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All Roads Lead from Vietnam to Your Home Town: How Veterans Have Become Casualties of the War on Drugs

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**ALL ROADS LEAD FROM VIETNAM TO
YOUR HOME TOWN: HOW VETERANS HAVE
BECOME CASUALTIES OF THE WAR ON
DRUGS**

*By Susan Stuart**

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*Professor Valparaiso University School of Law. For the Vietnam veterans whose lives intersected mine in so many important ways: Tom Mullen (U.S. Army & USAR ret.), Dick Mullen (U.S. Army), Doug Trolson (U.S. Army), and Bruce Brattain (U.S. Army).

INTRODUCTION

The War on Drugs was originally marketed as a public health issue. The poster boy for that War was the U.S. soldier in Vietnam who used heroin.¹ But the public health message soon got lost, and the law enforcement mission of the War on Drugs took over. “Heroin” struck fear in the hearts of Americans, and “heroin addicts” would undermine our very way of life with their criminality.² As it would turn out, heroin addiction was a mere blip on the radar of mental health and substance abuse problems emerging after soldiers left Vietnam.³ By then, law enforcement had become the concretized goal of the War on Drugs, and Vietnam veterans fell—and are still falling—victim to the increased criminalization of drugs and drug abuse.

The sad irony is that many of those veterans suffer drug abuse problems as a consequence of mental health problems caused by the actual theatre of war in Vietnam, particularly as a consequence of posttraumatic stress disorder (PTSD).⁴ Thus, we are punishing veterans for the natural consequences of war itself in homage to a metaphorical war. What is more frightening is that empirical evidence is piling up that even more veterans from Iraq and Afghanistan will be drug abusers because of the consequence of a real war—not just from PTSD but also from traumatic brain injury (TBI).⁵ Unfortunately, by both default and design, the burden and costs of veterans’ drug abuse will fall on local governments in both criminal and public health costs.⁶ As a consequence, local governments must make a better and more

¹ Lee N. Robins, *The Sixth Thomas James Okey Memorial Lecture: Vietnam Veterans’ Rapid Recovery from Heroin Addiction: A Fluke or Normal Expectation?*, 88 ADDICTION 1041, 1041 (1993).

² Lee N. Robins et al., *Vietnam Veterans Three Years after Vietnam: How Our Study Changed Our View of Heroin*, 19 AM. J. ADDICTION 203, 208 (2010).

³ Karen H. Seal et al., *Substance Use Disorders in Iraq and Afghanistan Veterans in VA Healthcare, 2001–2010: Implications for Screening, Diagnosis and Treatment*, 116 DRUG & ALCOHOL DEPENDENCE 93, 94 (2011).

⁴ *Id.* at 98.

⁵ Katherine M. Iverson et al., *Psychiatric Diagnoses and Neurobehavioral Symptom Severity among OEF/OIF VA Patients with Deployment-Related Traumatic Brain Injury: A Gender Comparison*, 21 WOMEN’S HEALTH ISSUE 210, 211 (2011).

⁶ *Overview and Inventory of HHS Efforts to Assist Incarcerated and Reentering Individuals and their Families*, U.S. DEPT. HEALTH & HUMAN SERVICES, <http://aspe.hhs.gov/hsp/11/incarceration&reentry/Inventory/SubstanceAbuseandMentalHealthServicesAdministration.shtml> (last updated Feb. 25, 2011).

concerted effort—as an interest group—to pry additional monies from their states and the federal government in order to sustain these burdens and costs for their veterans as communities deal with their return.

The War on Drugs in the United States had its genesis in a deliberate campaign by the Nixon Administration to divert attention from the Vietnam War.⁷ Two primary targets motivated the marketing of the War on Drugs: the anti-war protestors and the very real heroin use by servicemen stationed in Vietnam.⁸ At the time, popular support for the Vietnam War was waning. The Cold-War objective of containing the spread of communism in Southeast Asia was becoming more controversial in the United States, especially given that succeeding U.S. administrations had lied to the public about our involvement in Vietnam and the increasing dissension among the servicemen opposed to the War.⁹ President Nixon hit on a strategy that would both divert attention from the War and blame the anti-war movement for its lack of success in one fell swoop.¹⁰ By declaring a war on drugs, he could focus popular attention away from a foreign country to a “national emergency” here at home.¹¹ As an unfortunate consequence of the War on Drugs, we ignored the evidence of the connection between veterans’ mental health issues and drug abuse and, instead, criminalized their behavior. This circumstance affects veterans in particular because many of them abuse drugs as a consequence of war-inflicted mental health problems.

Today, we find ourselves in a dilemma vis à vis the War on Drugs and our Iraq and Afghanistan veterans. We purport to want to treat the service members returning from the current conflicts better than we did those who returned from Vietnam,¹² but they are returning just as damaged—and perhaps more so—than the Vietnam veterans. Fortunately, the medical and psychological communities have been very active recently in compiling empirical research on the problems active and veteran

⁷ See generally JEREMY KUZMAROV, *THE MYTH OF THE ADDICTED ARMY: VIETNAM AND THE MODERN WAR ON DRUGS* 1–2 (2009).

⁸ *Id.* at 2.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.* (quoting Richard Nixon).

¹² *E.g.*, Thomas D. Beamish et al., *Who Supports the Troops? Vietnam, the Gulf War, and the Making of Collective Memory*, 42 *SOC. PROBS.* 344, 344–45 (1995).

service members are experiencing with drug abuse, particularly their connection with mental health problems.¹³ Unfortunately, the national psyche is more attuned to the siren call of the law enforcement crusade rather than to what the science shows, that this country's drug abuse problem is a public health problem.¹⁴ Instead, the funds that might better go toward treatment of underlying problems are dedicated, instead, to law enforcement.

It has only been recently, with the Obama Administration, that the rhetoric of the War on Drugs has been reduced.¹⁵ Slowly, federal funding is increasing for public health initiatives to address drug abuse problems,¹⁶ especially for veterans.¹⁷ However, complete abandonment of the War on Drugs is still a long way away. Indeed, active service drug abuse may lead to less than honorable discharge and loss of veterans' benefits that might otherwise provide treatment.¹⁸ Being "tough on crime" remains a potent political issue, and both the U.S. government and state governments have long since become accustomed to funding the criminalization strategy rather than treatment and prevention.¹⁹

That leaves the local governments and their services to address the drug abuse problems posed by veterans, especially because the research indicates that drug abuse problems for the rest of the population often arise within the community milieu²⁰ and

¹³ See *infra* Part II.

¹⁴ See Susan P. Stuart, *A New Sheriff in Town: Armistice in the War on Drugs and Students' Civil Rights*, 13 FLA. COASTAL L. REV. 335, 340 (2012) [hereinafter Stuart, *Sheriff*].

¹⁵ *Id.* at 339 n.27.

¹⁶ OFFICE OF NAT'L DRUG CONTROL POL'Y, THE NATIONAL DRUG CONTROL BUDGET: FY 2013 FUNDING HIGHLIGHTS (2012), <http://www.whitehouse.gov/ondcp/the-national-drug-control-budget-fy-2013-funding-highlights> [hereinafter 2013 DRUG CONTROL BUDGET]; see also Stuart, *Sheriff*, *supra* note 14, at 340–43.

¹⁷ One of the new programs included in the White House's 2013 National Drug Control Budget is the Department of Defense's Defense Health Program to provide treatment for service members' drug abuse at both military and private facilities. 2013 DRUG CONTROL BUDGET, *supra* note 16, at 2. That budget also called for an increase in funding for drug abuse programs in the Department of Veterans Affairs. *Id.* at 6.

¹⁸ Major Tiffany M. Chapman, *Leave No Soldier Behind: Ensuring Access to Health Care for PTSD-Afflicted Veterans*, 204 MIL. L. REV. 1, 49 (2010).

¹⁹ Susan P. Stuart, *War as Metaphor and the Rule of Law in Crisis: The Lessons We Should Have Learned from the War on Drugs*, 36 S. ILL. U. L.J. 1, 11–12 (2011–2012) [hereinafter Stuart, *Metaphor*] (quoting Michael Kramer, *The Political Interest: The Phony Drug War*, TIME, Sept. 2, 1996, <http://www.time.com/time/magazine/article/0,9171,985050,00.html>).

²⁰ See, e.g., Stuart, *Sheriff*, *supra* note 14, at 370–77.

because the community is often the only resource for veterans. Those resources work: specialized criminal justice mechanisms, increased access to mental health services, and specialized substance abuse diversion programs are effective. Indeed, they save money over the law enforcement strategy of the War on Drugs.²¹ Although it might be a national obligation to treat our veterans, there are likely only local solutions available, at least in the short term. That leaves the problem of how local governments can provide those services. The answer is for local communities to join the appropriate local agencies, community-based assets, and local veterans groups to create a coherent lobbying group to state governments, a message that is framed around the evidence of the harm the War on Drugs is wreaking on veterans and the evidence of programs that work.

In pursuing that thesis, this Article must first pursue the increasing evidence that the War on Drugs was and always has been antithetical to very real problems our service members suffer upon their return from war that cause them to abuse drugs. Thus, Part I will address the convergence of the Vietnam War and the War on Drugs, which elevated soldiers' recreational drug use into a national criminal problem. Part II will examine the scientific literature that connects service members' mental health problems—often caused by war experiences—directly with subsequent (and even concurrent) drug abuse. Part III will examine the emerging concerns for returning Iraq and Afghanistan veterans, who may pose even more significant problems with drug abuse than those from Vietnam. And Part IV will examine those solutions that local governments—in tandem with other affected nonprofits—can use to serve these particular citizens. If effective, they can serve as models for the entire community, not just veterans.

I. F.U.B.A.R.²²

Why the history of the Vietnam War has become so wracked with urban myths is sometimes difficult to discern although it

²¹ Martha Mendoza, *U.S. Drug War has Met None of its Goals*, NBC NEWS (May 13, 2010, 4:06 PM), <http://www.nbcnews.com/id/37134751/ns/usnews-security/#.UUEa9xxOThI>.

²² A familiar military acronym for “Fucked up beyond all reason”. *Fubar*, URBAN DICTIONARY, <http://www.urbandictionary.com/define.php?term=fubar> (last visited Mar. 13, 2013).

probably had as much to do with the well-oiled propaganda machine of the U.S. government²³ as it did with media sensationalism.²⁴ For instance, the iconic picture of a civilian Huey evacuating Vietnamese military from the Pittman Apartments in Saigon²⁵ is instead, we have long been assured, an image of the last gasps of U.S. involvement in Vietnam as the military evacuates the U.S. embassy.²⁶ Or Vietnam veterans reputedly returned from service only to be called baby killers and spat on by anti-war protestors,²⁷ when there is very little evidence that any such spitting occurred, and if it did, it often was by World War II veterans against anti-war Vietnam veterans.²⁸ Perhaps the most iconic of these urban legends and one that continues to linger in the national memory and in our criminal justice system is that the service members in Vietnam had a heroin addiction problem, a problem serious enough to set off the War on Drugs.

