

SAFETY ON THE HOMEFRONT: ADEQUATELY ADDRESSING VIOLENCE IN FAMILIES IMPACTED BY MILITARY SERVICE

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The Scope of the Problem

More than 2 million servicemembers have deployed to Iraq or Afghanistan in the last decade. More than 1.2 million children have an active duty parent and almost three-quarters of a million have experienced at least one parental deployment since the onset of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Deployed servicemembers return to their children, spouses, families, and communities with visible and invisible injuries, such as combat-related post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). In addition, a small but growing number of returning servicemembers become involved with the criminal justice system for a range of crimes, including intimate partner violence (IPV) and child abuse. Communities nationwide are grappling with how to adequately serve this population of returning servicemembers and their families.

In its 2008 study, "Invisible Wounds of War," the RAND Corporation estimated that up to one third of servicemembers deployed to Iraq or Afghanistan were suffering from PTSD, TBI, or major depression (Tanielian, Jaycox, 2008). The Institute of Medicine also noted that one year after injury, psychosocial problems associated with TBI presented greater problems than the initially presenting issues of basic challenges of daily living (Institute of Medicine, 2008).

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In the decade since the current conflicts began, periodic reports about substance abuse, depression, IPV, suicide, homelessness, and other violent crime among traumatized veterans of Afghanistan and Iraq have captured headlines, while high unemployment compounds the problems faced by reintegrating veterans and their families (Carey, 2010).

Returning Servicemembers and the Justice System

The experience of America's World War II and Vietnam veterans demonstrates that war-related problems affect servicemembers long after they return from combat. Between 1946 and 1949, WWII combat veterans comprised 34% of new admissions to 11 U.S. prisons (Lunden, 1952). Many Vietnam veterans continue to file in and out of the U.S. criminal justice system and are considered high-risk for suicide, as are veterans of the current conflicts (Kaplan, Huguet, McFarland, & Newsom, 2007; Kang & Bullman, 2008).

A lack of longitudinal data contributes to difficulties in addressing the legacies of the ongoing conflicts in Iraq and Afghanistan. The last Department of Justice-Bureau of Justice Statistics "Veterans in Jail and Prison" included data up to 2004 and its next comparable national survey is not due until 2013. With a few localized exceptions, there is little reliable information on how many veterans returning from OIF, OEF, or Operation New Dawn (OND) are in jail, homeless, or attempting or succeeding at suicide (Carey, 2010). Local snapshots, however, are beginning to reveal what is transpiring in some communities, though more information is needed to generalize nationally. Among the local areas reporting data is Travis County, Texas (Austin). The "Veterans in Jail Report" corroborates anecdotal observations that IPV

and related offenses may constitute up to one quarter of all veteran offenders entering the justice system (Fairweather, Gambill, & Tinney, 2010).

The Intersection of Mental Wounds and Violent Behavior

Veterans with PTSD have consistently been found to have a higher incidence of IPV perpetration and also report significantly higher rates of generally violent behaviors and aggression than veterans without PTSD (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, Weiss, 1988; Taft, King, L.A., King, D.W., Leskin, & Riggs, 1999; Bryne & Riggs, 1996; Jordan, Marmar, Fairbank, Schlenger, Kulka, Hough, 1992; Freeman & Roca, 2001; Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997). With the current influx of servicemembers returning from deployment, family reintegration challenges are common. In a cohort of relatively healthy, recent military veterans referred for mental health evaluation, 75% reported family readjustment problems. Veterans also reported feelings of estrangement and insecurity upon returning to their own homes, feeling “like a guest in [their] own home”, “conflict about” household responsibilities, or “lack of warmth from child or child afraid” of their parent servicemember (Sayers, Farrow, Ross, & Oslin, 2009). Many of these veterans were also identified as having depression (72%) and PTSD (47%). Among those partnered or recently divorced, 60% reported mild to moderate IPV within the past 6 months. In contrast to research that links the hyperarousal symptoms of PTSD to IPV perpetration, neither depression nor PTSD were significantly related to IPV, but were significantly related to family reintegration problems (Taft, Vogt, Marshall, Panuzio, & Niles, 2007).

