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LEAVE NO SOLDIER BEHIND: ENSURING ACCESS TO HEALTH CARE FOR PTSD-AFFLICTED VETERANS

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[T]he detrimental effects of combat are deep and enduring and follow a complex course, especially in combat stress reaction casualties. PTSD, being the only disorder that distinctly stems from exposure to an external traumatic event, often entails medicolegal and political implications for soldiers who are sent by their nations to war.[1]

I. Introduction

Roadside bombs, snipers, ambushes: these events permeated Sergeant (SGT) Smith's daily life during his twelve-month deployment to Iraq in support of Operation Iraqi Freedom (OIF).[2] He faced heavy

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[1] Zahava Solomon & Mario Mikulincer, *Trajectories of PTSD: A 20-Year Longitudinal Study*, 163 AM. J. PSYCHIATRY 659, 665 (2006).

[2] Matthew J. Friedman, *Posttraumatic Stress Disorder Among Military Returnees from Afghanistan and Iraq*, 163 AM. J. PSYCHIATRY 586 (2006). Dr. Friedman poses the typical scenario for today's Reservist Soldier, upon which this account is loosely based. Although the Soldier in the account is fictional, his experiences resemble those of many deployed Soldiers.

and extensive combat exposure on patrols and witnessed horrible scenes of carnage. Haunted by intrusive visions of the deaths of civilians and his fellow Soldiers, SGT Smith returned from Iraq tormented, changed, and unable to leave the combat zone behind. Today, his preoccupation with personal safety and constant anticipation of a hostile act prevent him from reintegrating into normal life. He vividly relives combat experiences in his nightmares, particularly those in which his fellow Soldiers were wounded, and alternately feels emotionally dead and overwhelmed by strong surges of emotions. Since his return, SGT Smith drinks heavily, experiences suicidal thoughts, misses formations, and engages in physical altercations with other Soldiers. SGT Smith, like so many other Soldiers returning from Iraq and Afghanistan, is suffering from Posttraumatic Stress Disorder (PTSD). He is now at risk of being administratively separated and losing his veterans' benefits.[3]

A discharge Under Other Than Honorable Conditions (OTH)[4] is extremely problematic for a Soldier afflicted with PTSD. Current

[3] A strong correlation exists between PTSD and substance abuse, mental health problems, and persistent misconduct. NAT'L CTR. FOR PTSD, U.S. DEP'T OF VETERANS AFF., IRAQ WAR CLINICIAN GUIDE 24 (2d ed. 2004), *available at* http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/nc_ manual_iwcguide.html [hereinafter OIF CLINICAL GUIDE]; Erin M. Gover, *Iraq as a Psychological Quagmire: The Implications of Using Post-Traumatic Stress Disorder as Defense for Iraq War Veterans*, 28 PACE L. REV. 561, 566–67 (2008). These behaviors and conditions usually conflict with the interests of the military. Increased rates of attrition from military service, particularly involuntary administrative separations, evidence this conflict between PTSD's symptoms and the interests of the military. Charles W. Hoge et al., *Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan*, 295 J. AM. MED. ASS'N 1023, 1025, 1029 (2006). Attrition is defined as leaving military service for any reason. *Id.* at 1030. Among the 220,620 OIF veterans screened, 82.7% remained in military service during the twelve months following the deployment. *Id.* Of the remaining 17.3% that left military service within twelve months after deployment, approximately one-fourth of the Soldiers reported a positive response for a mental health issue on the Post-Deployment Health Assessment (PDHA). *Id.* Of the Soldiers returning from OIF or Operation Enduring Freedom (OEF) in Afghanistan, some 300,000 Soldiers expect to be discharged from the military even though they may be afflicted with PTSD. Gover, *supra*, at 561. These numbers continue to rise. Matthew J. Friedman, *Acknowledging the Psychiatric Cost of War*, 351 NEW ENG. J. MED. 75 (2004).

[4] Administrative separations comprise a portion of these discharges and consist of voluntary separations, generally initiated by the requesting Soldier, and involuntary separations, which are initiated by the Soldier's command. U.S. DEP'T OF ARMY, REG. 635-200, ACTIVE DUTY ENLISTED SEPARATIONS para. 3-7 (6 June 2005) [hereinafter AR 635-200]. Administrative separations are one of a commander's tools for involuntarily separating Soldiers in order to maintain the readiness and discipline of a unit. The underlying policy of administrative separations is to ensure the readiness and competency

legislation bars Soldiers who are administratively separated with an OTH discharge for "willful and persistent" misconduct from receiving Veterans' Affairs (VA) compensation; in some instances, these Soldiers are also barred from health care benefits.[5] In 1977, Congress passed Public Law 95-126,[6] which permitted some—but not all—who were discharged with an OTH for misconduct to receive health care benefits if the VA determined that the Soldier did not otherwise meet one of the statutory bars set forth in 38 U.S.C. § 5303(a).[7] Consequently, even Soldiers with service-connected disabilities[8] incurred in combat

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of the force. *Id.* para. 1-1. Since maintenance of high standards of conduct, discipline, and performance promote this policy, commanders retain great discretion of the administrative separation process, to include the determination of which individuals should be separated, the basis for separation, and the characterization of the discharge. *Id.* Although AR 635-200 provides factors for consideration when deciding between retention and separation, commanders are not required to justify their decision beyond the procedural requirements of the regulation. *Id.* para. 1-15. Since a commander may view a PTSD-afflicted Soldier's behavior as a detriment to the unit, a Soldier manifesting symptoms of PTSD is at risk of being involuntarily separated on several primary bases: substance abuse, personality disorders, and misconduct. Hoge et al., *supra* note 3, at 1030. These separations may be characterized as OTH conditions, particularly separations for misconduct, without regard to the underlying anxiety disorder. AR 635-200, *supra*, para. 1-15. An OTH discharge is the most adverse characterization of an administrative separation and is normally issued for misconduct "that constitutes a significant departure from the conduct expected of soldiers in the Army," such as acts involving use of force or violence to cause serious injury and deliberate acts or omissions "that seriously endanger the health and safety of other persons." *Id.* para. 3-7.

[5] 38 U.S.C. § 5303(a) (2006); 38 C.F.R. § 3.12(d) (2010). Soldiers who receive an OTH discharge for willful and persistent misconduct are barred from receiving compensation under 38 C.F.R. § 3.12(d), but may retain eligibility for health care unless they are subject to the statutory bars set forth in 38 U.S.C. § 5303(a).

[6] Pub. L. No. 95-126, 91 Stat. 1106 (1977) (codified as amended at 38 U.S.C. § 5303). Congress passed Public Law 95-126 to deny eligibility of veterans' benefits to "certain persons who would otherwise become so entitled solely by virtue of the administrative upgrading under temporarily revised standards of other than honorable discharges from service during Vietnam . . . ." *Id.*

[7] 38 U.S.C. § 5303(a); 38 C.F.R. § 3.12(d). The statutory bars consist of discharge or dismissal due to being a conscientious objector who refuses to wear a uniform, perform military duties, or obey lawful orders; receiving a sentence at a general court-martial; resigning as an officer for the good of the service; deserting; being discharged for alienage; and absenting one's self without leave (AWOL). U.S. DEP'T OF VETERANS AFF., M21-1MR ADJUDICATION PROCEDURES, at 1-B-7 (Mar. 7, 2006), *available at* http://www.warms.vba.va.gov/M21_1MR.html [hereinafter M21-1MR PROCEDURES].

[8] *See* U.S. Dep't of Veterans Affairs, Pub. & Intergovernmental Affairs, Federal Benefits for Veterans, Dependents, and Survivors, *available at* http://www1.va.gov/opa/Is1/2.asp (last visited Aug. 5, 2009). Disabilities incurred or aggravated during active service are usually considered service-connected. *Id.* The type and degree of disability are main factors in determining the amount of disability compensation a veteran will receive for service-connected disabilities. *Id.*

operations, such as PTSD, were ineligible for VA treatment if they met one of these statutory bars. The determination that the Soldier was "insane" at the time of the underlying offense is a limited exception to these statutory bars.[9]

For PTSD-afflicted Soldiers, proving insanity is an almost impossible hurdle. The VA General Counsel and the U.S. Court of Appeals for Veterans Claims (CAVC) have narrowly interpreted the definition of insanity. Although the regulatory definition appears expansive enough to include PTSD, the current VA interpretation of insanity precludes PTSD-afflicted Soldiers from meeting the criteria.[10] Additionally, since the Veterans' Judicial Review Act (VJRA) of 1988 prohibits judicial review of VA decisions or statutes beyond the courts within the statutory framework, Soldiers are unable to appeal their claims to other federal courts.[11] Subsequently, Soldiers who are suffering from

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[9] 38 U.S.C. § 5303(b); 38 C.F.R. § 3.354. The regulatory definition of insanity in 38 C.F.R. § 3.354 states that an insane person is one who "exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior;" "interferes with the peace of society;" or "has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack adaptability to make further adjustment to the social customs of the community in which he resides." 38 C.F.R. § 3.354(a). Other exceptions include the "minor-offense" exception, which excludes discharges based on a minor offense from the definition of willful and persistent misconduct if service is otherwise honest, faithful, and meritorious, and instances where the Soldier has "innocently acquired 100 percent disability." 38 C.F.R. §§ 3.12(d)(4), 4.17a.

[10] The VA General Counsel and VA adjudication boards equate the regulatory definition of insanity to the criminal affirmative defense of insanity, which is a higher standard. *See* Smith v. Principi, 2004 U.S. App. Vet. Claims LEXIS 403, at *3 (June 23, 2004), for a discussion of the difference between the criminal law standard of insanity and the definition set forth in 38 U.S.C. § 3.354(a). The military requires that an accused prove that he was "unable to appreciate the nature and quality or the wrongfulness of his acts." MANUAL FOR COURTS-MARTIAL, UNITED STATES, R.C.M. 916(k)(1) (2008) (defining the affirmative defense of lack of mental responsibility). Yet, the standard of insanity for an administrative finding should be lower than in criminal cases because it is used to determine whether the Soldier should receive health care and other benefits for his military service, not to absolve the individual's underlying misconduct or change the character of his discharge. By statute, the character of the discharge determines eligibility for VA benefits. 38 U.S.C. § 101(2) (2006).

[11] Slater v. U. S. Dep't of Vet. Aff., 2008 U.S. Dist. LEXIS 32440, at *12–14 (M.D. Fla. Mar. 20, 2008). Under the VJRA, veterans may appeal a regional VA office's decision to the Board of Veterans Appeals, and subsequently to the Court of Veterans Appeals. *Id.* Where the veteran questions the validity or interpretation of the statute or regulation or questions a controlling question of law, the veteran may appeal a decision to the U.S. Court of Appeals for the Federal Circuit and may subsequently petition the U.S. Supreme Court for review. *Id.* at *14–15.

legitimate, service-connected medical conditions,[12] like PTSD, are precluded from receiving compensation and, potentially, from accessing medical treatment after separation.

In order to ensure Soldiers can access VA healthcare for service-connected PTSD, the Army must first amend Army Regulation (AR) 635-200 and AR 40-501 to incorporate a mandatory PTSD evaluation process prior to separation. Under AR 635-200, Chapters 9, 5-13, or 14,[13] if the Soldier expresses PTSD symptoms in an evaluation with a clinician prior to separation, a qualified mental health specialist must evaluate and diagnose the symptoms. This change would ensure that clinicians diagnose service-connected PTSD and sufficiently document the condition for future VA determinations.[14]

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[12] When applying for VA benefits for a medical condition, veterans must produce medical evidence that the condition either occurred during service or that service aggravated an existing condition, as well as a nexus between the in-service injury or disease and the current claimed medical condition. Nema Milaninia, *The Crisis at Home Following the Crisis Abroad: Health Care Deficiencies for U.S. Veterans of the Iraq and Afghanistan Wars*, 11 DEPAUL J. HEALTH CARE L. 327, 337 (2008).

[13] AR 635-200, *supra* note 4. Each of these chapters indicates a separate basis upon which a Soldier may be separated administratively. *Id.* Chapter 9 provides authority for discharging Soldiers for failure of an alcohol or drug abuse rehabilitation program. *Id.* para. 9-2. Chapter 5-13 provides the process for separating a Soldier for a personality disorder that prevents the Soldier from performing his duties. *Id.* para. 5-13. Chapter 14 prescribes procedures for separating Soldiers for misconduct, including "minor disciplinary infractions, a pattern of misconduct, commission of a serious offense, conviction by civil authorities, desertion, and absence without leave." *Id.* paras. 14-1, 14-12.

[14] In 2007, the Army launched a one-year joint disability evaluation pilot program that seeks to combine the Army and VA evaluation standards and ratings into a single examination in order to address concerns of the timeliness, efficiency, and consistency of disability evaluations. U.S. GEN. ACCOUNTING OFF., GAO-08-1137, MILITARY DISABILITY SYSTEM: INCREASED SUPPORTS FOR SERVICEMEMBERS AND BETTER PILOT PLANNING COULD IMPROVE THE DISABILITY EVALUATION PROCESS 2 (Sept. 2008) [hereinafter GAO REPORT]. The VA recently announced that, as of July 2010, it will no longer require veterans seeking to establish that their PTSD is service-connected to provide detailed documentation of the traumatic event that they experienced during combat. Ed O'Keefe, *Rules on Filing PTSD Claims to Be Eased*, WASH. POST, July 9, 2010, http://ebird.osd.mil/ebfiles/e20100709762640.html. Although the U.S. Government Accounting Office (GAO) recommended that the Army and VA sustain "collaborative executive focus on the pilot," this initiative, as well as the changes to VA policy regarding establishing service-connected PTSD, are unlikely to have any impact on PTSD-afflicted Soldiers who are discharged with a statutory bar because eligibility for medical benefits hinges on the nature of the discharge, which the pilot program and the more relaxed documentation rules do not address. *Id.*; GAO REPORT, *supra*, at 5.

