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Less Fatalities, More Casualties: The Need To Prevent A Crisis Instead Of Finding A Cure

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Abstract

The resignation of former Secretary General of the Veterans Administration, United States Army General Eric Shinseki, reiterated the need for the development of extensive measures to address undue delays in the delivery of crucial services to veterans.

LESS FATALITIES, MORE CASUALTIES: THE NEED TO PREVENT A CRISIS INSTEAD OF FINDING A CURE

TRICIA-GAYE COTTERELL*

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I. INTRODUCTION

The resignation of former Secretary General of the Veterans Administration, United States Army General Eric Shinseki, reiterated the need for the development of extensive measures to address undue delays in the delivery of crucial services to veterans.¹ These systemic failures have proven particularly detrimental for those veterans with mental health conditions who rely on the Department of Veterans Affairs (“VA”) for

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1. See Michael D. Shear & Richard A. Oppel, Jr., *V.A. Chief Resigns in Face of Furor on Delayed Care*, N.Y. TIMES, May 31, 2014, at A1.

healthcare.² Delayed access to treatment for post-traumatic stress disorder (“PTSD”) and other mental healthcare conditions is one source of the complications that compromise veterans’ successful reintegration into civil society.³ Consequently, early detection and treatment of these mental health conditions are critical.⁴

In a bid to improve the timely access to treatment, much attention has been placed on modern United States warfare, which is seen as one trigger for the marked increase in the incidence of PTSD among veterans.⁵ Combat in the decade-long wars in Iraq and Afghanistan was characterized by frequent deployments of troops with fewer rest periods, and reduced mortality rates of those injured in battle—albeit coupled with higher rates of disability.⁶ Experts projected that at least 15% of troops who were deployed to Iraq and Afghanistan would, if some have not already, develop PTSD.⁷ Given the large number of troops that were deployed over the past fifteen years, the number of those affected will be taxing for any healthcare system to handle.⁸

Accordingly, the combat veteran’s unique disposition to developing PTSD and other mental health conditions did not escape the attention of the

2. *See id.*

3. *See* Madeline McGrane, Note, *Post-Traumatic Stress Disorder in the Military: The Need for Legislative Improvement of Mental Health Care for Veterans of Operation Iraqi Freedom and Operation Enduring Freedom*, 24 J.L. & HEALTH 183, 193, 197 n.103 (2011).

4. *Id.* at 186.

5. *See id.* at 185–86, 196; Melody Finnemore, *Firestorm on the Horizon: The Growing Problem of Post-Traumatic Stress Syndrome*, OR. ST. B. BULL., Apr. 2010, at 19, 22.

Rates of mental health injuries are still increasing, of course, because the conflict[] in . . . Afghanistan [is] ongoing. . . . Rates of mental health injuries are increasing not only because of the time it takes for troops’ psychological injuries to manifest, however. Longer tours and multiple deployments are also contributing to higher rates of mental health injuries.

VANESSA WILLIAMSON & ERIN MULHALL, IRAQ & AFG. VETERANS OF AM., INVISIBLE WOUNDS: PSYCHOLOGICAL AND NEUROLOGICAL INJURIES CONFRONT A NEW GENERATION OF VETERANS 6 (2009), http://media.iava.org/IAVA_invisible_wounds_2009_report.pdf.

6. *See* Finnemore, *supra* note 5, at 20–22; Andrea Gomes, Note, *Coverage for Veterans with Post-Traumatic Stress Disorder: A Survey Through the Wars*, 19 CONN. INS. L.J. 325, 328 (2013); WILLIAMSON & MULHALL, *supra* note 5, at 1.

7. U.S. GOV’T ACCOUNTABILITY OFF., GAO-04-1069, VA AND DEFENSE HEALTH CARE: MORE INFORMATION NEEDED TO DETERMINE IF VA CAN MEET AN INCREASE IN DEMAND FOR POST-TRAUMATIC STRESS DISORDER SERVICES 1 (2004).

8. Michael S. Baker, *Casualties of the Global War on Terror and Their Future Impact on Health Care and Society: A Looming Public Health Crisis*, 179 MIL. MED. 348, 348 (2014); *see also* McGrane, *supra* note 3, at 185–86.

federal government.⁹ Efforts continue to be multiplied across various agencies in order to provide care to those already diagnosed, or at risk for a future diagnosis.¹⁰ However, the record number of veterans waiting to receive care—or suffering high rates of substance abuse, unemployment, divorce, homelessness, penalties for criminal infractions, and suicide—flies in the face of these efforts.¹¹ More still needs to be done to meet the needs of the veteran population¹² because failure to address this dilemma sooner rather than later has a strong potential to cripple the sustainability of the VAs, as well as of the wider, public healthcare system.¹³ *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*¹⁴ Executive Order 13625 (“Executive Order”), signed by President Obama on August 31, 2012, offered one of several required preemptive actions in order to succeed in warding off a healthcare crisis.¹⁵

This Article supports the view that in order to reduce the number of soldiers who develop combat-related PTSD, the federal government’s long-term goal must be prevention.¹⁶ In fact, the sustainability of the Veteran’s Healthcare System and the efficiency of the VA depends on it.¹⁷ Part II will give a brief synopsis on the nature of the most recent past war efforts and why it will likely increase the incidence of mental health conditions in veterans.¹⁸ Part III will examine combat-related mental health conditions, and focus on PTSD and Traumatic Brain Injury (“TBI”).¹⁹ It will also briefly discuss the VA healthcare claims process and the challenges faced by veterans to access healthcare benefits for mental health conditions.²⁰ Although, PTSD appears to be an inevitable by-product of combat, in some

9. See U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 7, at 1. The report identifies efforts by the Department of Defense to identify service members who are at risk for developing PTSD and the VA’s public education drive to inform veterans of mental health services it provides for their benefit. *Id.* at 1–2.

10. See *id.*

11. See Harold M. Ginzburg & Kristie D. Holm, *The Struggle for DOD/VA Benefits*, 39 PSYCHIATRIC ANNALS 71, 71 (2009); Gomes, *supra* note 6, at 327–28. “Even some of the most mentally challenged veteran applicants for benefits are delayed.” Ginzburg & Holm, *supra*, at 71.

12. See Gomes, *supra* note 6, at 360.

13. See Baker, *supra* note 8, at 348.

14. Exec. Order No. 13,625, 3 C.F.R. § 13,625 (2013).

15. See *id.* § 13,625(1).

16. See *id.* § 13,625(2).

17. See U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 7, at 1–2; Baker, *supra* note 8, at 348.

18. See U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 7, at 1; *infra* Part II.

19. McGrane, *supra* note 3, at 189; see also *infra* Part III.

20. Peter W. Tuerk et al., *Combat-Related PTSD: Scope of the Current Problem, Understanding Effective Treatment, and Barriers to Care*, DEV. MENTAL HEALTH L., Jan. 2010, at 49, 51–52; see also *infra* Part III.

circles persons accept that PTSD can be preempted by effective psychological screening of military recruits and interventions facilitated by military training.²¹ For this reason, Part IV will examine the United States Army's resiliency training program, formerly known as Battlemind ("Battlemind"), and the Executive Order aimed at treatment and prevention of PTSD in veterans.²² This section will also examine other legislation, which proposed action for addressing mental health issues affecting veterans and service members, to determine their effectiveness for meeting their stated targets.²³

Part V will conclude by making the point that prevention is the optimal course to pursue for three reasons: First, given the perennial challenges facing the VA healthcare system and preliminary findings on the rate at which persons with PTSD seek medical attention, long term treatment of PTSD will not be sustainable.²⁴ Second, the toll that PTSD has taken on veterans, their families, and the nation is likely to dissuade the caliber of recruits the armed forces would otherwise attract.²⁵ Finally, past pronouncements by the former Chairman of the Joint Chiefs of Staff on the desire "to rebalance the use of military power" suggest that frequent deployment could be slowed in the coming years.²⁶ The use of military strategies, which would see a lull in deployment, could provide the necessary downtime the VA needs to get a handle on the number of veterans that will require specialized care for PTSD and other mental healthcare needs after a decade of war.²⁷

21. See Zahava Solomon et al., *Frontline Treatment of Combat Stress Reaction: A 20-Year Longitudinal Evaluation Study*, 162 AM. J. PSYCHIATRY 2309, 2309 (2005).

22. Exec. Order No. 13,625, 3 C.F.R. § 13,625(1) (2013); Tuerk et al., *supra* note 20, at 53; WALTER REED ARMY INST. OF RESEARCH, PDHRA BATTLEMIND TRAINING: CONTINUING THE TRANSITION HOME, http://www.floridajobs.org/pdg/vets/pdf/PDHRA_Battlemind_Trng_Brochure050707.pdf (last updated Mar. 8, 2006); *see also infra* Part IV.

23. Medical Evaluation Parity for Servicemembers Act of 2015, H.R. 1465, 114th Cong. § 2(a), (c) (2015); *see also infra* Part IV.

24. Baker, *supra* note 8, at 350; Ginzburg & Holm, *supra* note 11, at 73–74; *see also infra* Part V.

25. See Alan Zarembo, *THE NATION*; *High Rate of Mental Illness in Recruits: Nearly 1 in 5 Soldiers Was Afflicted Before Enlisting, a Study Says — Raising Questions About Army Screening*, L.A. TIMES, Mar. 4, 2014, at A6; James Kitfield, *Dempsey Wants to 'Rebalance the Use of Military Power'*, DEF. ONE: IDEAS (May 12, 2014), <http://www.defenseone.com/ideas/2014/05/dempsey-wants-rebalance-away-use-military-force/84271/>; *infra* Part V.

26. Kitfield, *supra* note 25.

27. See WILLIAMSON & MULHALL, *supra* note 5, at 6, 11, 17; Ginzburg & Holm, *supra* note 11, at 73; Kitfield, *supra* note 25.

