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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

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**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**

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I. INTRODUCTION

Sergeant Christian E. Bueno-Galdos came to the United States with his family in 1992.¹ He was seven when he began life in the United States, but it was not until he joined the Army that he became a United States citizen.² Bueno-Galdos loved being in the army and re-signed to complete a second tour of duty after returning home from his first tour in Iraq.³ Though married, Bueno-Galdos also supported his parents with his military paycheck.⁴ Tragically, Sergeant Bueno-Galdos arrived home on a 747, dead at the age of twenty-five; his coffin was draped with an American flag.⁵ Four more soldiers died that same day on May 11, 2009.⁶

Also on that day, during Sergeant John M. Russell's third tour of duty, Sergeant Russell snapped.⁷ Walking into a stress clinic at Camp Liberty in Baghdad, Russell took the lives of five American soldiers, including that of Bueno-Galdos.⁸ One week prior to the tragic shooting, Russell had been referred to counseling and his weapon had been taken away.⁹ His actions are described as "the single deadliest episode of soldier-on-soldier violence among American forces since the United States-led invasion" began in 2003.¹⁰

Although the motive for Russell's attack remains unclear, the fact that he had been referred to counseling at the stress clinic suggests the attack was a result of a mental disorder.¹¹ Major General Daniel Bolgier told the media that mental health issues come with a "stigma" and "[n]ot all injuries are physical, and so you've got to have that door open for the guys . . . it's particularly challenging for a fellow like

¹ Tomas Gines, *Paterson Family Mourns Soldier Killed in Camp Liberty Shooting in Iraq*, THE STAR-LEDGER (May 13, 2009), available at http://www.nj.com/news/index.ssf/2009/05/paterson_family_mourns_soldier.html.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ Jomana Karadsheh, et al., *U.S. Soldier Charged with Murder in Iraq Shooting Death* (May 12, 2009), available at <http://www.cnn.com/2009/WORLD/meast/05/12/iraq.soldiers.killed/#cnnSTCText>.

⁸ *Id.*

⁹ *Id.* Russell wrestled the gun he used to kill his fellow soldiers away from another soldier and proceeded to steal a military vehicle to drive to the stress clinic. "Maj. Gen. Daniel Bolger, the commander of Multi-National Division-Baghdad, also spoke to reporters, telling them that a 'tragedy like this' points to the 'challenges' troops face." *Id.* These challenges are the inability to understand the traumatic events they experience at war. They are then unable to deal with them on their own and do not know how to get help because stigma keeps them from talking to family and peers about their symptoms. Mandatory screenings would help to eliminate some of the challenges.

¹⁰ Timothy Williams, *U.S. Soldier Kills 5 of His Comrades in Iraq*, N.Y. TIMES (May 12, 2009), available at <http://www.nytimes.com/2009/05/12/world/middleeast/12iraq.html>.

¹¹ Karadsheh et al., *supra* note 7. Shooting five soldiers was clearly a result of suffering from a mental disorder as a result of his military service.

Sgt. Russell.”¹² Large numbers of military personnel suffer from Post-Traumatic Stress Disorder (“PTSD”) which results in increased homicides and suicides committed by veterans.¹³ In 2005, Congress proposed the Veterans Mental Health Services Enhancement Act (“Service Enhancement Act”) to offer rigorous mental health treatment programs to veterans of both Operation Iraqi Freedom (“OIF”) and Operation Enduring Freedom (“OEF”).¹⁴ While the bill failed to pass Congress, the problem of mental health disorders for OIF and OEF veterans remains. To solve this problem, Congress should enact legislation, similar to the Service Enhancement Act and other proposed Acts, that have the following goals: 1) reduce stigma surrounding PTSD; 2) lower the rates of suicides and homicides committed by veterans; and 3) assist veterans in diagnosing and treating PTSD. This legislation should increase the number of health care professionals and the efficacy of care, improve nationwide outreach and education, and implement mandatory mental health screening requirements.

This Note argues that legislation requiring improved mental health treatment for veterans of OIF and OEF is necessary to protect American service members from the dangers of mental illness. In order to prevent crimes and suicides committed by veterans of OIF and OEF as a result of undiagnosed PTSD, the United States Congress should enact legislation imposing requirements on all branches of the military that: 1) mandates screening of all veterans at risk for PTSD upon their return from deployment; 2) ensures veterans are provided with adequate and timely mental healthcare; and 3) increases education and outreach regarding mental health disease as serious and legitimate battle wounds. Perhaps if Sgt. Russell had been subject to immediate screening upon returning from his first two tours of duty, instead of commencing counseling during his third tour, the lives of Sergeant Russell and the five men he killed would have been spared. Part II of this Note details the relationship between the military and PTSD. Part III describes efforts already made by Congress and the military in responding to the challenges presented by PTSD and veterans of OIF and OEF. In Part IV, this Note suggests policy solutions that will help to decrease the number of veterans who suffer from PTSD, and thus decrease the number of suicides and homicides committed by them. Part IV also addresses budget concerns for implementing such legislation, and offers statewide programs that will assist veterans in the alternative of the suggested legislation.

II. OVERVIEW OF PTSD AND THE UNITED STATES MILITARY

The United States military is fighting two wars halfway across the world. Many service members are serving multiple tours of duty with little time at home in between. Physical war wounds are obviously identifiable, but mental wounds are difficult to spot and need special attention. PTSD is a mental war wound that is affecting the military in large numbers.¹⁵ PTSD occurs after someone witnesses a

¹² *Id.*

¹³ HANNAH FISCHER, UNITED STATES MILITARY CASUALTY STATISTICS: OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM (2009), at 1-2, available at <http://www.fas.org/gsp/crs/natsec/RS22452.pdf>.

¹⁴ Veterans Mental Health Services Enhancement Act of 2005, H.R. 922, 109th Cong. 2005.

¹⁵ *Veterans for Common Sense v. Peake*, 563 F. Supp. 2d 1049, 1062-63. (N.D. Cal. 2008) (citing RAND study). In this action, a non-profit organization brought suit against the VA,

stressful event involving severe injury or death and “causes feelings of extreme fear, helplessness, or horror.”¹⁶ Symptoms of PTSD arise after the stressful event, and can include “trouble sleeping...nightmares or daytime memories of the event and feel[ing] emotionally numb and cut off from others.”¹⁷ From 2003 to 2009, the Military Health System recorded 39,365 cases of PTSD.¹⁸ Because veterans of OIF and OEF are serving multiple tours of duty, they suffer from PTSD in greater numbers than veterans of any other war.¹⁹

A. PTSD: Definition and Treatment

Early diagnosis is essential to a successful treatment program for military members suffering from PTSD. The United States Department of Veterans Affairs (“VA”) diagnoses PTSD using the American Psychiatric Association’s (“APA”) diagnostic criterion set forth in the fourth edition of its Diagnostic and Statistical Manual of Mental Disorders (“DSM-IV-TR”).²⁰ There are six criteria: 1) a stressor; 2) intrusive recollection; 3) avoidant/numbing; 4) hyper-arousal; 5) duration of the symptoms lasts more than one month; and 6) a functional significance, causing clinical disturbance or social, occupational or other impairment.²¹ To satisfy the stressor requirement, the person must have been exposed to a traumatic event that dealt with death or serious injury to oneself or another, and the person’s response must have “involved intense fear, helplessness, or horror.”²² The traumatic event

alleging it violated statutory and constitutional rights because of the way it provided health care and disability benefits. The court denied the plaintiffs’ claim for injunctive relief because it would entail an entire overhaul of the VA, which is outside the court’s powers. *Id.* at 1080.

¹⁶ Health Library, *Post-Traumatic Stress Disorder (PTSD)*, ADULT HEALTH ADVISOR, http://www.uofmmedicalcenter.org/healthlibrary/content/aha_ptsd_bha.htm (last visited Sept. 25, 2010).

¹⁷ *Id.*

¹⁸ The RAND study found that approximately 303,000 veterans of OIF and OEF were suffering from PTSD or depression as of April, 2008. Testimony, *Assessing Combat Exposure and Post-Traumatic Stress Disorder in Troops and Estimating the Costs to Society: Implications from the RAND Invisible Wounds Study*, RAND CORP. (Mar. 2009), available at http://www.rand.org/pubs/testimonies/2009/RAND_CT321.pdf.

¹⁹ HANNAH FISCHER, UNITED STATES MILITARY CASUALTY STATISTICS: OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM (Mar. 25, 2009), at 1-2, available at <http://www.fas.org/sgp/crs/natsec/RS22452.pdf>.

²⁰ United States Department of Veterans Affairs, National Center for PTSD, <http://www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp> (last visited Nov. 30, 2009) (citing American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, 4th ed., (2000) (hereinafter “DSM-IV-TR”).

²¹ *Id.* (citing DSM-IV-TR).

²² *Id.* (citing DSM-IV-TR). For there to be a stressor, the person must have suffered from a traumatic event where “[t]he person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.” *Id.*

must be re-experienced by either recurrent images or dreams.²³ These recurring images or dreams are marked by an intense psychological distress, generated by “cues” that resemble an aspect of the original event, or by physiological reaction to those same cues.²⁴ The third criterion is an avoidance of stimuli and numbing of responsiveness associated with the event.²⁵ Three of the following seven characteristics must be present to satisfy the avoidant/numbing criterion: 1) avoiding all “thoughts, feelings, and conversations associated with the trauma”; 2) avoiding all places, people, and activities that bring back recollections of the trauma; 3) an inability to remember “an important aspect of the trauma”; 4) a “diminished interest or participation in significant activities”; 5) experiencing feelings of “detachment or estrangement from others”; 6) “a restricted range of affects” such as being unable to have loving feelings; or 7) a lack of ability to sense any sort of future such as a career or family life.²⁶ Finally, to satisfy the requirement of hyper arousal, a person must experience at least two of the following: “1) difficulty falling or staying asleep; 2) irritability or outbursts of anger; 3) difficulty concentrating; 4) hyper-vigilance; or 5) an exaggerated startled response.”²⁷ Fulfilling the preceding requirements can be difficult for soldiers as they are often unable to produce proof of their injuries and symptoms when seeking treatment from the VA.²⁸

Once diagnosed, a variety of treatments are available for PTSD ranging from therapy to medication. Studies show that the most effective types of psychotherapy are cognitive behavioral treatments and Eye Movement Desensitization and Reprocessing (EMDR).²⁹ Cognitive behavioral therapy helps a patient understand the traumatic event they witnessed and the stress caused by it.³⁰ With this therapy, a therapist helps the patient to identify the stress in his or her life caused by the traumatic event and to replace it with less distressing thoughts.³¹ Patients learn to cope with the anger, fear, and guilt associated with a traumatic event, and most importantly for some soldiers, patients learn the stressful event was not their fault.³²

²³ *Id.* (citing DSM-IV-TR). The person must relive the traumatic event by “[r]ecurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.” *Id.* The traumatic event can also be relived through dreams, flashbacks, or illusions.

²⁴ *Id.* (citing DSM-IV-TR).

²⁵ *Id.* (citing DSM-IV-TR).

²⁶ *Id.* (citing DSM-IV-TR).

²⁷ *Id.* (citing DSM-IV-TR). Disturbances must last more than one month and cause clinical distress or social impairment. *Id.*

²⁸ *See infra* notes 74-79. Veterans have a difficult time proving their PTSD is a result of their military service. This fact must be proved to receive treatment through the VA.

²⁹ Paula P. Schnurr, Ph.D., *Treatments for PTSD: Understanding the Evidence, Psychotherapy*, PTSD RES. Q., (Summer 2008), at 2, available at <http://www.ptsd.va.gov/professional/newsletters/research-quarterly/V19N3.pdf>.

³⁰ Jessica Hamblen, *Treatment of PTSD*, NAT’L CTR. FOR PTSD, 1, http://www.ptsd.va.gov/public/pages/handouts-pdf/handout_TreatmentforPTSD.pdf (last updated June 15, 2010).