Substance abuse is part of military life:

Historically, the use of alcohol, illicit drugs, and tobacco has been common in the military. Heavy drinking is an accepted custom . . . that has become part of the military work culture and has been used for recreation, as well as to reward hard work, to ease interpersonal tensions, and to promote unit cohesion and camaraderie Alcoholic beverages have long been available to service members at reduced prices at military installations, including during “happy hours” [I]ncreases in alcohol use may be associated with the challenges of war, the alcohol being used in part as an aid in coping with stressful or traumatic events and as self-medication for mental health problems.²⁹

Perhaps because of the military prohibition on supplying alcohol to soldiers under twenty-one³⁰ and perhaps because of the

²³ See JERRY LEMBCKE, *THE SPITTING IMAGE: MYTH, MEMORY, AND THE LEGACY OF VIETNAM* 94, 98, 126 (1998).

²⁴ See generally KUZMAROV, *supra* note 7, at 37, 47–48.

²⁵ Hubert Van Es, Op-Ed., *Thirty Years at 300 Millimeter*, N.Y. TIMES (Apr. 29, 2005), http://www.nytimes.com/2005/04/29/opinion/29van_es.html?_r=2&pagewanted=all&position=&.

²⁶ David Fromkin & James Chace, *What Are the Lessons of Vietnam?*, 63 FOREIGN AFF. 722, 722 (1985).

²⁷ See, e.g., John Wheeler, *Coming to Grips with Vietnam*, 63 FOREIGN AFF. 747, 756 (1985).

²⁸ LEMBCKE, *supra* note 23, at 29, 78–83.

²⁹ INST. OF MED., *SUBSTANCE USE DISORDERS IN THE U.S. ARMED FORCES* 29 (2013) (citations omitted).

³⁰ Lee N. Robins, *Vietnam Veterans' Rapid Recovery from Heroin Addiction: A Fluke or Normal Expectation?*, 88 ADDICTION 1041, 1045 (1993) [hereinafter

generational attitudes towards smoking marijuana,³¹ illegal drugs became the substance of choice to abuse in Vietnam and generally at a higher rate than the general population.³² One study of soldiers recently returned from Vietnam revealed that “[a]lmost half (45%) of Army enlisted men there in 1970–71 tried narcotics; 34% tried heroin and 38% tried opium. While fewer used heroin or opium than alcohol [>90%] or marijuana [>70%] . . . narcotics were used at a truly astounding rate.”³³ What worried authorities most, however, was the availability of heroin in Vietnam: “Heroin was so readily available in Vietnam that more than 80% were offered it, and usually within the week following arrival.”³⁴ What had been primarily recreational substance abuse by soldiers³⁵—as military tradition otherwise seems to encourage—was translated into an addiction problem that frightened a country and that would start the War on Drugs.

First reports of drug usage among the servicemen in Vietnam were about marijuana.³⁶ Fired up in large part by media reports, concerns about drug abuse in Vietnam were inflamed by overblown rhetoric about marijuana use, highlighted in a 1968 article by John Steinbeck IV, *The Importance of Being Stoned in Vietnam*.³⁷ In that article,

[Steinbeck] estimated that up to 75 percent of soldiers in Vietnam got high regularly. ‘The average soldier sees that for all intents and purposes, the entire country is stoned,’ Steinbeck observed. ‘To enforce a prohibition against smoking the plant [in Vietnam] would be like trying to prohibit the inhalation of smog in Los Angeles.’³⁸

Then in 1969, near the end of the Vietnam War, rumors of heroin

Robins, *Rapid Recovery*].

³¹ Stuart, *Metaphor*, *supra* note 19, at 31.

³² Robins, *Rapid Recovery*, *supra* note 30, at 1044–45.

³³ *Id.* at 1044, fig. 1.

³⁴ *Id.* at 1048; *see also* Lee N. Robins et al., *Vietnam Veterans Three Years after Vietnam: How Our Study Changed Our View of Heroin*, 19 AM. J. ADDICTIONS 203, 203 (2010) [hereinafter Robins et al., *Three Years After*].

One soldier was offered heroin as he descended from the plane on which he arrived in Vietnam by a soldier preparing to board that same plane to return home. He was offered the heroin in exchange for a clean urine [sic] so that the man due to leave would be able to get through the urine screen.

Id.

³⁵ KUZMAROV, *supra* note 7, at 17–18.

³⁶ Robins, *Rapid Recovery*, *supra* note 30, at 1041.

³⁷ *See* KUZMAROV, *supra* note 7, at 4.

³⁸ *Id.* at 4–5.

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abuse began to circulate.³⁹ In response to the reports of easy access to heroin in Vietnam, Congressmen Morgan F. Murphy and Robert H. Steele reported to Congress that 10–15% of servicemen in Vietnam were addicted to heroin.⁴⁰ As a consequence, President Nixon declared that heroin addiction was the “N[umber one] Public Health [P]roblem” in America,⁴¹ legerdemain designed to focus national attention elsewhere than the actual war itself.

By 1971, President Nixon’s War on Drugs message to Congress less than subtly suggested that soldiers’ drug abuse would threaten the entire country when they returned to the States:

While by no means a major part of the American narcotics problem, an especially disheartening aspect of that problem involves those of our men in Vietnam who have used drugs. Peer pressures combine with easy availability to foster drug use. We are taking steps to end the availability of drugs in South Vietnam but, in addition, the nature of drug addiction, and the peculiar aspects of the present problem as it involves veterans, make it imperative that rehabilitation procedures be undertaken immediately. . . . Further, a habit which costs \$5 a day to maintain in Vietnam can cost \$100 a day to maintain in the United States, and those who continue to use heroin slip into the twilight world of crime, bad drugs, and all too often a premature death.⁴²

The War on Drugs was a welcome diversion at that time because it focused on another “conflict” that had global implications. Also, because it involved troops in Vietnam, the Nixon Administration urged that failure in Vietnam was not the fault of policymakers⁴³

³⁹ Robins, *Rapid Recovery*, *supra* note 30, at 1041.

⁴⁰ KUZMAROV, *supra* note 7, at 4, 51–52; Stuart, *Metaphor*, *supra* note 19, at 7 n.25.

⁴¹ Robins, *Rapid Recovery*, *supra* note 30, at 1041.

⁴² PRESIDENT RICHARD NIXON, SPECIAL MESSAGE TO THE CONGRESS ON DRUG ABUSE PREVENTION AND CONTROL (June 17, 1971), <http://www.presidency.ucsb.edu/ws/?pid=3048>; *see also* KUZMAROV, *supra* note 7, at 1–2.

⁴³ BARBARA W. TUCHMAN, *THE MARCH OF FOLLY: FROM TROY TO VIETNAM* 234 (1984). Describing the U.S. Government’s failure to acknowledge the evidence that clearly pointed to ultimate failure in Vietnam, Tuchman stated:

Ignorance was not a factor in the American endeavor in Vietnam pursued through five successive presidencies, although it was to become an excuse. Ignorance of country and culture there may have been, but not ignorance of the contra-indications, even the barriers, to achieving the objectives of American policy. All the conditions and reasons precluding a successful outcome were recognized or foreseen at one time or another during the thirty years of our involvement. American intervention was not a progress sucked step by step into an unsuspected quagmire. At no time were policy-makers unaware of the

but about the servicemen, despite the fact that drug use did not affect combat performance.⁴⁴

In 1971, a mandatory urine-testing protocol—Operation Golden Flow—was implemented to screen soldiers for heroin as they departed from Vietnam.⁴⁵ That urine-testing detected heroin in only 3.6% of departing soldiers.⁴⁶ At the same time, a study was commissioned to try to determine the actual magnitude of the problem in Vietnam and upon veterans' return.⁴⁷ The results of that study concluded that soldiers' drug use in Vietnam had been grossly underestimated; however, those results also concluded that heroin addiction was not the scourge that it was marketed to be.

Between May and October 1972, researchers interviewed nine hundred Army enlisted men out of the fourteen thousand who had returned from deployment in September 1971.⁴⁸ The interviewees were randomly selected, with an oversampling of those who had tested positive for heroin upon departure from Vietnam.⁴⁹ Two years later, in 1974, 617 men were re-interviewed.⁵⁰ The overarching purpose of the research was to study heroin addiction itself and the "political" concerns of rampant addiction in the United States. The results showed that, even with only a tiny percentage of addicted soldiers going through drug abuse treatment programs, the soldiers' overall re-

hazards, obstacles and negative developments. American intelligence was adequate, informed observation flowed steadily from the field to the capital, special investigative missions were repeatedly sent out, independent reportage to balance professional optimism—when that prevailed—was never lacking. The folly consisted not in pursuit of a goal in ignorance of the obstacles but in persistence in the pursuit despite accumulating evidence that the goal was unattainable, and the effect disproportionate to the American interest and eventually damaging to American society, reputation and disposable power in the world.

Id.

⁴⁴ KUZMAROV, *supra* note 7, at 5–6, 20–22.

⁴⁵ *Id.* at 129; Stuart, *Metaphor*, *supra* note 19, at 7 n.25; *see also* Robins, *Rapid Recovery*, *supra* note 30, at 1041–42.

⁴⁶ KUZMAROV, *supra* note 7, at 19; *see also* Robins, *Rapid Recovery*, *supra* note 30, at 1044 (stating in one early study of returning soldiers, 20% self-reported being addicted or strung out while in Vietnam).

⁴⁷ Robins, *Rapid Recovery*, *supra* note 30, at 1042.

⁴⁸ Robins et al., *Three Years After*, *supra* note 34, at 203.

⁴⁹ *Id.*

⁵⁰ *Id.* (stating the original sample size of nine hundred was reduced for the re-interviews in order to include a representative sampling of non-veterans for comparison).

addiction was the same as for civilians who had gone through treatment: Within the first year of return, only 5% were addicted in the United States and after three years, only 12% were re-addicted but usually only briefly.⁵¹ “[T]heir history of brief addiction followed by spontaneous recovery, both in Vietnam and afterwards, was not out of line with the American experience; only with American beliefs.”⁵² Unfortunately, those American beliefs were entrenched, and the research results were assailed as being a Department of Defense whitewash.⁵³ Once the fear of heroin addiction had proved to be a potent marketing tool for the War on Drugs, the American public was not going to be deterred by evidence to the contrary.⁵⁴

Related to the Nixon Administration’s scapegoating the soldiers for the inevitable conclusion to the Vietnam War was its deliberate targeting of the anti-war movement, particularly for their casual use of drugs for recreational purposes.⁵⁵ It was upon this “drug psychology, the drug society” that later Administrations seized on as a marketing ploy. By the time the War on Drugs began to take on the ferocity of a crusade, it was no longer a public health problem, but a war against “them,” especially the generation that came of age in the 1960s and 1970s and fought against a War and for civil rights.⁵⁶ Far back in the mirror was the original image that the War on Drugs might have a public health rationale.

