"TO HAVE NO YESTERDAY":
THE RISE OF SUICIDE RATES IN THE
MILITARY AND AMONG VETERANS

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ABSTRACT

Suicide rates in the military and among veterans have increased significantly since the beginning of the Iraq and Afghanistan wars, despite the implementation of VA-sponsored programs to help stave off deaths of our war-beaten warriors. But the VA—in addition to a number of other relevant societal and governmental actors—has simply not done enough to prevent suicides among our veterans and military personnel. The first step in resolving this tragedy is to create an accurate and thoroughly detailed data system that can track the suicides of all military personnel and veterans. Such a database and related studies will provide government agencies the ability to accurately measure whether currently implemented or new suicide prevention programs are effective at reducing suicides, and the system will allow the government to determine which groups of military personnel or veterans have a higher risk of suicide. Additionally, laws and policies within the military justice system must be updated to address the increased suicides so as not to prevent servicemembers from getting the mental health care they desperately need.

"Death must be so beautiful. To lie in the soft brown earth, with the grasses waving above one's head, and listen to silence. To have no yesterday, and no to-morrow. To forget time, to forgive life, to be at peace."1

I. INTRODUCTION

In March 2010, the United States Department of Veterans Affairs ("VA") released a sobering statistic: every eighty minutes, a military veteran commits suicide. The number of suicides has increased significantly since the beginning of the Iraq and Afghanistan wars, despite the implementation of VA-sponsored programs to help stave off deaths of our war-beaten warriors. One such program, the Veterans Crisis Line, took more than 650,000 calls and claims to have saved more than 23,000 lives in the five years since its inception in 2007. Yet still, twenty-two veterans take their lives every day, and a currently serving sailor, Marine, soldier, or airman takes his or her life every thirty-six hours. The VA—in addition to a number of other relevant societal and governmental actors—has simply not done enough to prevent suicides among our veterans and military personnel.

"You have two minutes to convince me not to kill myself... starting now!" said the voice of an Army veteran who called the Veterans Crisis Line. Chuck had deployed during Operation Iraqi Freedom ("OIF") to Iraq, where he received a "mild" traumatic brain injury from a detonated improvised explosive device while in combat with the enemy. He witnessed a close friend get seriously injured and watched several others die as a result of the combat in Iraq. After Chuck's deployment, he was diagnosed with post-traumatic stress dis-

3. See infra Part II.D.
4. About the Veterans Crisis Line, VETERANS CRISIS LINE, http://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx (last visited Nov. 6, 2012). The Veterans Crisis Line was named the "National Veterans Suicide Prevention Hotline," until its name-change in 2011. Id.
6. See Veterans for Common Sense v. Shinseki, 644 F.3d 845, 850 (9th Cir. 2011), reh'g en banc granted, 663 F.3d 1033 (9th Cir. 2011), vacated, 678 F.3d 1013 (9th Cir. 2012).
7. VICTOR MONTGOMERY III, HEALING SUICIDAL VETERANS: RECOGNIZING, SUPPORTING AND ANSWERING THEIR PLEAS FOR HELP 26-30 (2009). The account of "Chuck" in its entirety is based on Mr. Montgomery's personal experiences as a veterans' suicide and crisis intervention therapist. See id. at xiii-xvii.
8. For confidentiality and privacy, Mr. Montgomery changed all names and personally identifiable information of those that called the Veterans Crisis Line. See id. at vii (providing an author's note).
9. Id. at 26-27.
10. Id. at 27.
order ("PTSD") and lost his faith in religion.\textsuperscript{11} Like many veterans returning from war, Chuck did not want to seek help from the VA or other medical professionals for fear others might view him as weak and helpless.\textsuperscript{12} He took to the streets instead and lived under a bridge with fifteen other homeless Iraq and Afghanistan war veterans.\textsuperscript{13}

When Chuck called the Veterans Crisis Line, he challenged the answering therapist to convince him to not commit suicide with the untwisted end of a metal coat hanger he had pointed at his jugular vein as he lay sitting on his motel bed.\textsuperscript{14} After a two-hour conversation with the therapist, an ambulance took Chuck to the nearest medical center.\textsuperscript{15} Three months later, Chuck was at a PTSD recovery center.\textsuperscript{16} He found his way back to his faith, and he even began a bible study with the homeless veterans under the bridge where he had lived just a few months prior.\textsuperscript{17} Chuck was saved—both literally and religiously—thanks to the availability of the Veterans Crisis Line and the suicide intervention therapist on the other end of the line. But not all veterans meet the same fate.

During the initial upswing of combat operations in OIF, Randen Harvey served two back-to-back deployments in Iraq from 2003 to 2005.\textsuperscript{18} While there, he was detailed to "clean up" duty: he was responsible for retrieving the dead bodies of fellow soldiers and Marines—as well as civilian women and children—and ensuring the dead received proper disposal or shipment back to the United States.\textsuperscript{19} This experience changed Randen for the rest of his life, and when the Marine Corps discharged him in November 2005 his family could see as much.\textsuperscript{20} Upon returning home his mother even commented, "[h]e looked so haunted."\textsuperscript{21} Randen was unable to sleep, could not stay long in any job (though not for lack of trying), and eventually moved out of his room in his mother's house to the porch, where he slept with a handmade machete.\textsuperscript{22}

\begin{itemize}
  \item \textsuperscript{11} \textit{Id.}
  \item \textsuperscript{12} \textit{Id.}
  \item \textsuperscript{13} \textit{Id.} at 26.
  \item \textsuperscript{14} \textit{Id.}
  \item \textsuperscript{15} \textit{Id.} at 26-29.
  \item \textsuperscript{16} \textit{Id.} at 29.
  \item \textsuperscript{17} \textit{Id.}
  \item \textsuperscript{19} \textit{Id.}
  \item \textsuperscript{20} \textit{See id.} (stating that Randen came home, "only to find he couldn't sleep, couldn't hold a job, couldn't stand to be in public, couldn't stay sober and couldn't be around the family who loved him").
  \item \textsuperscript{21} \textit{Id.}
  \item \textsuperscript{22} \textit{Id.}
\end{itemize}
Within four months of leaving the Marine Corps, Randen went to a VA urgent care facility claiming he could only sleep four hours a night and had cut himself on his arms.23 Two weeks later, he swallowed all the pills that the doctor prescribed to him and wound up back at a VA hospital.24 Yet another two weeks later, Randen was finally evaluated for and diagnosed with PTSD, agoraphobia,25 alcohol abuse, and panic anxiety disorder.26 Merely being diagnosed with these health problems, however, did not afford Randen the mental health care he desperately needed.

On June 11, 2006, Randen walked into the same VA medical center and warned that he “might jump off the roof or put a hose in his car exhaust.”27 Hospital staff did not heed his threats, and just four hours later he was found on the roof of the VA facility where he had to be coaxed down by hospital security.28 He told a VA psychiatrist, “Things would be much easier if I weren’t here,” yet Randen was discharged later that night.29 Randen returned the next day and continued to express his concerns of feeling helpless and ashamed.30

Despite the obvious and apparent warning signs that Randen was severely depressed and suicidal—indeed, he was admitted to the Detroit VA Medical Center for an attempted suicide—the VA did nothing to address his symptoms or suicidal ideation. Randen’s suicide came just three days later in his father’s home,31 a suicide that the VA could have prevented if its staff adequately performed their duties.

What is most disturbing about these two stories is that they are not unique. Quite to the contrary, they are representative of the thousands of veterans and military servicemembers that struggle with suicidal ideation on a daily basis.32
For these servicemembers to survive the battlefield only to return home and commit suicide is a notion that reeks of depressing irony. So how can the relevant actors—federal, state, and local agencies; Veteran Service Organizations ("VSOs") and other non-governmental actors; and society in general—reverse the trend of rising suicide rates among military personnel and veterans? The first thing that must be done is to create an accurate and thoroughly detailed data system that can track the suicides of all military personnel and veterans—regardless of which war. Such a system would need to track a great deal of information about each veteran that commits suicide, including which war(s) they served during (or, in the case of peacetime veterans, the data related to those specific dates), which geographical regions they served in, and their mental health history both in the military and after. This system should also measure a plethora of other factors that may be relevant in determining the risk factors associated with suicide. Without a thorough data system of this magnitude, the relevant actors cannot determine a suicide program’s effectiveness in preventing suicide, nor can they accurately determine which veterans and military members need help.

There are a number of programs that have been implemented by the VA, the United States Department of Defense ("DoD"), and non-governmental organizations ("NGOs") that are successful to the extent that they save lives. The problem is they have not saved enough lives. Using the aforementioned data systems to validate the effectiveness of these suicide prevention programs and highlight areas where the programs are not helping certain groups of veterans or military members, these organizations can create new, or augment existing, suicide prevention programs for specific groups of veterans. Not only do the current programs need tweaking or further expansion to reach more veterans, but the stigma and consequences that flow from suicide attempts must be resolved. To do this, Congress, the DoD, and the VA must make changes in policy, statutory law, and regulatory law.

This Article will discuss the growing problem of suicide rates in the military and among veterans, including and especially among those of the Iraq and Afghanistan wars. Part II of this Article compares suicide rates among this younger generation with those of past wars, including both World Wars, Vietnam, and Gulf War I. Part III of this Article explores the reasons why the suicide rate among Iraq and Afghanistan servicemembers and veterans is different from that of prior wars. This section also explains why accurate and thorough data reporting of those that commit suicide is absolutely crucial in

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33. See infra notes 37-79 and accompanying text.
34. See infra notes 80-138 and accompanying text.
solving the problem of rising suicide rates. Part IV covers some of the more successful and well-known programs that have been implemented in the last few years to help stave off the alarming increase of suicides in the military and among veterans. In closing, Part V provides a variety of legal solutions to help the DoD, VA, and military commanders prevent suicides and reduce the stigma of seeking help.