³¹ *Id.*

³² *Id.*

EMDR “is an integrative, comprehensive treatment approach that contains many elements of effective psychodynamic, cognitive-behavioral, experiential, interpersonal, and physiological therapies.”³³ This type of therapy is relatively new and is used to help a patient react differently to memories of the traumatic event they experienced.³⁴ Exposure therapy is also used to treat PTSD. The goal of exposure therapy “is to have less fear about your memories. It is based on the idea that people learn to fear thoughts, feelings, and situations that remind them of a past traumatic event.”³⁵ Exposure therapy requires patients to focus on their bad memories in order to alleviate future stress caused by them.³⁶

In addition to the preceding therapies, both group and family therapy can be used to treat PTSD.³⁷ Group therapy encourages those who suffer from PTSD to talk about the trauma they experienced with others who share similar experiences.³⁸ When like-experienced patients are together, a comfort zone is created that allows them to discuss the trauma they experienced as well as cope with their symptoms.³⁹ Family therapy enables family members to understand PTSD and cope with the symptoms one member exhibits, such as guilt or anger.⁴⁰ This therapy also improves the veteran’s family relationships—an important source of support for someone suffering from PTSD.⁴¹ Medications are also used to treat PTSD. Medication includes Selective Serotonin Reuptake Inhibitors (SSRIs), which are often used in conjunction with psychotherapy.⁴² SSRIs increase the level of serotonin in the brain in order to decrease depression.⁴³ These medications work as anti-depressants that help to lessen the symptoms of PTSD.⁴⁴ Regardless of the type of therapy used, treatment for PTSD lasts between three and six months. Where other mental health problems are present in addition to PTSD, treatment can last anywhere between one and two years.⁴⁵

³³ Sarah Schubert & Christopher W. Lee, *Adult PTSD and Its Treatment With EMDR: A Review of Controversies, Evidence, and Theoretical Knowledge*, 3 J. OF EMDR PRAC. & RES., 117, 120-21 (Nov. 3, 2009).

³⁴ Hamblen, *supra* note 30, at 2.

³⁵ *Id.* at 1.

³⁶ *Id.* at 1-2.

³⁷ *Id.* at 2-3.

³⁸ *Id.* at 2.

³⁹ *Id.*

⁴⁰ *Id.* at 3.

⁴¹ *Id.*

⁴² *Clinician’s Guide to Medication for PTSD*, NAT’L CTR. FOR PTSD, <http://www.ptsd.va.gov/professional/pages/clinicians-guide-to-medications-for-ptsd.asp> (last updated June 15, 2010).

⁴³ Hamblen, *supra* note 30, at 2.

⁴⁴ *Id.*

⁴⁵ *Id.* at 3.

B. Traumatic Brain Injury

While this Note focuses on the effects of PTSD and those veterans who suffer from it, a brief summary of Traumatic Brain Injury (TBI) will aid the reader in understanding the extent of mental conditions in veterans today by describing the other major mental condition veterans of OIF and OEF are suffering from. TBI is an injury suffered by troops that can have effects similar to PTSD. TBI is a “blow or jolt to the head that disrupts the functioning of the brain.”⁴⁶ It is more difficult to diagnose than PTSD, though it often shares the same symptoms such as headaches, disturbed sleep, depression, anxiety, personality changes, emotional outbursts, and verbal and physical aggression.⁴⁷ PTSD and TBI are the two most prevalent mental conditions combat veterans are likely to suffer upon returning from war and there has been an increase in the number of veterans who suffer from TBI as a result of serving in OIF and OEF.⁴⁸ “TBI has become a key issue in both the guilt and sentencing phases of murder trials involving combat veterans as defendants.”⁴⁹ Though TBI is as serious a threat to surviving veterans as PTSD, it is harder to diagnose. This Note focuses on PTSD because diagnosis and treatment are realistic goals.

C. Problems Resulting from Undiagnosed PTSD

Approximately 1.7 million troops have been deployed as a part of OIF and OEF since October, 2001.⁵⁰ An estimated 303,000 veterans of OIF and OEF were suffering from PTSD or major depression in April 2008.⁵¹ While 18.5% of veterans returning from Iraq and Afghanistan have PTSD, there are 300,000 soldiers currently deployed who suffer from PTSD or depression.⁵² PTSD and depression increase the

⁴⁶ Anthony Giardino, *Essay: Combat Veterans, Mental Health Issues, and the Death Penalty: Addressing the Impact of Post-Traumatic Stress Disorder and Traumatic Brain Injury*, 77 *FORDHAM L. REV.* 2955, 2977 (2009).

⁴⁷ *Id.* at 2977-78.

⁴⁸ *Id.* at 2975.

⁴⁹ *Id.* at 2975-76.

⁵⁰ *Assessing Combat Exposure and Post-Traumatic Stress Disorder in Troops and Estimating the Costs to Society Implications from the RAND Invisible Wounds of War Study: Hearing Before the Subcomm. on Disability Assistance and Mem'l Affairs of the H. Comm. On Veterans' Affairs*, 111th Cong. (2009) [hereinafter *Tanielian Testimony*] (statement of Terri Tanielian, Study Co-Director, Invisible Wounds of War Study Team, The RAND Corp.); see, e.g., Heathcote W. Wales, *Causation in Medicine and Law: The Plight of the Iraq Veterans*, 35 *NEW ENG. J. ON CRIM. & CIV. CONFINEMENT* 373, 373-74; see also RAND CTR. FOR MILITARY HEALTH POLICY RESEARCH, *INVISIBLE WOUNDS OF WAR: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY*, at iii, (Terri Tanielian & Lisa H. Jaycox eds., 2008) [hereinafter *RAND STUDY*], available at http://www.rand.org/pubs/monographs/2008/RAND_MG720.pdf.

⁵¹ *Tanielian Testimony*, *supra* note 50. Tanielian's testimony provided the findings from the RAND study of Invisible Wounds of War. The study assessed exposure to combat and its relationship to PTSD and depression among soldiers returning from OIF and OEF. The study focused on PTSD, traumatic brain injury, and depression.

⁵² *Veterans for Common Sense v. Peake*, 563 F. Supp. 2d 1049, 1062-63. (N.D. Cal. 2008) (citing RAND study).

risk of suicide when not properly treated, and are the two leading causes of suicide among veterans.⁵³ Suicide rates are the highest they have been in the Army in the last three decades,⁵⁴ and rates among veterans are “significantly higher than that of the general population.”⁵⁵

In addition to the increased suicide rates, the courts are seeing more cases where veterans are on trial for capital crimes.⁵⁶ The *New York Times* conducted a study to research the number of homicides committed in the United States by active duty personnel and new veterans.⁵⁷ This study showed an 89% increase in the number of homicides committed by active duty military personnel, three fourths of which were committed by veterans who served in Iraq and Afghanistan.⁵⁸ The study found 121 cases of veterans returning from Iraq or Afghanistan committed or charged with murder.⁵⁹ Of these 121 cases, only one was a woman and “the overwhelming majority of these young men, unlike most civilian homicide offenders, had no criminal history.”⁶⁰ A cursory mental health screening was given to these 121

⁵³ *Id.* at 1064.

⁵⁴ Erica Goode, *After Combat, Victims of an Inner War*, N.Y. TIMES, Aug. 2, 2009, at A1. From January to mid-July 2009, more American soldiers died as a result of suicide than in combat. *Id.*

⁵⁵ *Peake*, 563 F. Supp. 2d at 1063 (citing “Katz Suicide Study” from February 21, 2008, stating veteran suicide rates were 3.2 times greater than the general population).

⁵⁶ Giardino, *supra* note 46, at 2959 (citing; David Olinger, *Deadly Duty*, DENVER POST, Nov. 15, 2008, at 1A; Deborah Sontag & Lizette Alvarez, *Across America, Deadly Echoes of Foreign Battles*, N.Y. TIMES, Jan. 13, 2008, at A1; Deborah Sontag & Lizette Alvarez, *Combat Trauma Takes the Witness Stand*, N.Y. TIMES, Jan. 27, 2008, at A1; Deborah Sontag & Lizette Alvarez, *When Strains on Military Families Turn Deadly*, N.Y. TIMES, Feb. 15, 2008, at A1; Angela K. Brown, *Marine Charged in Ex-girlfriend's Death*, USA TODAY, Mar. 27, 2008, http://www.usatoday.com/news/nation/2008-03-27-1913814200_x.htm; Susan Davies, *Troop-Related Felonies Expected to Increase* (Feb. 5, 2009), <http://www.newsfirst5.com/news/troop-related-felonies-expected-to-increase/>.

⁵⁷ Deborah Sontag & Lizette Alvarez, *Across America, Deadly Echoes of Foreign Battles*, N.Y. TIMES, Jan. 13, 2008, §1, at 1.

⁵⁸ *Id.* The *New York Times* conducted this study by researching local newspapers and police, court, and military records. The years included in the study are the six years prior to and after the invasion of Afghanistan in 2001. *Id.*

⁵⁹ *Id.*

The Pentagon does not keep track of such killings, most of which are prosecuted not by the military justice system but by civilian courts in state after state. Neither does the Justice Department. To compile and analyze its list, The Times conducted a search of local news reports, examined police, court and military records and interviewed the defendants, their lawyers and families, the victims’ families and military and law enforcement officials. This reporting most likely uncovered only the minimum number of such cases, given that not all killings, especially in big cities and on military bases, are reported publicly or in detail. Also, it was often not possible to determine the deployment history of other service members arrested on homicide charges.

Id.

⁶⁰ *Id.*

veterans at the end of their tour, but very few were given follow-up treatment.⁶¹ Many also displayed symptoms of PTSD, but were neither evaluated nor diagnosed until they committed a homicide.⁶² In order to prevent veterans from committing suicides and homicides as a result of PTSD, immediate diagnosis is necessary. This requires mandatory mental health screenings at the end of each deployment.

D. Reasons PTSD is Frequently Undiagnosed

Suicide and homicide rates are rising because more veterans are suffering from mental illnesses, many of which go undiagnosed.⁶³ Because PTSD can go undiagnosed for many reasons, legislation must be enacted to ensure prompt diagnosis. First, PTSD can go undiagnosed because symptoms may not manifest themselves until many years after a person experiences a stressful event. Screening allows for earlier findings of PTSD symptoms. Second, because of the negative stigma surrounding mental disorders, many veterans are discouraged from seeking treatment for PTSD. Within the military, PTSD is often “equated with cowardice or lack of resilience or, even worse, with malingering to escape service or to receive unmerited compensation.”⁶⁴ When the branches of the military flaunt slogans such as “The Marines, The Few. The Proud”⁶⁵ and “There’s Strong, and then There’s Army Strong,”⁶⁶ it is unsurprising that a stigma of weakness might attach to an intangible mental wound. In addition to stigma, some veterans fear diagnosis will lead to their discharge.⁶⁷ During a press conference discussing PTSD, one soldier admitted that he was diagnosed with the disorder, and although he was offered an immediate discharge, taking it would have resulted in a loss of his VA benefits.⁶⁸ Further

⁶¹ *Id.*

⁶² *Id.* One such case involves Sergeant Strasburg, who was convicted of murder in 2006. He, like many others, had never been screened for PTSD. Strasburg said he filled out the Army’s questionnaire at the end of his tour of duty, and that no one took them seriously. The idea was to finish them and get home as soon as possible. *Id.*

⁶³ See generally Sontag & Alvarez, *supra* note 57.

⁶⁴ Letter to the Editor, *The Hearts and Minds of Soldiers*, N.Y. TIMES, Jan. 28, 2009, at A30.

⁶⁵ United States Marine Corps, <http://www.marines.mil/Pages/Default.aspx> (last visited Dec. 2, 2009).

⁶⁶ United States Army, <http://www.goarmy.com/strong/> (last visited Dec. 2, 2009).

⁶⁷ After crying on the rifle range during a shooting exercise, Marine Corps veteran Walter Smith was diagnosed with PTSD and medically discharged. Smith is a paradigm example of the need for mandatory PTSD screening. After he was discharged he tried to live a normal life, but in 2006, Smith drowned his girlfriend and mother of his twins in the bathtub. No one suspected he was responsible and Smith did not confess until one year later. Deborah Sontag, *An Iraq Veteran’s Descent; A Prosecutor’s Hard Choice*, N.Y. TIMES, Jan. 20, 2008, at A1. Walter Smith’s story shows that diagnosis is not enough on its own. Treatment for PTSD is just as important as being diagnosed.

