JOSHUA OMVIG VETERANS SUICIDE PREVENTION ACT OF 2007

Joshua Omvig was a twenty-two-year-old veteran Army specialist from Gillette, Wyoming, who served an eleven-month tour of duty in northern Iraq with the 339th Military Police Company.[1] Omvig returned from Iraq in 2005, less than a week before Thanksgiving.[2] While his family members celebrated the holiday and shared stories of the year's events, Omvig—"Josh" to his family—kept his thoughts on his experience overseas to himself.[3] He soon began to show signs of depression, suffering from flashbacks and nightmares, and he ultimately confided to his family that he believed he had post-traumatic stress disorder ("PTSD").[4] While his parents encouraged him to seek help, Josh never sought professional counseling because he worried that doing so would damage his career. In December 2005, finally, overwhelmed by his pain, Josh told his mother he had felt "dead ever since [he] left Iraq," sat in his truck in his parents' driveway, and shot himself.[5] Although he was only one of many veterans who have experienced debilitating mental health problems and whom the system of care has somehow neglected,[6] Josh has become the human face behind a legislative attempt to address the growing problem of suicide among veterans.[7]

Recently, veteran suicide and mental health issues have been gaining more widespread visibility.[8] The mental health problems facing veterans of Operation Iraqi Freedom ("OIF") and Operation Enduring Freedom ("OEF") first attracted attention in 2002 after four Special Forces veterans committed suicide and killed their wives in Fort Bragg, North Carolina,

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[1] Jane Norman, *Bill Aimed at Preventing Vets' Suicides Gets OK,* Des Moines Reg., Oct. 24, 2007, at 11A, *available at* http://www.desmoinesregister.com/apps/pbcs.dll/article?AID=/20071024/NEWS09/710240386; *see also* Whitney Woodward, *Parents of Iowa Veteran Hope Legislation will Help Prevent More Military Suicides*, Quad City Times, Jan. 27, 2008, *available at* http://www.qctimes.com/articles/2008/01/27/news/local/doc479ade23a463e954648442.txt.

[2] *Oversight on Mental Health Issues: Hearing Before the S. Comm. on Veterans' Affairs*, 110th Cong. (2007) (statement of Randall Omvig, father of Joshua Omvig) [hereinafter *Mental Health Issues Hearing*], *available at* http://veterans.senate.gov/public/index.cfm?pageid=16&release_id=10814&sub_release_id=11263&view=all.

[3] *See id.*

[4] *Id.*; *see also* Woodward, *supra* note 1.

[5] *See* Woodward, *supra* note 1.

[6] Ken Dennis committed suicide in his Washington state apartment in March 2004. Ilona Meagher, Moving a Nation to Care: Post-Traumatic Stress Disorder and America's Returning Troops 25 (2007). Mike Bowman, of Illinois, ended his life in 2005. *See Stopping Suicides: Mental Health Challenges Within the U.S. Department of Veterans Affairs: Hearing Before the H. Comm. on Veterans' Affairs,* 110th Cong. (2007) (statement of Mike and Kim Bowman), *available at* http://veterans.house.gov/hearings/Testimony.aspx?TID=11136. Greg Morris, of New Mexico, also ended his life in 2005. *See* Kimberly Hefling, *Data Sought on Veterans' Suicide*, USA Today, Dec. 12, 2007, *available at* http://www.usatoday.com/news/topstories/2007-12-12-1553356403_x.htm.

[7] *See* Meagher, *supra* note 6, at 64.

[8] Despite incidents linked to PTSD that occurred soon after U.S. troops invaded Afghanistan, the media did not give much attention to PTSD until 2006. *Id.* at xxiii.

shortly after returning from duty in Afghanistan.[9] Following a spate of combat theater suicides and mental health-related evacuations of personnel from Iraq in 2003, Army Surgeon General Lieutenant General James B. Peake, now Secretary of the Department of Veterans Affairs ("VA"), formed a Mental Health Advisory Team ("MHAT") to assess the mental health needs of U.S. troops serving in OIF and OEF.[10] MHAT wrote four reports between 2003 and late 2006.[11] The first report praised a new program that treated soldiers in the combat theater rather than evacuating them for treatment, but, nevertheless, the report concluded that the suicide rate for active-duty soldiers was high relative to the Army's eight-year average prior to OIF and OEF.[12] Suicide is also a problem among veterans who have returned from their service abroad. Three suicides and a number of other military-related homicides were reported in Washington state in 2005, suggesting that veterans' mental health problems persist beyond their tour of duty.[13]

Numerous studies have linked suicide to PTSD and other mental illnesses.[14] Omvig's classification as a "casualty of PTSD" on the "Fallen Heroes" section of the iraqwarheroes.org website demonstrates how closely suicide, PTSD, and combat are linked in the public perception.[15] Although some veterans returning from their tours of duty in Iraq and Afghanistan

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[9] *Id.* at 21.

[10] *Id.* at 31. MHAT's studies represented the first effort to survey soldiers concerning behavioral health issues. *See id.*

[11] Mental Health Advisory Team, U.S. Army Surgeon Gen., Mental Health Advisory Team Report I (2003); Mental Health Advisory Team, U.S. Army Surgeon Gen., Mental Health Advisory Team Report II (2005); Mental Health Advisory Team, U.S. Army Surgeon Gen., Mental Health Advisory Team Report III (2006); Mental Health Advisory Team, U.S. Army Surgeon Gen., Mental Health Advisory Team Report IV (2006).

[12] *See* Mental Health Advisory Team Report I, *supra* note 11, at 6. In 2006, the Army reported its highest combat theater suicide rate in 26 years: 17.3 deaths per 100,000 soldiers. This rate only reflects the Pentagon's data on suicide among active-duty and activated reserve-component troops, and does not capture suicide rates among veterans. Hefling, *supra* note 6. Also, in 2004, researchers from the Walter Reed Army Institute of Research revealed that the prevalence of major depression, generalized anxiety, or PTSD was significantly higher after the soldiers' duty in Iraq (15.6% to 17.1%) than before their deployment (9.3%). Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 New Eng. J. Med. 1, 13 (2004).

[13] Rick Anderson, *Home Front Casualties*, Seattle Wkly., Aug. 31, 2005, at 13. Meagher reports that the Department of Defense does not collect data on home-front suicides. However, some reports have estimated that seventy-nine individuals who served in OIF or OEF committed suicide between March 2003 and July 2006. Meagher, *supra* note 6, at 27. Between the start of OEF and the end of 2005, 144 deaths were reported. Hefling, supra note 6.

[14] *See, e.g.*, Marcello Ferrada-Noli et al., *Suicidal Behavior After Severe Trauma: PTSD Diagnoses, Psychiatric Comorbidity, and Assessments of Suicidal Behavior*, 11 J. Traumatic Stress 103 (1998)*; see also* Kent D. Drescher et al., *Causes of Death Among Male Veterans Who Received Residential Treatment for PTSD*, 16 J. Traumatic Stress 535, 540 (2003) (linking behavioral patterns among patients treated with PTSD to 62.4% of deaths in a 2003 study of veterans).

