

PTSD IN RETURNING WOUNDED WARRIORS: ENSURING MEDICALLY APPROPRIATE EVALUATION AND LEGAL REPRESENTATION THROUGH LEGISLATIVE REFORM

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I. INTRODUCTION

It is forecasted that up to 20% of Iraq and Afghanistan War veterans have either been diagnosed with or will suffer from symptoms of Post Traumatic Stress Disorder (PTSD).¹ Many of these veterans face challenges negotiating the minefield of the Department of Veterans Affairs (VA) disability claims process—a process that includes a lengthy application² and strict deadlines.³

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1. Benjamin R. Karney et al., *Invisible Wounds: Predicting the Immediate and Long-Term Consequences of Mental Health Problems in Veterans of Operation Enduring Freedom and Operation Iraqi Freedom* 5, 11-14 (RAND Center for Military Health Policy Research, Working Paper No. WR-546-CCF, 2008), available at http://www.rand.org/pubs/working_papers/2008/RAND_WR546.pdf; see also *How Common is PTSD?*, NATIONAL CENTER FOR PTSD (June 15, 2010, 3:23 PM), <http://www.ptsd.va.gov/public/pages/how-common-is-ptsd.asp> (stating 11-20% of OEF/OIF veterans experience PTSD).

2. U.S. DEP'T OF VETERANS AFFAIRS, VA COMPENSATION/PENSION FORM 21-526 (Sept. 2009), available at <http://www.vba.va.gov/pubs/forms/VBA-21-526-ARE.pdf>. Prior to September 2009, the application was twenty-three pages long. The current form is twelve pages long, including instructions.

3. A claimant has one year to complete an application, 38 C.F.R. § 3.109 (2011), one year from the date of the notification of a VA decision to file an appeal, 38 C.F.R. § 20.302

In order to receive a PTSD diagnosis and compensation, wounded warriors must work through two separate entities within the VA system. First, veterans must obtain a medical diagnosis from the Veterans Health Administration (VHA). Then, they must pursue disability compensation through the Veterans Benefit Administration (VBA). During this process, veterans confront a complex rating system with conflicting requirements.⁴ Confusion, inaccuracies, and missed deadlines often result in denial of claims and appeals.⁵ Veterans with PTSD are especially likely to fall through the cracks along the way. PTSD symptoms themselves, such as lack of concentration,⁶ exacerbate the complexities faced by wounded warriors and prevent some veterans from successfully completing a claim for disability.⁷

Statutes and VA regulations currently prohibit attorneys from receiving compensation for representing or assisting veterans during the initial application. These regulations essentially ban representation in all but a few cases.⁸ In 2006, Congress enacted the Veterans Benefits, Healthcare, and Information Technology Act.⁹ The Act allowed attorneys to be compensated for representing veterans only on appeal of denied disability claims. Prior to 2006, attorneys were allowed to represent veterans but could not be compensated for their work.¹⁰

While compensating appellate representation was a step in the right direction, this focus is inappropriate, particularly for PTSD-affected veterans. Attorney representation at the initial stages of a claim would help veterans during their time of greatest need, resulting in a PTSD file that is complete with

(2011), and one year before a claim is considered abandoned, 38 C.F.R. § 3.158 (2011).

4. See, e.g., 38 C.F.R. § 4.125 (2011).

5. See *Henderson v. Shinseki*, 589 F.3d 1201, 1220 (Fed. Cir. 2009) (holding Veterans Court lacked jurisdiction to consider veteran's appeal that was filed fifteen days late and rejecting the argument that the pro-claimant nature of the veterans system precluded the stringent application of a time of review provision), *rev'd and remanded*, 131 S.Ct. 1197 (2011) (noting that the deadline for filing a notice of appeal with the Veterans Court does not have jurisdictional attributes).

6. PTSD symptoms include lack of concentration; re-experiencing trauma; increased anxiety; desire to avoid recurrence of events; avoidance of activities, places, or people that arouse recollections of the trauma; diminished interest or participation in significant activities; and detachment or estrangement from others. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV-TR) 464 (Michael B. First ed., 4th ed. 2000).

7. The stigma associated with a PTSD diagnosis also keeps some veterans from seeking and receiving care. See Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 NEW ENG. J. MED. 13, 20-21 (2004).

8. See 38 U.S.C. § 5904(c) (2006). However, attorneys may represent veterans on a pro bono basis.

9. Veterans Benefits, Health Care, and Information Technology Act of 2006, PUB. L. No. 109-461, 120 Stat. 3404 (2006).

10. The passage of the Act created an incentive for attorneys to represent veterans at the appellate level.

substantiated claims, filed on time, and focused on the claims process and tasks. This would hopefully result in an award of the maximum disability benefits to which these veterans are entitled.

This piece proposes legislative reform that would allow veterans who struggle with the claims process, such as those with PTSD, the choice to hire an attorney to represent them during the initial claims process. It also calls for the use of clinically-focused evaluations of disability for PTSD and other mental health disorders through adherence to Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic standards to bring rationality into the process. Part II provides a background on the VA and discusses disability compensation, adjudication of claims, and the instruments used to rate a disability. Part III discusses PTSD and the increasing recognition of the disorder as a key disability in recently wounded warriors returning from Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF). Part IV reviews the inherent problems within the veteran compensation system, including those relating to PTSD, such as the VA's use of an outdated General Rating Formula (the Schedule), the confusing, combined use of the DSM-IV-TR and the Schedule for rating PTSD, proof issues in showing a service connected stressor, and problems with assessments. Part V outlines the system of attorney representation for Social Security Disability Income claims, which are comparable in size and scope to VA disability claims, and details arguments for adopting a similar attorney-friendly system for wounded warriors. To address the concerns raised, Part VI contains a proposed statute that would reform the veteran disability evaluation and assessment system. It objectifies the medically-oriented wounded warrior evaluation by requiring DSM-IV-TR use and standards to assess potential PTSD disability. It also permits both VA and non-VA physicians to perform this evaluation to maximize the number of veterans identified for disability benefits. In addition, the proposed statute would adopt the Social Security Administration model, providing veterans with the opportunity to employ early attorney representation, thereby addressing issues veterans face when initially filing disability claims for PTSD. Reasonable limits on attorney charges would be put into place. In Part VII, the paper concludes with some final remarks.

II. BACKGROUND

A. The Department of Veterans Affairs and Disability Compensation

Veterans suffering from a disability as a result of military service are entitled to compensation.¹¹ As President Lincoln stated in his 1865 inaugural

11. 38 U.S.C. § 1110 (2006) (stating the United States will pay compensation to any disabled veteran, unless the veteran was dishonorably discharged or the disability was caused by the veteran's own willful misconduct or abuse of alcohol or drugs).

address, it is the government's social and moral obligation "to care for him who shall have borne the battle, and for his widow and his orphan,"¹² that is, to care for those injured during war and to provide for the families of those who perished on the battlefield. The VA affirmed this belief in 1959 when they adopted this phrase as their official motto.¹³

There are two Administrations within the Department of Veterans Affairs, each independent of the other, but both critical to the compensation process. The VHA provides medical care to veterans through a network of 153 hospitals and hundreds of community clinics and Vet Centers.¹⁴ Hospitals within the VHA provide higher quality care than most private sector hospitals.¹⁵ In most cases, VHA healthcare professionals, or those under contract with the VA, conduct the physical examinations required for benefit determinations.¹⁶

The other administration that plays a role in veteran disability compensation is the VBA. The VBA's primary function is to manage non-medical benefits for the VA through fifty-seven Regional Offices (RO's).¹⁷ The VBA manages the Compensation and Pension Program for the VA, handles all claims processing, and schedules evaluations.¹⁸

Unlike the VHA, the VBA does not have a successful performance record.¹⁹ The VBA determines compensation through a ratings process that

12. President Abraham Lincoln, Inaugural Address (Mar. 4, 1865), available at <http://www.bartleby.com/124/pres32.html>.

13. U.S. Dep't of Veterans Affairs, *The Origin of the VA Motto: Lincoln's Second Inaugural Address*, <http://www1.va.gov/opa/publications/celebrate/vamotto.pdf> (last visited Feb. 8, 2011).

14. *Statistics at a Glance Pocket Card*, NATIONAL CENTER FOR VETERANS ANALYSIS AND STATISTICS (Apr. 28, 2010), http://www1.va.gov/VETDATA/Pocket-Card/4X6_spring10_sharepoint.pdf [hereinafter *VA Stats at a Glance*] (153 VA Hospitals; 788 VA Community-Based Outpatient Clinics; 232 VA Vet Centers).

15. OFFICE OF QUALITY AND SAFETY, U.S. DEP'T OF VETERANS AFFAIRS & VETERANS HEALTH ADMIN., 2009 VHA FACILITY QUALITY AND SAFETY REPORT 7, 11, 14 (Oct. 2009), available at <http://www1.va.gov/health/docs/HospitalReportCard2009.pdf> ("Where direct comparisons are available, the performance of VHA equals or exceeds that reported by commercial health plans, Medicare or Medicaid, in several instances, by a considerable margin.").

16. COMM. ON MED. EVALUATION OF VETERANS FOR DISABILITY COMP., A 21ST CENTURY SYSTEM FOR EVALUATING VETERANS FOR DISABILITY BENEFITS 7 (Michael McGeary et. al. eds., 2007) [hereinafter 21ST CENTURY].

17. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-10-213, VETERANS' DISABILITY BENEFITS: FURTHER EVALUATION OF ONGOING INITIATIVES COULD HELP IDENTIFY EFFECTIVE APPROACHES FOR IMPROVING CLAIMS PROCESSING 2 (2010); *VA Stats at a Glance*, *supra* note 14 (fifty-seven VBA Regional Offices).

18. 38 U.S.C. §§ 7701, 7703 (2006).

19. See H.R. REP. NO. 110-789, at 2 (2008), available at <http://thomas.loc.gov/cgi-bin/cpquery/T?&report=hr789&dbname=110&>; *Veterans' Disability Benefits, VA Has Improved Its Programs for Measuring Accuracy and Consistency, but Challenges Remain: GAO Testimony Before the H. Subcomm. on Disability Assistance and Memorial Affairs of the H. Comm. on Veterans' Affairs*, 111th Cong. 6 (2010) (Statement of Daniel Bertoni, Director Education, Workforce, and Income Security, U.S. Gov't. Accountability Office);

uses the Schedule and evidence from a veteran's service and medical records to determine disability compensation.²⁰

B. Compensation

Compensation is meant to make up for occupational losses a veteran may experience due to a disability.²¹ Yet the challenges that must be overcome to obtain compensation are significant, and recently injured veterans are often unable to successfully address them. For example, OEF/OIF wounded warriors are often vulnerable, because of severe emotional and physical disabilities, and face difficulties in supporting themselves financially.²² In fact, many OEF/OIF

see also id. at 11-12 (Testimony of Kerry Baker, Disabled American Veterans) (noting that skills certification tests resulted in only 25 and 29 percent pass rate, and only reached 42 percent after employees completed a 20 hour test prep course); *id.* at 45 (Statement of Kerry Baker, Disabled American Veterans) (finding nearly 20 percent of appeals reaching board, and that all that cleared local rating board and local appeals board, were *elementary*; and "many more cases were returned for more complex error"); OFFICE OF AUDITS & EVALUATIONS, DEP'T. OF VETERANS AFFAIRS, REPORT NO. 09-02135-107, AUDIT OF VA'S EFFORTS TO PROVIDE TIMELY COMPENSATION AND PENSION MEDICAL EXAMINATIONS 3-6 (2010) [hereinafter OIG REPORT NO. 09-02135-107], *available at* <http://www4.va.gov/oig/52/reports/2010/VAOIG-09-02135-107.pdf>; OFFICE OF AUDITS & EVALUATIONS, DEP'T. OF VETERANS AFFAIRS, REPORT NO. 10-00936-158, INSPECTION OF THE VA REGIONAL OFFICE, MUSKOGEE, OK 2 (2010), *available at* <http://www4.va.gov/oig/52/reports/2010/VAOIG-10-00936-158.pdf> (reporting 23% inaccuracy rating—incorrectly processed rating decisions for temporary 100% Evaluations, PTSD, and TBI); OFFICE OF AUDITS & EVALUATIONS, DEP'T. OF VETERANS AFFAIRS, REPORT NO. 10-00936-156, INSPECTION OF THE VA REGIONAL OFFICE, ALBUQUERQUE, NM 2, 4 (2010), *available at* <http://www4.va.gov/oig/52/reports/2010/VAOIG-10-00936-156.pdf> (reporting 36% inaccuracy rating, same criteria as above, resulting in one PTSD veteran being underpaid by \$30,642 over 21 months); OFFICE OF AUDITS & EVALUATIONS, DEP'T. OF VETERANS AFFAIRS, REPORT NO. 09-03848-130, INSPECTION OF VA REGIONAL OFFICE, WACO, TX 1 (2010), *available at* <http://www4.va.gov/oig/52/reports/2010/VAOIG-09-03848-130.pdf> (reporting 36% inaccuracy rating); OFFICE OF AUDITS & EVALUATIONS, DEP'T. OF VETERANS AFFAIRS, REPORT NO. 09-01996-41, INSPECTION OF VA REGIONAL OFFICE, SAN JUAN, PR 2 (2009), *available at* <http://www4.va.gov/oig/52/reports/2010/VAOIG-09-01996-41.pdf> (reporting 41% inaccuracy rating, same criteria as above; "[m]edical evidence revealed the veteran's PTSD symptoms warranted an evaluation of 50% disabling instead of 30%"). Finally, a VA OIG Report found that 7% of VA claims folders were misplaced, and 3% were lost (not found at the conclusion of the inspection) for a total of 10%, or 437,000 of 4.2 million claims. *See* OFFICE OF AUDITS & EVALUATIONS, DEP'T. OF VETERANS AFFAIRS, REPORT NO. 09-01193-228, AUDIT OF VETERANS BENEFITS ADMINISTRATION'S CONTROL OF VETERANS' CLAIMS FOLDERS i-ii (2009), *available at* <http://www4.va.gov/oig/52/reports/2009/VAOIG-09-01193-228.pdf>.

20. 38 U.S.C. § 1155 (2006); 38 C.F.R. § 3.203 (2011).

21. 38 U.S.C. § 1155 (2006).