⁶⁸ Kelly Kennedy, *Specialists, Patients Critical of PTSD Care*, MARINE CORPS TIMES (2009), http://www.marinecorpstimes.com/benefits/health/military_ptsd_070523w/. One of the reasons Joshua Omvig did not seek help for his symptoms was his fear that he would lose his job.

evidence that a stigma is attached to PTSD is the following language found on the VA's website under PTSD screening:

You may be wondering if you have symptoms of PTSD. To develop PTSD, a person must have gone through a trauma. Almost all people who go through trauma have some symptoms as a result. Yet most people do not get PTSD. A person who went through trauma can take a screen to see if he or she could have PTSD. A screen is a very short list of questions just to see if a person needs to be assessed further. A positive screen does not mean a person has PTSD. A positive screen means that this person should be assessed further by a mental health provider.⁶⁹

Though the website does go on to tell a reader how to obtain a screen, the language is discouraging. Stating that most people do not have PTSD and even a positive screen does not necessarily indicate PTSD, implies PTSD is not a serious illness. The VA's website should mention the importance of a screening by mental health professionals for those who believe they may have symptoms of a mental illness and the availability of 24-hour help.

A third reason why PTSD may go undiagnosed is because of inadequate healthcare for veterans. As of April 28, 2010, the VA projected there were 23,067,000 veterans, 3.1 million of whom receive disability compensation, including 386,600 for PTSD.⁷⁰ In contrast to these expansive numbers, there are only 153 VA hospitals and 788 VA community-based outpatient clinics in the United States.⁷¹ A

⁶⁹ Mental Health, *PTSD*, UNITED STATES DEP'T. OF VETERANS AFFAIRS, <http://www.mentalhealth.va.gov/ptsd.asp> (last updated Aug. 24, 2010). The online anonymous screen contains seventeen questions. Visitors are asked to rate the following questions, with answers range from not at all to extremely:

- 1) Repeated, disturbing memories, thoughts, or images of a stressful military experience?;
- 2) Repeated, disturbing dreams of a stressful military experience?;
- 3) Suddenly acting or feeling as if a stressful military experience were happening again (as if you were reliving it)?;
- 4) Feeling very upset when something reminded you of a stressful military experience?;
- 5) Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful military experience?;
- 6) Avoiding thinking about or talking about a stressful military experience or avoiding having feelings related to it?;
- 7) Avoiding activities or situations because they reminded you of a stressful military experience?;
- 8) Trouble remembering important parts of a stressful military experience?;
- 9) Loss of interest in activities that you used to enjoy?;
- 10) Feeling distant or cut off from other people?;
- 11) Feeling emotionally numb or being unable to have loving feelings for those close to you?;
- 12) Feeling as if your future somehow will be cut short?;
- 13) Trouble falling or staying asleep?;
- 14) Feeling irritable or having angry outbursts?;
- 15) Having difficulty concentrating?;
- 16) Being "superalert" or watchful or on guard?;
- 17) Feeling jumpy or easily startled?

Department of Veterans Affairs, *PTSD Screening*, available at https://www.myhealth.va.gov/mhv-portal-web/anonymous.portal?_nfpb=true&_pageLabel=mentalHealth&contentPage=mh_screening_tools/PTSD_SCREENING.HTML#noJavascript.

⁷⁰ NATIONAL CENTER FOR VETERANS ANALYSIS AND STATISTICS, VA BENEFITS & HEALTH CARE UTILIZATION (2009), http://www1.va.gov/VETDATA/pocket-card/4x6_spring10_sharepoint.pdf.

⁷¹ *Id.*

mere 114,685 health care professionals rotate through the VA.⁷² There are not enough professionals to properly serve the needs of veterans, whether it is for mental or physical illness. Because of the lack of professionals, veterans seeking help for PTSD have to wait up to eight weeks for an appointment.⁷³ When someone is suffering from PTSD or any other mental illness, care should be given upon request, especially if that person is experiencing suicidal or homicidal thoughts.

E. Stumbling Blocks for Receiving Treatment: Denial of Coverage and Inadequate Health Care Facilities

Receiving needed disability compensation from the VA is not always a simple task. In order for a veteran to receive disability compensation, he or she must show their disabilities are related to their military service.⁷⁴ Prior to July 13, 2010, a lesser burden of proof existed for those veterans who participated in combat with the enemy.⁷⁵ Participation in combat has a specific definition that often precludes veterans from proving they were involved in such combat in order to receive benefits.⁷⁶ VA regulations define engaging in combat as “personal participation in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality. It includes presence during such events either as a combatant or service member performing duty in support of combatants, such as providing medical care to the wounded.”⁷⁷ Many veterans cannot prove they were engaged in

⁷² *Id.*

⁷³ *Veterans for Common Sense v. Peake*, 563 F. Supp. 2d 1049, 1066 (N.D. Cal. 2008). “The wait times for PTSD referrals were longer [than referrals for depression], with only 33.6% reporting same-day evaluation, 26% reporting 2-4 weeks, and 5.5% 4-8 weeks. Nonetheless, the majority of veterans of Iraq and Afghanistan are being seen at clinics offering mental health service within 30 days.” *Id.* Eight weeks is too long of a wait for anyone, regardless of whether they are seeking physical or mental health care. Such a long wait can discourage veterans who initially sought help, but were not able to obtain it immediately. After two months pass, they may not be willing to undergo the screening as they had originally intended to do. Increasing health care professionals and facilities is necessary to make mental health care more available to veterans who seek help.

⁷⁴ CONG. BUDGET OFFICE, COST ESTIMATE FOR H.R. 5892: H.R. REP. NO. 110-5892 (2008), available at <http://www.cbo.gov/ftpdocs/96xx/doc9626/hr5892.pdf>. Generally, official records are necessary to prove that a disability is connected to military service. The process of obtaining official records can be lengthy and in the end, unproductive. Some veterans have to track down their old friends who they served with and ask them to testify to their combat experience. This can produce damaging results for the friend, who is now asked to stir up old traumatic memories. The official record requirement to prove combat experience is too strict for this reason.

⁷⁵ *Id.* Disabilities suffered by veterans who have participated in combat against an enemy “can be presumed to be service-connected if any type of evidence—verification from other members of the veteran’s unit, for example—is consistent with the circumstances of the veterans’ service.” *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.* This definition of combat has a detrimental effect on the ease with which a veteran can seek care for PTSD when they are unable to prove that they are combat veterans. Mandatory screenings would show signs of PTSD when a soldier returns home, making it easier to prove a connection between service and disability.

enemy combat, so they are unable to show that their disability to service-connected.⁷⁸ Due to this evidentiary stumbling block, fifty percent of PTSD claims were denied.⁷⁹ In 2010, the VA modified its requirements, lessening evidentiary burdens for veterans suffering from PTSD.⁸⁰

The new VA regulation, effective as of July 13, 2010, lessens the evidentiary burden on those veterans who are not categorized as combat veterans.⁸¹ Non-combat veterans were previously required to show extensive records proving a connection between the “stressor” that caused PTSD and military service.⁸² Under the new regulation, the process of receiving VA benefits for PTSD should prove easier:

[B]y eliminating this time-consuming requirement where the claimed stressor is related to ‘fear of hostile military or terrorist activity,’ is consistent with the places, types, and circumstances of their service, and a VA psychiatrist or psychologist, or contract psychiatrist or psychologist confirms that the claimed stressor is adequate to support a diagnosis of PTSD.⁸³

If the regulation is successfully carried out, it will increase the care given to veterans suffering from PTSD.

While the requirements for proving a PTSD stressor for the receipt of VA benefits are now less strict, the effectiveness of this change may not be seen for some time. Should the less rigorous requirement not prove efficient, there are other ways to aid a veteran who still finds proving mental illness to be difficult. One way to get past this evidentiary barrier is to mandate that each soldier returning from war be subject to a mental health screening. This immediate screening will serve as evidence that a soldier is suffering from PTSD that was caused by a service-connected stressor. Another way to allow for the acceptance of more claims is to expand the definition of “engaged in combat with the enemy.”⁸⁴ Outside of changes made within the VA, Congress is the only other solution.⁸⁵ Legislation was introduced in Congress that would “expand the presumption to all veterans who served in a combat area.”⁸⁶ Amending this definition to include all veterans who

⁷⁸ *Id.*

⁷⁹ *Id.* “VA reports 50 percent of disability claims for PTSD are approved and that the majority of denials are because of lack of evidence of service-connection.” *Id.*

⁸⁰ 38 C.F.R. § 3.304(f).

⁸¹ Questions & Answers, *New Regulation on PTSD Claims*, DEP’T. OF VETERANS AFFAIRS (July 12, 2010), available at http://www.va.gov/PTSD_QA.pdf.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ See generally Alison Atwater, *When is a Combat Veteran a Combat Veteran?: The Evidentiary Stumbling Block for Veterans Seeking PTSD Disability Benefits*, 41 ARIZ. ST. L.J. 243 (2009) (suggesting broadening the definition to make it easier for veterans to prove they were subject to a service connected stressor).

⁸⁵ *Id.* at 263.

⁸⁶ *Id.* Two items of pending legislation in 2008 would have changed the definition of “engaged in combat with the enemy.” The first would include service in a combat zone, and the second would include active duty in a theater of combat operations during war. *Id.*

served in a combat area is essential to leveling the playing field so that veterans who are subject to the same incidents in battle are eligible for the same benefits and are not burdened by a need to prove they participated in combat with an enemy.⁸⁷ Widening this definition would significantly reduce the number of PTSD claims that are denied by the VA.

In instances where claims are not denied and veterans are provided health care through the VA, they often face inadequate conditions and neglect at these healthcare facilities.⁸⁸ Some veterans, for example, are given torn hospital gowns to wear or broken wheelchairs.⁸⁹ Others are left immobile and unattended as there are not enough staff members to help care for each veteran during his or her daily routine.⁹⁰ Four hundred thousand benefit claims are backlogged and many of them are mental health related.⁹¹ The increase of mental health care needs from veterans of OIF and OEF contribute to the VA's burden.⁹² Veterans of OIF show higher levels of combat exposure resulting in higher rates of needed mental health services.⁹³

⁸⁷ *Id.* at 264. The author gives a hypothetical that emphasizes the need to eliminate a veterans search for documentary proof of combat:

Imagine two hypothetical veterans who both come under fire and witness death inside a combat zone. One veteran happens to be a member of an infantry unit that documents the firefight, and one is a truck driver on undocumented temporary duty with another unit. If each is later diagnosed with PTSD, and medical evidence links the diagnosis with the experience of coming under fire and witnessing death, then absent an evidentiary requirement the difference between these veterans is clear: There is no difference. Both experienced combat, both suffer debilitating effects. And yet, under the current system the first veteran will obtain benefits with little difficulty, while the second may spend years trying to prove his case or may never prove it at all.

Id. Based on this hypothetical, there is an obvious need to rework the system so that those who need help and deserve benefits are able to get both without having to prove their symptoms were a result of their military service.

⁸⁸ See Anne Hull & Dana Priest, *It Is Just Not Walter Reed*, WASH. POST (Mar. 5, 2007), available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/03/04/AR2007030401394.html>.

⁸⁹ *Id.*

⁹⁰ *Id.* Roberto Reyes Jr. suffered third degree burns when a nurse left him unattended in the shower. Because his war injuries left him immobile, he was unable to move himself out of the scalding water. Veterans should have more than adequate care on the home front.

⁹¹ *Id.* Many of these claims are a result of Vietnam veterans, who suffer from mental disorders. Cases of PTSD from that war are flooding the system.

⁹² 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 (2008). "56% of OIF veterans and other deployments referred to mental health care received a mental health evaluation either in the primary care or specialty mental health care setting. This is higher than what has been evidenced in civilian studies." *Id.* (citing Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 N. ENG. J. MED. 13, 1031 (2004)).

