The War Comes Home: How Congress’ Failure to Address Veterans’ Mental Health Has Led to Violence in America

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I. INTRODUCTION

The recent military operations, Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), embody the most pronounced military engagements involving U.S. armed services since the Vietnam War. Over

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“1,500,000 members of the Armed Forces have been deployed in” these operations.² More wounded soldiers have survived from these operations than from any other war.³ However, many of these survivors wake up each day only to be reminded of their traumatic injuries or debilitating mental disorders.⁴ A great majority of soldiers in combat experience traumatic events often considered horrific in a civilized society, such as seeing dead bodies or remains, or witnessing both friends and enemies killed in violent manners.⁵ Consistent with society’s view of the heroic bravery of the men and women in uniform, war veterans are often left to overcome substantial mental anguish with little professional assistance, receiving nothing more than a mere “cursory mental health screening” upon return.⁶

The rate of homicides committed by war veterans has drastically increased amid the return of thousands of those who have served in combat roles in Iraq and Afghanistan.⁷ States have responded to the increase in crime by combat veterans by beginning to carve out “a class of privileged offenders.”⁸ At least one Florida court has already extended war related post-traumatic stress disorder (PTSD) from a mere mitigating factor in a murder trial to a basis for acquittal by reason of insanity.⁹ Other state legislatures have sought to enact legislation to protect war veterans who commit crimes from punishment offenders would otherwise receive.¹⁰

Congress has taken note of these events and has introduced and passed several pieces of legislation in an effort to bring more focus to the growing

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2. Veterans’ Mental Health and Other Care Improvements Act of 2008, S. 2162, 110th Cong. § 301(1) [hereinafter Veteran’s Mental Health Act].
3. Seal et al., supra note 1, at 476.
4. See id.
5. Charles W. Hoge et al., Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care, 351 NEW ENG. J. MED. 13, 18 (2004) [hereinafter Hoge et al., Barriers to Care].
7. Id.
9. See id.
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In particular, the Veterans' Mental Health and Other Care Improvements Act of 2008 (Veterans' Mental Health Act) demonstrates that Congress has taken note of the source of the problem, and is seeking a solution. This paper will address the adequacy of the current efforts of Congress and the states in addressing the drastic increase in violent crimes. The first part of this paper will highlight specific instances of the war being brought home to local towns and neighborhoods with the return of combat veterans. Next, this paper will offer a detailed background and explanation of post-traumatic stress disorder, the frequently diagnosed mental disorder causing much of the chaos. Then, this paper will discuss the states' responses, including a precedent setting Florida case which has failed to receive much recognition. Finally, this paper will examine the various recent congressional responses to the inadequate mental health regulatory scheme regarding returning combat veterans.

II. Bringing the War Home

Carol Trevino and her nine-year-old son were startled awake from a deep sleep by several consecutive loud booms. With only seconds passing between the booms and Carol Trevino reaching for her pepper spray, her estranged husband, Jon Trevino, shot her five times, including one bullet to her head, and then took his own life. Their nine-year-old son watched silently as his family exploded before his eyes. Instead of remembering days of playing catch with his father, he will forever be able to recall that "[h]is father used a silver gun [which] didn't have a wheel on it, like the cowboys used," and the picture of the glowing numbers on the clock, of 4:32 a.m., staring back at him as the time his mother died. Prior to the murder-suicide, Jon Trevino suffered from an array of psychiatric problems, and despite the military's awareness, Jon Trevino was certified by the military to handle the increasingly taxing position of evacuating the wounded. In a health assessment following his return from Iraq, Jon Trevino reported, "that

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12. See generally Veteran's Mental Health Act, S. 2162, §§ 101-705.
14. Id.
15. Id.
16. Id.
17. Id.
he had ‘serious problems’ dealing with the people he loved and that he was feeling ‘down, helpless, panicky or anxious.’” The Air Force restricted him from “special operational duty” and diagnosed him with “acute PTSD.” However, in 2005, he was deemed “well enough to be deployed domestically.” But his family, which once saw him as an “affable, quick-witted sergeant,” instead could not see past the unpredictable changes in temper, paranoia, erratic behavior, continuous spousal abuse, and certain unpredictable behavior which frightened his son.

Needing alcohol to fall asleep, Matthew Sepi, an Iraq combat veteran, left his apartment in Las Vegas to make a trip to the nearest 7-Eleven. Dreading his venture outside, Matthew Sepi placed his assault rifle inside his trench coat before leaving. He was consistently plagued by lurking danger and could not rid himself of nightmares concerning the death his unit brought upon an Iraqi civilian. As Matthew Sepi stepped out into the darkness and continued to hurry down an alley, he ignored the screaming and threats from gang members. After obtaining his alcohol, Mr. Sepi was confronted by two armed gang members. In Mr. Sepi’s interview, he explained “that he spied the butt of a gun, heard a boom, saw a flash and ‘just snapped.’” As a result, one gang member was injured and the other died on the pavement. When the police caught up with Matthew Sepi he was shaking and crying, and he asked, “‘Who did I take fire from?’” Matthew Sepi explained that he was “ambushed and then instinctively ‘engaged the targets.’” Following Matthew Sepi’s arrest, his public defender questioned him about PTSD. As he started to tell her about Iraq, his eyes suddenly were filled with tears and he hysterically exclaimed, “‘We had the wrong house! We had the wrong house!’” Matthew Sepi recounted the nights where his unit was provided lists instructing them on their nightly captures. He graphically explained

19. Id.
20. Id.
21. Id.
23. Id.
24. Id.
25. Id.
26. Id.
28. Id.
29. Id.
30. Id.
31. Id.
33. Id.
that on one particular night, after blowing a gate, his unit found a man on fire just inside the gate, and after searching the home they realized they blew up the wrong house. Matthew Sepi never imagined that the mental picture of the blazing, staggering Iraqi civilian would stay with him forever.

Soon after returning from Iraq, Lance Corporal Walter Rollo Smith was dispatched to undertake a marksmanship instructor course in Quantico, Virginia. Upon setting foot in the firing range in Quantico, he peered through the scope of his gun and began shaking. Instead of viewing the inanimate targets in front of him, Smith explained that he saw “vivid, hallucinatory images of Iraq: ‘the cars coming at us, the chaos, the dust, the women and children, the bodies we left behind.’” Upon every pull of the trigger, Smith’s crying worsened until he was pulled away from the firing range. Smith was discharged from the Marines and sent off to get help from the veteran’s hospital for his PTSD. Smith recalls his unit filling out mental health questionnaires prior to their arrival in the United States. In an interview, Smith said, “Then they sat us down one after the other with an officer, and he looked over the form, and said, ‘Are you doing OK?’ and, no matter what we wrote, we’d say yup, and then he’d say, ‘Next!’” After being discharged from the Marines, Smith visited a psychiatrist a few times, attempted to take prescription medication for his trouble sleeping and anxiety, tried to end his life with one of his guns, and even left goodbye messages for his friends and family. The police were able to prevent Smith from taking his life and escorted him to a nearby mental health center. In 2004, Smith met Nicole Marie Speirs, who later became pregnant with twins. When learning of Speirs’ pregnancy, Smith broke up with her and it was not until seven months later that the couple reunited. They appeared to be a happy couple to everyone, including her family.