22. ERIC CHRISTENSEN ET AL., CTR. FOR NAVAL ANALYSES, ECONOMIC IMPACT ON CAREGIVERS OF THE SERIOUSLY WOUNDED, ILL, AND INJURED 4 (2009), *available at* <http://www.cna.org/documents/D0019966.A2.pdf> (stating average impact on caregiver is \$60,300 over 19 months).

veterans end up homeless.²³

Compensation for discharged veterans seeking service-related disability claims is based on a complex, three-step process. The first step in the process is filing a claim with the VA. Filing a claim involves a significant amount of paperwork. This is a daunting endeavor for those who lack focus and are unable to complete tasks, which is typical of veterans who return from engagements, particularly those with PTSD. Once a claim is filed, the veteran is assigned a claim number.

The second step of the process is scheduling a Compensations and Pension Examination (C&P). The C&P is a physical and abbreviated mental status assessment that is used to determine the overall health of the veteran. These examinations are scheduled by the RO and are conducted by VA healthcare professionals or outside professionals who meet strict educational and licensing requirements.²⁴ Once the C&P is completed, the results are sent to the VBA for a "Rater" to review. The Rater determines whether the disability is connected to, or caused/aggravated by, military service.

If no service connection is found, the claim is denied. If a service connection is found, then the Rater will grant, deny in part, or grant in part the veteran's claim. This includes determining the level of disability based on the percentage of lost occupational wages the "average" veteran would suffer as a result of the disability.²⁵ The Rater is required to calculate this percentage using the Schedule. Even if the Rater finds a service connection, he or she can rate a claim as 0% disabled, thus making the claim non-compensable, effectively denying the claim.²⁶ The Rater then must notify the veteran with a written

23. It is currently estimated that there are 107,000 homeless veterans, the majority of whom have substance abuse issues, and OEF/OIF returning veterans represent 5% of these homeless. *See VA's Plan for Ending Homelessness Among Veterans*, Hearing Before the S. Comm. on Veterans' Affairs, 111th Cong. (2010) (Statement of Pete Dougherty, Director, Homeless Programs, Mar. 24, 2010), *available at* http://www.veterans.senate.gov/hearings.cfm?action=release.display&release_id=a9e95052-3e13-4be3-aa28-f0b05cb692ef (last visited Feb. 16, 2011); *see also* Thom Patterson, *U.S. Seeing More Female Homeless Veterans*, CNN, Sept. 25, 2009, <http://www.cnn.com/2009/LIVING/09/25/homeless.veterans/>; *see also A National Commitment to End Veterans' Homelessness: Hearing Before the H. Comm. on Veterans' Affairs*, 111th Cong. 89 (2009) (statement of Mary Cunningham, Senior Research Associate, Metropolitan Housing and Communities Center, Urban Institute).

24. Worksheet, U.S. Dep't of Veterans Affairs, Review Examination for Post-Traumatic Stress Disorder (PTSD) (2007), *available at* <http://www.vba.va.gov/bln/21/benefits/exams/disexm56.pdf>.

25. 38 U.S.C. § 1155 (2006) ("[R]atings shall be based . . . upon the average impairments of earning capacity resulting from such injuries in civil occupations.").

26. 38 C.F.R. § 4.130 (2010) (citing a 0% rating: a mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication.). Claims have also been denied or underrated based on findings of pre-existing conditions such as personality or adjustment disorders. Discharges for personality disorders peaked at 1,072 cases in 2006 but were down to just 260 in 2009. Adjustment disorder discharges increased from 1,453 in 2006 to 3,844 in

decision.²⁷

Even if a veteran is diagnosed with, or even treated for, PTSD by a VHA treatment center, he or she is not eligible to receive compensation until a claim is granted by the VBA.

C. Claims Adjudication

Once a claim has been denied, granted in full, or granted in part, the veteran has the choice to do nothing, attempt to re-file the claim with new evidence, or appeal the claim result within one year. A large fraction of claims—approximately 39%—are denied each year at the local RO level.²⁸

To contest the denial of a claim a veteran must write a letter, known as a Notice of Disagreement (NOD),²⁹ to the VA stating that he or she disagrees with the decision.³⁰ Unfortunately, this requirement alone appears difficult for some wounded warriors, as fewer than 14%³¹ of denied claims are contested.³²

2009. See *Personality Disorder Discharges: Impact on Veterans' Benefits: Hearing Before the H. Comm. on Veterans' Affairs*, 111th Cong. (2010) (statement of Paul Sullivan, Executive Director, Veterans for Common Sense), available at <http://democrats.veterans.house.gov/hearings/Testimony.aspx?TID=73148&Newsid=622&Name=%20Paul%20Sullivan>. The VA attempted to review PTSD claims of 72,000 veterans in 2006, but quickly abandoned their effort, see *Post Traumatic Stress Disorder (PTSD) and Personality Disorders: Challenges for the U.S. Dep't of Veterans Affairs: Testimony Before the H. Comm. on Veterans' Affairs*, 110th Cong. (2007) (statement of Paul Sullivan, Executive Director, Veterans for Common Sense), available at <http://democrats.veterans.house.gov/hearings/Testimony.aspx?TID=42309&Newsid=45&Name=Mr.%20Paul%20Sullivan>. See also Tom Philpott, *PTSD Vets Win Retirement Deal*, MILITARY.COM, Jan. 28, 2010, <http://www.military.com/features/0,15240,209720,00.html> ("More than 4300 Iraq and Afghanistan war veterans who were diagnosed in service as suffering from Post-Traumatic Stress Disorder, but got low military disability ratings, have won an agreement with the Department of Defense to upgrade those ratings retroactively to 50%.").

27. In 2009, the average time to receive a written decision was 161 days (down from 179 days in 2008) after a claim was filed. U.S. DEP'T OF VETERANS AFFAIRS, FISCAL YEAR 2009 PERFORMANCE AND ACCOUNTABILITY REPORT II-10 (2009), available at http://www4.va.gov/BUDGET/docs/report/PartII/FY2009-VAPAR_PartII_Strategic_Goal_1.pdf.

28. Sixty-one percent were granted in part, fully granted, or granted with a later eligibility date. The VA does not keep records of or distinguish the specific disposition of these claims; it merely reports them as granted. See James D. Ridgway, *Why So Many Remands?: A Comparative Analysis of Appellate Review by the United States Court of Appeals for Veterans Claims*, 1 VETERANS L. REV. 113, 148 (2009).

29. No official form is required, and the letter may be in any format. See 38 U.S.C. § 7105 (2006).

30. NODs may be filed because either the veteran disagrees with the rating, disagrees with the effective date of the rating, or was denied benefits entirely.

31. The actual percentage could be much lower. Of the 14%, there is no way to determine how many veterans are contesting a full denial, versus contesting a partial denial or lodging a disagreement with their assigned eligibility date. This is because the VA does not keep record of how many claims were fully denied and then appealed. See BOARD OF

If a claim is contested, the VA is required to issue a Statement of the Case (SOC) explaining the decision based on legal reasoning.³³ At that point, if the veteran still disagrees with the decision, the veteran has sixty days to file a formal appeal.³⁴

A formal appeal is a request for a hearing at the local RO or before the Board of Veterans Appeals (Board). Veterans who choose to have a hearing at the RO level will meet with a Decision Review Officer (DRO). A DRO has the authority to consider any other evidence in support of a veteran's claim. Veterans still have the right to appeal the decision of the DRO to the Board. Alternatively, veterans can appeal directly to the Board without DRO review.

Although many claims are resolved at the local RO hearing, approximately 35% of contested claims are formally appealed (representing fewer than 5% of all claims filed) and eventually make it to the Board for review.³⁵ In over 60% of these cases in 2009, the Board either "allowed" the appeal, that is, overturned the decision of the RO, or, more frequently, remanded the case back to the RO for further development.³⁶ In other words, in 60% of the cases that are appealed, the Board concluded that the RO made an error, such as making an incorrect assessment, taking the wrong action, and/or prejudicing the veteran in some way.

The appeals process is slow and highly inefficient. Fewer than 25% of cases reviewed by the Board are granted in favor of the veteran without any

VETERANS' APPEALS, U.S. DEP'T OF VETERANS AFFAIRS, REPORT OF THE CHAIRMAN: FISCAL YEAR 2009 19 (2009), http://www.bva.va.gov/docs/Chairmans_Annual_Rpts/BVA2009AR.pdf (reporting that 133,376 NODs had been received) [hereinafter BOARD OF VETERANS' APPEALS, 2009 REPORT OF THE CHAIRMAN].

32. The 14% figure is based on the total number of NODs received by the VBA. By the end of fiscal year 2009, 133,376 NODs had been filed, out of approximately 1,000,000 claims made. *Id.*; News Release, U.S. Dep't of Veterans Affairs, White House Seeks \$125 Billion for Veterans in 2011: Homelessness, Claims Increases and Access – Priorities for VA Budget (Feb. 1, 2010), available at <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1848> (stating that the VA received 1,014,000 claims in 2009).

33. In 2009, the average time for a veteran to receive a SOC was 222 days. BOARD OF VETERANS' APPEALS, 2009 REPORT OF THE CHAIRMAN, *supra* note 31, at 16.

34. 38 U.S.C. § 7105(d)(3) (2006). Veterans may file a formal appeal by using either VA Form 9 or submitting a letter. The formal appeal must be filed 60 days from the day the SOC was mailed to the veteran (i.e., postmarked), not from the date when the veteran received the SOC.

35. The 35% figure is based on the number of formal appeals filed, divided by the total number of NODs received in fiscal year 2009. *See* BOARD OF VETERANS' APPEALS, 2009 REPORT OF THE CHAIRMAN, *supra* note 31, at 15, 19 (reporting 51,481 new appeals filed and 133,376 NODs received).

36. *Id.* at 20. The Board had the highest remand rate in 2009 (37.5%) of the last four years. *Id.* at 21; *see also* Henderson *ex rel.* Henderson v. Shinseki, 131 S.Ct. 1197, 1201 (2011) (noting that "[w]hile proceedings before the Veterans Court [appealing Board decisions] are adversarial . . . veterans have a remarkable record of success before that tribunal. Statistics compiled by the Veterans Court show that in the last decade, the court ordered some form of relief in around 79 percent of its 'merits decisions.'" (internal citation omitted)).

further action.³⁷ The remaining 73%³⁸ of appeals are remanded or denied, thus continuing the “hamster wheel” of the disability claims process within the VA.³⁹ In 2009, it took a *minimum* of three years from the day the NOD was filed to receive a decision from the Board.⁴⁰

Board decisions can be appealed to the United States Court of Appeals for Veterans Claims (CAVC). However, the appeal must be filed with the clerk within 120 days of when the final Board decision was mailed to the veteran.⁴¹ CAVC decisions can take an additional 3.5 years from the notice of appeal. Combine this with the three years for a Board decision, and the entire process can take up to seven years from the day the NOD was filed by the veteran.⁴² These calculations do not include the average remand time of 535 days (nearly 1.5 years) for 2009.⁴³ Although few claims are appealed to the Federal Circuit or the United States Supreme Court, it is plausible that these appeals can take

37. *Id.* at 20.

38. 36.1% of appeals (17,601 appeals) were denied by the Board and 37.3% (18,202 appeals) were remanded back to the RO. *Id.* at 21.

39. H.R. REP. NO. 110-789, *supra* note 19, at 18-20 (2008) (discussing problems with the high percentage of remanded cases). An appealed claim takes approximately another 2 years to make its way back to the Board after a case is remanded to the RO for further clarification or corrective action. *See Operations of the Board of Veterans' Appeals and Court of Veterans Appeals, and Review of H.R. 3212, with Respect to the Court of Veterans Appeals Retirement Plan*, 105th Cong. 12 (1998) (Statement of the Honorable Richard B. Standefer) (another 700 days added to wait for veterans appeals); *Veterans' Benefits: Despite Recent Improvements, Meeting Claims Processing Goals Will Be Challenging Before the H. Subcomm. on Benefits, H. Comm. on Veterans' Affairs*, 108th Cong. 6 (2002) (Statement of Cynthia A. Bascetta, Director, Health Care—Veterans' Health and Benefits Issues) (“In fiscal year 2001, the average time to resolve an appeal was 595 days – almost 20 months.”); *see also* *Veterans for Common Sense v. Peake*, 563 F.Supp.2d 1049, 1074 (N.D. Cal. 2008) (appealed claims times actually increased from 2005 to 2008).

40. *See* VETSFIRST, POST-BOARD OF VETERANS' APPEALS (BVA) APPELLATE PROCESS, available at <http://helpdesk.vetsfirst.org/index.php?pg=kb.page&id=49> (last visited Feb. 16, 2011).

41. VET. APP. R. 4(a), available at http://www.uscourts.cavc.gov/court_procedures/Rule4a.cfm. *See generally* THE UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS WELCOME PAGE, <http://www.uscourts.cavc.gov> (last visited June 20, 2010) (“The United States Court of Appeals for Veterans Claims is a national court of record, established under Article I of the Constitution of the United States. The Court has exclusive jurisdiction to provide judicial review of final decisions by the Board of Veterans' Appeals, an entity within the Department of Veterans Affairs.”)

42. H.R. REP. NO. 110-789, *supra* note 19, at 18; *Examining the U.S. Department of Veterans Affairs' Claims Processing System: Hearing Before the Subcomm. on Disability Assistance and Mem'l Affairs of the H. Comm. on Veterans' Affairs*, 110th Cong. (2008) (statement of Gordon P. Erspamer, Senior Counsel, Morrison and Foerster), available at <http://democrats.veterans.house.gov/hearings/Testimony.aspx?TID=41919&Newsid=189&Name=%20Gordon%20P.%20Erspamer>.

43. BOARD OF VETERANS' APPEALS, 2009 REPORT OF THE CHAIRMAN, *supra* note 31, at 16.

as long as ten to twelve years from the date of the Board decision.⁴⁴ In the interim, disabled veterans are either receiving no compensation or lower compensation than that to which they are entitled because of an error by the VA.