[15] *See* Iraq/Afghanistan War Heroes, http://www.iraqwarheroes.org/omvig.htm (last visited Mar. 5, 2008) (provides information on the name, age, military branch, rank, and circumstances of death for service members killed in Iraq and Afghanistan).

have committed suicide and a larger number are suffering from PTSD, mental health consequences of traumatic brain injuries, and other afflictions, there are conflicting statistics about precisely how many veterans are suffering from which forms of mental illness. MHAT's most recent study, MHAT-IV, reports a suicide rate of 16.1 deaths per 100,000 soldiers per year, which is considerably higher than the Army's reported average of 11.6 deaths per 100,000 soldiers per year.[16] By another count, there were 283 suicides between 2001 and 2005 among returned veterans, which, when added to the number of combat-theater suicides, amounted to 430 suicides—over ten percent of the total Iraq and Afghanistan war U.S. military casualty count.[17] Although Army officials assert that the rate of suicides among soldiers is lower than that among the civilian population as a whole,[18] a Portland State University study counters that male veterans are twice as likely as civilians to commit suicide regardless of VA contact or treatment.[19] CBS News reported even more alarming statistics, estimating the veteran suicide rate to be four times that of the non-veteran suicide rate.[20] Reports exclusively addressing the prevalence of PTSD among OIF and OEF veterans show rates as high as twenty percent.[21] MHAT-IV reports that as many as thirty-eight percent of veterans who served in OIF and OEF were diagnosed with some form of mental illness upon return from duty.[22]

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[16] Mental Health Advisory Team Report IV, *supra* note 11, at 4. Interestingly, MHAT IV reports a 2003–06 average rate for OIF, as opposed to the single calendar year-only rate reported previously. *See id.* The MHAT III study from May 2006 reported an OIF combat-theater suicide rate of 19.9 deaths per 100,000 soldiers for 2005. Mental Health Advisory Team Report III, *supra* note 11, at 6.

[17] Kimberly Hefling, *Iraq, Afghan Vets at Risk for Suicides*, USA Today, Oct. 31, 2007, *available at* http://www.usatoday.com/news/washington/2007-10-31-vet-suicide_N.htm. See also the U.S. military statistics from *Casualties of War*, N.Y. Times, http://www.nytimes.com/ref/us/20061228_3000FACES_TAB2.html (last visited Apr. 1, 2008). As of April 1, 2008, the *New York Times* counted a total of 4009 deaths based on Pentagon reports. *Id.*

[18] *See* Donna Miles, *2003 Suicide Rates Elevated Among Iraqi Freedom Troops; 2004 Rates Dip*, Am. Forces Press Service, Mar. 25, 2004, *available at* http://www.defenselink.mil/news/newsarticle.aspx?id=27000 (last visited Mar. 3, 2008).

[19] Mark D. Kaplan, et al. *Suicide Among Male Veterans: A Prospective Population-Based Study*, 61 J. Epidemiology & Community Health 619, 619 (2007).

[20] *CBS Evening News: Suicide Epidemic among Veterans* (CBS television broadcast Nov. 13, 2007), *available at* http://www.cbsnews.com/stories/2007/11/13/cbsnews_investigates/main3496471.shtml (transcript only). CBS reported 8.3 deaths per 100,000 people among the non-veteran population and 22.9–31.9 deaths per 100,000 among veterans aged 20 to 24 who served in OIF or OEF.

[21] Jessica Hamblen, What is PTSD?: A Handout from the National Center for PTSD 3, *available at* http://www.ncptsd.va.gov/ncmain/ncdocs/handouts/handout_What%20is%20PTSD.pdf. Although Karen H. Seal reports only a thirteen percent prevalence of PTSD among their population study of OIF and OEF veterans, estimates vary. A National Center for Post Traumatic Stress Disorder study reports the prevalence of PTSD ranging from twelve to twenty percent. *See* Karen H. Seal et al., *Bringing the War Back Home*, 167 Archives Internal Med. 479, 480 (2007). The rate greatly surpasses the prevalence among veterans of the first Gulf War (two to ten percent), and the prevalence among the general U.S. adult population (three to four percent). Hoge et al., *supra* note 12, at 20.

[22] Mental Health Advisory Team Report IV, *supra* note 11, at 21.

Given the scope of the problem, veterans' advocates complained that VA—which provides health care for 7.8 million enrollees nationwide—was not adequately serving veterans' mental health needs.[23] They noted that veterans face long waits to see mental health care providers, and Frances M. Murphy, VA's Deputy Under Secretary for Health Policy Coordination, has stated that "waiting lists render [mental health] care virtually inaccessible."[24] By some accounts, demand for care was simply outstripping the resources of an unprepared and under-funded VA.[25] VA responded that, in some instances, its unprecedented offerings of targeted care were going underutilized.[26] VA also contended that it began working to improve health care as early as 2003 and finalized the VA Mental Health Strategic Plan—a five-year plan with 200 independent initiatives—in late 2004.[27]

Unsatisfied with VA's claims that it was addressing deficiencies in its mental health service, some veterans and their families reached out for more help. Veterans and their advocates pursued their concerns by approaching

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[23] VA Benefits and Healthcare Utilization, http://www1.va.gov/vetdata/docs/4X6_winter08_sharepoint.pdf (last visited Mar. 5, 2008).

[24] For example, veteran Eugene Cherry, who served in Iraq in 2004 and 2005 and who experienced suicidal tendencies, was told the wait to see a mental health specialist was at least one month. Don Terry, *Bringing the War Home*, CHI. TRIB., Feb. 3, 2008, at 8. National Guard member Jonathon Johnson reported to KCCI, the local news affiliate in Des Moines, Iowa that "[t]here are just too many soldiers in the system right now. They cannot handle us all. They just can't." *National Guard Soldier Talks of Conditions at Medical Facility*, KCCI DES MOINES, Mar. 9, 2007, http://www.kcci.com/health/11215950/detail.html?rss=des&psp=news; *see also* Linda Bilmes, *The Battle of Iraq's Wounded*, L.A. TIMES, Jan. 5, 2007, at A23.

[25] Some authors have attributed this lack of access to the levels of funding originally allocated to VA in the initial years of the war and a corresponding underestimation of the number of claims that might be filed. MEAGHER, *supra* note 6, at xxii; *see also* Seal et al., *supra* note 21, at 479 (noting that current returned veteran VA enrollment rates for OIF/OEF are twenty-nine percent, compared with ten percent enrollment for Vietnam veterans).

[26] *Compare Mental Health Issues Hearing*, *supra* note 2 (statement of Patrick Campbell, Legislative Dir., Iraq and Afghanistan Veterans of Am.), *with* Jennifer Jacobs, *PTSD: Soldiers in Distress*, DES MOINES REG., May 21, 2006 ("Therapists are available for Iowa's veterans—and some are underused.").

[27] *Stopping Suicides: Mental Health Challenges Within the U.S. Department of Veterans' Affairs, Hearing Before the H. Comm. on Veterans' Affairs*, 110th Cong. (2007)(statement of Michael Shepherd, M.D., Physician, Office of Inspector Gen., U.S. Dep't of Veterans Affairs).

the media, litigating both class actions[28] and individual wrongful death claims,[29] and petitioning their congressional representatives.[30]

In response, Congress drafted several bills ordering VA to take specific measures to improve mental health care for veterans, but none of the proposals made it through committee in either house of Congress.[31] Finally, in early 2007, Representative Leonard L. Boswell (D-Iowa) introduced the Joshua Omvig Suicide Prevention Act, a bill that was less specific and wide-ranging than previous legislative attempts but would still require VA to address the problem of veteran suicide.[32]

I. Provisions of the Joshua Omvig Veterans Suicide Prevention Act

The Joshua Omvig Veterans Suicide Prevention Act (the "Act") mandates that VA create and implement a comprehensive program to address the mental health problems of all veterans. Congress expressed particular concern for "the special needs of veterans suffering from PTSD and the special

[28] In 2007, Veterans for Common Sense filed suit against then-VA Secretary Jim Nicholson, asking for, among other things, relief in the form of immediate mental health treatment for veterans who express thoughts of suicide. The suit was filed on behalf of 320,000 to 800,000 veterans or their survivors. *See* Bob Egelko, *Veterans Not Entitled to Mental Health Care, U.S. Lawyers Argue*, S.F. Chron., Feb. 5, 2008, at A8. Recently, the suit has been amended to claim that the new eligibility length (five years rather than two years) should necessarily include mental health care. The government has argued that a type of care itself is not guaranteed, only care that the Secretary deems appropriate and that falls within budgetary limitations. *Id.* Filed in July, the case survived a motion to dismiss and, at the time of this writing, is pending in federal district court in San Francisco. The group also wants VA to spend another $60 million on health care for returning soldiers, claiming "that the federal government's failure to provide timely treatment is contributing to an epidemic of suicides among returning soldiers." *Id.*

[29] The family of Lance Corporal Jeffrey Lucey, a veteran who committed suicide after allegedly being denied mental health benefits by VA, has also filed suit. The wrongful death action requests unspecified damages for Lucey's death. According to the complaint, Lucey was suffering from nightmares, fits of vomiting, and a drinking problem but was nevertheless turned away from VA on at least two occasions. Lucey was turned away once because VA said that he needed to be sober before they could assess him. When he returned a few days later VA again turned him away. Jennifer C. Kerr, *VA Secretary Faces Wrongful Death Suit*, Wash. Post, July 26, 2007, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2007/07/26/AR2007072601050.html?tid=informbox.

