

Healing a Broken System: Veterans Battling Addiction and Incarceration

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Reason. Compassion. Justice.

Thousands of veterans of the wars in Iraq and Afghanistan are returning with Post-Traumatic Stress Disorder (PTSD),¹ Traumatic Brain Injury (TBI),² and other illnesses and injuries³ that often contribute to substance abuse and addiction,^{4,5} fatal overdose,⁶ homelessness,⁷ and suicide.⁸ The current generation of veterans joins the large population of Vietnam-era veterans who have struggled with the same problems for decades.⁹

Left untreated, these underlying medical conditions also contribute to violations of the law, especially nonviolent drug offenses.¹⁰ Indeed, in 2004 roughly 140,000 veterans were in U.S. state and federal prisons,¹¹ with tens of thousands more in county jails.¹² Research shows that the single greatest predictive factor for the incarceration of veterans is substance abuse.¹³

As more veterans return from longer and repeated deployments to Iraq and Afghanistan, the number of incarcerated veterans is likely to increase significantly.^{14,15}

Incarcerated veterans with PTSD report more serious legal problems, higher lifetime use of alcohol and other drugs, and poorer overall health than those without PTSD.¹⁶

Existing literature strongly indicates that “incarcerated veterans may face a level of suicide risk that exceeds that attributable to either veteran status or incarceration alone.”¹⁷

Moreover, incarcerated veterans are highly vulnerable to death by overdose after release if they do not receive effective treatment.¹⁸

Veterans who are convicted of criminal offenses, particularly drug felonies, or those who have drug use histories, and their families, face a wide range of punitive policies that limit their access to social services necessary for their reentry to civilian life.¹⁹

This policy brief by the Drug Policy Alliance highlights some of the less-discussed but deeply

troubling issues affecting veterans and proposes proven, commonsense, and cost-effective ways to improve the health, reduce the likelihood of accidental death, and preserve the freedom of those who have served in our armed forces.

Substance Abuse and Mental Illness among U.S. Veterans

Approximately 30 percent of Iraq and Afghanistan War veterans report symptoms of PTSD, TBI, depression, or other mental illness or cognitive disability.²⁰

19 percent of current conflict veterans who have received VA care have been diagnosed with substance abuse or dependence.²¹

75 percent of Vietnam combat veterans with PTSD met criteria for substance abuse or dependence in a national study.²²

Veterans do not qualify for substance abuse disability benefits unless they also have PTSD.²³

Summary of Recommendations

The United States Department of Veterans Affairs (VA) and Department of Defense (DoD) must adopt overdose prevention programs and policies targeting veterans and service members who misuse alcohol and other drugs, or who take prescription medications, especially opioid analgesics.

Veteran treatment programs must greatly expand access to medication-assisted therapies like methadone and buprenorphine, which are the most effective means of treating opioid dependence.

State and federal governments must modify sentencing statutes and improve court-ordered drug diversion programs to better treat — rather than criminalize and incarcerate — veterans who commit nonviolent drug-related crimes.

Veterans of Every Major War Have Battled PTSD, Addiction, and Incarceration

PTSD was added to the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) after the Vietnam War, but the disorder has existed for as long as soldiers have gone to war.²⁴ What was called “soldier’s heart” during the Civil War, “shell shock” during World War I, and “combat exhaustion” or “combat fatigue” during World War II and the Korean War has evolved into what is now called PTSD.²⁵

Symptoms of PTSD include “strong memories and nightmares, feeling numb or detached, and difficulty sleeping,”²⁶ as well as hyper-arousal and hyper-vigilance, and a clinically recognized tendency to self-medicate with alcohol and other drugs.²⁷

Criminal justice involvement as a result of combat trauma is predictable after a major war. For example, 34 percent of new admissions to 11 U.S. prisons between 1946 and 1949 were WWII combat veterans.²⁸

Combat veterans from Vietnam onwards face an even greater risk of arrest and incarceration than previous generations of veterans because the U.S. now criminalizes behaviors—especially drug use—that were not covered under federal and state criminal codes until the 1970s.