D. The Schedule

A key challenge to, and weakness of, the veterans' disability process is the use of the Schedule. The Schedule was originally created in 1917 to address the needs of returning World War I veterans.⁴⁵ The Schedule brings together more than "700 diagnostic codes representing distinct physical and mental impairments that are grouped by body systems or like symptoms,"⁴⁶ and provides ten grades of disability, from 10% to 100%, in increments of ten.⁴⁷

Tables are used to rate veterans' disabilities and levels of compensation. A combined rating table is used when the veteran has more than one service-connected disability.⁴⁸ The percentages for each disability are combined, using a complex algorithm, rather than simply added together.⁴⁹

The extra-schedular rating schedule is used for an exceptional or unusual disability not adequately compensated or recognized by the regular schedule.⁵⁰ An example of an extra-schedular rating is when a veteran receives compensation for loss of an organ or extremity.⁵¹

Veterans can also receive additional compensation (an increase up to a 100% rating) for unemployability, defined in the statute as an inability "to secure or follow a substantially gainful occupation as a result of service-

44. See, e.g., *Marlow v. West*, 12 Vet. App. 548, 550 (Vet. App. 1999) (nineteen years from original time seeking benefits to appeals decision); *Blackwell v. Shinseki*, No. 07-2948, 2009 WL 1041433, at *3 (Vet. App. Apr. 20, 2009) (noting the court was "extremely troubled by the length of time [ten years] and number of remands [four] involved in this case").

45. H.R. Rep. No. 110-789, *supra* note 19, at 4.

46. *The U.S. Department of Veterans Affairs Schedule for Rating Disabilities: Hearing Before the Subcomm. on Disability Assistance & Mem'l Affairs of the H. Comm. on Veterans' Affairs*, 110th Cong. (2008) (statement of Bradley G. Mayes, Dir., Compensation and Pension Services, Veterans Benefits Admin., U.S. Dep't of Veterans Affairs), available at <http://democrats.veterans.house.gov/hearings/Testimony.aspx?TID=41902&Newsid=197&Name=%20Bradley%20G.%20Mayes>.

47. 38 U.S.C. § 1155 (2006).

48. 38 C.F.R. § 3.323(a) (2010).

49. See, e.g., 38 C.F.R. § 4.25 (2010):

[A] person having a 60 percent disability is considered 40 percent efficient. Proceeding from this 40 percent efficiency, the effect of a further 30 percent disability is to leave only 70 percent of the efficiency remaining after consideration of the first disability, or 28 percent efficiency altogether [through use of the combined ratings table]. The individual is thus 72 percent disabled.

50. 38 C.F.R. § 3.321(b)(1) (2010).

51. 38 U.S.C. § 1114 (2006); 38 C.F.R. § 3.350 (2010).

connected disabilities.”⁵² In addition to unemployability, in order to receive the additional compensation a veteran must have either a single disability with a rating above 60%, or two or more disabilities with a combined rating of 70%, with one of these disabilities having a rating of at least 40%. Certain enumerated disabilities (such as multiple injuries incurred in action or as a prisoner of war) are considered to be one injury for the purposes of the statute.⁵³ This is a key factor for many wounded warriors. For example, unemployability is very common with PTSD patients because PTSD symptoms themselves cause impairment in social and occupational functioning.

III. PTSD

A. Clinical Background

According to the DSM-IV-TR, PTSD is an anxiety disorder that can develop in a person after a traumatic experience in which “the person [has] experienced, witnessed, or [been] confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of [one]self or others.”⁵⁴ Furthermore, the individual’s “response involved intense fear, helplessness, or horror.”⁵⁵ The individual must also experience at least one symptom of intrusive recollections, at least three symptoms of avoidance/numbing, and at least two symptoms of hyper-arousal.⁵⁶ Symptoms of hyper-arousal include sleep problems, irritability, concentration problems, hyper-vigilance, and exaggerated startle response.⁵⁷ All symptoms must be present for one month or longer.⁵⁸ In order for PTSD to be diagnosed as a disorder, “clinically significant distress or impairment in social, occupational, or other important areas of functioning” must be present.⁵⁹

PTSD received official recognition and a separate diagnostic heading with the DSM-III publication in 1980. However, the symptoms of PTSD have been recognized for centuries. During the Civil War, generals noted that the troops

52. 38 C.F.R. § 4.16 (2010) (allowing the VA to pay at the 100% level if medical evidence demonstrates a veteran is unable to obtain or maintain substantially gainful employment as the result of a service-connected disability).

53. *Id.*

54. DSM-IV-TR, *supra* note 6, at 467 (PTSD Diagnostic Criteria A.1).

55. *Id.* at 467 (PTSD Diagnostic Criteria A.2).

56. *Id.* at 468 (PTSD Diagnostic Criteria B, C, and D).

57. *Id.* (PTSD Diagnostic Criteria D); *see also What is PTSD?*, NATIONAL CENTER FOR PTSD (June 15, 2010, 3:23 PM), <http://www.ptsd.va.gov/public/pages/what-is-ptsd.asp> (“You may be jittery, or always alert and on the lookout for danger. It can cause you to: Suddenly become angry or irritable, Have a hard time sleeping, Have trouble concentrating, Fear for your safety and always feel on guard, and be very startled when something surprises you.”).

58. DSM-IV-TR, *supra* note 6, at 468 (PTSD Diagnostic Criteria E).

59. *Id.* (PTSD Diagnostic Criteria F).

were suffering from “irritable heart” or “effort syndrome,” in World War I the diagnosis was “shell shock,” and in World War II it was called “battle fatigue” or “combat exhaustion.”⁶⁰ In modern engagements such as OEF/OIF, symptoms of PTSD are denoted “acute stress,” perhaps in an effort to reduce stigma among deployed troops.⁶¹ Whatever its appellation, it is deemed a “signature wound”⁶² of the Iraq and Afghanistan engagement veterans.

B. Prevalence of PTSD

1. Estimates: Static

PTSD prevalence is widely disputed in medical literature, particularly its predominance among military personnel.⁶³ However, “approximately 8% of the [general] population meets criteria for PTSD during their lifetime.”⁶⁴ PTSD stressors in the general public are often the result of a traumatic event (violent crime, accident, etc.). With regard to military personnel, the range of estimates is wide—“PTSD is the most prevalent mental health disorder among deployed

60. INST. OF MED., GULF WAR AND HEALTH: VOLUME 6, PHYSIOLOGIC, PSYCHOLOGIC, AND PSYCHOSOCIAL EFFECTS OF DEPLOYMENT-RELATED STRESS 75 (2008).

61. OFFICE OF THE SURGEON MULTINAT'L FORCE-IRAQ & OFFICE OF THE SURGEON GEN. U.S. ARMY MED. COMMAND, MENTAL HEALTH ADVISORY TEAM (MHAT) IV OPERATION IRAQI FREEDOM 05-07 FINAL REPORT 19 (2006) [hereinafter MHAT], available at <http://i.a.cnn.net/cnn/2007/images/05/04/mhat.iv.report.pdf>.

62. See Karney et al., *supra* note 1, at iii (noting that PTSD and Traumatic Brain Injury (TBI) have been referred to as “signature wounds” in other recent reports). PTSD is a critical part of mental health with which the Armed Forces are very concerned due to Afghanistan and Iraq deployments. According to a recent report outlining an assessment of mental health disorders including PTSD:

Since the onset of combat operations in Afghanistan and Iraq, many service members, like previous generations of veterans of U.S. conflicts, have experienced mental health problems associated with their service in the combat zones.

This report summarizes counts, incidence rates and estimated prevalences of five selected mental health disorders diagnosed among active component members of the U.S. Armed Forces. The five disorders are: *post-traumatic stress disorder (PTSD)*, major depression, bipolar disorder, alcohol dependence, and substance dependence. These specific disorders were selected for several reasons. First, they are among the most common mental health disorders among active component service members. Secondly, the disorders tend to be chronic in nature or long-lasting in duration, thereby increasing the likelihood that the diagnoses may adversely affect military service. Third, these five conditions may, in part, be associated with participation in ongoing combat operations. Lastly, these disorders may be preventable.

Jean Lin Otto et al., *Selected Mental Health Disorders Among Active Component Members, U.S. Armed Forces, 2007-2010*, 17(11) MED. SURVEILLANCE MONTHLY REP. 2, 2 (Nov. 2010) (emphasis added).

63. See, e.g., Rajeev Ramchand et al., *Disparate Prevalence Estimates of PTSD Among Service Members Who Served in Iraq and Afghanistan: Possible Explanations*, 23 J. TRAUMATIC STRESS 59 (2010); Lisa K. Richardson et al., *Prevalence Estimates of Combat-Related Post-Traumatic Stress Disorder: Critical Review*, 44 AUSTL. & N.Z. J. PSYCHIATRY 4 (2010).

64. Karney et al., *supra* note 1, at 5.

service members, and affects roughly 5 to 15% of service members, depending on who is assessed and when they are assessed.”⁶⁵

A recent RAND review assessed 29 studies to determine factors that caused disparities in PTSD prevalence estimates in the military.⁶⁶ According to its analysis, estimates vary based primarily on representativeness and the way PTSD is defined.⁶⁷ The only common predictor was combat exposure.⁶⁸ To put this into perspective, a review of the numbers of deployed personnel and more recent empirical data is instructive.

From October 2001 to April 2008, approximately 1.64 million U.S. troops had been deployed in OEF/OIF engagements.⁶⁹ As of October 2009, “more than 2 million men and women ha[d] shouldered [the] deployments, with 793,000 of them deploying more than once.”⁷⁰ Nearly 40% of OEF/OIF veterans had multiple deployments, and multiple “combat” exposures.⁷¹ Even at the low end, a 5% incidence of PTSD among deployed veterans would equal 100,000 OEF/OIF veterans with PTSD.

However, this 5% is questionable on broader assessment, and most likely an underestimate. Using VA data, 23% of OEF/OIF veterans seen at the VA received a preliminary diagnosis of “possible PTSD.”⁷² Further analysis of the same data shows that only half of these PTSD patients had approved PTSD claims.⁷³ Therefore, about 50% of OEF/OIF veteran patients receiving

65. *Id.* at xviii.

66. Ramchand et al., *supra* note 63, at 59-60.

67. *Id.* at 60, 65-66. Variances of representativeness include those seeking treatment and/or wounded versus those previously deployed members not seeking treatment. Variances in the methods used to define PTSD include self-reports and primary care screening versus clinical observations and checklists. Contact rates for treatment-seeking subjects were 46% and non-response bias for both groups was between 40 and 60%; *see also* Richardson et al., *supra* note 63, at 4-19 (stating that “variability in prevalence is likely due to sampling strategies; measurement strategies; inclusion and measurement of DSM-IV clinically significant impairment criterion; timing and latency of assessments; and combat experiences”).

68. *See* Ramchand et al., *supra* note 63, at 65.

69. *See* Karney et al., *supra* note 1, at iii.

70. Michelle Tan, *2 Million Troops Have Deployed Since 9/11*, THE MARINE CORPS TIMES, Dec. 18, 2009, *available at* http://www.marinecorpstimes.com/news/2009/12/military_deployments_121809w/; *see also* *Consequences of Iraq and Afghanistan Wars* (Fact Sheet), VETERANS FOR COMMON SENSE (Apr. 13, 2010), http://www.veteransforcommonsense.org/images/articles/PDFsforArticles/vcs_dod_fact_sheet_04-13-2010.pdf (showing 2,052,405 service members have been deployed and 831,169 deployed more than once, based on figures obtained from the Department of Defense under the Freedom of Information Act).

71. VETERANS FOR AMERICA, THE ALASKA ARMY NATIONAL GUARD: A “TREMENDOUS SHORTFALL”: A REPORT OF THE VETERANS FOR AMERICA NATIONAL GUARD PROGRAM 24 (Oct. 15, 2008), *available at* <http://www.veteransforamerica.org/wp-content/uploads/2008/10/vfa-alaska-ng-report.pdf>.

72. DEP’T OF VETERANS AFFAIRS, ORGANIZATIONAL BRIEFING BOOK 9 (2009).

73. “[O]nly about 50% of these veterans will get the treatment they need.” Ryan Jaroncyk, *After Nearly a Decade of War, PTSD is Afflicting the U.S. Military*, THE REALITY

treatment for PTSD from the VA were not receiving compensation,⁷⁴ and hence are likely undercounted as victims of PTSD.

In addition, since approximately 40% of service members are still active on active duty,⁷⁵ considering active duty military PTSD cases is also instructive. Surveys of deployed Army soldiers and Marines show between 14% and 17% met screening criteria for PTSD while they were deployed between 2003 and 2006.⁷⁶ This data lends additional support to the proposition that the estimate of

OF LIFE IN AFGHANISTAN, May 10, 2010, <http://www.rawa.org/temp/runews/2010/05/10/after-nearly-a-decade-of-war-ptsd-is-afflicting-the-u-s-military.html> (Feb. 16, 2011, 3:54 PM); T. L. TANIELIAN, RAND CORPORATION & CENTER FOR MILITARY HEALTH POLICY RESEARCH, *INVISIBLE WOUNDS OF WAR: SUMMARY AND RECOMMENDATIONS FOR ADDRESSING PSYCHOLOGICAL AND COGNITIVE INJURIES* (2008). In addition, note that diagnosis of PTSD does not guarantee a rating for PTSD. Veterans must submit a claim to be rated. But the very conditions that created the diagnosis may serve as barriers to effective self-advocacy on the part of the veteran. Indeed, it has been reported that only 23-40% of veterans returning from Iraq and Afghanistan with PTSD actually sought treatment. See Hoge et al., *supra* note 7. Combat veterans often report guilt and depression following stressful military experiences. The depressed veteran population often has higher levels of PTSD. See Bruce P. Dohrenwend et al., *The Psychological Risks of Vietnam for U.S. Veterans: A Revisit with New Data and Methods*, 313 *SCIENCE* 979 (2006). Guilt also appears to increase PTSD, which may result in avoidant coping, i.e., attempted avoidance of discussion or thoughts regarding the traumatic event, which may in turn lead to limited access due to poor communication by the veteran. See K. R. Henning & B.C. Frueh, *Combat Guilt and its Relationship to PTSD Symptoms*, 53 *J. CLINICAL PSYCHOL.* 801 (1997). This result is consistent with other PTSD-avoidance reaction research. See, e.g., A.E. Street et al., *Impact of Childhood Traumatic Events, Trauma-Related Guilt, and Avoidant Coping Strategies on PTSD Symptoms in Female Survivors of Domestic Violence*, 18 *J. TRAUMATIC STRESS* 245 (2005). Further, systemic problems within the VA may also discourage appropriate diagnoses of PTSD and concomitant difficulty in obtaining compensation. See ILONA MEAGHER, *MOVING A NATION TO CARE: POST-TRAUMATIC STRESS DISORDER AND AMERICA'S RETURNING TROOPS xxii-xxiii* (2006); see also Michael De Yoanna & Mark Benjamin, "I am under a lot of pressure to not diagnose PTSD", *SALON*, Apr. 8, 2009, available at http://www.salon.com/news/special/coming_home/2009/04/08/tape (reporting on military physician who told veteran that he was pressured to avoid PTSD diagnoses); *infra* notes 119-120 and accompanying text (noting only 43% of OEF/OIF veterans who were already diagnosed by VA mental health professionals with PTSD received compensation for PTSD in FY 2009, and only 42% of the more than 100,000 OEF/OIF veterans have been granted service-connected disability for their PTSD condition). Finally, physicians may misdiagnose PTSD and instead treat symptoms of somatic disorders, which they do not realize are manifestations of PTSD. See, e.g., MARSHA MCMURRAY-AVILA, *HOMELESS VETERANS AND HEALTH CARE: A RESOURCE GUIDE FOR PROVIDERS* 11 (2001), available at <http://www.nhchc.org/HomelessVetsHealthCare.pdf> (noting physician treatment of headaches, gastrointestinal complaints, immune system problems, dizziness, chest pain, or discomfort in other parts of the body that are common in people with PTSD, but with medical doctors treating the symptoms without being aware that they stem from PTSD).

