Contents

ADVOCATING THERAPEUTIC JUSTICE FOR VETS WITH PTSD AND TBI IN THE COURTROOM

Introduction to PTSD:[1]

A. Layman's view of PTSD: Posttraumatic stress disorder, or PTSD, can occur after someone goes through, sees, or learns about a traumatic event like combat exposure, child sexual or physical abuse, terrorist attack, sexual/physical assault or a natural disaster. Most people have some stress-related reactions after a traumatic event. If the reactions do not go away over time and are disruptive, then it is likely to be PTSD. Generally, a PTSD assessment takes no more than two visits to a mental health provider. See Appendix One - Excerpt from DSM-V Manual on Post Traumatic Stress Disorder
B. Statistics: Many Americans have had a trauma. About 60% of men and 50% of women experience at least one traumatic event. Of those who do, about 8% of men and 20% of women will develop PTSD. For some events, like combat and sexual assault, more people develop PTSD. See Appendix 2 on Veteran Statistics relating to PTSD
C. PTSD can cause troubling changes in emotions and behavior:
    a. Fear or anxiety - In moments of danger, human instinct prepares the individual to fight the enemy, flee the situation, or freeze in the hope that the danger will move past. But those feelings of alertness may stay even after the danger has passed. These feelings include feeling tense or afraid, being agitated and jumpy or feeling on alert.
    b. Sadness after a trauma may come from a sense of loss of a loved one, of trust in the world, faith, or a previous way of life. Individuals may have crying spells, lose

[1] Extrapolated from U.S. Department of Veterans Affairs, National Center for PTSD. (August 2013). *Understanding PTSD.* Retrieved from http://www.ptsd.va.gov/public/PTSD-overview/basics/what-is-ptsd.asp on 5/10/15.

interest in things previously enjoyed, want to be alone all the time, feel tired, empty, and numb

c. Guilt and shame - feeling guilty for not having done more to prevent the trauma (feeling responsible) or feeling ashamed for the actions or the lack of actions taken during the trauma.
d. Anger and irritability - Anger may result from a feeling of being unfairly treated. Anger can lowers one's threshold such that he or she lashes out at partner or spouse, have less patience with children, or overreact to small misunderstandings (road rage).
e. Negative behavior changes may include excessive alcohol and drug usage, driving aggressively, neglecting one's health or avoiding certain people or situations

D. PTSD has four types of symptoms.
   a. Reliving the event (also called reexperiencing) Memories of the trauma can come back at any time. Feeling the same fear and horror, one did when the event took place such as having nightmares or flash backs. Sometimes there is a trigger—a sound or sight that causes one to relive the event.
   b. Avoiding situations that remind one of the events. Avoiding situations or people that trigger memories of the traumatic event. Avoiding talking or thinking about the event. For example, avoiding crowds, because they feel dangerous or avoid driving because the Vet's military convoy was bombed. Some persons may keep very busy or avoid seeking help for this keeps them from having to think or talk about the event.
   c. Negative changes in beliefs and feelings - the way one thinks about himself and others changes because of the trauma. This symptom has many aspects, including the following:
      i. Not having positive or loving feelings toward other people and may stay away from relationships.
      ii. Forget about parts of the traumatic event or not be able to talk about them.
      iii. One may think the world is completely dangerous, and no one can be trusted.
   d. Hyperarousal -Feeling keyed up, jittery, or always on the alert and on the lookout for danger. Suddenly becoming angry or irritable. Examples include a need to have one's back to a wall in a restaurant or waiting room, being easily startled by a loud noise or going into a rage upon being bumped into in a crowd.

E. Predicting the Likelihood of whether a Person is to develop PTSD after trauma
   a. Individual Factors
      i. Intensity and duration of the trauma
      ii. If the trauma involved the death of a close friend or family member
      iii. If the person was hurt
      iv. The proximity the person was to the event
      v. How strong the person's reaction was
      vi. How much the person felt in control of events
      vii. The amount of help and support that was given to the person after the event

b. Other Factors that increase the likelihood of PTSD
    i. Female or minority
    ii. Less Educated
    iii. Experienced an earlier life-threatening event or trauma
    iv. Experience other mental health problems
    v. Family history of mental health problems
    vi. Little to no family or community support
    vii. Experienced recent, stressful life changes