II. COMPARATIVE ANALYSIS OF SUICIDE RATES OF PAST AND CURRENT WARS

For many of the most recent wars and military conflicts, a number of organizations and federal agencies have conducted numerous studies on suicide rates among veterans of specific wars. Some studies like those based on Vietnam War veterans produced a long-standing—yet factually inaccurate—stigma because of the vast numbers of suicidal veterans that were at a significantly higher risk of suicide than their non-veteran counterparts. Many of those studies were inadequate and based on faulty scientific methods. The problems with these studies compounded when the media would take a single, incorrect statement out of one of these reports and blow the statistic out of proportion. For other wars, such as the recent wars in Afghanistan and Iraq, studies are much more accurate and reflect the eerie reality of rising suicides in younger veterans. And yet, for earlier conflicts such as World War I and the Korean War, studies are sparse and unreliable, if they exist at all. This section attempts to clarify the suicide rates among veterans of each of the major wars in the last century.

A. WORLD WAR I AND WORLD WAR II

Little statistical information exists for military suicides during World War I (“WWI”), World War II (“WWII”), and for the veterans of these wars shortly thereafter. The few available statistical reports show that suicide rates decreased during each war, especially, and

35. See infra notes 139-96 and accompanying text.
36. See infra notes 197-228 and accompanying text.
37. Due to the lack of any reliable statistics on the number of suicide attempts, suicide attempts are not addressed in this Article, only suicide completions. See Paul Yessler, Suicide in the Military, in SUICIDAL BEHAVIORS: DIAGNOSIS AND MANAGEMENT 241, 246 (H.L.P. Resnick ed., 1968).
38. See COLEEN A. BOYLE ET AL., CTRS. FOR DISEASE CONTROL, POSTSERVICE MORTALITY AMONG VIETNAM VETERANS 58 (1987), available at http://www.cdc.gov/nceh/veterans/postservicemortalityamongvietnamveterans/postservicemortalityamongvietnamveterans1_2.pdf (“[T]he findings for the World War II and Korean War Army veterans are not particularly enlightening for deaths due to suicide . . . because of small number of such deaths and the lack of data on suicide . . . risks according to time period after discharge.”).
most noticeably, during WWI.\textsuperscript{39} Suicide rates among enlisted servicemen decreased from 50 per 100,000 men at the beginning of WWI to just 7 per 100,000 at the end of WWII.\textsuperscript{40} Even with this overall decrease in the suicide rates among enlisted servicemen, one study conducted within ten years of WWII revealed that veteran suicide rates were still three times greater than that of civilians of the same age.\textsuperscript{41} What may be even more telling, however, are the suicide rates of the WWII generation of military fighters \textit{today}.

In a 2010 study conducted by the California Department of Public Health, the Department found that California WWII veterans were committing suicide at a rate two times greater than younger generations of veterans—veterans that had recently returned from the conflicts in Afghanistan and Iraq.\textsuperscript{42} This analysis also found that this same group of veterans, those aged eighty and older, were committing suicide at a rate four times that of the non-veteran populace in the same age group.\textsuperscript{43}

**B. Vietnam War**

During the Vietnam War, there were relatively few suicides among active duty servicemembers. For the entire duration of the conflict, only 382 military members committed suicide.\textsuperscript{44} This is in stark contrast to the number of suicides among those who served in later conflicts.\textsuperscript{45} However, this may have been a temporary—and artificially low—statistic when considered with the number of veterans that committed suicide after they left service.\textsuperscript{46}

The Vietnam War is infamous for its stigma of record-high numbers of suicides among those who served in Vietnam area of operation. Disabled American Veterans, a national veteran service organization, published a booklet in 1980 that alleged an unusually high number of

\begin{footnotes}
\item \textsuperscript{39} Federico Sanchez, \textit{Understanding Suicide and Its Prevention} 41 (2010). However, part of this overall decrease may have been offset by overall trends among the population; civilian suicide rates declined during these same periods. \textit{See} George Howe Colt, \textit{November of the Soul: The Enigma of Suicide} 247 (2006).
\item \textsuperscript{40} Sanchez, \textit{supra} note 39, at 41.
\item \textsuperscript{41} Harold I. Kaplan & Benjamin J. Sadock, \textit{Clinical Psychiatry: From Synopsis of Psychiatry} 1834 (1988).
\item \textsuperscript{42} Aaron Glantz, \textit{Veteran Suicides by Age}, \textit{Bay Citizen} (S.F.) (Nov. 11, 2010, 8:22 AM), http://www.baycitizen.org/veterans/interactive/veterans-day-suicide-rates-age/.
\item \textsuperscript{43} Id.
\item \textsuperscript{44} Statistical Information About Fatal Casualties of the Vietnam War, Nat’l Archives (Apr. 29, 2008), http://www.archives.gov/research/military/vietnam-war/casualty-statistics.html.
\item \textsuperscript{45} \textit{See infra} Part II.D.
\item \textsuperscript{46} \textit{See discussion} \textit{infra} Part III.A.
\end{footnotes}
suicides among Vietnam veterans. The booklet claimed that more Vietnam veterans had lost their lives to suicide after the war than those servicemembers killed in combat. In the decade that followed, the media was rampant with unsubstantiated suicide rates among Vietnam veterans. In 1985, one magazine reported that an astounding 58,000 Vietnam veterans committed suicide. Within one year, the reported number was “more than 60,000.” By 1987, media outlets touted that over 100,000 Vietnam veterans committed suicide.

Despite the widespread news articles, books, and television broadcasts providing these scientifically unsubstantiated and shocking suicide numbers, the reality was vastly different. The first major study to dispute the mainstream media’s claims was conducted in early 1990. This study revealed that the number of Vietnam veteran suicides was closer to 9,000 total. The study specifically disputed the claim that the risk of suicide for Vietnam veterans was six to eleven times greater than that of men in the general population—the increased suicide rate for Vietnam veterans was only one and a half times greater than that of men of a similar age in the general population. This claimed higher rate of suicide—and thus the overinflated estimates of Vietnam veterans that committed suicide—was due to faulty scientific extrapolation of statistics. Dr. Daniel A. Pollock ex-

55. See supra note 52 and accompanying text.
56. Pollock et al., supra note 49, at 774. Dr. Pollock and his colleagues based their research primarily on death certificates and medical panel determinations of those deaths of Vietnam veterans through 1984. Id. at 773.
57. Id. at 774.
plained in the study that a "higher rate of suicide was observed among Vietnam veterans during the first five years after discharge from active duty," and mainstream media improperly assumed that this higher rate of suicide would continue from the early 1960s through the late 1980s. But the opposite occurred: "thereafter Vietnam veterans were at a relatively low risk of suicide." In sum, there was "no evidence to confirm the large numbers of suicides that have been reported in the print and broadcast news media." More recently, in 2004, a thirty-year follow up study showed that Vietnam veterans had suicide rates lower than their non-veteran counterparts.

As discussed in more depth in Part III.B of this Article, the errors of reporting inaccurately high suicide rates among Vietnam veterans serve as a warning to United States Department of Veterans Affairs ("VA"), the United States Department of Defense ("DoD"), and other reporting agencies. It is imperative that suicides are neither underreported, as Dr. Pollock caveats in his study, nor over-reported, as in the widely-reported media outlets. Otherwise, the agencies responsible for recognizing risk factors and preventing veterans from conducting suicide cannot effectively save lives.

C. PERSIAN GULF WAR (OPERATION DESERT STORM)

As opposed to those of the Vietnam War, soldiers and veterans of the Persian Gulf War do not have the false stigma of, nor the scientific evidence demonstrating, a higher suicide risk. With respect to military personnel, a number of studies found the suicide rates among those serving in the Persian Gulf War were up to fifty percent less

58. Id.
59. Id.
60. Id. at 775.
63. See Mark A. Zamorski, Suicide Prevention in Military Organizations, 23 INT'L REV. Psychiat 173, 177 (2011); see also Lisa A. Brenner et al., Suicide and Traumatic Brain Injury Among Individuals Seeking Veterans Health Administration Services, 26 J. HEAD TRAUMA REHABILITATION 257, 262-63 (2011).
65. See Harold Braswell & Howard I. Kushner, Suicide, Social Integration, and Masculinity in the U.S. Military, 74 Soc. Sci. & Med. 530, 530 (2012) (providing that 2006 marked the highest rate of suicides among active duty soldiers since the U.S. Army began collecting such statistics in 1980—10 years before the start of the Persian Gulf War).
than their civilian counterparts.\textsuperscript{66} With respect to veterans, most studies reveal that Persian Gulf War veterans had little or no increased risk of suicide compared to other veterans or the non-veteran general population. A medical study conducted a few years after the end of the Persian Gulf War revealed that, as compared to veterans who did not serve in the Persian Gulf War, veterans of the Persian Gulf War had nearly identical suicide rates three years after hostilities ended.\textsuperscript{67} Later studies have confirmed this early finding.\textsuperscript{68} These same studies also found that Persian Gulf War veterans were not committing suicide at rates higher than the general population.\textsuperscript{69}

D. IRAQ AND AFGHANISTAN WARS (OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM)

While the mantra of staggering Vietnam suicide rates was grossly inaccurate, the staggering suicide rates for the wars in Iraq and Afghanistan is a depressingly accurate statement. To date, the Iraq and Afghanistan Wars have resulted in 6,653 casualties.\textsuperscript{70} This number could shortly be eclipsed by the number of servicemembers that commit suicide while in service or shortly thereafter.\textsuperscript{71} At least 4,700 servicemembers and veterans have committed suicide since operations in the Middle East began in 2001.\textsuperscript{72} This number is comprised of ap-

