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PTSD and the Law: An update

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Thirteen years ago, this journal published "PTSD and the Law" (Pitman & Sparr, 1998), a review that examined developments and state of the art in law, forensic evaluation, and expert testimony, providing specific forensic guidance that continues to be critically relevant in today's courtroom. At the time, PTSD was characterized as a growth stock in the world of mental illnesses. Although more recently Sparr and Pitman (2007) note a waning enthusiasm for PTSD as the basis of a criminal defense, the wars in Iraq and Afghanistan and a renewed emphasis on rehabilitation and treatment in criminal justice institutions beginning in the late 1990s (Cullen, 2005) have revived interest in PTSD developments in the criminal justice area. This review briefly updates and confirms elements of the legal domains of the 1998 review and presents an outline within which to view the current and limited status of knowledge of PTSD intervention within forensic settings.

Updates in Court-Related Procedures

Sparr and Pitman (2007) viewed PTSD as an area of continued growth in the civil legal context, at least in part because it "posits a straightforward causal relationship that plaintiffs' lawyers welcome." Crediting its increased use in civil litigation to the removal from the DSM of the requirement that the traumatic event be beyond the range of ordinary human experience, they noted an increased prevalence of PTSD as a factor in civil litigation (for example, individuals involved in motor vehicle accidents can now seek to recover damages for PTSD). The DSM-IV requirement of actual or threatened physical injury or assault or a threat to physical integrity may make worker's compensation cases more difficult to establish, yet special features of PTSD have helped overcome legal barriers to worker's compensation cases, and mental harm claims in particular have increased dramatically. The prevalence of civil actions has expanded in both mental impairment and mental harm arenas, with implications for benefit programs (e.g. Social Security disability, Veterans' disability, worker's compensation) that address these issues and hinge upon various components of PTSD diagnosis (stressors, symptoms, functional impairments), giving rise to an increased potential for fraudulent claims.

Sparr and Pitman (2007) noted the infrequent use – and even more infrequent success – of the insanity defense in criminal cases, including when grounded in PTSD. As examples, they cited difficulty in use of "battered woman syndrome," specifically in proving reasonable belief (i.e. force used was reasonable and necessary in the context of the perceived threat) and presence of imminent harm, and in admissibility of expert testimony, and challenges to witness testimony regarding accuracy of memory of traumatic events.

The recent case of Jesse Bratcher was a much-discussed exception to the decline in use of the insanity defense. Bratcher, who was being treated and compensated for service-connected PTSD when the crime took place, argued that his killing of an unarmed man occurred while he was having a flashback. A Grant County, Oregon jury found him guilty but insane due to PTSD; instead of a possible 25-year prison term, Bratcher was committed to the Oregon State Psychiatric Board for evaluation.

In addition to the use of PTSD as the basis of an insanity defense, recent cases have seen the stress associated with combat exposure considered as a mitigating factor at sentencing. The U.S. Supreme Court recently recognized the importance of a

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defendant's military service, including his or her combat history and any related stress or mental health issues, to an effective presentation of mitigating evidence at sentencing in capital cases. *Porter v. McCollum*, 130 S. Ct. 447 (2009). A federal judge recently used an Operation Iraqi Freedom Veteran's *possible* PTSD as the basis of a downward departure from the federal Sentencing Guidelines. *United States v. John Brownfield,* No. 08-cr-00452-JLK (D. Colo. 2009).

Since 2008, a new treatment court model has addressed Veteran defendants' mental health and substance use issues; there are now 50 operational Veterans Treatment Courts (VTCs) (http://www.nadcp.org/JusticeForVets), modeled after the first such court in Buffalo, New York. Although generally not limited to defendants with a particular diagnosis, the perceived prevalence of PTSD among justice-involved Veterans is often cited as the impetus for these courts' formation (Russell, 2009; Clark et al., 2010). State legislatures have been active in proposing legislation that directs their court systems to address mental illness of Veterans in their courts: Six of 10 states that have recently considered such legislation have specifically mentioned PTSD as one of the target mental illnesses.

Holbrook (2010) has argued that jurisdictions embracing the VTC model have shifted from their traditional focus on victims' interests (retributive justice), toward defendants' interests (therapeutic justice). Holbrook sees this larger, thematic shift, while not problematic *per se*, as requiring the courts to pay particularly close attention to the views and needs of victims in individual cases (if any, as not all VTCs accept defendants charged with violent crimes, and those that do evaluate each case individually, requiring victims' consent to defendants' participation).