F. The two most common treatments are counseling and medication:
    a. Cognitive Behavioral Therapy (CBT) is the most effective treatment for PTSD. CBT usually involves meeting with your therapist once a week for 3-6 months. There are different types of CBT that are effective for PTSD.
        i. Cognitive Processing Therapy (CPT) is a CBT in which PTSD patients learn skills to better understand how a trauma changed their thoughts and feelings. It helps you identify trauma-related thoughts and change them so they are more accurate and less distressing.
        ii. Prolonged Exposure (PE) therapy is a CBT in which PTSD patients talk about their trauma repeatedly until the memories are no longer upsetting. They also go into situations that are safe but which they may have been avoiding because they are related to the trauma.
        iii. Eye Movement Desensitization and Reprocessing (EMDR) involves focusing on distractions like hand movements or sounds while PTSD patients talk about the traumatic events. Over time, it can help change how the patients react to memories of their trauma.
    b. Medication –
        i. Selective Serotonin Reuptake Inhibitors (SSRIs) can raise the level of serotonin in PTSD patient's brain, which can make him feel better. The two SSRIs that are currently approved by the FDA for the treatment of PTSD are sertraline (Zoloft) and paroxetine (Paxil).
        ii. Sometimes, doctors prescribe medicines called benzodiazepines for their patients with PTSD. These medicines are often given to people who have problems with anxiety. While they may be of some help at first, they do not treat the core PTSD symptoms. They may lead to addiction and are not recommended for long-term PTSD treatment.

Introduction to Traumatic Brain Injury (TBI)

A. Classifications - the DOD categorizes TBI cases as mild, moderate, severe, or penetrating.[2]

a. Mild TBI is characterized by a confused or disoriented state lasting less than 24 hours; loss of consciousness for up to 30 minutes; memory loss lasting less than 24 hours; and structural brain imaging that yields normal results.

b. Moderate TBI is characterized by a confused or disoriented state that lasts more than 24 hours; loss of consciousness for more than 30 minutes, but less than 24 hours; memory loss lasting greater than 24 hours but less than seven days; and structural brain imaging yielding normal or abnormal results.

c. Severe TBI is characterized by a confused or disoriented state that lasts more than 24 hours; loss of consciousness for more than 24 hours; memory loss for more than seven days; and structural brain imaging yielding normal or abnormal results.

d. A penetrating TBI, or open head injury, is a head injury in which the dura mater, the outer layer of the system of membranes that envelops the central nervous system, is penetrated. Penetrating injuries can be caused by high- velocity projectiles or objects of lower velocity, such as knives, or bone fragments from a skull fracture that are driven into the brain.

B. TBI Symptoms[3] - TBI can cause a number of difficulties for the person who is injured. This can include physical changes, changes in the person's behavior, or problems with their thinking skills. After an injury, a number of symptoms might be noted including headaches, dizziness/problems walking, fatigue, irritability, memory problems and problems paying attention. These changes are often related to how severe the brain injury was at the time of injury. (See Appendix 2 relating to prevalence of TBI and VETs)

C. Accessing treatment[4]

a. The Veterans Health Administration has a Polytrauma System of Care to treat and care for Veterans with TBI alone or in combination with other injuries and health conditions. Depending on their health care needs, Veterans with TBI can receive treatment at one of the specialized rehabilitation programs in the Polytrauma System of Care, or they can seek treatment through their local VA Medical Center or community healthcare providers.

b. Treatments for TBI focus on the symptoms that cause most problems in everyday life. These can include:

i. Medications

ii. Learning strategies to deal with health, cognitive, and behavioral problems;

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[2] Fisher, H. (2014, Nov.). *A Guide to U.S. Military Casualty Statistics: Operation Inherent Resolve, Operation New Dawn, Operation Iraqi Freedom, and Operation Enduring Freedom. CRS Report NO. RS-22452. Retrieved from Congressional Research Service website: https://www.fas.org/sgp/crs/natsec/RS22452.pdf*

[3] U.S. Department of Veterans Affairs. *Understanding Traumatic Brain Injury*. Retrieved on April 23, 2015.

[4] Id.

iii. Rehabilitation therapies (such as physical therapy, occupational therapy, speech-language therapy);
iv. Assistive devices and technologies.

Recent Trends with Vets with PTSD within the Judicial System:

A. U.S. Supreme Court brings Public Attention to Vets with PTSD in *Porter v. McCollum*[5]:
   a. Mr. Porter was convicted of capital murder by a Florida Court of killing his ex-girlfriend and her boyfriend. He filed a habeas corpus proceeding alleging ineffective assistance of counsel at sentencing based on counsel's failure to present mitigating evidence. The U.S. Supreme Court granted the Habeas Corpus and brought attention to Veterans with PTSD.
   b. The Supreme Court granted the Habeas in part for the defense counsel's failure to "humanize" his client. The Judge and Jury would have "heard about (1) Porter's heroic military service in two of the most critical--and horrific--battles of the Korean War, (2) his struggles to regain normality upon his return from war, (3) his childhood history of physical abuse, and (4) his brain abnormality, difficulty reading and writing, and limited schooling.[6]"
   c. "Our Nation has a long tradition of according leniency to veterans in recognition of their service, especially for those who fought on the front lines as Porter did.[7]"
   d. The Supreme Court noted that "PTSD is not uncommon among veterans returning from combat. See Hearing on Fiscal Year 2010 Budget for Veterans' Programs before the Senate Committee on Veterans' Affairs, 111th Cong., 1st Sess., 63 (2009) (uncorrected copy) (testimony of Eric K. Shinseki, Secretary of Veterans Affairs (VA), reporting that approximately 23 % of the Iraq and Afghanistan war veterans seeking treatment at a VA medical facility had been preliminarily diagnosed with PTSD).[8]"

B. Federal Sentencing Guidelines amended to provide an avenue of mitigation for Veterans under certain circumstance.
   a. Effective November 1, 2010, USSG §5H1.11, in relevant part, reads:
      > Military service may be relevant in determining whether a departure is warranted, if the military service, individually or in combination with other offender characteristics, is present to an unusual degree and distinguishes the case from the typical cases covered by the guidelines.
   b. "Two aspects of military service have been important in cases involving veteran defendants. First, courts have considered the type of service and whether it warrants consideration based on a traditional practice of recognizing military service to one's

[5] Porter v. McCollum, 558 U.S. 30 (2009)
[6] *Id.* at 41
[7] Id. at 43
[8] Id. at 36

country. Second, courts have considered whether the defendant suffers from a mental or emotional condition that is traceable to the defendant's military service and whether the condition contributed to commission of the offense.[9]"

C. Virginia's Current Approach:
   a. Statistics: According to U.S. Census Bureau data presented by the Joint Legislative Audit and Review Commission of Virginia, more than 143,000 active duty service members plus another 22,000 members of the National Guard and Reserve components were living in the Commonwealth. This is in addition to the roughly 820,000 veterans in the state. The majority of service members and veterans in Virginia are concentrated in six cities: Hampton, Virginia Beach, Norfolk, Newport News, Chesapeake, and Portsmouth.[10]
   b. Virginia - Va. Code Ann. § 2.2-2001.1 authorizes the Virginia Department of Veteran Affairs to work with localities to initiate Veteran's Treatment Courts/Dockets.
      i. Criteria: Veterans and active military service members who are in the criminal justice system for nonviolent offenses either misdemeanor or felony as set forth as defined in § 19.2-297.1.
      ii. Goal is to effectively treat, counsel, rehabilitate, and supervise these individuals who need access to proper treatment for mental illness including major depression, alcohol or drug abuse, post traumatic stress disorder, traumatic brain injury.
      iii. The policies, procedures, and treatment services shall be designed to provide:
         1. Coordination of treatment and counseling services available to the criminal justice system case processing;
         2. Enhanced public safety through offender supervision, counseling, and treatment;
         3. Prompt identification and placement of eligible participants;
         4. Access to a continuum of treatment, rehabilitation, and counseling services in collaboration with such care providers as are willing and able to provide the services needed;
         5. Where appropriate, verified participant abstinence through frequent alcohol and other drug testing;
         6. Prompt response to participants' noncompliance with program requirements;
         7. Ongoing monitoring and evaluation of program effectiveness and efficiency;

[9] Office of the General Counsel. (2012). *CASE ANNOTATIONS AND RESOURCES MILITARY SERVICE USSG §5H1.11 DEPARTURES AND BOOKER VARIANCES.* Retrieved from http://www.ussc.gov/sites/default/files/pdf/training/primers/2012_01_Military_Service_5H1-11_Departures_Booker_Variances.pdf on April 4, 2015.

[10] Tabatha Rentz, *VETERANS TREATMENT COURT: A HAND UP RATHER THAN LOCK UP*, University of Richmond Law Review, Vol. XVII:iii, page 701.

8. Ongoing education and training in support of program effectiveness and efficiency;
9. Ongoing collaboration among public agencies, community-based organizations and the U.S. Department of Veterans Affairs health care networks, the Veterans Benefits Administration, volunteer veteran mentors, and veterans and military family support organizations; and
10. The creation of a veterans and military service members' advisory council to provide input on the operations of such programs. The council shall include individuals responsible for the criminal justice procedures program along with veterans and, if available, active military service members.