74. See *supra* notes 72-73 (documenting large fraction of veterans with PTSD not obtaining compensation).

75. A. Kathryn Power, Dir., Center for Substance Abuse Prevention, U.S. Substance Abuse and Mental Health Services Administration, Strategic Initiative #3: Military Families 42 (Oct. 1, 2010), available at: <http://www.samhsa.gov/about/siDocs/militaryFamilies.pdf>.

76. GULF WAR AND HEALTH, *supra* note 60, at 79. This data shows that at least some veterans of Iraq and Afghanistan meet the criteria for PTSD, much like their counterparts

5% prevalence of PTSD is empirically low.

2. Estimates: Dynamic

In addition to looking at static diagnoses and screening criteria to determine incidence rates of PTSD, it is important to examine symptomology in a dynamic way to predict the impact that PTSD could have on OEF/OIF veterans. For example, one year after their return from Iraq, close to 17% of combat troops experienced PTSD symptoms.⁷⁷ This rate is significantly higher than the initial numbers reported immediately following their return from Iraq.⁷⁸ This increase indicates the latency of PTSD that may not be reflected in static estimates. Therefore, longitudinal studies that follow OEF/OIF veterans over several years are necessary. Since such studies have not yet been completed,⁷⁹ forecasting the long-term impact of PTSD on OEF/OIF veterans must be estimated using mathematical models.

To do so, one study using two dynamic mathematical models analyzed OIF data to predict the incidence of symptomatic PTSD cases over the next several years.⁸⁰ This analysis resulted in an estimate that 278,000 to 313,000 service members will exhibit PTSD symptoms by the year 2023, which equates to 32% of Reserve forces and 40% of Active Army and Marine forces.⁸¹ The higher rate takes into account repeated deployments and latency of PTSD among deployed veterans.⁸²

On this basis, researchers found that the relative risk of developing PTSD for Marines serving only one tour was 24%.⁸³ The risk increased to 39% for a second tour and to 64% for four or more tours.⁸⁴

who are no longer in service, and are not receiving compensation because they are still in the military.

77. *Id.* (citing Hoge et al., *supra* note 7 and MHAT, *supra* note 61) (noting that 16.6% of U.S. Army combat troops met criteria one year after return).

78. *Id.*

79. See ABOUT THE STUDY, THE MILLENNIUM COHORT STUDY, <http://www.millenniumcohort.org> (last visited May 27, 2010) (noting that the study—a multiyear longitudinal study of OEF/OIF—is divided into four enrollments and will not be complete until 2022).

80. Michael P. Atkinson et al., *A Dynamic Model for Posttraumatic Stress Disorder Among U.S. Troops in Operation Iraqi Freedom*, 55 MGMT. SCI. 1454, 1457, 1463 (2009) (using Poisson model and Probit models which varied by less than 10%).

81. *Id.* at 1461.

82. See *id.* at 1464. Note that delayed onset PTSD is controversial, with conflicting studies, definitions, and results. See, e.g., Bernice Andrews et al., *Delayed-Onset Posttraumatic Stress Disorder: A Systematic Review of the Evidence*, 164 AM. J. PSYCHIATRY 1319 (2007). One conclusion of this review is that delayed-onset PTSD without prior symptoms is rare, whereas delayed onsets representing exacerbations or reactivations of earlier symptoms did account for 38.2% of military and 15.3% of civilian cases of PTSD.

83. Atkinson et al., *supra* note 80, at 1465.

84. *Id.*

These projections appear reasonable.⁸⁵ Extrapolating from historical data on Vietnam veterans, it has been estimated that as many as 30%⁸⁶ of OEF/OIF veterans may experience PTSD at some point in their lives.⁸⁷

IV. ISSUES WITH VETERANS DISABILITY COMPENSATION AND PTSD

A. Inherent Problems with the Schedule

The Schedule has inherent weaknesses for calculating and addressing disability claims for wounded warriors. In particular, the key signature wound of PTSD for today's veterans returning injured from OEF/OIF engagements is not adequately assessed or determined under the Schedule, making it difficult and, at times, impossible to obtain disability benefits rightfully theirs.

Specifically, for disability assessments, the PTSD rating schedule has not changed in nearly fifteen years.⁸⁸ Therefore, it contains criteria that are at odds with modern standards of care.⁸⁹ Applying this outdated Schedule and other

85. The projected range of PTSD patients and claims caused by the two current wars is between 350,000 and 665,000. See Letter from Paul Sullivan, Exec. Dir., Veterans for Common Sense, to Robert McFetridge, Dir. Regulations Mgmt., Dep't of Veterans Affairs (Oct. 14, 2009), available at <http://www.veteransforcommonsense.org/index.php/veterans-category-articles/1424-vcs>.

86. GULF WAR AND HEALTH, *supra* note 60, at 80 (stating an estimated 30.9% of Vietnam Veterans had lifetime combat-related PTSD). But see EDGAR JONES & SIMON WESSELY, SHELL SHOCK TO PTSD: MILITARY PSYCHIATRY FROM 1900 TO THE GULF WAR 133-134 (2005) for criticism that 30% is an overestimate. In a reassessment of 260 Vietnam veterans from the original study, the estimate was reduced to nearly 20%. See Dohrenwend et al., *supra* note 73, at 979 (finding 18.7% of Vietnam veterans experience PTSD over their lifetime).

87. The VA reports that 11-20% of OEF/OIF veterans experience PTSD, 10% of Desert Storm veterans experience PTSD, and 30% of Vietnam veterans experience PTSD. See *How Common is PTSD?*, NATIONAL CENTER FOR PTSD (June 15, 2010, 3:23 PM), <http://www.ptsd.va.gov/public/pages/how-common-is-ptsd.asp>. Note also that Vietnam veterans had PTSD rates of 18.7% approximately 11-12 years after returning from that conflict, with 9.1% lifetime incidence. See Dohrenwend et al., *supra* note 73, at 979. Indeed, this latency effect can go on for decades; for example, 12% of World War II and Korean War veterans have been reported to have PTSD even forty-five years after combat. See Avron Spiro III et al., *Combat-Related Posttraumatic Stress Disorder Symptoms in Older Men*, 9(1) PSYCHOL. & AGING 17, 17 (1994).

88. 21ST CENTURY, *supra* note 16, at 111 (stating the ratings for mental disorders were last revised in 1996). The 1996 revision of the mental disorders section of the Rating Schedule used a single rating formula to rate all mental conditions except eating disorders. VETERANS' DISABILITY BENEFITS COMM'N, HONORING THE CALL TO DUTY: VETERANS' DISABILITY BENEFITS IN THE 21ST CENTURY 69 (2007) [hereinafter HONORING THE CALL TO DUTY], available at http://www.veteranslawlibrary.com/files/Commission_Reports/Veterans_Disability_Benefits_Com_Oct_2007.pdf.

89. 21ST CENTURY, *supra* note 16, at 5, 110-12; see also *infra* notes 99-105 and accompanying text (discussing *Mauerhan v. Principi*, 16 Vet. App. 436 (2002), which held that the medical DSM standards could not be considered definitive for disability assessment).

assessment tools poses a unique challenge to Raters, and may cause lower PTSD ratings. Indeed, in some cases, PTSD claims may be denied altogether because the veteran did not meet the bureaucratic Schedule criteria even though the veteran met the clinical diagnostic criteria.

The Schedule for evaluating PTSD claims uses the same set of criteria for rating all mental health disabilities. It focuses on symptoms from schizophrenia, mood, and anxiety disorders, rather than symptoms that PTSD patients more commonly experience such as episodes of recurrence, avoidance, and social withdrawal.⁹⁰

This systemic concern has not gone unnoticed. The Veterans' Disability Benefits Commission (VDBC), commissioned by Congress, did an extensive two-and-a-half year review of the VA's compensation system and produced a 500-page report in cooperation with the Institute of Medicine (IOM) and the Center for Naval Analysis.⁹¹ The Commission found that the Schedule's criteria are "at best a crude and overly general instrument for the assessment of PTSD disability."⁹² As a result, criteria from the Schedule might override PTSD symptoms in DSM-IV-TR, which could produce lower ratings or no rating at all. For example, the criteria for PTSD under the Schedule for a 100% disability rating are:

[G]ross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name.⁹³

Yet the only symptoms that are present on both the Schedule and clinical DSM-IV-TR for a 100% rating are hallucinations, and possible irritability or outbursts of anger (danger of hurting oneself or others is only on the Schedule). At least seventeen other PTSD symptoms listed in DSM-IV-TR are *not* found in the Schedule at the 100% rating.⁹⁴ Likewise, there are only two PTSD symptoms present on both the Schedule for a 70% rating and DSM-IV-TR.⁹⁵

90. *Review of Veterans' Disability Compensation: Expert Work on PTSD and Other Issues: Hearing Before the S. Comm. on Veterans' Affairs*, 110th Cong. 21-26 [hereinafter *Hearing*] (statement of Dean Kilpatrick, Professor and Dir., National Crime Victims Research and Treatment Center, Medical University of South Carolina). PTSD Diagnostic code 9411 falls under Anxiety Disorders, which are rated under the same Schedule of Ratings for all Mental Disorders. See 38 C.F.R. § 4.130 (2010).

91. See HONORING THE CALL TO DUTY, *supra* note 88; see also *Hearing*, *supra* note 90, at 2 (statement of Sen. Patty Murray, United States Sen. from Washington) (noting that the report "is the most expansive analysis of veterans' disability benefits in more than 50 years").

92. HONORING THE CALL TO DUTY, *supra* note 88, at 530.

93. 38 C.F.R. § 4.130 (2010).

94. Compare DSM-IV-TR, *supra* note 6, and 38 C.F.R. § 4.130 (2010).

95. 38 C.F.R. § 4.130 (2010).

These symptoms include: near continuous panic (compared to hypervigilance in DSM-IV-TR) or depression (compared to markedly diminished interest or participation in significant activities, feeling of detachment or estrangement from others, restricted range of affect, and sense of a foreshortened future in DSM-IV-TR).⁹⁶ Further, there is no mention of sleep disturbances, re-occurrence, difficulty concentrating, or exaggerated startle response anywhere in the 70% or 100% rating on the Schedule,⁹⁷ even though these are listed in the medically-based DSM-IV-TR.

These findings indicate that most of the clinical criteria for PTSD in DSM-IV-TR are not found at the highest levels of the Schedule and may, therefore, result in inappropriately lower disability ratings.⁹⁸ Although the VA Best Practice Guidelines state that “[a] veteran does not need to have any or all of the specific examples of signs and symptoms listed in the general rating formula for mental disorders in order for a particular evaluation level of PTSD to be assigned,”⁹⁹ there is no mention of this distinction in the Schedule itself.¹⁰⁰

B. Requirement to Use Both DSM-IV-TR and the Schedule

There is clearly a need for clarification and further development of the disability ratings process generally and as applied to PTSD. This has been recognized to some extent, as the VA and the courts have indicated that both the Schedule and DSM-IV-TR must be considered when rating veterans for disabilities.¹⁰¹ However, these pronouncements have not been clear, and have created conflicting criteria in disability claim analysis.

It is clear that officials at the VA must be familiar with both DSM-IV-TR and its associated nomenclature as well as the Schedule, since VA regulations make the DSM-IV-TR standards integral to the disability ratings process.¹⁰² However, neither the Schedule nor regulations specify *how* to use and integrate both the Schedule and DSM-IV in disability assessments for PTSD.

Importantly, the courts have not provided clarification in this regard. For example, in 2002 the Veterans Court attempted to clarify the relationship

96. *Id.*

97. *Id.*

98. Strict interpretation of the Schedule would put most PTSD symptoms found in DSM-IV-TR at the 50% or lower level.

99. PATRICIA WATSON, ET AL., DEP'T OF VETERANS AFFAIRS, BEST PRACTICE MANUAL FOR POSTTRAUMATIC STRESS DISORDER (PTSD) COMPENSATION AND PENSION EXAMINATIONS 56 (2001), available at <http://www.avapl.org/pub/PTSD%20Manual%20final%2006.pdf>.

100. 38 C.F.R. § 4.130 (2010) (stating that the phrase “symptoms such as” indicates examples, but does not acknowledge that the lack of any of the examples could still result in a rating).

101. See, e.g., *Sellers v. Principi*, 372 F.3d 1318 (Fed. Cir. 2004); *Mauerhan v. Principi*, 16 Ct. Vet. App. 436 (2002).

102. 38 C.F.R. §§ 4.125, 4.130 (2010).

between DSM-IV and the general rating formula for disability benefits for PTSD in *Mauerhan v. Principi*.¹⁰³ Mr. Mauerhan was a Vietnam veteran who appealed a Board denial of an increase in his disability claim for service-connected PTSD. Mr. Mauerhan claimed “the Board erred in relying on the 30% and 50% rating criteria listed under [the Schedule], as *requirements* rather than *examples*, because those criteria apply to all mental disorders.”¹⁰⁴ Instead, he claimed the Board “should have considered the criteria specific to PTSD, set forth in DSM-IV.”¹⁰⁵ He also observed that many of the symptoms listed in Schedule are not found in the DSM-IV for PTSD and, therefore, the criteria in DSM-IV should serve as a definitive basis for a disability rating in PTSD cases.¹⁰⁶

The court rejected Mr. Mauerhan’s assertion that the DSM-IV should serve as the definitive tool for disability analysis. It stated that the VA “is to consider all symptoms of a claimant’s condition that affect the level of occupational and social impairment, including, if applicable, those identified in DSM-IV.”¹⁰⁷

Other challenges have gotten no further. Two years later, in *Sellers v. Principi*, the Federal Circuit Court of Appeals similarly held that “the symptoms listed in DSM-IV do not replace, but rather supplement, the criteria listed in [the Schedule] as the basis for rating PTSD claims.”¹⁰⁸ Hence, it is clear that DSM-IV-TR has not replaced the ratings schedule, but the issue of how to use both DSM-IV-TR and the ratings schedule together generally, and for PTSD-afflicted wounded warriors in particular, has not been resolved.