However, a procedural change to Army Regulations alone is insufficient to ensure retention of a Soldier's eligibility for VA benefits due to the discretion that commanders exercise over the administrative separation process. If a Soldier falls under one of the statutory bars of 38 U.S.C. § 5303(a), legislation bars receipt of all benefits, without regard to his service-connected disability.[15] Therefore, as a matter of equity, Congress needs to amend 38 U.S.C. § 5303 to permit Soldiers that meet one of these statutory bars to receive health care for service-connected disabilities. In the alternative, if Congress maintains the statutory bars under 38 U.S.C. § 5303(a), Congress needs to incorporate PTSD as a valid interpretation of "insanity" for OTH discharges that fall under these statutory bars, thereby making veterans eligible for health care benefits.[16]

II. Background

A. History of PTSD: the Shift from "Shell Shock" to Anxiety Disorder

Historically, the military has either been ambivalent or even disdainful of Soldiers suffering from psychiatric symptoms resulting from combat.[17] The military considered these Soldiers as "lacking in moral fiber" rather than injured in combat.[18] During World War I, military physicians observed a neurological condition—termed "shell shock" because physicians believed the condition was directly related to the exploding shells of bombs—consisting of both physiological and psychological symptoms.[19] These Soldiers' inability to fight due to their condition presented a difficult dilemma for military officials: treat the Soldiers as medical patients suffering from a neurological condition, or court-martial the Soldiers as "malingerers or cowards."[20] The introduction of psychotherapy to the front lines during World War II slightly weakened this theory because psychiatrists discovered that the

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[15] 38 U.S.C. § 5303(a) (2006); 38 C.F.R. § 3.12(d) (2010).
[16] 38 U.S.C. § 5303.
[17] Hans Pols & Stephanie Oak, *War and Military Mental Health: The U.S. Psychiatric Response in the 20th Century*, 97 AM. J. PUB. HEALTH 2132, 2133 (2007). *See also* Major Timothy P. Hayes, Jr., *Post-Traumatic Stress Disorder on Trial*, 191 MIL. L. REV. 67 (2007).
[18] *Id*.
[19] *Id.* Symptoms of shell shock included anxiety attacks, insomnia, confusion, amnesia, hallucinations, and nightmares. *Id.*
[20] *Id.* The fact that only some Soldiers were affected perplexed commanders and bolstered the theory that the affected Soldiers were simply shirking their duty or mentally weak. *Id.*

affected Soldiers were otherwise normal individuals who had simply reached their psychological "breaking point" and "could no longer cope with the unremitting and horrendous stresses of war."[21]

After the extremely high rates of psychiatric "casualties" in the Korean War, military officials attempted to implement early intervention and treatment procedures for combat stress during the Vietnam War.[22] However, these measures did not prevent the soaring numbers of veterans suffering from PTSD after Vietnam, which went largely unnoticed until fifteen years after the conflict when psychiatrists first realized that prolonged exposure to combat experiences had adverse long-term consequences.[23] This discovery helped stimulate a "major shift in psychiatric interest," leading to PTSD's recognition as a diagnostic category in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980.[24] Unfortunately, the scale and variation of these numbers led to skepticism of the condition.[25] Additionally, most of our current knowledge regarding PTSD is based on twenty-year-old studies conducted on post-conflict Vietnam veterans; as a result, the studies primarily assessed the condition in its chronic phase instead of in early stages of development.[26]

The introduction of PTSD into the DSM-III in 1980, as well as the linkage between PTSD and combat trauma discovered during the Gulf

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[21] *Id.* at 2135.

[22] *Id.* at 2136. Military officials introduced "combat stress control teams" staffed by mental health care professionals to forward deployed units, time limits on tours of duty, and frequent periods of rest and relaxation. *Id.* Rates of mental health issues related to combat were estimated at 250 per 1000 per year. *Id.*

[23] *Id.* at 2137–38.

[24] *Id.* Additional epidemiological studies of Vietnam veterans in the mid-1980s revealed a prevalence of PTSD in 15% of male veterans, with an even higher lifetime prevalence of 30%. Friedman, *supra* note 3, at 75.

[25] Pols & Oak, *supra* note 17, at 2140. As of 1988, seventy percent of Vietnam veterans were diagnosed with PTSD at some time in their lives, even though the conflict ended some twenty years earlier. Gover, *supra* note 3, at 561.

[26] Solomon & Mikulincer, *supra* note 1, at 659. Prior to combat operations in OIF and OEF, researchers placed more focus on Gulf War Syndrome than PTSD, although retrospective studies in the late 1990s indicated that ten percent of Soldiers who experienced combat events during the Gulf War suffered from PTSD. Friedman, *supra* note 3, at 75. Researchers realized that the rate of prevalence, approximately four percent, was considerably lower in Soldiers who had not seen any combat during the Gulf War, drawing a direct correlation between combat experience and incidence of PTSD. *Id.*

War, helped change mental health specialists' views regarding diagnosis and treatment.[27] Recognition of PTSD as a legitimate diagnosis remains controversial, though, in part due to the difficulty of diagnosis and measurement in its initial phases. Although researchers identified factors that may increase an individual's susceptibility, researchers are unable to determine who will develop the symptoms once exposed to trauma. The unpredictability of PTSD's symptoms also remains a major factor. Regardless of the state of controversy, PTSD has become one the most frequently diagnosed psychiatric conditions since its inception into the DSM-III.[28]

B. Diagnosing PTSD Today Through Research and Expert Assessments

Today, experts consider PTSD an anxiety disorder directly attributed to experiencing "an event involving death, injury, or threat, coupled with the intense fear that the event generated, along with a feeling of helplessness . . . ."[29] The threshold determination of experiencing a traumatic event must be met in combination with four categories of symptoms: "reliving the event, avoidance, numbing, and feeling keyed up."[30] Mental health specialists consider these symptoms in the context

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[27] Pols & Oak, *supra* note 17, at 2140.

[28] Nina A. Sayer et al., *Compensation and PTSD: Consequences for Symptoms and Treatment*, PTSD RES. Q., Fall 2007, at 1.

[29] Edgar Garcia-Rill & Erica Beecher-Monas, *Gatekeeping Stress: The Science and Admissibility of Post-Traumatic Stress Disorder*, 24 U. ARK. LITTLE ROCK L. REV. 9 (2001). Mental health specialists believe PTSD may actually represent a "major rupture" of an individual's psychological well-being that completely alters the way that individual lives his life. Solomon & Mikulincer, *supra* note 1, at 664. Because an everyday occurrence, such as a car backfiring, may trigger a flashback or startled response, a PTSD-afflicted individual's mind inappropriately triggers a stress response throughout the day that triggers production of adrenaline. Garcia-Rill & Beecher-Monas, *supra*, at 18. Consequently, seemingly normal events that remind the Soldier of the traumatic experience may trigger this "fight or flight" response, in some cases, multiple times a day. *Id.* Over the course of time, the excess amount of hormones secreted in response to an abnormal amount of stressors damages the brain, decreasing the individual's chance for remission and recovery. *Id.* The resulting effect upon the individual may be so severe as to warrant VA disability benefits, since the ability of a veteran to function under the conditions of daily life, including employment, is the basis of a VA disability evaluation. 38 C.F.R. §4.10 (2010).

[30] U.S. Dep't of Veterans Affairs, Nat'l Ctr. for PTSD, What Is PTSD?, *available at* http://www. ptsd.va.gov/public/pages/what-is-ptsd.asp (last visited Mar. 24, 2010) [hereinafter Fact Sheet, What is PTSD?]. Before diagnosis can be made, the Soldier must have experienced these symptoms for at least a month; this duration allows an evaluator to determine "clinically significant distress or impairment in social, occupational, or other

of several phases: an immediate phase, "characterized by strong emotions, disbelief, numbness, fear, confusion" and hyperarousal; a delayed phase "characterized by persistence of autonomic arousal, intrusive recollections . . . and combinations of anger, mourning, apathy, and social withdrawal;" and a chronic phase, characterized by a continuation of some intrusive symptoms, hyperarousal, and resentment or sadness.[31]

After obtaining a Soldier's trauma history, a mental health specialist screens a Soldier for PTSD using one of a variety of screening instruments.[32] In some instances, a trained specialist conducts a more

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important areas of functioning." U.S. DEP'T OF VETERANS AFF., C&P SERVICE CLINICIAN'S GUIDE 201 (2002), *available at* http://www.warms.vba.va.gov/admin21/guide/cliniciansguide.doc [hereinafter C&P GUIDE]; Nat'l Ctr. for PTSD, U.S. Dep't of Veterans Affairs, FAQs About PTSD Assessment: For Professionals, *available at* http://www. ptsd.va.gov/professional/pages/faq-ptsd-professionals.asp (last visited Mar. 24, 2010) [hereinafter Fact Sheet, FAQs About PTSD Assessment]. DSM-IV further supplements the DSM-III criteria by requiring an assessment of the individual's disability or distress. Solomon & Mikulincer, *supra* note 1, at 660; *see also* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (text rev., 4th ed. 2000), *available at* http:/./www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp [hereinafter DSM-IV-TR]. The American Psychiatric Association (APA) recently reviewed DSM-IV and proposed new diagnostic criteria for PTSD to be published in DSM-V, the release of which is expected in May 2013. Am. Psychiatry Ass'n, DSM-5 Overview: The Future Manual, *available at* http://www.dsm5.org/Pages/Default.aspx (last visited June 15, 2010). The proposed revisions supplement DSM-IV by adding the following two criteria: the existence of negative alterations in cognitions and mood associated with the traumatic event, and a determination that the disturbance is not due to the direct physiological effects of a substance (e.g., medication or alcohol) or a general medical condition (e.g., traumatic brain injury, coma). *Id.* Even though the proposed revisions to DSM-V will focus more on aggressive, reckless, and self-destructive behavior and clarify other aspects of the disorder, such as delayed onset, there is still no movement to revise the regulatory definition of insanity under 38 C.F.R. § 3.354, creating an even greater divide between the eligibility standards used by the VA and the features of PTSD. *Id.*

[31] Fact Sheet, What Is PTSD?, *supra* note 30, at 1. During this chronic phase, mental health specialists are able to more accurately diagnose PTSD because of the persistence of symptoms. OIF CLINICIAN GUIDE, *supra* note 3, at 11–12.

[32] Friedman, *supra* note 2, at 588. The National Center for PTSD uses a baseline screening instrument consisting of four yes/no questions comprising the four major symptom categories. *Id.* If an individual endorses at least three of the four items, a mental health specialist conducts a more elaborate assessment. *Id.* at 588–89. Mental health specialists measure PTSD in several ways, ranging from the cursory four-item screening checklist to a more elaborate seventeen-item checklist, also developed by the National Center for PTSD, in which each item receives a single rating. Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 NEW ENG. J. MED. 13, 15 (2004). On the seventeen-item checklist, results are

detailed, structured interview to rate the individual's presented symptoms, usually as a follow-up to one of the initial screening mechanisms.[33] Regardless of the type of screening mechanism used, multiple instruments exist to further quantify or validate an individual's symptoms.[34] These scales are particularly helpful in distinguishing the severity of the condition and determining whether an individual over-exaggerates his condition.

1. Pseudo PTSD

Critics of PTSD diagnoses point to the ease of fabricating the symptoms due to the subjective nature of the evaluation.[35] In most households, PTSD is a familiar term, and many Soldiers recognize that service-connected PTSD may be potential mitigation in criminal misconduct cases.[36] Likewise, since many veterans understand that service-connected PTSD is a compensable disability, a concern exists that veterans will exaggerate or fabricate symptoms for financial gain.[37] The growing number of PTSD claims bolsters these skeptics' arguments.

Additionally, research indicates that, among PTSD-afflicted individuals, those seeking compensation express higher levels of symptoms than individuals not seeking compensation.[38] Although individuals seeking compensation may actually experience more psychiatric impairment than others afflicted with PTSD,[39] other studies

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"scored as positive if subjects reported as least one intrusion symptom, three avoidance symptoms, and two hyperarousal symptoms." *Id.* For a diagnosis of PTSD, the total score must be "at least 50 on a scale of 17 to 85 (with a higher number indicating a greater number of symptoms or greater severity)." *Id.*

[33] Fact Sheet, FAQs about PTSD Assessment, *supra* note 30, at 1. Although the seventeen-item assessment is a valid tool for determining whether an individual is experiencing symptoms in order to refer that individual for treatment, the more time-consuming, structured interview "yields more valid results" needed for a full and accurate diagnosis and treatment plan. *Id.*

[34] C&P GUIDE, *supra* note 30, at 203. The Mississippi Scale for Combat-Related PTSD (M-PTSD), for example, allows evaluators to quantify symptoms in order to discern PTSD from associated disorders. *Id.* The Minnesota Multiphasic Personality Inventory (MMPI) and Minnesota Multiphasic Personality Inventory 2 (MMPI 2) also enable the evaluator to assess the validity of an individual's symptoms. *Id.*

[35] Gover, *supra* note 3, at 563.

[36] Sayer et al., *supra* note 28, at 1.

[37] *Id.*

[38] *Id.*

[39] *Id.*

indicate that PTSD-afflicted veterans exaggerate symptoms to "establish a basis for their claims or to maximize payments."[40] Critics of the VA disability rating system argue that the ineffectiveness of the disability rating criteria for PTSD and other mental disorders causes individuals to inflate their symptoms in order to receive adequate compensation, indicating a need for change in other VA policies related to PTSD.[41]

Regardless, while individuals may fabricate symptoms in a preliminary self-reported screening, clinicians readily identify false claims upon a more extensive, one-on-one evaluation.[42] Since the threshold criterion of PTSD requires the evaluator to determine whether the individual actually suffered exposure to a traumatic event, individuals who are not able to refer to a particular event or series of events will not receive a referral for further screening.[43] The individual must then attest that he suffers from a triad of symptoms.[44] Validity scales, such as the

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[40] *Id.* When compared to non-compensation-seeking veterans, the veterans seeking compensation produced MMPI-2 validity scale scores indicative of "extreme exaggeration." *Id*. *See also* Scott Simonson, *Back from War—A Battle for Benefits: Reforming VA's Disability Ratings System for Veterans with Post-Traumatic Stress Disorder*, 50 ARIZ. L. REV. 1177 (2008) (recommending changes to the VA disability ratings system to more accurately assess fair benefits for PTSD-afflicted veterans).

[41] VETERANS' DISABILITY BENEFITS COMM'N, HONORING THE CALL TO DUTY: VETERANS' DISABILITY BENEFITS IN THE 21ST CENTURY executive summary, at 8 (2007), *available at* http://www.vetscommission.org/pdf/ExecutiveSummary_eV_9-27.pdf [hereinafter VETERANS' DISABILITY BENEFITS REPORT]. Congress created this Commission in 2004 out of concern for a variety of veterans' issues, including treatment and compensation for PTSD. *Id.* at 1. The Commission recommended substantive changes to how mental disorders, including PTSD, are evaluated and rated. *Id.* at 8. One of these recommended changes is the utilization of separate criteria for rating PTSD claims because current rating criteria do not provide adequate compensation based on earnings analysis of PTSD-afflicted veterans. *Id.*

[42] Karl Kirkland, *Post-Traumatic Stress Disorder vs. Pseudo Post-Traumatic Stress Disorder: A Critical Distinction for Attorneys*, 56 ALA. LAW. 90, 91 (1995).

[43] C&P GUIDE, *supra* note 30, at 204. In the military, an individual's claim must be verified by evidence in his record, such as an award citation, a commander's narrative, or other documentation of the event. U.S. DEP'T OF VETERANS AFF., M21-1 ADJUDICATION PROCEDURES, at 1-D-3–6 (Aug. 23, 1993), *available at* http://www.warms.vba.va.gov/M21_1.html [hereinafter M21-1 PROCEDURES]. An evaluator must also review the veteran's military record to confirm the "nature and extent of actual combat experience." Kirkland, *supra* note 42, at 92.