Veterans with PTSD and their children:

1. Introduction: Research in Vietnam Veteran's families has revealed that children of Veterans with PTSD are at higher risk for behavioral, academic, and interpersonal problems. Their parents tend to view them as more depressed, anxious, aggressive, hyperactive, and delinquent compared to children of non-combat Vietnam era Veterans who do not have PTSD. In addition, the children are perceived as having difficulty establishing and maintaining friendships. Chaotic family experiences can make it difficult to establish positive attachments to parents, which can make it difficult for children to create healthy relationships outside the family.[11]
2. Impact on the children and their response:[12]

Vet's Symptoms	Impact on the child	Common Children's Responses
Re-experiencing of Traumatic event	The children observing their parent re-experiencing a traumatic event may become frightened. Children may become concerned about the parent's well-being as well as their own.	1. Children might feel and behave just like their parent as a way of trying to connect with the parent. Such children might show many of the same symptoms as the parent with PTSD. 2. The "rescuer" child takes on the adult role to fill in for the parent with PTSD. The child acts too grown-up for his or her age.
Avoidance/Numbing	Children may feel that their parent does not care about them when the reality is that the parent is avoiding places that are just too frightening. When a parent is struggling with experiencing positive emotions, his	

[11] U.S. Department of Veteran Affairs, National Center for PTSD. June 27, 2014. When a Child's Parent has PTSD. Retrieved from http://www.ptsd.va.gov/public/family/children-of-vets-adults-ptsd.asp on 5/10/15.

[12] *Id.*

	or her children may interpret this "cut off" as the parent not caring about them.	3. The "emotionally uninvolved" child gets little emotional help. This results in problems at school, depression, anxiety (worry, fear), and relationship problems later in life.
Hyperarousal	The children may perceive that their parent is overprotective. The children may be exposed to anger and domestic violence.	

3. Addressing the children's needs:[13]
    a. Parent's Response:
        i. Explain the reasons for the traumatized parent's difficulties, without burdening the child with graphic details. It is important to help children see that the symptoms are not related to them; children need to know they are not to blame. How much a parent says should be influenced by the child's age and maturity level.
    b. Treatment -Multiple treatment options available for affected families.
        i. Individual treatment for the Veteran, as symptom improvement for the person suffering from PTSD would also benefit the family.
        ii. Family therapy can support the parent who is struggling with symptoms and teach family members how to get their own needs met. Family therapy is typically more effective if the Veteran with PTSD has first received some type of trauma therapy so that he or she is better able to focus on helping the children during family sessions.
        iii. Individual therapy for the child based on the child's age (e.g., play therapy for younger children, talk therapy for older children and adolescents).

Ethical Issue:

What obligation does an attorney have to ensure that a client with PTSD fully considers available options and makes informed decisions, especially if that client is suffering from distorted thinking or other adverse effects of PTSD?

1. Rule 1.14 of the Code of Professional Responsibility mandates to the extent possible that the attorney maintains a normal client-lawyer relationship with his impaired client. When the attorney has a reasonable basis to believe his client's diminished capacity places him at risk of harm and prevents him from acting in his own best interest, the lawyer must take protective action including consulting with individuals who can take action to protect the client and even seek the appointment of guardian ad litem etc…[14] In

[13] *Id.*
[14] Va. Sup. Ct. R. pt. 6, sec. II, 1.14 (b)

seeking such protective action, the attorney is implicitly authorized to reveal information about his client that is reasonably necessary to protect his client's interest.[15]

2. Rule 1.2 of the Virginia Code of Professional Responsibility governs the scope of maintaining a normal client-lawyer relationship. In general this rule directs the lawyer to abide by his client's decisions concerning the objectives of representation within the bounds of law and the lawyer's professional responsibilities. In addition the rule directs that lawyer to consult with the client as to the means by which the objectives are to be pursued. The Rule's comments recognize that in many instances no line can be drawn between objectives and means and the attorney and client must act jointly. The lawyer assumes the responsibility of technical and legal issues but defers to the client as questions of expense and decisions that might adversely affect third persons.[16]
3. LE Op. 1816 provides guidance on how the attorney handles additional responsibilities imposed on him by representing a client who is suspected of having a diminished capacity to adequately consider decisions in connection with the representation. The hypothetical sets forth a fact pattern in which a suicidal defendant indicted with capital murder is directing his attorney to forego putting on a defense and any mitigating circumstances at trial. The attorney believes that his client is unable to make a rational stable decision because of his suicidal impulses. The committee notes that even though a forensic psychologist may have previously found that his client was competent to stand trial, the client still might be under impairment with regards to making decisions in the matter. The committee puts forth several actions that the attorney may take including having the client re-evaluated by a forensic psychologist, having a GAL appointed, or putting on the evidence despite his client's objection. The committee recommends that the action taken depends on attorney's determination of the degree of his client's diminished capacity.