⁵¹ Robins, *Rapid Recovery*, *supra* note 30, at 1045–46.

It was not treatment that explained this remarkable rate of recovery. Only a third of the men addicted in Vietnam received even simple detoxification while in service, and only a tiny percentage of Vietnam enlisted men went into drug abuse treatment after return—less than 2% of those who used narcotics in Vietnam, 6% of those who were positive at departure, and 14% of those positive at departure who continued to use after return This surprising rate of recovery even when re-exposed to narcotic drugs ran counter to the conventional wisdom that heroin is a drug which causes addicts to suffer intolerable craving that rapidly leads to re-addiction if re-exposed to the drug.

Id.

⁵² *Id.* at 1051.

⁵³ *Id.* at 1048.

⁵⁴ Robins et al., *Three Years After*, *supra* note 34, at 208 (stating that although favoring the legalization of marijuana in the same proportion as civilians, Vietnam veterans were only slightly more likely to favor legalization of, or reduction in, penalties for narcotics use, despite their own exposure to and experience with heroin in Vietnam).

⁵⁵ Stuart, *Metaphor*, *supra* note 19, at 31–32.

⁵⁶ *Id.* at 32–33.

Everyday drug use in Vietnam was rampant, but then substance abuse in the military is common. What was lost in the *sturm und drang* of the War on Drugs was a very different drug abuse problem as veterans coped with mental health disorders after they returned—mental health disorders to which they are already disposed or that were caused by being in a real war. Vietnam soldiers became the poster-boys for the War on Drugs, primarily because they were of that generation who viewed drugs as just one more recreational substance,⁵⁷ like alcohol. And many of them likely did come home with drug abuse problems that were exacerbated by in-country recreational use.⁵⁸ But among those returning Vietnam veterans were those who experienced mental health problems that caused significant drug use issues. Even more vexing is that veterans returning from Afghanistan and Iraq are as likely, or more so, to have mental health problems and associated drug use as Vietnam veterans. The War on Drugs, as a national drug policy based on both an unfounded fear of heroin addiction and a smackdown of recreational drug use, is clearly not designed to welcome them home.

II. THE THINGS THEY CARRIED⁵⁹

Perhaps because of their “disgraceful” part in the War on Drugs, Vietnam veterans’ drug abuse problems were rarely examined. Instead, they were thrown in jail. “Combat veterans from Vietnam onwards face[d] 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.”⁶⁰ Although post-Vietnam studies of Vietnam veterans have led to greater awareness of the diagnosis and treatment for

⁵⁷ Robins, *Rapid Recovery*, *supra* note 30, at 1049 (“[W]hen we asked men why they used heroin, they did not tell us that they were overcome by fear or stress. Rather, they said it was enjoyable and made life in service bearable.”).

⁵⁸ One study reveals that Vietnam veterans have a lower comorbidity of substance abuse and mental illness than veterans of the current conflicts. Ismene L. Petrakis et al., *Substance Use Comorbidity Among Veterans with Posttraumatic Stress Disorder and Other Psychiatric Illness*, 20 AM. J. ADDICTION 185, 188 (2011).

⁵⁹ TIM O'BRIEN, *THE THINGS THEY CARRIED* (1990) (a collection of short stories written by a Vietnam veteran).

⁶⁰ *Healing a Broken System: Veterans and the War on Drugs*, DRUG POL'Y ALLIANCE 5 (Nov. 9, 2012), <http://www.drugpolicy.org/resource/healing-broken-system-veterans-and-war-drugs>.

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posttraumatic stress disorder (PTSD),⁶¹ studies exploring the confluence of drug abuse and mental health disorders in veterans are more recent. The increasing number of veterans seeking treatment through the Veterans Administration is just the tip of the looming public health problem we will face with veterans returning from the current conflicts: perhaps because we now know more about PTSD after Vietnam; perhaps because we have made a national effort to not treat current returning veterans the same way the Nixon Administration treated the Vietnam veterans.⁶² At any rate, evidence of the mental illness-drug abuse connection has been slow in coming. But the evidence long has been there to suggest that the War on Drugs' law enforcement focus has been wrong from the outset, and veterans have supplied that evidence.

One important finding from the Vietnam heroin study discussed above was the connection between addiction and pre-disposing factors.⁶³ Given that the study was designed only to study heroin use and addiction while serving in-country, the researchers found little correlation with the combat experience. Instead, "deviant behavior before service was a powerful predictor So was pre-service drug experience . . . ; the greater the variety of drugs used before entering service, the greater the likelihood that narcotics would be used in Vietnam."⁶⁴ In other words, there were early indications that something other than recreational drug use in Vietnam was at play in drug abuse problems in veterans.

National statistics of incarcerated veterans added more detail by suggesting a strong link between drug use and mental health disorders.⁶⁵ Between 1985 and 2000, the veteran population in

⁶¹ See generally Wilbur J. Scott, *PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease*, 37 SOC. PROBS. 294, 294 (1990). Furthermore, the Nixon Administration made political hay of PTSD to mark Vietnam veterans as victims of mental illness in order to draw attention away from their political involvement against the War. LEMBCKE, *supra* note 23, at 106, 115.

⁶² See generally LEMBCKE, *supra* note 23, at 18–19, 21, 68–69, 99, 119 (noting that the narrative that Vietnam veterans were not welcomed home by anti-war protestors was burnished to a bright sheen by the Bush I Administration to cut off opposition to the First Gulf War and describing ways in which Vietnam veterans were treated upon their arrival back in the United States).

⁶³ *Healing a Broken System: Veterans and the War on Drugs*, *supra* note 60, at 4; Robins, *Rapid Recovery*, *supra* note 30, at 1051.

⁶⁴ Robins, *Rapid Recovery*, *supra* note 30, at 1049.

⁶⁵ MARGARET E. NOONAN & CHRISTOPHER J. MUMOLA, U.S. DEP'T OF JUSTICE, *VETERANS IN STATE AND FEDERAL PRISON*, 2004, at 1 (2007).

prison rose by 53%.⁶⁶ In addition, the number of those incarcerated with mental health problems skyrocketed between 1997 and 2004,⁶⁷ until they mirrored those of nonveterans: 56.5% of nonveterans in state prisons reported mental health problems to 54.4% for veterans⁶⁸ while 45.0% of nonveterans and 42.9% of veterans in federal prisons had mental health problems.⁶⁹

Drug use problems for both populations were similarly high. Veterans in state prison had a high rate of previous thirty-day drug use before the offense (42.5%) although somewhat lower than nonveterans (57.6%).⁷⁰ Previous thirty-day drug use by veterans incarcerated in federal prison was slightly lower, at 42.6%, but more comparable to nonveterans' previous thirty-day drug use (51.1%).⁷¹ Veterans' drugs of choice were marijuana, hashish, cocaine, and crack.⁷² For both subsets of incarcerated veterans, the likelihood of ever having used drugs was exceedingly high (75.5% federal; 74.5% state) and comparable to nonveterans (79.2% federal; 84.3% state).⁷³ Veterans were also more likely to have used heroin/opiates, depressants, stimulants, and hallucinogens than nonveterans.⁷⁴ Clearly, the criminal consequences of the War on Drugs show starkly that incarcerated veterans have both drug use and mental health problems.

One explanation for the similarities of the veteran prison population with the nonveteran population is that both populations had similar predictors for both drug abuse and mental health disorders. Indeed, incarcerated veterans tend to share the same risk characteristics as the general population for purposes of predicting incarceration.⁷⁵ In other words, those veterans with pre-existing risk factors—especially mental health

⁶⁶ *Id.* at 2.

⁶⁷ This increase may have more to do with on-site diagnosis rather than actual increases between Reports. The 1997 statistics reveal significantly lower statistics for mental health issues in prison that would not otherwise explain the huge spike in mental illness identification. See CHRISTOPHER J. MUMOLA, U.S. DEP'T OF JUSTICE, VETERANS IN PRISON OR JAIL 12 (2000).

⁶⁸ NOONAN & MUMOLA, *supra* note 65, at 15.

⁶⁹ Interestingly, incarcerated combat veterans were less likely to have mental health problems. *Id.* at 7, 15.

⁷⁰ *Id.* at 14.

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ Greg A. Greenberg & Robert A. Rosenheck, *Mental Health and Other Risk Factors for Jail Incarceration Among Male Veterans*, 80 PSYCHIATRIC Q. 41, 48 (2009).

disorders—are probably no different in their rates of drug abuse than the general population. In addition to genetic predisposition, those factors include childhood abuse, personal violence, and family and peer risk factors.⁷⁶ For instance, a higher incarceration rate for post-Vietnam and noncombat veterans than for Vietnam veterans is blamed on recruits who entered the military with pre-existing problems.⁷⁷ And a recent study of First Gulf War veterans suggests that the connection with combat experience may be less suggestive of later incarceration than pre-existing mental health problems.⁷⁸ However, that doesn't necessarily address adequately the fact that all other socio-economic indicators reveal that veterans are significantly different than the nonveteran population in their predictors of incarceration.

In other words, veterans' backgrounds tend to make them less like the general population who would be incarcerated. Veterans tend to have shorter criminal histories before incarceration.⁷⁹ They also tend to be nearly ten years older than nonveterans with only 14% of them are under the age of thirty-five.⁸⁰ They are twice as likely to be white, non-Hispanics than nonveterans.⁸¹ They are also better educated: nearly 90% reported at least a high school diploma or GED, and they were at least twice as likely to have attended college.⁸² The risk factors they have in common with the general population are mental health disorders and drug use. Indeed, a recent study of First Gulf War veterans revealed that those "veterans who had been incarcerated at some point in their lives had a higher prevalence of mental health, addictive, and medical conditions than did non-incarcerated veterans."⁸³ One mental health disorder common to both the veteran and non-veteran populations is PTSD. "The rate of positive PTSD screenings observed among jailed veterans . . . (39[%]) was much

⁷⁶ INST. OF MED., *supra* note 29, at 98–99.

⁷⁷ Greenberg & Rosenheck, *supra* note 75, at 49–50. Similarly, previous drug use was a predictor of drug problems for First Gulf War veterans. Jillian C. Shipherd et al., *Predicting Alcohol and Drug Abuse in Persian Gulf War Veterans: What Role Do PTSD Symptoms Play?*, 30 ADDICTIVE BEHAVS. 595, 598 (2005).

⁷⁸ Donald W. Black et al., *Incarceration and Veterans of the First Gulf War*, 170 MIL. MED. 612, 616–17 (2005).

⁷⁹ NOONAN & MUMOLA, *supra* note 65, at 4; MUMOLA, *supra* note 67, at 7.

⁸⁰ NOONAN & MUMOLA, *supra* note 65, at 4.

⁸¹ *Id.* at 10.