Finally, forensic assessment for PTSD has been covered extensively in a number of publications (Sparr & Pitman, 2007; Simon, 2003) which have emphasized the importance of systematic diagnosis, use of standardized measures, inclusion of malingering assessment (Hall and Poirier, 2001), independent corroboration of reports, and if possible measurement of psychophysiological responses to recollection of traumatic events. Young and Yehuda (2006) cautioned against the use of a PTSD diagnosis as shorthand for a fully defined, universal experience, as "multicausal mechanisms" may contribute to outcomes of the disorder, and individual variability frustrates any effort to describe a standard course or prognosis, a fact about which courts require education.

PTSD and Intervention in Other Forensic Settings

Separate from PTSD-related criminal and civil defense considerations, the ways in which symptoms of PTSD can be associated with criminal behavior have been summarized on VA's National Center for PTSD website (http://www.ptsd.va.gov/public/pages/ptsd-criminal-behavior.asp). A dramatic behavioral example cited is the experience of a flashback during which aggression or a criminal act could occur when a Veteran thinks he or she is in danger again. O'Brien (1998) noted that there is no evidence of an association between criminal behavior and PTSD caused by non-combat trauma. The association of criminal behavior with PTSD does not establish a causal relationship between PTSD and criminal behavior: Antisocial personality and substance abuse have been found to be important intervening variables. Research has documented a strong relationship between PTSD and substance abuse (Management of Post-Traumatic Stress Working Group, 2004) which suggests that the relationship between PTSD and violence may be similar to that indicated by findings that discharged mental patients are no more violent than community residents, absent substance abuse (Steadman et al., 1998).

The Sequential Intercept Model (Munetz & Griffin, 2006) is the standard framework for considering the interface between criminal justice and mental health systems; it specifies a series of interception points at which mental illness can be addressed along the justice system continuum, including community law enforcement contacts and arrests, jails, courts, prisons and state forensic hospitals, and community corrections. PTSD is addressed to varying degrees across this continuum below, which excludes forensic state hospitals (no state or national data sources) and parole and probation (no institutional requirement to provide treatment, Taxman et al., 2007).

The initial intercept point is law enforcement. The increasing recognition of the role of mental illness in the daily work of law enforcement officers has led to the development of pre-booking diversion models – most prominently the Memphis Crisis Intervention Team (CIT) model – in which a) officers are trained in the management of mental illness during crisis and in diversion (replacing where possible arrest and incarceration), and b) a drop-off center is available to law enforcement where treatment need can be assessed and resources accessed in the community (Steadman et al., 2001). A Council of State Governments review (Reuland et al., 2009) found that law enforcement encounters with people with mental illness are a relatively small percentage (2-7%) of encounters overall, and are frequently low-level offenses, with the exceptions of suicide threats and attempts and the relatively infrequent risk of harm to others. Estimated to exist in as many as 1,050 American communities, the impact of the CIT approach upon arrest frequency of people with mental illness has not been fully established, yet evidence does indicate decreased number of injuries to officers, increases in frequency of linkage of individuals to mental health services, reduction of officer stigma toward those with mental illness, and reduction of specific law enforcement costs, including SWAT (Special Weapons and Tactics) call-outs. Although there has been a steady frequency of media reports of law enforcement response to people (frequently Veterans) with PTSD in crisis, the frequency of PTSD occurrence and the extent of training content for PTSD identification and management – while known to be included in VA law enforcement training – have not yet been identified.

A second intercept point is the local jail. Publications on epidemiological surveys by the U.S. Department of Justice Bureau of Justice Statistics, while estimating that 64% of jail inmates have a mental health problem (James & Glaze, 2006), have not reported specifically on the prevalence of PTSD. The only national estimate of PTSD among jail inmates, an adjusted estimate based on the National Co-Morbidity Survey of community populations, listed a 6-month prevalence range of 4-8% (National Commission on Correctional Health Care, 2002). Lengths of incarceration are generally short, as jails are holding facilities for inmates pending trial, awaiting sentencing, or serving a sentence usually less than 1 year. Jails are required to provide services to address serious healthcare needs, are acutely aware of the role that healthcare plays in the primary mission of security, and have increasingly developed programs internally and in collaboration with community providers to address a range of reentry needs (Cornelius, 2008). PTSD intervention in jails has not received attention in the clinical literature.