34. Id.
35. Id.
37. Id.
38. Id.
39. Id.
40. Id.
41. Sontag, From Iraq to Utah, supra note 36.
42. Id.
43. Id.
44. Id.
45. Id.
46. Sontag, From Iraq to Utah, supra note 36.
47. Id.
when Speirs put her head under the faucet to rinse off her hair, Smith held her head underwater until she drowned. 48

III. RECOGNIZING THE PROBLEM

These three stories are just a few, among the many cases, where veterans are suffering from debilitating mental health problems and innocent victims are suffering the violent consequences. 49 Tragically, there have been 121 cases found, in this country alone, in which Iraq and Afghanistan veterans, upon returning from war, have either been charged with killing someone or have actually killed another human being. 50 Spouses, significant others, children, and relatives make up about one-third of these victims. 51 A New York Times study found that many veterans coming back from war are experiencing great difficulty with the transition from war life to civilian life, but the commission of violent crimes is not the only behavior that deserves attention. 52 Veterans throughout the world are homeless, engage in substance abuse, and commit suicide. 53 A Pentagon task force study, released in June of 2007, revealed that the military's mental health system is “woefully inadequate” to meet all of the “daunting and growing” psychological problems of military members. 54 The study found “that hundreds of thousands of the more than 1 million U.S. troops who have served at least one war-zone tour in Iraq or Afghanistan are showing signs of [PTSD], depression, anxiety

48. Id.
49. See generally Johnny Waltz, Problems Transitioning Out of Warrior Mode, VETERANS TODAY, Jan. 9, 2008, http://www.veteranstoday.com/modules.php?name=News&file=article&sid=2745. Krisiauna Calaira Lewis, a two-year-old, was slammed against a wall by her father. Sontag & Alvarez, Across America, supra note 6. Richard Davis, a specialist of the Army, was hidden in the woods after being stabbed and set on fire by fellow soldiers. Id.
50. See id. “More than half the killings involved guns, and the rest were stabbings, beatings, strangulations and bathtub drownings.” Id. A New York Times study found an 89% increase of homicides, from 184 cases to 349, during the current wartime period. Id. Only one-quarter involves veterans from wars other than Iraq and Afghanistan. Sontag & Alvarez, Across America, supra note 6.
51. Id. Service member made up another quarter of those who were killed, and the rest of the victims were either acquaintances or strangers. Id.
52. Waltz, supra note 49.
53. Id. On average eighteen veterans commit suicide daily and around 300,000 veterans are homeless per year. Id.
or other potentially disabling mental disorders.”

However, even when mental health screenings are in place, they are often administered too early and only once. Members of the military are more likely to report symptoms of mental health problems months after returning from war than immediately upon leaving Iraq. To adequately assess military members for psychological disorders, the Department of Defense should intervene prior to the soldiers leaving active duty and again post-deployment. Of the 121 cases previously mentioned, many of the veterans, despite an apparent display of combat trauma, were only evaluated and diagnosed with PTSD once they were arrested. In fact, only a few of them were evaluated with “more than a cursory mental health screening at the end of their deployments.”

Previous research conducted after other military conflicts has shown that deployment and exposure to combat result in increased risk of PTSD, major depression, substance abuse, [and] functional impairment in social and employment settings . . . .” In an interview with the New York Times, one criminal defense lawyer stated, “To deny the frequent connection between combat trauma and subsequent criminal behavior is to deny one of the direct societal costs of war and to discard another generation of troubled heroes.”

In the decades following the Vietnam War, PTSD’s strong presence in the media dwindled during the relative peacetime. However, in 2002, at Fort Bragg, North Carolina, the tables turned and the recollection of veterans suffering from mental health problems came to the forefront of everyone’s mind. Four husbands, who were in the Special Forces, murdered their

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55. Id.; see also Charles S. Milliken et al., Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War, 298 JAMA 2141, 2141 (2007). Military surveys, conducted once at 90 days upon return from deployment and again at 120 days, revealed “that 38 percent of soldiers, 31 percent of Marines, 49 percent of Army National Guard members and 43 percent of Marine reservists reported symptoms of PTSD, anxiety, depression or other problems.” Tyson, supra note 54.

56. Milliken et al., supra note 55, at 2141.

57. Id. The percentage of active troops that showed signs of PTSD rose from 12% on the initial screening to 17% at the second screening. Id. at 2143. The same trend happened for guard troops and reservists. Id. Their numbers increased from 13% when leaving the war to almost 25% while at home. Id.

58. See Milliken et al., supra note 55, at 2145, 2147.


60. Id.

61. 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 JAMA 1023, 1023 (2006) [hereinafter Hoge et al., Mental Health Problems].


63. ILONA MEAGHER, MOVING A NATION TO CARE: POST-TRAUMATIC STRESS DISORDER AND AMERICA’S RETURNING TROOPS 20–21 (2007).

64. Id. at 21.
wives upon return from Afghanistan. The three of the men committed suicide, two by self-inflicted gunshot wounds, and the other by hanging. Following the wave of combat zone suicides in 2003, the Army and Marines sent a team of doctors to assess the reasons for these suicides, and in 2004, began sending mental health personnel with every combat division being deployed to provide help to the U.S. troops serving in OIF and OEF. The goal was to treat the soldiers and return them to duty as quickly as possible. In response to the Fort Bragg killings, Congress passed legislation in which the protection orders for civilians on military bases were binding, and the Army made changes which slowed the soldiers' transition from military life to civilian life to aid in their adjustment. Since then, many reports assessing the mental health treatment of American troops have been issued. According to the May 2007 Bureau of Justice Statistics Special Report, the number of veterans in State and Federal prison increased by more than 50,000 between 1985 and 2000, but this number has decreased between 2000 to 2004 by 13,100 veterans. Although this statistic seems promising, the Bureau has hypothesized that one reason behind this decline is that the decrease in numbers is directly proportional to the decline in the number of veterans currently residing in the United States. Another contributing factor is that the number of U.S. Armed Forces active duty personnel decreased by 34%. Moreover, although the prison population is comprised of more nonveterans than veterans, veterans account for a greater percentage of the incarcerated population with reference to violent crime. In State prison, where 57% of veterans were violent offenders, less than half of nonveterans, 47%, were

65. Id.
67. See Meagher, supra note 63, at 21.
68. Id.
71. Noonan & Mumola, supra note 70, at 2.
72. Id. The United States' veteran population has decreased by virtually 3,500,000 since 1985. Id.
73. Id.
74. Id. at 4.
serving time for violent offenses. The same trend follows for veterans and nonveterans in Federal prison. Veterans in State prison victimized females and minors at a higher percentage rate, nearly 20% more, than nonveterans. Finally, the veterans in State prison were more likely to be first time offenders and have shorter criminal histories than nonveterans.