⁸² *Id.*

⁸³ Black et al., *supra* note 78, at 616.

higher than the lifetime PTSD rate of 7.8[%] reported in the general population However, the positive screening rates . . . are commensurate with rates observed in other incarcerated populations.”⁸⁴ “Ever incarcerated veterans were more than three times as likely to [suffer from] PTSD,”⁸⁵ particularly those incarcerated after the war, and were more likely to have used street drugs.⁸⁶ Those who had participated in combat were at somewhat greater risk of incarceration,⁸⁷ consistent with earlier studies of Vietnam veterans that showed a connection with post-combat behavioral disorders, PTSD, and stress.⁸⁸ But the source of the commonality of PTSD is often different for the veteran population than for the nonveteran population. For some veterans, their military service itself will increase the likelihood of subsequent—as opposed to pre-existing—mental health disorders, especially PTSD.

PTSD is not unique to the military experience, but the odds of suffering from PTSD are greater in the military than in civilian life.⁸⁹ “Posttraumatic Stress Disorder . . . is an anxiety disorder that can occur following the experience or witnessing of a traumatic event.”⁹⁰ “The events that can cause PTSD are called ‘stressors’ and may include natural disasters, accidents or deliberate man-made events/disasters, including war.”⁹¹ Individuals who suffer from PTSD have three different kinds of symptoms: recurrent thoughts about the trauma; avoidance of places and people that are reminders of the trauma; and hyper-

⁸⁴ Andrew J. Saxon et al., *Trauma, Symptoms of Posttraumatic Stress Disorder, and Associated Problems Among Incarcerated Veterans*, 52 PSYCHIATRIC SERVS. 959, 962 (2001).

⁸⁵ Black et al., *supra* note 78, at 616.

⁸⁶ *Id.* at 617.

⁸⁷ *Id.* at 616.

⁸⁸ *Id.* at 616–17. Additionally, “combat exposure and related illnesses, such as Post Traumatic Stress Disorder (PTSD) and substance abuse, as well as difficulties with reintegrating into society after time away from civilian employment and community networks may put veterans at greater risk than non-veterans for incarceration.” Greenberg & Rosenheck, *supra* note 75, at 42.

⁸⁹ Erin M. Gover, Comment, *Iraq as a Psychological Quagmire: The Implications of Using Post-Traumatic Stress Disorder as a Defense for Iraq War Veterans*, 28 PACE L. REV. 561, 565–66 (2008).

⁹⁰ Jessica Hamblen, *What is PTSD? A Handout from the National Center for PTSD*, U.S. DEP’T FOR VETERANS AFF. 1, [http://www.militarymentalhealth.org/resources/pdf/What%20is%20PTSD%20\(NC-PTSD\).pdf](http://www.militarymentalhealth.org/resources/pdf/What%20is%20PTSD%20(NC-PTSD).pdf).

⁹¹ *Fact Sheet: New Regulations on PTSD Claims*, DEP’T VETERANS AFF. 1 (2010), http://www.va.gov/ptsd_qa.pdf.

alertness, irritability, and anxiety.⁹² Symptoms may last for days and weeks after the trauma while others last for years.⁹³

Combat-related stress with PTSD-like symptoms has been recorded as far back as 1900 B.C.⁹⁴ After the Vietnam War, those symptoms were formally called “PTSD” and recognized by the American Psychiatric Association in 1980.⁹⁵ Although at a baseline, service members have the same incidence of PTSD as the general population, increased exposure to combat will cause PTSD.⁹⁶

There are several risk factors associated specifically with military service. Examples include service-related injuries, trauma, and demands related to active duty (e.g., carrying heavy equipment; witnessing and experiencing traumatic events during deployment; being separated from family members; experiencing occupational stress and boredom when serving in isolated sites; and being the object of discriminatory treatment and, in some cases, acts of violence based on gender, race/ethnicity, or sexual orientation). Military service in general often involves exposure to stressful and traumatic events, and numerous studies have documented high rates of service-related mental health symptoms among military personnel, which are known to intensify the risk of substance use problems.⁹⁷

A study of Vietnam veterans outlined characteristics of those likely to suffer from war-induced PTSD: are non-white, entered the military at age eighteen or younger, had increased exposure to combat, were more likely to use illegal drugs, and had

⁹² *Id.*; Hamblen, *supra* note 90, at 1. The APA diagnosis for PTSD is due to change in 2013 with the publication of DSM-V. Mary Tramontin, *Exit Wounds: Current Issues Pertaining to Combat-Related PTSD of Relevance to the Legal System*, 29 DEV. MENTAL HEALTH L. 23, 25 (2010).

⁹³ Hamblen, *supra* note 90, at 1. The VA is seeing a recent uptick in Vietnam veterans seeking treatment for PTSD, thirty years after the cessation of hostility. Robert A. Rosenheck & Alan F. Fontana, *Recent Trends In VA Treatment Of Post-Traumatic Stress Disorder and Other Mental Disorders*, 26 HEALTH AFF. 1720, 1725 (2007). One reason for the increased demand for treatment is attributable to changes in VA disability policy, but researchers are concerned that PTSD symptoms increase as veterans get older and as local mental health services contract. *Id.* at 1726.

⁹⁴ F. Don Nidiffer & Spencer Leach, *To Hell and Back: Evolution of Combat-Related Post Traumatic Stress Disorder*, 29 DEV. MENTAL HEALTH L. 1, 4 (2010).

⁹⁵ *Id.*; see also Gover, *supra* note 89, at 564–65 (listing the symptoms of PTSD as set forth in the Diagnostic & Statistical Manual of Mental Disorders).

⁹⁶ JEAN-RODRIGUE PARÉ, BACKGROUND PAPER: POST-TRAUMATIC STRESS DISORDER AND THE MENTAL HEALTH OF MILITARY PERSONNEL AND VETERANS 1 (Library of Parliament 2011), <http://www.parl.gc.ca/Content/LOP/ResearchPublications/2011-97-e.pdf>.

⁹⁷ INST. OF MED., *supra* note 29, at 99 (citations omitted).

volunteered rather than been drafted.⁹⁸ Being in the military and being in a war theatre likely and artificially increase the risks of mental health disorders, such as PTSD, and as a consequence also increase the risk of veterans' drug abuse.

In the narrow field of drug use studies and veterans, co-occurring mental health problems are present in a significant portion of the veteran population. "[T]here are high rates of substance use disorders among those with mental illness, ranging from 21-35% across major diagnostic groups."⁹⁹ Comorbidity of substance abuse and psychological problems is a primary predictor for the re-hospitalization of veterans.¹⁰⁰ PTSD is not the only culprit. The highest correlation of substance abuse and mental illness is with bipolar disorder and schizophrenia,¹⁰¹ a correlation that is mirrored in the general population.¹⁰² Consequently, we can account for some comorbidity of mental illness and drug abuse with pre-existing conditions and predisposition.

But there is also a connection between war-related experiences, mental illness, and drug use. Although one study suggests there is a lower correlation between PTSD and drug abuse in veterans than for other mental health disorders,¹⁰³ "combat veterans with PTSD were likely to have worse substance abuse problems than veterans without PTSD."¹⁰⁴ The significance is that PTSD and trauma "typically precede substance use problems."¹⁰⁵ Indeed, given that PTSD and drug abuse are comorbid,¹⁰⁶ it is hypothesized that drug abuse is a self-medicating strategy for PTSD's symptoms.¹⁰⁷ Similar correlations exist for veterans

⁹⁸ Nidiffer & Leach, *supra* note 94, at 15.

⁹⁹ Petrakis et al., *supra* note 58, at 188.

¹⁰⁰ Brent B. Benda, *Predictors of Rehospitalization of Military Veterans Who Abuse Substances*, 25 SOC. WORK RES. 199, 205 (2001) (study of Vietnam veterans).

¹⁰¹ Petrakis et al., *supra* note 58, at 188.

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ Saxon et al., *supra* note 84, at 963.

¹⁰⁵ *Id.*

¹⁰⁶ Shipherd et al., *supra* note 77, at 598.

¹⁰⁷ *Id.* at 599; *see also* RAND, INVISIBLE WOUNDS OF WAR: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY 134 (Terri Tanielian & Lisa H. Jaycox eds., 2008) [hereinafter INVISIBLE WOUNDS]. "Prospective longitudinal studies have demonstrated that PTSD and depression symptoms precede or exacerbate drug and alcohol misuse, supporting the hypothesis that self-medication of psychiatric symptoms drives substance abuse in the context of PTSD and/or depression." Seal et al., *supra* note 3, at 98.

coping with chronic pain: “Mental health disorders were strongly associated with prescription sharing, [alcohol] or street drug use, or any aberrant pain management behavior Our findings support those of previous studies that found that mental health disorders are associated with substance misuse in patients with chronic pain.”¹⁰⁸ Nowhere is this concern for drug abuse and mental illness comorbidity becoming more apparent than in the increasing concerns about the drug abuse problems that are returning from Iraq and Afghanistan.

III. “MISSION ACCOMPLISHED”¹⁰⁹

Efforts to embrace many veterans returning from Afghanistan and Iraq more than those returning from Vietnam are likely to be thwarted by the War on Drugs. What started out as a way of scapegoating one group of veterans is likely to boomerang on a group of veterans returning from an equally unpopular war. It is not their fault, any more than it was the fault of the soldiers in Vietnam. What is especially unfortunate is that the veterans returning from the current conflicts really do have serious mental health problems that are likely to translate to higher drug abuse problems and, as a result, more arrests unless we can relent from our ceaseless concentration on law enforcement as the solution and focus more on public health treatment and prevention.

As a general matter, veterans returning from the current conflicts are at increased risk of all substance abuse. Their rates of substance abuse are higher than their age cohorts in the civilian population,¹¹⁰ including a higher rate of alcohol abuse.¹¹¹ Specifically, one survey of recently deployed soldiers revealed 12–

Interestingly, no such hypothesis could be formed to correlate alcohol abuse and PTSD. *Id.* at 94, 98. On the other hand, “73% of male Vietnam veterans met diagnostic criteria for comorbid PTSD and lifetime diagnosis of [alcohol use disorder].” *Id.* at 94.

¹⁰⁸ Joy R. Goebel et al., *Prescription Sharing, Alcohol Use, and Street Drug Use to Manage Pain Among Veterans*, 41 *J. PAIN & SYMPTOM MGMT.* 848, 854 (2011).

¹⁰⁹ *White House Pressed on ‘Mission Accomplished’ Sign*, CNN.COM (Oct. 29, 2003), http://articles.cnn.com/2003-10-28/politics/mission.accomplished_1_aircraft-carrier-conrad-chun-banner?_s=PM:ALLPOLITICS.

¹¹⁰ INST. OF MED., *supra* note 29, at 43.

¹¹¹ Seal et al., *supra* note 3, at 98. Another survey shows that upon their return, veterans’ alcohol misuse rose to 27%. Andrew J. Saxon, *Returning Veterans with Addictions: Issues and Implications for Clinical Practice*, *PSYCHIATRIC TIMES*, July 2011, at 49 [hereinafter Saxon, *Issues & Implications*].