⁹³ *Id.* at 334. "[S]tatistics show increasing need by the VA to provide for veterans returning home and that the characteristics of the Iraq war will create unprecedented demands on the VA." *Id.* Soldiers are serving multiple tours of duty and seeing more combat than in other wars. This effect has led to an increase of mental health problems for veterans of OIF

Insufficient medical care is a significant problem that veterans face and is another reason why those who suffer from PTSD may be deterred from seeking professional help.

III. CONGRESSIONAL AND MILITARY SOLUTIONS

Both Congress and the military have taken steps to cure the growing problem of PTSD. In Congress, passing the Joshua Omvig Veterans Suicide Prevention Act proved that PTSD is a growing problem that must be addressed through legislation. Although other bills have failed, members of Congress have kept the needs of veterans in mind. Both the Veterans Mental Health Care Capacity Enhancement Act and the Veterans Mental Health Services Enhancement Act address the challenges faced by returning veterans. In addition to these efforts in Congress, the military has also implemented its own programs to combat PTSD by raising awareness through outreach and education.

A. *The Joshua Omvig Veterans Suicide Prevention Act*

One way in which Congress addressed the problem of PTSD was through the enactment of the Joshua Omvig Veterans Suicide Prevention Act. The Omvig Act, enacted in 2007,⁹⁴ advanced mental health programs for veterans.⁹⁵ The Act sets out six major components for dealing with PTSD: “(1) education for VA staff; (2) increased emphasis on mental health assessments for veterans; (3) designation of suicide prevention counselors; (4) research on veterans’ mental health issues; (5) provision of round-the-clock mental health care; and (6) outreach and education for veterans and their families.”⁹⁶ The version of the bill that originally passed in the House of Representatives mandated that all veterans seeking medical care from the VA participate in a mental health screening.⁹⁷ Veterans participating in the screening would then be tracked by the VA.⁹⁸ This provision was removed, and the current Act

and OEF compared to any other war. Additionally, where some wounds were fatal in wars past, they are not today because of the advances in medicine. This also increases the number of surviving veterans who return home with a mental illness.

⁹⁴ 38 U.S.C. §1720F (2007).

⁹⁵ See Brittany Cvetanovich & Larkin Reynolds, *Joshua Omvig Veterans Suicide Prevention Act of 2007*, 45 HARV. J. ON LEGIS. 619 (2008). The sixth version of this bill was finally enacted in 2007. Twenty-two year old Joshua Omvig died in December 2005 from a self-inflicted gunshot wound. Omvig returned from Iraq approximately one month prior to his death and confided in his family that he believed he was suffering from PTSD. Omvig’s refusal to seek help stemmed from a fear that professional counseling would damage his career. *Id.*

⁹⁶ *Id.* at 624. This Act was signed by the President of the United States on November 5, 2007. Library of Congress, *Bill Summary & Status 110th Congress (2007-2008) H.R. 327 Major Congressional Actions*, THOMAS, available at

<http://thomas.loc.gov/cgi-bin/bdquery/z?d110:HR00327:@@R> (last visited Oct. 2, 2010).

⁹⁷ Cvetanovich & Reynolds, *supra* note 91, at 625.

⁹⁸ *Id.* (citing the Joshua Omvig Veterans Suicide Prevention Act, H.R. 327, 110th Cong. §3(a)(1)(c)-(e) (2007) (as passed by the House, Mar. 21, 2007)).

only requires that medical staff offer the option of receiving a mental health assessment.⁹⁹

Removing the stigma from mental health conditions is one of the most important aspects of the Joshua Omvig Act. The Act directs the VA to create outreach and education programs to reduce the stigma associated with PTSD.¹⁰⁰ Outreach and education programs should be designed to “‘encourage veterans to seek treatment and assistance,’ help veterans develop coping skills, and help veterans’ families understand and identify signs of mental illness.”¹⁰¹ In addition to mandatory education and outreach programs, the Act allows the VA to create a peer counseling program so that veterans may help each other to assimilate back into civilian life and encourage the exchange of information that veterans may only feel comfortable sharing with a peer.¹⁰² The VA has a mental health website dedicated to information on how to deal with PTSD; however, because stigma still exists today, Congress should enact legislation with more outreach and education guidelines to further destigmatize PTSD.

Lacking specific measures to reduce stigma is not the only inefficiency of the Omvig Act. Because the Joshua Omvig Veterans Suicide Prevention Act only requires that patients be asked if they would like to be screened for PTSD, it is overly broad. By leaving PTSD screening up to the discretion of the patient, this legislation does not eliminate the stigma associated with mental disorders, nor does it solve any of the numerous problems that currently prevent veterans from seeking treatment. Moreover, the Act directs the VA to provide for the mental health of veterans, but only after they initially readjust to life back home.¹⁰³

B. Other Acts

Congress has continued to show a commitment to veterans’ mental health through various other bills that have been proposed in Congress since 2005,

⁹⁹ *Id.* Senator Coburn objected to the mandatory screening provision of the Omvig Act and a debate subsequently took place. *See generally*, Rep. Grace Napolitano & Rep. Tim Murphy, *Other 109th Congress Mental Health Legislation*, MENTAL HEALTH CAUCUS-LEGISLATION, <http://www.napolitano.house.gov/mhcaucus/legislation-other109th.html> (last visited Dec. 2, 2009); Patrick Yoest, *Bill to Strengthen VA Suicide Prevention Programs Passes Senate*, CQ TODAY (Oct. 1, 2007), http://coburn.senate.gov/public/index.cfm/new?ContentRecord_id=5caa20cc-802a-23ad-458f-8b1b2bd9cba7&ContentType_id=abb8889a-5962-4adb-abe8-617da340ab8e&Group+id=dbe8b19c-d328-4028-8a57-a55b13828cd5.

¹⁰⁰ *See* Cvetanovich & Reynolds, *supra* note 95.

¹⁰¹ *Id.* (citing Joshua Omvig Veterans Suicide Prevention Act, H.R. 327, 100th Cong. § 3(a)(1)(c)-(e) (2007) (as passed by House, Mar. 21, 2007)).

¹⁰² *Id.* at 626-27. Joshua Omvig’s father, Randall Omvig, testified in front of the Senate to promote peer counseling. He testified that his son was unable to communicate with his family and friends because much of what he did and saw in Iraq was confidential. Randall Omvig also testified that when Joshua returned from Iraq, he was unable to communicate with men from his unit, and that was detrimental to his mental health because they were the only people with whom Joshua could discuss his experiences. *Id.* at 627.

¹⁰³ *Id.* at 636. The Joshua Omvig Act’s methods of dealing with PTSD may be too late for some veterans. Waiting until a veteran has returned home and is having problems adjusting to life is detrimental to his or her mental health. Prevention must begin immediately after a deployment ends.

including the Veterans Mental Health Care Capacity Enhancement Act (“Capacity Enhancement Act”), the Veterans Mental Health Services Enhancement Act (“Services Enhancement Act”) and the Veterans Mental Health Screening and Assessment Act (“Screening Act”).¹⁰⁴ Although the first two bills were never enacted, they display the growing concern for the mental health of United States veterans exhibited by Congress.¹⁰⁵ The Screening Act was introduced to the United States House of Representatives on February 17, 2009.¹⁰⁶

Each bill has components that improve the likelihood that veterans suffering from PTSD will be diagnosed promptly and subsequently treated in an encouraging environment.¹⁰⁷ The Capacity Enhancement Act would have increased the number of health care professionals in VA hospitals and clinics.¹⁰⁸ The bill also encouraged health care professionals to conduct mental health consultations during primary care visits.¹⁰⁹ Had the Capacity Enhancement Act been enacted, it would have educated veterans about mental health issues because each visit would have had a mental

¹⁰⁴ The goal of the Veterans Mental Health Care Capacity Enhancement Act of 2005 was to improve mental health services at all VA facilities. *See* Veterans Mental Health Care Capacity Enhancement Act of 2005, S. 1177, 109th Cong. (2005). This bill would improve mental health services by “(1) establishing appropriate staff-patient ratio levels; (2) fostering collaborative environments for providers; and (3) encouraging clinicians to conduct mental health consultations during primary care visits.” S. 1177. The Veterans Mental Health Services Enhancement Act of 2005 would have made many advancements in improving the way veterans with PTSD are diagnosed and treated, in addition to creating outreach and education programs that reduce the stigma surrounding PTSD. *See* Veterans Mental Health Services Enhancement Act of 2005, H.R. 922, 109th Cong. 2005. The Veterans Mental Health Screening and Assessment Act directly addresses mandatory mental health screenings. Veterans Mental Health Screening and Assessment Act of 2009, H.R. 1308, 111th Cong. 2009.

¹⁰⁵ *See generally* Veterans Mental Health Care Capacity Enhancement Act, S. 1177, 109th Cong. (2005); Veterans Mental Health Services Enhancement Act of 2005, H.R. 922, 109th Cong. (2005); *see also* SIDATH PANANGALA, CONG. RESEARCH SERV., RL32961, VETERANS’ HEALTH CARE ISSUES IN THE 109TH CONGRESS 21-24 (2006).

¹⁰⁶ *See* Veterans Mental Health Screening and Assessment Act, H.R. 1308, 111th Cong. (2009). A summary of the Screening Act can be found at <http://www.govtrack.us/congress/bill.xpd?bill=h111-1308&tab=summary>.

¹⁰⁷ *See generally* Veterans Mental Health Care Capacity Enhancement Act, S. 1177, 109th Cong. (2005); Veterans Mental Health Services Enhancement Act of 2005, H.R. 922, 109th Cong. (2005); Veterans Mental Health Screening and Assessment Act, H.R. 1308, 111th Cong. (2009). The Capacity Enhancement Act, Service Enhancement Act, and the Screening Act all propose ways to increase the mental health services available to veterans. The Screening Act, specifically, allows for immediate diagnosis of PTSD. H.R. 1308, 111th Cong. (2009). Where a diagnosis has been made, treatment options should be readily available by making mental health services more accessible to veterans by increasing the number of mental health care professionals in VA outpatient clinics. H.R. 1308, 111th Cong. (2009).

¹⁰⁸ *See* S. 1177, 109th Cong. §3(a)(D)(i) (2005); Congressional Research Service, S. 1177 [109th] – Summary: Veterans Mental Health Care Capacity Enhancement Act of 2005, *available at* <http://www.govtrack.us/congress/bill.xpd?bill=s109-1177&tab=summary>.

¹⁰⁹ *See* Congressional Research Service, S. 1177 [109th] – Summary: Veterans Mental Health Care Capacity Enhancement Act of 2005, *available at* <http://www.govtrack.us/congress/bill.xpd?bill=s109-1177&tab=summary>.

health component.¹¹⁰ The stigma surrounding PTSD also would have been reduced by the introduction of mental health consultations, alerting veterans that mental illness is a legitimate and frequently occurring war wound.¹¹¹

Similarly, the Services Enhancement Act also would have increased awareness while simultaneously decreasing stigma.¹¹² The bill authorized the employment of additional mental health specialists, including psychiatrists who specialized in the diagnosis and treatment of PTSD.¹¹³ It also required the seamless transition of health care needs and coverage of veterans, who suffer from PTSD, from care under the Department of Defense to care by the VA.¹¹⁴

Not only is there a need to increase the number of medical professionals, prioritize the need for mental health improvements, and increase awareness, but there is also a need for mandatory screening. The Screening Act addresses the serious problem of suicides among veterans of OIF and OEF.¹¹⁵ Under the Act, the Secretary of Defense would be required to conduct “mandatory, face-to-face, and confidential mental health and traumatic brain injury screening conducted by a licensed medical professional, for each member of the Armed Forces, during the period beginning 90 days after the member completes a deployment in support of a contingency operation and ending 180 days after such date.”¹¹⁶ By requiring mandatory screenings, the Act proposes the identification of suicide risk factors through face-to-face interaction, which would increase accurate and honest assessments, rather than lying on a self-administered questionnaire.¹¹⁷ Most

¹¹⁰ See S. 1177, 109th Cong. §§ 3(a)(D), 5 (2005). Adding a mental health component to each visit would greatly increase the awareness needed to reduce stigma and help veterans understand that mental illness is more prevalent now among veterans than ever before.