II. THE TURBULENT TIDES OF MORE THAN A DECADE OF WAR

Since 2001, more than two million troops have been deployed in support of Operation Iraqi Freedom (“OIF”) and Operation Enduring Freedom (“OEF”) in Afghanistan missions.²⁸ Of that number, approximately 800,000 were required to serve on multiple tours.²⁹ Armed with the Vietnam War veterans’ experience, experts’ preliminarily predicted that approximately 30% of troops would return with some type of mental health condition and that more than half that number would present classic symptoms of PTSD.³⁰ Given the number of cases we have seen, the withdrawal of troops supporting the OEF mission in late 2014, and the subsequent surge, the projected estimates are expected to increase because certain potential claims are not yet ascertainable.³¹ Submission of these claims will likely exacerbate the already unduly long wait times for care and will lengthen the administration and litigation of claims—which are characteristic of the VA claims process.³²

Several factors about the nature of the OEF and OIF conflicts point to the high probability that the severity of the mental health issues among veterans has not yet reached its peak.³³ “[W]e have yet to see the full extent of troops’ psychological and neurological injuries.”³⁴

“What is different [about] these wars is that soldiers have multiple tours, multiple kills, and multiple close calls without a break in between,” said Shad Meshad, president of the National Veterans Foundation and a pioneer in PTSD research. “One

28. NAT’L COUNCIL FOR BEHAVIORAL HEALTH, MEETING THE BEHAVIORAL HEALTH NEEDS OF VETERANS OF OPERATION ENDURING FREEDOM AND OPERATION IRAQI FREEDOM 2 (2012), <http://www.thenationalcouncil.org/wp-content/uploads/2013/02/Veterans-BH-Needs-Report.pdf>; Tuerk et al., *supra* note 20, at 49.

29. Finnemore, *supra* note 5, at 20.

30. U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 7, at 1–2; WILLIAMSON & MULHALL, *supra* note 5, at 6.

31. See WILLIAMSON & MULHALL, *supra* note 5, at 1; Finnemore, *supra* note 5, at 20; Kitfield, *supra* note 25.

32. See WILLIAMSON & MULHALL, *supra* note 5, at 14; Shear & Opper, Jr., *supra* note 1.

33. See Exec. Order No. 13,625, 3 C.F.R. § 13,625(1) (2013); NAT’L COUNCIL FOR BEHAVIORAL HEALTH, *supra* note 28, at 2; WILLIAMSON & MULHALL, *supra* note 5, at 1, 6.

The need for mental health services will only increase in the coming years as the Nation deals with the effects of more than a decade of conflict. . . . [W]e have an obligation to evaluate our progress and continue to build an integrated network of support capable of providing effective mental health services for veterans, service members, and their families.

3 C.F.R. § 13,625(1).

34. WILLIAMSON & MULHALL, *supra* note 5, at 1.

incident can cause . . . [people] to live with PTSD for the rest of their lives, and these people are experiencing multiple traumas.

“This is something we [have not] dealt with before, and [it is] scary because we [do not] know what is going to happen,” adds Meshad, a Vietnam vet[eran]. “Although those of us with forty-plus years of experience with PTSD have a pretty good idea of what will happen. [We are] going to see more homicides, suicides, domestic violence and divorces.”³⁵

One feature of the multiplicity Meshad highlighted was the frequency of roadside bombs—commonly using improvised explosive devices (“IEDs”)—which creates an environment where soldiers must be hypervigilant.³⁶ In effect, soldiers must always be on guard and ready to engage in combat at a moment’s notice.³⁷ This hypervigilance—which typically lasted for more than ten months³⁸—combined with the other stresses of combat have followed many soldiers home, and is also a classic symptom of combat-related PTSD.³⁹

Additionally, technological advancements, which facilitated the redesign of the protective gear worn in combat and provided life saving devices in the field, have acted as a double-edged sword.⁴⁰ On one hand, IEDs have not produced as many fatalities as would have occurred without the improvements.⁴¹ On the other hand, however, many survivors—the majority of whom are young men—now have to live with significant disabilities.⁴² “Following a life-threatening war injury, the [veteran]’s worldview is dramatically altered or shattered.”⁴³ Yet, there are some—one

35. Finnemore, *supra* note 5, at 20–21.

36. See Baker, *supra* note 8, at 349–50; Finnemore, *supra* note 5, at 21; WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

37. See WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

38. *Our Warriors Today and “Combat Trauma”*, AM. ASS’N CHRISTIAN COUNS., <http://www.aacc.net/2011/5/17/our-warriors-today-and-combat-trauma/> (last visited Apr. 18, 2018). In comparison, a tour in Vietnam included 240 days of combat per tour on average and most troops served one or two tours, while very rarely, some served three. *Id.* The OEF and OIF missions have seen redeployment of up to three times. See WILLIAMSON & MULHALL, *supra* note 5, at 6–7.

39. See Sydney J. Freedberg Jr., *Intimate Killing*, NAT’L J., July 2007, at 26, 28–29.

40. See Baker, *supra* note 8, at 348–49; Finnemore, *supra* note 5, at 22.

41. See Baker, *supra* note 8, at 348–50; Finnemore, *supra* note 5, at 21–22.

42. See WILLIAMSON & MULHALL, *supra* note 5, at 7; Baker, *supra* note 8, at 349–50; Finnemore, *supra* note 5, at 22.

43. Bonnie B. Benetato, *Posttraumatic Growth Among Operation Enduring Freedom and Operation Iraqi Freedom Amputees*, 43 J. NURSING SCHOLARSHIP 412, 412 (2011).

study found, who were able to experience growth as they made adjustments to overcome their significant injuries and altered lifestyles.⁴⁴ Notwithstanding this, those with no physical injury still have a strong potential for harboring undetected mild to moderate TBIs, which they carry daily as mementos of combat.⁴⁵

III. THE WAVE AND THE RIP CURRENTS

The Department of Defense (“DoD”) and the VA are charged with ensuring that all returning troops get the required support to help them recover from their physical and mental injuries.⁴⁶ This support is aimed at smooth readjustment to civil society and/or the army base where these troops can once again enjoy the way of life they fought to protect.⁴⁷ The majority of troops who have returned from the OIF and OEF missions *appear* to be having a successful transition to life—far from the combat zone.⁴⁸ Yet, for those who have mental healthcare needs, transition has been difficult and, in some cases, a complete failure ending in suicide.⁴⁹ What is worse, those with mental health needs do not receive the same degree of attention, nor care, as those with physical injuries.⁵⁰ This occurs, in part, because the severity of their injuries is not apparent to the naked eye, and, thus, remain veiled.⁵¹ If

44. *Id.* at 416–17. This is referred to as *posttraumatic growth* (“PTG”). *Id.* at 412. These veterans who underwent amputations and other significant life-threatening injuries were found to experience PTG in levels commensurate with the degree of emotional support and access to medical and other social support services coupled with the length of time since the event which caused the injury. *Id.* at 416–17.

45. See THOMAS R. FRIEDEN & FRANCIS S. COLLINS, CTRS. FOR DISEASE CONTROL & PREVENTION & NAT’L INST. OF HEALTH, REPORT TO CONGRESS ON TRAUMATIC BRAIN INJURY IN THE UNITED STATES: UNDERSTANDING THE PUBLIC HEALTH PROBLEM AMONG CURRENT AND FORMER MILITARY PERSONNEL 11 (2013), http://www.cdc.gov/traumaticbraininjury/pdf/report_to_congress_on_traumatic_brain_injury_2013-a.pdf; Baker, *supra* note 8, at 350.

46. See Ginzburg & Holm, *supra* note 11, at 71–72.

47. *Id.* at 72; Tuerk et al., *supra* note 20, at 52, 53.

48. See Michael L. Fessinger, *Balancing the Reasonable Requirements of Employers and Veterans Living with Traumatic Brain Injury — the Modern U.S. Military’s “Signature Injury” Is a Game Changer*, 53 WASHBURN L.J. 327, 329 n.13 (2014); Tuerk et al., *supra* note 20, at 49.

49. See U.S. GOV’T ACCOUNTABILITY OFF., GAO-12-12, VA MENTAL HEALTH: NUMBER OF VETERANS RECEIVING CARE, BARRIERS FACED, AND EFFORTS TO INCREASE ACCESS 2 (2011).

50. See Baker, *supra* note 8, at 352; Tuerk et al., *supra* note 20, at 52.

51. See Ginzburg & Holm, *supra* note 11, at 72; Tuerk et al., *supra* note 20, at 51.

the DoD and VA are going to successfully carry out their mandate, the same priority must be given to those with mental health conditions.⁵²

This success is critical because the failure to provide timely mental healthcare for those in need has facilitated complications in addition to socio-economic costs that are not always measurable.⁵³ Retired United States Navy Rear Admiral and Fellow of the American College of Surgeons, Michael S. Baker, has indicated that:

Another huge impact on society for which there is no metric is the tragic effect of this fiasco on veterans' families. The family members of those on long deployments, whose family members have been wounded or killed, manifest mental health issues, or develop substance abuse will be forever damaged These conditions ruin relationships, disrupt marriages, aggravate the difficulties of parenting, lead to child mistreatment, and result in psychological problems in children that may extend the consequences of combat trauma across generations. The DoD and [the VA] do not measure this *collateral damage*. It may represent the ugliest aspect of all social concerns related here. It is another future cost to society, which will be huge but is neither predictable nor quantifiable.⁵⁴

Left untreated, PTSD has been found to cause a downward spiral into substance abuse, criminal infractions, self-harming, and other violent behaviors.⁵⁵ Studies have shown a strong correlation between PTSD and unemployment as well as homelessness,⁵⁶ and, concomitantly, to an increase in the utilization of non-mental health services.⁵⁷ In fact, it has been found that persons suffering from PTSD “are 200% more likely to be diagnosed with an unrelated medical disease within [five] years of returning from deployment.”⁵⁸ Veterans with PTSD were also found to access non-mental healthcare services including:

[P]rimary care, ancillary services, diagnostic tests and procedures, emergency services, and hospitalizations—at a rate 71% to 170% higher than those without PTSD. Studies have [also] shown that TBI, often overlapping with PTSD, places sufferers at higher risk

52. See Ginzburg & Holm, *supra* note 11, at 71–73.

53. Tuerk et al., *supra* note 20, at 50.

54. Baker, *supra* note 8, at 352 (footnotes omitted).

55. McGrane, *supra* note 3, at 189–90; Tuerk et al., *supra* note 20, at 49–50.

56. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 49, at 2.