IV. THE MENTAL TOLL OF THE BATTLEFIELD: POST-TRAUMATIC STRESS DISORDER

A. Detailed Explanation of PTSD

The American Psychiatric Association (APA) formally recognized PTSD as an official diagnosis in 1980 when the APA published the disorder in their Diagnostic and Statistical Manual of Mental Disorders. Various labels such as “soldier’s heart, shell shock, Vietnam disorder,” and combat fatigue were used in earlier eras to describe the psychological injuries suffered by members of the military. PTSD is characterized as an anxiety disorder which can most succinctly be defined as “the reexperiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma.” The duration of symptoms can be identified as either acute, which describes symptoms lasting less than three months, or chronic, in which the symptoms last for three months or longer. There is typically a delayed onset between the traumatic event and the manifestations of the disorder. The manifestations begin once the stressor is removed and a period of relief follows. PTSD often surfaces when a person encounters a situation which symbolizes or resembles the original trauma. This stressor is often re-experienced by recurring

75. NOONAN & MUMOLA, supra note 70, at 4. Fifteen percent of veterans and 12% of nonveterans were serving time for homicide, and 23% of veterans and 9% of nonveterans were serving sentences for rape/sexual assault. Id.

76. Id.

77. Id.

78. Id.


82. Id. at 465.


84. Id. at 543.

85. Id.
nightmares, distressing recollections, hallucinations, or dissociative flashbacks.\textsuperscript{86}

PTSD manifestations are classified within four behavioral motivations: 1) overreaction to perceived danger; 2) flashbacks during a dissociative state; 3) stimulation-seeking behavior; and 4) attempts to rid survivor’s guilt by engaging in dangerous activity.\textsuperscript{87} Most often these behavioral motivations result in destructive actions by a veteran.\textsuperscript{88} Veterans suffering from PTSD, especially those who experienced intense trauma, are hypersensitive to danger cues and in turn overreact to inconsequential threats.\textsuperscript{89} Often times PTSD sufferers will apply greater force than necessary to a perceived threat, and that force often results in perilous situations for others.\textsuperscript{90} Other times, veterans may get lost in a dissociative state, typically called a flashback.\textsuperscript{91} A flashback causes distortions in reality with the surrounding setting or with one’s own body.\textsuperscript{92} When in this dissociative state one is inhibited from consciously appraising his or her own actions or the actions of others.\textsuperscript{93} Stressors that are connected to the traumatic event in some way can bring forth the flashback.\textsuperscript{94} For some veterans, benign stimuli such as car alarms or the smell of cleaning chemicals could trigger a flashback.\textsuperscript{95} A veteran can remain in this dissociative state for as little as a couple minutes or for several days at a time.\textsuperscript{96} Other veterans suffering from PTSD may seek out stimulation by changing their lifestyle or by engaging in risk taking behaviors such as criminal activity and substance abuse.\textsuperscript{97} The veterans who generally engage in risk taking behavior are survivors of war living with the constant

\begin{itemize}
\item \textsuperscript{86} DSM-IV, \textit{supra} note 81, at 468.
\item \textsuperscript{87} Aprilakis, \textit{supra} note 83, at 553.
\item \textsuperscript{88} \textit{Id.}
\item \textsuperscript{89} \textit{Id.}
\item \textsuperscript{90} \textit{Id.}
\item \textsuperscript{91} \textit{Id.}
\item \textsuperscript{92} \textit{See} Aprilakis, \textit{supra} note 83, at 553–54.
\item \textsuperscript{93} \textit{See id.}
\item \textsuperscript{94} \textit{Id.} at 554.
\item \textsuperscript{95} \textit{See Lizette Alvarez, \textit{After the Battlefield, Fighting the Bottle at Home}, N.Y. TIMES, July 8, 2008, at A1 [hereinafter Alvarez, \textit{After the Battlefield}].} One veteran described the experience:
   \begin{quote}
   Smells bring back the horror. “A barbecue pit–throw a stake on the grill, and it smells a lot like searing flesh . . . . You go to get your car worked on, and if anyone is welding, the smell of the burning metal is no different than burning caused by rounds fired at it. It takes you back there instantly.”
   \end{quote}
\item \textsuperscript{96} Aprilakis, \textit{supra} note 83, at 554.
\item \textsuperscript{97} \textit{Id.} at 554–55.
\end{itemize}
feeling of guilt and shame that they survived and others perished. Some other reasons for seeking stimulation include overcoming anxiety and depression; enlivening the exhilaration of combat; and countering the numbing detached feeling they continue to experience since returning from war.99

The effect that PTSD may have on troops serving in OIF and OEF, and the veterans returning from these operations is of utmost concern.100 A historically higher percentage of OIF and OEF veterans have taken the initiative to sign up for Veterans Affairs (VA) health care.101 An estimated 29% of OEF and OIF veterans have registered compared to the 10% of registered Vietnam veterans.102 One study revealed that 13% of OEF and OIF veterans have been diagnosed with PTSD, a percentage much higher than the 3.5% prevalence among the general U.S. population.103 Another study, which examined the mental health impact that these operations have had on members of the military, found that the estimated risk for PTSD from serving in Iraq is 18% and the estimated risk for PTSD from serving in Afghanistan is 11%.104 A RAND Corporation study released in April 2008, found that around half of the U.S. service members “who need treatment for PTSD seek it,” and of the service members who receive treatment, “only slightly more than half get ‘minimally adequate care.”1105

The severity of the traumatic experiences from being in combat is highly correlated with the risk of developing PTSD in the future.106 Many reports reveal that members of the military are at an increased risk for developing chronic PTSD as they become more involved in intense and frequent combat.107 The component that lends itself to an almost inevitable development of PTSD is the prolonged contact with trauma during extended tours.108 One study clearly sets out statistics which depicts the intensity of combat and severity of traumatic experiences witnessed by members of the military.109 This study indicates that 95% of marines in Iraq reported being attacked or ambushed, 97% were shot at or received small-arms fire, 94% saw dead bo-

98. Id. at 555.
99. Id.
100. See generally MEAGHER, supra note 63, at 123.
101. Seal et al., supra note 1, at 479.
102. Id.
103. Id. at 480.
104. Hoge et al., Barriers to Care, supra note 5, at 19 tbl.3.
106. See Aprilakis, supra note 83, at 546.
107. Id.
108. Id.
109. See Hoge et. al, Barriers to Care, supra note 5, at 18 tbl.2.
dies or remains, 87% knew someone who was critically injured or killed, 65% were responsible for the death of an enemy combatant and 28% for a death of a noncombatant.\textsuperscript{110}

B. The Pentagon Investigation

The VA provides health care for 7.8 million enrollees nationwide.\textsuperscript{111} A Pentagon task force report addressed availability of professional care, policy, training, and existing procedures.\textsuperscript{112} The task force report revealed that several barriers exist which prevent veterans and current members of the military from obtaining the appropriate care.\textsuperscript{113} These barriers include stigma related to seeking help from mental health providers, poor access to the mental health care providers and appropriate facilities, and disruption in mental health treatment as the members of the military are transferred to different locations.\textsuperscript{114}