Consequently, in 1985, 21 percent of all men in state prison and 23 percent of all men in federal prison were veterans—a direct legacy of Vietnam.²⁹ The largest study of Vietnam veterans, the National Vietnam Veterans Readjustment Study (NVVRS), found in 1988 that nearly half of male Vietnam combat veterans afflicted with PTSD had been arrested or incarcerated in jail one or more times, and 11 percent had been convicted of a felony.³⁰

PTSD and other psychological wounds of war may also emerge several years after returning from combat.³¹

Experts predict a tragic recurrence of these trends as current conflict veterans return home, unless urgent, evidence-based responses to support veterans battling addiction and incarceration are

implemented at the local, state, and national levels.³²

Veterans in Prison, as of 2004*

140,000 veterans were incarcerated in state and federal prisons.

46 percent of veterans in federal prison were incarcerated for drug law violations.

15 percent of veterans in state prison were incarcerated for drug law violations, including 5.6 percent for simple possession.

More than 25 percent of veterans in prison were intoxicated at the time of their arrest.

61 percent of incarcerated veterans met the DSM-IV criteria for substance dependence or abuse.

More than half of veterans in federal (64 percent) and state prisons (54 percent) served during wartime.

26 percent of veterans in federal prison and 20 percent in state prison served in combat.

38 percent of veterans in state prison received less than an honorable discharge, which may disqualify them for VA benefits.

* Source: United States Department of Justice, Bureau of Justice Statistics, “Veterans in State and Federal Prison, 2004” 1,4,5,6,11 (May 2007).

Veterans Face Heightened Risk for Drug Overdose and Hazardous Drinking

Veterans who struggle with substance abuse and mental illness are much more likely to die prematurely than their peers who are not afflicted with these conditions.³³ In particular, Vietnam veterans with PTSD from combat face a heightened risk of dying from a fatal drug overdose.³⁴

Media and anecdotal reports suggest that overdose is claiming many veterans of the current conflicts.³⁵ Their risk of fatal overdose is especially high given the widespread use of

prescription medications, especially opioid analgesics for relief of pain from combat injuries³⁶ and antidepressants for mental health treatment.³⁷

In addition to the many service members and veterans taking medicines by prescription, others may be self-medicating with these drugs.³⁸ Still others report being prescribed several of these medicines at the same time, sometimes with lax supervision from their doctors.³⁹ The VA conducted a recent audit of 20 inpatient rehabilitation facilities in its system and found that a majority did not have adequate screening policies for new patients, while a significant minority (roughly 10 percent) of patients who are permitted to administer their own narcotics received more than a week's supply at a time.⁴⁰

Prescription drugs are often taken alongside alcohol and other substances⁴¹ — practices that significantly raise the risk of overdose.⁴²

The experience of veterans coincides with that of the general population, among whom nonmedical opioid misuse is on the rise and increasingly linked to accidental death.⁴³ Patients who have not developed a therapeutic tolerance to such medicines also face an increased risk of accidental overdose.⁴⁴

While the U.S. military does not divulge full records of the prescription drugs that service members take while deployed, a 2005 military survey found prescription narcotics to be the most widely misused class of drug among members of the armed forces.⁴⁵ VA records reveal that prescription drugs are widely abused by veterans,⁴⁶ especially opioid pain medications and mood disorder medications, such as benzodiazepines.⁴⁷ The Office of the Surgeon General of the U.S. Army Multinational Force surveyed soldiers and found that one in eight was taking prescription medication for a sleeping disorder or combat stress,⁴⁸ and *USA Today* reported in late 2008 that the number of opioid pain prescriptions for injured troops increased from 30,000 to 50,000 per month since the Iraq War began.⁴⁹

Overdose can strike anytime, but incarcerated veterans are acutely vulnerable, especially during the period shortly after their release from jail or prison.⁵⁰

By far the most commonly abused drug among active duty military and veterans is alcohol.⁵¹ A recent study published in the *American Journal of Preventive Medicine* found that over 43 percent of active duty military reported binge drinking, and

nearly 20 percent reported frequent, heavy drinking, within the past month.⁵² More than half of military personnel who binge drink also reported alcohol-related problems, including a significantly greater likelihood of high-risk behavior and alcohol-related violations of the law.⁵³