15% with alcohol problems, with binge drinking among 53% of recently deployed soldiers with combat exposure.¹¹² These problems are not isolated to regular military: “National Guard and Reserve personnel were at increased risk for new-onset heavy weekly drinking, binge drinking, and alcohol-related problems, compared to active duty forces.”¹¹³ Just as concerning is that 11% of returning veterans have been diagnosed with alcohol use disorder (10%), with non-alcohol drug use disorder (5%) or both, rates that “are similar to or higher than [substance use disorder] rates in prior-era veterans.”¹¹⁴

In the wake of increasing attention to the substance abuse problems of veterans, the studies and empirical evidence reveal that mental health disorders play a significant role in veterans’ drug abuse.

Current projections of the rate of psychological disability resulting from service are not easy to validate, but some authors estimate that over 30% of combatants will develop demonstrable psychopathology, and currently, 40% of [Operation Enduring Freedom and Operation Iraqi Freedom] veterans presenting for services at a Department of Veterans Affairs (VA) Medical Center have been seen for mental health issues.¹¹⁵

In addition to PTSD and depression, veterans are returning with traumatic brain injury suffered during deployment.¹¹⁶ “Estimates from . . . data are that 300,000 service members and veterans may have diagnoses of PTSD or depression and that 320,000 have experienced possible [traumatic brain injury].”¹¹⁷ “[F]or the first time in history, the number of psychological casualties resulting from combat has far outstripped the number of physical injuries or deaths resulting from battle.”¹¹⁸ One of the

¹¹² Saxon, *Issues & Implications*, *supra* note 111, at 49.

¹¹³ Seal et al., *supra* note 3, at 93. Reserve and National Guard service members deployed to Iraq and Afghanistan were also at significantly increased risk for “new-onset heavy weekly drinking, binge drinking, and other alcohol-related problems” compared to non-deployed Reserve and Guard service members. Isabel G. Jacobson et al., *Alcohol Use and Alcohol-Related Problems Before and After Military Combat Deployment*, 300 J. AM. MED. ASS’N. 663, 663, 669 (2008). Younger service members were at greatest risk. *Id.* at 663.

¹¹⁴ Seal et al., *supra* note 3, at 99.

¹¹⁵ Morgan T. Sammons & Sonja V. Batten, *Psychological Services for Returning Veterans and Their Families: Evolving Conceptualizations of the Sequelae of War-Zone Experiences*, 64 J. CLINICAL PSYCH. IN SESSION 921, 922 (2008).

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 923.

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consequences of this is that the drug abuse problem being faced by returning veterans is prescription drug abuse, increasing the comorbidity of drug abuse and mental health disorders for veterans of the current service era.

Nationwide, prescription drug abuse has risen, nearly doubling in the past twenty years.¹¹⁹

Unfortunately, misuse of these drugs has risen more rapidly in military than civilian populations Misuse of prescription drugs in the military is associated with increases in the number of prescriptions for these medications that have been written to alleviate chronic pain among service members who have sustained injuries during a decade of continuous war. Indeed, . . . the key driver of prescription drug misuse in the military is misuse of pain medications. Holders of prescriptions for pain medications were found to be nearly three times more likely to misuse prescription pain relievers than those who did not have a prescription.¹²⁰

Illicit previous thirty-day drug use in the active-duty military quadrupled between 2002 and 2008, from 3% to 12%, with prescription drug abuse being the primary contributing factor.¹²¹ Although younger (eighteen to twenty-five) service members were slightly more likely to abuse drugs than their older colleagues, they were less likely to abuse drugs than their civilian counterparts.¹²² In contrast, the other age cohorts (up to age sixty-four), while nearly keeping up with the youngsters' drug abuse, were significantly more likely to engage in illicit drug use than their civilian counterparts,¹²³ primarily due to prescription drug misuse.¹²⁴ Less detail is available on illicit drug use by the Selected Reservists although one survey in 2006 revealed 6.6% previous thirty-day use and 12% past-year use.¹²⁵ As a consequence, diagnoses of drug-related disorders in both the active military and the reservists have been consistently rising since 2004, especially in the Army and Marines.¹²⁶

¹¹⁹ Karen H. Seal et al., *Association of Mental Health Disorders with Prescription Opioids and High-Risk Opioid Use in US Veterans of Iraq and Afghanistan*, 307 J. AM. MED. ASS'N. 940, 940 (2012) [hereinafter Seal et al., *Opioid Use*]; see also INST. OF MED., *supra* note 29, at 1.

¹²⁰ INST. OF MED., *supra* note 29, at 29–30.

¹²¹ *Id.* at 39–40 fig. 2-4, 41. Because illicit drug use is still against military policy, past thirty-day drug use may be underreported. *Id.* at 41.

¹²² *Id.* at 43–44, fig. 2-5b.

¹²³ *Id.* at 43, 47 fig. 2-5b.

¹²⁴ *Id.*

¹²⁵ *Id.* at 48.

¹²⁶ *Id.* at 50, 52–53 fig. 2-8.

Research has confirmed that mental illness remains the primary comorbidity with drug abuse: “Iraq and Afghanistan veterans with pain- and PTSD-prescribed opioids may be at particularly high risk of prescription opioid misuse given the high occurrence of substance use disorders among veterans with PTSD.”¹²⁷ Of veterans who entered VA healthcare between 2005 and 2008, nearly half received a pain diagnosis, and half of those had a mental health diagnosis: 32% for PTSD and 19% for other mental health issues.¹²⁸ Those diagnosed with mental health disorders—PTSD, “depression, anxiety, alcohol use disorders, drug use disorders, and traumatic brain injury—were significantly more likely to receive [prescription] opioids than veterans with no mental health diagnoses.”¹²⁹ Follow-up treatment of these subgroups revealed higher-risk use of opioids,¹³⁰ including injuries and overdose.¹³¹ Veterans with PTSD and presenting for substance abuse treatment at VA medical centers increased their rate of comorbidity between 2008 and 2010.¹³²

Although the Iraq and Afghanistan veterans currently present at lower rates of drug abuse than Vietnam veterans, the concern is that the delayed but progressive nature of PTSD will increase drug abuse disorders as time passes.¹³³ The current conflicts present a different arc of development of PTSD than previously treated. “Multiple deployments (widely accepted as a contributing factor to PTSD development), as well as a dangerous and relatively unpredictable war arena, have enhanced the psychological difficulties among returning service members.”¹³⁴ Enumerated factors of war that have tended to increase the risk of PTSD are multiple deployments, increased exposure to combat,

¹²⁷ Seal et al., *Opioid Use*, *supra* note 119, at 941. “Opioids are medications that relieve pain . . . [and] include hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin, Percocet), morphine (e.g., Kadian, Avinza), codeine, and related drugs.” *Prescription Drugs: Abuse and Addiction: What Are Opioids?*, NAT’L INST. ON DRUG ABUSE, <http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/what-are-opioids> (last updated Oct. 2011).

¹²⁸ Seal et al., *Opioid Use*, *supra* note 119, at 942.

¹²⁹ *Id.*

¹³⁰ *Id.* at 943–44.

¹³¹ *Id.*

¹³² Saxon, *Issues & Implications*, *supra* note 111, at 50 tbl.1. The absolute number of veterans seeking treatment increased simply because the absolute number of veterans going to the VA has increased. *Id.* at 49.

¹³³ *Id.* at 49.

¹³⁴ Nidiffer & Leach, *supra* note 94, at 11.

psychiatric conditions, youth, genetic predispositions, and “situations that led to feeling guilty or shameful.”¹³⁵ And Iraq and Afghanistan veterans might be more likely to experience PTSD

due to changes in modern warfare, including greater lengths of deployment, multiple deployments, and a heightened emphasis on air power and special operations troops, which puts soldiers in more dangerous situations. In addition, military training techniques that encourage emotional numbing and turning soldiers into “Rambo-like killing machines” are also likely to contribute to an increased incident of PTSD. As one soldier noted quite plainly, “[t]he military teaches you how to have PTSD.”¹³⁶

With an estimated 10–20% of the nearly two million returning veterans from Iraq and Afghanistan likely to develop PTSD,¹³⁷ drug abuse problems will follow as sure as night follows day.¹³⁸ “Iraq and Afghanistan veterans, like veterans before them, are at risk for an increasing incidence of substance use disorders over the coming years.”¹³⁹

The wars in Iraq and Afghanistan present the additional convergence of traumatic brain injury (“TBI”) and drug abuse. TBI refers to “relatively severe cases of brain trauma,”¹⁴⁰ and “TBI from bomb blasts, which cannot be prevented by body armor or rapid medical attention, is being called a ‘signature wound’ of the Iraq war.”¹⁴¹ In this context,

TBI is associated with decreased levels of consciousness, amnesia, and other neurological abnormalities; skull fracture; and intracranial lesions; and it can lead to death. Blasts are the primary cause of TBI for active duty military personnel in war zones. TBI diagnoses can range from mild to severe. In its milder forms, TBI can resolve quickly (often within three months of the injury), and it can be difficult to diagnose and distinguish from psychological co-morbidities.¹⁴²

¹³⁵ *Id.* at 15.

¹³⁶ Katherine Dubyak, *Close, But No Cigar: Recent Changes to the Stressor Verification Process for Veterans with Post-Traumatic Stress Disorder and Why the System Remains Insufficient*, 21 FED. CIR. B.J. 655, 664–65 (2011).

¹³⁷ Nidiffer & Leach, *supra* note 94, at 12.

¹³⁸ See Dubyak, *supra* note 136, at 660–661; James Geiling et al., *Medical Costs of War in 2035: Long-Term Care Challenges for Veterans of Iraq and Afghanistan*, 177 MIL. MED. 1235, 1239 (2012).

¹³⁹ Saxon, *Issues & Implications*, *supra* note 111, at 49; Heathcote W. Wales, *Causation in Medicine and Law: The Plight of the Iraq Veterans*, 35 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 373, 375 (2009).

¹⁴⁰ INVISIBLE WOUNDS, *supra* note 107, at 6–7.

¹⁴¹ Geiling et al., *supra* note 138, at 1239.

¹⁴² INVISIBLE WOUNDS, *supra* note 139, at 6 (citations omitted).

Because the study of TBI symptoms and causes is relatively new in military medicine,¹⁴³ the study of closed-head brain injuries and their relationship to primary-blast injuries is mainly anecdotal: “[E]stimating the prevalence of closed head injuries (when an object hits the head but does not break the skull) and primary blast injuries (injuries caused by wave-induced changes in atmospheric pressure) is difficult, even though such injuries are anecdotally noted as extremely prevalent among returning service members.”¹⁴⁴ One study suggests that TBI presented in 59% of veterans exposed to blasts.¹⁴⁵ It is feared that, overall, up to 30% of service members returning from Iraq may have TBI.¹⁴⁶

TBI has been specifically linked to both alcohol abuse disorders¹⁴⁷ and drug abuse.