\begin{itemize}
  \item 66. Martin J. Mahon et al., Suicide Among Regular-Duty Military Personnel: A Retrospective Case-Control Study of Occupation-Specific Risk Factors for Workplace Suicide, 162 AM. J. PSYCHIATRY 1688, 1689 tbl.1 (2005) (citing two studies in which the suicide rate among military personnel was approximately half that of the civilian population).
  \item 67. For Persian Gulf War veterans, suicide made up 1.53% of all deaths in the three years after the war. For veterans that did not serve in that war, suicide made up 1.54% of deaths. Han K. Kang & Tim A. Bullman, Mortality Among U.S. Veterans of the Persian Gulf War, 335 NEW ENG. J. MED. 1498, 1500 tbl.2 (1996).
  \item 68. Zamorski, supra note 63, at 174 (citing Gregory C. Gray & Han K. Kang, Healthcare Utilization and Mortality Among Veterans of the Gulf War, 361 PHIL. TRANSACTIONS ROYAL SOCY: BIOLOGICAL SCI. 553 (2006)).
  \item 69. See id.
  \item 70. U.S. Casualty Status, U.S. DEP’T DEF. (Jan. 11, 2013, 10:00 AM), http://www.defense.gov/news/casualty.pdf. There were 4,422 casualties as a result of the Iraq War (OIF). Id. To date, there have been 66 deaths due to support operations in Iraq (Operation New Dawn) and 2,165 casualties due to the Afghanistan War (OEF). Id.
  \item 71. Though this Article focuses more on veteran suicide rates than those of active duty military personnel, the number of suicides among active duty servicemembers is quite telling, given the low number of actual casualties due to the Iraq and Afghanistan Wars. I use these figures here to highlight and compare the number of suicides in the last 10 years with those of the wars during the same time.
  \item 72. ALAN BERMAN ET AL., U.S. DEP’T OF DEF., THE CHALLENGE AND THE PROMISE: STRENGTHENING THE FORCE, PREVENTING SUICIDE, AND SAVING LIVES 41 tbl.6-1 (2010), available at http://www.health.mil/dhb/downloads/Suicide%20Prevention%20Task%20Force%20final%20report%2008-23-10.pdf (providing that between 2001 and 2009, there were 1,917 deaths among all U.S. military branches, including the Reserves and National Guard); see Richard L. Dixon, Jr., Knowing and Caring: Leadership and the Pre-
proximately 2,810 military personnel who have committed suicide while on active duty, and at least an additional 2,000 Operation Enduring Freedom and Operation Iraqi Freedom ("OEF/OIF") veterans through the end of 2011. Somewhat shockingly, this number of veterans includes only those in the OEF/OIF conflicts; estimates indicate that at least 6,256 veterans from all conflicts committed suicide in 2005 alone. Even more appalling, the VA estimates that at least 6,500 veterans of all conflicts—nearly the equivalent to all casualties of the two wars in the last decade, and three times the estimated number of OEF/OIF veterans who committed suicide—committed suicide each year since 2005.

While every life lost to suicide is a tragedy, the annual rates of suicide among OEF/OIF servicemembers have actually been lower than that of civilian populations until just recently. The suicide rate among active duty Army soldiers, for example, was actually below that of the civilian population from 1980 thru 2005. Suicide rates among active duty Air Force airmen were similarly lower than their civilian counterparts from the mid-1990s thru 2008. However, despite the

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73. See supra note 72 and accompanying text.
74. Armen Keteyian, Suicide Epidemic Among Veterans, CBS NEWS (Feb. 11, 2009, 3:53 PM), http://www.cbsnews.com/stories/2007/11/13/cbsnews_investigates/main3496471.shtml ("In just . . . 45 states, there were at least 6,256 suicides among those who served in the armed forces. That's 120 each and every week, in just one year.").
75. See supra note 72 and accompanying text.
76. See Shinseki, supra note 2.
77. Berman et al., supra note 72, at 17.
78. See Tom Spoth, AF Suicide Numbers near Mid-1990s Levels, A.F. TIMES (Apr. 10, 2010, 10:28 AM), http://www.airforcetimes.com/news/2010/04/airforce_suicides_041010w/. At one point, the Air Force suicide rate was about half that of civilian counterparts. Id. The Navy has had relatively flat suicide rates—until 2011 when it spiked to 14.5 suicides per 100,000 sailors. See Berman et al., supra note 72, at 22; Statistics, U.S. NAVY PERSONNEL COMMAND, http://www.public.navy.mil/bupers-npc/support/
relatively recent increase in suicide rates among military personnel, suicide rates among OEF/OIF veterans have always been higher than that of their civilian counterparts.\textsuperscript{79}

As illustrated in this section, the suicide rates among military personnel and veterans vary wildly between the different wars, but this may or may not be as statistically accurate as one might assume. The following section attempts to uncover some of the reasons for the actual and perceived differences among suicide rates of military personnel and veterans of the various conflicts.

III. WHY IRAQ AND AFGHANISTAN SUICIDE RATES ARE DIFFERENT

The problem with the staggering statistic of twenty-two veterans committing suicides per day is that it includes veterans of all wars—from World War II ("WWII") through the Operation Enduring Freedom and Operation Iraqi Freedom ("OEF/OIF") conflicts. More outrage should exist not only from the military, but from all Americans—the suicide rate should never reach a level this high. However, it is difficult to resolve the problem without more data regarding which wars produced veterans that may have a higher risk of committing suicide than other wars. For example, if WWII veterans actually make up the majority of the current suicide numbers, the United States Department of Veterans Affairs' ("VA") recent live, online chat-room will not serve as an effective prevention strategy for a generation of veterans in their eighties and nineties who actually need the help more. This strategy would, however, be much more effective for the younger generations returning from OEF/OIF. This is why it is imperative for the VA, United States Department of Defense ("DoD"), and other agencies and non-governmental organizations ("NGOs") to figure out a way to specifically target and address suicide rates among that population. Thus, it is critical to know not only more details related to veteran and servicemember demographics, but also accurate data that truly reflects the number of suicides among veterans of all wars and conflicts.\textsuperscript{80}

\textsuperscript{79} Bagelman, supra note 72, at 2.

\textsuperscript{80} One study found that real "suicide totals may be as much as 21% higher than reported." Braswell & Kushner, supra note 65, at 1.
A. Is the Perception a Reality? Explanations for the Differences

Unfortunately, it is hard to discern whether the difference in suicide rates of veterans of different wars is real or perceived. For example, active duty suicide rates were shockingly low during the Vietnam conflict, but that war was infamous for producing the “suicidal veteran.” This is effectively the opposite of the current OEF/OIF conflict—the active duty suicide rates for OEF/OIF are at near-record highs. The suicide rates among the younger veterans appears, based on some studies, to be currently less than that of WWII veterans, yet more than that of Vietnam veterans.

There is some validity to the notion that the high suicide rate of OEF/OIF veterans is more perceived than real. The United States is still conducting on-going operations in Afghanistan (and to some extent, limited non-combat operations in Iraq), and more than two million men and women have served in the military in the last decade. Moreover, as discussed previously, the suicide rate among active military personnel is at a thirty-year high. However, it may be that this high rate of veteran suicides is not nearly as prevalent for the younger generations returning from OEF/OIF as it is for the aging populations from the wars of the twentieth century. If that is the case, then public perception of OEF/OIF veterans having a higher suicide risk is a mistaken generalization, just like the mistaken broad generalizations of Vietnam veterans.

1. Differences in the Wars and Conflicts Themselves

One major difference between the wars in the last century was tempo of combat operations and deployments. For example, the Persian Gulf War was far shorter and less costly—specifically in terms of

81. See discussion supra Part II.B.
82. See discussion supra Part II.
83. See Kara Zivin et al., Suicide Mortality Among Individuals Receiving Treatment for Depression in the Veterans Affairs Health System: Associations with Patient and Treatment Setting Characteristics, 97 AM. J. PUB. HEALTH 2193, 2193 (2007) (“Unlike the general population, older and younger veterans are more prone to suicide than are middle-aged veterans.”).
85. I specifically chose not to address the varying societal differences between the wars. It is common knowledge that there was widespread support for U.S. military personnel during World War II and far less for Vietnam. I believe there is some merit to the argument that public perception of the war and our military men and women during the respective conflicts could have a slight role in differing depression, alcohol abuse, and suicide rates.
the death count—than the Vietnam War.86 Shorter deployments to the Persian Gulf thus reduced the likelihood of incurring mental health issues, such as post-traumatic stress disorder (“PTSD”), which then decreased the risk of suicide among veterans and military personnel.87

When comparing these earlier conflicts with those of OEF/OIF, the tempo of combat is vastly different. Through 2009, over forty percent of active duty military personnel deployed two or more times, and more than twelve percent of servicemen deployed three or more times.88 Many studies and government officials blame the high operations tempo and numerous deployments as the culprits of increased instances of PTSD and suicide risk.89 However, some studies reveal that a more relevant factor to a soldier’s increased suicide risk is whether he or she deployed at all—“soldiers who deploy are more likely to die by suicide” than those who do not deploy at all.90 Regardless, deploying once or multiple times does not appear to be the sole reason for the increase in suicide rates.91

Those in the National Guard or Reserve military components have also seen a huge increase in deployment (and multiple deployments) since just the Persian Gulf War. Only eighteen percent of those deployed during the Persian Gulf War were from the Reserves, whereas more than forty percent of military personnel deployed to

87. See infra note 89 and accompanying text.
88. Armed Forces Health Surveillance Ctr., U.S. Dep’t of Def., Associations Between Repeated Deployments to OEF/OIF/OND, October 2001-December 2010, and Post-Deployment Illnesses and Injuries, Active Component, U.S. Armed Forces, MED. SURVEILLANCE MONTHLY REP., July 2011, at 2, 3. This report does not include the numerous deployments required of the Reserve and National Guard components, which have been comparatively much higher than in previous conflicts.
89. See, e.g., Lori S. Katz et al., War Experiences Inventory: Initial Psychometric and Structural Properties, 24 MIL. PSYCHOL. 48, 49 (2012) (citing deployment-related stress and “increased op tempo’’); Zamorski, supra note 63, at 177 (suggesting that placing limits on duration and spacing of deployments may help reduce the risk of suicide); Gordon Lubold, Soldier Rampage Hints at Stress of Repeated Deployments, CHRISTIAN SCi. MONITOR (May 13, 2009), http://www.csmonitor.com/USA/Military/2009/0513/p02s01-usmi.html (“Fifteen-month tours and repeated deployments are increasing the rate of suicide . . . and psychological problems, according to Pentagon data.”).
90. HARRELL & BERGLASS, supra note 2, at 2.
91. Michael Hoffman, Guard, Reserve Suicide Rate Sees Big Spike, ARMY TIMES (Jan. 19, 2011, 7:35 PM), http://www.armytimes.com/news/2011/01/army-guard-reserve-suicide-rate-sees-big-spike-011911w/ (“Blaming only deployments . . . would be incorrect . . . . Of 112 guardsmen who killed themselves in 2010, more than half had not deployed.”). See discussion infra Part III.B.1 for some exploration of other possible risk factors, many of which are not unique to military personnel.
OEF/OIF were from the Reserves. Given some studies have shown that military personnel mobilized from the Reserves and National Guard have higher risk of mental health issues compared to active duty personnel, which may lead to increased suicide risk, it is not surprising that the increased use of National Guard and Reserve forces has resulted in a simultaneous rise in suicides—including and especially among these components.