These findings echo a previous study of a sample of Iraq and Afghanistan war veterans, of which 40 percent screened positive for hazardous drinking and 22 percent screened positive for possible alcohol abuse, but less than a third of hazardous drinkers received any risk reduction counseling by a VA provider.⁵⁴

Among Guards and Reservists, the likelihood of alcohol-related problems increased with those reporting any mental illness or use of medication.⁵⁵ These findings are particularly troubling given the reliance on Guard and Reservist units to support operations in Iraq and Afghanistan, the prevalence of prescription medications for combat injuries, and the potentially lethal effect alcohol can have by itself or in combination with these medications.⁵⁶

Veterans incarcerated for drug offenses received average sentences that were *one year longer* than those of non-veterans incarcerated for the same offenses. *

* Source: United States Department of Justice, Bureau of Justice Statistics, "Veterans in State and Federal Prison, 2004." 1, 4, 5, 6, 11 (May 2007).

Recommendations to Prevent Accidental Drug Overdose and Hazardous Drinking

VA physicians should prescribe naloxone to all veterans who are taking opioid pain medications.^{57,58} Naloxone is an opioid antagonist medication that reverses the respiratory failure that commonly causes death from opioid overdose.

The VA should improve patient screening, monitoring, supervision, and education, as well as physician training, to guarantee the effective treatment of veterans' injuries while minimizing the risk of overdose or other adverse drug event.⁵⁹

The VA should increase access to methadone, buprenorphine and other medication-assisted therapies among opioid-dependent veterans. When properly administered, medication-assisted therapies decrease the risk of opioid overdose, particularly when made available to incarcerated veterans who suffer opioid dependence.

The VA, as well as state and federal correctional facilities, should provide comprehensive overdose prevention education to veterans. Prior to their release from jail or prison, incarcerated veterans should receive naloxone and training in its use.⁶⁰

States – and even military bases – should follow the lead of New Mexico and enact laws that provide legal amnesty to persons who report an overdose to emergency medical services. Research shows that many overdose fatalities occur because witnesses delay or forego seeking help out of fear of arrest or other disciplinary consequences.⁶¹ Medical amnesty policies will save lives.⁶²

The VA and DoD should improve screening and risk reduction counseling programs for people who misuse or abuse alcohol.⁶³

The VA Must Expand Medication-Assisted Therapies to Treat Addiction, Reduce Incarceration, and Prevent Overdose Deaths

Veterans with substance abuse disorders face significant barriers to treatment.⁶⁴ Foremost is the inability to receive the most effective treatments for opioid dependence – methadone and buprenorphine.

The Centers for Disease Control and Prevention,⁶⁵ the Institute of Medicine⁶⁶ of the National Institutes of Health,⁶⁷ the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services,⁶⁸ the National Institute on Drug Abuse (NIDA),⁶⁹ the World Health Organization,⁷⁰ and over four decades of government-funded, peer-reviewed medical research⁷¹ have unequivocally and repeatedly proven that substitution therapies like methadone maintenance are *the most effective* treatments for opioid dependence.^{72,73}

Methadone is one of the most widely studied medicines and is employed effectively around

the world to treat opioid dependence. Methadone and other substitution therapies lead to better health and social outcomes than any other treatment modality.⁷⁴ Medication-assisted treatments are also cost effective.⁷⁵ These medicines have been proven equally effective in treating heroin or prescription-type opioid dependence.⁷⁶ For these reasons, the above-mentioned medical, research, and public health arms of the federal government urge medical professionals to use medication-assisted therapies to treat opioid dependence.