Substance use and TBI co-morbidity has been specifically associated with military discharge. Compared with all those discharged from the military, persons with mild TBI were over two times more likely to be discharged for alcohol/drugs or criminal convictions, and persons with moderate TBI were about five times more likely to be discharged for alcohol/drug problems.¹⁴⁸

One reason is that TBI impairs the executive functions controlled by the brain’s frontal lobe, thereby making TBI sufferers more likely to abuse drugs and alcohol.¹⁴⁹ In addition, the pain associated with TBI will likely lead to greater abuse of prescription drugs. Abuse of prescription drugs remains as criminalized as any other illegal drug use, just like heroin.

IV. CATCH-22¹⁵⁰

The recent spate of research on returning veterans and both their mental health issues and their substance abuse issues has

¹⁴³ *Id.* at 7.

¹⁴⁴ Rajeev Ramchand et al., *Prevalence of PTSD, Depression, and TBI among Returning Servicemembers*, in *INVISIBLE WOUNDS*, *supra* note 107, at 35, 47 (citations omitted).

¹⁴⁵ Geiling et al., *supra* note 138, at 1239.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ Benjamin R. Karney et al., *Predicting the Immediate and Long-Term Consequences of Post-Traumatic Stress Disorder, Depression, and Traumatic Brain Injury in Veterans of Operation Enduring Freedom and Operation Iraqi Freedom*, in *INVISIBLE WOUNDS*, *supra* note 107, at 119, 134–35 (citations omitted); *see also* Saxon, *Issues & Implications*, *supra* note 111, at 49.

¹⁴⁹ *See* James M. Bjork & Steven J. Grant, *Does Traumatic Brain Injury Increase Risk for Substance Abuse?*, 26 *J. NEUROTRAUMA* 1077, 1079 (2009).

¹⁵⁰ JOSEPH HELLER, *CATCH-22* (1955).

filled a much needed void in the scientific literature to treat either or both of these problems.¹⁵¹ It was a long time coming, especially for Vietnam veterans, but this research should not be an end to itself. This research should also be the basis for understanding the need to change the War on Drugs, definitively altering its course from a law enforcement issue to a public health issue. It is also a moral issue: this War has criminalized behavior that is the natural consequence of a real war. As the war experience of veterans leads to mental health disorders so too does it often lead to comorbidity with drug abuse. In its current iteration, the War on Drugs often pre-empts treatment and rehabilitation in favor of incarceration, especially among veterans.¹⁵²

Once again, national statistics are informative. In 1997, veterans in state prisons were less likely than non-veterans to be in for drug offenses—14.4% to 21.5%—but with longer drug sentences (118 months to 107 months).¹⁵³ The incarceration of veterans for drug offenses in federal prisons was significantly higher, at 51.3% and comparable to the rate of nonveterans.¹⁵⁴ Seven years later, in 2004, the plight of veterans in prison had not improved much in their rate of incarceration for drug offenses: 15% in state prison and 46.3% in federal prison.¹⁵⁵ They still remained more likely to receive harsher sentences than the nonveteran population: veterans' federal sentences were a few months longer while veterans' state sentences averaged twenty-two months longer.¹⁵⁶ Unfortunately, decriminalization of drug abuse and the changes in the sentencing laws are slow in coming from either state or federal governments. There must be the political will in the current legislatures, and there is currently little indication that the scientific evidence of a public health problem will displace the religious fervor of the War on Drugs.

Those federal departments most involved with veterans have given lip-service to a public health approach to drug abuse but are still under the law enforcement focus of their funding

¹⁵¹ See Nidiffer & Leach, *supra* note 94, at 11.

¹⁵² *Healing a Broken System: Veterans and the War on Drugs*, *supra* note 60, at 4.

¹⁵³ MUMOLA, *supra* note 67, at 1, 5 tbl.3, 6 tbl.5. Interestingly, Vietnam-era veterans' incarceration for drug offenses was at nearly the same rate as for other veterans, 14.6%. *Id.* at 6.

¹⁵⁴ *Id.* at 5 tbl.3.

¹⁵⁵ NOONAN & MUMOLA, *supra* note 65, at 11 tbl.4.

¹⁵⁶ *Id.* at 5.

legislatures. For example, since 1986, the Department of Defense has promoted anti-alcohol and anti-drug policies as a matter of health policy in the military;¹⁵⁷ however, separation from service for drug abuse problems is still a very real threat.¹⁵⁸ As for the VA, much of the current empirical evidence on veterans' mental health and drug abuse problems was crafted by health practitioners affiliated with the VA.¹⁵⁹ However, funding is everything, and recent data reveals a 60% decline in inpatient substance abuse services available from the Veterans Health Administration.¹⁶⁰ Although the Veterans' Mental Health and Other Care Improvements Act of 2008¹⁶¹ authorized the VA to provide drug abuse treatment for veterans, such drug use must be comorbid with a mental health disorder.¹⁶² That comorbidity requires that the drug abuse be, "secondary to or is caused or aggravated by a primary service-connected disorder," such as PTSD.¹⁶³ Last, the VA doesn't provide services to veterans unless their military discharge has been other than dishonorable, and PTSD and drug abuse both may increase the number of service members who are dishonorably discharged.¹⁶⁴

¹⁵⁷ INST. OF MED., *supra* note 29, at 31. Previous thirty-day illicit drug use in the active military has decreased from 28% in 1980 to 3% in 2008. *Id.* at 38. Unfortunately, prescription drug abuse has tripled. *Id.* at 41. In addition, the Department of Defense has been less attentive to service members' need for mental health evaluations, perhaps in order to meet its retention goals. See Michael P. Atkinson et al., *A Dynamic Model for Posttraumatic Stress Disorder Among U.S. Troops in Operation Iraqi Freedom*, 55 MGMT. SCI. 1454, 1466 (2009).

¹⁵⁸ Chapman, *supra* note 18, at 45.

¹⁵⁹ See, e.g., Petrakis et al., *supra* note 58; see generally Saxon, *supra* note 84, at 959; Peter Tuerk et al., *Combat-Related PTSD: Scope of the Current Problem, Understanding Effective Treatment, and Barriers to Care*, 29 DEV. MENTAL HEALTH L. 49, 49 (2010).

¹⁶⁰ Richard Tessler et al., *Declining Access to Alcohol and Drug Abuse Services Among Veterans in the General Population*, 170 MIL. MED. 234, 234 (2005). It was reported in 2007 that a couple of VA facilities encouraged the misdiagnosis of PTSD to avoid having to pay higher benefits. See generally Chapman, *supra* note 18, at 15; DUBYAK, *supra* note 136, at 677.

¹⁶¹ P.L. § 110-387 (Oct. 10, 2008); see generally Alyson Sincavage, Note and Comment, *The War Comes Home: How Congress' Failure to Address Veterans' Mental Health Has Led to Violence in America*, 33 NOVA L.R. 481, 500-01 (2009).

¹⁶² See Sincavage, *supra* note 161, at 501.

¹⁶³ Chapman, *supra* note 18, at 45; see generally 38 U.S.C. § 1110 (1998) (basic entitlement to veterans' disability compensation); Madeline McGrane, Note, *Post-Traumatic Stress Disorder in the Military: The Need for Legislative Improvement of Mental Health Care for Veterans of Operation Iraqi Freedom and Operation Enduring Freedom*, 24 J.L. & HEALTH 183, 193 (2011).

¹⁶⁴ Chapman, *supra* note 18, at 24-26.

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Even treatment for mental health issues is in short supply. VA facilities are overwhelmed and unable to adequately serve veterans returning from Iraq and Afghanistan.¹⁶⁵ The waiting periods are excessive for both initial and follow-up appointments at VA facilities.¹⁶⁶ Not all veterans have easy access to VA services, particularly in rural areas,¹⁶⁷ and Reservists pose a particular problem because of their geographic dispersion after deactivation.¹⁶⁸ Until recently, the 800 community-based clinics that provide outpatient treatment to most veterans did not provide mental health care.¹⁶⁹ The Caregivers and Veterans Omnibus Health Services Act of 2010¹⁷⁰ requires mental health services at VA hospitals and outreach to community mental health centers.¹⁷¹ There also exists a general reluctance among both veterans and active service members to even seek mental health treatment for personal and professional reasons,¹⁷² including the military culture and concerns of stigma.¹⁷³ This is a

¹⁶⁵ Nema Milaninia, *The Crisis at Home Following the Crisis Abroad: Health Care Deficiencies for US Veterans of the Iraq and Afghanistan Wars*, 11 DEPAUL J. HEALTH CARE L. 327, 331–33 (2008).

¹⁶⁶ Press Release, Nat'l Council for Cmty. Behavioral Healthcare, Veterans Mental Health Act Still Not Implemented (Nov. 10, 2009).

¹⁶⁷ See, e.g., Marta Hoes, Comment, *Invisible Wounds: What Texas Should Be Doing for the Mental Health of Its Veterans*, 13 TEX. TECH. ADMIN. L.J. 369, 386–88 (2012).

¹⁶⁸ M. Audrey Burnam et al., *Systems of Care: Challenges and Opportunities to Improve Access to High-Quality Care*, in INVISIBLE WOUNDS, *supra* note 107, at 245, 259.

¹⁶⁹ Andrew Silverio, *Ninth Circuit Guts the VA: Amidst Alarming PTSD and Suicide Rates, The Current System Violates Veterans' Rights to Health Care*, 8 J. HEALTH & BIOMED. L. 117, 118–19 (2012); see also *Veterans for Common Sense v. Shinseki*, 678 F.3d 1013, 1015–16, 1036 (9th Cir. 2012), *cert. denied*, 133 S. Ct. 840, 184 L. Ed. 2d 653 (2013).

¹⁷⁰ Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. No. 111-163, 124 Stat. 1130 (2010).

¹⁷¹ *Caregivers and Veterans Omnibus Health Services Act of 2010*, AM. PSYCH. ASS'N, <http://www.apa.org/about/gr/issues/military/health-services-act.aspx> (last visited Mar. 20, 2013).

¹⁷² Press Release, Nat'l Council for Cmty. Behavioral Healthcare, *supra* note 166.

¹⁷³ Burnam et al., *supra* note 168, at 251; McGrane, *supra* note 163, at 205–07.

While seventy-five percent of the service members surveyed knew how to seek treatment for PTSD, sixty percent believed doing so would negatively affect their careers. More than half of those surveyed believed that if they sought counseling, their peers would think less of them, and very few had ever spoken to their family and friends about PTSD.