57. See Baker, *supra* note 8, at 350.

58. *Id.*

for lifelong health problems such as heart disease, dementia, and other chronic ailments.⁵⁹

A. *The Whys and Wherefores of PTSD?*

PTSD is defined in the *Diagnostic and Statistical Handbook of Mental Disorders* (“DSM”) as a psychiatric disorder that occurs after an individual’s direct or indirect exposure to a traumatic event “involv[ing] actual or threatened death or serious injury, or other threat to [the person’s] physical integrity.”⁶⁰ In making a PTSD diagnosis, the doctor must identify symptoms from three clusters: Intrusive recollection, avoidance or numbing, and hyperarousal.⁶¹ Intrusive recollection is often marked by the experience of nightmares or vivid flashbacks of the traumatic event.⁶² The individual exhibits symptoms of the avoidant or numbing cluster by avoiding people or activities that are reminiscent of the traumatic event, becoming emotionally detached, and/or self-medicating by abusing substances.⁶³ Hypervigilance, insomnia, and exaggerated startle response are symptoms that are typical of the hyperarousal cluster.⁶⁴

Generally, a diagnosis of PTSD is not made unless the tripartite clustered symptoms last for at least one month.⁶⁵ Persons who develop symptoms immediately, or less than three months after exposure to the traumatic event, are said to have an acute form of the illness.⁶⁶ Alternatively, a person is said to have chronic PTSD when symptoms appear or last for three months or longer after the event.⁶⁷ It should be noted that in some instances, symptoms emerge many months—or even years—later than the trigger event.⁶⁸ Interestingly, military combat is the first in a series of examples listed by the DSM as a traumatic or triggering event for PTSD.⁶⁹

No amount of training or natural aptitude can make war less . . . horrifying. Indeed, some degree of horror is the only

59. *Id.* (footnote omitted).

60. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 463 (4th ed. 2000). Direct exposure refers to personal experience of the trauma, whereas indirect means the individual is witnessing the threatened trauma to another person. *See id.* at 463–64.

61. *See id.* at 464, 468.

62. *Id.*

63. *Id.*; Finnemore, *supra* note 5, at 20.

64. AM. PSYCHIATRIC ASS’N, *supra* note 60, at 464–68.

65. *Id.*

66. *Id.* at 465.

67. *Id.*

68. *Id.* at 466.

69. AM. PSYCHIATRIC ASS’N, *supra* note 60, at 463.

appropriate reaction, said Dr. Jonathan Shay, a leading veterans psychiatrist. “If you look at the menu of PTSD [symptoms]”—the hair-trigger response to sudden noises, the sudden waking, the swift anger, the suppression of gentler emotions—they all are signs of “the mobilization of the mind and body for danger,” Shay said. “The primary injury from war is simply the persistence into civilian life of those absolutely valid adaptations that let you survive other human beings’ trying to kill you.”⁷⁰

“[M]ental health issues resulting from service in combat have been observed throughout history.”⁷¹ The stigma and suspicion that surrounded those affected in earlier times is still observed today, albeit not to the same degree.⁷² In earlier times, the suspicion was that the soldiers were feigning mental illness as a cover for their cowardice, or that they were merely *malingering*.⁷³ However, the large numbers of soldiers suffering from psychological issues after World War I prompted further study as to whether the external events in the war could cause psychological injury, which produced changes in the soldiers’ behavior.⁷⁴ Some in the psychiatric community held the view that individuals exposed to a sufficient amount of psychological stress could suffer a temporary *break*.⁷⁵ Conversely, where the symptoms were prolonged, the *break* was attributed to the psychological make-up of that individual and not exposure to the stressful situation.⁷⁶ These individuals were said to suffer from *war neuroses*.⁷⁷

Accordingly, prior to being sent into combat during World War II, soldiers in the British and American armies were screened for predisposition to war neuroses.⁷⁸ Those who were found to have such a psychological make-up were excluded from combat.⁷⁹ At the end of World War II, however, the number of casualties with psychological injuries far exceeded the numbers projected by then-experts, who had anticipated improvement over the numbers reported for World War I since those predisposed to war

70. Freedberg Jr., *supra* note 39, at 28–29 (alteration in original).

71. Katherine Dubyak, *Close, but No Cigar: Recent Changes to the Stressor Verification Process for Veterans with Post-Traumatic Stress Disorder and Why the System Remains Insufficient*, 21 FED. CIR. B.J. 655, 657 (2012).

72. See McGrane, *supra* note 3, at 191–92.

73. See Betsy J. Grey, *Neuroscience, PTSD, and Sentencing Mitigation*, 34 CARDOZO L. REV. 53, 58 n.14 (2012).

74. *Id.*

75. See Deirdre M. Smith, *Diagnosing Liability: The Legal History of Posttraumatic Stress Disorder*, 84 TEMP. L. REV. 1, 13, 14 & n.116 (2011).

76. *Id.* at 13.

77. *Id.*

78. *Id.* at 14.

79. See *id.*

neuroses had been left behind.⁸⁰ These findings shifted the school of thought from some persons being predisposed to *breaking* to the consensus that “every[one] has his breaking point.”⁸¹ Soldiers with psychological injuries were no longer removed from combat, but were instead removed from the front and given brief periods of rest before rejoining the fight.⁸² Today, this is referred to as *frontline treatment*.⁸³

Seen as a kind of psychiatric first aid in the combat zone, *frontline treatment* uses the principles of proximity, immediacy, and expectancy as a preventative measure to stop or abate the development of PTSD.⁸⁴ Treatment is administered in proximity to the front line of battle, immediately after symptoms emerge, and with the expectation that the soldier will resume duties with his unit after the intervention.⁸⁵ The two- to three-day mini-retreat from combat gives the soldier an opportunity to get rest and food in an environment where the traumatic event can be discussed.⁸⁶ Here, the soldier’s response to the trauma is not seen as weakness, but rather a natural response to the stress of battle.⁸⁷

Sanders’s recovery from an experience that could have easily caused disabling PTSD underlines the importance of simple things in keeping troops mentally fit to fight. First is that his fellow marines knew him so well, and so understood his anguish, that they gave him time to grieve without guilt or pressure. Second is the value of sleep. In fact, the time-tested first resort of military psychologists is “three hots and a cot”: [T]hree hot meals a day and as much sleep as the combatant requires. “People can look incredibly crazy, completely gone, wildly psychotic,” Dr. Shay said, “but you let them sleep for [twelve] or [fourteen] hours, and they wake up and say, ‘Hey, hey, where’s my unit? I need to get back.’”⁸⁸

Early intervention offered by *frontline treatment* helps the potential PTSD casualty to avoid the complications present in the chronic phase.⁸⁹ In effect, it prevents the development of the disorder before the need arises for a

80. See Smith, *supra* note 75, at 14.

81. *Id.* (quoting BEN SHEPHARD, A WAR OF NERVES: SOLDIERS AND PSYCHIATRISTS IN THE TWENTIETH CENTURY 326 (Harvard Univ. Press 2001) (2000)).

82. *Id.* at 14–15.

83. Solomon et al., *supra* note 21, at 2309.

84. *Id.* at 2309–10.

85. *Id.* at 2309.

86. *Id.*

87. *Id.*

88. Freedberg Jr., *supra* note 39, at 32.

89. Solomon et al., *supra* note 21, at 2309; see also WILLIAMSON & MULHALL, *supra* note 5, at 2–3.

cure.⁹⁰ When intervention is not early and symptoms are present for a month or more, Cognitive Behavioral Therapy (“CBT”) is the preferred psychotherapeutic option, which has been proven to be effective in treating PTSD.⁹¹ Like frontline treatment, Cognitive Restructuring (“CR”)—one type of CBT—encourages the soldier to talk about upsetting thoughts surrounding the trauma with the aim of processing the memory of the event.⁹² Instead of avoiding it, the ordeal is confronted and the soldier can move past it.⁹³ Frontline treatment attacks PTSD by preempting symptoms of nightmares or vivid flashbacks from the intrusive recollection cluster, whereas CBT attacks PTSD by preempting symptoms of avoiding people or activities, becoming emotionally detached, or self-medicating by abusing substances in the avoidant or numbing cluster.⁹⁴

Studies have shown that the longer the period of deployment—and the greater the number of deployments—the more likely that the soldier will develop PTSD.⁹⁵ In the context of ongoing combat, during a deployment period of twelve to fifteen months, early intervention via *frontline treatment* is not likely to be successful since the soldier tends to suffer re-exposure after re-exposure to similar traumatic events.⁹⁶ The *frontline treatment* option is meant to be preemptive rather than curative and, therefore, does not have its best results when combat is as protracted as the OEF and OIF wars.⁹⁷ Similarly, the CBT option would neither be practical nor preemptive during periods of long deployment or with frequent deployment.⁹⁸

It has also been suggested that “only half [of the veterans of the OEF and OIF missions] who need treatment for major depression or PTSD seek it.”⁹⁹ Although much effort has been made in recent times to destigmatize the need for therapy, classic symptoms of PTSD dispose soldiers to avoid admission of mental health difficulties.¹⁰⁰ Much of it, though, may be due to *delayed detection* by the armed forces, *delayed onset of symptoms*, or failure

90. See Solomon et al., *supra* note 21, at 2309.

91. NAT’L COUNCIL FOR BEHAVIORAL HEALTH, *supra* note 28, at 7.

92. See *Cognitive Restructuring (CR) for Posttraumatic Stress Disorder (PTSD)*, BRIDGE, http://www.thebridgecm.org/treatment-models/cr_posttraumatic_stress_disorder.html (last visited Apr. 18, 2018).