¹¹¹ See *id.* Raising awareness about PTSD and TBI is the easiest way to reduce the stigma associated with mental health. Simply letting people know that mental health is a serious issue for returning veterans can have a stigma reducing effect. The more people talk about mental health, the more it will become a part of everyday life, and the stigma associated with it will begin to disappear.

¹¹² See Veterans Mental Health Services Enhancement Act of 2005, H.R. 922, 109th Cong. (2005), *see also* Panangala, *supra* note 101, at 21-24.

¹¹³ Congressional Research Service, H.R. 922 [109th] – Summary: Veterans Mental Health Services Enhancement Act of 2005, *available at* <http://www.govtrack.us/congress/bill.xpd?bill=h109-922&tab=summary>.

¹¹⁴ See *id.* In transitioning from health care services under the Department of Defense to that of the VA, veterans can get lost in the system. It is important to make sure there are procedural protocols to prohibit this from happening to any veteran.

¹¹⁵ Congressional Research Service, H.R. 1308 [109th] – Summary: Veterans Mental Health Screening and Assessment Act, *available at* <http://www.govtrack.us/congress/bill.xpd?bill=h111-1308&tab=summary>, *see generally* H.R. 1308, 111th Cong. (2009).

¹¹⁶ Congressional Research Service, H.R. 1308 [109th] – Summary: Veterans Mental Health Screening and Assessment Act, *available at* <http://www.govtrack.us/congress/bill.xpd?bill=h111-1308&tab=summary>, *see generally* H.R. 1308, 111th Cong. (2009). While the Screening Act mandates mental health screenings, a period of 90 to 180 days after deployment ends is lengthy and measures should be taken to lessen that time if the legislation is enacted.

¹¹⁷ Congressional Research Service, H.R. 1308 [109th] – Summary: Veterans Mental Health Screening and Assessment Act, *available at* <http://www.govtrack.us/congress/bill.xpd?bill=>

importantly, mandatory screening would not only decrease the stigma associated with mental illness, but also increase the awareness among health care professionals, veterans, and communities that mental illness is a serious and common issue for veterans.¹¹⁸

C. Individual Programs Implemented by the Department of Defense and Individual Branches of the Military

In addition to congressional efforts, the military has also begun to recognize that there is a problem with mental health issues and returning veterans. The Department of Defense (“DOD”) and the individual branches of the military have implemented programs to deal with PTSD and other mental health issues. On January 15, 2009, the DOD opened a 24-hour outreach center to help counsel those with questions about psychological health and traumatic brain injury.¹¹⁹ “The center can address everything from routine requests for information about psychological health and traumatic brain injury, to questions about symptoms a caller is having, to helping callers find appropriate health care resources.”¹²⁰

Further, the specific branches of the military are also addressing the problem at hand. The Army, in response to the Mental Health Advisory Team study, implemented its Real Warriors campaign. “The campaign seeks to remove the barriers that often prevent Soldiers from obtaining care or treatment for psychological health and traumatic brain injury the same way they would for a physical wound or illness.”¹²¹ The Naval Center for Combat and Operational Stress Control (NCCOSC) aims to “improve the psychological health of Navy and Marine Corps forces through training, education, care system improvement and facilitating research and information distribution. NCCOSC offers specialized knowledge and intervention on psychological resilience, PTSD and an interactive website housing a library of operational stress control content and best practices.”¹²² While the individual branches are beginning to focus on PTSD and providing mental health services to veterans, there is still a problem with diagnosis and stigma, which must be reduced by the enactment of legislation that requires mental health screening for all combat veterans at the end of each deployment.

h111-1308&tab=summary), *see generally* H.R. 1308, 111th Cong. (2009). The rate of suicide among veterans is so high that it should be a priority situation for Congress and the Military. The safety of our soldiers is extremely important while they are at war, and their safety upon returning home should be equally important.

¹¹⁸ *See* Panangala, *supra* note 101, at 21-24.

¹¹⁹ *Psychological Health, Traumatic Brain Injury Outreach Center Opens*, U.S. DEP’T OF DEF. (Jan. 15, 2009), <http://www.defenselink.mil/releases/release.aspx?releaseid=12443>.

¹²⁰ *Id.*

¹²¹ *The Real Warriors Campaign: Reaching out Makes a Real Difference*, U.S. ARMY (Sept. 09, 2009), <http://www.army.mil/standto/archive/2009/09/09/>.

¹²² *Wounded Warrior Resources*, NAVY MEDICINE (Dec. 02, 2009), <http://www.med.navy.mil/Pages/WoundedWarrior.aspx>.

IV. PROPOSED LEGISLATIVE SOLUTIONS, BUDGETARY CONCERNS, AND INTERMEDIARY STATE ACTION

Though Congress and the military are taking steps in the right direction to decrease suicides and homicides committed by veterans of OIF and OEF as a result of PTSD, stricter regulations must be implemented. Combining key elements of the Capacity Enhancement Act, the Services Enhancement Act, and the Screening Act would produce appropriate legislation to provide mandatory mental health screenings, increase the number of mental health care facilities, and professionals available to assist veterans, and provide additional outreach and education to destigmatize PTSD.

The goal of the Capacity Enhancement Act was to improve mental health services at all VA facilities.¹²³ Congressional findings showed that mental health services were inadequate at community-based outpatient clinics.¹²⁴ In response to these findings, the Capacity Enhancement Act would allow for more mental health professionals to be hired at outpatient clinics and encourage mental health consultations during primary care visits.¹²⁵

As with the goals of the Capacity Enhancement Act, the Services Enhancement Act was introduced to “improve treatment of post-traumatic stress disorder for veterans of service in Afghanistan and Iraq and the war on terrorism.”¹²⁶ Though this bill never made it out of committee in the U.S. House of Representatives, it offered the guidelines necessary for improving mental health services for veterans of OIF and OEF. The Services Enhancement Act aimed to increase the number of psychiatrists and mental health professionals working in VA medical centers and out-patient clinics; conduct a national outreach program for veterans who may be suffering from PTSD; review and improve the efficiency of mental health care of the Armed Forces; provide seamless transition from care under the DOD to care under the VA for those suffering from PTSD; and assess and improve the privacy safeguards for veterans with PTSD.¹²⁷

Finally, the Screening Act provides the most beneficial program for combat veterans—mandatory and confidential mental health screenings.¹²⁸ The goal of the Screening Act is to make mental health screenings mandatory at the end of each

¹²³ See Congressional Research Service, S. 1177 [109th] – Summary: Veterans Mental Health Care Capacity Enhancement Act of 2005, *available at* <http://www.govtrack.us/congress/bill.xpd?bill=s109-1177&tab=summary>).

¹²⁴ See Panangala, *supra* note 101, at 21-24.

¹²⁵ See generally S. 1177, 109th Cong. (2005).

¹²⁶ Veterans Mental Health Services Enhancement Act of 2005, H.R. 922, 109th Cong. (2005).

¹²⁷ See H.R. 922, 109th Cong. (2005); Congressional Research Service, H.R. 922 [109th] – Summary: Veterans Mental Health Services Enhancement Act of 2005, *available at* <http://www.govtrack.us/congress/bill.xpd?bill=h109-922&tab=summary>.

¹²⁸ Congressional Research Service, H.R. 1308 [109th] – Summary: Veterans Mental Health Screening and Assessment Act, *available at* <http://www.govtrack.us/congress/bill.xpd?bill=h111-1308&tab=summary>), *see generally* H.R. 1308, 111th Cong. (2009). Stigma needs to be eliminated in all communities, not just among veterans and their families. The greater the reach of awareness of the challenges veterans face, the more likely stigma will be eliminated.

deployment to reduce the rate of suicides committed by veterans.¹²⁹ Destigmatization of PTSD is an important goal of the Screening Act.¹³⁰ Congress should enact similar legislation incorporating the important components of each act, leading to an increased number of health care professionals available to treat veterans, a better level of care for all veterans, a national system of outreach and education, and a mandatory mental health screening. Through these provisions, the stigma associated with PTSD will be reduced and the rates of suicides and homicides committed by veterans will likely decrease.

A. Mandatory Mental Health Screening

Implementing mandatory PTSD screenings for all combat veterans of OIF and OEF upon returning home from each tour of duty is the most crucial change needed. In 2008, Adm. Michael Mullen, chairman of the Joint Chiefs of Staff, recognized that PTSD is a bigger problem than the country thinks it is and called for the mandatory screening of all combat veterans, regardless of rank.¹³¹ Mullen agreed that giving a mental health screening to everyone would help eliminate the stigma surrounding PTSD.¹³² When troops leave combat zones, they fill out surveys that are used to help determine whether they are suffering from any psychological issues; however, many do not take the surveys seriously and do not answer questions truthfully so they may avoid a PTSD diagnosis.¹³³ Troops are also examined by medical professionals at the end of each deployment, but only for physical injuries.¹³⁴ If mental health experts were on hand to examine veterans simultaneously, they would be able to identify signs of PTSD in a matter of minutes.¹³⁵ Mandatory, face-to-face, mental health screenings required by the

¹²⁹ See H.R. 1308, 111th Cong. (2009); Panangala, *supra* note 101, at 21-24.

¹³⁰ See Veterans Mental Health Screening and Assessment Act, H.R. 1308, 111th Cong. § 3(b) (2009).

¹³¹ See Tom Vanden Brook, *Joint Chiefs Head Wants PTSD Screenings*, USA TODAY, Oct. 13, 2008, at A11, available at http://www.usatoday.com/news/military/2008-10-12-ptsd_N.htm.

¹³² See *id.* USA Today quoted Mullen as saying “‘I’m at a point where I believe we have to give a (mental health) screening to everybody to help remove the stigma of raising your hand . . . Leaders must lead on this issue or it will affect us dramatically down the road.’” *Id.* Mullen’s belief in mandatory screening is precisely the change in thinking that ought to be adopted by Congress and the Military in order to help the growing number of veterans who suffer from PTSD. Mandatory, confidential, and anonymous screenings can be accomplished through the enactment of the Screening Act. See Veterans Mental Health Screening and Assessment Act, H.R. 1308, 111th Cong. § 3(a) (2009).

¹³³ See Vanden Brook, *supra* note 131, at A11. Troops are also inspected for physical wounds, but not by mental health experts. Vanden Brook, *supra* note 131, at A11. Troops know how to answer the questionnaires in a manner that avoids treatment. See Vanden Brook, *supra* note 131, at A11. The Screening Act would eliminate many of the false answers that troops give on these questionnaires because the Act requires face-to-face screening. See H.R. 1308, § 3(a).

¹³⁴ See Vanden Brook, *supra* note 131, at A11.

¹³⁵ See Vanden Brook, *supra* note 131, at A11.

Service Enhancement Act encourage veterans to be honest during their assessment.¹³⁶

Currently, under the Joshua Omvig Veterans Suicide Prevention Act, PTSD screening is only offered to veterans when they seek medical care.¹³⁷ These screening procedures do not reach enough veterans because the procedure involves a two-step process that the veteran must initiate.¹³⁸ First, the veteran must voluntarily seek some kind of medical care. A mental health examination is only offered to a veteran after he or she seeks medical attention.¹³⁹ The veteran must not only take the first step in seeking help, but also agree to a voluntary screening. However, there are many reasons why a veteran would not accept an invitation for a mental health screening. Some believe that PTSD is a weakness, and a “tough guy” image may keep him or her from being screened.¹⁴⁰ Similarly, some veterans may fear a PTSD diagnosis will interfere with their jobs and gaining or keeping security clearance.¹⁴¹

The controversy associated with mandatory mental health screening was well addressed by Senator Tom Coburn in his objections to the original version Joshua Omvig Veterans Suicide Prevention Act. Senator Coburn argued that mandating such screening could interfere with veterans procuring jobs in the future and constituted a waste of medical resources.¹⁴² Senator Coburn believed that the mandatory screening and tracking of veterans limited their opportunities in the future.¹⁴³ For example, Coburn claimed that screening would prohibit veterans from ever becoming police officers or pilots, as well as other professions.¹⁴⁴ However, the VA offers confidential and anonymous PTSD screenings.¹⁴⁵ Coburn also argued that a mandatory screening would be a waste of resources; for example, a WWII veteran seeking a simple strep test would have to submit to the required testing.¹⁴⁶ Coburn also found the repetitive testing to be an insult to veterans because mandatory

¹³⁶ Veterans Mental Health Screening and Assessment Act, H.R. 1308, 111th Cong. § 3(a), 3(b) (2009).

