD

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (1). The diagnostic criteria are specified below.

Note that DSM-5 introduced a preschool subtype of PTSD for children ages six years and younger. The criteria below are specific to adults, adolescents, and children older than six years.

Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-5. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted.

Criterion A: stressor

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts, professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: intrusion symptoms

The traumatic event is persistently re-experienced in the following way(s): (one required)

1. Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.

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5. Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Criterion D: negative alterations in cognitions and mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

Criterion E: alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

Criterion F: duration

Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

Criterion G: functional significance

Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criterion H: exclusion

Disturbance is not due to medication, substance use, or other illness.

Specify if: With dissociative symptoms.

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

- 1. **Depersonalization:** experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
- 2. **Derealization:** experience of unreality, distance, or distortion (e.g., "things are not real").

PTSD Site Map | Public Ser

The National Center for PTSD does not

For help please see:
Where to Get Help for PTSD or
Get Help with VA PTSD Care, Benefits, or

For Web site help: Web Policies

Specify if: With delayed expression.

Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

References

- 1. American Psychiatric Association. (2013) *Diagnostic and statistical manual of mental disorders*, (5th ed.). Washington, DC: Author.

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