93. See *id.*

94. AM. PSYCHIATRIC ASS’N, *supra* note 60, at 463–64; NAT’L COUNCIL FOR BEHAVIORAL HEALTH, *supra* note 28, at 7; Solomon et al., *supra* note 21, at 2309–10.

95. WILLIAMSON & MULHALL, *supra* note 5, at 6–7.

96. See *id.* at 6; Solomon et al., *supra* note 21, at 2309–10.

97. Solomon et al., *supra* note 21, at 2309–10; see also WILLIAMSON & MULHALL, *supra* note 5, at 6.

98. See NAT’L COUNCIL FOR BEHAVIORAL HEALTH, *supra* note 28, at 7; WILLIAMSON & MULHALL, *supra* note 5, at 6.

99. Baker, *supra* note 8, at 350; see also Dubyak, *supra* note 71, at 662.

100. U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 49, at 11–12.

on the part of the individual *to self-recognize the problem* coupled with the choice in many instances to “self-medicate with drugs or alcohol.”¹⁰¹

If the government is serious about minimizing the development of PTSD in our troops, then policy should dictate that—even where there are resource constraints—deployment periods must not exceed six months.¹⁰² Long deployment periods provide an incubator for PTSD development.¹⁰³ This is especially true when the battle is intense and service members’ exposure puts them at risk for bomb blasts from IEDs and mortar fire.¹⁰⁴

B. *TBI and Other Mental Health Conditions*

TBI has been labeled the *signature injury* of the OEF and OIF missions.¹⁰⁵ It typically arises from a “blow or jolt to the head or a penetrating head injury that disrupts brain function” or produces neurological damage resulting in mood changes and other cognitive problems.¹⁰⁶

[TBI] can be caused by bullets or shrapnel hitting the head or neck, but also by the blast from mortar attacks or roadside bombs. Closed head wounds from blasts, which can damage the brain without leaving an external mark, [were] especially prevalent in Iraq. [Most of those] wounded in action experienced blast-related injuries.¹⁰⁷

There are three forms of injury: Mild, moderate, and severe.¹⁰⁸ Mild TBI is commonly known as a concussion and can produce symptoms such as: Brief loss of consciousness, nausea, dizziness, headache, anxiety disorder, fatigue, depressed mood, and confusion.¹⁰⁹ Typically, persons who suffer a mild TBI recover within a few weeks or months.¹¹⁰ However, without a diagnosis—and if untreated—mild TBI can result in death.¹¹¹

101. Baker, *supra* note 8, at 350.

102. See WILLIAMSON & MULHALL, *supra* note 5, at 6.

103. *Id.* at 3, 6–7.

104. See WILLIAMSON & MULHALL, *supra* note 5, at 3, 7; Baker, *supra* note 8, at 349–50; Fessinger, *supra* note 48, at 327, 328–29.

105. Fessinger, *supra* note 48, at 328 (quoting Charles W. Hage et al., *Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq*, 358 NEW ENG. J. MED. 453, 454 (2008)).

106. BIAA — Maine: Advocacy & Awareness, BRAIN INJ. ASS’N OF AM., <http://www.biausa.org/find-bia/states/maine/links> (last visited Apr. 18, 2018); WILLIAMSON & MULHALL, *supra* note 5, at 3.

107. WILLIAMSON & MULHALL, *supra* note 5, at 3.

108. Fessinger, *supra* note 48, at 331, 333.

109. *Id.* at 331, 334.

110. *Id.* at 331.

111. *Id.*

Approximately one-third of the persons diagnosed with the moderate form of the injury have resulting permanent mental disabilities.¹¹²

The rates for combat-related TBI more than doubled between 2000 and 2011.¹¹³ “This marked increase is due to the inherent nature of OEF/OIF, where United States service members are exposed to [IEDs] and other non-fatal combat trauma on a daily basis.”¹¹⁴ During the same period, “approximately 230,000 cases of TBI were reported”—77% of which were classified as being mild and 20% of them as being moderate.¹¹⁵ By November 2017, the number rose to 375,230—with approximately 82% classified as mild and 9% as moderate.¹¹⁶ Many persons within the armed forces with mild or moderate forms of TBI remain undiagnosed.¹¹⁷ Both forms are difficult to diagnose for several reasons including the fact that symptoms of mild and moderate TBI overlap with symptoms of PTSD and major depressive disorder.¹¹⁸

As a result, it is often unclear [whether] a service member is suffering primarily from biological damage to the brain or a psychological injury. TBI and PTSD may, in fact, compound one another’s effects. At least one study suggests that combat stress can have a visible, physical effect on the brain, and veterans with PTSD who were exposed to blasts are “more likely to have lingering attention deficits.” Soldiers who reported an injury that caused them to lose consciousness are nearly three times [more]

112. *Id.* at 333.

113. Fessinger, *supra* note 48, at 328.

114. *Id.* at 328–29.

115. *Id.* at 328; DoD Worldwide Numbers for TBI, DEF. & VETERANS BRAIN INJ. CTR., <http://dvbic.dcoe.mil/dod-worldwide-numbers-tbi> (last visited Apr. 18, 2018) (The 77% of Mild TBI Classifications is found by clicking on each year’s “DoD TBI Worldwide Numbers, PDF” from 2000 through 2011 and averaging the mild percentage under Worldwide-Totals).

116. DEF. & VETERANS BRAIN INJURY CTR., DoD WORLDWIDE TBI NUMBERS (2017), <http://dvbic.dcoe.mil/files/tbi-numbers/WorldwideTotals2000-2017Q1-Q3Nov%2014-2017508.pdf>.

117. Fessinger, *supra* note 48, at 333; WILLIAMSON & MULHALL, *supra* note 5, at 1.

Persons with severe TBI frequently have . . . weakness, stiffness, slurred speech, incoordination, posttraumatic epilepsy and commonly require long-term assistance. [Those] who survive their injuries frequently require extensive rehabilitation, first as an inpatient and later as an outpatient. Neurological recovery might take place over months or even years.

FRIEDEN & COLLINS, *supra* note 45, at 47.

118. WILLIAMSON & MULHALL, *supra* note 5, at 5; Fessinger, *supra* note 48, at 331–32.

likely to [develop] PTSD. Depression is also commonly associated with TBI.¹¹⁹

Much of what is known about TBI is learned from medical treatment of injuries sustained from motor vehicle accidents and athletic or other injuries.¹²⁰ No guaranteed benefits are known to derive from applying findings from TBIs sustained in civil society to the treatment of TBIs sustained at war.¹²¹ Consequently, more research needs to be carried out on the impact that pressure waves have in producing brain damage during exposure to roadside bombs and other IEDs in combat zones.¹²² There is currently no diagnostic test that is able to detect mild or moderate forms of the injury via brain imaging.¹²³ These research findings will inform the development of a diagnostic test which can rule out TBI in soldiers exposed to roadside bombs and other blasts.¹²⁴

An accurate diagnosis is fundamental to receiving the appropriate treatment for TBI.¹²⁵ The development of the required diagnostic test is the necessary first step for determining what proportion of those who have served in the OEF and OIF missions are walking around with undetected, mild, or moderate TBIs unknown to them.¹²⁶ This is particularly crucial because both mild and moderate TBIs have the potential to result in permanent mental disability through correlation to later development of brain disorders, such as Parkinson's or Alzheimer's.¹²⁷ Prevention or preemption

119. WILLIAMSON & MULHALL, *supra* note 5, at 5 (quoting Emily Singer, *Brain Trauma in Iraq*, MIT TECH. REV.: REWRITING LIFE (Apr. 22, 2008), <http://www.technologyreview.com/s/409938/brain-trauma-in-iraq/>) (footnote omitted).

120. *Id.* at 3. "There is nothing novel about the returning veterans' struggle to find their place and mission in civilian society." Ginzburg & Holm, *supra* note 11, at 72.

121. *See* WILLIAMSON & MULHALL, *supra* note 5, at 3.

122. *See id.* at 3, 5.

123. *Id.*; *see also* Fessinger, *supra* note 48, at 331. However, neuroimaging is commonly used to detect bleeding inside the skull in persons with TBI because post-traumatic bleeding is associated with worse prognosis and can be life-threatening. *See* Benjamin J. Hayempour et al., *The Role of Neuroimaging in Assessing Neuropsychological Deficits Following Traumatic Brain Injury*, 39 J. PSYCHIATRY & L. 537, 538–39. On occasion, such evidence of TBI is discovered on neuroimaging in persons in which the clinical suspicion of TBI was low. *See id.* at 538–40. Although not all neuroimaging modalities are able to identify all TBIs, some techniques, for example MRI, are better able to identify patients with some potentially critical injuries. *See id.* at 539–40, 547.

124. *See* WILLIAMSON & MULHALL, *supra* note 5, at 3; Fessinger, *supra* note 48, at 334.

125. Fessinger, *supra* note 48, at 332–33; *see also* WILLIAMSON & MULHALL, *supra* note 5, at 3, 5.

126. Fessinger, *supra* note 48, at 328, 332–33; WILLIAMSON & MULHALL, *supra* note 5, at 5.

127. WILLIAMSON & MULHALL, *supra* note 5, at 3; Fessinger, *supra* note 48, at 333.

of these complications requires that the necessary research and development occur without delay.¹²⁸ Prevention also requires access to medical care that will facilitate prompt diagnosis and treatment of TBIs and other mental health conditions.¹²⁹

C. *Navigating the Icy Waters of the Veterans' Healthcare System*

The veterans' struggle to obtain mental health benefits has been an ongoing one for decades.¹³⁰ These benefits are, in many ways, crucial to providing financial and other support required for veterans' readjustment to civilian life.¹³¹ No group knows this better than the Vietnam War cohort, who—after fighting an unpopular war—came home to find that benefits earmarked for them were inaccessible because there was no formal diagnosis for their mental health conditions or for which they could state a claim.¹³² The group collaborated with noted psychoanalysts at that time to lobby the VA and the American Psychiatric Association to include a formal diagnosis for which veterans could claim their mental injuries arising from combat.¹³³ Without this diagnosis, veterans were unable to receive “compensation for their [significant and] persistent psychiatric difficulties” from the VA.¹³⁴ The collaborative effort bore fruit in 1980, when the editors of the DSM were persuaded to include the PTSD diagnosis in the third edition.¹³⁵

Having cleared the absence-of-a-diagnosis iceberg, the submission of a disability claim on the basis of a PTSD diagnosis proved to be another blockade for veterans on the high seas of acquiring benefits to aid their successful transition to civilian life.¹³⁶ Submission required documentation to substantiate the claim that the traumatic event that caused the veteran's psychological injury was connected to, or occurred during, service in the

128. See Fessinger, *supra* note 48, at 332–34.

129. WILLIAMSON & MULHALL, *supra* note 5, at 17; see also Fessinger, *supra* note 48, at 332–34; Ginzburg & Holm, *supra* note 11, at 72.