Circumstances dictate whether communications between mental health providers and clients are privileged communications

1. In a civil context, the general rule is that communications between mental health professionals and their patients are privileged (Va. Code § 8.01-400.2). For the most part, the privilege has little to no application in the JD&R Court.
    a. Major Exceptions to the Doctor-Patient Privilege:
        i. Mental health professionals, doctors, etc… are legally mandated to report child abuse to the Department of Social Services (Va. Code § 63.2-1509 (A)(7))[17]
        ii. When the physical or mental condition of the client is at issue, the privilege does not exist.[18] Examples where mental conditions of parents are at issue

[15] Va. Sup. Ct. R. pt. 6, sec. II, 1.14 (c)
[16] Va. Sup. Ct. R. pt. 6, sec. II, 1.2 (notes)
[17] Va. Code § 8.01-400.2

include custody cases (see Va. Code Ann. § 20-124.3 (Best Interest Factors) and foster care/termination of parental right hearings.

iii. When a court, in the exercise of sound discretion, deems such disclosure necessary to the proper administration of justice, no fact communicated to, or otherwise learned by, such practitioner in connection with such counseling, treatment or advice shall be privileged, and disclosure may be required.[19]

iv. The privilege does not extend to testimony in matters relating to child abuse and neglect.[20]

b. Court's Authority over compelling a party to sign a release of information authorizing a GAL to review a party's mental health records:

i. No order shall be entered compelling a party to sign a release for medical records from a health care provider, including a clinical psychologist unless they are not located in the Commonwealth or are a federal facility. If an order is issued pursuant to this section, it shall be restricted to the medical records that relate to the physical or mental conditions at issue in the case.[21]

ii. Compare Va. Code Ann. § 8.01-399 pertaining to doctors and practitioners of the healing arts, including clinical psychologist as set forth in Chapter 29 of Title 54.1 of the Code of Virginia which contains the above provision to Va. Code Ann. § 8.01-400.2 which addresses the privilege for mental health professionals as defined in other chapters of Title 54.1 of the Code of Virginia but contains no express language about the court's authority or lack thereof over compelling signed releases.

iii. GAL's authority to obtain records pertaining to the child's treatment records is mandated by Va. Code Ann. § 16.1-266 (G) but does not provide express authority to obtain treatment records of parents etc… The issue arises whether the court can mandate a parent to sign a release authorizing GAL to obtain the parent's medical records.

> Any state or local agency, department, authority or institution and any school, hospital, physician or other health or mental health care provider shall permit a guardian ad litem or counsel for the child appointed pursuant to this section to inspect and copy, without the consent of the child or his parents, any records relating to the child whom the guardian or counsel represents upon presentation by him of a copy of the court order appointing him or a court order specifically allowing him such access. Upon request therefor by the guardian ad litem or counsel for the child made at least 72 hours in advance, a mental health care provider shall

[18] *Id.*
[19] *Id.*
[20] Id.
[21] Va. Code Ann. § 8.01-399

make himself available to conduct a review and interpretation of the child's treatment records which are specifically related to the investigation. Such a request may be made in lieu of or in addition to inspection and copying of the records.

c. For instructions on subpoenaing mental health records see Va. Code Ann. § 32.1-127.1:03

2. The privilege does not exist in the criminal setting, except to the extent provided in § 19.2-169.1 (D) or § 19.2-169.5 (E) Competency to Stand Trial or Preparing for Insanity Defense.
   a. Would the attorney's hiring of the mental health professional create a privileged communication for his client accused of a crime?
   b. Long Shot - see Via v. Commonwealth, 42 Va. App. 164, 188-189, 590 S.E.2d 583 (2004), where the court held the attorney client privilege/work product doctrine did not protect the communications of the mental health provider.
   c. The Via Court held that "The privilege attaches to communications of the client made to the attorney's agents . . . when such agent's services are indispensable to the attorney's effective representation of the client."(Cite omitted) "Nevertheless, the privilege is an exception to the general duty to disclose, is an obstacle to investigation of the truth, and should be strictly construed." (cite omitted). And "[t]he party seeking to assert the attorney-client privilege bears the burden of persuasion on the issue." (cite omitted).[22]
      i. Via Litmus Test
         1. Is the mental health provider an agent of the lawyer?
         2. Is the mental health provider's services "indispensable" to the attorney's effective representation of the client?
         3. Can the attorney meet the burden of persuasion when asserting this attorney client privilege?

[22] Via v. Commonwealth, 42 Va. App. 164, 188-189, 590 S.E.2d 583 (2004)