[44] Kirkland, *supra* note 42, at 91. For disability compensation, a Soldier must exhibit at least one measure of reliving the traumatic experience, three measures of avoidance of stress stimuli, and two measures of hyperarousal. C&P GUIDE, *supra* note 30, at 201. Examples of reliving measures include recurrent nightmares or flashbacks about the traumatic event. *Id.* Examples of persistent avoidance measures include feeling of detachment from others, feeling numb or emotionless, and a loss of interest in normal

Minnesota Multiphasic Personality Inventory (MMPI) and Minnesota Multiphasic Personality Inventory 2 (MMPI 2), also help a mental health specialist determine whether an individual is exaggerating symptoms.[45] Use of these validity scales in combination with an in-person assessment and a "careful review of records" distinguish valid claims from false ones, negating most concerns of pseudo-PTSD.[46]

2. Associated Features

Although the quantification scales screen out false claims of PTSD, a number of factors may frustrate diagnosis of PTSD. First, individuals suffering from PTSD may not immediately experience symptoms; onset of symptoms may occur six months to a year after the triggering stressor.[47] Some researchers attribute higher rates of delayed onset among Soldiers to "emotional numbing and denial facilitated by troop management and military training."[48] Rates of delayed onset may be as high as twenty percent depending on the severity of the traumatic event.[49] Because avoidance is a classic characteristic of PTSD, afflicted individuals may also withdraw and hesitate to seek treatment even though they are experiencing symptoms.[50] Additionally, the nature and extent of symptoms may vary over the passage of time.[51] A "fluctuating course" of "relapses and remissions" characterizes PTSD, which also thwarts diagnosis and treatment and reduces the chance of full recovery.[52]

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activities. *Id.* Examples of symptoms of hyperarousal include increased irritability, inability to concentrate, and insomnia. *Id.*

[45] Sayer et al., *supra* note 28, at 2. According to a 2003 study, "20% of compensation-seeking veterans produced extreme scores on MMPI-2 validity scales." *Id.* The researchers conducting the study determined that, under the VA disability compensation procedures, individuals have an incentive to exaggerate their symptoms, which in turns leads to the referenced extreme scores. *Id.* at 4.

[46] Kirkland, *supra* note 42, at 92.

[47] DSM-IV-TR, *supra* note 30. In some studies, delayed onset is defined as the appearance of symptoms a year after the initial stressor. Solomon & Mikulincer, *supra* note 1, at 662.

[48] Bernice Andrews et al., *Delayed-Onset Posttraumatic Stress Disorder: A Systematic Review of the Evidence*, 164 AM. J. PSYCHIATRY 1319, 1325 (2007).

[49] Solomon & Mikulincer, *supra* note 1, at 665. The "posttraumatic environment" and a delay in follow-up may also contribute to varying rates of delayed onset. *Id.*

[50] Friedman, *supra* note 2, at 588.

[51] *Id.* at 661.

[52] *Id.* at 662. In one study, combat veterans typically re-experienced the traumatic event in nightmares or flashbacks, had interrupted sleep patterns, and felt hypervigilant during

Second, in addition to its fluctuating nature, PTSD is also strongly associated, or comorbid, with other psychiatric and physical disorders and conditions.[53] This further complicates accurate diagnosis because some of these conditions share or mask the symptoms of PTSD.[54] A Soldier's PTSD symptoms may appear in the form of substance abuse, depression, or increased acts of violence, which are not normally diagnosed with, or considered related to, PTSD.[55] Additionally, no single case of PTSD shares the same characteristics of another, and no indicators exist to determine whether an individual will develop an associated disorder or condition in addition to it.[56]

Although PTSD is unpredictable, studies indicate that substance abuse is significantly related to PTSD because alcohol or drug use is a method of coping with intrusive thoughts, nightmares, insomnia, and hyper-alertness.[57] One study completed in February 2006 indicates that among 26,613 active-duty personnel polled, 6% engaged in "heavy weekly drinking" after returning from Iraq or Afghanistan.[58] Additionally, approximately 26.6% began binge drinking, and 4.8% reported the onset of "alcohol-related problems."[59] The odds of developing an alcohol-related problem increased with the number of

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the first two years after the traumatic event, especially in response to stressors reminiscent of combat. *Id.* at 661. In the third year of assessment, however, the veterans' initial symptoms were augmented by a greater feeling of detachment, avoidance of social activities, and loss of memory. *Id.* at 661–62. Over the course of three years, the predominance of certain symptoms varied, potentially leading the afflicted individual or health care provider to think the individual has recovered. *Id.*

[53] Friedman, *supra* note 2, at 589; *see also* Paula P. Schnurr et al., *Cognitive Behavioral Therapy for Posttraumatic Stress Disorder in Women*, 297 J. AM. MED. ASS'N 820 (2007). Women in the military are at a six percent higher risk for "[l]ifetime prevalence" than men. *Id.*

[54] Friedman, *supra* note 2, at 589.

[55] OIF CLINICIAN GUIDE, *supra* note 3, at 11–12.

[56] *Id.* at 12.

[57] Editorial, *Reserve, National Guard at Higher Risk of Alcohol-Related Problems after Returning from Combat*, SCI. DAILY (Aug. 26, 2008), http://www.sciencedaily.com/releases/2008/08/080812160607.htm. *But see* Steven H. Woodward et al., *Hippocampal Volume, PTSD, and Alcoholism in Combat Veterans*, 163 AM. J. PSYCHIATRY 674 (2006). Although the authors found that PTSD "was not strongly associated with an elevated frequency of alcohol abuse/dependence," they also state that "further examination . . . of brain structure and function in PTSD appears warranted." *Id.* at 674, 677.

[58] Editorial, *supra* note 57, at 1.

[59] *Id.*

combat experiences and were higher in those individuals suffering from PTSD.[60]

Commanders with Soldiers suffering from PTSD may only observe the effects of substance abuse on the Soldier's discipline and performance, considering the substance abuse to be the primary issue rather than a manifestation of an underlying anxiety order.[61] This distinction is crucial because legislation prohibits the VA from paying disability compensation for alcohol or drug abuse, unless the substance abuse disability is "secondary to or is caused or aggravated by a primary service-connected disorder."[62] Therefore, without a primary diagnosis of service-connected PTSD, a Soldier discharged for substance abuse will be barred from future treatment and benefits.[63]

Posttraumatic Stress Disorder may also be confused with other mental health disorders, such as depression, personality disorders, and even schizophrenia.[64] While depression is closely associated with PTSD, personality disorders and mental diseases usually are not directly induced by a traumatic stressor and rarely exist without "early signs in adolescence."[65] In some severe cases of PTSD, though, the symptoms may be mistaken for borderline personality disorders "because of . . . [the] severity of behavioral disruptions."[66] Soldiers discharged for personality disorders are also barred from VA benefits because,

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[60] *Id.* To understand the correlation between substance abuse and PTSD, one must understand what alcohol or drugs do to the brain. The brain's reticular activating system (RAS) triggers the hormonal "fight or flight response" experienced in times of stress. Garcia-Rill & Beecher-Monas, *supra* note 29, at 12–14. Individuals with PTSD often "self-medicate with alcohol" or drugs to calm an overactive RAS. *Id.* at 21.

[61] Garcia-Rill & Beecher-Monas, *supra* note 29, at 22.

[62] Allen v. Principi, 237 F.3d 1368, 1381–82 (Fed. Cir. 2001) (holding that 38 U.S.C. § 1110 does not preclude disability compensation for substance abuse if a servicemember can establish, with clear medical evidence, that the substance abuse disability is secondary to or is caused by the primary service-connected disorder, such as PTSD, and not due to the servicemember's "willful wrongdoing").

[63] 38 U.S.C. § 1110 (2006); C&P GUIDE, *supra* note 30, at 210.

[64] C&P GUIDE, *supra* note 30, at 204. An individual's reliving of the traumatic event in the form of a hallucination or vivid flashback may lead an evaluator to believe the individual is schizophrenic. *Id.*

[65] *Id.* Generally, diagnosis of a personality disorder requires evidence of existence of certain pathological traits during childhood or adolescence, which include general alienation, reluctance to talk to professionals, violent outbursts and assaults, intolerance or distrust of authority, and dysfunctional living patterns. *Id.* Since these symptoms resemble PTSD's symptoms, determining when these symptoms began is crucial for proper diagnosis.

[66] *Id.*

generally, the VA considers personality disorders as "pre-existing" entry into military service.[67] As a result, misdiagnosis results in grave consequences for PTSD-afflicted Soldiers.

In 2007, growing concerns that agencies were intentionally misdiagnosing PTSD as personality disorders to avoid paying disability and medical benefits prompted members of Congress, including then-Senator Barack Obama, to send a letter of concern to the Secretary of Defense, Dr. Robert Gates.[68] The Congressmen urged Dr. Gates to conduct "a thorough and independent review of the personality disorder discharge process" and to investigate allegations that this process was being abused.[69] In response, the Under Secretary of Defense for Personnel and Readiness, Dr. David S. C. Chu, admitted that "some behavioral manifestations associated with combat service overlap with the signs and symptoms of other disorders associated with combat service such as major depressions and [PTSD]."[70]

Another associated feature of PTSD is misconduct, usually in the form of violent acts; in these cases, afflicted Soldiers are unable to transition from "survivor mode," where aggressiveness and hyper-vigilance is a necessity, to the relative calm of garrison life.[71] If a

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[67] 38 U.S.C. §§ 1110, 1131 (2006); 38 C.F.R. § 3.303 (2010).

[68] Letter from Sen. Barack H. Obama [et al.], Members of U.S. Congress, to Dr. Robert Gates, U.S. Sec'y of Def. (June 21, 2007) (on file with author).

[69] *Id.*

[70] Letter from David S.C. Chu, Under Sec'y of Def. for Pers. & Readiness, to Sen. Barack H. Obama (Aug. 8, 2007) (on file with author). In an effort to alleviate concerns about the accuracy of the separation process, Dr. Chu pointed to the effectiveness of the mandatory health screenings conducted in conjunction with the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA). *Id.* Dr. Chu further emphasized that DoD mental health specialists "are expected to accurately distinguish between symptoms related to exposure to traumatic stress and those that are longstanding and related to a personality disorder," even though some of the behaviors related to personality disorders "tend to emerge only during periods of stress." *Id.* Yet, as studies of the PDHA and PDHRA depict, these screenings do not identify the entire population of Soldiers suffering from PTSD, and some Soldiers with mental health concerns fail to receive or request treatment. Hoge et al., *supra* note 3, at 1030.

[71] Gover, *supra* note 3, at 566–67. In a 1983 study of Vietnam veterans, individuals exhibited an inability to shift from survival mode in three distinct ways: with a "dissociative reaction," through a "sensation-seeking syndrome," and/or through a "depression/suicide syndrome." *Id.* at 567. Of the three, dissociation was most common and led to a higher incidence of violent behavior because it caused the afflicted Soldier to respond to seemingly mundane events with the level of violence that would normally only be appropriate in combat. *Id.* Sensation-seeking syndrome, defined by a propensity to "engage in dangerous or thrilling behavior in order to maintain control over the

Soldier exhibits any of these behaviors, even if uncharacteristic, the outside observer may fail to understand the underlying medical cause. Yet, a major distinction between the misconduct attributed to PTSD and other acts of misconduct is the lack of premeditation and the uncharacteristic nature of the acts, indicating the type of impulsive behavior normally associated with PTSD.[72] This distinction may help commanders determine when a Soldier should be referred for mental health diagnosis and treatment.

Given the strong correlation between PTSD and substance abuse, mental health problems, and persistent misconduct,[73] as well as the trend to misdiagnose or misunderstand the underlying condition, commanders and healthcare professionals should carefully screen Soldiers prior to separation. This need is especially acute among Soldiers returning from combat operations.[74]

C. PTSD and Operation Iraqi Freedom and Operation Enduring Freedom

Soldiers in combat operations are at a higher risk than the rest of the population for developing PTSD.[75] As of 2004, the prevalence rate of PTSD in Soldiers returning from Iraq was between fifteen and seventeen percent in Soldiers returning from Afghanistan.[76] These prevalence rates

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traumatic imagery [PTSD-afflicted individuals] are experiencing," may also help explain an uncharacteristic increase in non-violent misconduct. *Id.*

[72] Andrew Moskowitz, *Dissociation and Violence: A Review of the Literature*, 5 TRAUMA, VIOLENCE, & ABUSE 22 (2004). The author asserts that flashbacks to the traumatic event may trigger violent behavior, which is "associated with a lack of premeditation, significant emotional arousal, and alcohol use." *Id.*

[73] OIF CLINICIAN GUIDE, *supra* note 3, at 24.

[74] Hoge et al., *supra* note 32, at 13.

[75] Gover, *supra* note 3, at 563.

[76] Hoge et al., *supra* note 32, at 13. In 2004, researchers conducted an unprecedented early assessment regarding prevalence of combat-related mental health disorders among military members three to four months after their redeployment. *Id.* The study groups consisted of two Army infantry brigades from 82d Airborne Division after a year-long deployment to Iraq or a six-month deployment to Afghanistan, an Army infantry brigade from 3d Infantry Division after an eight-month deployment to Iraq, and two Marine battalions from the 1st Expeditionary Force after a six-month deployment to Iraq. *Id.* Using the seventeen-item National Center for PTSD checklist, the evaluators discovered that rates of "major depression, generalized anxiety, or PTSD [were] significantly higher," at 15% to 17%, in Soldiers returning from OIF than OEF; incidence of PTSD comprised the largest difference in rates between OIF and OEF veterans, potentially due

increased in a linear fashion with the number of firefights or similar combat events the Soldier experienced; the rates were significantly higher among Soldiers suffering injury in combat.[77] Researchers expect these numbers to increase exponentially for a multitude of reasons, ranging from prolonged exposure to armed conflict, to defective screening mechanisms, to fear of stigmatization for seeking mental health care.[78] These numbers also do not take into consideration the likelihood of delayed onset of PTSD, so prevalence rates may surpass these anticipated numbers.

In addition to documenting a link between PTSD and participation in combat operations, researchers also confirmed the strong association with substance abuse, depression, and misconduct.[79] Also, due to the likelihood of delayed onset, researchers asserted that the optimal period for conducting a mental health survey was not immediately after a deployment—when the military initially screened individuals—but approximately three to four months after the deployment.[80] Previously, these discoveries posed several distinct problems for PTSD-afflicted Soldiers. First, as a result of ineffective screening mechanisms, many Soldiers may abuse alcohol, become depressed, or engage in misconduct before receiving a PTSD diagnosis. In some instances, these Soldiers may be administratively separated for these associated behaviors without ever receiving a diagnosis of PTSD, diminishing the possibility of showing a service-connected disability. Further, a lack of diagnosis, either due to misdiagnosis or delayed onset, reduces the Soldier's ability to argue insanity for PTSD-related offenses. In either instance, a PTSD-afflicted Soldier may lose access to benefits and health care after separation from service.

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to the nature of the conflict in Iraq. *Id.* at 13. The prevalence of PTSD rose from 4.5% in individuals with no combat experiences to 9.3% in individuals reporting involvement in one or two firefights. *Id.* at 16. The rates substantially increased with the number of combat experiences; the highest prevalence rate, 19.3%, belonged to individuals involved in more than five firefights. *Id.*

[77] *Id.* at 16.

[78] *Id.*

[79] *Id.* The study indicated that these high PTSD prevalence rates were "significantly associated" with alcohol abuse and depression, which were previously considered unconnected conditions. *Id.*

[80] *Id.* at 20.

1. DoD Efforts to Screen for Combat-Related Mental Health Issues

In April 2003, the U.S. Department of Defense (DoD) mandated that all servicemembers complete a Post-Deployment Health Assessment (PDHA) immediately before departing a theater of operations or upon return to home station from a deployment in order to screen for mental health issues, among other health issues.[81] Initially, installations administered the PDHA approximately two weeks after Soldiers returned from deployment.[82] The PDHA screens specifically for PTSD by asking servicemembers to respond to four questions that cover the primary characteristics of PTSD, as well as questions regarding an interest to receive care for any reported concerns.[83] The PDHA does not include a screening for substance abuse, mainly because alcohol and drugs are prohibited in theater. Nor is the PDHA able to distinguish among overlapping symptoms of disorders that may be closely related to PTSD.[84] Therefore, many Soldiers suffering from PTSD or PTSD-related conditions may escape attention in this screening process as a result of inadequate survey results and delayed onset of symptoms.