[30] Early in 2003, U.S. and state representatives were aware of some of the complaints of lines at VA medical facilities nationwide. *See* Ann Marie Somma, *More Than a Home, Veterans From World War I to Iraq War Find Connections*, Hartford Courant, Nov. 17, 2003, at A1.

[31] *See, e.g.*, Joshua Omvig Veterans Suicide Prevention Act, H.R. 5771, 109th Cong. (2006)(stalled in committee late in the second session of the 109th Congress); Comprehensive Assistance for Veterans Exposed to Traumatic Stressors Act of 2005, H.R. 1588, 109th Cong. (2005); Veterans Mental Health Services Enhancement Act of 2005, H.R. 922, 109th Cong. (2005); Comprehensive Assistance for Veterans Exposed to Traumatic Stressors Act of 2004, H.R. 5244, 108th Cong. (2004).

[32] Joshua Omvig Veterans Suicide Prevention Act, H.R. 327, 110th Cong. (2007) (as introduced to the House, Jan. 9, 2007) [hereinafter Omvig Bill I].

needs of elderly veterans who are at high risk for depression," the veteran populations most likely to commit suicide.[33]

The program has six major components, detailed in section 3 of the Act: (1) education for VA staff; (2) increased emphasis on mental health assessments for veterans; (3) designation of suicide prevention counselors; (4) research on veterans' mental health issues; (5) provision of round-the-clock mental health care; and (6) outreach and education for veterans and their families.[34] The VA also "may provide for other actions to reduce the incidence of suicide among veterans that the Secretary considers appropriate."[35] Finally, Congress mandated that the VA report on the implementation status of the program, its estimated timeline for completion, the estimated costs of the program, and any additional actions deemed necessary to fully address veterans' mental health issues.[36]

A. *Components of the Act*

1. *Training, Research, and Staffing*

Under section 3(a)(1)(b) of the Act, all VA staff, including medical staff and contractors who interact with veterans, must be trained to "recogniz[e] risk factors for suicide," and be trained in protocols for handling crisis situations involving high-risk veterans.[37] This provision also mandates that staff be trained in "best practices for suicide prevention" more generally.[38] Because the best practices training requirement is listed separately from the crisis management training requirement, the text of the Act suggests that this best practices training would encompass practices for preventing suicide in veterans who are not in acute crisis.[39] The Act does not prescribe any set of best practices in veteran suicide prevention. Instead, it requires the VA to conduct research in conjunction with the Department of Health and Human Services, the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, and the Centers for Disease Control and Prevention to determine the best practices in veteran suicide prevention.[40] Given the Act's pragmatic focus on reducing veteran suicide as quickly as possible, the results of this best practices research may be incorporated into the required staff training programs. Finally, in addition to training all VA staff who interact with veterans, each VA medical facility must

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[33] *Id.* § 2.
[34] *Id.* § 3(a)(1).
[35] *Id.* § 3(a)(1)(k).
[36] *Id.* § 3(b). This report, due on February 5, 2008, according to the terms of the Act, was not available at the time this Recent Development was written.
[37] *Id.* § 3(a)(1)(b).
[38] *Id.* § 3(a)(1)(b)(3).
[39] *Id.*
[40] *Id.* § 3(a)(1)(e).

designate a suicide prevention counselor to coordinate the outreach to, and mental health care of, veterans.[41]

2. *Mental Health Assessments of Veterans*

VA medical staff must "offer mental health [evaluations] in their overall health assessment" when veterans seek any kind VA care.[42] VA medical staff are also required to provide referrals, "at the request of the veteran concerned, to appropriate counseling and treatment programs for veterans who show signs or symptoms of mental health problems."[43] The bill that originally passed in the House would have mandated mental health screenings, tracking of all veterans seeking VA medical care, and mandatory referrals for at-risk veterans.[44] However, Senator Tom Coburn (R-Okla.) objected to the mandatory nature of the provisions, resulting in a compromise which removed the tracking provision from the Act, transformed the mandatory screening provision into a requirement that VA medical staff "offer" mental health assessments to veterans, and required mental health referrals only at a veteran's request.[45]

3. *Twenty-Four-Hour Mental Health Care and Hotline*

Section 3(a)(1)(g) of the Act requires the VA to make mental health care available to veterans twenty-four hours a day, and section 3(a)(1)(h) authorizes VA to "provide for a toll-free hotline for veterans . . . available at all times."[46] While the text of the Act does not require the VA to establish the hotline, the VA had already done so by the time the Act became law.[47] A House bill introduced during the Senate's consideration of the Act would have appropriated $2.5 million per year for three years to VA and required VA to contract with an outside party to provide such a hotline, according to very detailed specifications.[48]

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[41] *Id.* § 3(a)(1)(d).

[42] *Id.* § 3(a)(1)(c).

[43] *Id.*

[44] Joshua Omvig Veterans Suicide Prevention Act, H.R. 327, 110th Cong. § 3(a)(1)(c)–(e) (2007) (as passed by House, Mar. 21, 2007) [hereinafter Omvig Bill II].

[45] *Compare id., with* Joshua Omvig Veterans Suicide Prevention Act, H.R. 327, 110th Cong. (2007) (engrossed amendment as agreed to by Senate, Sept. 27, 2007) [hereinafter Omvig Bill III]. *See also* Press Release, Office of Sen. Coburn, Senators Coburn, Harkin Reach Agreement on Joshua Omvig Veterans Suicide Prevention Act (Sept. 27, 2007), http://coburn.senate.gov/public/index.cfm?FuseAction=Issues.View&Issue_id=5feea2ca-5637-4b00-8450-a3b64e0eccea&CFID=23611163&CFTOKEN=79956287.

[46] The Joshua Omvig Veterans Suicide Prevention Act, Pub. L. No. 110-110 § 3(a)(1)(g)–(h), 121 Stat. 1031, 1032 (2007) [hereinafter Omvig Act]

[47] In coordination with the federally funded National Suicide Prevention Hotline, VA launched its hotline for veterans on July 25, 2007. 153 CONG. REC. H11,870 (daily ed. Oct. 23, 2007) (statement of Rep. Boozman (R-Ark.).

