

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD
TASK FORCE ON MENTAL HEALTH

Arlington, Virginia
Monday, December 18, 2006

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LTG KILEY: Please be seated. Welcome all to this open meeting session of the Department of Defense Task Force on Mental Health. This Congressionally mandated Task Force has been asked to look into the current military health care system. The overall intent of our visit here today is to gain some insight into that system and ultimately provide Congress with recommendations for areas of improvement but also to acknowledge areas that are flourishing.

We've asked you here today because we're particularly interested in your perspective and experiences, and we'd also like to ask you to be mindful of our fellow persons here and allow those who are speaking courtesy and respect.

We have some important topics on our agenda for today, so we'll get started.

Ms. Ellen Embrey, the Designated Federal Official for the Task Force's parent federal advisory committee, the Defense Health Board, had

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1 an unavoidable conflict and will not be able to
2 attend the meeting. In her absence, she has
3 appointed COL Jeffrey Davies, the Army Surgeon
4 General Executive Officer, as the alternate
5 Designated Federal Official.

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6 COL Davies, would you please call the

7 meeting to order.

8 COL DAVIES: Thank you, GEN Kiley. As
9 the acting Designated Federal Official for the
10 Defense Health Board, a federal advisory committee
11 of the Secretary of Defense, which serves as a
12 continuing advisory body to the Assistant
13 Secretary of Defense for Health Affairs and the
14 Surgeons General of the military departments, I
15 hereby call this meeting to order.

16 LTG KILEY: Thank you, COL Davies. The
17 next thing I'd like to do is start down here to my
18 right and let each one of the Task Force members
19 introduce themselves.

20 LTC CAMPISE: Good afternoon, I'm LTC
21 Rick Campise. I'm the Air Force person in charge
22 of DuPont Behavioral Health, and I work at the Air

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1 Staff with their Air Force Surgeon General.

2 MS. FRYAR: Good afternoon. I'm Deborah
3 Fryar, the family member representative on the
4 Task Force.

5 COL DAVIES: I'm COL Jeff Davies. I'm
6 the Alternate Designated Federal Official for
7 today's meeting.

8 LTG KILEY: I'm Dr. Kevin Kiley, the
9 Army Surgeon General Commanding General of the

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U. S. Army Medical Command and one of the co-chairs

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of this committee.

DR. McCORMICK: I'm Dick McCormick, a
clinical psychologist, one of the civilian members
of the Task Force.

CAPT McKEATHERN: I'm CAPT Margaret
McKeathern, a Navy child and adolescent
psychiatrist and the Navy representative of the
Task Force.

CAPT POWER: Kathryn Power, Director of
the Center for Mental Health Services at the
Department of Health and Human Services.

LTC DOUGLAS: LTC John Douglas,

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Headquarters Marine Corps Manpower Reserve
Affairs.

DR. MacDERMID: Shelley MacDermid. I'm
an elected co-chair of the Task Force, and I'm a
Professor of Child Development and Family Studies
at Perdue University.

DR. ZEISS: Dr. Toni Zeiss. I'm the
Deputy Chief Consultant for the Office of Mental
Health Services in the Department of Veterans
Affairs, and I'm the VA representative to the
committee -- Task Force.

COL ORMAN: I'm Dr. Dave Orman. I'm an
adult psychiatrist, and I travel full time in

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support of the Task Force.

15 LCDR WERBEL: LCDR Aaron Werbel. I'm a
16 Navy clinical psychologist, and I'm the Behavioral
17 Health Affairs Officer at Headquarters Marine
18 Corps.

19 CAPT KLAM: I'm CAPT Warren Klam. I'm
20 the Navy psychiatry special leader, and I also
21 practice at Naval Medical Center San Diego.

22 COL PEREIRA: I'm COL Angela Pereira,

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1 social work representative to the Task Force.

2 DR. McCURDY: I'm Layton McCurdy, a
3 general psychiatrist, Professor of Psychiatry and
4 Dean Emeritus of the Medical University of South
5 Carolina.

6 LTG KILEY: Okay, thank you all very
7 much. I think next Dr. Burke has some
8 administrative remarks.

9 DR. BURKE: Thank you, GEN Kiley. Good
10 afternoon, and welcome. I would like to ask
11 everyone in attendance to please sign the general
12 attendance roster on the table out front if you
13 have not done so already. We will be transcribing
14 the open sessions of this meeting, so please use
15 the microphones when speaking and clearly state
16 your name. The transcripts will be published on
17 the Task Force website within 90 days of this

18 Washington DC 20061218 TF meeting transcripts FINAL.txt
meeting.

19 We would also like to ask you to be
20 mindful of your fellow persons here and allow
21 those who are speaking courtesy and respect.
22 Thank you.