130. See Ginzburg & Holm, *supra* note 11, at 72; Gomes, *supra* note 6, at 327, 344.

[I]nsurance coverage in the form of military benefits from the government has become the main source of financial, psychological, and medical support for soldiers and veterans. . . . Thousands of soldiers have been unable to secure assistance for their mental health and today, thousands of veterans are still fighting for health care.

Gomes, *supra* note 6, at 327.

131. *Id.* at 327–28.

132. Ginzburg & Holm, *supra* note 11, at 72; Gomes, *supra* note 6, at 347.

133. Smith, *supra* note 75, at 3.

134. *Id.* at 23–24.

135. *Id.* at 21, 25; see also AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 236–38 (3d ed. 1980).

136. See Dubyak, *supra* note 71, at 668–70.

military—and, specifically, on the field of combat.¹³⁷ Additionally, submission required proof of veteran status, disability, degree of disability, and effective date of disability.¹³⁸ The requirement for proof of service connection was a difficult one to overcome because the combat zone did not provide logistics for veterans to keep a log of daily occurrences and documentation that took place long after the traumatic event was not likely to be an entirely accurate account.¹³⁹

Moreover, veterans who were deployed to the combat zone to support troops in combat, were automatically excluded from submitting a claim because their duties did not involve combat.¹⁴⁰ Even though they were susceptible to the same hostilities—and therefore, the same physical, mental, and neurological injuries—to which service members participating in combat were exposed, these veterans were left out in the cold.¹⁴¹ Legislative action has improved the plight of those who were unable to access disability benefits and services from the VA on the basis of a mental health need.¹⁴² Today, several groups of persons are presumed eligible for mental health services related to readjustment under 38 U.S.C. § 1712A.¹⁴³ These groups include those who were on active duty in a combat zone or area where there were hostilities; those “who provided . . . emergency medical or mental [healthcare], or mortuary services” but were not themselves present in the “combat [zone] or area of hostilities;” and those “who engaged in combat . . . by remotely controlling an unmanned aerial vehicle, notwithstanding” not being physically located in the area of combat.¹⁴⁴

Despite the way being cleared for veterans to access the benefits earmarked for them—or, as explained in some circles, because of the progress made—the vast number of veterans seeking care has overwhelmed the operational structure of the VA in such that veterans are still being denied access to crucial services.¹⁴⁵ The systemic failings of the VA have been cited as an ever-present blockade to providing the care that veterans need in order to transition to life outside of the armed forces.¹⁴⁶ The VA’s current state of

137. *Id.* at 667–69.

138. *Id.* at 667–68.

139. *Id.* at 672.

140. Gomes, *supra* note 6, at 346–47; *see also* Dubyak, *supra* note 71, at 675–76.

141. *See* Dubyak, *supra* note 71, at 675–76; Gomes, *supra* note 6, at 347.

142. Gomes, *supra* note 6, at 358.

143. 38 U.S.C. § 1712A(a)(1)(C) (2012). This piece of legislation makes it mandatory for the VA to provide counselling and other mental health support to veterans.

144. *Id.* § 1712A(a)(1)(C)(i)–(iii).

145. *See* U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 7, at 1–3.

146. Fessinger, *supra* note 48, at 327. “The [VA] marred with a

unpreparedness for the influx of veterans requiring healthcare, disability, and other benefits is difficult to excuse because as early as 2004, the Government Accountability Office had conducted a study to evaluate the VA's capacity to handle the increase of persons who would require mental healthcare services arising from the OEF and OIF operations.¹⁴⁷ At that time, the writing was on the wall that certain administrative failings needed to be corrected.¹⁴⁸ The jury is still out on the ability of the VA to remedy the long wait times and cumbersome bureaucracy that veterans must navigate in order to access services.¹⁴⁹

The nationwide shortage of primary healthcare physicians and the availability of mental healthcare specialists are not within the VA's control.¹⁵⁰ The VA remains the provider of choice for mental health services for veterans because the healthcare and mental health support services are of a high quality.¹⁵¹ Additionally, veterans are likely to prefer speaking to counselors at the VA who are, in most cases, themselves veterans and, therefore, more readily understand the field of combat and their experiences.¹⁵²

reputation of inefficiency and ineffectiveness, has been bluntly described as a *failure* and a *national embarrassment*, and the infamous disability claims backlog has recently garnered outrage." *Id.* (citing Michael Serota & Michelle Singer, *Veterans' Benefits and Due Process*, 90 NEB. L. REV. 388, 390 (2011)); David Gotfredson, *Vets on VA Claims: "Delay, Deny, Wait Till I Die."*, CBS NEWS 8 (Apr. 26, 2013, 4:03 AM), <http://www.cbs8.com/story/22082924/veterans-on-the-va-claim-process-delay-deny-wait-til-i-die>.

147. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 7, at 1.

The [VA] . . . has intensified its efforts to inform new veterans from the Iraq and Afghanistan conflicts about the health care services — including treatment for PTSD — it offers to eligible veterans. These efforts, along with expanded availability of VA health care services for Reserve and National Guard members, could result in an increased percentage of veterans from Iraq and Afghanistan seeking PTSD services through VA. Concerns have been raised about whether VA can provide PTSD services for a new influx of veterans, while at the same time continuing these services for veterans that [the] VA currently treats for PTSD.

Id.

148. *See id.* at 3.

149. *See* WILLIAMSON & MULHALL, *supra* note 5, at 11–12; Shear & Oppel, Jr., *supra* note 1.

150. *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 7, at 11; Richard A. Oppel, Jr. & Abby Goodnough, *Doctor Shortage Is Cited in Delays at V.A. Hospitals*, N.Y. TIMES, May 30, 2014, at A1; Shear & Oppel, Jr., *supra* note 1.

151. WILLIAMSON & MULHALL, *supra* note 5, at 14. "[T]he VA healthcare system . . . is considered by experts to be 'equivalent to, or better than, care in any private or public healthcare system' in the United States." *Id.* (footnote omitted) (quoting DEP'T VETERAN AFFAIRS, THE INDEPENDENT BUDGET: FISCAL YEAR 2008, 35 (2008)).

152. *Id.*; Freedberg Jr., *supra* note 39, at 31–32. "But most care still comes as it has since ancient times: [C]omrade to comrade. 'They had combat stress teams, and it was

IV. CHARTING THE HIGH SEAS

During his administration, President Obama reiterated his commitment to improving the lives of veterans by “evaluat[ing] [the] progress [made] and continu[ing] to build an integrated . . . support capable of providing effective mental health services for veterans.”¹⁵³ The Executive Order was issued on August 31, 2012.¹⁵⁴ It outlined an action plan for preventing and treating mental health illness and substance abuse, which have been plaguing veterans, service members, and their families in increasing numbers.¹⁵⁵ Preventative objectives included but were not limited to: The expansion of the suicide prevention strategies of the Departments of Defense, Education, Health and Human Services, Homeland Security, and the VA; the establishment of an Interagency Task Force responsible for reviewing current legislation and proposing programs for the achievement of the objectives of the Executive Order; and the establishment of the joint National Research Action Plan.¹⁵⁶

The Executive Order also outlined the following treatment measures to: Extend the hours of service and operation of the Veterans Crisis Line, expand the mental healthcare staff by employing 800 peer-to-peer counselors and 1600 mental healthcare professionals, and “develop a plan for a rural mental health recruitment initiative to promote opportunities for the [VA] and rural communities to share mental health providers when demand is insufficient.”¹⁵⁷ The increased number of mental health professionals, peer counselors, and expanded suicide prevention programs have all been realized; yet, the plight of veterans is the same and suicide rates have not decreased.¹⁵⁸

The state of affairs is not lost on the current administration.¹⁵⁹ Five years later, the new administration still finds itself dealing with the

nice they were there’ . . . ‘But when people are talking like they understand what you went through, they [do not].’” Freedberg Jr., *supra* note 39, at 31–32.

153. Exec. Order No. 13,625, 3 C.F.R. § 13,625(1) (2013).

154. *Id.*

155. *See id.*

156. *Id.* §§ (1)–(2), (5)–(6).

157. *Id.* §§ (2)(a), (3)(c), (4). Expansion of the Veterans Crisis Line is treated as curative rather than preventative because it is not preempting or preventing the mental health condition but instead operates on the basis of remediation. *See* 3 C.F.R. § 12, 625(2)(a)–(b).

158. *See* 3 C.F.R. § 12, 625(2)(a), (3)(c), (4); Lolita C. Baldor, *Active Duty Military Suicides Drop; Reserves Go Up*, NEWSMAX: AM. (Apr. 26, 2014, 7:37 AM), <http://www.newsmax.com/us/u-smilitary-suicides-national-guard/2014/04/26/id/567877/>.