[48] Veterans Suicide Prevention Hotline Act of 2007, H.R. 2219, 110th Cong. (2007). In contrast, the Omvig Act does not include appropriations for any of its provisions, but requires

The sponsor of the House bill, Representative Jim Moran (D-Va.), disagreed with VA's plans to combine the veteran hotline with the existing, federally-funded National Suicide Prevention Hotline.[49] Appending the hotline for veterans to the national hotline would require veterans to call the main number and then be rerouted to speak with VA medical staff if they chose.[50] At a Committee on Veterans' Affairs hearing in June 2007, Moran defended his proposal for an independent hotline, arguing that veterans should be able to speak to other veterans about their problems and expressed concern that the already over-extended and under-funded VA would be lax in its commitment to a program it operated.[51] Speaking for VA, Michael J. Kussman, Under Secretary for Health for the Veterans Health Administration, objected to the Act, asserting that VA had already incorporated a national twenty-four-hour toll-free hotline into its Mental Health Strategic Plan that would be "more comprehensive" than the independent hotline Representative Moran proposed.[52] Responding more specifically to Moran's ideas about the hotline, Kussman said that while VA "respect[s] the idea of peer-to-peer counseling . . . [it] believes it is more appropriate from a clinical standpoint to staff VA's national hotline with trained health care professionals."[53] As Moran's bill stalled in committee after the hearing, VA went forward with its hotline plans, enabling veterans to speak with VA-trained operators by pressing "1" when calling the National Suicide Prevention Lifeline.[54] The hotline began operating in July 25, 2007, more than three months before the Act was signed into law, and in its first six weeks, the hotline received hundreds of calls and conducted fifty-six rescues of veterans in crisis.[55]

4. Outreach, Education, and Peer Counseling

Under section 3(a)(1)(i), the Act directs VA to develop outreach and education programs that de-stigmatize mental illness, "encourage veterans to seek treatment and assistance," help veterans develop coping skills, and help veterans' families understand and identify signs of mental illness. Section 3(a)(1)(j) provides that VA may choose to create a peer counseling program

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VA to report to Congress its estimated costs for implementing the Act. *See* Omvig Act, *supra* note 46, § 3(b)(2)(B).

[49] *Legislative Hearing on H.R. 1448, H.R. 1853, H.R. 1925, H.R. 2005, H.R. 2172, H.R. 2173, H.R. 2378, H.R. 2219, H.R. 2192, and H.R. 2623: Hearing Before the H. Comm. on Veterans' Affairs*, 110th Cong. (2007) (statement of Rep. James P. Moran), *available at* http://veterans.house.gov/hearings/Testimony.aspx?TID=11587.

[50] *See id.*

[51] *Id.*

[52] *See id.*

[53] *Id.*

[54] 153 Cong. Rec. H11,870 (daily ed. Oct. 23, 2007) (statement of Rep. Boozman); *see generally* National Suicide Prevention Lifeline, http://www.suicidepreventionlifeline.org (last visited Feb. 27, 2008).

[55] 153 Cong. Rec. H11,870 (daily ed. Oct. 23, 2007) (statement of Rep. Boozman).

that would train volunteer veterans to help other veterans readjust to civilian life and to carry out the outreach provisions of the Act that VA assigns to its volunteers. The optional nature of this provision is the result of a Senate amendment; the House version of the bill mandated the peer counseling program.[56]

Randall Omvig's Senate testimony indicates that the inclusion of peer counseling provision was motivated by the sense that veterans may only feel truly understood by other veterans.[57] Randall Omvig testified that his son was bound to keep most of the information about what he did and where he was stationed in Iraq confidential.[58] He also testified that his son had no opportunity to interact with the other men in his unit after his return from Iraq.[59] Randall Omvig expressed his belief that his son needed to be able to interact with other veterans because they were the only people with whom he would have felt comfortable discussing his experiences in Iraq and his feelings about those experiences.[60]

5. *Sexual Trauma Research*

Finally, the Act directs VA to "provide for research on mental health care for veterans who have experienced sexual trauma while in military service."[61] In the military, "sexual trauma" is a term of art that refers not only to sexual assault but also to sexual harassment or unequal treatment of any kind based on gender.[62] The Senate's hearing on the Act included testimony from psychologist Connie Best, who explained that military sexual trauma, like combat stress, can lead to PTSD, depression, and suicide.[63] Best also testified that twenty-three percent of female veterans seeking health care at VA facilities "had reported experiencing at least one sexual trauma while in the military."[64] She also explained the multiplying effect of sexual trauma for service members in stressful combat situations; if a service member was "unfortunate enough to have experienced both combat-related trauma and military sexual trauma, the risk for developing significant mental health problems would increase exponentially."[65] In a written statement submitted to the Committee, a female veteran described the sexual harassment and un-

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[56] Omvig Bill II, *supra* note 44, § 3(a)(1)(l).

[57] *See Mental Health Issues Hearing*, *supra* note 2, at 12–13 (statement of Randall Omvig).

[58] *Id.* at 12.

[59] *Id.*

[60] *See id.* at 12–13.

[61] Omvig Act, *supra* note 46, § 3(a)(1)(f).

[62] *Mental Health Issues Hearing*, *supra* note 2, at 67 (statement of Connie L. Best, Ph.D., Senior Faculty Member, Nat'l Crime Victims Research and Treatment Ctr., Med. Univ. of S.C., and submission of Sgt. Carolyn Schapper, Va. Nat'l Guard). The hearing did not address issues of the interaction between sexual orientation and sexual trauma.

[63] *Id.* at 29 (statement of Connie Best).

[64] *Id.*

[65] *Id.* at 31.

equal treatment she and other women experienced during their service, and the mental anguish that stemmed from these experiences.[66] Responding to this issue, the Act directs VA to tailor its best practices research to the unique mental health care needs of veterans affected by sexual trauma.[67]

B. *Floor Debate and Compromise*

The bill that became the Joshua Omvig Veterans Suicide Prevention Act was introduced in the House of Representatives on January 9, 2007, and was cosponsored by 132 House Democrats and 20 House Republicans.[68] It passed the House with no substantive changes on March 21, 2007, by a vote of 423 to 0.[69] However, the bill encountered opposition in the Senate when Senator Coburn placed a hold on the bill in August 2007.[70] The media characterized Coburn's objections as a Second Amendment rights activist's concern that the mandatory screening and tracking provisions of the bill would result in documented mental health histories, which would then hinder veterans' future attempts to secure gun permits.[71] In an editorial entitled "Locked, Loaded, and Looney," the *New York Times* wrote that "[e]ven the craven gun lobby should manage some shame over this absurd example of Second Amendment idolatry."[72]

However, this over-simplified characterization of Senator Coburn's objections ignored his more substantive critiques of the bill. In an open letter to the press, Coburn expressed concern that Congress was passing the legislation too hastily and without carefully analyzing its implications.[73] Senator Coburn wrote that "our veterans need more than our good intentions and political posturing. Our veterans have the right to expect that the legislation we draft can deliver on our good intentions."[74] In the letter and during floor debate on September 5, Coburn explained four specific concerns with the bill.[75] First, he objected to making a mental health screening a prerequisite for receiving any VA health care, arguing that it was "insulting" to veterans

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[66] *Id.* at 67–72 (submission of Sgt. Carolyn Schapper).

[67] Omvig Act, *supra* note 46, § 3(a)(1)(f).

[68] Omvig Bill I, *supra* note 32. The bill had ninety co-sponsors when it was introduced.

[69] 153 CONG. REC. H2,785-86 (daily ed. Mar. 21, 2007) (containing the record of yeas and nays).

[70] *See* 153 CONG. REC. S11,097 (daily ed. Sept. 5, 2007) (statement of Sen. Harkin).

[71] *See, e.g.,* T.M. Lindsey, *Harkin: Sen. Coburn's Hold on Veterans' Suicide Prevention Bill "Bogus,"* IOWA INDEP., Sept. 7, 2007, *available at* http://www.iowaindependent.com/showDiary.do?diaryId=968; *Coburn seizes veterans care bill: He Fears Information from Mental Health Screenings Could Jeopardize Gun Rights*, TULSA WORLD, Aug. 25, 2007, at A1.

[72] Editorial, *Locked, Loaded, and Looney*, N.Y. TIMES, Aug. 30, 2007, at A22.

[73] Press Release, Office of Sen. Coburn, Combat Veterans Need Medical Care; Not Forced Mental Health Screenings (Sept. 5, 2007), http://coburn.senate.gov/public/index.cfm?FuseAction=LatestNews.PressReleases&ContentRecord_id=d7b4f1ac-802a-23ad-4cc7-1a17291bb56b&Issue_id=.

[74] *Id.*

[75] *Id.*; *see also* 153 CONG. REC. S11,094 (daily ed. Sept. 5, 2007) (statement of Sen. Coburn).