"Stigma in the military remains pervasive" and consequently prevents members of the military from accessing the necessary and appropriate care.\textsuperscript{115} The existing processes, which assess members of the military for psychological disorders, "are insufficient to overcome the stigma inherent in seeking mental health services."\textsuperscript{116} The subjects of a 2004 study were soldiers and marines who have already met the screening criteria for a mental disorder.\textsuperscript{117} Of this subject pool, 50% believed that seeking mental health services would harm their career, 59% believed that less confidence would be instilled in them by members of their unit, 63% believed they would be treated differently by their unit leaders, and 65% believed they would be viewed as weak.\textsuperscript{118}

After assessing military treatment facilities, TRICARE benefits for mental health needs, people holding positions in the mental health care profession, and sufficiency of fiscal resources, the task force study found that

\textsuperscript{110} Id.
\textsuperscript{111} VA Benefits & Health Care Utilization (Oct. 27, 2008), http://www1.va.gov/vetdata/docs/4X6_spring08_sharepoint.pdf.
\textsuperscript{112} INSPECTOR GENERAL, supra note 70, at 2.
\textsuperscript{113} Tyson, supra note 54.
\textsuperscript{114} Id.
\textsuperscript{115} INSPECTOR GENERAL, supra note 70, at 2. One marine who was later diagnosed with PTSD explained, "I was trying to be the tough marine I was trained to be—not to talk about problems, not to cry . . . . I imprisoned myself in my own mind." Alvarez, After the Battle-field, supra note 95.
\textsuperscript{116} TASK FORCE, supra note 70, at ES-3.
\textsuperscript{117} See Hoge et. al, Barriers to Care, supra note 5, at 21 tbl.5.
\textsuperscript{118} Id.
the number of people holding positions in the mental health care profession is inadequate.\textsuperscript{119} Additionally, treatment facilities are unable to provide adequate mental health care to members of the military and their families because of insufficient resources.\textsuperscript{120} Veterans often face long waits to receive appropriate care from mental health care professionals.\textsuperscript{121} Disappointingly, there is also a shortage of active duty mental health professionals and the number of health care professionals leaving the military is growing rapidly.\textsuperscript{122} Twenty percent of mental health professionals in the Air Force resigned from active duty between 2003 and 2007.\textsuperscript{123} In addition, the percent of active duty mental health professionals decreased by 15% and 8% for the Navy and Army respectively.\textsuperscript{124} In a Pentagon news conference, Donald Arthur, co-chairman of the Department of Defense Mental Health Task Force, stated, "Not since Vietnam have we seen this level of combat . . . . With this increase in . . . psychological need, we now find that we have not enough providers in our system."\textsuperscript{125} He further explained that post Vietnam, this nation tragically learned too late that as time goes by, untreated mental illness increases dramatically.\textsuperscript{126} Seeing as history repeats itself and by learning from past mistakes, action needs to be taken to adequately serve the veterans' mental health needs.\textsuperscript{127} Steve Robinson, a veteran from the Persian Gulf War and Veterans for America spokesman stated:

\begin{quote}
The biggest message I want to say besides it's a tragedy for [a soldier] asking for help and not getting it, is there are going to be
\end{quote}

\textsuperscript{119} Inspector General, \textit{supra} note 70, at 4.
\textsuperscript{120} Task Force, \textit{supra} note 70, at ES-3.
\textsuperscript{121} See Daniel Zwerdling, \textit{Soldiers Say Army Ignores, Punishes Mental Anguish}, NPR Dec. 4, 2006, http://www.npr.org/templates/story/story.php?storyId=6576505. One soldier explains that once he finally had the courage to seek help from the Army hospital they told him he "had to wait a month and a half before [he could be] seen." \textit{Id.} Another OIF veteran described his feelings prior to seeking help, "I was on the verge of having a serious nervous breakdown or seriously hurting someone . . . . It was getting to a point where the restraints I had were slipping away." Don Terry, \textit{Bringing the War Home}, Chi. Trib., Feb. 3, 2008, at 8. After seeing a psychiatrist on the Army base for thirty minutes, one soldier was prescribed an antidepressant and sent on his way. \textit{Id.} Not long after his first meeting with the psychiatrist he finished his tour in Iraq and sought help at his army base where he checked "yes" on a questionnaire as to whether he was suicidal or homicidal. \textit{Id.} Even in the face of this answer, the social worker explained to this veteran that he would have to wait a minimum of one month before he could make an appointment to receive help from a therapist. \textit{Id.}
\textsuperscript{122} Task Force, \textit{supra} note 70, at ES-3.
\textsuperscript{123} Tyson, \textit{supra} note 54.
\textsuperscript{124} \textit{Id.}
\textsuperscript{125} \textit{Id.}
\textsuperscript{126} \textit{Id.}
\textsuperscript{127} See generally \textit{id.}
more veterans having the courage to go for help and not getting it. . . . It's the biggest betrayal, to seek the care that has been promised to you and be told to come back another day.\textsuperscript{128}

The task force report revealed insufficient continuity of care, gaps in service, inadequate treatment plans and monitoring, and insufficient mechanisms for aiding family members.\textsuperscript{129} The effectiveness of care is not measured by an objective source and no universal method is in place to track patient progress, especially when members are transitioned among providers.\textsuperscript{130} Furthermore, feedback is rarely given to the service members who seek treatment.\textsuperscript{131} By not monitoring the effectiveness of mental health treatment and making psychological assessments part of normal military life, members of the military can easily terminate treatment unnoticed.\textsuperscript{132}

One final barrier depriving veterans from accessing adequate mental health services is the denial of health care benefits due to a preexisting mental health condition or due to a discharge on "less-than-honorable" terms.\textsuperscript{133} When a veteran who is suffering from PTSD is later diagnosed with a personality disorder, the veterans are no longer eligible to receive the benefits and care they need.\textsuperscript{134} Since 2001, over 22,500 members of the service were discharged from the military due to a Personality Disorder diagnosis.\textsuperscript{135} To be eligible for benefits, a veteran must make a claim proving that his or her "prior existing condition was aggravated or worsened by military service which is difficult to do."\textsuperscript{136} For service members suffering from PTSD, men-

\begin{itemize}
\item \textsuperscript{129} INSPECTOR GENERAL, \textit{supra} note 70, at 3.
\item \textsuperscript{130} \textit{Id.} at 4.
\item \textsuperscript{131} \textit{Id.} at 3.
\item \textsuperscript{132} \textit{See id.} at 4.
\item \textsuperscript{134} Kennedy, \textit{supra} note 133. One soldiers explains:

\begin{quote}
I had obvious symptoms of PTSD, and I was going to do the medical evaluation board . . . . But they sent me to psychiatrists who said I had a personality disorder. . . . My commander told me it wouldn't affect my benefits, . . . [b]ut I lost everything, and had to pay the Army $3,000 back because I re-enlisted and got a bonus. That's what I got for seven years of service.
\end{quote}

\item \textsuperscript{136} \textit{Id.} One journalist who interviewed soldiers expressed his suspicions:

\begin{quote}
\end{quote}
\end{itemize}
tal health benefits appear to be awarded to those who act on their best behavior. This notion is verified each time a veteran diagnosed with PTSD is punished for engaging in behavior knowingly linked to PTSD, such as drinking and drug abuse. Once a service member is discharged because of less-than-honorable behavior, their VA benefits are denied and they are prevented from receiving adequate help to treat their combat stress.