159. *See* Calvin Woodward & Hope Yen, *Fact Check: Trump on Veterans’ Health Care, Economy*, J. TIMES (Nov. 13, 2017),

challenges that have been overwhelming the VA healthcare system.¹⁶⁰ In August 2017, the VA Choice and Quality Employment Act (“Act”) was signed into law.¹⁶¹ The law is aimed at providing veterans with access to private healthcare—in realization that the VA is not capable of meeting the needs of the vast number of veterans who still find themselves on long waiting lists.¹⁶² The Act also makes funding available for additional VA medical facilities.¹⁶³ However, despite these improvements, pronouncements by former VA Secretary, David Shulkin, point to the need for Congress to approve funding for employment surges to clear the current backlogs.¹⁶⁴

The seemingly insurmountable task of treating PTSD and other mental health conditions points to the need for a more comprehensive preemptive approach to stem the tide of complications arising from mental health conditions.¹⁶⁵ Generally, three levels of intervention are used to reduce the impact or incidence of psychological injury associated with war.¹⁶⁶ At the primary level, prevention is focused on selecting those individuals who will be adaptable to training in preparation for likely exposure to combat.¹⁶⁷ This occurs at the time of initial screening of the new recruits during their medical assessment.¹⁶⁸ The recruit must then be exposed to realistic training, which will provide *stress inoculation* for building resiliency.¹⁶⁹ *Stress Inoculation Training*—a component of CBT—teaches anxiety reduction techniques and coping skills to reduce PTSD symptoms related to the trauma.¹⁷⁰ Secondary intervention also involves a training component whereby the individual is taught what should be done following exposure to combat.¹⁷¹ This includes techniques for relaxation and

http://www.journaltimes.com/news/national/fact-check-trump-on-veterans-health-care-economy/article_97ba111d-9dcd-51ea-9504-beadb72e03ab.html.

160. *Id.*

161. VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46, § 1, 131 Stat. 958, 958 (codified as amended in scattered sections of 38 U.S.C.).

162. *Id.* § 1, 131 Stat. at 959; Joel Gehrke, *Trump Signs Bill Helping Vets Get Access to Private Medical Care*, WASH. EXAMINER (Aug. 12, 2017, 3:45 PM), <http://www.washingtonexaminer.com/trump-signs-bill-helping-vets-get-access-to-private-medical-care/article/2631366>.

163. § 1, 131 Stat. at 968–69; Gehrke, *supra* note 162.

164. *See* Woodward & Yen, *supra* note 159.

165. *See* Solomon et al., *supra* note 21, at 2309.

166. *See id.*

167. *See id.* at 2309–10.

168. *See id.* at 2310.

169. *See id.* at 2309–10; *Treatment of PTSD*, U.S. DEP’T VETERANS AFF.: NAT’L CTR. FOR PTSD, <http://www.ptsd.va.gov/public/treatment/therapy-med/treatment-ptsd.asp> (last updated Aug. 18, 2017).

170. *Treatment of PTSD*, *supra* note 169.

171. *See* Solomon et al., *supra* note 21, at 2309–10.

typically involves some type of psychological debriefing.¹⁷² Tertiary level intervention is made after symptoms of the psychological injury develop.¹⁷³ Success at this stage will be driven by individual characteristics, such that a person's predisposition will be a measure of whether the goal of prevention is achieved.¹⁷⁴

A. *Improved Access to Mental Health Services*

1. Suicide Prevention

Historically, suicide rates in the Army have been lower than rates in civil society.¹⁷⁵ However, rates have climbed steadily since 2001, despite suicide intervention strategies and the withdrawal of troops from Iraq and most of Afghanistan.¹⁷⁶ Many have attributed the rise in the incidence of suicide to untreated PTSD, other mental health conditions, and to difficulties with the transition to civilian life after combat.¹⁷⁷ Undoubtedly, “[d]eployment and exposure to combat can act as catalysts that worsen existing problems in a service member’s life, like drug abuse, or cause new ones, like post-traumatic . . . brain injuries, which may contribute to suicidal behavior.”¹⁷⁸ However, since 2001, more than half of the victims’ deaths took place in the United States and some victims had never been deployed.¹⁷⁹ The DoD’s report on suicide rates for 2013 revealed that the number of suicides across all branches of the armed forces was 479, a marked improvement over the 522 reported in 2012.¹⁸⁰ However, improved rates were not achieved over all branches.¹⁸¹ The annual suicide rate for those who were Active Duty across all branches was 18.7, a four point improvement over the previous year.¹⁸² The rate for the Reserves across all

172. *See id.*; *Treatment of PTSD*, *supra* note 169.

173. *See Treatment of PTSD*, *supra* note 169.

174. Solomon et al., *supra* note 21, at 2311, 2313.

175. Robert J. Ursano et al., *The Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)*, 77 *PSYCHIATRY* 107, 108 (2014); Zarembo, *supra* note 25.

176. James Dao & Andrew W. Lehren, *Baffling Rise in Suicides Plagues U.S. Military*, *N.Y. TIMES*, May 16, 2013, at A1.

177. *See* U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 7, at 1; McGrane, *supra* note 3, at 191; Dao & Lehren, *supra* note 176.

178. Dao & Lehren, *supra* note 176.

179. *See* DAVID D. LUXTON ET AL., DEP’T OF DEF., DEPARTMENT OF DEFENSE SUICIDE EVENT REPORT: CALENDAR YEAR 2011 ANNUAL REPORT 30 (2012); Dao & Lehren, *supra* note 176.

180. *See* JACQUELINE GARRICK, DEP’T OF DEF., QUARTERLY SUICIDE REPORT: CALENDAR YEAR 2013 4TH QUARTER 2 (2014).

181. *See id.*

182. *Id.*

branches showed a slight increase up to 23.4 from 19.3 in 2012; while the National Guard registered at 28.9 up from 28.1 the previous year.¹⁸³ Suicide rates, reported per every 100,000 service members,¹⁸⁴ reveal that among veterans the number had risen to an average of twenty-two per day.¹⁸⁵

Of the four branches, the Navy—both Active Duty and Reserve—reported tremendous improvement in its suicide rates for the year.¹⁸⁶ While not willing to claim that they had turned the corner on the rising number of suicides, the Navy reported that it has changed the manner of support provided to the group within its service, among which the highest suicide rates had been found.¹⁸⁷ It was also felt that some success had been achieved in changing the culture to one where no stigma surrounds the request for help.¹⁸⁸

Although no verifiable link has been found between serving in combat and the likelihood of committing suicide, at least half of the National Reserve victims reportedly served in Iraq or Afghanistan.¹⁸⁹ Remarkably, members of the National Reserve comprised approximately 40% of the troops deployed to Iraq and Afghanistan over the period commencing in 2001.¹⁹⁰ “Troops facing financial or family troubles while deployed have higher rates of PTSD”—financial and family troubles members of the Army Reserve disproportionately “because they lack the social safety net of active duty military life.”¹⁹¹ It is also suggested that based on the nature of their schedules, members of the Army Reserve may not have had access to the initiatives and suicide prevention strategies offered to those residing on army bases.¹⁹² It seems, then, that members of the National Guard and other

183. *Id.*

184. *Id.*

185. JANET KEMP & ROBERT BOSSARTE, DEP’T OF VETERANS AFFAIRS, SUICIDE DATA REPORT, 2012 15, 18 (2013).

186. *See* GARRICK, *supra* note 180, at 2.

187. *See* Baldor, *supra* note 158.

188. *Id.*

189. *Id.*

190. John F. Greden et al., *Buddy-to-Buddy, a Citizen Soldier Peer Support Program to Counteract Stigma, PTSD, Depression, and Suicide*, 1208 ANNALS N.Y. ACAD. SCI. 90, 90 (2010).

191. WILLIAMSON & MULHALL, *supra* note 5, at 7 (footnotes omitted).

Some troops are at higher risk for psychological and neurological injuries, including the combat-wounded, younger troops, National Guardsmen and Reservists . . . Troops facing financial or family troubles while deployed have higher rates of PTSD. Because these problems are common among troops in the reserve component, and perhaps because they lack the social safety net of active duty . . . life, National Guardsmen . . . are reporting higher rates of PTSD.

Id.

192. Baldor, *supra* note 158.

Scattered across the United States, often in small or remote rural communities, many members of the Army National Guard and Reserve report for

Reservists were predisposed to higher than usual rates of stress and trauma and, therefore, at higher risk for suicide.¹⁹³

As suggested by the Executive Order, by the end of the 2014, Reservists were specially targeted for suicide prevention strategies.¹⁹⁴ The success enjoyed by the Navy, even in the Reservist quotient, points to the fact that despite the unique familial and financial challenges faced by Reservists, suicide rates can be improved.¹⁹⁵ Based on their unique circumstances, the recent positive outcomes of the pilot Buddy-to-Buddy program should be explored and expanded for application to Reservists.¹⁹⁶

Buddy-to-Buddy ensures contact with every returning [Michigan Army National Guard] soldier by using soldier peers. Trained peers regularly contact their assigned panel of soldiers to *check in*, help identify those with clinical needs, encourage registration and entry into Veterans Administration Hospital . . . or military programs, and develop strategies to enhance enrollment in community treatment programs that are perceived as safe and acceptable should other alternatives be unworkable or unacceptable.¹⁹⁷

The DoD Suicide Event Report for Calendar Year 2015 was released in June 2016.¹⁹⁸ The latest reported figures on the suicide rate among veterans reveal a slight decrease in the daily rate to twenty.¹⁹⁹ Whereas, the average yearly suicide rate has not improved since 2013, it has increased among women and persons situated in the western rural areas in the

training about one weekend a month and two weeks in the summer. And they often [do not] have quick access to military medical or mental health services that may be on bases far from their homes. That means the outreach effort by the armed services to address the increase in suicides may not always get to reservists in need—particularly those who [do not] actively seek help.

Id.

193. *See id.*

194. *See* Exec. Order No. 13,625, 3 C.F.R. § 13,625(1), (2)(c) (2013).

195. *See* GARRICK, *supra* note 180, at 2; WILLIAMSON & MULHALL, *supra* note

5, at 7.

196. *See* Greden et al., *supra* note 190, at 94, 96.

197. *Id.* at 93, 96.