C. Problems with PTSD Assessments

Beyond the uncertain sign and symptom standards for disability review, potential PTSD is also assessed by a variety of other methods, including questionnaires, patient interviews, and biological and neurological tests. One of the earliest PTSD assessment tools was the Global Assessment of Functioning (GAF) Scale, which was adapted from the Global Assessment Scale developed in 1976 as a structured interview for patients with schizophrenia.¹⁰⁹ The GAF became the fifth axis in the DSM-III profile, and has remained so in subsequent revisions to the present DSM-IV-TR.¹¹⁰

103. *Mauerhan*, 16 Ct. Vet. App. at 436.

104. *Id.* at 440 (emphasis in original). Note that DSM-IV was current at the time of the case.

105. *Id.*

106. *Id.*

107. *Id.* at 443.

108. *Sellers v. Principi*, 372 F.3d 1318, 1327 (Fed. Cir. 2004).

109. COMM. ON VETERANS’ COMP. FOR POSTTRAUMATIC STRESS DISORDER, INST. OF MED. AND NAT’L RESEARCH COUNCIL, PTSD COMPENSATION AND MILITARY SERVICE 91 (2007) [hereinafter PTSD COMPENSATION AND MILITARY SERVICE].

110. WATSON ET AL., *supra* note 99, at 9.

The GAF used by the VA employs a scale of 1-100 where 1 represents the lowest level of functioning and 100 the highest.¹¹¹ The VA started using GAF scores in 1991 to chart progress of discharged psychiatric patients.¹¹² The VA began an initiative in 1998 to increase mental health scores of severely mentally ill (SMI) patients by tracking them with GAF scores. The goal was to increase the average GAF scores of SMI patients by 5% between fiscal years (FY) 1998 and 2003.¹¹³ To do this, the Department of Veterans Affairs mandated that starting in FY 1998, “mental health clinicians [were] required to record at least one GAF score . . . reflecting the ‘current level of functioning’ for each VA patient seen at any VHA mental health inpatient or outpatient setting.”¹¹⁴

Unfortunately, the GAF score soon became a benchmark to measure disability and compensation, whereby anyone scoring above 40 is deemed not disabled, and anyone scoring under 40 is deemed disabled.¹¹⁵ The most significant problem with using the GAF for PTSD is that “the anchors for the most severe levels (1-40) are almost universally drawn from symptoms of mood disorders and schizophrenia.”¹¹⁶ This means that the GAF does not adequately capture symptoms that are more common to PTSD.

Additionally, even the VA warns in its Best Practice Guidelines of 2001: “Do not base a rating solely or mainly on the GAF score . . . the GAF score does not translate directly to the rating schedule criteria.”¹¹⁷ The Best Practice Guidelines explain that “[t]he GAF scale is generally acknowledged to be an unreliable tool for assessment, although it may have value for treatment and prognostic purposes.”¹¹⁸ Despite these deficiencies, the GAF is still widely used today as a disability ratings tool.

D. Proof of Service Connection

Assuming wounded warriors can navigate the medical-legal landscape of the Schedule application, varied DSM-IV-TR assessments, and a potentially inappropriate GAF review, to obtain a PTSD diagnosis and disability designation, veterans still have to prove that their PTSD was caused by a stressor that occurred in service or was the result of military service.¹¹⁹ For

111. *Id.*

112. DEP'T OF VETERANS AFFAIRS, VHA DIRECTIVE 97-059, INSTITUTING GLOBAL ASSESSMENT OF FUNCTION (GAF) SCORES IN AXIS V FOR MENTAL HEALTH PATIENTS (Nov. 25, 2007), available at <http://www.hadit.com/forums/lofiversion/index.php/t2636.html>.

113. *Id.*

114. *Id.*

115. WATSON, et al., *supra* note 99, at 11.

116. PTSD COMPENSATION AND MILITARY SERVICE, *supra* note 109, at 91.

117. WATSON, et al., *supra* note 99, at 56.

118. *Id.* at 60.

119. 38 C.F.R. §§ 3.303(a), 3.304(f) (2010).

some “combat” veterans this task may be straightforward. A combat veteran can show a combat medal or award, or some other proof of combat actions, and provide lay testimony thereof. However, for most “non combat” veterans, proving service connectedness is very difficult, particularly for those with PTSD. It can take years for the VA and/or the veteran to secure and review documentation or proof.

For example, a VA healthcare use report obtained using the Freedom of Information Act (FOIA) showed that less than half (43%) of OEF/OIF veterans who were *already* diagnosed by VA mental health professionals with PTSD received compensation for PTSD in FY 2009.¹²⁰ Likewise, in FY 2008, the Chairman of the Veterans Affairs Subcommittee on Disability Assistance and Memorial Affairs reported that more than 100,000 OEF/OIF veterans had been found to have PTSD, but only about 42,000 had been granted service-connected disability for their condition.¹²¹ The most common reason why these veterans are uncompensated is the lack of service connection, whereby the veteran was not able to prove ‘combat’ experience or that they engaged with the enemy.

Further, about 12,600 OEF/OIF veterans who are currently receiving compensation for other conditions had disability claims for PTSD denied over the period from October 2001 through March 2008 because their PTSD could not be verified as service-connected.¹²² These veterans received a lower rating than they were entitled to because they were unable to prove their PTSD was combat related.

The financial impact of this type of underrating is significant. Monthly compensation rates for single veterans without children for 30%, 40%, 50% and 60% ratings are \$376, \$541, \$770, and \$974, respectively.¹²³ By comparison, a veteran in this same category with a 70% rating receives \$1,228 per month¹²⁴ resulting in more than a \$10,000 annual difference between a 30% and 70% rating.¹²⁵ This increases to nearly \$11,000 for a veteran with a spouse, and \$11,500 adding one child.¹²⁶ Veterans who are clearly in need of assistance, and who have already met the criteria for PTSD as determined by VA healthcare professionals, are therefore not receiving the financial assistance

120. See Letter from Paul Sullivan, *supra* note 85 (discussing VA healthcare use report obtained by Veterans for Common Sense through FOIA).

121. Press Release, John Hall, U.S. Representative from New York, Hall Announces Major Veterans PTSD Legislation (Feb. 9, 2009), *available at* http://johnhall.house.gov/index.php?option=com_content&task=view&id=715&Itemid=32.

122. H.R. REP. NO. 110-789, *supra* note 19, at 23.

123. U.S. DEP'T OF VETERANS AFFAIRS, VETERANS COMPENSATION BENEFITS RATE TABLES - EFFECTIVE 12/1/09, *available at* <http://www.vba.va.gov/bln/21/Rates/comp01.htm>.

124. *Id.*

125. *Id.* The Congressional Budget Office (CBO) reports similar results. It estimates that the annual difference between a 40% and a 70% rating will increase to nearly \$20,800 by 2018. See Press Release, John Hall, *supra* note 121.

126. See Letter from Paul Sullivan, *supra* note 85.

to which they are entitled.

Because of the backlog of pending PTSD claims, in 2008 the VA decided to eliminate the proof of stressor requirement if a veteran received a diagnosis of PTSD during service and the in-service stressor is consistent with the circumstances, conditions, or hardships of the veteran's service.¹²⁷ For a veteran diagnosed with PTSD while in service, the veteran's description of the stressor alone is enough to establish a service-connected claim.¹²⁸ This rule will help alleviate the struggle that many veterans face in overcoming this hurdle of the claims process. However, the stigma associated with PTSD will likely keep many veterans from receiving this diagnosis while in service.¹²⁹ Indeed, one of the most significant barriers to care for active service members is stigma. Service members are "not very likely to seek professional help if they have a mental health problem, and they are concerned that they may somehow be treated different if they do."¹³⁰ This concern includes being accused of abandoning their fellow service members, being labeled a malingerer, or worse. Although unfounded, research shows that active duty service members with security clearances fear losing their clearance or even their job if diagnosed with a mental health condition.¹³¹ This led the Department of Defense in 2008 to alter a question on its long-standing security clearance form¹³² referencing an

127. See 38 C.F.R. § 3.304(f) (2010); U.S. DEP'T OF VETERANS AFFAIRS, FAST LETTER 08-08, ADDITIONAL GUIDANCE ON POST TRAUMATIC STRESS DISORDER (PTSD) (Apr. 7, 2008), available at <http://jimstrickland912.com/uploads/FL08-008.doc>; *Military PTSD Requirements Relaxed*, MILITARY.COM (May 2, 2010, 9:29 PM), <http://www.military.com/military-report/military-ptsd-requirements-relaxed>.

128. DEP'T OF VETERANS AFFAIRS, FAST LETTER 08-08, *supra* note 127.

129. Hoge et al., *supra* note 7. See also *supra* note 62 and accompanying text (noting "acute stress" appellation for PTSD in a potential effort to reduce stigma associated with the diagnosis). This also includes "social and military stigmas associated with seeking or receiving mental health care." See Otto et al., *supra* note 62, at 5. And, "because of real or perceived stigmas and/or fears of negative impacts on their military careers, older (and higher ranking) service members may be more reluctant to seek mental health care than those who are younger." See *Mental Disorders and Mental Health Problems, Active Component, U.S. Armed Forces, January 2000 - December 2009*, MED. MONTHLY SURVEILLANCE REP., Nov. 2010, at 6, 11.

130. CHARLES W. HOGE & CARL A. CASTRO, IMPACT OF COMBAT DUTY IN IRAQ AND AFGHANISTAN ON THE MENTAL HEALTH OF U.S. SOLDIERS 11-1, 11-3 (2005), available at <http://ftp.rta.nato.int/public/FullText/RTO/MP/RTO-MP-HFM-124/MP-HFM-124-11.pdf>.

131. See Press Release, Dep't of Defense, *DoD Changes Security Clearance Question on Mental Health* (May 1, 2008), available at <http://www.defense.gov/news/newsarticle.aspx?id=49735> (citing an Army Inspector General and RAND Study that indicated, "Soldiers were hesitant to get counseling because of the fear of losing their security clearances").

132. Question 21 on Standard Form 86, Questionnaire for National Security Positions, asks if the applicant, in the past seven years, has consulted with any a mental health professional or any health care provider about a mental health related condition. See U.S. OFFICE OF PERS. MGMT., QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS, FORM SF86, 13 (2008), available at http://www.opm.gov/forms/pdf_fill/sf86.pdf.

applicant's mental health history, since officials believed it might needlessly prevent some from seeking counseling.¹³³

Another effort in reducing the burden of proof of combat service is the new regulation, published July 13, 2010 in the Federal Register, concerning the evidence a veteran must present to the VA if the claimed PTSD stressor is tied to fear of hostile military or terrorist activity.¹³⁴ The rule recognizes that service members do not need to be in combat to experience intense fear and, depending on the individual, that fear may become debilitating even when individuals are removed from a threatening environment.¹³⁵

On its face, the rule seems like a significant advance for veterans who have struggled to prove stressors occurred in a combat environment. However, further analysis of the rule reveals that only a VA psychiatrist or psychologist, or those under contract with the VA, can make the nexus determination between the PTSD diagnosis and the stressor resulting from hostile military or terrorist activity.¹³⁶ This may result in the same system issues as the Schedule, clinical DSM-IV-TR, GAF application, as well as the other factors arising and limiting the appropriate disability scores and claims of the wounded warrior, and create challenges for veterans who are not in close proximity to VA providers or prefer not to use VA systems in evaluating their condition.

E. Increased Claims

Even if veterans receive a PTSD diagnosis and establish a service connection, they will still face challenges in obtaining compensation due to the overwhelming number of disability claims already in the system. According to a VA OIG Report,

the national C&P exam workload exceed[ed] 900,000 requests in FY 2009," and projections for FY 2010 were 1.1 million exam requests and 1.2 million claims.¹³⁷ This is approximately a 75% increase over the 579,000 claims received in 2000, and the VA expects a 30% increase in claims from 2009 levels, to 1.3 million in 2011.¹³⁸ Inevitably, because of the increase in claims, the length of time for processing claims has also increased, as has the time to obtain final appeal decisions.¹³⁹ In addition to an increase in the number of

133. See Baker, *supra* note 131.

134. Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843 (July 13, 2010) (to be codified at 38 C.F.R. § 3.304).

135. *Id.*

136. *Id.*

137. OIG REPORT NO. 09-02135-107, *supra* note 19, at 9-10.

138. VA Claim Delays Continue, SWORDS-TO-PLOWSHARES.ORG, <http://www.swords-to-ploshares.org/newsDetails?id=122> (last visited May 27, 2010).

139. BOARD OF VETERANS' APPEALS, 2009 REPORT OF THE CHAIRMAN, *supra* note 31, at 16 (citing Substantive Appeal Receipt to Certification of Appeal to Board for 2006 (489 days), 2007 (531 days), 2008 (561 days), and 2009 (590 days)). Current appeals before the courts are over 10 years old and the claimants, typically Vietnam or WWII vets, often die

claims, the claims have become more complex, with “[t]he number of cases with eight or more disabilities claimed nearly tripl[ing] from 21,814 in 2000 to 61,598 in 2008.”¹⁴⁰

Aside from the increase in claims, many veterans of Iraq and Afghanistan have only a high school diploma or less and will find the process of applying for disability complicated.¹⁴¹ PTSD symptoms themselves further compound the problem. Symptoms such as difficulty maintaining concentration and completing tasks may prevent veterans from actually finishing the process. As a result, it is evident that substantial assistance is required for these veterans.¹⁴²

F. Consequences of the Current System

There are significant economic and ethical consequences of underrating or denying a legitimate PTSD disability claim. The societal costs of PTSD are tremendous. These include loss of productivity, unemployment, costs of treatment, and suicide, and are estimated at approximately \$6.2 billion over only two years.¹⁴³

Of course, the ethical consequences are similarly dramatic. Considering the commitment that the country has made to ensure support for wounded warriors, this treatment represents a social injustice. Shifting the burden of care for veterans with PTSD to their families or local communities violates a social contract, and failing to appropriately compensate all veterans with PTSD reflects poorly on society.¹⁴⁴

during the appeal process. Most cases currently pending before the Veterans Court are appeals from 2004-2005. Until 2003, the disability claim died with the veteran. Now, accrued benefits may be paid to the veteran’s beneficiary. *See* 38 U.S.C. § 5121 (2006); *see also The Challenges Facing the U.S. Court of Appeals for Veterans Claims: Hearing Before the Subcomm. on Disability Assistance and Mem’l Affairs of the H. Comm. on Veterans’ Affairs*, 110th Cong. 1-3 (2007) (statement of The Hon. John J. Hall, Chairman, H. Subcomm. on Disability Assistance and Mem’l Affairs), *available at* <http://babel.hathitrust.org/cgi/pt?id=pst.000063518191;page=root;view=image;size=100;seq=5;num=1> (last visited Dec. 23, 2010).