State and federal prisons constitute a third major intercept point. The National Commission on Correctional Health Care also reported an estimated prevalence of PTSD among prison inmates, with lifetime prevalence ranges of 6-12% in state prisons and 5-7% in federal prisons. Studies using structured clinical interviews with inmates have found lifetime rates ranging from 20-33% (Scott, 2010). Inmates are serving sentences of extended duration – a year or longer – which allows opportunity for extended mental health evaluation and treatment (Patterson & Greifinger, 2007). Three quarters of prisons report availability of substance abuse and education services, over half report group counseling for substance abuse, and almost 60% provided mental health counseling services (Taxman et al., 2007). In a survey conducted in 2004, Peters and Bekman (2007) found 20 co-occurring disorders treatment programs (CDTs) identified in 13 state prison systems, with PTSD as the second most common (19%) mental disorder treated. They also noted research findings that 72-87% of inmates with severe mental disorders have co-occurring substance abuse disorders, noting that available treatment services are inadequate to meet the needs of the vast majority of offenders with such problems. Key interventions included psychoeducational skills groups, criminal thinking groups, peer support groups (e.g. AA and NA groups), regular behavioral feedback from peers and staff, individual assignments, behavioral contracts, and role playing and modeling of behaviors.

Wolff and Shi (2010) expanded the PTSD net to the wider population of inmates who have either experienced interpersonal trauma prior to, or will experience during, incarceration, citing research indicating that 15-24% of people who experience a potentially traumatic event will develop PTSD. In a study of 13 prisons including one female prison, they found that two-thirds of both males and females had been physically victimized in the community, and that significant proportions had also been physically victimized in prison; they also found large overlapping sexual victimization experiences for both genders. Wolff and Shi discussed various trauma interventions ranging from prevention to specific interventions (e.g. Seeking Safety, Trauma Recovery and Empowerment, exposure therapy), and underlined the importance of assessing and treating other mental illness and substance abuse co-morbidities.

Clearly, across these forensic settings, much remains unknown about PTSD and PTSD intervention, yet it is likely that a number of factors – increasing incidence of combat-related PTSD, national leadership demanding mental health treatment as both an alternative to and a part of incarceration, a SAMHSA-supported initiative to address trauma across large segments of the justice-involved population, and continued development of national standards of treatment for correctional settings – will exert continuing pressure to conduct research to answer specific prevalence and outcome questions relevant to PTSD. The abstracts and citations that follow illustrate a developing focus on these issues and also indicate a further maturing of legal process knowledge and skills since 1998.

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Management of Post-Traumatic Stress Working Group. (2004). VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress. Version 1.0. Washington.

Pitman, R. K., & Sparr, L. F. (1998). **PTSD and the law.** *PTSD Research Quarterly, 9* (2), 1-6. Retrieved from http://www.ptsd.va.gov/professional/newsletters/research-quarterly/V9N2.pdf.

Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisson, T., et al., (1998). **Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods.** *Archives of General Psychiatry, 55*, 393-401. doi: 10.1001/archpsyc.55.5.393.

Steadman, H. J., Stainbrook, K. A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). **A specialized crisis response site as a core element of police-based diversion programs.** *Psychiatric Services, 52*, 219-221. doi: 10.1176/appi.ps.52.2.219.

FEATURED ARTICLES

Clark, S., McGuire, J., & Blue-Howells, J. (2010). **Development of veterans treatment courts: Local and legislative initiatives.** *Drug Court Review, 7*, 171-208. Veterans treatment courts are a recent but rapidly growing phenomenon in the judicial system, driven by a need for mental health and substance abuse treatment among justice-involved veterans. As of January 2010, there were 24 operational veterans treatment courts in the United States, with another 40 in planning or development. This article examines how these courts have developed out of and been informed by existing treatment court theory and practice, and identifies the unique elements that characterize this new form of treatment court. An analysis of legislative initiatives targeting veterans in the courts finds that legislative proposals generally include more restrictive admission criteria than typical veteran court practice: a finding which may limit coverage on legislation-driven veterans treatment court dissemination. We conclude with a review of potential benefits of this collaboration between the courts and the U.S. Department of Veterans Affairs, and emphasize the importance of systematic evaluation of both veteran outcomes and policy effects of legislative initiatives that seek to influence development of the veterans treatment court model.

