

HB

313

<TARGET><BILL>HB 313</BILL><SUBJECT>HB
313</SUBJECT><COMM>HMLV28</COMM></TARGET>

REPRESENTATIVE LES GARA

(907) 465-2647 | State Capitol Building, Room 400 | <http://www.replesgara.com>

HB313

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Sponsor

Statement

House Bill 313 "Mitigating Factor: Combat-Related PTSD"

"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.

A handwritten signature in black ink, appearing to read "Les Gara".

REPRESENTATIVE LES GARA



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

**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



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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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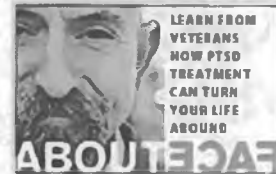
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GET HELP FOR PTSD



- 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.

For help please see:

Where to Get Help for PTSD or
Get Help with VA PTSD Care, Benefits, or Claims

For Web site help: Web Policies

PTSD Information Voice Mail
(802) 296-6300

Contact Us: ncptsd@va.gov
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Traumatic Brain Injury and PTSD

E. Lanier Summerall, 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 TBI's 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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What Is PTSD?

PTSD

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

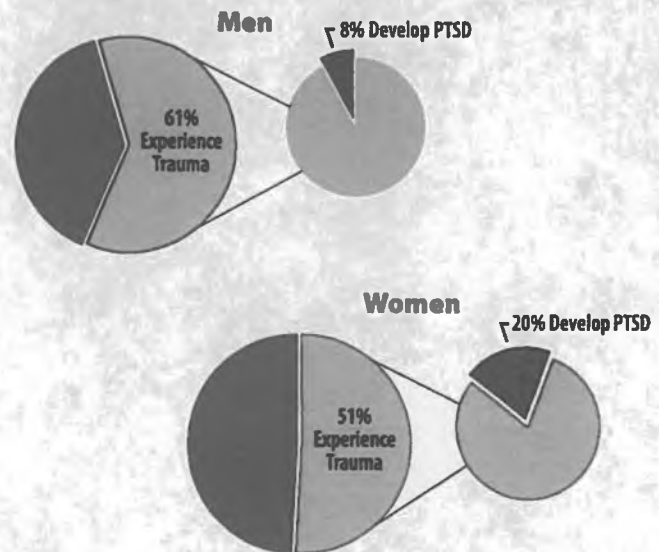
- Combat exposure
- Child sexual or physical abuse
- Terrorist attack
- Sexual/physical assault
- Serious accident
- Natural disaster

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

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-DOC-OC-03-07-14 Dept. Affected Corrections
Title MITIGATING FACTOR: COMBAT-RELATED PTSD Appropriation Admin and Support
Allocation Office of the Commissioner
Sponsor GARA
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	Included in Governor's	Out-Year Cost Estimates				
	Appropriation Requested	FY15 Request	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)

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.

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	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY15 Request	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 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-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							

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.