140. *See* Jonathan Creekmore Koltz, *Unstacking the Deck: In Defense of the Veterans Benefits, HealthCare, and Information Technology Act of 2006*, 17 FED. CIR. B.J. 79, 90 (2007) (showing 21,814 for 2000); PowerPoint Presentation: Veterans Benefits Administration, Advisory Committee for Women Veterans, at 10 (Oct. 28, 2009), *available at* <http://www1.va.gov/womenvet/docs/VBA.ppt#395>, at 10, Disability Compensation - Highlights (showing 61,598 for 2008) (last visited Dec. 10, 2010).

141. *Veterans for Common Sense*, 563 F.Supp.2d at 1070.

142. *Id.*

143. H.R. REP. NO. 110-789, *supra* note 19, at 14.

144. Many also consider supporting veterans a moral issue:

[W]e find our veterans homeless, out-of-work and struggling for health benefits. We are living in a country that talks about how proud we are of our men and women in uniform, while failing to put our words into effective action on their behalf.

Our men and women in uniform represent the ultimate in selfless sacrifice. They volunteer to serve and do so with pride and courage. Our country often takes them for granted, forgetting who is prepared and ready at a moments [sic] notice to defend our countrymen

Failing to compensate veterans who have been disabled leads to additional harm because PTSD has a high risk of co-occurring disorders. These disorders strike deeply at veterans' ability to function normally in society, with 88% of men and 79% of women with PTSD meeting criteria for another psychiatric disorder, including alcohol abuse or dependence (51.9%), major depressive episodes (47.9%), and drug abuse and dependence (34.5%).¹⁴⁵ Indeed, these co-occurring disorders are associated with the social and occupational problems, unemployment, and homelessness suffered by these veterans.¹⁴⁶

PTSD compensation is not only necessary for daily living, but is also directly linked to access to health care treatment. A higher overall rating provides access to low cost/no cost health care.¹⁴⁷ Claim approval is hence associated with increased participation in PTSD treatment.¹⁴⁸ An appropriate disability rating also entitles a veteran to ancillary services, such as vocational rehabilitation and employment counseling that can provide the wounded warrior with the skills necessary to reenter civilian society.¹⁴⁹ These are critical services needed by returning wounded warriors, as PTSD is associated with impaired cognitive performance,¹⁵⁰ greater health care needs, and higher risk of

without distinction of political affiliation, religion, race, gender or creed.

The care of our veterans is a moral obligation of the American people. We cannot expect the government or the Veteran's Administration to do it all. We must do our part as well.

Will Griffith, *Our Veterans Are Our Moral Obligation*, STARTUPNATION.COM (Feb. 19, 2009, 1:00pm), <http://www.startupnation.com/OUR-VETERANS-ARE-A-MORAL-OBLIGATION/topic/>. This consideration also extends to the families of veterans, as noted by President Obama: "As America asks ever more of military families, they have a right to expect more of us – it is our national challenge and moral obligation to uphold that promise." Barack Obama, *Presidential Proclamation--Military Family Month*, Proclamations of the White House, Oct. 29, 2010, available at <http://www.whitehouse.gov/the-press-office/2010/10/29/presidential-proclamation-military-family-month>. See also Florence Wagman Roisman, *National Ingratitude: The Egregious Deficiencies of the United States Housing Programs for Veterans and the "Public Scandal" of Veterans' Homelessness*, 38 IND. L. REV. 103 (2005) (discussing the moral obligations of society to returning veterans who become homeless).

145. *PTSD Fact Sheet*, ATHEALTH.COM (Apr. 22, 2008), <http://www.athealth.com/Consumer/disorders/ptsdfacts.html>.

146. See, e.g., McMurray-Avila, *supra* note 73, at 11; see also R. Rosenheck & P. Koegel, *Characteristics of Veterans and Nonveterans in Three Samples of Homeless Men*, 44 HOSP. AND COMMUNITY PSYCHIATRY 858 (1993) (noting that healthcare providers treating homeless veterans in outreach programs, hospital emergency departments, and in specialized homeless clinics should inquire about military service history to best serve these patients).

147. 21ST CENTURY, *supra* note 16, at 3.

148. See Nina A. Sayer et al., *Use of Mental Health Treatment Among Veterans Filing Claims for Posttraumatic Stress Disorder*, 20 J. TRAUMATIC STRESS 15 (2007); Michele Spont et al., *Does Filing a Post-Traumatic Stress Disorder Disability Claim Promote Mental Health Care Participation Among Veterans?*, 172 MILITARY MED. 572 (2007); Letter from Paul Sullivan, *supra* note 85 (noting that "claim approval is associated with increased participation in mental health treatment").

149. 21ST CENTURY, *supra* note 16, at 3.

150. See, e.g., K.W. Samuelson et al., *Neuropsychological Functioning in Posttraumatic Stress Disorder and Alcohol Abuse*, 20(6) NEUROPSYCHOL. 716 (2006); J. J.

a spectrum of debilitating health conditions,¹⁵¹ including dementia.¹⁵²

The incidence of PTSD, the long-term effects PTSD can have on veterans, and the consequences of a vague, inconsistent, and unsound rating system help to put into perspective the magnitude of the problems encountered with PTSD disability compensation. Reform is therefore needed.

V. COMPARISON TO SOCIAL SECURITY DISABILITY

A. Social Security Administration

It is apparent that systemic reform is needed to assist in the administration of disability claims and benefits for wounded warriors. The Social Security Administration (SSA) provides important lessons for consideration.

SSA handles similar claims, with a similar population. In 2009, SSA paid nearly \$109.5 billion¹⁵³ to eight million disabled Americans.¹⁵⁴ The number of applications for disability insurance surpassed three million in 2009.¹⁵⁵ The average processing time for initial claims in 2009 was only 101 days.¹⁵⁶

Vasterling et al., *Neuropsychological Outcomes of Army Personnel Following Deployment to the Iraq War*, 296(5) J. AM. MED. ASS'N 519 (2006).

151. See, e.g., J. A. Boscarino, *Posttraumatic Stress Disorder and Physical Illness: Results from Clinical and Epidemiologic Studies*, 1032 ANN. N.Y. ACAD. SCI. 141 (2004); K. D. Drescher et al., *Causes of Death Among Male Veterans Who Received Residential Treatment for PTSD*, 16 J. TRAUMATIC STRESS 535 (2003); P. P. Schnurr et al., *Physician-Diagnosed Medical Disorders in Relation to PTSD Symptoms in Older Male Military Veterans*, 19(1) HEALTH PSYCHOL. 91 (2000).

152. See, e.g., K. Yaffe et al., *Posttraumatic Stress Disorder and Risk of Dementia Among US Veterans*, ARCHIVES OF GEN. PSYCHIATRY, June 2010, at 608, 608. Indeed, some research has indicated that PTSD accelerates the aging process generally. See Rachel Yehuda et al., *Relationship Between Cortisol and Age-Related Memory Impairments in Holocaust Survivors with PTSD*, PSYCHONEUROENDOCRINOLOGY, May 2005, at 678, 678.

153. *Budget Fact Card 2009*, SOCIALSECURITY.GOV, <http://www.socialsecurity.gov/budget/FactCard2009.pdf> (May 27, 2010, 7:25 PM).

154. *Social Security Disability Claims Top the 3 Million Mark*, DISABILITY-BLOG.COM (June 16, 2010, 10:47 AM), <http://disability-blog.com/2010/06/social-security-disability-claims-top-the-3-million-mark/>.

155. SOC. SEC. ADMIN., PERFORMANCE AND ACCOUNTABILITY REPORT FISCAL YEAR 2009 12 (2009) [hereinafter SSA REPORT FY 2009], available at <http://www.ssa.gov/finance/2009/Full%20FY%202009%20PAR.pdf>.

156. *Id.* at 17 (21% of SSA claims were filed online). Compare this to the VA, which “takes an average of more than six months to make a decision—70% more time than it took four years ago.” Amanda Ruggeri, *Veterans Groups Sue Bush Administration Over Delayed Benefits Claims*, U.S. NEWS & WORLD REP., Nov. 10, 2008, available at <http://www.usnews.com/articles/news/national/2008/11/10/veterans-groups-sue-bush-administration-over-delayed-benefits-claims.html?PageNr=1>. The courts have ruled that these delays at the VA are not “unreasonable.” See, e.g., Peake, *supra* note 40, at 1084 (ruling that alleged delays by the VA in adjudicating service-connected claims which include an average 183 days (about 6 months) to adjudicate a claim filed by a veteran, and an average 1,419 days (about 3 years) to receive a decision on appeal, were not unreasonable).

Applicants can appeal denied claims to an Administrative Law Judge (ALJ). About 554,000 cases were decided by ALJs in 2009. The judges approved benefits in 63% of those cases, after an average processing time of 491 days, which dropped to 442 days in 2010.¹⁵⁷ At the end of 2009, less than 1% (0.14%) of pending hearings exceeded 850 days.¹⁵⁸ The entire process takes an average of 777 days, or a little more than two years.¹⁵⁹

Despite the larger volume of cases (nearly three times that of the VA) and an almost identical backlog of 1 million claims, the SSA still manages to process claims much faster and with a higher approval rate than the VA. The reason is most likely due to the claimant friendly and investigatory nature of SSA's claims process, and, importantly, attorney representation.¹⁶⁰

under the Administrative Procedures Act).

157. SSA REPORT FY 2009, *supra* note 155, at 11. *See also* Stephen Ohlemacher, *Spike in Disability Claims Clogs Overloaded System*, ASSOCIATED PRESS, May 9, 2010, available at http://www.boston.com/business/articles/2010/05/09/spike_in_disability_claims_clogs_overloaded_system/?page=2 (last visited Dec. 24, 2010).

158. SSA REPORT FY 2009, *supra* note 155, at 49.

159. Ohlemacher, *supra* note 157.

160. Along with this investigatory model, a program that prioritized wounded warriors from OEF/OIF has created dramatic results. A retrospective review of approximately 16,000 OEF/OIF veterans that would otherwise be eligible for VA disability, also applied for SSDI benefits. It is telling that the approval rate for these wounded warriors identified in SSA data was 34% within six months, and 60% within twelve months of application. *See* SSA REPORT FY 2009, *supra* note 155, at 54-56. Note, however, that there have been criticisms of the Social Security Administration. *See* DAVID A. MORTON, *NOLO'S GUIDE TO SOCIAL SECURITY & DISABILITY: GETTING AND KEEPING YOUR BENEFITS* 142, 145, 152-54 (2010) (Social Security Administration will not consider nontraditional medical treatments, uneven claims examiner quality, disability determination services director disability denials impacted by fraud, corruption, incompetence, and problematic medical consultants.). In addition, one critic has indicated that the Social Security Administration's "process for determining eligibility for benefits has not worked well when needed the most—for the most difficult cases, which are, most often, those involving claims for disability benefits." *See* FRANK S. BLOCH, *BLOCH ON SOCIAL SECURITY* § 4:1 (updated 2010). Also, there may be confusion of standards of review on initial disability determination and appellate review. *See* Frank S. Bloch et al., *Developing A Full and Fair Evidentiary Record in A Nonadversary Setting: Two Proposals for Improving Social Security Disability Adjudications*, 25 *CARDOZO L. REV.* 1, 28-29 (2003). Further, the U.S. Supreme Court's decision that courts cannot order the Social Security Administration to meet "mandated" time limits in processing disability claims is also a criticism. *See* *Heckler v. Day*, 467 U.S. 104, 119 (1984) (noting that "it would be an unwarranted judicial intrusion into this pervasively regulated area for federal courts to issue injunctions imposing deadlines with respect to future disability claims."). However, despite some challenges to administration, the Social Security Administration has developed at least some robust IT and online systems to improve and address these concerns. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, *GAO-09-966, INFORMATION TECHNOLOGY: SOCIAL SECURITY ADMINISTRATION'S DATA EXCHANGE SUPPORT CURRENT PROGRAMS, BUT BETTER PLANNING IS NEEDED TO MEET FUTURE DEMANDS* (2009).

B. Legal Representation

1. SSA

The claims process is much less time consuming with SSA claims. This can be attributed to the fact that attorneys are not only allowed, but rather encouraged, to assist applicants for Social Security disability benefits. Attorneys are, however, limited to contingency fees of 25% of past due benefits or a maximum of \$6,000, whichever is lower, unless unusually complex claims or circumstances exist.¹⁶¹ Another difference between the SSA system and that of the VA is that “the SSA adheres to an ‘investigatory model’ of hearings once benefits have been denied. This system is inquisitorial, with the ALJ bearing a duty to develop arguments both in favor of the claimants and in favor of the government.”¹⁶² Within the VA claims process, the veteran has the burden to prove the claim was denied in error.¹⁶³

2. VA

In deep contrast to SSA assessments, legal representation is discouraged in veterans’ cases. This policy has a long history.

In 1862, Congress imposed a \$5 cap on the fee attorneys could charge to represent veterans of the Civil War. Their reasoning was to prevent unscrupulous lawyers from charging veterans with limited literacy exorbitant fees for filling out uncomplicated forms for pension benefits.¹⁶⁴ The cap remained at \$5 until 1864, when it was moderately increased to \$10.¹⁶⁵ From 1864 to 1988 the cap remained at \$10,¹⁶⁶ essentially preventing attorneys from representing veterans unless they did so pro bono.