Holbrook, J. G. (2010). **Veterans' court and criminal responsibility: A problem solving history and approach to the liminality of combat trauma.** In D. C. Kelly, D. Gitelson, & S. H. Barksdale (Eds.), *Young Veterans: A Resilient Community of Honor, Duty and Need.* Springer, Forthcoming; *Widener Law School Legal Studies Research Paper* No. 10-43. In September 2010, a federal judge dismissed a criminal case involving a veteran accused of assaulting a federal police officer to allow the case to be heard by the Buffalo Veterans Treatment Court, a division of Buffalo City Court. For those involved in veterans' advocacy and treatment, the case is significant for a number of reasons. First, it is the first criminal case nationwide to be transferred from federal court to a local veterans' treatment court where the goal is to treat - rather than simply punish - those facing the liminal effects of military combat. Second, the case reignites the still unsettled controversy over whether problem-solving courts generally, and veterans' courts

specifically, unfairly shift the focus of justice away from the retributive interests of victims to the rehabilitative interests of perpetrators. Third, the case serves as a signal reminder to all justice system stakeholders, including parties, judges, attorneys, and treatment professionals, of the potential benefits of sidestepping courtroom adversity in favor of a coordinated effort that seeks to ameliorate victim concerns while advancing treatment opportunities for veterans suffering from combat-related trauma. This chapter explores these issues in light of the history of combat-related trauma and the development of veterans' treatment courts around the country.

Simon, R. I. (2003). *Posttraumatic stress disorder in litigation: Guidelines for forensic assessment* (2nd ed.). Washington: American Psychiatric Publishing. Topics treated: Persistent reexperiences in psychiatry and law: current and future trends in PTSD litigation; Recent research findings on the diagnosis of PTSD: prevalence, course, comorbidity, and risk; Toward the development of guidelines in the forensic psychiatric examination of PTSD claimants; Guidelines for the psychiatric examination of PTSD in children and adolescents; Guidelines for the forensic psychological assessment of PTSD claimants; Guidelines for the evaluation of malingering in PTSD.

Sparr, L. F., & Pitman, R. K. (2007). **PTSD and the law.** In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and Practice* (pp. 449-468). New York: Guilford Press.
In previous articles we have discussed the relationship between PTSD and the law, particularly in regard to assessment of criminal intent, criminal behavior, the insanity defense, civil issues, tort actions, and factitious behavior. This chapter is intended to supplement, not to replace, these earlier contributions. As PTSD has aged as an official psychiatric diagnosis, its forensic face has changed as well. Initial enthusiasm for PTSD as a criminal defense has waned, and initial fears about misuse have not materialized. Appelbaum and colleagues have shown that despite early concerns, the PTSD insanity defense is raised infrequently and, like other insanity pleas, is usually unsuccessful. Instead, the primary thrust of PTSD criminal defenses has been as an occasional factor in diminished capacity considerations, pretrial plea bargaining, or sentencing. The more significant growth of PTSD in forensic deliberations has been in the civil area. In this chapter we suggest that this is due in part to changes in the PTSD stressor criteria. As a result, civil issues now dominate the relationship between PTSD and the law. PTSD's broad and vast influence applies to workers' compensation, social security disability, tort litigation, and Veterans' Affairs disability compensation. On the criminal side we focus on two areas: battered woman syndrome and the nascent relationship between PTSD and deficits in explicit memory function. [Text, p. 450]

Wolff, N. L., & Shi, J. (2010). **Trauma and incarcerated persons.** In: Scott, C. L. (Ed.), *Handbook of Correctional Mental Health* (2nd ed.) (pp. 277-320). Washington: American Psychiatric Publishing.
In the context of interpersonal trauma, Wolff and Shi compare general population and prison population rates of abuse and PTSD, focusing in particular upon prison violence and victimization. Detailed statistics are reported from a study they conducted on a sample of 7,528 inmates drawn from 13 adult prisons, providing data on specific types of physical and sexual victimization for males and females, using Venn diagrams to represent overlapping population proportions experiencing trauma prior to and during incarceration. They conclude with recommendations for prevention of prison-based interpersonal trauma and for identification of prior victimization history at classification conducted at entry to the prison system.

Young, G., & Yehuda, R. (2006). **Understanding PTSD: Implications for court.** In G. Young, A. W. Kane, and K. Nicholson (Eds.), *Psychological knowledge in court: PTSD, pain, and TBI* (pp. 55-69). doi: 10.1007/0-387-25610-5_3 New York, New York: Springer.
PTSD is a disorder that has captured the attention of the legal profession in the area of psychological injury, in some part perhaps by providing for plaintiffs a more tangible way of expressing "pain and suffering" inflicted by injury. This view assumes that the research regarding etiology, phenomenology, prevalence, course, comorbidity, and biologic underpinnings has fully resolved all outstanding issues. Yet, the nature and description of PTSD is still in the process of being more carefully studied. In this review, we highlight some of the current issues that researchers are studying and suggest which ones necessitate caution in the legal arena. [Text, p. 55]