Between 1 May 2003 and 30 April 2004, researchers conducted an extensive study of the PDHA results.[85] This study established the connection between combat deployment, use of mental health care services in the first year following the deployment, and attrition from military service.[86] The study showed that, out of 424,451 active duty servicemembers returning from OIF, 18.4% "screened positive for [one] of the mental health concerns" in the PDHA.[87] Of this positive screening percentage, approximately 4.8% to 9.8% met the PDHA's criteria for

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[81] Hoge et al., *supra* note 3, at 1024. The PDHA is completed using Department of Defense Form 2796. *Id.* It consists of three pages of "self-administered questions pertaining to deployment location, general health, physical symptoms, mental health concerns, and exposure concerns." *Id.* The mental health portion includes questions related to "posttraumatic stress disorder symptoms, depression, suicidal ideation, aggression, and interest in receiving mental health services." *Id.*

[82] *Id.* The PDHA consists of a written survey, followed by a meeting with a health care professional to discuss concerns documented on the PDHA. *Id.* Following the servicemember's interview, the PDHA is maintained in two locations: the servicemember's permanent medical records and in the Defense Medical Surveillance System (DMSS) database. *Id.*

[83] *Id.* at 1025.

[84] *Id.* at 1030.

[85] *Id.* at 1025.

[86] *Id.*

[87] *Id.* at 1027.

PTSD, further supporting the position that PTSD may have a delayed onset, rather than an immediate effect in a large number of cases.[88] In the year after the deployment, one-third of the servicemembers returning from OIF in the study group accessed mental health care services; however, 23% received no mental health diagnosis after accessing healthcare, indicating impediments to mental health care access still exist.[89]

In addition to affirming concerns that PTSD may not appear immediately upon return from a deployment, the study also showed that OIF veterans who screened positive for a mental health concern[90] were "significantly more likely to leave military service," with an attrition rate of 21.4% within a year of returning, compared to 16.4% of OIF veterans with no mental health concerns.[91] Attrition rates included separation under both voluntary and involuntary circumstances.[92] Although neither study definitively assigned a primary reason for these higher attrition rates, both studies indicated that a large percentage of servicemembers who met the criteria for a mental health concern did not seek treatment, either voluntarily or due to lack of referral.[93]

In March 2005, the DoD mandated completion of an additional health assessment, the Post-Deployment Health Reassessment (PDHRA),

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[88] *Id.* at 1030.
[89] *Id.*
[90] A mental health concern is defined as a "positive response" to any of the following criteria:

> little interest or pleasure (a lot); feeling down (a lot); interest in receiving help for stress, emotional distress, family problem (yes); thoughts of hurting self (some or a lot); a positive screening of PTSD; thoughts of serious conflicts with others (yes); thoughts of hurting someone or sense of a loss of control with others (yes); and have sought or intend to seek care for mental health (yes).

Id. at 1027.
[91] *Id.* at 1030. Similar studies of U.S. servicemembers and British military members also reported a strong correlation between mental health issues and attrition from service: approximately twenty-seven percent of those participants receiving outpatient mental health care separated within six months. Mark Creamer et al., *Psychiatric Disorder and Separation from Military Service: A 10-Year Retrospective Study*, 163 AM. J. PSYCHIATRY 733 (2006). The participants of the study served in the military during the Gulf War between August 1990 and September 1991; approximately fifty percent of the participants deployed in support of the conflict. *Id.*
[92] *Id.* at 1031.
[93] *Id.*; Hoge et al., *supra* note 3, at 1031.

within three to six months after deployment.[94] Once again, researchers tested the results of the PDHA and PDHRA among a similar demographic of servicemembers returning from Iraq.[95] The study revealed that the second assessment captured a larger group of individuals with mental health and substance abuse concerns not previously identified during the PDHA.[96] Another important finding was that twice as many servicemembers reported a qualifying number of PTSD symptoms on the PDHRA than on the PDHA,[97] confirming the previous study's assertions that the optimal screening period was three-to-four months after redeployment. Unlike the PDHA, the PDRHA also includes two questions regarding substance abuse,[98] providing servicemembers their first opportunity to report a substance abuse concern. The researchers discovered that, although approximately eleven percent of servicemembers reported misuse of alcohol since redeployment, less than one percent received referrals for substance abuse treatment.[99] One rationale for these incongruent results is that referral for substance abuse treatment triggers more extensive command involvement and, in some cases, may result in negative action if the treated individual relapses while undergoing treatment.[100]

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[94] Memorandum from the Assistant Sec'y of Def. for Health Affairs, to the Assistant Sec'y of the Army et al., subject: Post-Deployment Health Reassessment (Mar. 10, 2005), *available at* http://www.ha.osd.mil/policies/2005/05-011.pdf. As with the PDHA, the servicemember completes a survey, and a health care provider reviews the PDHRA with the servicemember, subsequently entering the assessment into the servicemember's permanent medical records and DMSS. *Id.* at 3.

[95] Charles S. Milliken et al., *Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War*, 298 J. AM. MED. ASS'N 2141 (2007). The PDHRA forms of 111,484 Army Soldiers and 12,686 Marines, completed between 1 June 2005 and 31 December 2006, formed the basis of the study's results. *Id.* at 2142.

[96] *Id.* at 2141. Concerns about interpersonal conflict marked the most dramatic increase, from 3.5% to 14%, closely followed by a 6% increase in concerns about depression. *Id.* at 2143.

[97] *Id.*

[98] *Id.* at 2142. Overall, the two assessments have several minor differences. *Id.* In addition to the substance abuse screen in the PDHRA, the PDHA contains several questions relating to the servicemember's combat experiences and pre-deployment heath that are not administered in the PDHRA. *Id.*

[99] *Id.* at 2143.

[100] U.S. DEP'T OF ARMY, REG. 600-85, ARMY SUBSTANCE ABUSE PROGRAM (ASAP) (24 Mar. 2006) [hereinafter AR 600-85]. Like other administrative tools and programs, ASAP is command-driven. *Id.* para. 1-31. Because the program's goal is to facilitate unit readiness, the commander makes the ultimate decision whether an individual will be separated or retained for failure of a rehabilitation program. *Id.* Commanders are

Although an increased number of mental health concerns are identified in the PDHRA, treatment of these issues remains a concern. Many Soldiers receive no diagnosis and therefore do not receive successful treatment due to several reasons.[101] First, compliance with PDHRA completion goals is less than 100%; approximately 21,257 Soldiers did not complete the PDHRA within three to six months after the deployment.[102] In other instances, Soldiers fear that accessing mental health care will lead to stigmatization and a negative impact on their careers, particularly since confidentiality is not absolute.[103] The symptomatic avoidance that afflicts individuals suffering from PTSD greatly exacerbates this fear.[104] Therefore, many afflicted individuals are likely to shy away from treatment due to the military's institutional culture. This in turn raises their chances of developing chronic PTSD and other associated disorders, increases the likelihood of not being diagnosed correctly, and endangers their eligibility for VA health care and benefits.

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encouraged to separate Soldiers who fail to respond successfully to rehabilitation, "except under the most extraordinary circumstances." *Id.*

[101] Hoge et al., *supra* note 3, at 1028.

[102] Message, 251027Z Dec 08, Pentagon Telecomms. Ctr., subject: ALARACT 314/2008-Post-Deployment Health Reassessment (PDHRA) Screening Guidance for Commanders of Active Component (AC) Soldiers.

[103] Milliken et al., *supra* note 95, at 2146. In the Army, referral to alcohol treatment "triggers automatic involvement of a [S]oldier's commander" and makes the Soldier vulnerable to punishment or separation from the military if the Soldier fails to meet the program's requirements. *Id.*; *see also* AR 600-85, *supra* note 100. The Army's "Limited Use Policy" is designed to encourage Soldiers to self-refer for substance abuse problems by prohibiting the use of certain evidence related to substance abuse against a Soldier in punitive actions under the UCMJ or to determine the characterization of discharge. *Id.* para. 6-3. However, the Soldier's command may still initiate separation proceedings for substance abuse upon receipt of information regarding the Soldier's substance abuse. *Id.* para. 6-4(e). A counselor in the rehabilitation program is not prohibited from revealing to the commander that the Soldier committed "certain illegal acts which may compromise or have an adverse impact on mission, national security, or the health and welfare of others." *Id.* para. 6-4(b). Further, information regarding the Soldier's current possession or use of illegal drugs or commission of an offense while under the influence of alcohol or illegal drugs is not covered under this policy. *Id.*; Friedman, *supra* note 2, at 589.

[104] In an early study of servicemembers returning from Iraq, only twenty-three to forty percent of those who screened positive for a mental health concern pursued treatment, in large part because of fear of stigmatization, loss of confidence from peers, and appearing weak. Hoge et al., *supra* note 32, at 13, 16, & 21; *see also* Friedman, *supra* note 2, at 589; Jacqueline M. Hames, *Army Reducing Stigma of Psychological Care, Offering Telepsychiatry* (May 7, 2008), *available at* http://www.army.mil/-news/2008/05/07/9013-army-reducing-stigma-of-psychological-care-offering-telepsychiatry/ (discussing new Army initiatives to provide mental health care to deployed Soldiers in remote locations while reducing the stigma associated with such treatment).

2. Relationship Between Traumatic Brain Injury and PTSD

Researchers have long debated what factors may increase the probability of developing PTSD, but no method exists that would profile potential PTSD patients accurately.[105] The risk of developing PTSD is particularly acute among Soldiers who suffered a traumatic brain injury (TBI) in combat.[106] The DoD estimates that TBI comprises 22% of combat casualties in OIF and OEF, and up to 80% of Soldiers in theater may have experienced "other blast injuries."[107] Unlike PTSD, clinicians measure the severity of TBI in terms of the nature of the injury, such as loss of consciousness or loss of memory, rather than the severity of symptoms.[108] Although TBI and PTSD are assessed differently, the two conditions are closely affiliated, in large part because TBI may affect the areas of the brain implicated by PTSD.[109] Further, TBI may actually cloak the effects of PTSD because individuals with severe TBI may suffer from "post-traumatic amnesia," which may temporarily block the intrusive nightmares or flashbacks that are symptomatic of PTSD.[110]

In response to the massive numbers of TBI cases occurring in OIF and OEF, DoD launched a mandatory training program in the summer of 2007.[111] This program, administered in one- to two-hour sessions, teaches Soldiers how to recognize "the symptoms associated with TBI

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[105] Gover, *supra* note 3, at 566. Factors linked to susceptibility for developing PTSD include "family history, . . . childhood experiences[,] and preexisting mental conditions." *Id.*; *see also* Nat'l Ctr. for PTSD, U.S. Dep't of Veterans Affairs, How Common Is PTSD?, *available at* http://www.ptsd.va.gov/public/pages/how-common-is-ptsd.asp (last visited Mar. 25, 2010) [hereinafter Fact Sheet, How Common is PTSD?] (indicating that an individual's ethnicity, level of education, sex, age, and use of alcohol may also increase the likelihood of developing PTSD).

[106] E. Lanier Summerall, Nat'l Ctr. for PTSD, U.S. Dep't of Veterans Affairs, Traumatic Brain Injury and PTSD, *available at* http://www.ptsd.va.gov/professional/pages/traumatic-brain-injury-ptsd.asp (last visited Mar. 25, 2010) [hereinafter Fact Sheet, TBI and PTSD].

[107] *Id.*

[108] *Id.* The DoD uses the American College of Rehabilitation Medicine criteria for rating a TBI as mild, moderate, or severe. *Id.*

[109] *Id.*

[110] *Id.* Conversely, since individuals with TBI may appear to have the same behavioral symptoms of PTSD, studies indicate a high rate of "false positives" for PTSD that may not be ascertained from a cursory screening alone. *Id.*

[111] Charlie Reed, *PTSD and TBI Awareness Programs Launched*, STARS & STRIPES (Mideast), Nov. 5, 2007, http://www.stripes.com/article.asp?section=104&article=57571&archive=true.

and PTSD."[112] Although both injuries have become the "hallmark injuries" of OIF and OEF,[113] Soldiers suffering from TBI do not share the same reticence in seeking treatment as PTSD-afflicted Soldiers. This discrepancy is due, in part, to the fact that TBI is viewed as a physical injury and not a mental health issue. In the minds of some Soldiers, mental health issues, such as PTSD, are shameful, weak conditions.[114]

The DoD needs to place the same amount of emphasis on identifying and treating PTSD as it does TBI. Specifically, DoD needs to educate Soldiers and commanders that PTSD is a legitimate medical condition, and diagnosis does not warrant shame or stigma. Without diagnosis and treatment, PTSD's symptoms and other comorbid disorders may overwhelm the Soldier. Consequently, unable to assimilate and act "normally," the Soldier's condition manifests through misconduct, violence, substance abuse, and other seemingly unrelated behaviors. The more troublesome a Soldier's behavior becomes, the more likely a commander will view the Soldier as a liability to his unit. The Soldier's commander may decide to separate the Soldier from the military administratively. Depending on the circumstances, the character and basis of the discharge may effectively end the Soldier's eligibility for further benefits as a veteran. The Soldier who risked his life in combat, in some instances, returns home only to become a casualty of the system.

III. Separation from Service

Commanders separate Soldiers from military service through several channels: voluntary separation at the end of a duty tour, an unfavorable discharge following criminal proceedings, and involuntary separation under administrative procedures are the primary methods. The Army's regulation governing active duty enlisted administrative separations, AR 635-200, establishes the procedural framework for administratively separating Soldiers for a variety of circumstances, including misconduct, personality disorders, and substance abuse.[115] A Soldier's administrative discharge may be characterized by one of three categories: honorable,

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[112] *Id.* This training may be accessed at www.army.mil. Army Knowledge Online homepage, *available at* http://www.army.mil (last visited June 11, 2010) (follow "PTSD/TBI Chain Teaching Program" hyperlink; then follow "Strategic Messages" hyperlink).
[113] *Id.*
[114] Friedman, *supra* note 2, at 589.
[115] AR 635-200, *supra* note 4.

general under honorable conditions, and under other than honorable conditions.[116] Among other effects, the type of discharge dictates eligibility for post-separation benefits provided by the VA.[117]

A. Eligibility for Veterans Benefits

Congress established the VA in 1930 to "consolidate and coordinate government activities affecting war veterans."[118] Congress designed veterans' benefits to serve as "a means of equalizing significant sacrifices that result directly from wartime military service."[119] Today, the VA provides a wide range of support and benefits to veterans, regardless of wartime service, and their families, primarily through the Veterans Benefits Administration (VBA).[120] Additionally, the Veterans Health Administration (VHA) operates a nation-wide system of medical support encompassing a wide range of services.[121] The VA administers benefits in accordance with rules prescribed by the Secretary of VA in the Code of Federal Regulations (C.F.R.).[122]

The VA adjudicates claims for benefits by first determining a veteran's eligibility.[123] Only those individuals who served in the active military and received a discharge "under conditions other than dishonorable" meet the threshold determination of eligibility.[124] The

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[116] *Id.* para. 3-7. Army Regulation 635-200 advises that an OTH discharge is "normally appropriate" where misconduct serves as the basis. *Id.* para. 4-13.

[117] *Id.* para. 3-6; *see also* 38 U.S.C. § 101(2) (2006) (defining "veteran," in terms of eligibility for VA benefits, as "a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable"). An OTH discharge deprives a veteran of most of the benefits afforded to a veteran with an honorable discharge and causes substantial prejudice in civilian life, particularly when seeking employment. Statutes prevent veterans with an OTH discharge from reenlisting in the Reserves or National Guard, seeking educational assistance, or accessing benefits under the G.I. Bill. 10 U.S.C. §1150 (2006), 38 U.S.C. §1411, 3011 (2006).