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1 Thank you, GEN Kiley.
2 DR. MacDERMID: One other business item
3 which I don't want to leave unattended to is that
4 restrooms are outside the door at the back of the
5 room and off to your right, and Ms. Severine
6 Bennett, who's at the table just inside the doors
7 can assist you if there's anything else that you
8 need. I noticed on my way by she has an EASY
9 button, so that should make life much simpler.
10 Thank you all for coming, and welcome to
11 the folks who will be presenting to us today. Our
12 first speaker is going to talk with us about the
13 Army National Guard Bureau, and, I'm sorry, I'm
14 going to pronounce the name wrong -- COL Fortuin?
15 Is that correct?
16 COL FORTUIN: (off mi ke)
17 DR. MacDERMID: Sorry about that.
18 Welcome. The room setup here reminds me a little
19 of Daniel and the lion's den, but we'll let you be
20 at the podium and not down in the pit.
21 COL FORTUIN: Oh, thank you. As

22 Washington DC 20061218 TF meeting transcripts FINAL.txt
mentioned, my name is COL Nancy Fortuin, so that's

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1 pretty good actually. I'm the Deputy Surgeon for
2 the Army National Guard.

3 We were -- we had the opportunity to
4 meet with Dr. Orman and Mr. Burke a couple of
5 months ago and learned a little bit about the --
6 what the Task Force was doing, and I wanted to --
7 they asked us to come here today to just give you
8 some programmatic considerations for mental health
9 in the Army National Guard.

10 Next slide, please. These are some of
11 the issues that I want to be covering this
12 afternoon. Next slide, please. Program
13 definition is very important to us and kind of
14 guides how we do business, and the first thing is
15 how to identify soldiers who would benefit from
16 assistance. How do we quantify and qualify
17 soldiers at risk? That tends to be very
18 challenging. As I go through the programmatic
19 aspects, I think that will become apparent. How
20 do soldiers who need assistance or care access the
21 system? What access do they have, and what are
22 the barriers for them to have that access? And,

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1 lastly, how do we improve the program?

2 This is particularly challenging to the
3 Reserve components, because we simply don't
4 control our soldiers for most of the days in the
5 year. They are civilians for most of the day of
6 the year, so we have less access to them and to
7 data pertaining to them. And additionally,
8 because their civilian lives, when data is
9 collected, there are lots of confounding factors
10 that go along with that.

11 Next slide, please. I wanted to talk a
12 little bit about the population. Next slide.
13 This is fairly dramatic, and most people aren't
14 aware of the contribution that the Army Reserve
15 components provide to the war fight, and I'm not
16 here today to speak for all of the Reserve
17 components; I just want to speak, in my case,
18 specifically for the Army National Guard.

19 There are many comparisons to all the
20 Reserve components. In particular, we have
21 certain comparisons to the Air National Guard,
22 obviously. We also probably have more comparisons

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1 to the Army Reserve. But these are the

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2 percentages of Reserve component soldiers who have

3 been mobilized since 9/11/01. So, you can see
4 that the Army National Guard does have the
5 preponderance of those forces.

6 Next slide, please.

7 DR. McCURDY: Do you have a number?

8 COL FORTUIN: Yes, 20 -- yes, next
9 slide. Go to the next slide. Yes, 260,000.

10 LTG KILEY: Now back up just one.

11 DR. MacDERMID: Back up one, sorry.

12 There you go. No. You set me up.

13 Over 260,000 soldiers is what the Army
14 National Guard is on there.

15 And something very important I think
16 that a lot of people don't realize is that the
17 Army National Guard Reserve components overall,
18 but particularly the Army National Guard, is a
19 community-based force, okay? We are probably the
20 most community based of all of the Reserve
21 components. What is important about this is we
22 are different from the Active component, which is

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1 installation centric. So, when programs are being
2 designed at the installation, you've got everyone
3 there in one location, okay, whereas in the
4 Reserve, and particularly the Army National Guard,
5 you can see we're at almost 3,000 communities

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6 across the United States.

7 The Guard is primarily a combat arms
8 force, which, as you look at some of the research
9 that's been done, has some conclusions that can be
10 drawn from that, and one of the things
11 demographically is that in the combat arms you
12 have a lower ranking force. The percentage of
13 enlisted and junior enlisted to officer is much,
14 much greater.