Id. at 205.

particular concern for active service members with mental health issues because self-identification risks their losing benefits due to a less than honorable discharge.¹⁷⁴

Dependent as the VA is upon congressional appropriations and given all that we know to be true about the reluctance of Congress to increase federal funding to anybody, we can surmise that the local communities are likely going to take the brunt for finding solutions for their veteran neighbors who are returning from the current conflict. Indeed, community-based partnerships have been anticipated for the past four or five years. For instance, the Veterans' Mental Health and Other Care Improvements Act in 2008 directed the VA to develop a pilot program to target mental health services for veterans in rural areas.¹⁷⁵ And President Obama recently issued an Executive Order that directs the VA to contract out with community-based mental health programs to reduce wait-times at VA facilities.¹⁷⁶

Unfortunately, state funding for those community-based health programs—especially for substance abuse treatment—has declined disproportionately in the past few years: “A majority of states reported an absolute decline in their substance abuse treatment funding between fiscal years 2009 and 2010.”¹⁷⁷ State budgets for mental health and substance abuse services have been slashed all across the country in the past few years.¹⁷⁸ “The economic downturn has forced state budgets to cut approximately \$4.35 billion in public mental health spending over the 2009–2012 period—the largest combined reduction since de-institutionalization. Based on new data coming from the states, it appears that this trend will likely continue for several years.”¹⁷⁹

¹⁷⁴ Chapman, *supra* note 18, at 2–3.

¹⁷⁵ Veterans' Mental Health and Other Care Improvements Act of 2008, Pub. L. No. 110-387, 122 Stat. 4110 (2008).

¹⁷⁶ *Executive Order-Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*, WHITE HOUSE, (Aug. 31, 2012), <http://www.whitehouse.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service>.

¹⁷⁷ Jeffrey A. Buck, *The Looming Expansion and Transformation of Public Substance Abuse Treatment Under the Affordable Care Act*, 30 HEALTH AFF. 1402, 1405 (2011).

¹⁷⁸ ROBERT W. GLOVER ET AL., NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS., PROCEEDINGS ON THE STATE BUDGET CRISIS AND THE BEHAVIORAL HEALTH TREATMENT GAP: THE IMPACT ON PUBLIC SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT SYSTEMS 1 (2012).

¹⁷⁹ *Id.*; see also NAT'L ALLIANCE ON MENTAL ILLNESS, STATE MENTAL HEALTH CUTS: A NATIONAL CRISIS 1, 3 (2011) [hereinafter A NATIONAL CRISIS]; NAT'L ALLIANCE ON MENTAL ILLNESS, STATE MENTAL HEALTH CUTS: THE CONTINUING

At the same time, these community-based programs experienced a 10% increase in patients.¹⁸⁰ State funding for substance abuse treatment is even more abysmal. Only one million of the twenty-two million Americans who have substance dependencies are receiving the treatment they need,¹⁸¹ especially because states are reluctant to provide substance abuse services under Medicaid.¹⁸² So despite the apparent will to create partnerships with community-based mental health and substance abuse treatment organizations, those organizations are seeing a precipitous decline in funding for those services,¹⁸³ and it's unlikely that federal contracts will be sufficient to replace them on a dollar for dollar basis.

All that leaves the burden on the local communities to provide the necessary services out of budgets not intended to deal with drug abuse and mental health problems, even for veterans: "Communities pay a high price for the cuts of this magnitude. Rather than saving states and communities money, these cuts to services simply shift financial responsibility to emergency rooms, community hospitals, law enforcement agencies, correctional facilities and homeless shelters."¹⁸⁴ Often, these entities do not have the wherewithal to provide those services so community members have to do without. The consequence of not providing treatment for either mental health disorders or substance abuse is feeding the loop back to law enforcement solutions, thereby continuing the cycle of the worst that is the War on Drugs.

All that leaves the plight of veterans' drug use problems on local governments. Local governments must, first of all, recognize the public health problem posed by drug abuse and abandon the law enforcement focus of the War on Drugs. They must buy into the Obama Administration's Drug Control Strategy for comprehensive services for prevention and treatment, in

CRISIS 3 (2011). "Good access to mental health care in the United States has long been hampered . . . by cost-constrained publicly funded services that provide access to the most severely disabled but have limited resources for serving a broader array of problems and populations." Burnam et al., *supra* note 168, at 247.

¹⁸⁰ GLOVER ET AL., *supra* note 178, at 1.

¹⁸¹ *Id.* at 2.

¹⁸² Buck, *supra* note 177, at 1407–09 (stating that the Affordable Care Act might ameliorate some, but not all, state funding problems with substance abuse treatment); *see also* Tessler et al., *supra* note 160, at 234.

¹⁸³ A NATIONAL CRISIS, *supra* note 179, at 1, 3; GLOVER ET AL., *supra* note 178.

¹⁸⁴ A NATIONAL CRISIS, *supra* note 179, at 1; GLOVER ET AL., *supra* note 178, at 2.

collaboration with and not subservient to law enforcement.¹⁸⁵ That Strategy specifically envisions collaboration between local governments and community-based organizations.¹⁸⁶ Although federal funding is anticipated under this Strategy, local governments and community-based organizations have pretty much come to understand that their needs rank pretty low on federal and state priorities in any particular budget cycle. However, pooling their requests and resources streamlines the funding requests and expands the horizons for new community-based funds.

This collaboration can take the form of a task force, a committee, a new bureau, a delegation to an existing office (like the township trustee), or a programmatic line item on the budget, but whatever its form, it needs to coordinate all the funds available under other, disparate line items. Nothing is more inefficient than the duplication of efforts, but nothing is more contentious than several budgets seeking to protect their turf. In order to focus requests particularly for funds available for veterans, members of the collaboration must include law enforcement, community-based mental health and substance abuse organizations, local veterans groups, and local school districts. The inclusion of law enforcement representatives should speak for itself. If this collaboration can keep veterans from being incarcerated or of treating them while incarcerated, then law enforcement has a financial stake in improving treatment of veterans' drug abuse problems.¹⁸⁷ Schools must be involved—not just because of the separate funding opportunities for prevention and treatment¹⁸⁸—because veterans' drug abuse problems often arise before entry into the military along with other adolescent predictors for mental health disorders and substance use, including pre-existing drug use.

Local veterans groups are also essential because they represent and serve the constituency at risk and because they often tend to be of the same political persuasion of those legislatures that are

¹⁸⁵ Stuart, *Sheriff*, *supra* note 14, at 341.

¹⁸⁶ *Id.*

¹⁸⁷ Christopher M. Weaver et al., *Prevalence and Nature of Criminal Offending in a National Sample of Veterans in VA Substance Use Treatment Prior to the Operation Enduring Freedom/Operation Iraqi Freedom Conflicts*, 10 PSYCH. SERVS. 54, 60, 63 (2012) (stating that the VA's treatment of veterans with substance abuse disorders "is emerging as a model health care system with regard to addressing justice system needs and complications of its patients").

¹⁸⁸ Stuart, *Sheriff*, *supra* note 14, at 365–66, 368–70.

disinclined to fund “soft” services for mental health and drug abuse treatment. If they can be persuaded to lobby for their constituents, they can be formidable advocates.¹⁸⁹ Persuading veterans’ organizations is also essential in speaking with a unified voice about the needs of veterans with drug abuse problems, especially as they relate to mental health issues. This may mean that these organizations put aside their own parochial interests that compete for attention dependent upon service era.¹⁹⁰ This may also mean overcoming, within each organization, a military culture that stigmatizes mental illness.¹⁹¹ “Approximately half of the service members who screened positive for mental disorders cited concerns about appearing weak, being treated differently by leadership, and losing the confidence of members of the unit as barriers to receiving behavioral health care.”¹⁹² Instead, veterans’ organizations can be crucial in outreach and education,¹⁹³ especially in distinguishing violence from mental illness.¹⁹⁴ Veterans’ organizations should be pro-active in getting the necessary mental health and drug abuse treatment for their constituencies.

Local governments also need to consider developing joint programs or regional collaborations or otherwise considering how to have a minimum of duplication for the maximum effect. Rural areas in particular need to buy in to the need for community-based treatments because those areas often have unique drug abuse problems and few treatment resources, both because of lack of funding and because of community dysfunction.¹⁹⁵ Combining resources that cross municipal, township, and county lines will

¹⁸⁹ See, e.g., BROCKTON D. HUNTER, ECHOES OF WAR: THE COMBAT VETERAN IN CRIMINAL COURT 19–20 (2009), http://dva.state.wi.us/WebForms/Data_Fact_sheets/EchoesOfWar012009.pdf; see also IRAQ & AFGHANISTAN VETERANS OF AMERICA, <http://iava.org> (last visited Mar. 24, 2013); *Veterans Treatment Court State Legislation*, JUSTICEFORVETS.ORG, <http://www.justiceforvets.org/state-legislation> (last visited Mar. 24, 2013).

¹⁹⁰ Burnam et al., *supra* note 168, at 268.

¹⁹¹ *Id.* at 275–82.

¹⁹² *Id.* at 277.

¹⁹³ *Id.* at 280. “There is some limited evidence that public-education campaigns can influence attitudes toward mental health conditions in nonmilitary populations.” *Id.*

¹⁹⁴ *Id.* at 276; see also Eric B. Elbogen et al., *Brief Report: Criminal Justice Involvement, Trauma, and Negative Affect in Iraq and Afghanistan War Era Veterans*, 80 J. CONSULTING & CLINICAL PSYCH. 1097, 1099 (2012) (stating that veterans suffering from PTSD are more prone to violence if they present with hyperarousal symptoms of irritability and anger).

¹⁹⁵ See, e.g., Stuart, *Sheriff*, *supra* note 14, at 376–77.

serve, ultimately, a greater number of veterans within easy travel distance but will also present fewer hands grasping for funds.

Regardless, the local government collaborative team needs to commit to a coordinated plan under which all engaged entities have their roles and understand where their resources are going. The agenda for local government collaborations for veterans' recovery from drug abuse and/or mental illness has one primary goal, filling the gap between local veterans and federal assistance through either the VA or the DoD. That gap is virtually unavoidable, given the limitations of funding for and access to VA and DoD services. So the first collaborative step is to coordinate with the VA to better determine what holes in services exist for veterans in the community. If the funding is available in accordance with the Caregivers and Veterans Omnibus Health Services Act and President Obama's recent Executive Order for contracting out for community-based services, the local government needs to know what services are needed, what services are already in place, and what needs to be replaced or added in order to work with the VA and VHA.

But it must also be understood that the gap in services arises as a funding vacuum created by the absence of the national will to fund these services in the first place. As a consequence, that gap is virgin territory for many local governments. There is virtually no literature that has assessed community-based interventions for veterans' drug abuse and mental health problems.¹⁹⁶ But given the paucity of funding for treatment throughout the War on Drugs, the absence of experience with community-based interventions shouldn't be surprising.

That leaves a lot to the imagination of the collaborative team to develop a coordinated approach to veterans' drug abuse problems. What is not left to the imagination of the collaborative team is that comorbid drug abuse and mental health disorders, particularly PTSD, must be treated together:

With an increasing recognition that it is often the PTSD symptoms driving the drinking or drug use, the trauma field in general has moved to an understanding that the experiences of the traumatic event must be addressed before expectations of decreases in substance use can realistically be expected. The good news is gradual dismantling of the "silos" of geographically and functionally distinct programs for substance abuse treatment, PTSD treatment, and smoking cessation and related health

¹⁹⁶ Burnam et al., *supra* note 168, at 303.