[118] M21-1 PROCEDURES, *supra* note 43, at 1-D-2.

[119] PRESIDENT'S COMM'N ON VETERANS' PENSIONS, VETERANS' BENEFITS IN THE UNITED STATES 10 (1956), *available at* http://www.vetscommission.org/Bradley_Report.pdf [hereinafter BRADLEY COMMISSION REPORT].

[120] *Id.* at 1-I-2.

[121] *Id.* The VHA provides inpatient and outpatient care, as well as residential and in-home care programs. *Id.*

[122] *Id.* at 3-I-1.

[123] *Id.* at 6-1.

[124] *Id.*; *see* 38 C.F.R. § 3.12 (2010) (defining character of discharge needed for purposes of eligibility for veterans benefits); *see also* U.S. Dep't of Veterans Affairs, Fact Sheet

VA's use of the character of an individual's discharge as the threshold determination for eligibility traces back to The Economy Act of 1933, which stated that only individuals with a period of active service terminated by an honorable discharge were eligible for VA benefits.[125] Congress liberalized this requirement in the Servicemen's Readjustment Act of 1944, in part due to the number of World War II veterans who received administrative separations that were not characterized as "honorable."[126] Instead, the Readjustment Act gave the VA the discretion to determine what discharges were considered "dishonorable," which is the criteria reflected in the current 38 C.F.R. § 3.12 and 38 U.S.C. § 5303(a).[127]

The VA's discretion to determine the standard for eligibility remains relatively unchanged. Individuals with an OTH discharge who meet the disqualifying criteria of 38 C.F.R. § 3.12[128] are ineligible for VA compensation but may retain eligibility for health care for service-connected disabilities unless subject to one of the statutory bars in 38 U.S.C. § 5303(a).[129] If the 38 U.S.C. § 5303(a) bars to eligibility apply, however, the Soldier loses all benefits. The effects are tangible: in 2005, the VA determined that 100,781 veterans were dishonorably discharged

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16-8, Other Than Honorable Discharges, Fact Sheet 16-8 (Mar. 2010), http://www.va.gov/healtheligibility/Library/pubs/OtherThanHonorable/OtherThanHonorable.pdf [hereinafter Fact Sheet, OTH Discharges]. An individual with an honorable or general discharge is qualified for VA benefits, whereas an individual with an OTH discharge may be disqualified depending on the basis for the discharge. *Id.*

[125] Donald E. Zeglin, *Character of Discharge: Legal Analysis*, *in* VETERANS' DISABILITY BENEFITS REPORT, *supra* note 41, at A-4.

[126] *Id.*

[127] *Id.* at A-5.

[128] 38 C.F.R. § 3.12. Under this regulation, discharge for one of the following offenses is considered to have been issued under dishonorable conditions: acceptance of an undesirable discharge in lieu of general court-martial; mutiny or spying; an offense involving moral turpitude (generally, a felony conviction); willful and persistent misconduct; and homosexual acts involving aggravating circumstances or other factors affecting the performance of duty. *Id.* § 3.12(d).

[129] 38 U.S.C. § 5303(a) (2006). For purposes of health care, the servicing VA office determines whether the claimed injury has a service connection. M21-1 PROCEDURES, *supra* note 44, at 1-D-2. For claims of PTSD, establishing a service connection requires "credible evidence that the claimed in-service stressor occurred[,] medical evidence diagnosing the condition [in conformance with the DSM-IV and findings in the examination report] and[,] a link, established by medical evidence, between current symptoms and an in-service stressor." *Id.* Although a claimant's testimony may be sufficient to establish a service connection, the adjudication manual emphasizes that "primary evidence," or written records and other documents, is preferable. *Id.* at 1-D-6.

for VA purposes.[130] These numbers are likely to grow with the number of Soldiers afflicted with PTSD.[131]

B. Statutory Bars under 38 U.S.C. § 5303(a)

Prior to 1977, all individuals with discharges characterized as dishonorable were barred from all VA benefits.[132] However, Congress liberalized eligibility requirements for VA benefits in 1977 with Public Law 95-126, providing that individuals who meet the disqualifying criteria of 38 C.F.R. § 3.12, but not the statutory bars of 38 U.S.C. § 5303(a), retained eligibility for health care benefits for service-connected disabilities.[133] The bars to benefits under both 38 U.S.C. § 5303(a) and 38 C.F.R. § 3.12 do not apply if the VA makes a determination of insanity for the period of time during which the offense causing the discharge occurred.[134]

Public Law 95-126's stated purpose was to deny VA benefits to certain veterans who received upgraded discharges for certain offenses during the Vietnam era.[135] When President Jimmy Carter signed Public Law 95-126, he expressed concerns that the provisions raised "serious equal protection problems," particularly with regard to individuals whose records indicated that they were absent without leave (AWOL) for more than 180 consecutive days.[136] For instance, if an individual received an OTH discharge for an AWOL that is less than 180 days, that individual retained health care benefits, at a minimum.[137] If, however, the AWOL leading to the OTH discharge exceeded 180 days, legislation bars receipt of all benefits, unless the Soldier can prove "compelling circumstances"

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[130] VETERANS' DISABILITY BENEFITS REPORT, *supra* note 41, at 6. The VA compiled these results out of 46,476,819 veterans' records. *Id.*

[131] Simonson, *supra* note 40, at 1179. Numbers of veterans receiving VA benefits for PTSD grew 125% between 1999 and 2006. *Id.* at 1178. An additional 400,000 veterans of OIF and OEF are expected to eventually apply for veterans benefits. *Id.* at 1179.

[132] Jimmy Carter, Veterans Benefits Statement on Signing S. 1307 Into Law (Oct. 8, 1977), http://www.presidency.ucsb.edu/ws/print.php?pid=6771 [hereinafter Carter Statement].

[133] Pub. L. No. 95-126, 91 Stat. 1106 (1977) (codified as amended at 38 U.S.C. § 5303); Zeglin, *supra* note 125, at A-7.

[134] 38 U.S.C. § 5303(b); 38 C.F.R. § 3.12(b) (2010).

[135] Pub. L. No. 95-126, 91 Stat. 1106 (1977) (codified as amended at 38 U.S.C. § 5303).

[136] Carter Statement, *supra* note 132.

[137] 38 C.F.R. § 3.12(c)(6).

for the AWOL or insanity at the time of the offense.[138] Given the close correlation between PTSD and misconduct, particularly avoidance-type behavior, such as AWOL, a PTSD-afflicted Soldier may be barred from all benefits, including health care, unless he can show that his condition amounted to insanity.

Congress needs to amend 38 U.S.C. § 5303(a) for several reasons. The legislative history regarding VA eligibility demonstrates a desire to provide benefits to a larger class of veterans, particularly with regard to treatment of service-connected disabilities.[139] In 1956, the Bradley Commission Report on Veterans' Benefits in the United States recommended to the President that "an undesirable discharge," now an OTH discharge, should not render an individual ineligible for health care if the individual suffered a service-connected disability under circumstances unrelated to the discharge.[140] Current legislation has the opposite result by ignoring the fact that PTSD may be a service-connected disability because of its debilitating effects, that it is often incurred in combat operations, and that PTSD manifests through misconduct, violence, and substance abuse. Further, in some instances, the severity of PTSD may qualify as insanity under the regulatory definition. However, asserting a defense of insanity to overcome a statutory or regulatory bar to benefits is a seemingly insurmountable hurdle under the current interpretation.

1. Insanity as an Exception to Statutory and Regulatory Bars

For purposes of VA eligibility, 38 C.F.R. § 3.354 defines an insane person as

> one who, while not mentally defective or constitutionally psychopathic . . . exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack adaptability to make

[138] *Id.* § 3.12(b), (c)(6).
[139] *See infra* Part IV.C.
[140] BRADLEY COMMISSION REPORT, *supra* note 119, at 396.

> further adjustment to the social customs of the community in which he resides.[141]

Although the definition seems broad enough to include some cases of PTSD, some individuals believe that PTSD does not—and should not—meet the definition of insanity for purposes of eligibility for VA benefits.[142] Critics believe that PTSD does not compel individuals to engage in misconduct, and to decide otherwise would erode standards of conduct, destroy unit discipline, and dishonor veterans who chose not to engage in misconduct.[143] These arguments, however, are fallacies: since the unpredictable nature of PTSD affects how the brain perceives and processes stimuli, it causes individuals to behave in unpremeditated, uncharacteristic ways.[144] In contrast, Soldiers suffering from TBI likely will not be punished for erratic behavior because TBI is viewed as a "legitimate" physical injury. Critics' arguments against PTSD only confirm the existence of the stigma attached to mental disorders and the continued reticence to view PTSD as an actual injury.

In actuality, PTSD is the ideal condition for meeting the insanity definition, depending on the severity of the symptoms. Because PTSD-afflicted Soldiers may uncontrollably overreact to "danger cues," re-experience their trauma in a dissociative state, or engage in impulsive sensation-seeking or avoiding behaviors, Soldiers suffering from PTSD may satisfy the definition of insanity.[145] A Soldier may satisfy the first prong of the definition by demonstrating that his PTSD symptoms significantly altered his behavior for an extended period of time.[146] Because Soldiers suffering from PTSD consistently show increased aggression, violence, irritability and outbursts of anger, combined with a decreased ability to self-monitor their behavior,[147] many Soldiers have viable arguments that their behavior either "interferes with the peace of society" or is antisocial and lacks the capability for further adjustment.

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[141] 38 C.F.R. § 3.354(a).
[142] Jim Spencer, *Vets Group Stands Tall for Sick GIs*, DENV. POST, May 11, 2007, http://www.denverpost.com/headlines/ci_5867431.
[143] Gregg Zoyora, *Discharged: Troubled Troops in No-Win Plight*; *Marines Kicked Out for Conduct Linked to Stress Disorder Are Often Denied Treatment by the VA*, USA TODAY, Nov. 2, 2006, at A1.
[144] Garcia-Rill & Beecher-Monas, *supra* note 29, at 18.
[145] Constantina Aprilakis, Note, *The Warrior Returns: Struggling to Address Criminal Behavior by Veterans with PTSD*, 3 GEO. J.L. & PUB. POL'Y 541, 555–56 (2005).
[146] 38 C.F.R. 3.354(a).
[147] OIF CLINICIAN GUIDE, *supra* note 3, at 70.

Comorbid substance abuse and depression may also cause further uncharacteristic deviation from behavioral norms.

Despite these considerations, both the Board of Veterans Appeals (BVA) and the CAVC narrowly construe the definition to more closely resemble a definition of mental incapacity used in criminal proceedings. Examining the plain text of the definition reveals that this higher standard is inappropriate in claims for veterans' benefits since these proceedings are merely administrative and have no affect on the individual's service records. However, under the current interpretation, a PTSD-afflicted Soldier stands little to no chance of being considered insane for purposes of VA eligibility.[148]

The CAVC first interpreted the definition of insanity in *Cropper v. Brown*."[149] The Soldier in *Cropper* received an OTH discharge for misconduct and submitted a claim for VA benefits under both the minor-offense exception and the insanity exception.[150] Since the Soldier had been diagnosed with pyromania, substance abuse, and antisocial personality behaviors while on active duty, the court considered whether any of these conditions were sufficient to meet the definition of insanity.[151] The court determined that the insanity defense could not be used where a Soldier received an OTH discharge for "acts of misconduct over which he ultimately had control but failed, in fact, to control."[152] Although the Soldier submitted a psychiatric report stating he had a "long history of impulsive, antisocial behavior[,]" and that he did "not appear to have any sense of responsibility for many of [his criminal] actions[,]" the court concluded that the Soldier's pyromania, substance

[148] Many of the claimants are Vietnam veterans who were diagnosed with PTSD after their separation from service. In one case, a veteran claimed compensation for service-connected PTSD approximately thirty years after his dishonorable discharge. No. 05-14 103, 2008 BVA LEXIS 695, at *1 (BVA 2008). The veteran was separated for misconduct and claimed he was insane at the time of the underlying offenses because he was suffering from PTSD. *Id.* at *1–2. The Board of Veterans Appeals (BVA) rejected the veteran's claim, stating that his PTSD failed to meet the definition of insanity. *Id.* at *16–17. Although a physician diagnosed the veteran with "'war neurosis,'" an antiquated term for PTSD, during active service, the BVA applied the more stringent definition of insanity and found no "competent medical evidence of record" supporting a claim for insanity because he was capable of standing trial for the underlying offenses. *Id.* at *16. Further, the BVA stated that the lack of evidence of "chronic psychiatric" deficiency after service further undermined the veterans' claim. *Id.*

[149] Cropper v. Brown, 6 Vet. App. 450, 452–54 (1994).

[150] *Id.* The court summarily rejected the Soldier's minor-offense argument. *Id.*

[151] *Id.* at 452–53.

[152] *Id.* at 453.

abuse, and antisocial behaviors failed to meet the required level of insanity "such that it legally excuses the acts of misconduct."[153] The regulatory definition, however, requires no such determination.[154]

After *Cropper*, subsequent cases slightly modified the definition of insanity. In *Stringham v. Brown*, the CAVC considered a Soldier's claim for disability compensation for PTSD when the Soldier was discharged under dishonorable conditions for willful and persistent misconduct.[155] Since the characterization of the Soldier's discharge statutorily barred eligibility for VA benefits, the court considered whether the claim fell under any of the statutory exceptions.[156] The court also considered the insanity exception since the Soldier's file indicated a documented diagnosis of service-connected PTSD.[157] The court stated that misconduct leading to discharge and the insanity must share a "simultaneous temporal relationship."[158] The court found that this temporal relationship did not exist in *Stringham* because, although the Soldier's file indicated a diagnosis of service-connected PTSD, there was "simply no medical evidence of record to show a relationship between any mental disease, including PTSD, and the appellant's misconduct."[159] The court was silent, though, regarding whether the severity of the Soldier's PTSD was sufficient to meet the definition of insanity.

The CAVC continued to apply a stringent definition of insanity to other PTSD-afflicted Soldiers' claims for VA benefits in *Struck v.*

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[153] *Id.* at 454–55.
[154] 38 C.F.R. § 3.354(a) (2010).
[155] Stringham v. Brown, 8 Vet. App. 445, 447 (1995). On four instances, the appellant received nonjudicial punishment for absence without leave (AWOL), and on one occasion, the appellant received nonjudicial punishment for failure to obey a lawful order. *Id.* at 445. In 1990, the VA determined that the appellant's PTSD was service-connected for purposes of eligibility for VA health care benefits. *Id.*
[156] *Id.* First, the court determined that the minor-offense exception did not apply because its applicability was limited to single offenses; in this case, the Soldier's discharge was based on several instances of unauthorized absences (AWOL) and failure to obey a lawful order. *Id.* Even if the minor-offense exception could apply to multiple offenses, the court reasoned, these offenses were not minor because, quoting *Cropper v. Brown*, they "were the type of offenses that would interfere with [the] appellant's military duties, indeed preclude their performance, and this could not constitute a minor offense." Cropper v. Brown, 6 Vet. App. 450, 452–53 (1994), *overruled in part by* Struck v. Brown, 9 Vet. App. 145 (1996). *Struck v. Brown* overruled the *Cropper* requirement of a causal connection between the insanity and the misconduct. *Struck*, 9 Vet. App. at 145.
[157] *Stringham*, 8 Vet. App. at 447–48.
[158] *Id.* at 448.
[159] *Id.* at 449.