15 We are made up of units. Unlike the
16 IRR, the Army Reserve, we don't have -- we are not
17 individually based, and we can leverage that unit
18 cohesion when we are looking at programs. And
19 then I've included some -- just some general
20 demographics there for you.

21 Next slide, please. You know, something
22 of a joke, but it rings very true for us as we try

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1 to develop programs, is that in the Guard we
2 consider 54 Armies because we're spread across 54
3 states and territories. At National Guard Bureau,
4 where I work, our job is to establish policy;
5 obtain resources and distribute those resources to
6 the states and territories; and provide oversight.
7 What is very important is we do not have command
8 and control over the states and the National
9 Guards in those states ever. We have no command

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10 and control authority, okay? Command and control
11 is vested in peacetime in the governor via the
12 adjutant general for that state. The state, on
13 the other hand -- during peacetime they execute
14 the programs and policies that are -- that we
15 publish.

16 Great sound effects in here. The states
17 have a tremendous amount of autonomy in
18 accomplishing those policies and programs, but
19 they are obligated to follow the DoD and DA
20 policies that are published.

21 Next slide, please. I wanted to talk
22 something about the authority, because this gets

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1 directly to access to care.

2 Next slide, please. Okay, a point I
3 want to make here is that access to health care is
4 very different from accessing health care, and as
5 I mentioned earlier, barriers to accessing may
6 still exist. We have -- in the Guard, our access
7 to care is limited by the type of orders you are
8 on and the length of time you are on those orders,
9 okay? One thing we found out during the airport
10 security mission back in 2001 and 2002 was that
11 our soldiers were not entitled to the TAMP benefit
12 -- the Transition Assistant Management Program
13 benefit. But the length of orders is key here.

14 If you're on for less than 30 days, the soldier
15 gets full care for whatever occurs at that time --
16 sick call as well as any line-of-duty injury
17 occurs. If the soldier is on orders for greater
18 than 30 days, then both they and their family are
19 entitled to health care, okay? Now, the soldiers
20 -- if a soldier has a line-of-duty injury or
21 illness, then the care will continue even once
22 that soldier comes off of orders, whereas the

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1 family's care is pretty much limited to just the
2 time that that soldier is on orders.

3 Line of duty is very important in the
4 Reserve components. Without a piece of paper
5 showing that the injury was incurred or aggravated
6 in the line of duty, that soldier has no way of
7 accessing care or having the authority to get care
8 either in the VA often or at an Active component
9 MTF.

10 I mention the Transitional Assistant
11 Management Program. That was put in place for
12 soldiers who come off of a mobilization, and it
13 extends for 179 days past, and that's full care
14 for both the soldier and their family. But it is
15 not intended for line-of-duty care. There are
16 co-pays involved with the TAMP Program. It is a
17 transitional program only. It is to allow the

18 soldier to get back into their civilian life and
19 transition back to civilian life. So we have to
20 separate out -- you know, if the soldier becomes
21 ill or injured in the line of duty, they should
22 not be having to pay for that care that they

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1 obtain or access after they come off of orders.

2 Then most of you should know about
3 TRICARE Reserve Select, a huge improvement in
4 access to care or the -- a soldier's ability to
5 access care. There are premiums and co-pays and
6 so on that go with that, but it's a very nice
7 program. However, we don't -- you can see what
8 our enrollment is of our eligible soldiers.

9 An important point here. A lot of
10 people think that because we have doctors and
11 dentists and so on in our force structure that we
12 can provide health care. We cannot, okay? Health
13 care is only provided under the Defense Health
14 Program. It is not the Army National Guard's
15 mission to provide health care.

16 Next slide, please. Next slide. Under
17 Policy, in the first three policies I have listed
18 -- I'm sure you're all very familiar with our DoD
19 policies, and these are ways that we go back to
20 identifying those soldiers that are at risk: The
21 Post- Deployment Health Assessments;

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1 90 to 120 days post-MO, so think about that --
2 it's right about the time they're starting to lose
3 their TAMP benefit, okay? -- and then there's DoD
4 policy. It's a moratorium on drilling for 90 days
5 after the last unit member is REFRADed. So, in
6 most cases we don't see our soldiers for about 90
7 days after they come off of their mobilization.
8 Important point.

9 And then a couple of DA policies are
10 MRP2 or Medical Retention Processing. It was the
11 way we had that when soldiers come back from their
12 mobilization either they are evacuated back or
13 they're about to REFRAD or they had something
14 happen during training before they even went once
15 they were mobilized, that they can be retained on
16 active duty but not in a mobilized status, and the
17 sole purpose of them being retained on active duty
18 is to treat their injury or illness, mental
19 health, whatever it might be.