In 1988, Congress passed the Veterans’ Judicial Review Act.¹⁶⁷ Under this Act, veterans were banned from paying attorneys to represent them until after the first time the Board made a final decision in the case. This Act’s prohibitions remained unchanged for 20 years.

In 2000, Congress passed the Veterans Claims Assistance Act of 2000

161. 42 U.S.C. § 406 (2006); Maximum Dollar Limit in the Fee Agreement Process, 74 Fed. Reg. 6,080 (Feb. 4, 2009) (announcing maximum dollar amount for fee agreements would increase to \$6,000).

162. Koltz, *supra* note 140, at 92.

163. Known as a clear and unmistakable error (“CUE”). See 38 U.S.C. §§ 5109A(b), 7111 (2006); see also 38 C.F.R. § 20.1404(b) (2010) (explaining that when a veteran asserts CUE the motion must specifically identify the error of fact or law).

164. STEVEN W. FELDMAN, 8 WEST’S FEDERAL FORMS § 13421, n.2 (2d ed. 2010).

165. *Id.*

166. *Id.*

167. Act of Nov. 18, 1988, Pub. L. No. 100-687, 102 Stat. 4105 (1988).

(VCAA).¹⁶⁸ In seeking to support a “pro-veteran” process, a duty to assist the veteran was created. This duty shifted the burden from the veteran to the VBA to produce medical and service records necessary to substantiate a claim. In addition to creating a duty to assist all claimants in collecting the evidence necessary to substantiate their claim,¹⁶⁹ the VCAA also mandated a grant of the “benefit of the doubt” to veterans when VBA analyzes their claims.¹⁷⁰ However, no legal representation reform was included for veteran assistance.

In 2006, the Veterans Benefits, Healthcare, and Information Technology Act was signed into law.¹⁷¹ Instead of promoting legal assistance to veterans, this law continued the almost century-and-a-half old bias against representation. Under this law, fees are prohibited from being “charged, allowed, or paid for services of agents and attorneys with respect to services provided before the date on which the Board of Veterans’ Appeals first makes a final decision in the case.”¹⁷² Therefore, representation continues to be barred for initial claims, and is only permitted for appeals.¹⁷³

C. VA Arguments for the Status Quo

The VA claims that the system is pro-veteran, and relies on Veteran Service Officers (VSO’s) to help veterans navigate the system free of charge.¹⁷⁴ The VA highlights that there is no specific form required to file a notice of disagreement, only a simple written notification of appeal.¹⁷⁵ The VA also indicates that it is “mandated” to err in favor of the veteran with respect to notice and even with respect to deciding between criteria for rating disabilities.¹⁷⁶ Lastly, the VA states that veterans get to keep 100% of any award or back pay.¹⁷⁷

168. Veterans Claims Assistance Act of 2000, PUB. L. 106–475, 114 Stat. 2096 (2000).

169. 38 C.F.R. § 3.159 (2010).

170. 38 C.F.R. § 3.102 (2010); *see also* 38 U.S.C. § 5107(b) (2006):

The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.

171. Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, 120 Stat. 3404 (2006).

172. 38 U.S.C. § 5904(c)(1) (2006).

173. An attorney representing a claimant before the Board of Veterans’ Appeals must file a copy of any fee agreement with the Board, and the total fee payable to the attorney is limited to 20% of the total amount of any past-due benefits awarded. *See* 38 C.F.R. § 14.636 (e)-(g) (2010).

174. *Walters v. Nat’l Ass’n of Radiation Survivors*, 473 U.S. 305, 311 n.4 (1985); *see also* 38 U.S.C. § 5902(b)(1) (2006).

175. *See* 38 U.S.C. § 7105(d)(3) (2006).

176. 38 C.F.R. § 4.3 (2010) (resolution of reasonable doubt).

177. However, under 38 U.S.C. § 5904(d) (2006), reasonable attorney fees for appellate representation are paid out of any award received.

However, despite these VA claims, the empirical experience paints a different picture. Over 37% of cases are remanded to the RO and delayed.¹⁷⁸ Moreover, the system is not pro-veteran for physically or mentally impaired veterans because they may have diminished capacity, capability, or resources to access VA facilities and work through their complex cases.¹⁷⁹ This reality is highly applicable to and especially true for PTSD-afflicted veterans.

Arguments to permit paid expert assistance are compelling.¹⁸⁰ Attorneys could help streamline and case manage the difficult process for veterans, who are often enduring the most difficult period in their lives.¹⁸¹ This assistance could eliminate errors and result in greater compensation compared to what the veteran can do alone. The veteran may pay a small percentage of back compensation in attorney's fees; however, representation may result in a more successful resolution of the claim with greater and more comprehensive compensation. For example, if a veteran pays the 20% maximum allowed for contingency fees to an attorney from a total award of \$100,000, then the veteran would sacrifice \$20,000 of his or her back pay from the settlement. However, if the veteran receives a higher disability rating (i.e., 70% instead of 40%) because he or she had legal representation, the annual compensation would be nearly \$20,000 more per year.¹⁸² The veteran would break even in

178. BOARD OF VETERANS' APPEALS, 2009 REPORT OF THE CHAIRMAN, *supra* note 31, at 21.

179. Researchers have noted the extensive barriers for PTSD-afflicted veterans to obtain benefits from the VA: "It is only recently that PTSD and similar mental disabilities have been taken seriously for purposes of disability compensation screenings. Even now, the VA is still slow to recognize and provide effective treatment for veterans with mental illness." Michael Waterstone, *Returning Veterans and Disability Law*, 85 NOTRE DAME L. REV. 1081, 1124 (2010). Further, other areas are similarly weak and lead to an adversarial, not cooperative, veteran-centered approach:

Even when eligible, the waiting times and geographic restrictions for certain VA health services are so prohibitive that the VA has admitted that in many instances, veterans with disabilities are denied access to needed care. Job training programs have also been criticized as having weak leadership and accountability, limited data and analysis to manage programs, a low success rate, and not having a proactive approach to serving veterans with serious employment handicaps. Underfunding, poorly integrated administration, and excessive bureaucracy are often cited as causes of these problems. The VA, which is by law supposed to be an accommodating forum for veterans, has by many estimates developed an adversarial relationship with those it is supposed to serve.

Id. at 1126-27 (citations omitted).

180. Paid competence in other settings of vulnerable patient populations has been shown to be more effective than volunteer-based efforts. *See, e.g.*, Bryan A. Liang, *Elder Abuse Detection in Nursing Facilities: Using Paid Clinical Competence to Address the Nation's Shame*, 39(4) J. HEALTH L. 527 (2006) (reporting paid clinical experts superior to volunteer ombudsmen when identifying and reporting elder abuse in nursing homes).

181. *See* Bryan A. Liang, Systems Issues Regarding Treatment of Returning Wounded Warriors, Testimony for President's Commission on Care for America's Returning Wounded Warriors, Navy Medical Center San Diego, May 25, 2007 (discussing streamlining systems and case management to address challenges with returning wounded warrior treatment) (on file with author).

182. H.R. REP. NO. 110-789, *supra* note 19 at 2.

year one, and continue to collect the additional \$20,000 annually for the remainder of the time he or she is disabled.

Furthermore, fears that attorneys would “run amok” and take advantage of veterans have not materialized. It has been expressly noted that “[t]here is no evidence that veterans have been abused by their attorneys (by charging exorbitant fees, for example) upon their being provided representation services before the Veterans Court and then on remand from the Court to the [Board].”¹⁸³ However, few attorneys have actually been certified to represent veterans.¹⁸⁴

D. Veterans with Representation Have Better Results

Prior to 1985, lawyers represented only 2% of veterans before the Board.¹⁸⁵ The percentage of claims with attorney representation before the Board has slowly increased from 3.2% in 1995, to 6.3% in 2000, and 7.7% in 2009.¹⁸⁶

Analysis of available data indicates that legal representation may provide significant benefits to veterans. Using veterans’ appeal results, legal representation provides greater recoveries for these wounded warriors before the Board. For FY 2008 and 2009, unrepresented veterans fared, on average, worse than their represented counterparts did. Figures for 2008 and 2009 show that 21.9% and 24% of all dispositions before the Board resulted in full

183. Richard F. Weidman, Dir. of Gov’t Relations, Vietnam Veterans of America, *Testimony Before the Committee on Veterans’ Affairs United States Senate* (June 8, 2006), available at http://veterans.senate.gov/hearings.cfm?action=release.display&release_id=78144e06-546b-48d2-a151-78b9db596225.

184. Under current regulations, the VA regulates and “certifies” all private attorneys who represent veterans before the VA. 38 C.F.R. § 14.629(b) (2010). Yet the accreditation process has proven to be slow. Despite being implemented 2006, formal accreditation procedures were not completed until 2007. The VA had only 400 accredited attorneys through September 2008. As of April 2009, the total number of accredited attorneys totaled just over 2,146, and it now stands at 5,050. See UNITED STATES DEPARTMENT OF VETERANS AFFAIRS, COMPLETE LIST OF ACCREDITED ATTORNEYS, available at <http://www4.va.gov/ogc/apps/accreditation/attorneyexcellist.asp> (last visited May 31, 2010). This is likely because of the prohibition against representing veterans until the appeals stages.

185. *Walters v. Nat’l Ass’n of Radiation Survivors*, 473 U.S. 305, 312 n.4 (1985).

186. BOARD OF VETERANS’ APPEALS, REPORT OF THE CHAIRMAN: FISCAL YEAR 1995 20 (1995), available at http://www.bva.va.gov/docs/Chairmans_Annual_Rpts/BVA1995AR.pdf (reporting 3.2% of veterans were represented by an attorney); BOARD OF VETERANS’ APPEALS, REPORT OF THE CHAIRMAN: FISCAL YEAR 2000 6 (2000), available at http://www.bva.va.gov/docs/Chairmans_Annual_Rpts/BVA2000AR.pdf (reporting that 6.3% of veterans were represented by private attorneys); BOARD OF VETERANS’ APPEALS, 2009 REPORT OF THE CHAIRMAN, *supra* note 31, at 21 (reporting that 7.7% of veterans were represented by attorneys). Veterans at the initial stages are sometimes provided with counselors to help them gather their records and fill out the paperwork. Roughly 86% of veterans use VA provided counselors, but these counselors are not lawyers. Melinda F. Podgor, Note, *The Inability of World War II Atomic Veterans to Obtain Disability Benefits: Time is Running Out on Our Chance to Fix the System*, 13 ELDER L.J. 519, 545 (2006).

allowances (i.e., the case was won, claim approved).¹⁸⁷ However, those veterans without representation only had 16.3% and 18.7% of their allowances granted, respectively.¹⁸⁸

Furthermore, even in cases that did not initially result in a full allowance, veterans with attorneys had the highest remand rate out of all the groups, 46.4% or 1,743 cases compared to 32.9% or 1,554 cases for unrepresented veterans.¹⁸⁹ Remands allow the attorney or veteran to continue to build a case and gather evidence to support a claim. This result provides the represented wounded warrior with additional opportunities to obtain appropriate disability compensation, rather than having the claim rejected.

In terms of full denial, unrepresented veterans in 2008 had nearly half (49%) of their claims denied.¹⁹⁰ This was the highest rate of denied claims out of all groups. In 2009, that figure dropped slightly to 46.1%, but still remained the highest percentage of denials of all groups, totaling 2,181 cases.¹⁹¹ Yet attorney represented veterans had a much lower 28.8% denial rate (1,083 cases) in 2009, similar to its the 29.9% denial rate (1,037 cases) in 2008.¹⁹²

Finally, assessing absolute compensation awards of represented versus unrepresented veterans reveals the former received significantly greater awards than their unrepresented counterparts (average of \$11,162 vs. \$4,728).¹⁹³ These figures demonstrate that veterans represented by an attorney may receive more favorable decisions, fewer denials, and better outcomes than those who do not have representation. Providing unrepresented veterans access to an attorney may help strengthen claims and decrease the disparities in appeals and remands.

187. BOARD OF VETERANS' APPEALS, 2009 REPORT OF THE CHAIRMAN, *supra* note 31, at 21 (noting that 9,571 claims were allowed of 43,757 total claims during 2008 are equal to 21.9% and 11,727 claims allowed of 48,804 total claims for 2009 are equal to 24%).

188. *Id.*; BOARD OF VETERANS' APPEALS, REPORT OF THE CHAIRMAN: FISCAL YEAR 2008 23 (2000) [hereinafter BOARD OF VETERANS' APPEALS, 2008 REPORT OF THE CHAIRMAN], *available at* http://www.bva.va.gov/docs/Chairmans_Annual_Rpts/BVA2008AR.pdf. (noting that 842 claims allowed for veterans without representation out of a total of 5,153 unrepresented veterans for 2008 equal 16.3% and 886 claims allowed for veterans without representation out of a total of 4,727 unrepresented veterans in 2009 equal 18.7%).

189. BOARD OF VETERANS' APPEALS, 2009 REPORT OF THE CHAIRMAN, *supra* note 31, at 21.

190. BOARD OF VETERANS' APPEALS, 2008 REPORT OF THE CHAIRMAN, *supra* note 188, at 23 (noting that 2,526 cases denied for unrepresented veterans out of 5,153 cases for unrepresented veterans in 2008 equal 49%).

191. BOARD OF VETERANS' APPEALS, 2009 REPORT OF THE CHAIRMAN, *supra* note 31, at 21.

192. *Id.* Only the Vietnam Veterans of America (26.4%) and the Paralyzed Veterans of America (24.6%) fared better than represented veterans.

193. *Injured Vets Shortchanged Again*, ASSOCIATED PRESS, July 19, 2007, *available at* <http://www.military.com/NewsContent/0,13319,142878,00.html>.

VI. PROPOSED LEGISLATION

A. Major Concerns

There is a clear need for reform in the wounded warrior compensation system. The basis of disability evaluation must be founded first and foremost on rational, clinically established standards, i.e., the DSM-IV-TR and equivalents, rather than an amalgam of antiquated and non-medical approaches under current jurisprudence and practice. This effort will bring the veterans' disability assessment system into the modern era. It will provide wounded warriors with a medically-founded diagnosis and concomitant treatment through better access to care and targeted strategies to optimize their health.

In addition, attorney representation is key to assist wounded warriors during disability claim efforts. Attorneys can help level the disparities in benefits awarded to veterans, particularly those with psychological wounds of war. Specifically, veterans with PTSD are already at a disadvantage because of the difficulty of concentrating on and completing tasks essential to the claims process.¹⁹⁴ Navigating the initial claims process alone places them at an even greater disadvantage. These highly vulnerable populations therefore require legal expertise, which has been shown to have substantively assisted these patient populations to obtain the medical and support resources needed to address key social needs.