198. LARRY D. PRUITT ET AL., DEP'T OF DEF., SUICIDE EVENT REPORT: CALENDAR YEAR 2015 ANNUAL REPORT i (2016).

199. OFFICE OF MENTAL HEALTH & SUICIDE PREVENTION, DEP'T OF VETERANS AFFAIRS, SUICIDE AMONG VETERANS & OTHER AMERICANS: 2001–2014 4 (2016); Leo Shane III & Patricia Kime, *New VA Study Finds 20 Veterans Commit Suicide Each Day*, MILITARY TIMES: VETERANS (July 7, 2016, 6:03 AM), <http://www.militarytimes.com/veterans/2016/07/07/new-va-study-finds-20-veterans-commit-suicide-each-day/>.

nation.²⁰⁰ The figures reported for the rural western region coincides with the shortage of services for veterans in that region.²⁰¹ This highlights the distance which veterans must travel in order to access mental health services acts as a barrier to care.²⁰²

2. Legislating Mandatory Mental Health Screening

A study of mental health risk and resilience was conducted by the United States Army as part of its initiative to combat the high rates of suicide, which began increasing at the start of the OEF and OIF missions.²⁰³ Although combat-related PTSD has been attributed as a leading cause for veteran and soldier suicides, the study carried out in conjunction with the National Institute of Mental Health (“NIMH”) revealed that the “[t]he existence of . . . suicide risk among never-deployed soldiers argues . . . against the view that exposure to combat . . . is the [sole] cause of the increase in Army suicides.”²⁰⁴

In light of the fact that Army suicide rates have now exceeded that of the civilian population, one strategy employed by the study was to compare “the prevalence of mental disorders among [Army and] . . . civilian[] [populations].”²⁰⁵ Research findings revealed that, “[t]he rate of major depression was five times as high among soldiers as civilians; intermittent explosive disorder was six times as high; and PTSD nearly [fifteen] times as high.”²⁰⁶ More importantly, “[n]early 60% of soldier suicide attempts can be

200. See GARRICK, *supra* note 180, at 1; Benjamin Brown, *US Veterans’ Suicide Rates Highest in West, Rural Areas*, FOX NEWS (Sept. 17, 2017), <http://www.foxnews.com/us/2017/09/17/us-veterans-suicide-rates-highest-in-west-rural-areas.html>.

201. See Brown, *supra* note 200.

202. See *id.*

203. See Tuerk et al., *supra* note 20, at 49; Ursano et al., *supra* note 175, at 108. This study found that 20% of Army recruits had entered the armed forces with pre-existing mental health issues and indicates that the mental health questionnaire completed by recruits at enlistment was insufficient in assessing an individual’s fitness for military service. Ursano et al., *supra* note 175, at 110, 114; Zarembo, *supra* note 25.

204. Michael Schoenbaum et al., *Predictors of Suicide and Accident Death in the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)*, 71 JAMA PSYCHIATRY 493, 493; see also McGrane, *supra* note 3, at 189–90.

205. *Study: Nearly 1-in-5 US Army Soldiers Had Mental Illness Before Enlistment*, CBS DC (Mar. 4, 2014, 9:58 AM), <http://washington.cbslocal.com/2014/03/04/study-nearly-1-in-5-us-army-soldiers-had-mental-illness-before-enlistment/>; see also McGrane, *supra* note 3, at 190.

206. Ursano et al., *supra* note 175, at 114.

traced to pre-enlistment mental disorders which [were] much more common among non-deployed United States Army soldiers.²⁰⁷

The research findings point to the fact that mental health screening during recruitment and enlistment was not thorough enough because the assessment tool relied on recruits to self-report mental health history.²⁰⁸ The findings also preliminarily support the view that most of those who committed suicide in recent years, or have developed PTSD in recent years, may have been predisposed to those mental health conditions because of pre-enlistment mental health problems.²⁰⁹

Congress contemplated legislative action based on the findings of the study.²¹⁰ The Medical Evaluation Parity Act for Servicemembers Act of 2015 was a bill aimed to bring mental health to parity with physical health by mandating a mental health assessment before enlisting in the Army.²¹¹ Assessments prior to enlistment would give the Army baseline data, which could then be used for comparative analysis with other mandatory mental health assessments given prior and subsequent to deployments.²¹² The bill proposed that the assessment tool be designed by the NIMH, in conjunction with the DoD and other experts.²¹³ Congress, however, did not enact the bill.²¹⁴

The study also provided the type of findings that can be used to prevent the development of PTSD from exposure to combat.²¹⁵ Thorough mental health assessment at enlistment will determine whether, based on a recruit's mental health history, that individual is suitable for the rigorous training for combat.²¹⁶ It is reminiscent of abandoned post-World War I findings by psychiatrists at the turn of the twentieth century that persons who developed war neuroses were predisposed to that condition, given that not all soldiers received psychological injuries during or after the war.²¹⁷

207. Jake Miller, *Suicidal Ideation Among U.S. Soldiers Precedes Enlistment*, HARV. MED. SCH.: NEWS (Mar. 3, 2014), <http://hms.harvard.edu/news/health-care-policy/suicidal-ideation-among-us-soldiers-precedes-enlistment-3-3-14>.

208. *Id.*; see also Ursano et al., *supra* note 175, at 113–16.

209. Ursano et al., *supra* note 175, at 114–15.

210. See Medical Evaluation Parity for Servicemembers Act of 2014, H.R. 4305, 113th Cong. § 2 (2014).

211. Medical Evaluation Parity for Servicemembers Act of 2015, H.R. 1465, 114th Cong. § 2(a) (2015).

212. See *id.*

213. *Id.* § 2(c).

214. *H.R. 1465 (114th): Medical Evaluation Parity for Servicemembers Act of 2015*, GOVTRACK: CONGRESS, <http://www.govtrack.us/congress/bills/114/hr1465> (last visited Apr. 18, 2018).

215. See Ursano et al., *supra* note 175, at 114.

216. See H.R. 1465 § 2(a).

217. See Smith, *supra* note 75, at 10–11.

Congress also mandated mental health screenings for airmen in the National Defense Authorization Act for Fiscal Year 2015.²¹⁸ Mandatory mental health screenings went into effect on July 31, 2017.²¹⁹ The assessment has similar components to the evaluation for Army recruits and is aimed at helping airmen evaluate and discuss their mental health as part of their medical readiness to take on deployment.²²⁰

B. *Frontline Treatment*

Frontline treatment is a secondary level of prevention.²²¹ It appears to be an important intervention tool for two reasons.²²² First, although a soldier is suffering from symptoms of PTSD, removal from front line duty altogether could have a worse effect because of the stigma which soldiers suffering from mental illness perceive—that they have not lived up to their training and what was expected by their superiors or other unit members.²²³ Second, the ability to find, in the combat zone, acceptance that the condition is not a sign of weakness and the opportunity to decompress and resume duties increases the likelihood that a complete recovery can be made.²²⁴

The United States has sent mental health professionals into combat zones to support troops since World War II as a means of identifying and treating mental health conditions before they became debilitating.²²⁵ No information has been found to indicate whether frontline treatment within the United States military experience has been effective.²²⁶ That is, whether without frontline treatment, the number of service members suffering from mental health illnesses would have been greater.²²⁷ Research efforts should be trained on evaluating the successes of the frontline team.²²⁸ It is known, for example, that the rates of suicides committed at home are greater than

218. Carl Levin and Howard P. “Buck” McKeon National Defense Authorization Act for Fiscal Year 2015, Pub. L. No. 113-291, sec. 701, § 1074n, 128 Stat. 3292, 3408 (2014).

219. Peter Holstein, *New Annual Mental Health Assessment Requirement Begins July 31*, U.S. AIR FORCE: NEWS (July 20, 2017), <http://www.af.mil/News/Article-Display/Article/1253411/new-annual-mental-health-assessment-requirement-begins-july-31/>.

220. *Id.*

221. Hans Pols & Stephanie Oak, *WAR & Military Mental Health: The US Psychiatric Response in the 20th Century*, 97 AM. J. PUB. HEALTH 2132, 2135 (2007).

222. *Id.*

223. McGrane, *supra* note 3, at 191; Solomon et al., *supra* note 21, at 2309–10.

224. See McGrane, *supra* note 3, at 191–92; Pols & Oak, *supra* note 221, at 2138.

225. Pols & Oak, *supra* note 221, at 2133.

226. Solomon et al., *supra* note 21, at 2310.

227. *Id.*

228. See *id.*

those committed abroad.²²⁹ While this is not indicative of the value of the frontline treatment team, it does raise questions as to whether frontline treatment can have the sort of impact it is meant to have in contemporary combat operations.²³⁰

C. *Resiliency Training*

The events of war produce symptoms of trauma.²³¹ Although PTSD appears to be an inevitable by-product of combat, it is accepted in some circles that its debilitating effects can be preempted by interventions facilitated by military training.²³² Resiliency training is part of the DoD's response to the increase in soldier suicides and other mental health conditions associated with the OEF and OIF missions.²³³ The program teaches that combat stress is normal but controllable, and teaches soldiers to use virtues such as self-discipline and comradeship as a platform for readjusting to life with their families at the end of deployment.²³⁴ One perspective sees the first line of psychological defense to be that of soldier supporting soldier.²³⁵ This is due to the fact that the only person who can truly understand what the soldier has gone through is one who witnessed—in the same time and space—the trauma the soldier experienced.²³⁶

As a primary prevention strategy, the program uses a “strength-based psychoeducation [curriculum] to encourage positive coping strategies.”²³⁷ Service members are taught core resiliency skills that can make them successful in combat.²³⁸ The program has a pre-deployment and post-

229. Dao & Lehren, *supra* note 176.

230. See Solomon et al., *supra* note 21, at 2310, 2314.

231. AM. PSYCHIATRIC ASS'N, *supra* note 60, at 463–64; Tuerk et al., *supra* note 20, at 49–50.

232. See Tuerk et al., *supra* note 20, at 50–51.

233. DEP'T OF THE ARMY, ARMY REGULATION 350–53, COMPREHENSIVE SOLDIERS AND FAMILY FITNESS 11 (2014); Tuerk et al., *supra* note 20, at 53.