¹³⁷ See Cvetanovich & Reynolds, *supra* note 95, at 625.

¹³⁸ Cvetanovich & Reynolds, *supra* note 95, at 625.

¹³⁹ Cvetanovich & Reynolds, *supra* note 95, at 625.

¹⁴⁰ See Cvetanovich & Reynolds, *supra* note 95, at 634.

¹⁴¹ See Thom Shanker, *Combating the Stigma of Psychological Injuries*, N.Y. TIMES, Oct. 26, 2009, <http://atwar.blogs.nytimes.com> (Enter “Combating the Stigma” in “Search This Blog” engine; then follow the “Combating the Stigma of Psychological Injuries” hyperlink).

¹⁴² See 153 CONG. REC. S11092, 11094 (2007), available at http://coburn.senate.gov/public/index.cfm?FuseAction=LatestNews.FloorStatements&ContentRecord_id=3e45fb8a-802a-23ad-4768-249ccf8ef172&Issue_id=.

¹⁴³ See *id.*

¹⁴⁴ See *id.*

¹⁴⁵ States Department of Veterans Affairs, <http://www.mentalhealth.va.gov/ptsd.asp> (last visited Sept. 20, 2010). According to the VA’s website, “[m]y healthvet offers confidential, anonymous screen for PTSD. None of the results are stored or sent anywhere. You can choose to print a copy of the results for your own records or to give to your physician or a mental health professional.” *Id.*

¹⁴⁶ See 153 CONG. REC. S11092, 11094 (2007).

screening assumes service members are unable to do their jobs without “having some disruption in their capability to function in this society.”¹⁴⁷

Despite the problems identified with mandatory mental health screening, the benefits outweigh the harm. In order to prevent limiting job opportunities, screening results should be confidential.¹⁴⁸ While Senator Coburn saw mandatory screening as an insult to veterans, the greater insult is to assume that the theater of war leaves anyone unaffected. Perhaps even more insulting is the fact that some veterans are crying for help by committing murder and suicide, and society does nothing to prevent them.¹⁴⁹ Keeping screening records confidential is one way to prevent possible harm. Another safeguard against an abuse of mandatory screening is to prevent discharge from the military where a veteran is diagnosed with PTSD. Assuming one’s involvement in the military is the cause of such an illness, it is up to the military to support veterans until they are cured or choose to leave of their own volition.¹⁵⁰

B. Increase the Number of Health Care Facilities and Professionals

In addition to requiring mental health screenings, legislation ensuring that veterans receive adequate and timely healthcare would greatly benefit those suffering from PTSD. Veterans seeking medical attention from the VA can wait anywhere from one day to eight weeks for medical services.¹⁵¹ When a veteran decides to take the steps to seek mental health care, he or she should not have to wait weeks for help, as violent and suicidal tendencies require immediate attention. Had prompt attention been given to Sgt. Russell,¹⁵² Bueno-Galdos and his four fallen comrades would still be alive today. Early identification and treatment is a necessary component of addressing PTSD issues in order to prevent crimes and suicides among veterans, and long waiting periods for medical attention are inadequate.¹⁵³

Where inadequate health care is a major problem for veterans seeking physical and mental help, a legislative solution must involve hiring many more health care providers to work throughout the VA. All VA facilities must increase the number of

¹⁴⁷ *Id.*

¹⁴⁸ See Veterans Mental Health Screening and Assessment Act, H.R. 1308, 111th Cong. § 3(a) (2009).

¹⁴⁹ See generally Dinges, *supra* note 1; Huspeni, *supra* note 56; Olinger, *supra* note 56; Sontag & Alvarez, *Across America*, *supra* note 56; Sontag & Alvarez, *Combat Trauma*, *supra* note 56; Sontag & Alvarez, *When Strains*, *supra* note 56; Young, *supra* note 56; Brown, *supra* note 56; Davies, *supra* note 56.

¹⁵⁰ See Vanden Brook, *supra* note 131.

¹⁵¹ Veterans for Common Sense v. Peake, 563 F. Supp. 2d 1049, 1066 (C.D. Cal. 2008). “The wait times for PTSD referrals were longer [than referrals for depression], with only 33.6% reporting same-day evaluation, 26% reporting 2-4 weeks, and 5.5% 4-8 weeks. Nonetheless, the majority of veterans of Iraq and Afghanistan are being seen in clinics offering mental health service within 30 days.” *Id.* (citation omitted).

¹⁵² See generally Dinges, *supra* note 1. Sergeant Russell shot and killed Christian Buenos-Galdos in a stress clinic in Iraq. See *id.* He also killed four other soldiers. See *id.*

¹⁵³ See Peake, 563 F. Supp. 2d at 1064.

mental health professionals.¹⁵⁴ Long waitlists are clearly a result of the fact that the number of veterans seeking medical care greatly outnumbers the amount of health care professionals.¹⁵⁵ The efficacy of care can be improved where VA hospitals and VA outpatient clinics increase the number of health care professionals, and more specifically, mental health care professionals. Another solution to long waiting periods and inadequate care is to add to the number of existing VA hospitals. There are currently only 153 hospitals and 788 outpatient clinics,¹⁵⁶ and of those outpatient clinics, most lack the professionals needed for proper mental health care.¹⁵⁷

C. Reduce the Stigma Associated with PTSD through Outreach and Education

While inadequate health care is preventing some veterans from being treated for PTSD, even the most efficient system cannot assist those who do not seek help. The military is taking steps to overcome one of its greatest obstacles in the diagnosis and treatment of PTSD: identifying and breaking down the stigma associated with mental health wounds. “Concern about stigma is disproportionately greatest among those most in need of help from mental health services.”¹⁵⁸ In 2008, the results of two hundred military men and women surveyed showed that there is definitely still a stigma of shame associated with suffering from PTSD as a result of military service.¹⁵⁹ 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.¹⁶⁰ 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.¹⁶¹ The fact that most veterans in the survey were unable to speak to their family, friends, or peers about PTSD is a clear indication of the need to reduce the stigma associated with veterans and mental illness.

A nationwide program is needed to reduce stigma among veterans returning from OIF an OEF. The best way to reduce stigma is to “remove the institutional and

¹⁵⁴ Veterans Health Care, Capital Asset, and Business Improvement Act of 2003, Pub. L. No. 108-170, 117 Stat. 2042 (2003).

¹⁵⁵ See NATIONAL CENTER FOR VETERANS, *supra* note 70.

¹⁵⁶ See *supra* text accompanying note 71. The number of veterans who suffer from PTSD significantly outnumber the amount of VA medical centers and outpatient clinics that exist.

¹⁵⁷ Veterans Mental Health Care Capacity Enhancement Act of 2005, S.1177, 109th Cong. §2(1), §2(3) (2005).

¹⁵⁸ Milaninia, *supra* note 92, at 330.

¹⁵⁹ Kathleen Kingsbury, *Stigma Keeps Troops From PTSD Help*, TIME (May 1, 2008), <http://www.time.com/time/printout/0,8816,1736618,00.html> (two hundred military men and women were interviewed by the American Psychiatric Association, resulting in an April 2008 report).

¹⁶⁰ *Id.*

¹⁶¹ *Id.* “The APA’s findings echo previous studies on the mental health toll faced by the more than 1.6 million U.S. troops deployed to Iraq and Afghanistan. In a comprehensive survey released this month by the...Rand Corporation, researchers concluded that nearly 20% of returning military personnel from these two front . . . symptoms of post-traumatic stress disorder.” *Id.*

cultural barriers that discourage soldiers from seeking care.”¹⁶² Education and outreach are vital to spreading the message that the number of veterans suffering from PTSD has risen after OIF and OEF. Congress must enact legislation that would increase education and outreach programs defining mental health disease as serious and legitimate battle wounds. This will increase the probability that those who think they have a problem will seek help. Education and outreach are essential to eliminating stigma, and the implementation of a 24-hour hotline was an excellent start for the DOD.¹⁶³ However, more needs to be done. All military bases should initiate educational programs that help to inform soldiers and their families about the real risks of PTSD, and more importantly, how to spot the warning signs. Family support groups on military bases would encourage an open environment where those who are affected by PTSD, or their loved ones, can engage in an open forum addressing the issues involved.¹⁶⁴ The more people talk about PTSD, the more it will become a part of everyday life, and the stigma will reduce gradually.¹⁶⁵

In addition to outreach and education, stigma can be reduced by changing the models of health care delivery by increasing mental health care services in VA hospitals and outpatient clinics.¹⁶⁶ Offering confidential counseling at health service centers may also reduce stigma.¹⁶⁷ Most importantly, imposing a mandatory screening requirement will aid in outreach, education, and the reduction of stigma. One of the core principles of the original Joshua Omvig bill’s strategy “was to make mental health care routine so that VA medical staff could more easily identify struggling veterans who did not proactively seek mental health care.”¹⁶⁸ This strategy was incorporated in the mandatory screening process, which should not have been eliminated from the final bill.¹⁶⁹ It would have not only helped to identify issues plaguing struggling veterans, but also aided in reducing the stigma associated with mental health. By requiring a mental health screening, the military can send a message to veterans that mental health issues are so prevalent and intertwined with the theater of war that it is more likely than not that one’s mental health has been affected. Stigma is a major barrier that must be broken down through outreach and education in order to increase the awareness and acceptability of PTSD as a result of

¹⁶² *Id.* (quoting Terry Tanielian, one of the authors of the RAND study).

¹⁶³ *See Military Creates Mental Health Hotline*, MILITARY.COM (Jan. 30, 2007), <http://www.military.com/NewsContent/0,13319,123699,00.html>. *Service Member and Family Support Services*, DEPLOYMENT HEALTH CLINICAL CENTER (last visited Sept. 30, 2010), <http://www.pdhealth.mil/hss/smfss/asp> (encouraging family and friends, not just veterans, to call line created to support troops and provide anonymous screening services).

¹⁶⁴ *See Kingsbury*, *supra* note 159.

¹⁶⁵ *See id.*

¹⁶⁶ *See Milaninia*, *supra* note 92, at 330-31. The author states that “[r]educing the perception of stigma and the barriers to care among military personnel is a priority for research and a priority for the policymakers, clinicians, and leaders who are involved in providing care to those who have served in the armed forces.” *Id.* Until the stigma created by mental health disease is eliminated, adequate care will not reach those in need.

¹⁶⁷ *Milaninia*, *supra* note 92, at 330.

¹⁶⁸ *Cvetanovich & Reynolds*, *supra* note 95, at 632.

¹⁶⁹ *See Id.*

war. The recognition of PTSD as a real and legitimate battle wound “helps veterans, family members, doctors and therapists attend to the injury and its consequences.”¹⁷⁰

E. Budgetary Concerns

With suggested legislation comes the question of how all of the changes prescribed will be paid for.¹⁷¹ The Pentagon spent \$300 million to study the effects of PTSD and TBI on troops.¹⁷² This money was used to research ways to reduce stigma, bring mental health services to rural areas, and finding new medications for TBI.¹⁷³ Now that money has been spent on researching the issues and solutions,¹⁷⁴ it is time to implement additional mental health services, increase the number of mental health professionals, and begin the mandatory screening process. It is obvious that any solution will be costly. In 2009, President Obama proposed a 10% increase in the funding for the Department of Veterans Affairs to occur by 2010.¹⁷⁵ This additional money would be spent on mental health screenings for veterans in rural areas.¹⁷⁶ The 2010 Budget for the U.S. Department of Veterans Affairs (“VA”) is currently \$112.8 billion dollars, whereas it was only \$97.7 billion in 2009.¹⁷⁷ A twenty-five billion dollar spike in spending will occur over the next 5 years.¹⁷⁸ “The budget increases health care funding for veterans, enabling the VA to provide timely, high-quality care to 5.5 million veterans, develop Centers of Excellence, and enhance access to mental health and cognitive care.”¹⁷⁹ In addition to those

¹⁷⁰ Letter to the Editor, *supra* note 64, at A30.