Brown, even though the court struck down the temporal requirement established in *Cropper*.[160] In *Struck*, a Soldier was separated with an OTH discharge for AWOL.[161] Before his discharge, the Soldier reported to a mental health specialist that he felt suicidal and "that his mind was 'falling apart.'"[162] Physicians diagnosed the Soldier with narcissistic personality disorder, which, according to his psychiatrist, was "part of a character and behavior disorder due to deficiencies in emotional and personality development of such degree as to *seriously impair his function* in the military service."[163] Citing *Cropper*, the court determined that the Soldier's mental condition must rise to the level of severity "such that it legally excuses the acts of misconduct" and that the insanity must exist "at the time of the commission of an offense leading to a person's . . . discharge."[164] Since the Soldier's file contained contradictory evidence that he went AWOL because his unit wasn't "cutting him any slack" for an injured leg, the court concluded that it was reasonable to find the Soldier was not insane at the time he went AWOL.[165]

Both the BVA and CAVC continue to apply a definition of insanity that more closely resembles an affirmative defense in a criminal case,[166] imposing a higher burden on the veteran to show that his condition was so severe that he was unable to appreciate the wrongfulness of his acts. In one recent claim, a claimant's file indicated a diagnosis of PTSD upon returning from Vietnam.[167] The claimant stated that he was "haunted by his experiences in Vietnam," felt "detached from reality," and drank heavily in an effort to escape intrusive thoughts and memories from

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[160] *Struck*, 9 Vet. App. at 147.
[161] *Id.*
[162] *Id.* The Soldier had a history of psychiatric hospitalization for anxiety, schizophrenia, and "marked social inadaptability." *Id.*
[163] *Id.* at 147–48 (emphasis added). Although the Soldier's mental condition pre-existed his entry into military service, a psychiatrist stated that military service was "[o]ne of the main exacerbations of [the Soldier's] mental illness," and after separation, the Soldier was repeatedly hospitalized for "chronic and disabling schizophrenia." *Id.* at 149.
[164] *Id.* at 153–54.
[165] *Id.* at 154–55.
[166] *See, e.g.*, United States v. Long Crow, 37 F.3d 1319 (8th Cir. 1994) (discussing the requirements of establishing insanity as an affirmative defense to a federal charge under 18 U.S.C. § 17 and whether evidence of defendant's PTSD was sufficient to meet these requirements). Generally, the defendant must prove by clear and convincing evidence "that (1) he was suffering from a severe mental disease or defect at the time [of] the charged offenses and (2) that his disease or defect rendered him unable to appreciate the nature and quality or the wrongfulness of his acts." *Id.* at 1323.
[167] No. 06-15 418, 2008 BVA LEXIS 21421, at *13 (BVA 2008).

Vietnam.[168] Unable to assimilate into garrison life after his return, much like the hypothetical SGT Smith, the claimant went AWOL several times, often isolating himself in a motel for a period of "detoxing, dissociating, and reliving combat."[169] Although the veteran was AWOL for a period in excess of 180 days during these binges, the BVA rejected the veteran's claim because there was no evidence that the veteran "experienced prolonged deviation from his normal behavior; or interfered with the peace of society; or became antisocial."[170] Further, the BVA cited that there were no findings that he had been "adjudicated incompetent" or that he suffered from any psychiatric conditions before entry to service, [171] although the existence of such condition would most likely render the veteran ineligible for benefits as well. Finally, the BVA emphasized that a substance-abuse disorder, regardless of severity, did not fall within the scope of insane behavior, even though the claimant's record indicated that disorder appeared at the same time as his PTSD symptoms.[172]

Even in a case where the veteran had a well-documented diagnosis of service-connected PTSD in which a physician considered the condition so severe as to warrant consideration for medical discharge, the BVA found that the severity was insufficient to render the claimant "insane" for purposes of VA eligibility.[173] Although the BVA acknowledged that the claimant had mental difficulties as a result of the PTSD, it found that a diagnosis of PTSD is not "the equivalent of insanity."[174] Admittedly, assertion of PTSD should not result in an automatic finding of insanity without assessing the facts; however, VA boards and courts have

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[168] *Id.*
[169] *Id.*
[170] *Id.* at *16, *19.
[171] *Id.* at *14.
[172] *Id.* at *16–17.
[173] No. 06-38 748, 2008 BVA LEXIS 10866, at *16 (BVA 2008). The claimant received an OTH discharge for "willful and persistent misconduct," consisting of two periods of AWOL and use of illegal drugs. *Id.* at *1–2. A physician opined that the claimant began experiencing PTSD symptoms shortly after returning from Vietnam, which was the same period during which the claimant committed his acts of misconduct. *Id.* at *16–17.
[174] *Id.*; *see also* No. 05-37 442, 2008 BVA LEXIS 19258, at *22 (BVA 2008) (holding that, although compelling evidence existed to support a diagnosis of PTSD and anxiety disorder, combined with uncharacteristic incidences of AWOL and injury to claimant's self after return from Vietnam, "such facts do not establish 'insanity' for VA purposes").

demonstrated a determined resistance to use a definition of insanity that is more appropriate for administrative proceedings.[175]

One finding, however, may indicate a potential shift in analysis regarding whether PTSD may rise to the level of insanity required by statute and regulation. In *Henry v. Nicholson*, a 2007 CAVC case, a physician diagnosed a Vietnam veteran with "anxiety, depression, and apparent passive-aggressive traits" during service, as well as PTSD after separation for misconduct.[176] Although the BVA noted that the veteran's in-service psychiatric evaluations indicated that he would "stare out into space, sit for long periods of time, would not respond to orders to shower, clean self, etc.," the BVA summarily determined that the statute and regulations barred the veteran from VA benefits due to the character of his discharge for misconduct and that his PTSD did not qualify as insanity.[177] Reviewing the BVA decision under a "clearly erroneous standard," the court ruled that the BVA failed to apply the "expansive definition" of insanity found in 38 C.F.R. § 3.354 when it determined the veteran was not insane at the time of the offenses.[178] Whether this claim represents an actual change in analysis or merely an aberration remains to be seen.

2. VA General Counsel Opinion Regarding Insanity Parameters

In addition to a judicial narrowing of the definition of insanity, the VA General Counsel also analogized the seemingly expansive definition

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[175] In 2006, on appeal from the BVA to the CAVC, one veteran separated with an OTH discharge for misconduct argued that an exception should be made specifically for misconduct caused by PTSD. Marret v. Nicholson, 2006 U.S. App. Vet. Claims LEXIS 841, at *1 (2006). The Secretary of VA argued that PTSD was insufficient to rise to the level of insanity that would qualify as an exception to reinstate eligibility for VA benefits; the court agreed, and the BVA's decision to deny eligibility was affirmed. *Id.* at *1–3; *see also* Henry v. Nicholson, 2007 U.S. App. Vet. Claims LEXIS 52 (2007) (holding that PTSD was insufficient to overcome the statutory bar related to OTH discharges for misconduct); Mudge v. Nicholson, 2006 U.S. App. Vet. Claims LEXIS 1495 (2006) (holding that PTSD was not a compelling circumstance to excuse AWOL and was insufficient to show that the claimant was insane or unable to determine right from wrong).

[176] *Henry*, 2007 U.S. App. Vet. Claims LEXIS, at *2–3. The CAVC remanded this case to the BVA, and appellant is currently awaiting a rehearing.

[177] *Id.* at *3–5.

[178] *Id.* at *6.

to the more rigorous standard for mental capacity.[179] Although the CAVC held that a determination of insanity requires an examination of the facts and circumstances surrounding the particular case,[180] the VA General Counsel's opinion reflects a very different stance. In essence, the opinion establishes a blanket prohibition on applicability of insanity to certain conditions, many of which are manifestations or associated disorders of PTSD.

First, the VA General Counsel's opinion reiterates the court's ruling in *Winn v. Brown*[181] that personality disorders will not qualify as "a disease," as required by the regulatory definition, because it is not a disease for VA compensation purposes.[182] Further, the opinion states that, although substance abuse may be considered a compensable disease for purposes of disability, a substance abuse disorder does not constitute insanity because the conduct associated with the disorder "does not exemplify the gross nature of conduct which is generally considered to fall within the scope . . . of insanity."[183] Finally, the VA General Counsel determined that all three clauses of the definition must be interpreted "in light of the commonly accepted meaning of the term [insanity]" to mean "such unsoundness of mind or lack of understanding as prevents one from having the mental capacity required by law to enter into a particular relationship, status, or transaction or as excuses one from criminal or civil responsibility."[184] The VA General Counsel bolstered this assertion by stating that Congress's underlying intent regarding the definition of insanity may be presumed from commonly-accepted meanings, which are generally criminal or civil law standards of insanity.[185]

The VA General Counsel's opinion fails, however, to address the inconsistency between the purpose behind other insanity standards and the administrative standard: the definition of insanity for purposes of criminal or civil responsibility is intentionally rigorous because the individual asserting insanity seeks to be absolved of liability for his wrongdoing. For purposes of VA eligibility determinations, though, the

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[179] Definition of Insanity in 38 C.F.R. § 3.354(a), 20 Op. Vet. Admin. Gen. Counsel 5 (1997) [hereinafter VA Gen. Counsel Opinion].
[180] Stringham v. Brown, 8 Vet. App. 445, 448 (1995).
[181] Winn v. Brown, 8 Vet. App. 510 (1996).
[182] VA Gen. Counsel Opinion, *supra* note 179, at 11.
[183] *Id.*
[184] *Id.*
[185] *Id.*

VA uses a finding of insanity to determine whether the Soldier should receive healthcare and other benefits for his military service. The individual's underlying misconduct is not absolved, and the character of his discharge is not changed upon a finding of insanity.

The opinion also ignores the legislative and regulatory history of the definition of insanity. Since the U.S. Veterans' Bureau first defined the term in 1926 as "a persistent morbid condition of the mind characterized by a derangement of one or more of the mental faculties to the extent that the individual is unable to understand the nature, full import and consequences of his acts, and is thereby rendered incapable of managing himself or his affairs,"[186] legislators have revised the definition several times.[187] With each revision, the definition has grown more expansive and shifted farther away from the more stringent definition applied in criminal proceedings. Yet, in light of this growing expansiveness, numerous VA decisions quelled the application of a broader interpretation.

Although the Secretary of the Department of Veterans Affairs possesses the authority to prescribe all necessary rules and regulations with respect to adjudication of veterans' claims, as well as "the nature and extent of proof and evidence" required to establish eligibility for benefits,[188] he is unlikely to do so for veterans with OTH discharges for several reasons. First, bureaucratic institutions must overcome a great amount of inertia to make substantive changes to existing rules and regulations. These changes may also require significant coordination within the institution as well as public comment—a time-consuming

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[186] *Id.* General Order No. 348 was published on 20 April 1926.

[187] Within the same year, this definition was replaced with a determination that "a person will be deemed insane when he is mentally incapable of attending to his affairs." *Id.* General Order No. 348-A was published on 21 July 1926. *Id.* The following year, the definition was redefined to require a "prolonged deviation from normal behavior"—similar to the current definition—that rendered the individual "incapable of managing his own affairs or transacting ordinary business." *Id.* General Order No. 348-C was published on 26 October 1927. *Id.* The definition offered an additional basis of showing insanity if the person were "dangerous to himself, to others, or to property." *Id.*; *see also* Zang v. Brown, 8 Vet. App. 246, 254 (1995) (noting that Congress excised the provision regarding incompetency in 38 U.S.C. § 3.354 and moved the provision to 38 U.S.C. § 3.353(a)).

[188] 38 U.S.C. § 501(a) (2006).

process.[189] Further, the VA has no incentive to make a change that would flood the system with more eligible veterans given its current under-resourced, overwhelmed state, particularly in light of the projected growth of veterans needing healthcare.[190]

3. Limitations Under the VJRA Framework

In addition to an overwhelming number of VA cases imposing strict, if not insurmountable, insanity criteria, the VA adjudication framework is an additional barrier to fair and accurate adjudication of veterans' claims. The adjudication process begins when a veteran files a claim for benefits at a VA regional office.[191] The claimant may appeal a decision from the regional office to the BVA, which either remands the claim "for further development" or issues "the final decision of the Secretary."[192] The claimant may subsequently appeal BVA decisions to the CAVC, an Article I court with exclusive jurisdiction over BVA appeals.[193] Under the VJRA, a claimant has limited opportunity to appeal to the U.S. Court of Appeals for the Federal Circuit for issues relating to interpretation of "constitutional and statutory provisions."[194] The VJRA prohibits judicial review of VA decisions or statutes in any other court except the U.S. Supreme Court.[195] Therefore, a limited opportunity exists for an objective reassessment of a Soldier's claim.

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[189] The Administrative Procedure Act, 5 U.S.C. §§ 552–54 (2006), requires independent and executive agencies to inform the public about procedures and rules and to allow public participation in the rulemaking process.

[190] Bruce Patsner et al., *The Three Trillion Dollar War: The True Cost of the Iraq Conflict*, 11 DEPAUL J. HEALTH CARE L. 359 (2008) (book review). The authors of the book project that, by 2012, 1.8 million veterans will be eligible for VA health care. *Id.* at 363. In 2000, the VA backlog of initial claims for VA benefits was 228,000; in 2007, the total number of claims exceeded 600,000. *Id.* at 365. Additionally, the VA must account for an increase of at least $5.2 billion in benefits payments over ten years due to more relaxed documentation rules for establishing service-connected PTSD, creating a greater number of veterans eligible for benefits. O'Keefe, *supra* note 14, at 2.

[191] Slater v. U.S. Dep't of Vet. Aff., 2008 U.S. Dist. LEXIS 32440, at *12 (M.D. Fla. Mar. 20, 2008); *see also* Landy F. Sparr et al., *Veterans' Psychiatric Benefits: Enter Courts and Attorneys*, 22 BULL. AM. ACAD. PSYCHIATRY & L. 205, 207–08 (1994) (describing the adjudication process at each level, starting with the initial review of the claim for eligibility at a regional office to the decision by the U.S. Court of Appeals for the Federal Circuit).

[192] *Slater*, 2008 U.S. Dist. LEXIS 32440 at *12.

[193] *Id.* at *12–13.

[194] *Id.* at *13–14.

[195] *Id.*

Veterans' lack of recourse outside of the VJRA statutory framework is problematic in several respects. First, the regional offices and BVA follow the guidance of the VA Secretary and General Counsel, who have both narrowly restricted application of the insanity exception.[196] Second, upon appeal, CAVC reviews BVA decisions under a "clearly erroneous" standard of review, which requires the court to uphold all factual determinations "if there is a plausible basis in the record."[197] This standard of review is extremely deferential to the BVA unless it literally fails to consider the facts of the case at all.

Constitutional challenges of the underlying statutes face a further obstacle: the U.S. Supreme Court has never answered the question whether applicants for government benefits have property rights in benefits that have not been awarded.[198] The Supreme Court has acknowledged, though, that when applicable statutes and regulations are silent as to notice and opportunity to be heard, such due process is implicit "[when] viewed against our underlying concepts of procedural regularity and basic fair play[.]"[199] Even with this implied right to due process, veterans have little chance of overcoming an adverse decision under the current statutory framework. To some extent, veterans are provided due process when filing claims for benefits because a veteran has an opportunity to be heard by both the regional office reviewing the claim and the BVA on appeal.[200] However, the opportunity for due process in claims adjudication appears to have little value if the CAVC and the VA General Counsel adhere to a flawed insanity standard.