2. Medical and Technological Advancements

Advances in medicine, technology, and battlefield protocol over the last fifty-plus years are also prevalent reasons for the differences of suicide rates among military personnel during the various periods of war. One explanation for the recent increase in suicide rates among military personnel and veterans are the medical and technological advances made in the last century. Military personnel are surviving at higher rates than in prior wars because protective gear is far more advanced than in prior wars. However, “[s]oldiers hit in the head or knocked out by improvised explosive devises (‘IED’) blasts often don’t display visible wounds.” As a result of higher survival rates, these same soldiers are thus at an increased rate of traumatic brain injury (“TBI”) and PTSD. TBI and PTSD are linked to higher incidents of suicide attempts and increased suicidal behavior. Thus, while the number of military personnel dying in combat has decreased precip-

92. Dawne S. Vogt et al., Deployment Stressors and Posttraumatic Stress Symptomatology: Comparing Active Duty and National Guard/Reserve Personnel from Gulf War I, 21 J. TRAUMATIC STRESS 66, 67 (2008). This only represents the OEF/OIF conflict through 2007. In the last few years, and with the drawdown in Iraq, the number of those deployed and/or mobilized from the Reserves and National Guard has decreased. See Michelle Tan, Army Mulls Future of National Guard, Reserve, ARMY TIMES (May 23, 2011, 8:03 AM), http://www.armytimes.com/news/2011/05/army-mulls-guard-reserve-future-052311w/.


94. But, it is interesting to note that while the raw numbers of suicides within the National Guard and Reserves has increased steadily (and skyrocketed in 2010), the rate of suicides has remained somewhat stable, and in fact decreased between 2007 and 2009. Berman et al., supra note 72, at 41; Dixon, supra note 72 (providing that the number of suicides of National Guard and Reserve personnel doubled from 2009 to 2010).

95. Katz et al., supra note 89, at 49.

96. MONTGOMERY, supra note 7, at 189.

97. See id.

98. See Brenner et al., supra note 63, at 257-61.
itously since the World Wars, the incidence of severe mental health issues has increased because of increased survival rates.

Additionally, changes in medical protocol on the battlefield may have contributed to the difference of suicide rates among military personnel during the various periods of war. During WWII, some army personnel would label any psychological issue as "exhaustion," rather than a more appropriate psychiatric term. This could have resulted in vastly inaccurate accounts of deaths due to suicide or psychiatric problems. During the Korean and Vietnam Wars, on-site medical personnel provided immediate treatment so military members could return to combat as soon as possible, thus not addressing any potential serious psychiatric issues until after the servicemen came home. In fact, the Vietnam War was the first war in which medical personnel administered significant amounts of drugs to those serving in Vietnam to keep the servicemen fighting. This policy staved off the evacuation of some men who were likely too mentally unstable to realistically continue serving in that country. It is possible that the administration of these drugs resulted in artificial suppression of suicide ideation among actively serving military personnel, and once they returned home, they no longer received the medication that prevented suicide ideation.

In today's OEF/OIF conflicts, the ethical issue of prescribing psychiatric drugs to soldiers on the battlefield in order to keep them in combat operations, or to return them quickly to the conflict, still exists. More drugs are being prescribed to military personnel both abroad and once they return home after being diagnosed with PTSD or similar mental disorders. Some military psychiatrists and medi-

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99. See Sanchez, supra note 39, at 449 (reporting that 30% of wounded soldiers died in World War II, 24% of wounded died in the Vietnam and Persian Gulf Wars, and yet only 10% of wounded have died in the OEF/OIF conflicts "thanks to medical improvements").

100. See Disabled Am. Veterans, supra note 47, at 4 (explaining "psychiatric casualties" during World War II had increased 300% from World War I); Sanchez, supra note 39, at 449 ("Men and women with terrible and formidable injuries are being saved on a scale never seen before and will carry psychological scars that we haven't even begun to comprehend."); see also Katz et al., supra note 89, at 49 (finding that "Vietnam veterans who sustained an injury during combat were at increased risk for PTSD than those who did not"). However, it is worth noting that the estimates of military veterans with PTSD for Korean War veterans are equal to that of OEF/OIF veterans. Montgomery, supra note 7, at 145, 189.


102. Id. at 4-5.

103. Id. at 9 ("There was widespread use of cannabis but . . . it had created almost no psychiatric problems. Quite to the contrary, it served its own medicinal purpose as a buffer against the stresses of the Vietnam experience, submerging and delaying symptoms.").

104. See Harrell & Berglass, supra note 2, at 7.
cal personnel have counseled their colleagues in the Middle East to maintain large quantities of these newer prescription drugs in order to "conserve the fighting strength." Unfortunately, even the diagnosis of such disorders, and being heavily medicated upon returning from combat, will not prevent a soldier's redeployment to the conflicts. Redeployment can further compound a servicemember's already-fragile state of mind if sent back into combat without fully recovering from the physical and mental wounds of the first deployment.

Finally, medical professionals, and thus government agencies implementing medical policy, treat mental health issues differently today as compared to those in the 20th century. While the symptoms of PTSD and related psychiatric issues have been recognized since WWI, differences in the characterization of PTSD has affected the way the VA and DoD have treated military personnel and veterans over the years. Indeed, it was suggested that when a PTSD-like mental health diagnosis was deleted from a popular American Psychiatric Association medical treatise in 1968, the medical organization did so to "reduce the financial liability of the VA following the Vietnam War." The removal of this provision may have had two deleterious results in suicide rates among Korean and Vietnam War veterans. First was the inability of veterans to receive VA benefits and treatment for PTSD-like psychiatric health issues, thereby exacerbating the risk of suicide, and possibly attributing to the rise of suicide rates among Vietnam veterans in the five years after servicemen left military service. Second, because these psychiatric issues were not necessarily reported among agencies, many of which directly adopted the medical treatise's medical definitions via regulations, the risk factors associated with suicide may not have been accurately tracked, and

105. Catherine L. Annas & George L. Annas, Enhancing the Fighting Force: Medical Research on American Soldiers, 25 J. Contemp. Health L. & Pol'y 283, 304 (2009). Newer psychotropic medications, especially "selective serotonin-reuptake inhibitors (SSRIs)," are used for anxiety disorders and depressive disorders. Id.

106. This statement is based on my personal observations and conversations I had with a particular soldier, who was diagnosed with PTSD after a tour in the Middle East. Despite years of psychological counseling and still receiving disability benefits for PTSD, he was told he would re-deploy to Afghanistan in spring 2012.

107. See Gross, supra note 86 ("In the intervening years between Vietnam and the gulf war post-traumatic stress disorder has been recognized as a psychiatric illness, thus making it likely the latest victims will be diagnosed early and will get the best care available.").


109. Id. at 46.

110. See supra Part II.C.; see also Pollock et al., supra note 49, at 774.
thus not adequately addressed within the VA and DoD. As discussed more thoroughly below, not knowing or tracking the risk factors for suicide among military personnel and veterans only further hinders the agency and military officials from preventing suicide. By updating the medical treatise a decade later, the two problems of properly diagnosing PTSD and its related psychiatric health issues could largely be resolved.

B. REPORTING ACCURACY AND ITS IMPORTANCE IN PREVENTING SUICIDES

The DoD currently tracks all completed suicides among active duty and Reserve/National Guard personnel within the Armed Forces. While the DoD has access to military personnel and health records, including relevant psychiatric documentation, and thus the ability to draw from these records to build a clearer picture of why military personnel commit suicide, the DoD still wants more data. Indeed, the DoD admitted in mid-2010 that they simply did not have procedures in place to standardize suicide investigations to get all the data necessary to create the perfect weapon against suicide. Further, in exploring a historical analysis of veteran suicide rates among all wars, there is no “one-stop-shop” to find relevant data of those that committed suicide.

Individual state health agencies, not the DoD or VA, are primarily and traditionally responsible for tracking the cause of death and other relevant factors pertaining to decedent characteristics, such as

111. For example, instead of attributing suicide risk factors to PTSD, the agencies may have attributed suicide risk instead with depression, personality disorder, or otherwise inaccurate mental health diagnoses, which may have only been partial reasons for suicide ideation.


114. However, unit commanders have very limited access to this type of data of their troops. There have been recent developments within the Army itself to encourage mental health professionals to warn military leaders when one of their troops is at “high risk” of suicide. Harrell & Berglass, supra note 2, at 7-8.


117. Suicide Rates Soar Among U.S. Veterans, Google News (Nov. 11, 2010), http://www.google.com/hostednews/afp/article/ALeqM5ip7r1SIFog5dxs_RyeomhhRTvdZxA.
sex, residence, and veteran status. While the Centers for Disease Control ("CDC") attempts to track suicides in the U.S. population, they depend on reports from the individual state health agencies for pertinent veteran or military-related data, usually to no avail. Many states do not provide this data out of privacy concerns. In fact, only about a third of U.S. states provides suicide-related cause of death data to the CDC, as well as provide data concerning the veteran-status of decedents at the time of death. However, this data is often years old and extrapolated to the remaining states to determine the "nationwide" suicide rate among veterans. Thus, there is currently no way to know the true number of how many veterans commit suicide.

So why is accurate reporting data so important? What would it do to know exactly how many veterans commit suicide each year, which wars they fought in (or, alternatively, if they are veterans of peacetime eras), or their mental health history? There are three major reasons why accurate data is not just necessary, but critical, to help prevent suicides in the military and among veterans: to identify suicide risk and protective factors to implement effective screening methods; to create targeted suicide prevention programs; and to validate implemented suicide prevention programs and mental health services.