Yet physicians on the federal payroll within the VA fail to prescribe these highly effective treatments to the majority of veterans who need them.⁷⁷ The prerequisite physician training to prescribe methadone and buprenorphine is simple, inexpensive and can be conducted online with relative ease. Nevertheless, few VA physicians are given the opportunity – or the encouragement – to receive such training. Hospital administrations' lack of commitment and interest in buprenorphine is one reason why physicians do not press for these treatments for their patients. Some physicians – especially primary care physicians, who provide the majority of overall VA care – may feel ill-informed and be deterred from prescribing methadone and buprenorphine. Other doctors may choose not to prescribe because of professional stigma. As a consequence, most veterans are left without effective treatment for their conditions.⁷⁸

Unfortunately, the Department of Defense's TRICARE insurance system explicitly prohibits coverage of methadone and buprenorphine treatment for active duty personnel or for veterans in the process of transitioning from DoD care.⁷⁹ As a result, active and recently active military personnel are outright denied effective treatment for opioid dependence,⁸⁰ often at a critical, early juncture when full-blown addiction could still be avoided.⁸¹

Moreover, incarcerated veterans with opioid dependency problems should be able to receive medication-assisted therapies while behind bars and, if necessary, upon release. According to the National Institutes of Health, "... all opiate-dependent persons under legal supervision should have access to methadone maintenance therapy..."⁸²

Whereas Vietnam veterans famously struggled with heroin dependency, more recent veterans are at increased risk of becoming dependent on opioid painkillers.⁸³ Regardless of when or where

they served, all opioid-dependent veterans deserve medication-assisted therapy.

Recommendations for VA Hospital and Vet Center Administrators

- Require all veterans to be screened for opioid dependence;
- Train physicians who treat veterans, including primary care doctors, how to prescribe methadone, buprenorphine, and other medication-assisted therapies to opioid-dependent persons;
- Ensure the availability of these medication-assisted therapies to all veterans who would benefit from them; and
- Inform veterans that effective opioid-dependency treatment is available through the VA.

State and federal governments, with assistance from the VA, should make methadone and/or buprenorphine available to incarcerated veterans who would benefit from these therapies.

The DoD should eliminate restrictions preventing TRICARE from covering buprenorphine and methadone for active military, veterans, and their families.

Recommendations to Improve Alternatives to Punitive Criminal Justice Interventions

As states run increasingly crowded jails and prisons with steadily shrinking budgets,⁸⁴ it is time to rethink how the criminal justice system handles veterans who commit nonviolent crimes, often as a result of untreated substance abuse or mental health disorders. Emphasizing community-based treatment over incarceration has proven both effective and cost effective.

A handful of jurisdictions are moving in this direction. A California law provides that veterans who suffer from PTSD, substance abuse, or psychological problems as a result of their service in combat and who commit certain nonviolent offenses may be ordered into a local, state, federal, or private nonprofit treatment program instead of jail or prison.⁸⁵ The law, however, is not widely used; many defense attorneys are not even aware of its impact for their clients, and it does not automatically apply to veteran

defendants.⁸⁶ Furthermore, the law only applies to lesser, probation-eligible offenses, so many veterans do not make use of it, choosing standard probation instead. Minnesota, for its part, permits sentence mitigation for veterans facing criminal prosecution who suffer from combat-related mental health disorders.⁸⁷ Connecticut, Illinois, New Mexico, Nevada, and Oklahoma considered similar legislation this year. More states need to adopt and expand upon these initial reform efforts.

Another effort underway is to allow more veterans to participate in so-called drug treatment diversion courts. In 2008, Buffalo, New York began the first treatment court devoted exclusively to veterans.⁸⁸ Using the “drug court” model and principles,⁸⁹ the Buffalo court works with the VA and other support services to divert nonviolent offenders away from incarceration and into treatment. Upon successful completion of the year-long program, graduates have their charges expunged from their record.⁹⁰

Similar courts have been established in Orange, Santa Clara, and San Bernardino counties, California⁹¹; Tulsa, Oklahoma⁹²; Anchorage, Alaska; Cook and Madison counties, Illinois⁹³; Minneapolis, Minnesota; Lackawanna County, Pennsylvania⁹⁴; Rochester, New York⁹⁵; and Rock County, Wisconsin⁹⁶; and are being considered by Phoenix and Mesa, Arizona⁹⁷; Colorado Springs, Colorado; Ionia County, Massachusetts⁹⁸; Las Vegas, Nevada⁹⁹; Hamilton County, Ohio¹⁰⁰; Alleghany County, Pennsylvania¹⁰¹; King and Kitsap counties, Washington¹⁰²; Chippewa, Dunn, Eau Claire, La Crosse, Milwaukee and Dane counties, Wisconsin¹⁰³; and several other communities.¹⁰⁴ In 2008, SAMHSA and the National GAINS Center at the Center for Mental Health Services funded pilot jail diversion programs for veterans in six states (Colorado, Connecticut, Georgia, Illinois, Massachusetts, and Vermont).¹⁰⁵ SAMHSA recently awarded additional grants totaling over \$10 million over five years for six more veteran diversion pilots in the states of Florida, New Mexico, North Carolina, Ohio, Rhode Island, and Texas for new state and local jail diversion pilot programs for veterans.¹⁰⁶ Such programs may operate as stand alone courts, or through existing special docket courts.