"to assume they cannot [have seen combat] without having some disruption in their capability to function in this society."[76]

Second, Coburn expressed concern that tracking veterans' mental health status would create a mental health history that might bar them not only from gun ownership but from professions requiring mental health background checks, like law enforcement, emergency medical services, and certain airline professions.[77] Josh Omvig himself attributed his reluctance to seek mental health care to the probability that the "the Army would find out" and that "it would affect his military and personal career."[78] Senator Tom Harkin (D-Iowa), one of the bill's original Senate sponsors, responded that he was willing to compromise on the tracking provision and characterized Coburn's concerns as primarily about veterans' access to guns.[79] Harkin dismissed Coburn's concerns about the stigma facing veterans treated for mental illness by claiming that the peer counseling provision of the statute would decrease the stigma surrounding mental health counseling enough that veterans would not worry about the effect of a history of mental health treatment or evaluation on their future careers.[80] However, Harkin did not address the fact that some professions consider an applicant's mental health history as a standard part of their hiring practice. Even if all returning veterans were required to submit to mental health screening, civilian employers might not distinguish between veterans and civilians with records of mental health evaluation. Furthermore, Harkin did not respond to the suggestion in Coburn's open letter that any plan to track veterans must also include provisions barring the information gathered by such tracking from being used against veterans seeking employment.[81]

Third, Senator Coburn pointed out that most of the provisions in the bill were already part of VA's Strategic Mental Health Plan, adopted in 2004.[82] Indeed, a VA spokesperson objected to the bill on grounds that it was duplicative of VA efforts already underway.[83] In rebuttal, Senator Harkin argued

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[76] 153 Cong. Rec. S11,094 (daily ed. Sept. 5, 2007) (statement of Sen. Coburn).

[77] *Id.*

[78] *Mental Health Issues Hearing*, *supra* note 2, (statement of Randall Omvig).

[79] 153 Cong. Rec. S11,097 (daily ed. Sept. 5, 2007) (statement of Sen. Harkin).

[80] *See id.* at S11,099-100.

[81] Press Release, Office of Sen. Coburn, Combat Veterans Need Medical Care, *supra* note 73.

[82] 153 Cong. Rec. S11,094 (daily ed. Sept. 5, 2007) (statement of Sen. Coburn); *see also* VA Office of the Inspector Gen., Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention i-ii (2007), *available at* http://www.va.gov/oig/54/reports/VAOIG-06-03706-126.pdf.

[83] *See Hearing on Pending Health Care Legislation: Hearing Before the S. Comm. on Veterans Affairs,* 110th Cong. 7 (2007) (statement of Gerald M. Cross, Acting Principal Deputy Under Sec'y for Health, Dep't of Veterans Affairs) [hereinafter *Pending Health Care Legislation Hearing*]. VA also made this point through the Congressional Budget Office's estimate of the cost of implementing the bill, which was included in the House report on the bill. The estimate explained that VA was already implementing almost all of the bill's provisions and therefore needed no supplemental funding to meet the mandates of the bill. H.R. Rep. No. 110-55, at 7 (2007).

that VA implementation of these plans had been too slow and that only a congressional mandate could supply the impetus necessary for VA to deliver on its promised program.[84] Harkin was mistaken that VA had failed to implement any part of its program—the suicide prevention hotline was launched in July 2007—but he correctly noted that VA had spent years planning its response to the growing veteran suicide crisis without taking many concrete actions to address it.[85] Thus, much of the Act was designed to force VA to act on its own plans within two years.[86]

Finally, Coburn questioned the wisdom of the bill's peer counseling provision, claiming that peer counseling "has already been shown in the literature to not be effective."[87] VA had also raised a specific objection about the peer counseling provision at a May Senate hearing.[88] VA Acting Principal Under Secretary for Health Gerald M. Cross asked the Senate to strike the peer counseling program if Congress proceeded with the bill.[89] He claimed that "[t]he use of adult veterans as [peer counselors] in caring for other veterans who suffer from mental health issues is simply not advisable" because of a lack of scientific agreement about the efficacy of such peer counseling programs.[90]

The exchange between Senators Coburn and Harkin presents issues that were obscured in the bill's initial rush through the House. First, in pursuing the bill, Congress mandated a two-year timeline for VA's own plans, adopted in its Mental Health Strategic Plan of November 2004, rather than engaging in a creative policy-making process from the ground up.[91] Second, Coburn's objections illuminated the important ways in which the bill fell short of its goals of reducing stigma and decreasing the number of veterans who slip through the cracks of VA's mental health care system. The bill's supporters assumed that universal mental health screening and tracking would automatically meet these goals by making treatment routine.[92] They reasoned that if all veterans coming to VA were screened for mental health issues, those veterans too timid or proud to ask for help would still be untreated. Furthermore, if help were not optional, accepting treatment or counseling might not

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[84] *See* 153 Cong. Rec. S11,101 (daily ed. Sept. 5, 2007) (statement of Sen. Harkin).

[85] 153 Cong. Rec. H11,870 (daily ed. Oct. 23, 2007) (statement of Rep. Boozman).

[86] *See* Omvig Act, *supra* note 61, § 3(b).

[87] 153 Cong. Rec. S11,094 (daily ed. Sept. 5, 2007) (statement of Sen. Coburn).

[88] *See Pending Health Care Legislation Hearing*, *supra* note 83, at 10 (statement of Gerald M. Cross).

[89] *Id.*

[90] *Id.*

[91] *See* 153 Cong. Rec. S11,101 (daily ed. Sept. 5, 2007) (statement of Sen. Harkin). Indeed, the provision of the Omvig Act least duplicative of VA efforts already underway was the peer counseling provision, which VA is free to ignore by the terms of the Act. *See* Omvig Act, *supra* note 46, §3(a)(1)(j); *see also* Office of the Inspector Gen., Dep't of Veterans Affairs, Healthcare Inspection, i–ii (2007).

[92] *See Mental Health Issues Hearing*, *supra* note 2, at 13 (statement of Patrick Campbell, OIF Veteran Liaison, Iraq and Afghanistan Veterans of Am.)(discussing how the ideal policy would go "beyond what is in this bill and that is that it is a required face-to-face mental health screening with a licensed professional. It is the only way to take away the stigma.").

be viewed as a sign of weakness. However, these supporters did not produce any empirical or clinical evidence demonstrating the connection between the bill's programs and its goals. Coburn pointed out that routine mental health care might actually increase rather than decrease the discrimination against veterans by suggesting that all veterans necessarily suffer from mental illness.[93]

Senator Coburn also instigated a debate about the bill's peer counseling provisions, but did not engage with the scholarly literature on the subject any more than his opponents did. Coburn agreed with VA's position that peer counseling has not been shown conclusively to be an effective means of treating PTSD in veterans.[94] Harkin and the bill's other proponents, reiterating Omvig's parents' conclusion that their son most needed to share his burdens with other veterans, assumed that a veteran peer counseling program must be a good thing without referring to any specific study. Neither side cited literature on peer counseling programs, the pragmatic considerations of the safety or efficacy of such a program, or the difficulties VA might face in implementing such a program. It is possible that the body of scholarship on peer counseling is inapplicable to veterans of OIF and OEF; veterans who are battling PTSD at a time when psychological treatment is becoming more widely accepted in the population overall may not feel stigma in the same way other veterans have.[95] However, neither side explained their choice to avoid discussing the literature on the subject.

Neither the debate over mandatory screening and tracking nor the debate over the peer counseling program was carried past Senator Coburn's statement and Senator Harkin's rebuttal on September 5, 2007. On September 27, Coburn's office announced that he and Harkin had reached a compromise over the mandatory provisions that would satisfy all sides,[96] and an amended version of the bill passed the Senate by unanimous consent that day. The amended version was introduced to the House as "slightly modified by the Senate to ensure that referrals for mental health counseling and treatment considered the request of the veteran concerned"[97] and quickly passed unanimously.[98]

While the amendments were slight in that they changed very few of the words of the bill, the changes were significant because they removed many of the mandatory treatment provisions. Where the version enacted by the House required that "the Secretary shall provide for screening of veterans . . . for risk factors for suicide," and "shall provide for referral of veterans at

[93] 153 Cong. Rec. S11,094 (daily ed. Sept. 5, 2007) (statement of Sen. Coburn).