1. Suicide Risk and Protective Factors

While there have been some studies revealing a number of suicide risk factors for military personnel, these risk factors are overbroad generalizations that may not correlate with attempting or committing suicide. Additionally, many of the risk factors identified are just as relevant in civilian suicide investigations: they are not unique to military personnel or veterans. Examples of these joint civilian-military suicide risk factors include prior suicide attempts, mental and substance-use disorders (including depression, PTSD, and anxiety), and

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118. Malbran, supra note 113.
119. Id.
120. In CBS's 2008 investigation into veteran suicide rates, they noted that a number of states were extremely hesitant to give over some data in case it could be determined, using additional sources, who exactly those veterans were that committed suicide. Id.
122. Harrell & Berglass, supra note 2, at 9.
prior history of physical or sexual abuse. While some risk factors, such as PTSD, may be more prevalent in military personnel and veterans, given their exposure to psychologically traumatic events far more often than civilians, these factors are still equally relevant in determining suicide risk among civilians and military personnel/veterans alike. Therefore, more thorough and accurate data of military personnel and veterans who commit suicide could potentially uncover suicide risk factors that are unique to them.

This is not to say that the risk factors already identified are not useful; quite to the contrary, they can be very important in suicide prevention screenings. These risk factors can also prove helpful to mental health professionals. After initial mental health screenings for disorders like depression or PTSD, these risk factors could help determine what additional screening the servicemember or veteran requires, allowing that servicemember or veteran to be placed in a program specifically targeting his or her individual needs. However, aside from higher rates of PTSD and TBI among military personnel verses their civilian counterparts, many of the suicides occurring in the military are from those who have never deployed. Thus, there is something more than just the joint civilian/military suicide risk factors at play: there is something causing the suicide rates to increase within the military and among veterans, but not civilians. Without additional studies to uncover what that “something” is, the mystery of increased suicide rates among military personnel and veterans will never be solved.

2. Targeted Suicide Prevention Programs

There is no “one-size-fits-all” suicide prevention program. These programs must be tailored to address the problems with which servicemembers and veterans struggle. Using the newly-found risk factors, government agencies and NGOs can tailor suicide prevention programs to specific groups of veterans, such as a program specifically geared towards preventing suicide in soldiers with TBI, those military members and veterans with substance-use problems, or veterans who experienced sexual trauma while in service.

But these newly-found risk factors are not the only data needed in creating targeted programs. Differences in the type of service of military members could potentially lead to different needs from a suicide

124. See generally id.
126. Despite the fact that many of the Army's suicide prevention programs were described as “one-size-fits-all.” Hoffman, supra note 91.
127. See Tilghman, supra note 116.
prevention program. For example, suicide rates among Reservists and National Guardsmen are increasing even though active duty rates are stabilizing (or at least, not increasing at a statistically significant rate). This type of knowledge should be exploited to create an outreach program geared towards these specific servicemembers, which, based on the different nature of their military duties, would look quite different from a program geared towards active duty components. 128 One particular difference between the two components is that National Guardsmen and Reservists are activated from civilian life, and activation can sometimes be initiated unexpectedly. Additionally, different military and veteran benefits regulations govern these servicemembers. A suicide prevention program geared specifically towards Reservists and National Guardsmen would thus need to be tailored to their specific needs and challenges as compared to active duty servicemembers.

Other differences that may require a variety of suicide outreach programs are the age of and war period served by the veteran. If suicide rates among younger veterans differ compared to older generations (regardless of the war era they served during), outreach programs should focus on the generational differences: suicide hotlines and chatrooms would be very effective for younger generations and younger soldiers, but not nearly as much for WWII veterans or older veterans.

3. Validation of Suicide Prevention Programs

Finally, the third major reason to maintain and manage an extensive data collection on suicides in the military and among veterans is to track progress and validate suicide prevention programs. Organizations have initiated a number of programs in the last few years since the rise of suicide rates drew public attention, and while the U.S. Army stated that many of these programs and initiatives were "good ideas," little evidence existed to determine whether they were actually reducing suicide rates or not. 129 Additionally, the VA and DoD can use such information to better tailor suicide ideation screenings and further understand the relationship between military/VA mental health care by validating suicide prevention efforts. 130

128. See Hoffman, supra note 91.
130. See Sundararaman et al., supra note 32, at 10.
C. RECENT EFFORTS TO INCREASE AND EFFECTIVELY USE METRICS

While there is very scant data available to the VA and DoD to help resolve these three major issues, both agencies have completed some work to improve not only the amount of data, but the quality as well. For example, the VA has recently forged agreements with forty-nine states in order to obtain more data on veterans who commit suicide; the VA hopes to finalize a commitment from the last holdout state of Colorado as soon as possible.131 The VA continues to collect suicide-related data by veterans currently using VA medical health care (specifically the hospital and medical facilities), but it does not have access to such data of veterans who are not enrolled in the VA health care system, or who do not use the VA health facilities.132 The CDC does receive some of this information from veterans not enrolled in the VA system, but, as previously mentioned, only from about one-third of the states.133 Thus, by expanding the net to cover all veterans, whether or not enrolled with the VA health care system, and to cover all states, not just a select few that choose to report such data to the CDC, the VA will finally have better access to the data it needs to address the increasing suicide rates of veterans.134 Until the VA and each state begins this joint venture, the VA is left trying to link its records to those of the CDC and DoD database via social security numbers.135 This is a cumbersome task that still leaves the VA without a complete picture of veteran suicides among all states.136

The VA is not alone, however, in attempting to increase its access to more data. In late 2010, the DoD launched a three-year program to “study multiple aspects of suicide [and] look at the work of other studies,” the results of which will be put in a large database immediately available for policy makers.137 The database will not consist of information related to characteristics of those that commit or attempt suicide, like the joint VA-CDC program, but rather it will consist of

131. Kime, supra note 121. Colorado is one of the 18 states that currently provide the CDC with information regarding whether a victim of suicide was a veteran or not. HARRELL & BERGLASS, supra note 2, at 12 n.48.
132. SUNDARARAMAN ET AL., supra note 32, at 3 (“However, because only about one-third of veterans receive their health care from the VA, using VA health systems data for linkage would not capture the complete experience of suicide among veterans.”).
133. Id. at 2-3; Kime, supra note 121.
134. Some efforts have been made by the VA to directly access the CDC’s data. See SUNDARARAMAN ET AL., supra note 32, at 3. The information, however, is still limited to those 18 states that submit data to the CDC, and it often does not allow for a complete picture of veteran characteristics that would be necessary to create individualized or tailored suicide prevention programs. See id.
135. HARRELL & BERGLASS, supra note 2, at 9.
136. SUNDARARAMAN ET AL., supra note 32, at 3.
137. Elliot, supra note 129.
policies and studies conducted to prevent suicide.\textsuperscript{138} It is not a perfect system, but it is a first step in the right direction to validating the implemented programs that the DoD and VA have created in the last few years.

IV. IMPLEMENTED PROGRAMS

There are a number of suicide prevention programs implemented as a result of the increasing number and rates of suicides within the military and among veterans. The United States Department of Defense ("DoD") and United States Department of Veterans Affairs ("VA") have been the front-runners in developing and implementing such programs, but they are not alone, and many of the other programs have reported great success—despite some setbacks. This section provides a brief overview of some of the most successful and well-known suicide prevention programs implemented by government and non-governmental organizations ("NGOs") alike, as well as some of the gaps that still need to be addressed.

A. GOVERNMENT SPONSORED PROGRAMS

The DoD and VA are the two primary government agencies that have tried to develop the most comprehensive suicide prevention programs within the federal government. Other federal agencies, such as the Department of Health and Human Services as well as the Centers for Disease Control ("CDC"), have either provided support to the DoD and VA or have implemented additional services: but these agencies are primarily, if not solely, used only by veterans and not active duty military personnel.\textsuperscript{139}

1. Transitional Training—From Combat back to Non-Combat and Civilian Life

Both the DoD and VA have created transitional training programs for military personnel that leave the service. These organizations provide training to help servicemembers become aware of the various benefits they are entitled to (primarily from the VA, but can include benefits from the DoD as well), offer financial advice, and provide em-

\textsuperscript{138} See id.

\textsuperscript{139} Because active duty personnel receive all their health care through the DoD for free as a benefit of being in the armed forces, there is little need for these other non-DoD sponsored programs to target military personnel. This is not the case, however, for the millions of veterans who do not receive their healthcare from the VA. Many veterans simply do not qualify for free healthcare from the VA, and thus are more likely to obtain health care from private health care providers or via federal/state health care programs such as Medicare.
ployment assistance.\textsuperscript{140} Many of these programs are geared towards helping military personnel return to civilian life, but some of the programs are actually designed to help military personnel returning from combat to resume a non-combat lifestyle while still serving in the military. The former type of program can be molded to provide long-term solutions to help reduce suicide rates among veterans by teaching separating military personnel about warning signs of post-traumatic stress disorder ("PTSD"), what VA benefits they are entitled to, and other suicide prevention information. The latter type of program should be used as a short-term solution to reduce the suicide rates among active-duty personnel who stay in the military for more than one combat tour.

One particular problem with transitional training programs is that traditionally only those in the active duty components were able to use the programs, and thus, for the most part, Reserve and National Guard personnel who returned to civilian life after being activated (or mobilized) for a specific time period were excluded.\textsuperscript{141} Given the high number of Reserve and National Guard military personnel that deployed to Operation Enduring Freedom and Operation Iraqi Freedom ("OEF/OIF"), it was crucial that these transitional programs were made available to these individuals as well.\textsuperscript{142} Thankfully this recently changed, and Reserve and National Guard components began receiving the same transition training as their active duty counterparts.\textsuperscript{143}

Other problems with the effectiveness of these transitional training programs has been that the information provided during these programs is often either confusing for servicemembers,\textsuperscript{144} inapplicable to their situation,\textsuperscript{145} or servicemembers simply do not pay as much attention during these training sessions as necessary to fully glean

\textsuperscript{140} For general information regarding the DoD's current, overarching transitional training, see TURBO TAP, http://turbotap.org/ (last visited Jan. 13, 2013).
\textsuperscript{141} In the last decade, a significant number of National Guard and Reserve members were activated to serve tours in OEF/OIF. See supra Part III.A.1.
\textsuperscript{142} See supra Part III.A.1.
\textsuperscript{144} Amy N. Fairweather, Compromised Care: The Limited Availability and Questionable Quality of Health Care for Recent Veterans, HUM. RTS., Spring 2008, at 2, 7.
\textsuperscript{145} For example, a servicemember who is or believes that he or she is completely healthy and thus has no current foreseeable reason to apply for VA disability benefits will not pay particular attention during a portion of the training that may include how to file for VA disability benefits, and thus may "zone out" (so to speak) during much of the training, even if subsequent information is not inapplicable to the individual servicemember. Another example may be the servicemember who is single with no dependents and required to sit through portions of training that deal with family-related services.
the relevant and important information. These problems seem to be most prevalent among younger military personnel. The transitional training programs' significance needs to be emphasized within the military—specifically among non-commissioned officers and military commanders—so that younger servicemembers get the most out of these sessions.