In one study, male OEF/OIF veterans with PTSD were approximately 1.9 to 3.1 times more likely than Vietnam veterans to perpetrate aggression toward their female partners. With this data in mind, partner aggression among recent veterans with PTSD may be an important treatment consideration and target for prevention (Teten, et al., 2010). In another study of OIF/OEF veterans presenting for care at a Veterans Affairs Deploy-

ment Health Clinic, over half (53%) acknowledged at least one act of physical aggression in the past 4 months (Jakupcak, Coneybeare, Phelps, Hunt, Holmes, Felker, Klevins, & McFall, 2007). Study authors noted the importance for practitioners to know how to screen for and respond to reports of hostility and aggression, although such awareness and skills are not yet in place in most community settings where many veterans seek care.

While violent family conflict is not present in most families impacted by military service, evidence points to an increase during both the deployment and reintegration periods for servicemembers (Karney, & Crown, 2007). Recognizing war-time deployments as especially stressful periods, and parental stress as a critical factor in child maltreatment, a 2007 study found that the rate of substantiated child maltreatment among married Army personnel was 42% greater during deployments compared to times when servicemembers were not deployed. Severity of maltreatment was also elevated – especially for neglect – whereas physical abuse was higher during periods when the servicemember was home (Gibbs, Martin, Kupper, & Johnson, 2007). Similar findings show an upward trend in child maltreatment in the Army between 1990 and 2004 (Rentz, Marshall, Loomis, Casteel, Martin, & Gibbs, 2007; McCarroll, Fan, Newby, & Ursano, 2008).

Recognizing the Gap in Support

Studies on the increase in violence in families impacted by military service have intensified military support for mental health services and resiliency training for servicemembers and their families. The civilian support community – including child protective services, domestic violence programs, mediators, and most family and dependency courts – is ill-prepared to adequately interface with the separate and complex military/veteran systems in which many of these families are embedded. Anecdotal evidence from civilian Dependency and Family Courts suggests that the courts’ inability to competently manage cases of families affected by military service can lead to deleterious effects on the children, including potentially unwarranted

out-of-home placements, jurisdictional problems, and delays in timely hearings and case resolution (West, K., 2011).

Veterans who perpetrate violence against family members or intimate partners are entering the criminal justice system every day. Veteran perpetrators are seen in all types of courts, including the 60-plus veterans treatment courts now operating. In the absence of longitudinal data about the recent OIF/OEF/OND cohort, policymakers, service providers, law enforcement officers, and judges face uncharted territory in how to work effectively and equitably with this population. Based on the assumption that many, if not most, justice-involved veterans' criminal behaviors are due to psychological trauma from combat exposure (an assumption that may or may not be correct), efforts to divert such individuals at the intersection of justice systems, and even at pre-booking, are occurring throughout the country (Center for Mental Health Services, National GAINS Center, August 2008).

It is clear that many veterans coming into contact with the criminal justice system have a number of unmet service needs (Mcguire, et. al. 2003; Saxon, et. al, 2001). The quandary faced today by our justice system – which is neither a service provider nor a research entity – is how to simultaneously implement justice, ensure the safety and rights of individual victims, and protect the public. A challenging question that is often left to the courts today is how to determine a causal relationship between combat deployment and the perpetration of intimate partner and/or family violence, as well as how to rule if such cases are identified.