[94] *Id.*; *see also Pending Health Care Legislation Hearing*, *supra* note 83, at 10 (statement of Gerald M. Cross).

[95] *See* Ramin Mojtabai, *Americans' Attitudes Toward Mental Health Treatment Seeking: 1990-2003*, 58 Psychiatric Servs. 642 (2007).

[96] Press Release, Office of Sen. Coburn, Senators Reach Agreement, *supra* note 45.

[97] 153 Cong. Rec. H11,870 (daily ed. Oct. 23, 2007) (statement of Rep. Boozman).

[98] 153 Cong. Rec. H11,886 (daily ed. Oct. 23, 2007) (containing the record of the yeas and nays).

risk for suicide for appropriate counseling and treatment,"[99] the Senate's amended version required that "the Secretary shall direct that medical staff offer mental health in their overall health assessment," and "shall . . . make referrals, at the request of the veteran concerned."[100] The tracking provision was eliminated in its entirety.[101] Finally, where the House version directed VA to establish a peer counseling program,[102] the Senate version changed "shall establish" to "may establish."[103] This change permits VA to completely ignore its least favorite provision of the bill.[104]

The Senate amendment's effect on the efficacy of the bill is not immediately clear. Senator Coburn was able to secure language that assuaged each of his concerns, converting the mandatory screening, referral, and peer counseling programs into optional provisions and eliminating the troublesome tracking provision altogether. The elimination of the tracking provision will allow veterans to seek mental health care without fear that the resulting record will damage their future employment prospects. However, the tracking provision would have served a useful purpose, making it easier for VA to keep track of veterans who seek mental health care but do not follow through on a course of treatment or who move from one geographic area to another.

Likewise, making treatment and referrals available only at the veteran's request addresses Senator Coburn's concern that veterans seeking VA treatment for any medical condition would have a record of a mental health screening, and prevents veterans from being forced into mental health care treatment by a referral they do not seek. But, a central part the original bill's strategy was to make mental health care routine so that VA medical staff could more easily identify struggling veterans who did not proactively seek mental health care.[105] Making mental health assessment optional undermines this strategy.

The debate over peer counseling presented a different problem: both sides made largely unsupported claims about the efficacy of such programs.[106] While peer counseling was incorporated into the comprehensive program, validating the suggestions of the Omvigs and other supporters, Coburn was satisfied that VA would be able to avoid actually implementing such programs if it found them ineffective or unwise. However, the optional nature of the peer counseling provision makes its inclusion in the Act a

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[99] Omvig Bill II, *supra* note 44, § 3(a)(1)(c), (e).

[100] Omvig Bill III, *supra* note 45, § 3(a)(1)(c).

[101] *Compare* Omvig Bill II, *supra* note 44, § 3(a)(1)(d), *with* Omvig Bill III, *supra* note 45, § 3.

[102] Omvig Bill II, *supra* note 44, § 3(a)(1)(l)(1).

[103] Omvig Bill III, *supra* note 45, § 3(a)(1)(j)(1).

[104] *See Pending Health Care Legislation Hearing*, *supra* note 83, at 10 (statement of Gerald M. Cross).

[105] *See supra* note 92 and accompanying text.

[106] *See supra* notes 94–95 accompanying text.

hollow victory, given the fact that VA is unlikely to implement an optional program that it explicitly requested be struck from the Act before passage.[107]

II. Other Veterans' Mental Health Issues

A. *Confronting Stigma*

While the Act attempts to reduce the stigma veterans may face as a result of seeking mental health care, it does not carefully define the issue of stigma or make policies on how best to address it. In a 2003 Senate hearing, Harold Kudler noted that service members "see posttraumatic stress disorders not as the reaction of a normal person living through a very abnormal situation (such as combat) but rather as a failure of training, leadership, strength or character."[108] While Randall Omvig called "[d]e-[s]tigmatization of [m]ental [h]ealth" the first goal of the Act,"[109] only one plan was ever proposed for directly meeting this goal. The mandatory screening and tracking provisions in the House version of the bill explicitly sought to reduce stigma by making mental health care automatic and routine,[110] but the compromise between Senators Coburn and Harkin allowed mental evaluations to remain optional. Because veterans still have to ask for mental health treatment, they may continue to struggle with feelings of weakness or failure if they seek treatment.[111]

Provisions of the Omvig Act that provide for additional outreach and public education may conceivably reduce stigma simply by increasing the percentage of veterans involved in the mental health system. Although the Act does not require mental health screenings, these screenings may become more common as a result of increased outreach and thereby reduce the stigma attached to seeking treatment. Veterans could come to see mental illness, like physical injury, as a common result of the stresses of military service.[112] However, these effects on stigma are indirect, and the Act lacks a strong vision for how to reduce the stigma surrounding mental health care.

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[107] *See supra* notes 87–90 and accompanying text.

[108] *Handoff or Fumble: Do VA and DOD Provide Seamless Health Care Coverage to Transitioning Veterans?: Hearing Before the H. Comm. on Veterans' Affairs* 107th Cong. (2003) (statement of Harold Kudler, Co-Chair, Under Sec'y for Health's Special Comm. on PTSD, Dep't of Veterans Affairs), *available at* http://veterans.house.gov/hearings/schedule108/oct03/10-16-03/hkudler.html.

[109] *Mental Health Issues Hearing*, *supra* note 2, at 14 (statement of Randall Omvig).

[110] *See* 153 Cong. Rec. S11,097 (daily ed. Sept. 5, 2007) (statement of Sen. Harkin).

[111] *Compare* Omvig Bill II, *supra* note 44, § 3(a)(1)(c)–(d), *with* Omvig Act, *supra* note 46, § 3(a)(1)(c).

[112] Pfc. Jason Schoerman, a serviceman who took his life while on duty in Iraq, consistently denied symptoms of mental illness. *Investigations into Scheuerman's Death*, The News-Times (Danbury, Conn.), Dec. 19, 2007, *available at* http://www.newstimes.com/national/ci_7760841.

B. *Preexisting Conditions and Denial of Benefits Based on Less-Than-Honorable Discharge*

Another barrier to veterans' mental health care is the denial of benefits due to a determination of a preexisting condition.[113] One such preexisting condition is "personality disorder," which caused the denial of benefits in 22,500 claims between 2000 and 2006.[114] Veterans are also ineligible for medical benefits if they have been discharged on "less-than-honorable" terms. National Public Radio documented the plight of a few veterans who were denied benefits after being diagnosed with PTSD while on active duty. These veterans came "back from combat, couldn't get adequate help, 'flipped out' and misbehaved in some way—and as a result, were kicked out of the military without all the financial and medical benefits that veterans usually receive."[115] Receiving a less-than-honorable discharge, even for offenses linked to PTSD (such as drug abuse, being absent without leave, and assault), renders a veteran ineligible to receive medical benefits.[116] As of December 2007, there had been 28,000 behavior-based discharges since the start of the Iraq War.[117] Some lawyers have petitioned for a legislative change to allow any person returning from service abroad to seek VA treatment, regardless of the discharge status.[118] Senator Christopher "Kit" Bond (R-Mo.) has spoken publicly on the issue and has asked President Bush to consider a Special Discharge Review Program, which would review less-than-honorable discharges that may have been influenced by PTSD or traumatic brain injury ("TBI").[119] The Omvig Act takes no position on this problem, but the National Defense Authorization Act for Fiscal Year 2008, signed into law on January 28, 2008, may provide a partial solution.[120] That law provides healthcare eligibility for five years to members who received

[113] *See* Press Release, House Veterans' Affairs Comm., "Personality Disorder": A Deliberate Misdiagnosis to Avoid Veterans' Health Care Costs! (July 25, 2007), *available at* http://veterans.house.gov/news/PRArticle.aspx?NewsID=111.