¹⁷¹ Mental health treatment is not the only cost to be considered. There is also a cost to society. The RAND study evaluated these costs. When a veteran suffers from PTSD or any other mental wound as a result of his or her military experience, there can be many negative economic and societal effects. Mental health can impair future health, decrease work productivity and deteriorate familial and societal relationships. Some of the negative outcomes of these effects are suicide, crime, and homelessness. These problems can also wear on children and “extend the consequences of combat experiences across generations.” Tanielian, *supra* note 50, at 6.

¹⁷² Gregg Zoroya, *Pentagon Spends \$300M to Study Troops’ Stress, Trauma*, USA TODAY, Aug. 5, 2008, available at http://www.usatoday.com/news/health/2008-08-04-military-research_N.htm?loc=interstitialskip.

¹⁷³ *Id.*

¹⁷⁴ *Id.* In 2008, research money was given to fund 171 different projects, and the research is to be completed any where from 18 months to 5 years from that time.

¹⁷⁵ Traci Watson, Dan Vergano, Ken Dilanian, Chris Buckle, Thomas Frank, Alan Levin, Gregg Toppo, Matt Kelley and Mimi Hall, *Budget Expands Tax Cuts, Military Spending*, USA TODAY, Feb. 27, 2009 available at http://www.usatoday.com/news/washington/2009-02-26-budget-side_N.htm

¹⁷⁶ *Id.*

¹⁷⁷ Office of Mgmt. & Budget: U.S. Dep’t of Veterans Affairs, *President Budget Fact Sheet*, THE WHITE HOUSE (last visited Sept. 30, 2010), http://www.whitehouse.gov/omb/fy2010_department_veterans/.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* This funding will allow the VA to create additional care centers, though there is no indication they will specialize in mental health care.

enhancements, the budget “also restores health care eligibility for modest-income veterans, steps up investment in technology for the delivery of services and benefits to veterans, and provides improved benefits for veterans who are medically retired from active duty.”¹⁸⁰ The VA claims that the increased budget “enhances outreach and services related to mental health care and cognitive injuries with a focus on access for veterans in rural areas.”¹⁸¹ This will be achieved by increasing the number of clinics where veterans can access mental health screening and treatment, as well as educating families and veterans as to the availability of these resources.¹⁸²

Because early diagnosis and treatment of PTSD is integral to a full recovery, increased spending on mental health services for returning veterans will aid that recovery. These initiatives also aim to reduce the stigma associated with PTSD “by adding mental-health professionals to educate veterans and their families about their injuries and options.”¹⁸³ However, the reduction of stigma alone will not ensure that veterans who need mental help seek it on their own. Enacting a mandatory screening requirement is necessary to reduce the number of veterans who suffer from PTSD in America.

F. Proactive Solutions on the State Level

While a congressional solution to aid veterans who suffer from PTSD would be the most wide-reaching and effective, in the mean time, states can also do their part in taking care of veterans. Until appropriate legislation is enacted and implemented, states should use alternative solutions to help veterans who suffer from PTSD and TBI. One solution is the installment of a veterans treatment court.¹⁸⁴ This allows the criminal justice system to cater to the special needs of veterans. Another solution is to allow veterans who commit crimes as a result of PTSD or TBI to use the insanity defense to mitigate their sentences and encourage psychiatric treatment.¹⁸⁵

1. Veterans Treatment Courts

Veterans Treatment Courts are an alternative program that states can use to assist veterans in getting their lives on track. Although these courts are not the needed preventative measures in the proposed congressional solutions, they are proactive and allow some veterans who find themselves in the criminal justice system to steer

¹⁸⁰ *Id.* By 2013, healthcare should be available to an additional 500,000 veterans who are currently ineligible because their income disqualifies them. *Id.*

¹⁸¹ *Id.*

¹⁸² Office of Mgmt. & Budget: U.S. Dep’t of Veterans Affairs, *President Budget Fact Sheet*, THE WHITE HOUSE (last visited Sept. 30, 2010), http://www.whitehouse.gov/omb/fy2010_department_veterans/.

¹⁸³ Donna Miles, *VA Budget Adds Mental-Health Services for Returning Combat Vets*, AMERICAN FORCES PRESS SERVICE, Apr. 9, 2009, available at <http://www.defense.gov/news/newsarticle.aspx?id=53873>.

¹⁸⁴ See J. Russell, *infra* note 186. Veterans Treatment Courts are an alternative for veterans who have committed a crime as a result of mental illness.

¹⁸⁵ See *infra* note 204 & 205. In both Oregon and California, veterans’ sentences have successfully been mitigated with evidence of PTSD as a result of their military service. See *infra* note 204. The United States Supreme Court also required that evidence of PTSD must be used during the sentencing phase of trial. See *infra* note 205.

their way out. A Veterans Treatment Court is a specialized court that “allows for veterans to go through the treatment court process with people who are similarly situated and have common past experiences and needs.”¹⁸⁶ Because statistics show that many veterans suffer from both addiction and mental disorders upon returning from war, Veterans Treatment Courts are a mix of drug treatment courts and mental health treatment courts.¹⁸⁷ Eligible veterans who have committed non-violent crimes are diverted to a specialized Veterans Treatment Court docket.¹⁸⁸ Veterans referred to this docket have a substance dependency and mental illness. Their participation is voluntary.¹⁸⁹

The first Veterans Treatment Court was created in Buffalo, New York and held its first session in January 2008.¹⁹⁰ Buffalo’s Veterans Treatment Court is based on ten key components.¹⁹¹ Three of these components are critical to increasing the effectiveness of the program as well as decreasing the stigma associated with PTSD and substance abuse among veterans. If all states adopted programs that incorporated these three components, whether or not as part of a treatment court, there would be a greater understanding of the mental struggles that veterans face as well as the destigmatization of mental illness. First, the Veterans Treatment Court provides continued access to alcohol, drug and mental health treatment.¹⁹² This includes assigning a veteran peer mentor to each participant.¹⁹³ Peer mentoring interaction is crucial because “[a]ctive support from a veteran peer mentor throughout treatment increases the likelihood that a veteran will remain in treatment and improves the

¹⁸⁶ Judge Robert T. Russell, *Veterans Treatment Court: A Proactive Approach*, 35 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 357, 364 (2009).

¹⁸⁷ *Id.* In 2003, 56.6% of veterans used alcohol in the past month, whereas only 50.8% of comparable non-veterans had done the same. In addition, 13.2% of veterans had admitted to driving under the influence of alcohol or drugs. OFFICE OF APPLIED STUDIES AND MENTAL HEALTH SERVICES ADMIN., THE NATIONAL SURVEY ON DRUG USE AND HEALTH REPORT: ALCOHOL USE AND ALCOHOL-RELATED RISK BEHAVIORS AMONG VETERANS I (2005), available at <http://www.oas.samhsa.gov/2k5/vetsAlc/vetsAlc.htm>.

¹⁸⁸ J. Russell, *supra* note 186, at 367-68.

¹⁸⁹ J. Russell, *supra* note 186, at 367-68.

¹⁹⁰ J. Russell, *supra* note 186, at 364.

¹⁹¹ J. Russell, *supra* note 186, at 364-69. The ten key components of Buffalo’s Veterans Treatment Courts are: 1) integration of alcohol and drug treatment as well as mental health services with the justice system; 2) the use of a non-adversarial approach where counsel from both sides protect the participant’s due process rights as well as promoting public safety; 3) early identification of participants and prompt placement in the appropriate court; 4) providing alcohol, drug, and mental health treatment and rehabilitation services throughout the process; 5) frequent alcohol and drug testing to monitor abstinence; 6) using a strategy that rewards veterans cooperation and responds to noncompliance; 7) judicial interaction with each veteran throughout the entire process; 8) monitoring the program’s goals and effectiveness; 9) providing interdisciplinary education to Veterans Treatment Court staff; and 10) working with the VA and community-based organizations in order to receive local support and increase effectiveness. *Id.*

¹⁹² J. Russell, *supra* note 186, at 366.

¹⁹³ J. Russell, *supra* note 186, at 366.

chances for sobriety and law-abiding behavior in the future.”¹⁹⁴ As many veterans of OIF and OEF return home from tours of duty, they find the general population continues to carry on as if there is no war. Veteran mentors “act as a support for the veteran participant in a way that only other veterans can.”¹⁹⁵ The use of veteran mentors may also act to reduce the stigma associated with PTSD and other post-war problems as they become better known and accepted throughout the veteran and military community.

The second key component that will aid in the acceptance of PTSD as a legitimate war wound and the reduction of stigma is continuing interdisciplinary education. “Interdisciplinary education exposes criminal justice officials to veteran treatment issues, the Department of Veterans affairs...veteran volunteer mentors, and it exposes treatment staff to criminal justice issues.”¹⁹⁶ The Veterans Treatment Court relies on the community to help veterans reach their goals. The criminal justice system works with “the VA Health Care Network, the Veterans Benefits Administration, the Western New York Veterans Project, the Veterans Treatment Court team, volunteer veteran mentors, and a coalition of community health care providers.”¹⁹⁷ Working with these partners allows the veterans to receive treatment through the VA because of the availability of specialized care, resources and coverage.¹⁹⁸ Involving the VA in the treatment court process will also serve as a means of outreach to veterans who are suffering from a mental condition and do not feel they can seek help. It may help veterans to know that the court system recognizes mental illness and seeks to treat them instead of throwing them in jail.

Finally, the third key component of the Veterans Treatment Court that allows veterans to succeed is the early identification of participants.¹⁹⁹ A veteran who commits a crime that is already suffering from PTSD will be even less likely to seek treatment after an arrest for criminal behavior.²⁰⁰ It is important to recognize a participant promptly in order to encourage their voluntary participation in the treatment program. This will allow the veteran to recognize that there is something

¹⁹⁴ J. Russell, *supra* note 186, at 366.

¹⁹⁵ J. Russell, *supra* note 186, at 370.

¹⁹⁶ J. Russell, *supra* note 186, at 367.

¹⁹⁷ J. Russell, *supra* note 186, at 368-69. Working together with community partners can also help to reduce stigma. First, it can show veterans just how many people and organizations care about their success and well-being. Second, it increases awareness in the community as to the problems that veterans of OIF and OEF face upon returning home from war. Providing support for veterans is as much the obligations of the community as it is that of the military.

¹⁹⁸ J. Russell, *supra* note 186, at 369. When veterans in the treatment court receive services and treatment at the VA, there should an educational component involved in their receipt of services. The veterans going through the program should have a public face at the VA to show others who may be suffering from PTSD that there is a way to get treatment, hopefully before they commit a crime.

¹⁹⁹ J. Russell, *supra* note 186, at 365. “Early identification of veterans entering the criminal justice system is an integral part of the process of placement in the Veterans Treatment Court program. An arrest can be a traumatic event in a person’s life. It creates an immediate crisis and can compel recognition of inappropriate behavior into the open, making denial for the need for treatment difficult for the veteran.” J. Russell, *supra* note 186, at 365.

²⁰⁰ J. Russell, *supra* note 186, at 365-66.

beyond his control that needs rehabilitation. Early identification is also imperative for non-criminal veterans who suffer from PTSD. The need for mandatory screening is essential as veterans must be aware that they suffer from a mental illness that is treatable before they cause harm to themselves or others.