V. STATES RESPOND TO THE INCREASED VIOLENCE

A. Insanity Defense and PTSD

PTSD has become judicially accepted in state courts where introduction of evidence of PTSD in various mitigating circumstances has been permitted. The Supreme Court of Kansas notes that the majority of cases where PTSD is asserted as a basis of an insanity defense are cases where “the defendant has claimed he experienced a dissociative state at the time of the crime, during which he believed he was back in Vietnam.” However, most instances of asserting PTSD as a basis for an insanity defense have failed due to the difficulty of establishing “severe” mental distress at the time of the offense.

Florida follows the M’Naghten Rule for determining insanity. To be legally insane under the M’Naghten Rule, “the defendant must have been unable to understand the nature of his act or its consequences, or incapable of

“Recruits who have a severe, pre-existing condition like a Personality Disorder do not pass the rigorous screening process and are not accepted into the army.” [This journalist] interviewed soldiers that passed the first screening and were accepted into the Army. “They were deemed physically and psychologically fit in a second screening as well, before being deployed to Iraq, and served honorably there in combat . . . . In each case, it was only when they came back physically or psychologically wounded and sought benefits that their pre-existing condition was discovered.”

Id. 137. See Zoroya, supra note 133.
138. Id.
139. Id. One Lieutenant Colonel expressed his dissatisfaction with the military’s actions by stating: “The Marine Corps has created these mental health issues’ in combat veterans . . . and then we just kind of kick them out into the streets.” Id.
142. See, e.g., United States v. Cartagena-Carrasquillo, 70 F.3d 706, 712 (1st Cir. 1995).
distinguishing right from wrong."144 The Supreme Court of Florida has es-
tablished that the mental disease, infirmity, or defect necessary to maintain a
defense under the M'Naghten Rule for insanity does not include abnormal
mental defects that do not impair the ability to distinguish between right and
wrong.145 To distinguish from mitigating factors, insanity, if proven, excuses
a defendant from all responsibility for criminal acts.146

PTSD as exculpatory evidence and the M'Naghten Rule for insanity
combined in Florida when Brian Christopher Wothers, an Iraq war veteran,
was charged with the murder of a twenty six year old construction worker.147
Wothers argued, with the support of psychiatrists, that "he was having a
flashback when he shot and killed a man."148 After a non-jury trial, Wothers
"was found not guilty by reason of insanity."149 Instead of prison for murder,
Wothers was ordered to "live in a mental health treatment facility until he is
no longer" a societal threat.150 Circuit Judge Kim C. Hammond, who pre-
sided over Wothers' trial, apparently determined that his conduct while act-
ing under the stress of military flashbacks brought him within the boundaries
of the M'Naghten standard.151

B. States Seek to Codify Protected Class

Other states have taken more proactive measures and "have passed laws
or begun programs to encourage alternative sentences, often including treat-
ment, for veterans with substance-abuse and mental-health problems,"152 In
2007, almost half of the states in the country filed over fifty pieces of legisla-
tion to address these issues.153 Of those states, "Colorado, Hawaii, Iowa,
Illinois, Massachusetts, Maryland, Minnesota, New Hampshire, New Jersey,
New York, Texas, Utah and Wyoming enacted 23 bills,"154 and laws have
been passed in California, Connecticut, and Minnesota.155 California's law

144. Reese v. Wainwright, 600 F.2d 1085, 1090 (5th Cir. 1979).
147. Sonis, supra note 8.
148. Id.
149. Id.
150. Id.
151. Id.
152. Alvarez, After the Battlefield, supra note 95.
154. Id. In Maryland, Oregon, Texas, and West Virginia, six bills were denied. Id. As of
December 2007, Illinois, Massachusetts, New Jersey, Pennsylvania and Wisconsin were still
in session and thirteen bills were pending. Id.
155. Alvarez, After the Battlefield, supra note 95.
gives judges the power to mandate veterans who have been convicted to treatment instead of jail.\textsuperscript{156} The sentencing guidelines are no longer applied and the judge is given complete discretion.\textsuperscript{157} The Minnesota courts tried to push the law implemented in California further when they enacted a law that allowed judges to send veterans on trial for criminal acts to treatment prior to any decision being rendered.\textsuperscript{158} However, after much “[o]pposition from prosecutors and victims advocates,” the Minnesota law was rewritten to be similar to the law in California.\textsuperscript{159}

VI. CONGRESS Responds to the Growing Crisis

Unsatisfied with the VA’s attempts, the absence of disability compensation and medical care the veterans deserve and need, and the lack of access to mental health services, a veterans’ advocacy group took their concerns a step further when they filed a law suit against the VA.\textsuperscript{160} Two non-profit advocacy groups, Veterans for Common Sense and Veterans United for Truth, are dedicated to improving veterans’ lives.\textsuperscript{161} In July 2007, these two groups filed suit against “the VA on behalf of 320,000 to 800,000 veterans who they expect will seek treatment for [PTSD] by the end of the current wars in Iraq and Afghanistan.”\textsuperscript{162} Specifically, the groups wanted the court “to grant a preliminary injunction that would force the VA to spend about $60 million to provide immediate care to the roughly 600,000 veterans they say have pend-

\textsuperscript{156} Russell Carollo, \textit{Suspect Soldiers: Is There a Link Between Postwar Stress and Crime?}, SACRAMENTO BEE, July 14, 2008, at A16. The California Act specifically amended legislation from 1982 to be sufficient for the returning OIF and OEF combat veterans. \textit{See} Assem. 2586, Reg. Sess. (Cal. 2006). This Act recognized PTSD and the fact that a significantly large number of service members returning from combat are suffering from the disease. \textit{Id.} Moreover, the Act recognized that a significant amount of these veterans engaged in behaviors associated with their “misunderstood and untreated PTSD.” \textit{Id.} It was the intent of the California Legislature to:

\textit{[E]xtend the opportunity for alternative sentencing to all combat veterans, regardless of where or when those veterans served our country, when those veterans are found by the court to be suffering from PTSD. . . . It is the intent of the Legislature to ensure that judges are aware that a criminal defendant is a combat veteran with these conditions at the time of sentencing and to be aware of any treatment programs that exist and are appropriate for the person at the time of sentencing if a sentence of probation is appropriate.}

\textit{Id.}

\textsuperscript{157} Carollo, \textit{supra} note 156.

\textsuperscript{158} \textit{Id.}

\textsuperscript{159} \textit{Id.}

\textsuperscript{160} \textit{See generally} Veterans for Common Sense v. Peake, 563 F. Supp. 2d 1049 (N.D. Cal. 2008).

\textsuperscript{161} \textit{Id.} at 1055.