B. A Proposed Annotated Statute

The following proposed annotated bill addresses some of these key issues for the modern wounded warrior. We adopt a statutory approach due to its efficiency to accomplish these important goals.¹⁹⁵

H.R. —

A BILL

To amend Title 38, United States Code, to ensure appropriate and adequate determinations of disability for mental health disorders for wounded warriors, and to remove certain limitations on attorney representation of claimants for veterans benefits in administrative proceedings before the Department of Veterans Affairs, and for other purposes.

Section 1. Short Title. This Act may be cited as the "Veterans Disability Compensation Reform Act."

194. For example, making and keeping appointments, going out in public, meeting new physicians, and recounting histories of wartime stressors.

195. See, e.g., Richard A. Epstein, *The Social Consequences of Common Law Rules*, 95 HARV. L. REV. 1717 (1982) (noting that legislation is more efficient and effective for achieving social change as compared to common law).

Section 2. Findings.—Congress makes the following findings:

- (1) Veterans from recent conflicts, including Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), have returned from these engagements with significant mental health disorders, including post-traumatic stress disorder (PTSD).
- (2) PTSD is a 'signature wound' of OEF/OIF conflicts, and afflicts a large fraction of returning wounded warriors.
- (3) However, to receive disability benefits for PTSD, veterans must engage in a complex administrative system, using conflicting standards in assessing disability, and without legal representation to assist in initial claims, which may take years to process.
- (4) The complexity of the veterans disability claims system may preclude wounded warriors, who return severely injured and with limited ability to navigate the administrative requirements for fair claims review, to obtain the benefits to which they are entitled.
- (5) The General Ratings Formula (Schedule) used in determining disability benefits for wounded warriors is an antiquated, non-medically founded system for assessing disability and has been described by the Veterans' Disability Benefits Commission, the Institute of Medicine, and the Center for Naval Analysis as 'at best a crude and overly general instrument for the assessment of PTSD disability.'
- (6) In addition to Schedule concerns, the Veterans Administration's Global Assessment of Functioning (GAF) used in mental health evaluations as used by the Department of Veterans Affairs in mental health disability assessments has been inappropriately applied.
- (7) Legal representation has been shown to increase favorable benefits determinations in other similar circumstances, such as the Social Security Administration, and has resulted in efficiencies in claim filing and outcomes.
- (8) Because of the concatenation of these factors associated with mental health disability evaluation and administrative review, inconsistent findings with respect to disorders such as PTSD has occurred, and the negative consequences of the complex process includes inadequate and inefficient grant of disability benefits to veterans as well as veteran homelessness.

Here, the title of the proposed Act is provided, as well as the key findings that require attention in the proposed legislation. Importantly, the Congressional findings focus upon the challenges of veterans in navigating a complicated administrative system when they have suffered mental trauma and are afflicted with PTSD, issues with the Schedule and its use, and limited legal representation when wounded warriors need it most: at the initial claims benefit stages.

To address these issues, current laws must be amended to fill the systemic holes in the benefits process for veterans. The first area addressed is moving modern assessments of disability for mental health disorders to focus on diagnosis using accepted medical approaches, including DSM-IV-TR.

Section 3. To ensure appropriate and adequate determinations of wounded veterans disabilities for mental health disorders benefits in administrative

proceedings before the Department of Veterans Affairs—

(a) Section 1154 of Title 38 of the United States Code is amended by inserting after subsection (b) the following:

“(c) Notwithstanding (a) and (b), and any regulations promulgated thereto, evaluation of disability claims by veterans by the Department of Veterans Affairs for mental health disorders, including PTSD and all disorders within the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR), shall be based on the DSM-IV-TR criteria for the purposes of diagnosis of PTSD and other mental health disorders. The use of DSM-IV-TR as noted in this section may include future updates and releases of the DSM.

(d) The DSM-IV-TR shall replace the Schedule and GAF, and the Department of Veterans Affairs shall issue regulations that describe disability calculations using DSM-IV-TR, as updated, in determining disability levels and benefits for veterans afflicted with mental health disorders, including PTSD.”

Here, the bill addresses the key concern of clinically outdated and/or inappropriate application of the Schedule and GAF to mental health disability assessments, including those for PTSD. Importantly, a focus of using the medically validated DSM-IV-TR, as updated,¹⁹⁶ for disability assessments is expressly required, replacing the outdated and conflicting Schedule. In addition, elimination of the GAF scale as used by Raters is also noted. Recall that the DSM-IV-TR has its own GAF scale as its fifth axis of diagnosis, and hence the replacement of the Schedule and GAF by the DSM-IV-TR also includes a GAF scale for evaluation. Regulations are called for in the legislation to implement these criteria. These sections hence clarify the standards by which disability assessment for PTSD and other mental health disorders is done, and eliminates confusion of using both DSM-IV-TR and the Schedule.

To ensure that veterans are able to use convenient health care providers in claiming disability benefits, all veterans who are in need of disability evaluations for mental health disorders, including PTSD, should be able to use VHA providers or physicians of their own choosing. This is addressed next.

“(e) Notwithstanding provisions in this Section and Section 5125, Title 38 of the United States Code, or any regulations thereof or relating thereto, the assessment of mental health disorders for a definitive diagnosis as it relates to a mental health disability claim by a veteran shall be performed by VA psychiatrist or psychologist, a psychiatrist or psychologist with whom the VA has contracted, or a private psychiatrist or psychologist of the veteran’s choosing.

196. We adopt the use of the DSM for three reasons. First, it is the standard classifying methodology for mental disorders in the United States. Second, it represents an important public health tool to collect accurate statistics. *See* AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL (2010), available at <http://www.psych.org/mainmenu/research/dsmiv.aspx>. Third, we also adopt it because of its current use in veterans disability benefit determinations, and hence it is familiar to reviewers. *See supra* Part IV.B.

“(f) Once a diagnosis is established as contemplated in this Section, in the absence of clear and convincing evidence to the contrary, a finding that the claimed stressor is consistent with the places, types, and circumstances of the veteran’s service may be based on a veteran’s lay testimony alone, establishing the nexus between the claimed in-service stressor and the disability.

“(g) It is expressly noted that the provisions associated with subsection (e) and (f) shall include both combat and non-combat veterans.”

In these provisions, additional weaknesses associated with the disability evaluation process for veterans are addressed. Specifically, to expand access and availability of the modernized provisions that utilize DSM-IV-TR, veterans would be able to use any VA, VA-contracted, or private physicians when providing proof of a diagnosis of PTSD or other mental health disorder. This provision hence improves veterans’ access to providers for this purpose and also addresses key trust issues that have emerged in comments to the approved, but limited, regulations.¹⁹⁷ In addition, the nexus between the diagnosis and the veteran’s experienced stressor, in the absence of clear and convincing evidence to the contrary, can be established by the veteran’s lay testimony, with these provisions expressly including both combat and non-combat veterans. This extends PTSD and mental health disorder reforms to all those who are afflicted based on earlier changes in policy for PTSD-diagnosed veterans.

Once the standards of evaluation are brought into the modern era through the use of DSM-IV-TR and service connectedness is established using testimony and a valid provider diagnosis of a mental health disorder including PTSD, the wounded warrior should have access to legal representation to shepherd him or her through the complex administrative process. This is addressed below.

Section 4. To ensure equal representation for veterans claims before the Department of Veterans Affairs.

(a) Subsection (a) of Section 5904 of Title 38, United States Code, is amended—

197. The current regulations, as noted previously, only permit veterans to use VA or VA-contracted physicians for PTSD diagnosis. *See* Stressor Determinations for Posttraumatic Stress Disorder, *supra* note 134, at 39852. As well, the reliance upon VA or VA-contracted health care providers was negatively received by veterans: “[t]he majority of comments that VA received expressed disagreement with the requirement that the evidentiary standard for establishing occurrence of the stressor will be liberalized only if [VA or VA-contracted providers are used].” *See id.* at 39846. We believe by requiring a data-driven, medically-founded evaluation process using DSM-IV-TR coupled with the ability to use the veteran’s own physician, will build trust by addressing concerns of veterans that the process is not relying upon medical diagnosis or is biased because of government policy to limit PTSD diagnosis. *See supra* notes 101-105 and accompanying text (discussing *Mauerhan v. Principi*, which rejected a veteran’s perspective that medical DSM standards should be considered definitive for disability assessment); Yoanna & Benjamin, *supra* note 73 (reporting military physician’s taped comments that indicated he was pressured by VA to avoid PTSD diagnoses).

(1) by striking the paragraph (1); and replacing it with the following:

“(1) Except as provided in paragraph (4), a reasonable fee as described in paragraph (5), may be paid or charged in connection with an initial or appealed claim or proceeding before the Department of Veterans Affairs with respect to benefits under laws administered by the Secretary.”;

(2) by striking paragraph (2); and replacing it with the following:

“(2) A person who, acting as agent or attorney in a case referred to in paragraph (1) of this subsection, represents a person before the Department with respect to the case shall file a copy of any fee agreement between them with the Secretary pursuant to regulations prescribed by the Secretary.”;

(3) by striking paragraph (5); and replacing it with the following:

“(5) The Secretary may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Department under this Section, and any agreement in violation of such rules and regulations shall be void. Whenever the Secretary, in any claim before the Department for benefits under this Section, makes a determination favorable to the claimant, the Secretary shall, if the claimant was represented by an attorney in connection with such claim, evaluate the fee agreement to ensure fairness to the veteran. A fee that does not exceed 20% of the amount of benefits awarded on a claim shall be presumed to be reasonable. If there is no fee agreement, or if the fee agreement is deemed by the Secretary as unreasonable, the Secretary shall fix, in accordance with the regulations prescribed pursuant to this Section, a reasonable fee to compensate such attorney for the services performed by him or her in connection with such claim.:

(b) Subsection (c)(1) of Section 5904 of Title 38, United States Code, is amended—

(1) by striking the paragraph (1); and replacing it with the following:

“(1) Attorney or agent fees charged with respect to services provided for initial or appealed claims or proceedings before the Department shall be permitted and subject to the fee requirements in this Section. The limitation in the preceding sentence does not apply to fees charged, allowed, or paid for services provided with respect to proceedings before a court.”

Section 5. Effective Date—The amendments made by this Act shall apply on or after the date that is 90 days after the date of the enactment of this Act.

These provisions address the important attorney representation needs of veterans when attempting to navigate the disability process. Of note, both initial and appellate proceedings would now permit veterans to have legal guidance to create effective claims files for veterans with mental health disorders. As noted previously,¹⁹⁸ legal assistance may be particularly important and apt for PTSD-afflicted wounded warriors. Importantly, there are limits to fees charged by attorneys, but they are consistent with previous assessments and amounts, and they may be changed by rule and regulation by

198. See, e.g., *supra* Part III (discussing cognitive and other mental health challenges of wounded warriors with PTSD).

the Secretary of Veterans Affairs as needed. The statute also ensures that the fee limitations indicated are only applicable to Department of Veterans Affairs adjudications, rather than any court-based litigation. Finally, the law indicates that it will take effect within 90 days of enactment.

VII. CONCLUSION

PTSD is not a new disease. The symptoms of PTSD are as old as war itself. However, PTSD has become a signature wound of the Iraq and Afghanistan wars. We must diagnose, treat, and compensate our veterans so that they can live the fullest lives possible in exchange for their service and sacrifice. PTSD may not manifest itself like other diseases, but it is a silent killer. Left untreated, veterans turn to alcohol and drugs to treat the symptoms themselves, which cause even more severe symptoms and co-occurring disorders. Unchecked, PTSD can lead to social impairment, loss of employment, homelessness, incarceration, risk of suicide, and even death.

To avoid these adverse outcomes, the disability evaluation system applied to wounded warriors must be reformed. Lincoln addressed the social and moral obligation that society and the government have to veterans in his now-famous inaugural address. In this speech, Lincoln expressed his desire to help heal the wounds of a Civil War that split our country in two and pitted citizen against citizen. This part of his speech is less known, perhaps because the VA omitted it from their motto, but it answers the question of why we should care for our veterans. He stated, "let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan."¹⁹⁹

While many recommendations have been made to substantially change the VA's compensation system,²⁰⁰ the primary step must be to ensure that veterans receive the compensation they deserve. Reforming an antiquated review standard through introduction of express and explicit medically-based standards such as the DSM-IV-TR and its associated provisions provides a rational basis on which to assess a diagnosis and function of a wounded veteran. Further, allowing veterans to have attorney representation during the initial claims process, like SSA claimants, provides veterans with a better chance of submitting complete and accurate initial claims, which in turn could result in more approvals, and a reduced backlog.

Indeed, more deeply, attorneys can help veterans gather documentation to better substantiate their claims, which, in turn, may help veterans struggling with the lack of medical knowledge and conflicting requirements to make more

199. President Abraham Lincoln, Inaugural Address (Mar. 4, 1865), *available at* [http://memory.loc.gov/cgi-bin/ampage?collId=lprbscsm&fileName=scsm0553/lprbscsm0553.db&recNum=0&itemLink=h?ammem/scsmbib:@field\(DOCID+@lit\(scsm000553](http://memory.loc.gov/cgi-bin/ampage?collId=lprbscsm&fileName=scsm0553/lprbscsm0553.db&recNum=0&itemLink=h?ammem/scsmbib:@field(DOCID+@lit(scsm000553).

200. HONORING THE CALL TO DUTY, *supra* note 88, at 11 (making 113 recommendations).

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timely findings. Consequently, the entire process may be shortened if the first claim submitted is “ready to rate.”²⁰¹ Therefore, allowing attorney assistance earlier in VA proceedings would likely improve the quality and reduce administrative costs.

The way to bind our nation’s current wounds is to treat the invisible wounds of war and to revamp the compensation system. Efforts must be made to reform rating requirements and to eliminate inequities in disability evaluation and compensation with attorney representation. Only then can we “finish the work we are in” and care for those who have “borne the battle.” It is our ethical and moral duty to do so.

201. Also, veterans will avoid having to resubmit claims, unless absolutely necessary. The VDBC found that 81% of claims were reopened claims (claims that were initially denied, or the veteran was dissatisfied with the disability rating or effective date of a decision) and approximately 20% were original claims. HONORING THE CALL TO DUTY, *supra* note 86, at 304-05.