Federal legislation currently before Congress—the Services, Education, and Rehabilitation for Veterans Act (SERV)¹⁰⁷—also calls for the creation of court diversion programs serving veterans, and would appropriate \$25 million annually towards these purposes from 2010-

2015.¹⁰⁸ Under the SERV Act guidelines, qualifying veterans must be non-violent offenders who served in active duty and were released from service by means other than dishonorable discharge.¹⁰⁹ Courts would be required to provide ongoing judicial supervision of veterans in treatment, integrated substance abuse and mental health treatment (frequently involving inpatient residential treatment), mandatory drug testing during periods of supervised release or probation, and “offender management” and “aftercare services.”¹¹⁰

While the desire to provide veterans with treatment instead of incarceration is well founded, serious shortcomings require fixing before drug court approaches will adequately serve veterans’ needs.

To realize their promise, drug courts must undertake the following improvements (among others):

Do not require a veteran to plead guilty to access treatment.

Most diversion programs in the country, including many, if not all, of the emerging veterans’ treatment courts, require veterans to plead guilty to criminal charges before being directed to treatment.

Yet the consequences of an arrest and conviction can be lifelong and devastating, including disenfranchisement, restrictions on licensure and employment, restrictions on housing, denial of public benefits, disqualification for financial aid, inability to adopt or foster a child, a forfeiture of one’s assets and/or property, the loss of other privileges and opportunities, as well as the use of arrest data in background checks for employment, housing, and credit access.¹¹¹

Collateral consequences and sanctions fall most harshly on people with drug convictions, who are often singled out under federal and state laws for permanent bans on accessing services and exercising rights.¹¹²

The burdens of criminal conviction and arrest intensify the struggles veterans face on the road to recovery and rehabilitation. In 2003, an estimated 585,355 U.S. veterans were denied the right to vote because of a prior criminal conviction.¹¹³ Inability to secure housing and employment because of a criminal record or recent incarceration is a major cause of veterans’ overrepresentation among the U.S. homeless population.¹¹⁴ According to the National Alliance to End Homelessness, veterans comprise 11 percent of the general population, yet one in

three homeless people in the United States today are veterans.¹¹⁵

To minimize or avoid the effect of collateral sanctions and consequences, new veterans’ treatment court programs—and those already in operation—should adopt deferred adjudication or deferred sentencing procedures. Also known as pre-plea or pre-adjudication diversion, such programs allow a defendant to enter treatment without pleading guilty or receiving a sentence of guilt. If he or she succeeds in treatment, the charges are dismissed. According to the National Association of Criminal Defense Lawyers, “A pre-plea, pre-adjudication program preserves due process rights, allows defendants an opportunity to seek treatment ... provides a strong incentive for successful completion ... [and] permits informed, thoughtful decision-making by defendants and counsel.”¹¹⁶

Legislation currently proposed in California, Assembly Bill 674, would provide for diversion of psychologically wounded veterans to therapy instead of jail or prison, and would drop charges upon completion of therapy, for probation-eligible offenses.¹¹⁷ Drug testing results could only be used for treatment purposes, not as the basis of a new criminal charge.¹¹⁸ The defendant would not have to plead guilty and would emerge with no criminal record.¹¹⁹

Expand treatment options and quality.