[114] *Id.*

[115] Daniel Zwerdling, *All Things Considered: Effort Builds to Help "Forgotten" Troops* (NPR radio broadcast Dec. 20, 2007), *available at* http://www.npr.org/templates/story/story.php?storyId=17362654.

[116] *See id.*

[117] *Id.*

[118] *Id.*

[119] Letter from Sen. Christopher (Kit) Bond to President Bush (Dec. 21, 2007), *available at* http://media.npr.org/documents/2007/dec/bond_letter.pdf (also signed by Sen. Barbara Boxer (D-Cal.), Sen. Barack Obama (D-Ill.), Sen. Claire McCaskill (D-Mo.), Sen. Thad Cochran (R-Miss.), Sen. Edward M. Kennedy (D-Mass.), Sen. Chuck Grassley (R-Iowa), Sen. Sam Brownback (R-Kan.), Sen. Barbara A. Mikulski (D-Md.), Sen. Hillary Rodham Clinton (D-N.Y.), Sen. Bernard Sanders (I-Vt.), Sen. Blanche L. Lincoln (D-Ark.), Sen. Ken Salazar (D-Colo.), Sen. Joseph R. Biden, Jr. (D-Del.), and Sen. Patty Murray (D-Wash.)). One veteran, Patrick Uloth, was given a less than honorable discharge, which lead to the denial of disability payments despite the fact that Uloth had been diagnosed with "uncontrollable trembling," "memory loss," and "chronic PTSD." Zwerdling, *supra* note 115.

[120] Pub. L. No. 110-181, 121 Stat. 2573 (2008).

something other than a dishonorable discharge.[121] Ostensibly, individuals who received a "less-than-honorable" discharge may now be eligible for benefits.[122]

C. Claims Processing Backlog and Waiting for Treatment

By focusing on efforts to improve the quality of veterans' health care, the Omvig Act neglected to adequately ensure that VA has the resources to provide services to all veterans in need. At the first step of eligibility determinations, VA is currently experiencing a backlog of 650,000 unprocessed claims.[123] Paul Sullivan, the Executive Director of Veterans for Common Sense, posited five reasons for the current backlog: insufficient funding to train and maintain staff; the unnecessarily complex and adversarial nature of the Veterans Benefits Administration, including a twenty-six page claim form; a seventeen percent increase in the applications for benefits; 245,000 unanticipated claims generated by OEF and OIF; and the failure of VA's leadership to proactively deal with this crisis.[124] The volume of claims and the nature of the conflicts may limit Congress's ability to remedy the backlog, but the Omvig Act could have addressed the understaffing and complicated application procedure.[125] However, the Act is silent on how to measure VA's efforts to provide reasonable access to care as opposed to any specific type of care. Therefore, the Omvig Act does little to ensure that all veterans have the opportunity to seek treatment.[126]

After making their claims for benefits, veterans must also wait to receive treatment from a mental health professional. Because the Omvig Act does not require the VA to hire new mental health professionals, there is no mandate for VA to ensure that veterans receive treatment in a reasonable

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[121] *Id.*

[122] *See id.* The National Defense Authorization Act for Fiscal Year 2008 also provided for the "review of gender and ethnic group specific mental health services and treatment for members of the armed forces." *Id.* § 716.

[123] *Examining the Department of Veterans Affairs' Claims Processing System: Hearing Before the H. Subcomm. on Disability Assistance and Memorial Affairs, H. Comm. on Veterans' Affairs*, 110th Cong. (Feb. 14, 2008) (statement of Paul Sullivan, Executive Dir., Veterans for Common Sense). Incomplete claims doubled between 2002 and the present—from 325,000 claims in 2002 to 650,000 claims today. *Id.*

[124] *See id.*

[125] *See id.*

[126] Another limiting element of claims processing was the verification requirement. A veteran who sought benefits for mental health treatment was required to submit written verification—supplied by a commander, doctor, or coworkers—that he or she had witnessed a traumatic event, even if the nature of the veteran's physical injuries would create a reasonable presumption that the event that caused the physical injury had itself been psychologically traumatic. On February 18, 2008, in response to an inquiry from Senator Daniel Akaka (R-Haw.), VA dropped this requirement for veterans who had been diagnosed with PTSD during their active duty. *See* Press Release, Senate Comm. on Veterans' Affairs, Veterans Diagnosed with PTSD on Active Duty No Longer Required to Provide Further Evidence of PTSD (Feb. 15, 2008), *available at* http://veterans.senate.gov/public/index.cfm?pageid=12&release_id=11549.

time frame. Ira Katz, VA's head of mental health, testified that VA has made headway on this issue by responding to the complaints and recommendations of the President's New Freedom Commission on Mental Health and in implementing its Mental Health Strategic Plan.[127] VA's efforts to improve access include allocating more money for the provision of mental health care and hiring 3600 new mental health personnel since 2005.[128] It remains to be seen whether these measures are sufficient to provide veterans with adequate access to these services.

III. Continuing Policy Efforts

Congress remains concerned with issues of veterans' mental health. The Dignified Treatment of Wounded Warriors Act ("Wounded Warriors Act")—passed September 5, 2007, and partially incorporated into the Fiscal Year 2008 Department of Defense Authorization Act ("Authorization Act")—contains a number of provisions specifically addressing mental health issues among active-duty service members and recently-returned veterans.[129] The Authorization Act differs from the Omvig Act in that the Authorization Act directs the Department of Defense to provide for the mental health needs of active-duty servicemembers and recently-returned veterans, while the Omvig Act directs VA to provide for the health needs of veterans after their initial readjustment.[130] Many of the provisions incorporated into the Authorization Act focus on the underlying causes of suicide among veterans and service-members by regulating their treatment in the combat theater and after their return to civilian life. The Authorization Act also specifically requires the Secretaries of Defense and Veterans Affairs to establish a "comprehensive plan" to "prevent, diagnose, mitigate, treat, and otherwise respond to [traumatic brain injury] and [PTSD] in members of the Armed Forces" by July 1, 2008.[131] Each service member must "be provided the highest quality, evidence-based care in facilities that most appropriately meet the specific needs of the individual" and "be rehabilitated to the fullest extent possible using up-to-date evidence-based medical technol-

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[127] *Stopping Suicides: Mental Health Challenges Within the U.S. Department of Veterans' Affairs: Hearing Before the H. Comm. of Veterans' Affairs*, 110th Cong. (2007) (statement of Ira Katz, M.D., Deputy Chief of Patient Care Servs., Office of Mental Health, Veterans' Health Admin.), *available at* http://veterans.house.gov/hearings/Testimony.aspx?TID=11145.

[128] *Id.*

[129] *To Receive Testimony on Improvements Implemented and Planned by the Department of Defense and the Department of Veterans Affairs for the Care, Management, and Transition of Wounded and Ill Servicemembers: Hearing before the S. Comm. on Armed Services*, 110th Cong. (2008) (opening statement by Sen. Levin (D-Mich.), Chairman, Senate Comm. on Armed Services), *available at* http://levin.senate.gov/senate/statement.cfm?id=292798; The Dignified Treatment of Wounded Warriors Act, H.R. 1538, 110th Cong. (2008); National Defense Authorization Act for Fiscal Year 2008, Pub. L. No. 110-181, 121 Stat. 2573.

[130] *Compare* Omvig Act, *supra* note 46, *with* National Defense Authorization Act.