ADDITIONAL CITATIONS

Cornelius, G. F. (2008). *The American jail: Cornerstone of modern corrections.* Upper Saddle River, NJ: Prentice Hall. Cornelius' book is about the local American jail - how it developed and how it functions in daily operations and administration. Chapters include learning objectives, review questions, definitions of terms, and a "point of view" written by a jail practitioner. Topics covered include the history and development of the American jail, jail security, jail climate, booking and initial intake, classification and inmate housing, programs and services, profile of the jail population and special categories, staff, relationship to courts, standards, community corrections, and the future of the American jail. Special categories provide statistics on prevalence of categories of mental illness and substance use disorders, and management of, and services for, these conditions in the jail environment.

Council of State Governments. (2005). *Report of the Re-Entry Policy Council: Charting the safe and successful return of prisoners to the community.* New York: Council of State Governments. This report summarizes the results of a series of meetings among 100 of the most respected workforce, health, housing, public safety, family, community, and victim experts in the country.

Hall, H. V., & Poirier, J. G. (2001). **Post-traumatic stress disorder and deception.** In H. V. Hall & J. G. Poirier (Eds.), *Detecting malingering and deception: Forensic distortion analysis* (2nd ed.) (pp. 171-204). Boca Raton, FL: CRC Press. The authors cite the many problems in diagnosing PTSD, ranging from professional bias against the diagnosis, to data exaggeration and corroboration issues, to overlap with other behavioral problems, to complexities of identifying stressors and symptoms. Any PTSD symptom has potential for deception because PSTD is well described in the media. The authors review the search for biological anchors to PSTD, a scientific enterprise based on the concept that trauma can alter the neurochemistry of the brain. They note that the 1990s had seen continued investigation of traditional PTSD psychological

instruments and the development of new PTSD scales, review these tools, and conclude that gains hold promise with detecting deception regarding PTSD, while identifying many critical issues still to be resolved.

James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates.* U.S. Department of Justice, Bureau of Justice Statistics: Washington Report NCJ 213600. The authors estimate the prevalence of mental health problems among prison and jail inmates using self-reported data on recent history and symptoms of mental disorders. The report compares the characteristics of offenders with a mental health problem to those without, including current offense, criminal record, sentence length, time expected to be served, co-occurring substance dependence or abuse, family background, and facility conduct since current admission. It presents measures of mental health problems by gender, race, Hispanic origin, and age. The report describes mental health problems and mental health treatment among inmates since admission to jail or prison. Findings are based on the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002.

Munetz, M. R., & Griffin, P. A. (2006). **Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness.** *Psychiatric Services, 57,* 544-549. doi: 10.1176/appi.ps.57.4.544. The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are: law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment.

National Commission on Correctional Health Care. (2002). *The health status of soon-to-be-released inmates. (*Vols. 1-2). This national, 3-year-long study was the largest and most comprehensive of its kind ever undertaken. With funding from Congress through the National Institute of Justice, and with substantial support from the Centers for Disease Control and Prevention, the National Commission on Correctional Health Care convened expert panels that included the nation's most respected researchers, practitioners, and scholars in the fields of public and correctional health care. The final report was delivered to Congress by the National Institute of Justice in May 2002. Prisons and jails offer a unique opportunity to establish better disease control in the community by providing improved health care and disease prevention to inmates before they are released. A series of papers (summarized in Volume 1 and provided in full in Volume 2) documents indisputably that tens of thousands of inmates are being released into the community every year with undiagnosed or untreated communicable disease, chronic disease, and mental illness. The experts concluded that it is cost-effective to treat these diseases while the individuals are incarcerated.

O'Brien, L. S. (1998). **Medicolegal aspects of post-traumatic illness.** In L. S. O'Brien (Ed.), *Traumatic events and mental health* (pp. 242-261). Cambridge: Cambridge University Press. doi: 10.1017/CBO9780511570124.010. The authors examine the medicolegal connotations of Post-traumatic Illness (PTI), with a focus on England and Wales. The chapter examines both criminal and civil legal issues from the point of view of the expert clinician.