It is heartening that the Buffalo veterans’ treatment court coordinates with the VA to provide integrated substance abuse and mental health services.¹²⁰ Yet according to SAMHSA, as of mid-2009, the Buffalo court was the only court program that exclusively serves veterans.¹²¹ Most others are grafted onto existing drug court programs.¹²² Treatment services traditionally available through drug court programs are often quite limited. As a result, drug courts frequently fail to meet the multi-faceted needs of their clients.¹²³ Accordingly, if veterans are added to the dockets of existing drug courts, these courts will have to expand their treatment offerings.¹²⁴ Evidence-based practices must be utilized to guide all veterans’ treatment courts.

Embrace medication-assisted therapies.

Many, if not most drug court programs refuse to allow clients to participate in or remain on methadone, buprenorphine or other medication-assisted therapies,^{125, 126} despite the fact that the National Association of Drug Court Professionals (NADCP) urges its members to make use of medication-assisted therapy.¹²⁷

Such prohibitions belie uncontroverted medical evidence (and the recommendations of federal agencies and commissions as well as the professional body representing every drug court in the country). More importantly, such prohibitions are a certain recipe for high rates of drug relapse and criminal recidivism.¹²⁸ Drug courts must allow clients who would benefit from medication-assisted therapies to access them without prejudice.

“Medications such as methadone, buprenorphine, and naltrexone have been shown to clearly improve treatment outcomes for opioid-addicted individuals over detoxification followed by counseling and rehabilitative services alone. Similarly, naltrexone, acamprosate, and disulfiram have been shown to improve the outcome of treatment for alcohol dependence... The data fully justify the conclusion that medications should be considered as an integral part of any drug court treatment program. Given these data, to deny drug court participants the option of receiving medications for their treatment is in our opinion unethical.”^{129}*

* Source: National Drug Court Institute, National Association of Drug Court Professionals.

Prohibit jail sanctions.

Short jail sentences for participants who relapse during treatment are a central and common practice of most drug courts.¹³⁰ The efficacy of jail sanctions (as opposed to non-jail sanctions) is not supported by research evidence.¹³¹ Moreover, the harms posed by jail are manifest: drugs, risky drug-taking behaviors, infectious diseases, violence, and stress are endemic to the nation’s jails.¹³² Drug addiction is a chronic, relapsing medical condition – drug relapse is expected, and its treatment should be therapeutically based.¹³³ In short, jail sanctions – even short term – are unlikely to help and may compromise the physical and mental health of veterans.¹³⁴ Accordingly, incarceration should play no role in efforts to provide substance abuse or mental health treatment;¹³⁵ indeed, “each instance of incarceration may actually increase the likelihood of future incarcerations.”¹³⁶

Collect and evaluate good data.

No systematic, much less uniform, collection or evaluation of drug court data exists. As a result, little is known about how they operate, whom they serve, or how well they perform.¹³⁷ In other words, drug court programs largely operate without meaningful oversight or accountability.

Drug courts must begin keeping reliable data and have independent evaluators assess that data to determine how effectively drug courts are providing needed treatment, reducing criminal recidivism, improving client functioning and employability, promoting healthier lifestyles, reuniting families, and saving taxpayer dollars.¹³⁸

Create more uniform processes and reduce “cherry picking” of clients.

Drug courts tend to operate by the rules and practices imposed by a particular judge and drug court team. Thus, drug courts vary widely between, and sometimes within, jurisdictions in terms of the clients they accept, the treatment they offer, the sanctions they impose, and their requirements for successful completion.¹³⁹ Many drug courts “cherry pick” for the least-addicted or “easiest” offenders to inflate their success rates. As a matter of fairness, drug courts should adopt more uniform standards of operation and criteria for admission.¹⁴⁰ As a matter of public safety and fiscal efficiency, drug courts should dedicate their limited judicial and treatment resources for the more seriously addicted offenders with more extensive criminal histories, who require the most intensive treatment and supervision.¹⁴¹ Less expensive and restrictive diversionary options than drug court should be provided for veterans who commit minor offenses.¹⁴²

Treatment professionals, not judges, should make treatment decisions.