IV. Recommended Changes to Legislation

Congress and the military must amend current legislation to afford equitable relief to Soldiers with service-connected PTSD who are currently barred from health care access. They can achieve this objective with a combination of the following specific measures.

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[196] VA Gen. Counsel Opinion, *supra* note 179, at 3.
[197] Stringham v. Brown, 8 Vet. App. 445, 447–48 (1995).
[198] Thurber v. Brown, 5 Vet. App. 119, 122 (1993). The Supreme Court has only recognized "continued receipt" of veterans' benefits as a constitutionally-protected property interest under the Fifth Amendment. *Id.* at 122–23.
[199] Gonzales v. United States, 348 U.S. 407, 411–12 (1955).
[200] Sparr et al., *supra* note 191, at 207–08.

A. Equitable Relief

Generally, courts provide equitable relief "only sparingly," and this remedy is often extended to parties that detrimentally relied on the conduct of another party when a remedy does not exist elsewhere in the law.[201] With regard to VA benefits, entitlement is "established by service to country at great personal risk."[202] Today, Soldiers voluntarily enter service and risk their lives in combat operations in Iraq and Afghanistan. Through no fault of their own, Soldiers may incur disabilities in the course of that service and rely on the assurance that the VA system will identify and treat their service-connected injuries. When the VA denies Soldiers' claims, Soldiers have no remedy beyond the VJRA framework. Further, Soldiers may be misdiagnosed, fail to acquire documentation of a service-connected condition, or fall short of realizing the impact of the discharge characterization until access to health care is barred.

Recognizing the vulnerability of veterans, the court in *Friedman v. United States* expressed similar concerns over the statute of limitations in military disability compensation cases and offered equitable relief.[203] The court, seeking to protect veterans who either did not know they were injured or failed to appreciate the severity of their injury at the time of separation from service, wanted to ensure that the rules for presenting disability claims "are fair to the plaintiff in giving him adequate time to bring suit and to protect his rights in court."[204] The court acknowledged the equitable nature of its decision but determined that the rights of veterans deserved protection.[205]

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[201] Cintron v. West, 13 Vet. App. 251, 257 (1999) (discussing equitable tolling of filing notices of appeal for veterans benefits).

[202] *Thurber*, 5 Vet. App. at 123 (citing Walters v. Nat'l Ass'n of Radiation Survivors, 473 U.S. 305, 333 (1985), *superseded by statute*, Veterans' Judicial Review Act of 1988, Pub. L. No. 100-687, 102 Stat. 4105).

[203] Friedman v. United States, 310 F.2d 381 (1962). The court in *Friedman* introduced the First Competent Board Rule, which permits a veteran to raise a claim for disability compensation after separation if the veteran was separated without a physical evaluation board (PEB) determination of fitness for active duty. *Id.* at 396.

[204] *Id.* at 402.

[205] Raymond J. Jennings, Friedman v. United States, *the First Competent Board Rule and the Demise of the Statute of Limitations in Military Physical Disability Cases*, ARMY LAW., June 1994, at 25, 31. The author, however, criticizes the court for incorrectly focusing on whether the veteran had notice of future disability rather than knowledge of an existing disability at time of separation. *Id.*

In the context of veterans who received an OTH discharge for misconduct while suffering from service-connected PTSD, an equitable remedy is needed to ensure "procedural regularity and basic fair play."[206] These Soldiers suffered an injury while in service, and their acts of misconduct may be directly attributed to this injury.[207] As in *Friedman*, many Soldiers not previously diagnosed with PTSD may leave service without knowing that they are suffering from PTSD, or failing to appreciate the severity and complexity of their condition.[208] Further, PTSD is directly linked to substance abuse, misconduct, and acts of violence.[209] These Soldiers may discover that they are ineligible for benefits when they seek treatment after separation and, further, that they have no recourse. Since the BVA and courts within the VJRA framework have already narrowly construed the definition of insanity in VA disability cases, these courts will likely continue to consistently apply the more stringent definition in accordance with the VA General Counsel's opinion.

Congress should apply the same equitable rationale used by the court in *Friedman* and revise 38 U.S.C. § 5303(a) to permit access to health care for service-connected disabilities. In the alternative, the VA should amend 38 C.F.R. § 3.354(a) to require application of a more expansive definition of insanity. This amendment must expressly state that PTSD falls within the parameters of the definition. Otherwise, legislation bars receipt of benefits because of the character and underlying basis of a veteran's discharge, which is potentially based on acts of conduct or behaviors attributable to his medical disability. This legislation would not only afford PTSD-afflicted Soldiers the equitable relief that they deserve but would also benefit society as a whole.[210]

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[206] Gonzales v. United States, 348 U.S. 407, 411–12 (1955).

[207] A determination of this causal connection is best made by a diagnosing clinician during the claims adjudication process.

[208] The disorder often follows a "fluctuating course" of "relapses and remissions." Friedman, *supra* note 2, at 662.

[209] OIF CLINICIAN GUIDE, *supra* note 3, at 24.

[210] Statistics show that untreated servicemembers increase economic costs to society. CHRISTINE EIBNER, INVISIBLE WOUNDS OF WAR: QUANTIFYING THE SOCIETAL COSTS OF PSYCHOLOGICAL AND COGNITIVE INJURIES (June 12, 2008), *available at* http://www.rand.org/pubs/testimonies/CT309/ (reprinting testimony before the House Joint Economic Comm). The author estimated that, over a two-year period, the post-deployment costs resulting from PTSD for 1.64 million servicemembers was $1.2 billion. *Id.* at 7. The study analyzed the costs of immediate medical treatment, as well as the societal costs in terms of lost productivity, reduced quality of life, and premature mortality that would accrue to all members of society. *Id.* at 2. The study produced

B. Ramifications of Amending Current Legislation

Requiring application of a more expansive definition of insanity is not without pitfalls; the numbers of claims will likely increase, along with demands and costs on the VA system. The VA system already experiences overwhelming health care demands, and some individuals believe that the system is incapable of handling these current demands, particularly with regard to mental health issues.[211] For instance, in 2007, a record number of claims—over 800,000—flooded the VA system.[212] Of the 263,000 OIF and OEF veterans currently enrolled in the VA system, approximately 52,000 have been diagnosed with PTSD.[213] Without access to healthcare, though, PTSD-afflicted Soldiers face great difficulties in becoming contributing members of society if unable to assimilate and gain employment.

Further, limiting VA benefits to certain types and characterizations of discharges "has been considered to be vital to the good order, discipline, and morale of the military."[214] Critics argue that offering benefits to Soldiers who commit misconduct lessens the "incentive to perform well and faithfully in service."[215] But these assertions ignore the fact that, in cases of misconduct caused by PTSD symptoms, the threat of a less than an honorable discharge would not deter improper behavior. Although these assertions should be taken into account when deciding eligibility for benefits, treating Soldiers for service-connected disabilities—particularly disabilities incurred in combat operations—would not necessarily tarnish the achievements of veterans with honorable discharges. Rather, treatment of PTSD-afflicted Soldiers benefits society. Since violence and aggression are features of PTSD,[216] separating and sending untreated Soldiers into society, where less structure, supervisory control, and oversight exist, endangers the community and creates additional societal costs to taxpayers.[217]

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compelling evidence that PTSD significantly impacts the labor market since it affects servicemembers' ability to return to employment, their work productivity, and their future employment opportunities. *Id.* at 3.

[211] Milaninia, *supra* note 12, at 328.

[212] *Id.*

[213] Patsner, *supra* note 190, at 368 n.20.

[214] Zeglin, *supra* note 125, at A-2.

[215] *Id.*

[216] Gover, *supra* note 3, at 566–67.

[217] EIBNER, *supra* note 210, at 2.

C. Current Pending Legislation Regarding PTSD

A number of current legislative proposals, seeking to protect the benefits of OEF and OIF veterans, point to the timeliness and importance of addressing PTSD-related concerns. Both the Senate and the House of Representatives proposed legislation that would place a moratorium on discharges for personality disorders in response to growing congressional concerns that Soldiers suffering from PTSD and other combat-related mental disorders are either inadvertently or intentionally discharged for a personality disorder.[218] In both instances, legislators recognized the need to ensure that PTSD-afflicted Soldiers receive an accurate diagnosis and treatment plan prior to separation.

Also, with an increasing number of Soldiers reporting PTSD-related symptoms, earlier intervention would help the DoD and VA mental health systems to better meet the needs of these individuals before chronic disorders become entrenched. Since PTSD is closely associated with attrition from military service,[219] diagnosing and treating Soldiers before they leave military service may mitigate the increased burdens on the VA system. The Psychological Kevlar Act of 2007 focuses on this need for early intervention by directing the development of a new plan that would "incorporate preventative and early-intervention measures . . . [to] reduce the likelihood that personnel in combat will develop PTSD or other stress-related psychopathologies, including substance use conditions."[220] The bill gives the Secretary of Defense discretion to develop and implement this plan, which would also include providing periodic updates and training programs designed "to educate and

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[218] Senate Bill 2644 would prohibit a Secretary of a military department from discharging a servicemember for a personality disorder unless the servicemember "has undergone testing by DOD for PTSD, TBI, and any related mental health disorder or injury prior to a final action with respect to the discharge." S. 2644, 110th Cong. (2008). This bill was referred to the Senate Committee on Armed Services in February 2008, but no further action has occurred. House Resolution 3167, titled the Fair Mental Health Evaluation for Returning Veterans Act, addresses similar concerns by imposing a temporary moratorium on discharges for personality disorders except in certain specified cases, such as in instances where the Soldier provided "false or misleading information . . . that is material to discharge for personality disorder." Fair Mental Health Evaluation for Returning Veterans Act, H.R. 3167, 110th Cong. (2007). This resolution was referred to the Subcommittee on Military Personnel in August 2007; no further action has occurred.

[219] Milliken et al., *supra* note 95, at 2145.

[220] The Psychological Kevlar Act of 2007, H.R. 3256, 110th Cong. (2007). This resolution was referred to the Subcommittee on Military Personnel on 25 September 2007, but to this date, no further action has occurred.

promote awareness among [military personnel and] front-line medical professionals and primary care providers . . . about the signs and risks of combat stress . . . ."[221]

Other proposed legislation addresses VA benefits and services provided to veterans with mental health disorders after separation from the military. For example, the Veterans' Disability Benefits Claims Modernization Act addresses requirements for establishing a service connection for PTSD.[222] The Act seeks to establish a presumption of service-connection for PTSD for veterans who deployed in support of a contingency operation, such as OIF or OEF.[223] Currently, in order for a veteran to establish service-connected PTSD, he must have: a current diagnosis of PTSD, credible supporting evidence of occurrence of an in-service stressor, and medical evidence establishing causation between diagnosis and the in-service stressor.[224]

Other legislation addresses VA health care benefits: Senate Bill 2963 specifically addresses the mental health treatment of veterans who served in OIF or OEF.[225] These veterans would be eligible for readjustment counseling and related mental health services through VA health care centers upon request by the veteran.[226] Similarly, Senate Bill

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[221] *Id.*

[222] Veterans' Disability Benefits Claims Modernization Act of 2008, H.R. 5892, 110th Cong. (2008). The Senate received this resolution on 30 July 2008, and referred it to the Committee on Veterans' Affairs.

[223] *Id.*

[224] M21-1MR PROCEDURES, *supra* note 7, at 4-H-5. The proposed legislation would not create an automatic presumption of PTSD, but it would create a presumption that the in-service stressor occurred if the veteran served in support of a contingency operation and the stressor is related to enemy action. H.R. 5892. The July 2010 policy regarding the establishment of a service connection for PTSD does not create a presumption of PTSD, either. O'Keefe, *supra* note 14, at 1. Rather, the new policy requires that veterans be screened by a VA clinician to confirm that the claim of PTSD is "consistent with the location and circumstances of military service and PTSD symptoms." *Id.* Although supporters of the new policy anticipate that the more relaxed requirements will benefit female veterans and veterans in non-combat arms positions, the new policy fails to address the issue of eligibility for benefits. *Id.*

[225] S. 2963, 110th Cong. (2008). On 30 May 2008, the bill was referred to the Committee on Veterans' Affairs. No further action has occurred.

[226] *Id.* Once a veteran requests this counseling, the VA is obligated to provide the mental health referrals and must advise the veteran of his rights to request review of his discharge. *Id.* The bill also directs that, if a veteran commits suicide within two years after separation from the service and had a medical history of PTSD or TBI, the veteran's death will be considered in the line of duty for purposes of survivors' eligibility to burial benefits and Survivor Benefit Plan benefits. *Id.*

2965 explores the possibility of including severe and acute PTSD among the conditions covered by traumatic injury protection coverage under Servicemembers' Group Life Insurance.[227] Additionally, The Veterans Mental Health Treatment First Act addresses long-term treatment of PTSD and comorbid conditions.[228] The Act directs the Secretary of the VA to implement a program of mental health care and rehabilitation for veterans diagnosed with PTSD, as well as PTSD-related depression, anxiety, or substance abuse.[229]

These pending initiatives highlight the need for increased awareness and training for both the medical community and the VA regarding PTSD, and they direct expanded care of PTSD-afflicted veterans. Unlike the VA General Counsel opinion and judicial interpretation of insanity, these initiatives represent a positive movement towards protecting veterans with service-connected PTSD. More immediate changes are needed, however, to ensure that PTSD-afflicted Soldiers would retain access to health care after discharge. Many of these legislative initiatives remain stalled in Congress, and most fail to remedy the current bar to health care access that PTSD-afflicted Soldiers face if separated for misconduct. Further, none of the initiatives addresses the comorbid disorders or behaviors of PTSD; separation for these comorbid disorders may also serve as a barrier to health care access.

D. Recommended Changes to Army Regulations

A Soldier suffering from PTSD risks involuntarily separation on several bases. One basis for separation is for acts of misconduct under Chapter 14 of AR 635-200, which addresses acts ranging from "minor disciplinary infractions" and "pattern[s] of misconduct" to serious offenses, such as drug abuse or desertion.[230] When a commander separates a PTSD-afflicted Soldier for misconduct stemming from PTSD, the Soldier's underlying medical condition essentially serves as a basis for separation. Soldiers separated under Chapter 14 for misconduct

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[227] S. 2965, 110th Cong. (2008). This bill was introduced to the Senate on 1 May 2008 and referred to the Committee on Veterans' Affairs; no further action has occurred.

[228] Veterans Mental Health Treatment First Act, S. 2573, 110th Cong. (2008). This bill was introduced to the Senate and referred to the Committee on Veterans' Affairs on 29 January 2008. To this date, no action has occurred.