Patterson, R. F., & Greifinger, R. B. (2007). **Treatment of mental illness in correctional settings.** In R. B. Greifinger (Ed.), *Public health behind bars: From prisons to communities* (pp. 347-367). New York, New York: Springer. The incarcerated mentally ill, whether in lockups, jails, or prisons, require a broad range of psychiatric and other mental health services while in correctional facilities. What these services should be and how they should be provided in a correctional setting are described in detail in this chapter. The descriptions encompass six major areas essential for a comprehensive mental health services delivery system: (1) initial intake screening and referral; (2) suicide assessment; (3) intake mental health screening; (4) mental health assessment; (5) treatment planning; and (6) discharge planning.

Peters, R. H., & Bekman, N. M. (2007). **Treatment and reentry approaches for offenders with co-occurring disorders.** In R. B. Greifinger (Ed.), *Public health behind bars: From prisons to communities* (pp. 368-384). New York, New York: Springer. This chapter explores emerging and innovative approaches for treatment and reentry of offenders who have co-occurring disorders in jails, prisons, and diversion settings. Key areas highlighted in this chapter include evidence-based models of treatment, program features and principles, reentry approaches, and program outcomes. Several challenges to correctional program implementation and funding are also explored, and implications are discussed for policy development and future research.

Reuland, M., Schwarzfeld, M., & Draper, L. (2009). *Law enforcement responses to people with mental illnesses: A guide to research-informed policy and practice.* New York, New York: Council of State Governments Justice Center. To ensure law enforcement policies and practices related to people with mental illnesses are data-driven and well informed, this guide summarizes the available research on law enforcement encounters with people with mental illnesses and strategies to improve these interactions.

Russell, R. T. (2009). **Veterans Treatment Court: A proactive approach.** *New England Journal on Criminal and Civil Confinement, 35,* 357-372. As the veteran population in the United States continues to rise, so too does the need for greater understanding of the impact of military service. As of October 2008, the estimated United States veteran population was 23,442,000. Military service can impact the lives of veterans and their families in countless ways. Many returning veterans and their families cope with serious issues such as alcohol

and substance abuse, mental illness, homelessness, unemployment, and strained relationships. Oftentimes, these serious issues go unaddressed, and many of the veterans end up in our criminal justice system. With the increase of veterans with serious needs in our criminal justice system comes the need for the system to develop innovative ways of working to address these issues and needs. This article describes one court in Buffalo, NY, which has developed a plan for meeting the serious needs of veterans within the criminal justice system and has created the nation's first specialized Veterans Treatment Court.

Scott, C. L. (Ed.) (2010). *Handbook of correctional mental health* (2nd ed.). Washington: American Psychiatric Publishing. The jail and prison population is at an all-time high, and those inmates with a mental disorder constitute a rapidly growing proportion of persons involved with the criminal justice system. The challenge of assessing and treating these individuals has never been greater. The *Handbook of Correctional Mental Health* aims to provide practical, up-to-date guidelines for mental health care providers who work in a correctional setting. This new edition includes eight new chapters that include clinically focused guidelines on the assessment and treatment of inmates with substance use disorders, geriatric offenders, juvenile offenders, inmates with self-injurious behaviors, offenders who have experienced various traumas during their lives, and inmates housed on maximum security units and death row.

Taxman, F. S., Perdoni, M. L., and Harrison, L. D. (2007). **Drug treatment services for adult offenders: The state of the state.** *Journal of Substance Abuse Treatment, 32,* 239-254. doi: 10.1016/j.jsat.2006.12.019. We conducted a national survey of prisons, jails, and community correctional agencies to estimate the prevalence of entry into and accessibility of correctional programs and drug treatment services for adult offenders. Substance abuse education and awareness is the most prevalent form of service provided, being offered in 74% of prisons, 61% of jails, and 53% of community correctional agencies; at the same time, remedial education is the most frequently available correctional program in prisons (89%) and jails (59.5%), whereas sex offender therapy (57.2%) and intensive supervision (41.9%) dominate in community correctional programs. Most substance abuse services provided to offenders are offered through correctional programs such as intensive supervision, day reporting, vocational education, and work release, among others. Although agencies report a high frequency of providing substance abuse services, the prevalence rates are misleading because less than a quarter of the offenders in prisons and jails and less than 10% of those in community correctional agencies have access to these services through correctional agencies; in addition, these are predominantly drug treatment services that offer few clinical services. Given that drug-involved offenders are likely to have dependence rates that are four times greater than those among the general public, the drug treatment services and correctional programs available to offenders do not appear to be appropriate for the needs of this population. The National Criminal Justice Treatment Practices Survey provides a better understanding of the distribution of services and programs across prisons, jails, and community correctional agencies and allows researchers and policymakers to understand some of the gaps in services and programs that may negatively affect recidivism reduction efforts.