Where the government has failed to provide adequate transitional assistance for members leaving the military, non-profit veteran organizations ("non-profits") have tried to fill in the gap. One example is the U.S. Military Endowment, whose mission is "to provide resources to our brave men and women, so that they may successfully transition from military to civilian life." Many similar programs have been created by other Veteran Service Organizations ("VSOs") and non-profits.

Other private organizations have also tried to create programs to help rehabilitate military members. In an effort to increase veterans' success rates in the workplace, some private employers have developed initiatives within their company or institution. Many companies actively recruit and hire veterans and focus on providing new veteran employees mentoring programs such as Pacific Gas and Electric Company's Employee Resource Group, and DuPont's Veteran's Network. However, even companies that have such initiatives in place are still hesitant to hire veterans out of concern with recent trends of PTSD among returning veterans from OEF/OIF. This is despite the numerous benefits to hiring veterans, and laws preventing discriminatory hiring of veterans diagnosed with PTSD and other mental health problems. Nearly half of employers polled

146. This observation is based on conversations I have had with a number of veterans and military personnel—both enlisted and officer alike.
151. Harrell & Berglass, supra note 149, at 24. As I discuss briefly in the next section, another problem companies have in hiring veterans is the existence of too many veteran-hiring programs and initiatives. Id. at 28.
152. See generally id. at 6, 17-20.
by the Society for Human Resource Management cited PTSD and related mental health issues as a challenge of hiring military veterans.\textsuperscript{154} Disturbingly, one way that an employer's perception of veterans has been tainted is via the media,\textsuperscript{155} whose recent coverage is reminiscent of the media-hyped depression problems alleged of Vietnam War veterans.\textsuperscript{156} Continued unemployment for veterans may only exacerbate their mental health problems, and hopelessness in employment may increase risk of suicide.\textsuperscript{157}

After the significant increase in suicide rates from 2008 to 2010, the DoD itself has begun adding new programs, or components to already existing programs, to help ease deployed military personnel returning from combat. One such program, coined the "decompression chamber,"\textsuperscript{158} requires units returning from combat to remain on base for ninety days before being allowed to return to civilian life.\textsuperscript{159} The DoD instituted this program for a Marine Corps unit that incurred an unusually high death toll in Afghanistan in 2010, in hopes of helping the unit ease back into a non-combat mentality and thus reduce the incidence of mental trauma.\textsuperscript{160} During the ninety-day "decompression period," the Marines held memorial services for fallen comrades and, most significantly, had the opportunity to talk about their experiences in OEF with each other.\textsuperscript{161} Prior to this program, Marines would often "go their separate ways" with no chance to grapple with the initial shock of returning from war with the men and women they served with in the Middle East.\textsuperscript{162} Military officials are waiting to announce it as a success because the program is so novel, but many who have deployed to OEF and OIF have stated their support and hope for the programs continuance.\textsuperscript{163}
be able to determine this program's effectiveness on reducing suicide rates among veterans and military personnel by conducting long-term follow-up checks on the Marines required to complete this program. Nonetheless, the Marine Corps has since required a "decompression period" for all its units that return from OEF. Its apparent, yet unofficially announced, success is a clear indication that the program has worked for the Marine Corps, and thus, is a program that should be implemented among all returning units in all military branches.  

2. Programs and Initiatives Within the VA

The VA has responded to the rise of suicides among veterans by creating a number of programs to help stave off additional suicide attempts, including a national suicide prevention hotline, a confidential and anonymous online chat room, and even a "smartphone application." Some critics, however, believe that there are actually too many suicide-prevention programs to make the overall goal successful. Since the inception of many of these programs, the number of active duty suicides has decreased slightly, but there is no evidence that the number of veterans committing suicide has similarly decreased. Much of the data used by agencies in determining suicide rates among veterans, as discussed above in Part II, is sometimes years old, and thus there simply is not recent-enough data to determine whether the programs have had a statistically significant impact in reducing suicide rates among veterans. The VA must perform studies on the recently instituted programs to determine whether they will be effective or not in both the short- and long-term.

Nonetheless, the VA is hailed for the numerous panels, commissions, initiatives, and programs it has created in the last five years, as well as the tangible numbers of lives the VA has saved through these programs. But these efforts were not without a slow start. For example, before 2008, the VA had a policy of not televising advertisements for VA benefits or services. Thus, the VA was effectively barred

164. This would not be very difficult, as the Navy requires this for sailors and Marines returning from ship duty. See id. Thus, the other branches could easily model these "decompression period" programs after those already implemented by the Navy and Marine Corps.


166. HARRELL & BERGLASS, supra note 2, at 8.

167. See supra Part II.D. It should be noted that, as new numbers come in, the suicide rates have fluctuated among all branches of the military in the last few years and seem to have stabilized more than "decreased," at least in any statistically meaningful way.

168. Examining the Progress of Suicide Prevention Outreach Efforts at the U.S. Department of Veterans Affairs: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Veterans Affairs, 111th Cong. 2 (2010) [hereinafter Examining
from using one of the easiest modes of advertising services; services
that could have potentially helped prevent suicides if only the VA
could have reached out to veterans to get them the help they needed.
This policy was reversed in 2008, in part due to pressure from the
legislative branch after receiving reports of the increased suicide rates
among veterans.\footnote{See id.} Calls from the Washington, D.C.-metropolitan area to
the VA's suicide prevention hotline doubled during the time period
public service announcements were present on buses and in subway
stations in Washington, D.C.\footnote{Ryan Steinbach, \textit{Lives on the Line}, VANGUARD,
May-June 2009, at 6, 8, available at \url{http://www.va.gov/opa/publications/vanguard/09mayjuneVG.pdf}.}
Yet despite the success of the advertising campaign, the VA ceased the bulk of its advertising in 2010.\footnote{Examining the Progress of Suicide Prevention Hearing, supra note 168.}
For these programs to continue preventing suicide among veterans,
effective outreach and advertising must persist.\footnote{Id.}

One incredibly successful program the VA implemented within
the last five years is the Veterans Crisis Line.\footnote{Id.} Instituted in July
2007, the Veterans Crisis Line is staffed by a number of suicide and
crisis prevention counselors who take calls from veterans, friends of
veterans, and concerned family members of veterans twenty-four
hours a day, 365 days a year. The center has answered more than half
a million calls and claims to have saved more than 23,000 lives.\footnote{Id.}
The expanded crisis center now includes a confidential and anonymous chat room dubbed “Veterans Chat,” which allows veterans to chat with VA-trained counselors. Veterans Chat, however, is not
meant as a replacement for the Veterans Crisis Line: where necessary,
the Veterans Chat counselor will attempt to transfer the veteran

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\textit{the Progress of Suicide Prevention Hearing} (statement of Rep. Mitchell, Chairman,
Subcomm. on Oversight & Investigations), available at \url{http://www.gpo.gov/fdsys/pkg/CHRG-111hhrg58058/pdf/CHRG-111hhrg58058.pdf}.
\end{flushleft}

\begin{itemize}
\item \footnote{See id.}169. See id.
\item \footnote{Ryan Steinbach, \textit{Lives on the Line}, VANGUARD, May-June 2009, at 6, 8, available at \url{http://www.va.gov/opa/publications/vanguard/09mayjuneVG.pdf}.}
\item \footnote{Examining the Progress of Suicide Prevention Hearing, supra note 168. Thank­fully, new public service announcements were reinitiated in mid-2011. Press Release, Dep't of Veterans Affairs, VA Launches New PSA on Suicide Prevention for Veterans (Mar. 15, 2011) (on file with author), available at \url{http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2071}.}
\item \footnote{Id.}170. The VA admits that advertising and outreach programs can produce tangible suicide prevention results: “As of April 2010, the VA had reported nearly 7,000 rescues of actively suicidal veterans which were attributed to seeing ads, PSAs (public service announcements), or promotional products.” Examining the Progress of Suicide Prevention Hearing, supra note 168. The VA also noticed an increase in referrals to VA mental health services. \textit{Id.}
\item \footnote{Id.}171. For the website that advertises and provides a great deal of information regarding the hotline and other services, see \textit{About the Veterans Crisis Line}, supra note 4.
\item \footnote{Id.}172. \textit{Id.}
\end{itemize}
or family member to the Veterans Crisis Line to speak with someone via the phone. 175

While the VA is making significant improvements in reaching service members and veterans alike, there are still major problems that need to be addressed. First, one major shortfall with many of the suicide prevention programs, especially those like the confidential Veterans Chat and other technology-based outreach campaigns, is that they still do not reach specific target audiences of veterans. 176 Online-based outreach programs (for example, those on Twitter, Facebook, or the recent smartphone application) 177 and the Veterans Chat are no doubt effective methods for reaching the younger generations of veterans and military personnel returning from OEF/OIF conflicts. But for older generations, specifically veterans of WWII and the Korean War, and for homeless veterans, who have little if any access to online services, these outreach and awareness methods are just not as effective as compared to younger veterans. This is especially true in light of the current veteran demographics: fifty percent of veterans are over the age of sixty, and twenty percent of veterans are over the age of seventy. 178 These online services serve a purpose and they should not cease, but the VA needs to ensure they create a comprehensive collection of outreach methods that can reach all veterans, of all ages, sexes, generations, and wars. Examples of practical outreach methods for homeless veterans, especially those in major metropolitan areas, are: public service announcements that are targeted during specific television segments; other forms of public advertising, such as the recent ads placed in and on public transportation; 179 or those ads in non-VA hospitals, clinics, and health centers.