The lawyer representing the two advocacy groups expressed, "'There is a crushing caseload that the VA can't keep up with.... You could easily wait 15 years before you get any treatment.'" After reviewing all items of relief asked for by the advocacy groups, the United States District Court for the Northern District of California concluded that the grievances were misdirected. This court lacked jurisdiction to remedy "the problems, deficiencies, delays and inadequacies complained of." Instead, the authority to remedy this problem "lies with Congress, the Secretary of the Department of VA, the adjudication system within the VA, and the Federal Circuit" Court. Congress has entrusted the VA Secretary to handle decisions pertaining to veterans' medical care. Among the statutes that explain the limited jurisdiction of the courts is 38 U.S.C. section 511. This section states:

The Secretary shall decide all questions of law and fact necessary to a decision .... by the Secretary to Veterans or the dependants or survivors of veterans .... [T]he decision of the Secretary as to any such question shall be final and conclusive and may not be reviewed by any other official or by any court ....

A. History of Reintegration

"Throughout history, societies have made 'special efforts to protect or restore the souls of their warriors during times of war.'" Soldiers found

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163. Id.
164. Id. The advocate groups explain that like William Rogers, a veteran of the Persian Gulf War who sought help multiple times and had his claims denied, too many veterans are prevented from obtaining the help they need. Id. Not until fifteen years after he first sought help and told his story, the same story, to every doctor, was William Rogers finally diagnosed with PTSD. Id. William Rogers commented on his long and drawn out journey to finally have someone take his problems seriously:

I just don't know why it was such a huge uphill battle.... If they don't do something to make it easier for other people, there's going to be more veterans who are going to do drugs and alcohol. There are going to be more veterans on the street. And there will be more in prison. I guarantee you that.

Gorlick, supra note 162.
166. Id.
167. Id.
168. Id.
171. Meagher, supra note 63, at 122 (quoting Edward Tick, War and the Soul: Healing Our Nation's Veterans from Post-Traumatic Stress Disorder 17 (2005)).
comfort in the rituals which, after completion, allowed them to feel welcome in the communities they left and cleansed from all of the guilt resulting from actions taken in war. 172 By taking part in such rituals with men who experienced the same trauma, soldiers felt comfortable reliving their battle experiences without feeling vulnerable. 173 Although most societies afford cleansing rituals to soldiers returning from war, most modern western societies fail to provide such rituals to acknowledge the soldiers’ importance. 174 The contemporary western society’s idea of reintegrating soldiers back into the community is a “Welcome Home” parade, which shows the community’s support but leaves the soldier without a method for decompression. 175

Providing soldiers with a method of decompression allows for an easier transition from military life back to civilian life. 176 In the absence of such methods, veterans may brood over their guilt and emptiness which in turn increases the soldiers’ risk for developing PTSD. 177 One major lesson learned from the years following the Vietnam War was that denying a soldier’s need for societal acceptance is a critical mistake. 178 In an attempt to learn from mistakes made after the Vietnam War, legislation is being drafted to try to prevent the same mistakes from being made. 179

172. Id. (quoting RICHARD A. GABRIEL, NO MORE HEROES: MADNESS AND PSYCHIATRY IN WAR, 155–56 (1988)).
173. Id. Cleansing rituals date back to 1879 when Zulu fighters, “‘underwent many days of cleansing before they were free enough of their contagious pollution to be permitted to present themselves to King Cetshwayo at the royal kraal.’” Id. at 122–23 (quoting ROBERT B. EDGERTON, LIKE LIONS THEY FOUGHT: THE ZULU WAR AND THE LAST BLACK EMPIRE IN SOUTH AFRICA 45 (1988)).
174. Id. at 123.
175. MEAGHER, supra note 63, at 123.
176. Id.
177. Id.
178. Id. Veterans returning to a life with “‘little acknowledgment and much misunderstanding by their families and society at large’” may have been a contributing factor to many soldiers’ diagnosis of PTSD. Id. at 123–24 (quoting David Read Johnson et al., The Impact of the Homecoming Reception on the Development of Posttraumatic Stress Disorder: The West Haven Homecoming Stress Scale (WHHSS), 10 J. TRAUMATIC STRESS 259, 261 (1997)).
B. A Good Step: The Veterans’ Mental Health and Other Care Improvements Act of 2008

On June 3, 2008 the United States Senate passed the Veterans’ Mental Health and Other Care Improvements Act of 2008.\textsuperscript{180} The "bill is for Justin Bailey, a young veteran of the Iraq war who died tragically while under VA care" where he was receiving treatment for PTSD and a substance use disorder, "and all veterans who suffer with invisible wounds because of their service to this Nation," stated U.S. Senator, Daniel Akaka, when he announced that the Senate unanimously consented to the bill being passed.\textsuperscript{181} In his press release, Senator Akaka further commented:

> Returning home from battle does not necessarily bring an end to conflict. Service members return home, but the war often follows them in their hearts and minds. Their invisible wounds are complicated and wide-ranging, and we must provide all possible assistance. . . . Solid and reliable information is critical to our understanding of the issues.\textsuperscript{182}

This bill addresses several vital issues facing U.S. veterans.\textsuperscript{183} The Veterans’ Mental Health and Other Care Improvements Act of 2008 consists of seven major components: 1) Health Care Matters; 2) Pain Care; 3) Substance Use Disorders and Mental Health Care; 4) Mental Health Accessibility Enhancements; 5) Mental Health Research; 6) Assistance for Families of Veterans; and 7) Homeless Veterans Matters.\textsuperscript{184} Of focus for this note are components three, four, five, and six.

1. Addressing Substance Use Disorders and Mental Health Care

Section 301 acknowledges the comorbidity of substance abuse with suicide, mental disorders, deterioration of family support, and heightened risk for unemployment and homelessness.\textsuperscript{185} This provision also recognizes that "[w]hile the Veterans Health Administration has dramatically increased health services for veterans from 1996 through 2006, the number of veterans

\textsuperscript{181}. \textit{Id.}
\textsuperscript{182}. \textit{Id.}
\textsuperscript{183}. \textit{See id.}
\textsuperscript{184}. Veterans’ Mental Health Act, S. 2162, § 101–705.
\textsuperscript{185}. \textit{Id.} § 301(2).
receiving specialized substance abuse treatment services decreased 18 percent during that time.\textsuperscript{186} In response to the inadequate treatment received by veterans, section 302 ensures that veterans enrolled in the VA's health care system who seek treatment will be guaranteed appropriate care.\textsuperscript{187} For veterans suffering from comorbid disorders of both substance use and a mental health disorder, section 303 ensures that treatment for the comorbid disorders will be provided for concurrently by a licensed professional with training and expertise in the treatment of both disorders.\textsuperscript{188} Of most relevance, section 304 requires the Secretary to establish at least "six national centers of excellence on [PTSD] and substance use disorders" for the purpose of "inpatient or residential treatment and recovery services for veterans diagnosed with both [PTSD] and a substance use disorder."\textsuperscript{189} In addition the Secretary must "conduct a review of all residential mental health care facilities, including domiciliary facilities, of the Veterans Health Administration; and not later than two years after . . . the completion of the review . . . conduct a follow-up review."\textsuperscript{190}