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problems. Concurrent integrated treatments have become the norm.¹⁹⁷

This integrated treatment necessarily includes both community and family involvement. Some of the current community-based initiatives to assist veterans tend to focus on pro bono mental health counseling, such as the Coming Home Project, Give an Hour, Operation Comfort, Returning Veterans Resources Project NW, the Soldiers Project, Strategic Outreach to Families of All Reservists, and Support Our Family in Arms.¹⁹⁸ These programs feature mental health counseling to returning veterans and their families both nationwide and in selected communities where mental health professionals donate their time and expertise. More community-oriented programs for veterans include ONE Freedom¹⁹⁹ and Swords to Plowshares.²⁰⁰ The latter was formed in 1974 to address the issues faced by Vietnam veterans with other than honorable discharges and provides mental health and drug abuse counseling as well as advocacy for government benefits.²⁰¹

A small handful of states has developed state-wide programs to address veterans' mental health challenges. Illinois' Veteran's Care has created an affordable, comprehensive health care program for veterans as well as a statewide program for PTSD and TBI treatment for National Guard service members.²⁰² Ohio's National Guard set up the OHIOcares network for mental health assistance while the Veterans Task Force of Rhode Island gathered the expertise of several interest groups, including local, state, and federal agencies, to address special needs of all veterans, such as addiction, public awareness, and community involvement.²⁰³ Vermont created the Vermont Military, Family

¹⁹⁷ Nancy C. Bernardy et al., *Co-occurring Posttraumatic Stress Disorder and Substance Use Disorder: Recommendations for Management and Implementation in the Department of Veterans Affairs*, 7 J. DUAL DIAGNOSIS 242, 254 (2011) (citations omitted).

¹⁹⁸ Burnam et al., *supra* note 168, at 398–401. The State of Washington has also created a statewide, free PTSD program of community-based services. *Id.* at 402.

¹⁹⁹ A Colorado-based nonprofit organization, ONE Freedom engages both civilian and military resources, including veterans' organizations, community leaders, and families. It limits its focus, however, to stress management. *Id.* at 399.

²⁰⁰ *Id.* at 401.

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Id.* at 401–402.

and Community Network to specifically create a web of community networks.²⁰⁴

One piece that is missing from these programs is drug abuse treatment for veterans, the absence of which may well render veterans' mental health treatment less than helpful. However, "[a]n emerging area is in the 'Community Reinforcement and Family Training (CRAFT)' model that teaches concerned significant others how to change their own behavior toward their loved ones in order to support improved substance abuse outcomes."²⁰⁵ CRAFT was developed to increase the likelihood that unmotivated drug abusers would seek treatment.²⁰⁶ CRAFT teaches "the concerned significant others (CSOs) of substance-abusing individuals to engage the treatment-refusing substance-abusing loved one . . . into treatment."²⁰⁷ This approach to addiction and substance abuse "rearrange[s] the person's life so that abstinence is more rewarding."²⁰⁸ It rearranges the client's "lifestyle and social environment," by focusing on his "own intrinsic reinforcers in the community."²⁰⁹ Similar programs are listed on the registry of evidence-based programs and practices maintained by the Substance Abuse and Mental Health Services Administration.²¹⁰

Once the strategic goals are outlined, the local government collaboration must seek out funding sources from the available federal grants or the appropriate state agencies for drug abuse treatment for veterans; if linked with mental health, so be it. The request for funds for local uses is likely familiar to many local governments to fund street repairs and add police officers. Now, they have the emotional appeal of assistance for veterans. Where funding for mental health and drug abuse might otherwise be

²⁰⁴ *Id.* at 402.

²⁰⁵ Bernardy et al., *supra* note 197, at 256 (citations omitted); see also Substance Abuse & Mental Health Servs. Admin., *Behavioral Health Issues Among Afghanistan and Iraq U.S. War Veterans*, 7 IN BRIEF 1, 6 (2012).

²⁰⁶ Robert J. Meyers et al., *Community Reinforcement and Family Training (CRAFT): Engaging Unmotivated Drug Users in Treatment*, 10 J. SUBSTANCE ABUSE 291, 294 (1998).

²⁰⁷ Jennifer K. Manuel et al., *Community Reinforcement and Family Training: A Pilot Comparison of Group and Self-Directed Delivery*, 43 J. SUBSTANCE ABUSE TREATMENT 129, 129–30 (2012).

²⁰⁸ William R. Miller et al., *The Community-Reinforcement Approach*, 23 ALCOHOL RES. & HEALTH 116, 116 (1999).

²⁰⁹ *Id.* at 120.

²¹⁰ SAMHSA's National Registry of Evidence-based Programs and Practices, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <http://www.nrepp.samhsa.gov/> (last visited Mar. 28, 2013).

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ignored, funding to help veterans has a particular appeal, especially in those statehouses that represent substantial populations of returning veterans from the National Guard and Reserves or that are home to a major military presence.²¹¹ Those veterans put a face to the problem that might otherwise be ignored and serve as a reminder that politics are local. Indeed, the local government collaboration might consider appointing a specific veterans' advocate to be ombudsman, expert, and lobbyist for these community-based programs. These advocates could be a particularly powerful voice in persuading legislators to give due attention to alternative uses of state funding for community purposes if drug sentencing costs for prisons and jails could be reduced by drug sentencing reforms.

Related to that and integral to the community-based approach will likely have to be cooperative engagement with the criminal justice system itself. Unless and until the community-based approach to drug abuse replaces the predominant strategy of the War on Drugs, veterans with drug abuse problems will continue to be arrested. Many states have specialized drug treatment and mental health treatment courts that offer specialized diversionary programs that send drug users to treatment as an alternative to incarceration.²¹² In line with that specialization, the Obama Administration's drug control budgets have included funding for veterans treatment courts.²¹³ Independently, some states have passed legislation for such treatment courts.²¹⁴ Other

²¹¹ See, e.g., Hoes, *supra* note 167, at 370 ("The State of Texas sets the bar high for the treatment of veterans.").

²¹² OFFICE OF NAT'L DRUG CONTROL POLICY, DRUG COURTS: A SMART APPROACH TO CRIMINAL JUSTICE (2011), http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/drug_courts_fact_sheet_5-31-11.pdf.

²¹³ *Id.*

²¹⁴ Legislation for veterans' treatment courts has passed in Colorado, Florida, Illinois, Maine, and Texas. *Veterans Treatment Court State Legislation*, *supra* note 189. Minnesota has a special provision for the psychological evaluation of veterans who are criminal defendants. HUNTER, *supra* note 189, at 4; see also Tiffany Cartwright, "To Care for Him Who Shall Have Borne the Battle": *The Recent Development of Veterans Treatment Courts in America*, 22 STAN. L. & POL'Y REV. 295, 305 (2011); Jillian M. Cavanaugh, *Helping Those Who Serve: Veterans Treatment Courts Foster Rehabilitation and Reduce Recidivism for Offending Combat Veterans*, 45 NEW ENG. L. REV. 463, 478–79 (2011); Michael Daly Hawkins, *Coming Home: Accommodating the Special Needs of Military Veterans to the Criminal Justice System*, 7 OHIO ST. J. CRIM. L. 563, 566–67 (2010); Michael E. McCarthy, *Diversionary Tactics: Alternative Procedures for the Prosecution of Military Veterans*, 50 DUQ. L. REV. 475, 479–80 (2012); Robert T. Russell, *Veterans Treatment Court: A Proactive Approach*, 35 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 357, 357, 372 (2009); Samantha Walls, *The Need for*

such courts have been formed without the benefit of legislation.²¹⁵ Their focus is similar to the more familiar drug court model,²¹⁶ but with a special population—veterans—that has federal treatment options not available to civilians.²¹⁷ In that regard, these courts tend to neglect the needs of veterans who have been other than honorably discharged,²¹⁸ making them less than a match for the veteran community as a whole. However, even in the absence of an official veterans treatment court, the community-based project should reach out to local bar associations and veterans advocacy groups to provide diversionary options for veterans who show up in court, not unlike the CASA and Guardian ad Litem programs that operate for children in court.

Perhaps the most important service that local governments and community-based programs can perform is community education. That educational outreach must not confine itself to merely passing along information. Instead, that educational outreach must assign collective responsibility to the community for care of its neighbors and for ownership of its own drug abuse problems.²¹⁹ That educational outreach must also enlist the experts to present the empirical evidence of the harms wreaked on fellow citizens by the myths arising from the War on Drugs and of the merits of a public health approach. Communities need to be weaned from the criminality associated with drug abuse, particularly as it happens in their backyards.

V. ONWARD, CHRISTIAN SOLDIERS²²⁰

Either by default or design, local governments are bearing the brunt of the expenses that have been incurred from the mess that is the War on Drugs, especially for the treatment of veterans who abuse drugs. The evidence of that War's spurious foundations were early detected, but ignored. Instead, the War on Drugs has been prosecuted like a crusade with religious overtones, science

Special Veteran Courts, 39 DENV. J. INT'L L. & POL'Y 695, 717 (2011).

²¹⁵ Cartwright, *supra* note 214, at 305 n.72.

²¹⁶ Hawkins, *supra* note 214, at 563.

²¹⁷ Cartwright, *supra* note 214, at 303–05.

²¹⁸ *Id.* at 305–06.

²¹⁹ Stuart, *Sheriff*, *supra* note 14, at 372, 374.

²²⁰ *Onward, Christian Soldiers*, SONGSANDHYMNS.ORG, <http://www.songsandhymns.org/hymns/detail/onward-christian-soldiers> (last visited Mar. 28, 2013) (Nineteenth century English hymn written by Sabine Baring-Gould and Arthur Sullivan).

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be damned. President Reagan invoked God,²²¹ and President George H.W. Bush invoked the image of moral and spiritual crusaders,²²² all as part and parcel of our Puritanical desire to control the lives of others.²²³ As a consequence, the federal government set the tone for the debate with draconian drug laws and penalties, which states were eager to follow with equally draconian drug laws and penalties.²²⁴

Veterans have been especially punished by these draconian measures. By relying on the increasing evidence that studies of veterans are now providing on how to prevent and treat drug abuse, local governments may be able to clean up this mess. Unfortunately, the magnitude of the drug problems presented by veterans of the current conflicts is going to be a huge test of the resolve and resources of local governments. But for the time being, no other governmental entities seem inclined to divert sufficient funds from law enforcement to commit to the public health problem that drug abuse actually is.

As proxies for our global conflicts, our veterans deserve as good as we can give; we have found out to our dismay what happened to the Vietnam veterans in the War on Drugs, with whom it all started. Perhaps it is time to listen to those experiences but perhaps it is also time stop blaming them for their drug use in-country, which started this conflagration. They were just serving their country, and this is how their government repaid them.

²²¹ Stuart, *Metaphor*, *supra* note 19, at 9.

²²² *Id.* at 10.

²²³ *Id.* at 6.

²²⁴ *See, e.g., id.* at 14.