176. The VA Chief of Staff, John R. Gingrich, stated that most veterans who are suicidal do not call the Veterans Crisis Hotline, and therefore more must be done to identify, and thus target, those most at risk. Meeting Minutes, Advisory Comm. on Women Veterans, Dep’t of Veterans Affairs 3 (Mar. 29-30, 2011) (on file with author), available at http://www.va.gov/WOMENVET/docs/ACWVMarch2011Minutes.pdf; see also Part III.B.


Second, and most significantly, one change that must occur is clearing the massive claims backlog at the VA\textsuperscript{180} and improving access-to-care timeliness for veterans. The VA is currently experiencing serious inefficiencies with respect to a colossal backlog of veteran disability claims that are currently pending: as of the summer of 2012, there were 911,000 veterans waiting for approval to receive disability compensation or access to VA healthcare.\textsuperscript{181} Two-thirds of these claims took four months or longer to process,\textsuperscript{182} and the average length of time to process a claim has been six months.\textsuperscript{183} Additionally, many veterans must wait weeks or months to actually see a doctor, and they often have to wait longer to see a mental health specialist.\textsuperscript{184} Thankfully, when veterans and military personnel cannot get access to care from government agencies, they can have some solace in finding informal programs from VSOs and community-led organizations.

B. COMMUNITY AND VSO SPONSORED EFFORTS: HELPING VETERANS AT A LOCAL LEVEL

Where the VA and DoD fail to provide veterans the help they need, many non-profits and VSOs attempt to fill in the gaps. Many of these organizations provide transitional training, whereas others simply provide a safe place for veterans of all wars to come together to discuss their experiences and to work through them. This latter effort—veterans helping veterans, so to speak—is novel and somewhat controversial,\textsuperscript{185} but evidence shows this type of informal counseling

\textsuperscript{180}. I merely state that this is a massive problem for the VA, without going into the details of how to resolve this specific problem. I recommend, for the curious reader who would like to know more about this specific issue of the claims backlog, to review the 2011 United States Court of Appeals for the Ninth Circuit panel opinion, Veterans for Common Sense v. Shinseki, 644 F.3d 845, 850 (9th Cir. 2011), rehe\textsuperscript{g} en banc granted, 663 F.3d 1033 (9th Cir. 2011), vacated, 678 F.3d 1013 (9th Cir. 2012); see also Michael Serota & Michelle Singer, Veterans' Benefits and Due Process, 90 Neb. L. Rev. 388 (2011).


\textsuperscript{182}. Id.

\textsuperscript{183}. Why the VA Frustrates Veterans, CBS News (Jan. 3, 2010 11:10 PM), http://www.cbsnews.com/2100-18560_162-6045148.html. There is some indication that this number will go down over the next two to three years, such that by 2015, no veteran will have to wait more than four months for his or her claim to be processed. Maze, supra note 181.


\textsuperscript{185}. Jill Carroll, Older Vets Now Helping Vets of Iraq and Afghanistan, CHRISTIAN SC. MONITOR (June 10, 2008, 12:00 AM), http://www.csmonitor.com/USA/Military/2008/
helps heal veterans’ unseen wounds. 186 Such programs, including the volunteer group American Combat Veterans of War, provide something that many civilian psychologists and counselors cannot provide: the relatability of going to war and combat. 187 By talking with military peers, rather than civilians who have never served in the military, these combat veterans, both young and old, feel more open to discuss their combat and war-related experiences. As one psychiatrist noted, there is an “enormous chasm of understanding between people who have been to war and civilians . . . It’s not that credentialed professionals have no role . . . . It’s that they don’t belong on center stage.” 188 By encouraging VSOs and other non-profits, community-based programs that bring together not only the veterans of all wars but those that have so far survived the aftermath of war can ensure that veterans of new conflicts can receive community-based help in a safe environment that otherwise may not exist within the VA.

Another incredibly successful—yet woefully underfunded and underutilized—program is pet therapy. 189 Employed in small numbers by both the VA and non-profits, both horses 190 and dogs 191 are used to help veterans through suicidal ideation and other mental health issues. Some of these programs focus on the companionship and coping mechanisms dogs and horses provide veterans. 192 Others focus on training service dogs to watch for mental health “cues” in the veteran, such as training a dog to sense when a veteran’s mood changes and

186. Id.
187. Id.
188. Id. (quoting Dr. Jonathan Shay).
189. Bryan Jordan, Vets Using Watchdogs Against PTSD, MILITARY.COM (Sept. 8, 2010), http://www.military.com/news/article/vets-using-watchdogs-against-ptsd.html. For example, a New Mexico-based program called “Paws and Stripes” needs $1,800 for each “psychiatric service dog” trained for a veteran. There are currently only 10 veterans in the program, with 40 more waiting to start once more funding is available. Id.
192. Tarrant, supra note 190. In describing the Horses for Heroes program at the Rocky Top Therapy Center, Iraq veteran Robert MacTamhais stated, “[T]alking with the horse is what’s helped me the best.” Id.
then react accordingly. Further, there is a current congressional effort to require the VA to establish a pilot program allowing veterans suffering from PTSD to train service dogs that, upon completion of that training, will be given to other physically disabled veterans. Given the measured success of these programs, and the growing popularity to help heal veterans suffering with mental health disorders and suicidal ideation, these programs must continue to be supported locally and nationally via congressional funding.

V. PROPOSED LEGAL CHANGES IN THE MILITARY, CONGRESS AND IN COURTS

Despite the major advances made in the Department of Defense ("DoD"), the Department of Veterans Affairs ("VA"), and within local communities to help stave off staggering suicide rates among military personnel and veterans, laws and policies within and outside of the military bar many veterans from receiving the benefits they so desperately deserve. While in service, military personnel are subject to a different set of laws than civilians: the Uniform Code of Military Justice ("UCMJ"). As a result, military personnel can be punished for acts that would otherwise be dismissed in civilian courts, such as adultery. Further, when servicemembers separate from the military under conditions "Other than Honorable," VA laws and regulations prevent these veterans from receiving benefits—even when the reason they were separated was a direct result of post-traumatic stress disorder ("PTSD") or traumatic brain injury ("TBI"), which they incurred in combat and as a result of serving in the military. This section outlines legal problems such as these and what the federal government—Congress, the DoD, and the VA—must do to resolve them.

193. Veterans Services, supra note 191. For example, dogs can be trained to wake a veteran and turn on bedroom lights if the veteran is experiencing night terrors.


195. See, e.g., Harris, supra note 190. One study revealed that 100% of PTSD soldiers who have participated in the Equine Assisted Psychotherapy program have "met with success" in "getting beyond" PTSD. Id.

196. For a personal account of how dogs can save veterans, see generally Luis Carlos Montalvan & Bret Witter, Until Tuesday: A Wounded Warrior and the Golden Retriever Who Saved Him (2011).

A. BEFORE THEY LEAVE: LEGAL SOLUTIONS FROM WITHIN

Private ("Pvt.") Lazzaric Caldwell was diagnosed with PTSD and a personality disorder in 2009 while serving in the Marine Corps. Within a year, the military charged him with a number of offenses (such as larceny); his former fiancée stabbed him; and he incurred the loss of many family members. The day after he learned of the death of his friend, Pvt. Caldwell tried to commit suicide by cutting his wrists.\(^{198}\) After being "patched up," he was charged with a UCMJ crime: "intentional self-injury without intent to avoid service."\(^{199}\) A military judge sentenced Pvt. Caldwell to 180 days in jail, and he was given a bad conduct discharge from military service.\(^{200}\) Though he pled guilty, he has appealed the decision, which was recently decided by the United States Court of Appeals for the Armed Forces.\(^{201}\)

Pvt. Caldwell's attorney argued on appeal that Pvt. Caldwell could not have had the requisite intent to commit the crime due to mental illness: his diagnosed PTSD from a year earlier.\(^{202}\) While there may be cases where the servicemember attempts to commit suicide to avoid military service, if the servicemember has a history of any mental health disorder—including, but especially PTSD, TBI, depression, and other related diagnoses—related to combat and military service, that servicemember should not be charged with a crime after an attempted suicide. There is far too much evidence to suggest that there is not a correlation between suicidal ideation, TBI, and PTSD, especially because both TBI and PTSD are prevalent in military personnel.\(^{203}\) Mental health breaking the mens rea element within the criminal justice system—including the military justice system—is not a new phenomenon,\(^{204}\) and there is no reason to disallow this type of defense in military courts, especially at a time when Congress and the

199. 10 U.S.C. § 934 (codifying the text from UCMJ art. 134).
200. Dishneau, supra note 198.
201. United States v. Caldwell, 72 M.J. 137 (C.A.A.F. 2013); see also Dishneau, supra note 198. Pvt. Caldwell's conviction for his suicide attempt was overturned by the court. However, the court limited its decision to the facts of the case, and despite numerous judges (including the dissenting judges and lower court military judges) questioning the military's policy of prosecuting suicide attempts, the option to prosecute such offenses still exists under Article 134 of the UCMJ. See Caldwell, 27 M.J. 197; see also id. (Ryan, J., dissenting).
202. Id.
203. See supra Part III.
public watches the rising suicide rate within DoD with a magnifying glass.

Additionally, as pointed out by Pvt. Caldwell's attorney, there is an inherent unfairness between military personnel that attempt suicide, and those that commit suicide. For those military personnel that "merely" attempt suicide, they can often be charged with a crime via the UCMJ, similar to Pvt. Caldwell. For those that are "successful," however, the military servicemember is treated as having died "in the line of duty"; and thus, he or she receives an Honorable discharge that allows his or her family to receive a multitude of benefits from the DoD and VA. This flawed system rewards a successful suicide attempt while punishing those who attempt and fail. The significant ramifications that result from treating suicide attempts as a crime should be reason enough not to treat them as crimes. Suicidal military personnel are convicted, kicked out of the military, and barred from receiving any future benefits or mental health care from the DoD or VA. This treatment of suicidal military personnel is in stark contrast to the civilian system, where being charged after a suicide attempt usually ensures the civilian will receive the necessary mental health care he or she needs to recover. In fact, even after charging Pvt. Caldwell, and hearing his guilty plea of attempted suicide, the military judge accepted the plea without so much as ordering a mental health examination. The military must change its policy, or the UCMJ, to ensure that servicemembers and veterans who are in desperate need for mental health help are not merely kicked out of the system and left to fend for themselves.