Most drug court judges are not trained as treatment professionals and possess no specialized knowledge of alcohol or other drugs.¹⁴³ Nevertheless, drug court judges frequently decide the type and length of treatment clients receive without adequate input from or deference to the considered opinions of substance abuse and/or mental health professionals. Courts should require – and follow – the recommendations of qualified health professionals who have adequately assessed the needs of the client.¹⁴⁴

The national SERV Act should incorporate the above recommendations to ensure that, if enacted, the programs it creates will provide the most effective treatment services possible.

Other important criminal justice reforms are also needed at the federal level, such as:

- The United States Sentencing Commission should amend federal sentencing guidelines to allow wider discretion in sentencing veterans whose crimes are related to a mental health or substance abuse condition.

- Under current VA directives, incarcerated veterans are not afforded any VA care.¹⁴⁵ This denial is a missed opportunity for the VA to provide critical services and support for veterans to recover from the psychological wounds that caused their criminal activity in the first place. The VA should rescind its 2002 directive barring assessment or treatment of veterans incarcerated in U.S. jails and prisons, and inform incarcerated veterans of all VA-community resources.¹⁴⁶

Efforts to divert combat veterans at the intersection of justice systems are taking place at the local level as well. A number of law enforcement agencies have become involved in designing pre-booking diversions that are veterans-specific.¹⁴⁷

In these programs, local law enforcement agencies may divert veterans to appropriate VA care instead of booking and arresting them, when such a disposition is in the interest of the veteran and public safety. Importantly, pre-booking and pre-arrest diversion approaches may spare veterans a criminal record that can exacerbate the difficulties of readjustment after returning home.

The Chicago Police Department became the first to design and implement a 40-hour, veterans-specific training program based on the Crisis Intervention Training model, which provides law enforcement officers with a set of tools to structure responses to community members in mental health crisis.¹⁴⁸ These models follow the recommendations of SAMHSA and other experts that identify several points for intervention among veterans along the justice continuum, including at first contact with local law enforcement.¹⁴⁹ The Los Angeles and San Francisco Police Departments have begun similar efforts.¹⁵⁰

Conclusion

Post-Traumatic Stress Disorder and Traumatic Brain Injury have been called the “signature wounds” of the wars in Iraq and Afghanistan.¹⁵¹ Substance abuse, too, must be counted among the signature wounds of the current conflicts. Returning veterans have increasingly become casualties of the U.S. war on drugs, a war that emphasizes punitive incarceration over treatment and rehabilitation.

The VA system holds great promise for delivering integrated, individualized treatment

programs that address the PTSD-, TBI- and substance abuse-treatment needs of veterans.¹⁵² But much work remains to be done by the VA, the DoD, other public and private health providers, and criminal justice agencies.

These bodies must improve and greatly accelerate efforts to prevent veterans from succumbing to drug overdoses, and include incarcerated veterans in national suicide prevention efforts.¹⁵³

They must also expand and improve access to methadone, buprenorphine, and other medication-assisted therapies for veterans who are opioid dependent, whether they are in community-based treatment or behind bars.

Finally, drug treatment diversion courts, which are increasingly opening their doors to veterans, must expand the range and improve the quality of treatment services provided to meet the varied and unique needs of veterans in the criminal justice system. Veterans’ treatment court programs should operate on a pre-plea or pre-adjudication basis, so that veterans can be spared the lingering collateral consequences of justice involvement and better reintegrate into society without barriers to employment, education, housing, and other basic needs.

In pursuing these goals, we can begin replacing the failed war on drugs at home with proven, effective public health approaches that save lives, improve wellbeing, and build stronger families and communities. The veterans of our foreign wars deserve no less; indeed, they deserve a great deal more.

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About the Drug Policy Alliance

The Drug Policy Alliance is the nation's leading organization promoting policy alternatives to the drug war that are grounded in science, compassion, health, and human rights. Our supporters are individuals who believe the war on drugs is doing more harm than good. Together we advance policies that reduce the harms of both drug misuse and drug prohibition and seek solutions that promote safety while upholding the sovereignty of individuals over their own minds and bodies. We work to ensure that our nation's drug policies no longer arrest, incarcerate, disenfranchise, and otherwise harm millions of nonviolent people. Our work inevitably requires us to address the disproportionate impact of the drug war on people of color.

Endnotes

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