Screening and Diversion Issues for Veterans

Because the stakes are so high, courts and allied agencies must have access to appropriate IPV screening and assessment tools to be effective in their rulings and case plans. Awareness of histories of violence or pre-deployment patterns of coercive control in intimate relationships is criti-

cal for determining whether a returning servicemember or veteran with an abusive history is appropriate for inclusion in a veterans' treatment court. Differentiation between cases with and without backgrounds of IPV/family violence may have significant implications for determining required services, as well as sentencing and safety plans. In the absence of standardized IPV/family violence protocols within the Veterans Administration, such assessments (if conducted at all) are usually obtained from community-based programs that work with IPV and child abuse and neglect. These entities, however, are generally unfamiliar with the unique issues facing veterans and families impacted by military service. As such, they frequently offer little guidance for management of servicemembers and veterans who commit IPV offenses and who also have combat-related co-occurring conditions.

A final consideration in these cases is the need for clarity with regard to judicial monitoring of behaviors and sanctions for any re-offense. Collaboration across military and civilian systems and among various courts involved in these cases is critical. IPV victims often continue to have contact with offenders, especially in cases involving child custody and visitation disputes or divorce proceedings, which can be dangerous. Regardless of the type of court, ongoing risk assessment and safety planning must be ensured for victims. Courts must therefore be aware of multiple civil actions that may occur concurrently, such as protection orders and support actions that impact the veteran, the victim, and the family.

Furthermore, although access to firearms is not unique to military and veterans, the issue of how to address firearm access in IPV cases may be challenging for both active duty and Guard or Reserve members. Especially for servicemembers diagnosed with depression, TBI, and/or PTSD, firearms access coupled with suicidal ideation or threats is a major risk factor for lethality (Campbell, et.al., 2003; Roehl, et al.,

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2005; Websdale, 2000). Although Veterans' Treatment Courts practice relapse prevention, there is often an expectation that substance abuse relapses are likely to occur. Because a "relapse" in IPV cases means that a victim has been re-victimized, IPV re-offenses should not be expected or tolerated and cannot be treated the same as relapses in substance abuse cases.

All stakeholders in a coordinated community response to IPV and family violence must also ensure mechanisms for obtaining victim input and ongoing safety monitoring rather than interacting solely with the offender. An example of best practice that could serve as a model for responding to IPV among families impacted by military service is the Praxis International "Saint Paul Blueprint for Safety" which describes an interagency response to domestic violence crimes (April 2010).

Recommendations

Addressing the challenges of IPV involving veterans, many of whom may have co-occurring combat-related conditions, is complex. In order to ensure safety for servicemembers, veterans, and their families—as well as to hold IPV offenders accountable—the following strategies are recommended:

1. Support technical assistance to communities in order to successfully implement strategies for coordination on cases involving servicemembers and veterans.
2. Develop formalized agreements among key stakeholders, such as the Department of Justice Office on Victims of Crime and the Office on Violence Against Women, and the Department of Health and Human Services, to coordinate military/civilian domestic violence collaborative efforts and grant programs that advance effective systems of care.
3. Provide outreach, comprehensive training, and support to victim advocates who serve military-related victims working in either military or civilian sector programs in order to help victim advocates 1) negotiate both military and civilian systems, 2) understand the special risk, danger, and safety implications of offender combat exposure, and 3)

learn how combat-related co-occurring conditions may intersect with IPV.

4. Establish new—or adapt existing—protocols and tools for military/veteran-involved IPV screening and assessment that take into account combat exposure, PTSD, TBI, depression, and substance abuse, as well as how these factors relate to safety, risk, and danger for the victim, perpetrator, and family members.
5. Ensure that the VA implements 1) routine computerized screening and assessment protocols for IPV victimization and perpetration, and 2) follow-up to provide appropriate interventions based on assessment findings.
6. Establish standards for IPV-offender intervention programs involving combat-related co-occurring conditions, such as PTSD and TBI, that incorporate comprehensive risk assessment to determine interventions based on the context of the violence.
7. Establish demonstration intervention program models that treat IPV perpetration as a discrete problem—not only as a symptom of a co-occurring problem or condition such as PTSD, TBI, or substance abuse—and use best practices that ensure victim safety and offender accountability.

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