The case of Pvt. Caldwell brings up another issue as well. Due to the self-injury conviction in court-martial, Pvt. Caldwell was discharged from the Marine Corps with a "bad conduct discharge." This class of discharge, along with the more commonly-known "Dis-

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205. Veterans courts offer treatment similar to that of specialized drug courts, and these courts are another option for veterans charged with crimes in some jurisdictions. Instead of being sentenced to jail or prison, many veterans instead undergo specialized treatment based on their circumstances, and the treatment often involves the successful completion of mental health care programs. For a background of some of the veterans courts and their success, see generally Jillian M. Cavanaugh, Helping Those Who Serve: Veteran Treatment Courts Foster Rehabilitation and Reduce Recidivism for Offending Combat Veterans, 45 NEW ENG. L. REV. 463 (2011); Samantha Wells, The Need for Special Veterans Courts, 39 DENV. J. INT'L L. & POL'Y 695, 714-28 (2011).

206. Dishneau, supra note 198.


208. Dishneau, supra note 198.
honorable Discharge," will prevent Pvt. Caldwell from receiving mental health benefits that he needs from the VA.209

B. THE ROLE OF OTHER THAN HONORABLE DISCHARGES FOR VETERANS INFLECTED WITH MENTAL HEALTH DISORDERS

The bad conduct discharge Pvt. Caldwell received as a result of his suicide attempt will prevent him from receiving any VA benefits, including mental health care for the PTSD and the personality disorder he was diagnosed with while in service.210 While there are a number of reasonable justifications for giving benefits only to veterans that receive an Honorable discharge, those justifications do not easily apply to servicemembers, like Pvt. Caldwell, who are separated from service due to their actions resulting from their PTSD, TBI, and other mental health disorders incurred while in service. The following example helps to humanize the problem: A soldier receives a TBI from an improvised explosive device ("IED") explosion in Afghanistan, and, upon returning home from combat, begins to develop a number of mental health issues as a result of the TBI. Reeling from these problems, and while still serving on active duty, the soldier commits a petty crime.211 Medical evidence exists demonstrating the act was a result of the mental health issues, and yet the DoD separates the soldier from service with an Other than Honorable discharge. Neither the VA nor DoD forgive or dismiss the servicemember's conduct that resulted from his underlying mental health condition.212 He is no longer able to receive any mental health care for the TBI he incurred while serving his country in a foreign war. Instead, the soldier is left to fend for himself for a petty crime that in the civilian world would have instead resulted in mental health care.

These types of situations can be prevented in two ways: one internal to the command authority within the DoD, and the other via VA statutes and regulations. First, command authorities must recognize that while good order and discipline is certainly a necessity for military success, suicidal acts that are a direct result of PTSD, TBI, and other related mental health issues that the servicemember incurred in service should not be found guilty of, or even charged under, UCMJ

209. For an extended discussion of the intersection of other-than-honorable discharges and PTSD, and their role in preventing veterans from receiving adequate mental health care, see Tiffany M. Chapman, Leave No Soldier Behind: Ensuring Access to Health Care for PTSD-Afflicted Veterans, 204 MfL. L. Rev. 1 (2010).

210. See Fairweather, supra note 144, at 7.

211. In the end, it does not really matter how petty or serious the crime is. Just about any crime, from a misdemeanor up to a felony, can result in an "other than honorable" discharge. See MANUAL FOR COURTS-MARTIAL, supra note 207, at app. 12.

212. See Chapman, supra note 209, at 43.
crimes. The same policy should apply for acts that are criminal or behavioral in nature if the act stems from a mental health disorder that the servicemember incurred in service. Instead, command authorities should, if necessary, opt to separate the individual using administrative means and without recommending an Other than Honorable type of discharge to ensure the servicemember can still receive mental health benefits through the VA health care system.

Second, Congress can amend statutes and the VA can update their regulations so that veterans who receive Other than Honorable discharges can still receive minimal mental health care. This is not to say the VA should "open the flood gates," allowing all veterans, regardless of the type of separation they receive, to receive any and all benefits the VA offers. Instead, the VA should continue to provide the necessary mental health care to any veteran that receives an Honorable discharge and to any veteran that receives an Other than Honorable discharge whose discharge was related to the mental health disorder they received while in service. In the example above, the soldier who was separated due to a petty crime, which was activated by his TBI and other related mental health disorders, should be able to receive mental health care for these problems he incurred while in Afghanistan.

To otherwise prohibit mental health care benefits is to deny veterans help that they desperately need and often can literally be the difference between life and death. Veterans with mental health disorders cannot always be held completely responsible for their crimes or acts; sometimes the mental health disorders prevent them from acting like a reasonable person. For the DoD and VA to avoid responsibility, and treat such servicemembers and veterans as if they have the same mental capacity as someone without TBI, PTSD, or suicidal ideation, is to put one's head in the sand and hope that once

213. There are some options to allow voluntary separations, which would allow the servicemember to receive an honorable discharge. This option is left largely up to the commanding officer. See Chapman, supra note 209, at 2 n.4.


216. One very small exception exists: where the servicemember is deemed insane at the time of the underlying offense for which they are separated from service. 38 U.S.C. § 5303(b); 38 C.F.R. § 3.354(b). However, this exception rarely, if ever, applies to PTSD and TBI-like cases. See Chapman, supra note 209, at 4.

217. I limit this to proposal to mental health care. There are a number of veterans who cannot receive health care from the VA due to budget constraints, and there are only limited funds available for other benefits, such as pension and disability benefits, that should be limited to those that honorably served.

218. "Through no fault of their own, Soldiers may incur disabilities in the course of that service and rely on the assurance that the VA system will identify and treat their service-connected disabilities." Chapman, supra note 209, at 98.
the servicemember has left the military he or she will be someone else's problem.219

If the veterans that needed mental health care did receive the care they needed after service, a number of positive consequences would occur. By providing mental health care, the DoD and VA would actually save money because they would be preventing future suicides among such servicemembers and veterans.220 Providing mental health care would better integrate veterans into civilian life and allow them to become more productive members of society.221 Ultimately, this would mean they would be less likely to commit crimes.222

C. AFTER SERVICE: THE LEGAL RAMIFICATIONS FROM CALLING THE VETERANS CRISIS LINE AND RELATED STIGMA

No veteran should be punished for contemplating or attempting suicide. Yet this is exactly what happened to Navy veteran Sean Duvall in June 2011. Shortly after losing his job as a part-time cook and becoming homeless, the divorced father of two contemplated committing suicide with a homemade gun he fashioned from a steel pipe, a nail, and a shotgun shell.223 Reeling from deep depression, Mr. Duvall called the Veterans Crisis Line at "his lowest moment."224 The counselor at the other end of the line assured Mr. Duvall that he would receive help. Mr. Duvall did not commit suicide. Instead, a police officer arrived to Mr. Duvall's location to drive him to a psychiatric hospital. Mr. Duvall received the medical help he needed, and with the help of counseling and medication was even able to find a new job. Yet just a week later, the state charged Mr. Duvall with a misdemeanor under state law: illegally carrying a concealed weapon. As if that was not bad enough, the state dropped the charges at the request of a federal prosecutor so that Mr. Duvall could be charged with four federal felony charges related to the makeshift weapon with which he planned to commit suicide.225

219. See Chapman, supra note 209, at 27 ("Current legislation . . . ignore[s] the fact that PTSD may be a service-connected disability because of its debilitating effects, that it is often incurred in combat operations, and that PTSD manifests through misconduct, violence, and substance abuse.").


221. Id.


224. Id.

225. Id.
Thankfully, veteran and mental health advocates intervened on Mr. Duvall's behalf, and Mr. Duvall's federal charges were delayed to allow Mr. Duvall an opportunity to enroll in a Veterans Treatment Court program. If he successfully completes the program, the federal prosecutor will drop the charges.\textsuperscript{226}

The biggest problem with how the government—both local and federal authorities and agencies—treated Mr. Duvall was that it simply was in stark contrast to all of their publicized statements. At a time when government agencies are spending millions of dollars on suicide prevention efforts, and encouraging military personnel and veterans to seek help, they are hindering their own efforts. Government agencies are doing so by not providing the confidentiality they promised to veterans who call services such as the Veterans Crisis Line, and by punishing those veterans who they claim they are trying to protect. It was only after public outrage and the intervention of many veteran and mental health advocates that Mr. Duvall was finally given the option to seek help via a Veterans Treatment Court,\textsuperscript{227} but even this was almost too little too late. To charge veterans who are known to be suicidal, especially those who are actively seeking help by utilizing services such as the Veterans Crisis Line, could easily plunge these veterans into committing a successful suicide. Additionally, veterans who were contemplating calling the Veterans Crisis Line may now hesitate to do so, especially if they believe that they may be charged with a crime. The Veterans Crisis Line must maintain the upmost degree of confidentiality. Otherwise, it will simply not succeed at its mission of helping suicidal veterans stay alive.\textsuperscript{228}

VI. CONCLUSION

The atrocious rise of suicide rates in the military and among veterans is a cause of concern for the Department of Defense ("DoD"), the Department of Veterans Affairs ("VA"), and society in general. Despite the historically low rates of suicides within military personnel, especially during war, some force is causing the tides to turn. Some of the symptoms are known, but it is the underlying cause that must be uncovered and analyzed in order for federal and state agencies to properly diagnose and cure the rising suicide rates. The VA and DoD have implemented a number of programs to help stave off increased suicides rates, but they may only have stopped the numbers from ris-
ing further instead of actually treating the problem, which would decrease the number of suicides. Many of the programs initiated by Veteran Service Organizations ("VSOs") and community organizations have been highly successful, and the VA, with congressional support, should expand or implement the same programs on a much larger scale for "[t]here is nothing more tragic than the death by suicide of even one of the great men or women who have served this nation." 229

Regardless of these short-term successes, until the DoD and VA develop a valid metric system to track suicide rates of those enrolled in such programs, the long-term effectiveness may never be known.

Additionally, these programs can only go so far. If there are not changes made via statute, regulation, and policy, military personnel and veterans will continue to be punished for attempting suicide and prevented from receiving the mental health care they so desperately need. To forego these necessary changes will only alienate those who would otherwise seek help and thereafter commit suicide. The difference is literally one of life and death.

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