2. Mental Health Accessibility Enhancements

Section 401 of this Act requires the Secretary to carry out a three year "pilot program to assess the feasibility and advisability of providing" peer outreach services, peer support services, readjustment counseling services, and other services pertaining to mental health of OIF and OEF veterans.\textsuperscript{191}

For veterans living in rural areas and who cannot adequately access the ser-

\textsuperscript{186} Id. § 301(4). In the 1990's the VA cutback "its alcohol and drug-abuse services" for veterans, leaving only a few programs for extreme addicts, because the veteran population was relatively low during those years. \textit{See} Alvarez, \textit{After the Battlefield}, supra note 95. Veterans living in rural areas where the clinics are smaller have trouble obtaining the help they need because these smaller clinics only offer the bare-minimum when it comes to treatment, if any treatment is even offered. \textit{Id.}

\textsuperscript{187} Veterans' Mental Health Act, S. 2162 § 302. Each veteran should receive: "(1) Short term motivational counseling services; (2) Intensive outpatient or residential care service; (3) Relapse prevention services; (4) Ongoing aftercare and outpatient counseling services; (5) Opiate substitution therapy services; (6) Pharmacological treatments aimed at reducing craving for drugs and alcohol; (7) Detoxification and stabilization services; (8) Such other services as the Secretary considers appropriate." \textit{Id.}

\textsuperscript{188} Id. § 303.

\textsuperscript{189} Id. § 304. These centers will collaborate with the National Center for PTSD on all current research. \textit{Id.}

\textsuperscript{190} Veterans' Mental Health Act, S. 2162 § 305. The Secretary is required to submit a report to the veterans' committees following the initial review. \textit{Id.}

\textsuperscript{191} Id. § 401. This pilot program is interested in focusing on National Guard members or Reserve members. \textit{Id.} The peer support to be provided will be given by licensed providers or veterans who have experienced mental illness before. \textit{Id.}
VICES, the Secretary will ensure that such services will be provided by community mental health centers or through the Indian Health Service.\textsuperscript{192} This program requires the mental health centers to report to the Secretary all clinical information on every veteran seeking help from the mental health center.\textsuperscript{193} The Secretary must carry out training programs for all clinicians who will work in any of the mental health centers to guarantee that all clinicians can provide adequate services.\textsuperscript{194} The clinicians must be trained to respond to the unique experiences of all veterans deployed to serve in OIF or OEF on active duty, and must be able to counsel in a manner that takes these special factors into consideration.\textsuperscript{195} Each center must submit an annual report including the number of veterans treated, the types of treatment provided, and the “demographic information for such services, diagnoses, and courses of treatment.”\textsuperscript{196} The Secretary must assess the impact that the implementation of these mental health programs had on veterans and whether such implementation affected veterans’ mental health needs.\textsuperscript{197}

3. Mental Health Research

Section 501 mandates that a program be created to research the comorbidity of PTSD and substance use disorder.\textsuperscript{198} The National Center for Post-traumatic Stress Disorder (NCPTSD) will be conducting the research.\textsuperscript{199} Through this program the NCPTSD will develop goals for the program and will research the comorbidity of the disorders, the integration of treatment involving both disorders, and will develop protocols to assess the care veterans with these disorders are receiving.\textsuperscript{200}

\begin{footnotesize}
\begin{enumerate}
\item[192.] Veterans’ Mental Health Act, S. 2162 § 401(b)(1)–(2).
\item[193.] \textit{Id.} § 401(a)(2).
\item[194.] \textit{Id.} § 401(h)(1)–(2).
\item[195.] \textit{Id.}
\item[196.] \textit{Id.} § 401(i)(1)–(2).
\item[197.] See Veterans’ Mental Health Act, S. 2162 § 401(j). The Secretary must assess the: Access to mental health care by veterans in need of such care; the use of telehealth services by veterans for mental health care needs; the quality of mental health care and substance use disorder treatment services provided to veterans in need of such care and services; and the coordination of mental health care and other medical services provided to veterans. \textit{Id.} § 401(j)(2)(A)–(D).
\item[198.] \textit{Id.} § 501(a).
\item[199.] \textit{Id.} § 501(b).
\item[200.] \textit{Id.}
\end{enumerate}
\end{footnotesize}
4. Assistance for Families of Veterans

In a sign of progress, section 602 describes "a pilot program to assess the feasibility and advisability of providing readjustment and transition assistance . . . to veterans and their families." This pilot program will be lead by a non-VA entity and entail "[r]eadjustment and transition assistance that is preemptive, proactive, and principle-centered." Veterans and their families will learn to cope with everyday difficulties and confrontations related to transitioning back to civilian life from life in the military.


On October 1, 2007, Congress passed the National Defense Authorization Act for Fiscal Year 2008. As part of this Act, section 1611 discusses how members of the armed forces will be provided the care they need, and transitions will be made easier when the service members return from war. This Act focuses on service members currently in active duty and the veterans who have recently returned. One goal of this comprehensive plan is to implement "[p]rocesses, procedures, and standards for" service members to have a smoother transition between the care they receive from the Department of Defense and the treatment they will receive from the Department of Veterans Affairs. The Secretary of Defense will ensure that the family members of service members will readily have access to "medical care and counseling." Section 1631 requires the Secretary of Defense to submit a plan "to prevent, diagnose, mitigate, treat, and otherwise respond to traumatic brain injury (TBI) and [PTSD]." Goals for this section are to identify gaps in the Department of Defense's current capabilities to prevent, diagnose, mitigate, treat, and rehabilitate service members suffering from PTSD, improve the methods of detecting and treating PTSD, further research on the

201. Veterans’ Mental Health Act, S. 2162 § 602(a).
202. Id. § 602(b)(1).
203. Id. § 602(b)(2).
205. See id. § 1611.
206. Id.
207. Id. § (a)(D)(i). The transition should be “[a] uniform, patient-focused policy to ensure that the transition occurs without gaps in medical care and the quality of medical care, benefits, and services.” Id. Cooperation between the case managers from each site is guaranteed to aid in this transition. National Defense Authorization Act, H.R. 1585 § 1611(a)(D)(ii).
208. Id. § 1626(a)(3).
209. Id. § 1631(a).
disorder, and develop uniform criteria for the disorder which will "be employed uniformly across the military departments."\textsuperscript{210} In addition, the means of detecting, assessing, and monitoring service members with PTSD will be more developed and effective, and an awareness training program on PTSD will be established to reduce the stigma related to the disorder and treatment.\textsuperscript{211}

Also under this Act, a program for all service members suffering from PTSD will be implemented ensuring that all members will:

[B]e provided the highest quality of care possible based on the medical judgment of qualified medical professionals in facilities that most appropriately meet the specific needs of the individual; and be rehabilitated to the fullest extent possible using the most up-to-date medical technology, medical rehabilitation practices, and medical expertise available.\textsuperscript{212}