[131] National Defense Authorization Act §§ 1618(b), 1611.

ogy, and physical and medical rehabilitation practices and expertise."[132] The Authorization Act additionally provides for the establishment of a "wounded warrior resource center," which would act as a central clearinghouse for service members' and their families' complaints about general and specialty medical facilities and housing.[133] Section 1691 of the Authorization Act provides for further study of the "physical and mental health and other readjustment needs" of service members who are serving or who served in OIF and OEF, and their families.[134] The Authorization Act also imposes some concrete guidelines for improving care. The plan must include a review of current policies and practices, and a program to assign to each service member both medical and non-medical "care managers," who will focus on the welfare and quality of life of each service member during his or her transition from duty to civilian life.[135] The Departments of Defense and VA must set minimum standards for access to care and maximum waiting times for non-urgent care, but these mandates are only required for care provided by Department of Defense medical facilities or given under the military's TRICARE health care plan and do not apply to VA.[136]

Certain provisions that Congress passed as part of the Wounded Warriors Act were not included in the Authorization Act. The Wounded Warriors Act required that the Secretary of Defense make recommendations to address shortages of personnel in the Department of Defense Mental Health Workforce and increase the Department's efforts to recruit mental health professionals.[137] Furthermore, the Wounded Warrior Act might have cut down on the denial of benefits due to "preexisting conditions" by providing that, absent "evidence or medical judgment . . . warrant[ing] a finding that the disability existed before the member's entrance on active duty," a member will not be denied benefits based on a previously undocumented preexisting condition.[138] The provisions ultimately included in the Authorization Act gave the Department of Defense a much less specific mandate, requiring only "improvements to the processes, procedures, and standards for the conduct by the military departments of medical evaluations."[139]

Other legislation pending at the time of this printing also addresses veterans' mental health issues. On January 31, 2008, Senator Harkin introduced the Armed Forces Suicide Prevention Act of 2008, a companion bill to the

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[132] *Id.* § 1618(c)(2).

[133] *See id.* § 1616.

[134] *Id.* § 1691.

[135] *Id.* § 1691(c)(3)–(4).

[136] *Id.* § 1611(e)(5). "TRICARE is the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses worldwide." What is TRICARE?, http://www.tricare.mil/mybenefit/home/overview/WhatIsTRICARE (last visited Apr. 2, 2008).

[137] The Dignified Treatment of Wounded Warriors Act, H.R. 1538, 110th Cong. § 143(a)(1), (b) (2008).

[138] *See id.* § 151(a), (b).

[139] National Defense Authorization Act §1612(a)(1).

Omvig Act.[140] The original House sponsors of the Omvig Act introduced a bill parallel to Senator Harkin's on February 6, 2008.[141] The new bill would extend the outreach, training, study, and support initiatives of the Omvig Act to current and recently-returned members of the armed forces. The bill also requires annual training for all active duty, National Guard, and Reserve members on suicide prevention and additional training for Department of Defense medical personnel on identification of suicide risk factors and combat stress.[142]

The new bill's outreach initiatives are similar to those in the Omvig Act but provide more direction on how to use outreach to reduce the stigma attached to mental health care. The bill mandates public addresses and programs to teach service members and their families "that mental health is essential to overall health" and that mental health care is routine, normal, and no source of shame.[143] The bill addresses the lack of information about how to effectively reduce stigma by authorizing grants for third parties to study and develop "innovative and effective strategies for reducing the stigma associated with seeking mental health treatment."[144] Additionally, the bill aims to ease the transition between active service and veteran status by mandating a program of outreach to the spouses and parents of returning soldiers for six months following their return.[145] This program would give families information on available resources, equip them to understand the issues veterans are likely to face, and help them identify risk factors for suicide.[146]

Finally, the bill has two strengths that the Omvig Act lacked: more robust reporting requirements and a $6 million appropriation to implement the bill's initiatives. An independent entity would review the training and outreach programs for efficacy,[147] and the Secretary of Defense would be required to submit annual reports documenting statistics for suicide among service members, describing the implementation status of the training and outreach programs, reporting on the coordination between the Departments of Defense and VA, and recommending further initiatives for reducing suicide among active and veteran members of the armed forces.[148]

Other bills addressing veterans' mental health issues are currently pending in Congress. The Veterans Mental Health Outreach and Access Act of 2007 seeks to "require the Secretary of Veterans Affairs to establish a program for the provision of readjustment and mental health services to veterans who served in Operation Iraqi Freedom and Operation Enduring

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[140] S. 2585, 110th Cong. (2008).
[141] Armed Forces Suicide Prevention Act of 2008, H.R. 5223, 110th Cong. (2008).
[142] S. 2585 § 2(b).
[143] *Id.* § 2(d).
[144] *Id.* § 5.
[145] *Id.* § 2(e).
[146] *See id.*
[147] *Id.* § 2(f).
[148] *Id.* § 3.

Freedom."[149] Although the Omvig Act rendered this bill moot in some ways, the bill would make important inroads into problems the Omvig Act does not fully address. The bill would provide mental health services to recently-returned veterans from Iraq and Afghanistan for three years, including peer outreach, support, readjustment counseling.[150] The legislation would also provide mental health care access to more veterans by requiring VA to contract with "community mental health centers and other qualified entities" to provide services for veterans and their families who do not live near VA medical facilities.[151] The Veterans Mental Health Treatment First Act, introduced in January 2008 by Senator Richard Burr (R-N.C.), would provide short-term monetary stipends to veterans seeking mental health care.[152] The Fair Mental Health Evaluation for Returning Veterans Act "impos[es] a temporary moratorium on the discharge of members of the Armed Forces for personality disorder" until the Defense Department has amended its policies on these discharge determinations.[153] Other more general laws, like the Veterans' Health Care Improvement Act of 2007, contain some of the peer outreach provisions present in the Omvig Act but also contain appropriations provisions and policies addressing issues of homeless veterans.[154] The Mental Health Improvements Act of 2007 proposes the creation of six "national centers of excellence on post-traumatic stress disorder and substance use disorders," to "provide comprehensive inpatient treatment and recovery services for veterans newly diagnosed with both post-traumatic stress disorder and a substance use disorder."[155] This bill would also require VA to report on the conditions within its mental health care facilities and mandate research on comorbidity of PTSD and substance use disorders.[156]

IV. Conclusion

The suicides of Joshua Omvig and other service members might have been prevented. If these individuals had received the support they so needed, they might have survived their illnesses and saved their loved ones a lifetime of heartache. These individuals made tremendous sacrifices to serve their country in a time of war and therefore deserved the utmost support.

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[149] S. 38, 110th Cong. (2007) (statement of purpose).

[150] *See id.* § 2(a)(1)(a)–(d).

[151] *Id.* § 2(b)(a); *see also Hearing on Pending Legislation: Hearing Before the S. Comm. on Veterans' Affairs*, 110th Cong. (Oct. 24, 2007)(statement of Joy J. Ilem, Assistant Nat'l Legislative Dir. of the Disabled Am. Veterans), *available at* http://www.senate.gov/~svac/public/index.cfm?pageid=16&release_id=11417&sub_release_id=11420&view=all.

[152] S. 2573, 110th Cong. (2008). The stipends are conditioned on the veteran's compliance with the treatment regimen and rehabilitation plan eventually prescribed. *Id.*

[153] Fair Mental Health Evaluation for Returning Veterans Act, H.R. 3167, 110th Cong. (statement of purpose) (2007).

[154] Veterans' Health Care Improvement Act of 2007, H.R. 2874, 110th Cong. (2007).

[155] Mental Health Improvements Act of 2007, S. 2162, 110th Cong. § 105 (2007).

[156] *Id.* §§ 106, 301.

Policy makers almost unanimously recognize the importance of veterans' mental health issues and the demand for an effective solution, but there is disagreement over what these solutions should be, who should devise them, and how they can be implemented in a timely fashion. Furthermore, a tension between veterans' autonomy and their safety underlies Congress' struggles in passing the Omvig Act and will likely affect all future inquiries into this subject. Any solution to the problem of veteran suicide must balance veterans' privacy and personal autonomy and efforts to protect their mental health and possibly save their lives.

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