The Veterans Treatment Court program has many benefits that assist veterans in regaining their lives. It also has the potential to save the state millions of dollars in incarceration costs.²⁰¹ Long-term benefits of the Veterans Treatment Court may include lower crime rates and a healthier community.²⁰² Despite its benefits, the program is not a solution that will solve all of the problems that veterans with mental illness face. The program does not cater to veterans who have committed violent crimes.²⁰³ Most importantly, though the program is proactive, it is not preventative. While it may prevent veterans from being locked away for long periods or from becoming repeat offenders, the program does not prevent veterans from committing a crime in the first instance. Mandatory screenings would identify veterans suffering from PTSD immediately and prompt treatment would allow veterans to reintegrate into society without having committed a crime. As stated above, the state can save itself and the national government money by creating Veterans Treatment Courts. However, because the treatment court relies heavily on the VA for benefits, it may be in the VA's best interest to spend that money on a preventative cure to PTSD, not a post-crime cure.

2. PTSD, the Insanity Plea and the Death Penalty

States can implement an additional alternative, such as the Veterans Treatment Court, that mitigates the sentences of veterans with PTSD who have committed a crime. In cases where PTSD has gone undiagnosed and prevention is not an option, society must provide alternate care for veterans who suffer from PTSD or TBI. Ordinary courts should consider allowing veterans who suffer from PTSD and other combat related mental illness to use the insanity plea as a defense. Examples of this have occurred in California and Oregon.²⁰⁴ The Supreme Court of the United States

²⁰¹ J. Russell, *supra* note 186, at 371.

A study of New York drug courts concluded that by diverting 18,000 individuals to treatment court, the state saved approximately \$254 million in incarceration costs alone. Another study by the National Institute of Justice calculated that in Multnomah County, Oregon, an average of \$2,328.89 was saved, per person per year by utilizing the drug court model versus the traditional court model. This study also estimated that, if the cost to victims is accounted for, the figure rises to \$3,596.92 per individual."

Id. (citing National Drug Court Institute, Court Facts: Drug Court Benefits, http://www.ndci.org/courtfacts_benefits.html).

²⁰² J. Russell, *supra* note 186, at 371.

²⁰³ J. Russell, *supra* note 186, at 368. The typical offender that is diverted to the Buffalo Veterans Treatment Court committed a felony or misdemeanor, but not a violent crime.

²⁰⁴ See generally *PTSD Successfully Tied to the Insanity Defense, Today in the Military*, MILITARY.COM (Jan. 14, 2009), <http://www.military.com/news/article/ptsd-tied-to-ex-gis-insanity-defense.html> (concluding that Army Captain convicted of robbery and diagnosed with PTSD may use insanity defense);

has also made a ruling requiring evidence of PTSD be shown in a murder trial when it is a result of military service.²⁰⁵ These three instances show a need for deferential treatment of veterans in the court system as well as an increased recognition of the fact that PTSD is a serious problem for many veterans.

On January 14, 2009, former soldier Captain Binkley was tried in front of a California jury for robbing a pharmacy in 2006 and faced a minimum of 12 years imprisonment.²⁰⁶ Captain Binkley suffered from PTSD and was found not guilty by reason of insanity.²⁰⁷ Based on the jury's finding in the sanity phase of the trial, Binkley was not sentenced to serve prison time; instead, he was sentenced to treatment for PTSD in a state hospital.²⁰⁸ Similarly, in Oregon, twenty-seven year old veteran Jessie Bratcher was found not guilty of murder after using PTSD as an insanity defense.²⁰⁹ Bratcher was on trial for violently murdering a man by shooting him repeatedly in the back.²¹⁰ Instead of being sentenced to 25 years in prison for murder, he was found not guilty and placed under the supervision of the Oregon Psychiatric Security Review Board for life.²¹¹ Jessie's case "is at the leading edge of courts considering war experience as a mitigating factor."²¹² In both California and Oregon, the courts have allowed PTSD to be a mitigating factor in sentencing.²¹³ Through these decisions, courts have recognized that PTSD is a major problem. These veterans deserve special treatment because they suffer from PTSD as a result of their military service.

Julie Sullivan, *Iraq Veteran Sentenced to State Hospital in PTSD Murder Case*, THE OREGONIAN, (Dec. 7, 2009), available at http://www.oregonlive.com/news/index.ssf/2009/12/post_34.html (concluding that Iraqi veteran convicted of murder and diagnosed with PTSD may use insanity defense).

²⁰⁵ Porter v. McCollum, 130 S. Ct. 447 (2009) (requiring defense attorney to produce evidence of military related PTSD during the sentencing phase of trial); Adam Liptak, *Justices Say Capital Cases Must Weigh War Trauma*, N.Y. TIMES, Dec. 1, 2009, available at <http://www.nytimes.com/2009/12/01/us/01penalty.html>.

²⁰⁶ See PTSD Successfully Tied to the Insanity Defense, *supra* note 204.

²⁰⁷ See PTSD Successfully Tied to the Insanity Defense, *supra* note 204.

²⁰⁸ See PTSD Successfully Tied to the Insanity Defense, *supra* note 204.

²⁰⁹ Sullivan, *supra* note 204. The defense argued for a three-year sentence in "New Directions, a residential treatment center he likened to a medium-security prison on the grounds of the Los Angeles Veterans Affairs campus. More than 14,000 veterans have received care at New Directions, founded 17 years ago by a Vietnam veteran and convicted felon." Sullivan, *supra* note 204. The Prosecutor argued for the stricter sentence that was in fact imposed on Bratcher. Sullivan, *supra* note 204. The Prosecutor argued that Bratcher faked and exaggerated his PTSD symptoms. Sullivan, *supra* note 204.

²¹⁰ Sullivan, *supra* note 204. Bratcher's girlfriend told him that she was raped by the victim, and this information prompted Bratcher to buy a gun from the local hardware store. Sullivan, *supra* note 204. Then, Bratcher allegedly called the victim into his front yard and repeatedly shot him in the back and head. Sullivan, *supra* note 204.

²¹¹ Sullivan, *supra* note 204.

²¹² Sullivan, *supra* note 204.

²¹³ Sullivan, *supra* note 204.; Liptak, *supra* note 205.

In the case of *Porter v. McCollum*, the United States Supreme Court recently held that defense counsel must present mitigating evidence of defendant's mental health as a result of military service during the penalty phase of trial.²¹⁴ During sentencing, defendant Porter's attorney did not mention any evidence of his military service and mental health issues he suffered from it.²¹⁵ The Court held:

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. Moreover, the relevance of Porter's extensive combat experience is not only that he served honorably under extreme hardship and gruesome conditions, but also that the jury might find mitigating the intense stress and mental and emotional toll that combat took on Porter.²¹⁶

The emotional toll that war takes on veterans deserves leniency in the courts. Porter's case is an example of a man who committed murder as a result of suffering from PTSD.²¹⁷

While Veterans Treatment Courts and allowing evidence of PTSD to mitigate sentencing can keep veterans away from death row, they do not prevent all courts from sentencing veterans with PTSD to death.²¹⁸ Some suggest that the death penalty should not be a sentencing option for veterans who suffer from PTSD and other mental illnesses.²¹⁹ Currently, defendants suffering from PTSD are able to present mitigating evidence during the sentencing portion of their trial in order to avoid the death penalty.²²⁰ Because "the death penalty is truly only for the worst offenders, justice requires that combat veterans suffering at the time of their offenses, from service-related PTSD or Traumatic Brain injury not be executed or sentenced to death. This should be so because PTSD is a severe mental disorder."²²¹ For veterans who suffer from these mental illnesses, the death penalty should be taken off the table as a sentencing option because the presence of a mental illness reduces the veteran's personal culpability.²²² This is especially apparent when viewed in light of

²¹⁴ See *Porter v. McCollum*, 130 S. Ct. 447, 448-452 (2009). Defendant, a Korean War veteran, was convicted of murdering his ex-girlfriend and sentenced to death. During the sentencing hearing, his lawyer failed to present any evidence that showed the defendant had mental health problems. The decision shows ample evidence that Porter's mental health was negatively affected after serving in the Korean War.

²¹⁵ *Id.* at 448.

²¹⁶ *Id.* at 455.

²¹⁷ *Id.*

²¹⁸ *Id.* at 448. Porter was originally sentenced to death before he took his case to the United States Supreme Court.

²¹⁹ See generally Giardino, *supra* note 46.

²²⁰ *Id.* at 2957.

²²¹ *Id.* at 2959-60.

²²² *Id.* at 2961. The author argues that PTSD and TBI do not completely excuse a criminal's behavior but suggests that his capacity to understand his actions as a crime at the time were diminished by a mental disorder.

the fact that the military has trained these men and women to kill and, further, to desensitize the act.²²³

Where a veteran has committed a crime, and preventative measures are of no use, the use of evidence of PTSD to mitigate sentencing is imperative to keeping the defendant off death row.²²⁴ Critics will argue that murderers do not deserve special treatment, whether they have served in the military or not. However, where the military has trained someone to kill, and they now have a mental illness that was a result of military duty, society has an obligation to cater to veterans' special needs.

VI. CONCLUSION

The military's approach to veterans of OIF and OEF who suffer from PTSD is inadequate. Too many suicides and homicides are committed by veterans as a result of undiagnosed or untreated PTSD.²²⁵ In order to eliminate the problem, Congress must enact legislation that requires the military to provide mental health screening for every veteran, each time a veteran completes a tour of duty. Because of the stigma associated with PTSD, many veterans will not ask to be screened, making the current system inefficient.²²⁶ Because of this, education and outreach programs must be implemented to decrease the stigma associated with PTSD and to increase the

²²³ See *id.* at 2964-65.

The effect of modern military training is most apparent when a combat veteran suffering from service-related PTSD or TBI commits an act of violence. The act of violence may take place as a reflexive response to a set of stimuli, such as a "flashback" at the time of the killing, or as another similar violent reaction to an event due to the judgment-altering effects of PTSD or TBI. Because military personnel have been conditioned to kill, desensitized to the act of killing, and taught to deny to themselves that they have in fact killed, combat veterans who suffer from the judgment-altering effects of PTSD and TBI are less culpable than others suffering from the same mental illnesses. This is true because military training has impaired their ability to appreciate fully the wrongfulness of killing and, when they act violently in response to a set of stimuli, to conform their conduct to the requirements of the law.

Id.

²²⁴ See *supra* notes 204 and 205 and accompanying text.

²²⁵ See generally Tanielian Testimony, *supra* note 50. The costs of war are greater than physical health care of wounded veterans. Mental wounds have a price as well.

The costs of these invisible wounds go beyond the immediate costs of mental health treatment. Adverse consequences that may arise from post-deployment mental and cognitive impairments include suicide, reduced physical health, increased engagement in unhealthy behaviors, substance abuse, unemployment, poor performance while at work, homelessness, marital strain, domestic violence, and poor parent-child relationships. The costs stemming from these consequences are substantial and may include costs related to lost productivity, reduced quality of life, substance abuse treatment, and premature mortality.

Id. 5-6.

²²⁶ See Sontag & Alvarez, *supra* note 57; Cvetanovich & Reynolds, *supra* note 95. Stigma, job security, and availability of medical care are all reasons why veterans refrain from being screened for PTSD.

awareness that many veterans, as a result of their military experience, do suffer from some form of mental health problem. Further, none of these solutions will be possible unless the number of health care professionals in the VA hospitals and outpatient clinics increase to address the large amount of veterans in need of medical care.²²⁷ Without adequate medical facilities and professionals, mandatory screening will be a burden, and the appropriate level of efficient treatment that American veterans deserve will never be achieved. While there are legislative, budgetary, and implementation concerns, Congress has the ability to ensure that these initiatives are met through appropriate legislation.

Congress should begin by combining key elements of the Capacity Enhancement Act, the Services Enhancement Act, and the Screening Act. The most important element is mandating mental health screening. Without such a provision, the problems created by PTSD from military service will continue to plague veterans. Until Congress takes this necessary action, states can be proactive in recognizing PTSD in its veterans and providing them with alternative solutions such as treatment courts and mitigated sentences. For the sacrifices the troops make every day, we must ensure their mental health to enjoy the free society they defend.

²²⁷ See *supra* text accompanying note 92.