Furthermore, Section 1691 of this Act reveals that further study will commence "on the physical and mental health and other readjustment needs of members and former members of the Armed Forces who deployed in [OIF] or [OEF] and their families as a result of such deployment."\textsuperscript{213} The study consists of two phases.\textsuperscript{214} The first phase will assess all service members’ current "physical and mental health and other readjustment needs."\textsuperscript{215} The second phase includes the administration of a comprehensive assessment of the same needs on the same subject pool, but also will include:

[A]n assessment of the psychological, social, and economic impacts of . . . deployment . . . ; an assessment of the particular impacts of multiple deployments . . . ; an assessment of the effects of undiagnosed injuries such as [PTSD], . . . an estimate of the long-term costs associated with such injuries, and an assessment of the efficacy of screenings and treatment approaches for [PTSD] and other mental health conditions within the Department of Defense and Department of Veterans Affairs.\textsuperscript{216}

Reports on "the completion of each phase of the study" and preliminary plans addressing the finding in each report will be exchanged between the
National Academy of Sciences and the Department of Defense and Department of Veterans Affairs. 217 Congress will then receive a report from the Secretary of Defense and the Secretary of Veterans Affairs on the established joint plan. 218

D. Getting the American People Involved in the Solution

In an effort to make the transition from military life to civilian life one which is less jarring, the House of Representatives passed a resolution encouraging Americans to take a more proactive approach. 219 This resolution recognizes that there are over 25,000,000 veterans living in the United States and every veteran has honorably served and sacrificed for our country. 220 Through this resolution, the House of Representatives hopes to show that the American people truly appreciate all sacrifices made by veterans from all wars by:

1. [Encouraging] the American people to recognize and acknowledge the sacrifices the American veteran demonstrates in the name of freedom; (2) encouraging the education of the American people on the many great contributions of the American veteran to American society; and (3) showing support of the goals and ideals of the Year of the American Veteran. 221

VII. THE WAY FORWARD: THE REGULATORY SCHEME THAT MUST BE ESTABLISHED

Americans demonstrate great pride and patriotism when speaking of those who serve in the armed forces. Often, domestic political debates regarding war and foreign policy turn into competitions of who can paint the opponent as someone who disparages the military and the brave men and women in the war zone. However, common sense tells us that individual soldiers do not decide whether to go to war, but rather are ordered to go by elected officials. American citizens do not individually decide whether to engage in military conflict, but elect those who do every election cycle. While there is no doubt that Americans take great pride in those that volunteer to serve, our pride and proclamation of undying support for our military men and women is grossly misplaced. Criticizing a decision to engage in a

218. Id. § 1691(g)(4).
220. Id.
221. Id.
war does not criticize those men and women who bravely serve any more than flying an American flag above a garage door supports them. While citizens of this country try to demonstrate military pride on both sides of the political spectrum, American citizens caught up in the fighting have failed to support our military veterans and active duty soldiers in the most important way that they can. While troops may be greeted with homecoming parades and Congressmen may repeatedly express their love for those in uniform, Congress and the American citizenry have largely abandoned our soldiers in their toughest battle once they return home, coping with the extraordinary mental readjustment to civilian life and suppressing horrifying battlefield images. Congress must act quickly to implement a new approach and regulatory scheme to avoid the tragic consequences that they have failed to learn from after the Vietnam War.

Congress has taken an important step in moving towards a proper reintegration and treatment program in the Veterans Mental Health and Other Care Improvements Act of 2008. But Congress must do more than just implement a pilot program regarding reintegration and treatment. Such practices must be made mandatory as soon as possible for both returning combat soldiers and veterans who have already returned and reintegrated back into society. If soldiers returned from the battlefield with a treatable but highly contagious and dangerous physical ailment, the solution would be clear. Quarantine would be necessary to avoid the dangers of such an ailment to the general population, and to effectuate the proper treatment of those affected. It is important to recognize mental disorders, such as PTSD, as treatable conditions with dangerous consequences to the general public. It is imperative to treat all returning servicemen and women for battlefield mental conditions before a full reintegration into society takes place. Only then can proper treatment be offered without risk to the unsuspecting public.

Availability of resources and treatment options is simply not enough. The very culture of the military makes it unlikely for suffering soldiers to seek mental health treatment at the risk of being stigmatized by their fellow soldiers. Additionally, many soldiers fail to acknowledge the need for treatment and consider such thoughts as signs of weakness. A uniform and mandatory screening and treatment program will abolish all effects of stigmatization and launch a period where such treatment is simply a normal step in the reintegration process for all soldiers. Such a feeling of normalcy will likely increase cooperation by soldiers and lead to more effective treatment overall.

Additionally, Congress and the military must cooperate to fill a dangerous gap in military medical benefits. Discharged soldiers, such as Chris Packley, who was expelled from the Marines for misconduct after he left the base without permission and took other steps to escape the mental trauma of the battlefield, lost all access to free counseling and medication needed to
treat those very mental traumas that led to discharge.\textsuperscript{222} Congress and the military must acknowledge this issue, and mandate that soldiers discharged due to an underlying mental ailment suffered during active duty continue to receive mandatory treatment as if no discharge occurred.

States have begun to establish a dangerous precedent and are beginning to carve out a "class of privileged offenders."\textsuperscript{223} In Florida, extending PTSD suffered in the war zone from a mitigating factor during sentencing to a basis for acquittal of murder charges establishes a means for an entire class of defendants to commit violent crimes with little consequence. Other states have taken efforts to codify such an approach, eliminating mandatory sentencing for criminal acts committed by war veterans suffering from PTSD. State legislatures recognize the responsibility in failing to offer adequate treatment to war veterans, but excusing criminal conduct to an entire class of potential defendants is unconscionable and leaves an entire class of innocent victims without proper closure to violent crimes. Instead of protecting a class from prosecution out of guilt, the government, including the states, must take proactive measures to eliminate the problem from the source. Adequate mandatory treatment may substantially reduce the occurrences of violent crimes from war veterans. Such an approach will truly demonstrate society’s concern for war veterans’ well-being and safeguard potential victims from violence.

\textbf{VIII. CONCLUSION}

For many years, and throughout many military conflicts, Congress and state governments have taken a passive approach regarding the reintegration of combat veterans into society. Today, an extraordinary number of war veterans suffer from untreated mental disorders, which often manifest themselves in violent ways on city streets. States, taking a sympathetic approach to the plight of America’s heroes, began to establish an entire class of criminal defendants to which the laws of justice would not apply. Extending applicability of the insanity defense, and actually codifying PTSD as a criminal excuse into law, establishes a system where violent crimes against innocent victims are foreseeable and yet excused, with justice for victims unattainable. While the sympathy for war veterans is justified, policies of avoiding prosecution are unconscionable to the victims who suffer. While Congress has shown signs in recent years to implement mandatory treatment programs, no regulatory schemes so far enacted are nearly sufficient to deal with this ma-

\textsuperscript{222} Zoroya, \textit{supra} note 133.
\textsuperscript{223} Sonis, \textit{supra} note 8.
jor crisis. As Americans who love to show support for the men and women in uniform, it is time to establish the proper legal framework to carry out that support by offering protection from the evils of the battlefield that follow them home.