[229] *Id.* In order to receive treatment, participating veterans must agree to certain conditions, such as compliance with a specified treatment and rehabilitation plan. *Id.*

[230] AR 635-200, *supra* note 4, para. 14-12.

face a greater likelihood of receiving an OTH discharge and are particularly vulnerable to loss of benefits. Current legislation bars receipt of VA compensation, and potentially health care, when a Soldier receives an OTH discharge.[231]

Although some individuals separated with an OTH discharge may be eligible for a treatment of a service-connected disability in limited circumstances,[232] any discharge issued for "willful or persistent misconduct" constitutes a statutory bar to most benefits.[233] If the misconduct falls under one of the statutory bars of 38 U.S.C. § 5303(a), then the Soldier is precluded from access to health care. In order to remain eligible for VA benefits, a Soldier separated for misconduct with an OTH discharge must show that his claim falls within one of several exceptions: that the Soldier "innocently acquired 100 percent disability" while on active duty,[234] that the discharge was for a "minor offense,"[235] or that he was considered "insane" at the time of the misconduct.[236] Until Congress amends current legislation to permit Soldiers meeting statutory bars to access health care, the only option for PTSD-afflicted Soldiers is to argue that they met the definition of insanity at the time of their misconduct.

Commanders may also recommend separation of a PTSD-afflicted Soldier under Chapter 5-13 of AR 635-200 for a personality disorder.[237] A personality order is defined as "a deeply ingrained maladaptive pattern of behavior of long duration that interferes with the [S]oldier's ability to perform duty."[238] Although a mental health specialist must diagnose the personality disorder prior to separation, PTSD symptoms may be

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[231] 38 U.S.C. § 5303 (2006); 38 C.F.R. § 3.12 (2010). Statutory bars are found in 38 U.S.C. § 5303(a) and are further supplemented by regulatory bars in 38 C.F.R. § 3.12(c) and (d).
[232] 38 C.F.R. § 3.360.
[233] *Id.* § 3.12.
[234] *Id.* § 4.17a.
[235] *Id.* § 3.12(d)(4).
[236] *Id.* § 5303(b); *id.* § 3.354; *see also* Stringham v. Brown, 8 Vet. App. 445 (1995) (discussing the applicability of the minor-offense exception under 38 C.F.R. § 3.12(d)(4) and the insanity exception under 38 C.F.R. § 3.12(b) to claims that are otherwise ineligible for benefits under 38 U.S.C. § 5303). For the minor-offense exception, Soldiers will rarely have a viable claim because courts interpreted this exception to generally apply to single offenses that don't interfere with performance of military duties. Cropper v. Brown, 6 Vet. App. 450, 452–53 (1994).
[237] AR 635-200, *supra* note 4, para. 5-13.
[238] *Id.*

confused with borderline personality and other personality disorders.[239] Soldiers separated for a personality disorder also risk losing eligibility for VA health benefits because VA regulations state that personality disorders are considered "pre-existing conditions" with no service-connection.[240] Soldiers afflicted with PSTD are consequently rendered ineligible for treatment in the VA system.

Further, since substance abuse often accompanies PTSD, Soldiers may be at greater risk for separation for a substance abuse-related issue. Chapter 9 of AR 635-200 provides the procedure for separating a Soldier when he fails an alcohol or substance abuse rehabilitation program.[241] Typically, once a Soldier either self-refers or is command-referred into the Army Substance Abuse Program (ASAP), a commander may involuntarily separate a Soldier "because of inability or refusal to participate in, cooperate in, or successfully complete such a program . . . ."[242] If a Soldier is discharged for a disability relating to the Soldier's alcohol or drug abuse, current legislation bars compensation for that disability unless "caused or aggravated by a primary service-connected disorder."[243] Since substance abuse is a method of coping with intrusive thoughts, nightmares, insomnia, and hyper-alertness that are symptomatic of PTSD,[244] commanders may believe the substance abuse is the Soldier's primary issue. Determining whether substance abuse is the primary issue as opposed to a secondary or related issue to another medical problem is crucial because VA is prohibited from paying disability compensation for alcohol or drug abuse, unless the substance abuse disability is "secondary to or is caused or aggravated by a primary service-connected disorder."[245] Consequently, if PTSD is not diagnosed as the primary disorder, a Soldier discharged for substance abuse alone will be barred from future treatment and benefits.

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[239] C&P GUIDE, *supra* note 30, at 204.
[240] 38 U.S.C. §§ 1110, 1131 (2006); 38 C.F.R. § 3.303 (2010). The House Veterans' Affairs Committee recently discovered that over 22,500 Soldiers were discharged from the military for personality disorders in the last six years. Press Release, House Comm. on Veterans' Aff., "Personality Disorder": A Deliberate Misdiagnosis to Avoid Veterans' Health Care Costs! (July 25, 2007), http://veterans.house.gov/news/PRArticle.aspx?NewsID=111. The Committee expressed concerns that the military may be attempting to save resources by purposefully discharging Soldiers for personality disorders when the Soldiers have legitimate claims for PTSD. *Id.*
[241] AR 635-200, *supra* note 4, para. 9-1.
[242] *Id.* para. 9-2.
[243] 38 U.S.C. § 1110; C&P GUIDE, *supra* note 30, at 210.
[244] Editorial, *supra* note 57, at 1.
[245] C&P GUIDE, *supra* note 30, at 210.

Since the PDHA and PDHRA fail to identify all PTSD-afflicted Soldiers, one method of achieving early intervention is to reexamine current Army regulations governing administrative separations and medical fitness determinations. Currently, the procedure for separation under Chapters 5-13, 9, and 14 varies in several aspects, particularly with regard to the type of medical and mental evaluation afforded to the Soldier. Although AR 635-200 mandates that the Soldier receive a medical and mental evaluation prior to separation under Chapter 14, only Soldiers separated under Chapter 5 for personality disorders or other enumerated mental conditions receive an evaluation by a licensed psychiatrist or similarly accredited mental health specialist.[246] Because the evaluations for separation under Chapter 9 and 14 are less comprehensive, a Soldier who either fails to recognize the presence of PTSD or is too embarrassed to seek treatment for it will likely not have the opportunity to be properly evaluated for PTSD before separation, risking loss of a lifetime of VA health care for his service-connected condition.[247] At a minimum, if a Soldier expresses concerns about PTSD or related symptoms in the PDHA, PDHRA, or during separation screening for Chapter 5, 9, or 14, the Soldier should be referred to a mental health specialist qualified to diagnose PTSD, determine the severity of the condition, and recommend a treatment plan. This information must also be documented in the Soldier's records. If a Soldier is diagnosed with PTSD, his commander should then be required to reevaluate the characterization of discharge and confirm knowledge of this information before selecting a basis and characterization. However,

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[246] AR 635-200, *supra* note 4, paras. 1-32, 5-13, 5-17. For Chapter 14 separations, AR 635-200 requires the mental status evaluation to be conducted by a master-level psychologist or licensed clinical social worker. *Id.* Soldiers separated for personality disorders or other mental conditions under Chapter 5 must be evaluated by a psychiatrist or doctoral-level psychologist "with necessary and appropriate professional credentials who is privileged to conduct mental health evaluations for the DoD components." *Id.*

[247] A more thorough mental health screening, conducted by a mental health specialist with training in combat stress-related disorders, is important for several reasons. First, PTSD is a treatable anxiety disorder; if misdiagnosed as a personality disorder, the Soldier is not eligible for further benefits because his condition will likely not be considered service-connected. Next, PTSD patients are at increased odds for abusing alcohol and drugs, and if they are separated under Chapter 9 for failure of a substance abuse rehabilitation program, they will be barred from veterans' benefits unless their substance abuse is related to another service-connected disability. Additionally, if not treated, PTSD symptoms may develop into misconduct, and the Soldier may be barred from future benefits if separated with an OTH discharge for misconduct. Finally, given the fact that Soldiers are likely to under-report mental health issues due to fear of stigmatization and other barriers in the system, an additional stop-gap measure is needed to identify Soldiers suffering from PTSD.

the commander retains discretion to separate the Soldier and characterize the separation.[248]

In addition to requiring a more rigorous mental health screening in the separation process, AR 40-501 also needs revision. Currently, AR 40-501 prescribes the requirements of a Separation Health Assessment (SHA), conducted before a Soldier is involuntarily separated from active duty.[249] The SHA consists of the Soldier's self-reported health status and an interview with a medical care provider, accompanied by a physical examination.[250] The regulation provides no specifics regarding the mental evaluation, and the SHA may be waived entirely if the Soldier "has undergone a physical examination of assessment within 12 months prior to separation or discharge."[251] Although annual periodic health assessments that encompass screening for traumatic brain injury, substance abuse, and "deployment related health problems" are required for all Army personnel, these assessments are primarily based on a Soldier's self-reported health status and review of the Soldier's medical records.[252] As with the SHA, these periodic assessments, usually performed immediately before or after a deployment, are insufficient to

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[248] *But see* U.S. DEP'T OF DEF., DIR. 1332.14, ENLISTED ADMINISTRATIVE SEPARATIONS (28 Aug. 2008) [hereinafter DODD 1332.14] (implementing new procedural requirements for separating Soldiers under Chapter 5-13). Department of Defense Directive 1332.14 requires corroboration by a mental health specialist and endorsement by the Surgeon General of the Military Department when Soldiers who served or are serving in imminent danger pay areas are diagnosed with personality disorders. *Id.* Department of Defense Directive 1332.14 also requires the mental health specialist to address the comorbidity of PTSD or other mental illness prior to separation. *Id.* Finally, DoDD 1322.14 prohibits separation for personality disorder if the Soldier is diagnosed with service-connected PTSD. *Id.*; *see also* Message, 111948Z Feb 09, Pentagon Telecomms. Ctr., subject: ALARACT 036/2009-Policy Changes for Separation of Enlisted Soldiers Due to Personality Disorder (implementing Army efforts to restructure its diagnosis and separation procedures for Soldiers with PTSD and TBI). These policy changes specify that enlisted Soldiers "who have served or are currently serving in imminent danger pay areas" may only be separated for personality disorder if "a psychiatrist or PhD-level psychologist" diagnoses the personality disorder, the diagnosis is corroborated "by a peer or higher-level mental health professional and endorsed by the Surgeon General of the Army," and a medical review confirms that "PTSD, TBI, and/or other comorbid mental illness" is not a "significant contributing factor to the diagnosis." *Id.* If PTSD, TBI, or other comorbid mental illness is a contributing factor, the Soldier must "be evaluated under the Physical Disability System in accordance with AR 635-200." *Id.*

[249] U.S. DEP'T OF ARMY, REG. 40-501, STANDARDS OF MEDICAL FITNESS (14 Dec. 2007).

[250] *Id.* para. 8-12.

[251] *Id.* para. 8-24.

[252] *Id.* para. 8-20.

identify and diagnose individuals with PTSD because the Soldier must be able to recognize and report his symptoms.[253]

These measures may further identify PTSD-afflicted Soldiers for diagnosis and treatment. Campaign awareness programs are also needed to reduce the stigmatization attached to mental health disorders, particularly PTSD. Finally, although the VA system attempts to provide comprehensive mental health services such as counseling and individualized treatment plans to veterans with PTSD,[254] these services are useless to a Soldier who never received a diagnosis of PTSD. Given the increased efforts that DoD and Congress have made to implement systems that detect and treat PTSD-afflicted Soldiers, the Army must change current regulations to require more rigorous and effective mental health screenings during the separation process.

V. Conclusion

Out of fairness to the Soldier who risked his life in combat, Congress must amend current legislation to ensure that all veterans who suffer from service-connected PTSD are able to obtain treatment regardless of the circumstances under which they were separated from the military. In the alternative, Congress must redefine insanity to include PTSD as a potential exception to statutory and regulatory bars. Although the existing definition appears expansive enough to include PTSD, in application, it requires an inappropriate incapacitation determination. Given the current emphasis on new legislation designed to provide treatment and benefits to PTSD-afflicted Soldiers and veterans, the issue clearly warrants more attention. While the PDHA and PDHRA are steps in the right direction, they do not identify a Soldier's PTSD-related issues accurately.[255] Efforts to detect PTSD in early stages are stymied

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[253] Even if a Soldier reports a medical condition or symptom that is documented in his records, the GAO found that, in some instances, only sixty-six percent of medical records were even available for periodic review. U.S. GEN. ACCOUNTING OFF., GAO-30-997T, DEFENSE HEALTH CARE: ARMY HAS NOT CONSISTENTLY ASSESSED THE HEALTH STATUS OF EARLY-DEPLOYING RESERVISTS 3 (July 9, 2003).

[254] Susan Okie, *Reconstructing Lives—A Tale of Two Soldiers*, 355 NEW ENG. J. MED. 2609 (2006). The author states that approximately eighty percent of recently-discharged OIF veterans are not enrolled in the VA system because the veterans live too far from military or VA facilities to receive frequent treatment. *Id.* at 2615.

[255] Milliken et al., *supra* note 95, at 2146 (showing that, among 804 Soldiers that were referred for mental health concerns, 349, or 43.4%, did not access mental health care services).

by the complexity of the disorder, the individuality of each case, and—in the military—the fear of being stigmatized and appearing weak. Researchers confirm that the effects of PTSD are persistent and wide-ranging,[256] and although disagreements regarding diagnosis and measurement remain,[257] the influx of Soldiers suffering from PTSD is indisputable.[258] Currently, the DoD health care system is unable to diagnose every individual accurately, even when that individual reports PTSD-related symptoms.[259]

Regulatory changes are needed to ensure that a Soldier is not erroneously discharged for the wrong condition and that service-connected PTSD is sufficiently documented for future VA treatment. Both AR 635-200 and AR 40-501 need to incorporate a mandatory PTSD evaluation that will be conducted by a mental health specialist "with necessary and appropriate professional credentials who is privileged to conduct mental health evaluations for the DoD components,"[260] prior to separation under Chapters 5, 9 and 14. A Soldier's and a unit's ability to recognize symptoms is crucial, as well as the capacity to communicate with a mental health specialist to prevent erroneous discharges.[261]

Even with these preventative measures, Soldiers afflicted with PTSD still face a great risk of losing VA benefits and access to health care. The statutory bars encompassed in 38 U.S.C. § 5303(b) preclude Soldiers with an OTH discharge for certain offenses—even if that misconduct is directly related to PTSD—from receiving any benefits, to include health care. Because the VA General Counsel and courts within the VJRA rubric interpreted insanity narrowly, PTSD-afflicted Soldiers have no judicial recourse. Further, the VA has no incentive to change its current interpretation due to the growing demands placed upon the system. Changing judicial access to allow a veteran to appeal to federal district

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[256] Solomon & Mikulincer, *supra* note 1, at 665.
[257] Pols & Oak, *supra* note 17, at 2138.
[258] Gover, *supra* note 3, at 561 (predicting that the number of Soldiers affected by PTSD may equal 1,050,000 as a result of OIF).
[259] Hoge et al., *supra* note 3, at 1030. Utilization of mental health services is higher among OIF veterans, but 23% of the OIF veterans who accessed mental health services in the study did not receive any type of mental health diagnosis. *Id.* Further, although studies showed greater success in identifying Soldiers with PTSD several months after the deployment, 60% of OIF veterans "who screened positive for PTSD, generalized anxiety, or depression did not seek treatment." *Id.* at 1031.
[260] AR 635-200, *supra* note 4, para. 1-32.
[261] Milliken et al., *supra* note 95, at 2147.

court still leaves the determination of insanity a matter of discretion, potentially leading to inconsistent and unfair results.

Soldiers need congressional action to overcome this institutional inertia. Although giving more Soldiers the ability to remain eligible for VA health care services and benefits will increase costs and the demand for more resources, untreated individuals also increase economic costs to society.[262] Congress must revisit veterans' eligibility for benefits, particularly health care, and redefine insanity to protect those who gave so much to their country. Such an important change benefits not only Soldiers with service-connected PTSD but our national interests as well.

[262] EIBNER, *supra* note 210, at 7.