234. See DEP'T OF THE ARMY, *supra* note 233, at 8, 15; WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

235. WALTER REED ARMY INST. OF RESEARCH, *supra* note 22; see also Carl Andrew Castro et al., Walter Reed Army Inst. of Research, *Battlemind Training: Building Soldier Resiliency*, in NATO: RESEARCH & TECH. ORG., HUMAN DIMENSIONS IN MILITARY OPERATIONS — MILITARY LEADERS' STRATEGIES FOR ADDRESSING STRESS AND PSYCHOLOGICAL SUPPORT 42-1, 42-6 (2006).

236. See WALTER REED ARMY INST. OF RESEARCH, *supra* note 22; see also Castro et al., *supra* note 235, at 42-6.

237. Tuerk et al., *supra* note 20, at 53.

238. *Id.*; see also Castro et al., *supra* note 235, at 42-5; WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

deployment component.²³⁹ The pre-deployment component offers stress inoculation by giving a realistic picture of combat.²⁴⁰ Service members are told, for example that: members of their unit will get injured or killed; no matter how well they perform during training, no one knows how they will perform during combat until the moment arrives; fear is common; and innocent women and children are sometimes killed.²⁴¹

The post-deployment phase of the program is conducted three to six months after servicemembers return to the United States.²⁴² During this component, members are given the opportunity to evaluate their transition to date.²⁴³ As part of the evaluation, a set of scenarios are produced, and servicemembers are encouraged to see whether their natural responses are Battlemind responses.²⁴⁴ Battlemind refers to the core resiliency skillset, which is suitable for combat, but inappropriate for family life and other social contexts.²⁴⁵ Servicemembers are taught how to recognize if they are using their Battleminds and how to adjust their approach.²⁴⁶ They are encouraged to be patient with themselves and to be deliberate about spending time with their families;²⁴⁷ although, the natural inclination is to spend time with their troopmates.²⁴⁸ The program also gives servicemembers certain behaviors to look out for in themselves, and also in their friends, as cues for getting a mental check-up.²⁴⁹

239. Castro et al., *supra* note 235, at 42-3–42-4; DEP'T OF THE ARMY, *supra* note 233, at 11.

240. Castro et al., *supra* note 235, at 42-3; *see also* DEP'T OF THE ARMY, *supra* note 233, at 15; WALTER REED ARMY INST. OF RESEARCH, 10 TOUGH FACTS ABOUT COMBAT: WHAT LEADERS CAN DO TO MITIGATE RISK AND BUILD RESILIENCE, <http://www.armyg1.army.mil/dcs/docs/10%20Leaders%20Tough%20Facts%20About%20Combat%20Brochure%2011%20SEP%2006.pdf> (last updated Sept. 11, 2006).

241. Castro et al., *supra* note 235, at 42-3; WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

242. Castro et al., *supra* note 235, at 42-6; DEP'T OF THE ARMY, *supra* note 233, at 11.

243. *See* Castro et al., *supra* note 235, at 42-4–42-6; WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

244. *See* Castro et al., *supra* note 235, at 42-4–42-5; WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

245. Castro et al., *supra* note 235, at 42-5; WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

246. Castro et al., *supra* note 235, at 42-5; *see also* WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

247. *See* Castro et al., *supra* note 235, at 42-4–42-5; WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

248. WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

249. Castro et al., *supra* note 235, at 42-6; WALTER REED ARMY INST. OF RESEARCH, *supra* note 22.

The resiliency program appears to be successful in assisting service members to make the transition to combat, and then from combat to home, with their families.²⁵⁰ Canadian Forces adapted the framework as part of their Third-Location Decompression exercise, which is carried out immediately after returning from deployment and held in a third location, away from combat and away from home.²⁵¹ As part of its evaluation of DoD programs, the Inter-Agency Task Force should be evaluating the success of these programs—not only locally, but where they are implemented internationally—so that any best practices which are developed may be instructive for our armed forces.²⁵² For example, the Canadian Force found that staging the program immediately after combat—before returning home—was more useful than three to six months after returning from their tour of duty.²⁵³

V. CONCLUSION

The triple threat of PTSD, TBI, and major depressive disorder in veterans is on the verge of becoming a pandemic in the United States; having far greater socio-economic costs than have been so far quantified.²⁵⁴ The nature of these mental health conditions leave them undiagnosed, for one reason or the other.²⁵⁵ In the case of PTSD, one symptom cluster disposes the individual to avoid seeking treatment.²⁵⁶ Moreover, mild and moderate TBI share overlapping symptoms with PTSD and major depressive disorder which, while not impossible, makes an accurate diagnosis difficult.²⁵⁷ This is compounded by the fact that there is no available diagnostic test for confirming mild to moderate TBI,²⁵⁸ and findings that other neuroimaging techniques have been found to miss the presence of mild to moderate TBI in patients.²⁵⁹

250. See Mark A. Zamorski et al., *Beyond Battlemind: Evaluation of a New Mental Health Training Program for Canadian Forces Personnel Participating in Third-Location Decompression*, 177 MIL. MED. 1245, 1245, 1252 (2012).

251. See *id.* at 1245.

252. See *id.* at 1245, 1247–49.

253. See DEP'T OF THE ARMY, *supra* note 233, at 11; Zamorski, *supra* note 250, at 1245–49.

254. WILLIAMSON & MULHALL, *supra* note 5, at 5; Tuerk et al., *supra* note 20, at 49–50; Finnemore, *supra* note 5, at 20.

255. See U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 49, at 11; WILLIAMSON & MULHALL, *supra* note 5, at 4.

256. Tuerk et al., *supra* note 20, at 50.

257. WILLIAMSON & MULHALL, *supra* note 5, at 5–6.

258. *Id.* at 3.

259. *Id.*

The VA healthcare system is already stretched thin.²⁶⁰ The influx of veterans needing care, and the nationwide shortage of primary care doctors and mental healthcare specialists—coupled with an absence of facilities in rural areas of the country—add to the picture of tens of thousands of veterans who have left the service and have been languishing on doctor waiting lists for months.²⁶¹ Studies have found that persons with untreated PTSD are at risk for developing other major illnesses.²⁶²

The DoD has taken many steps to implement programs aimed at early detection of PTSD among troops.²⁶³ Early detection and treatment are essential to overcoming the trauma of war and a successful reintegration to life after combat.²⁶⁴ However, more can be done where only new recruits and airmen are required to go through mandatory mental health screening.²⁶⁵ Every soldier who has the potential to be deployed should undergo mental health assessments as a means of determining baseline behavioral responses.²⁶⁶ Knowledge of one's baseline responses will help the individual to seek help when exposed to triggers in combat.²⁶⁷ PTSD, however, can have late onset, so thorough post-deployment screening is equally required.²⁶⁸

At this point, when the OIF and OEF wars have ended or wound down, more will have to be done by way of treatment for those troops and veterans who have already been exposed to trauma.²⁶⁹ With due regard to the fact that the United States is still expected to play a leadership role in global conflicts, a plan for prevention must be created now to avoid the toll that war and other military operations take on the mental health of troops and the social fabric of the nation.²⁷⁰ Given the challenges still facing the VA healthcare system, and preliminary findings on the rate at which persons with PTSD seek medical attention, prevention is the optimal course to pursue.²⁷¹

Prevention is also optimal because the toll PTSD takes on veterans, their families, and the nation can dissuade the caliber of recruits the armed

260. Ginzburg & Holm, *supra* note 11, at 73.

261. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 49, at 6, 12; McGrane, *supra* note 3, at 192–93.

262. Baker, *supra* note 8, at 350.

263. See U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 49, at 3–4.

264. McGrane, *supra* note 3, at 191 n.67.

265. See Medical Evaluation Parity for Servicemembers Act of 2014, H.R. 4305, 113th Cong. §§ 2–3 (2014).

266. See *id.*

267. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 7, at 7.

268. *Id.* at 6–7; Ginzburg & Holm, *supra* note 11, at 76.

269. Baker, *supra* note 8, at 348; Ginzburg & Holm, *supra* note 11, at 75–76.

270. See Baker, *supra* note 8, at 352–53; Kitfield, *supra* note 25.

271. Baker, *supra* note 8, at 350, 353.

forces could otherwise attract.²⁷² Under President Obama’s leadership, United States foreign policy, as echoed in pronouncements by the former Chairman of the Joint Chiefs of Staff, focused on rebalancing the use of military power and suggested that frequent deployment would be slowed in the coming years.²⁷³ This was crucial because direct military action costs the American population more than any other use of power.²⁷⁴ However, the current administration appears to have a different foreign policy focus and military strategy, which could see the deployment of troops.²⁷⁵ “The problem is . . . [w]henver a crisis comes up—whether it [is] a humanitarian crisis, disaster relief, or particularly a security threat—we tend to just deal with them” without due regard to the suffering, mental and otherwise, which both our active duty personnel and veterans will endure.²⁷⁶

272. See Kitfield, *supra* note 25; Zaremba, *supra* note 25. “The kind of people who join the Army are not typical people . . . They have a lot more acting-out kind of mental disorders. They get into fights more. They [are] more aggressive.” Zaremba, *supra* note 25.

273. Kitfield, *supra* note 25.

Over the past [ten] years we [have] done most of our heavy-lifting on the direct action side. Increasingly, we are doing more, however, to build partners so that they can counter threats in their own regions. We are also enabling other nations to act. A good example is the way we [are] partnering with the French in Mali [to counter al-Qaeda-linked terrorists] in West Africa.

As I look forward and think about the need to rebalance the use of military power, I think we will need less direct action because it is the most costly, disruptive, and controversial use of American power. By contrast, we need to do more in terms of building partners. I [am] a huge advocate of doubling or even tripling our effort to build credible partners around the globe. And I [am] also a huge advocate of enabling others who have the will, but perhaps not the capability to act.

Id.

274. *Id.*

275. See Alex Lockie, *US Military Could Deploy to Libya ‘Any Day’*, BUS. INSIDER (May 20, 2016, 8:24 PM), <http://www.businessinsider.com/chairman-joint-chiefs-us-military-could-deploy-to-libya-any-day-2016-5>.

276. Kitfield, *supra* note 25; see also Baker, *supra* note 8, at 348.