20 This is a voluntary program, however.
21 So, I don't want to confuse this, that every
22 single soldier who comes back with a problem is

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1 retained in an MRP status. That is not the case.
2 The soldier must sign up, must volunteer to remain
3 on active duty. So, we can't use that as an
4 indication of how many issues there are or might
5 be.

6 MRP2 is simply if a soldier is REFRADED
7 and then gets back to their civilian life and
8 realizes oh, you know, my knee's hurting or I do
9 have a mental health problem that I need to deal
10 with, it is a way that they can reapply and
11 attempt to come back into an active duty status to
12 have that issue dealt with. And you can see how
13 many soldiers -- Army National Guard soldiers are
14 currently in the medical holdover population.

15 Next slide, please.

16 LCDR WERBEL: Do you know what
17 percentage that does represent, that 2400 soldiers
18 of the (off mike)

19 COL DAVIES: Dr. Werbel, could you
20 please speak into the microphone so we can get
21 that?

22 LCDR WERBEL: I'm wondering if you know

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1 who -- back one slide -- if you know what

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2 percentage that 2400 soldiers does represent of

3 the entire population of soldiers who have had a
4 line-of-duty injury or illness.

5 COL FORTUIN: No. Great question, and
6 it's something important for us to find out.
7 There is currently no centralized database for
8 line-of-duty paperwork. We're working on getting
9 to that, but we don't know what the total
10 population is.

11 Next slide, please. Okay, some of our
12 resources, I mention again, were not funded to
13 provide mental health services per se within the
14 Army National Guard itself. The only thing the
15 Army National Guard is funded to do is to provide
16 pre-mobilization readiness services -- your
17 physical exam, immunizations, and things along
18 those lines.

19 The Department of Defense has funded the
20 PDHRA teams and a call center. In other words,
21 when we post a PDHRA event, a reassessment event,
22 we can access these teams with a mental health

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1 provider on it to come into the armory to do the
2 assessments and to help us with the referrals if
3 follow-on evaluation is necessary. However, there
4 are only 20 of those teams currently available.
5 It is -- our greatly preferred way of doing

6 business is to use these teams as opposed to using
7 the call center. Again, we're a unit-based
8 organization. We think it's much more important
9 to have the entire unit go in to do the
10 Post-Deployment Health Reassessment altogether as
11 opposed to having people call individually to the
12 call center, and we believe the results are more
13 comprehensive and more thorough as a result.

14 We also incorporate -- when we do a
15 PDHRA event, we also incorporate Battlemind
16 Training into that event. Battlemind Training was
17 developed by the Walter Reed Army Institute of
18 Research, and it's gone over -- it's basically a
19 way to develop mental toughness or talk about
20 mental toughness, and it helps the soldier
21 himself. It trains the soldier himself how to
22 identify what may or may not be a mental health

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1 issue that they should get follow-on evaluation
2 for and where and how to get that evaluation and
3 referrals.

4 We have a very strong partnership with
5 the Veterans' Administration. The National Guard
6 Bureau, both the Army and the Air, created a
7 memorandum -- or signed a Memorandum of
8 Understanding last may, because most of our
9 referrals come -- that we get out of Post-

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Deployment Health Reassessment go to the Veterans'

10 Administration for the initial evaluation.

11 National Guard Bureau has placed a VA
12 coordinator in each state to help that liaison or
13 that linkage between the soldiers and the
14 Veterans' Administration. And of course there is
15 that Veterans' Administration eligibility for OIF
16 and OEF soldiers to have access to the Veterans'
17 Administration for 24 months following their
18 release from active duty from immobilization.

19 We also have Military One Source, which
20 allows a soldier to call or go online and get
21 referrals, and they can do that in an anonymous
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1 way.

2 We also have a Web page called HOOAH 4
3 HEALTH. It's a dot-com Web page and it's kind of
4 -- it's another one-stop shopping for our
5 soldiers. It's another way to help promotion, but
6 they also have a lot of mental health things on
7 there, as well as direct links to Battlemind
8 Training and Military One Source.

9 Next slide, please. Next slide.

10 DR. McCORMICK: Colonel, what is the
11 eligibility time for Military One Source for the
12 National Guard?

13 COL FORTUIN: Oh, a great question. I

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14 don't have an answer for that right now. Because

15 it is anonymous, it's -- I'm not sure how they
16 track that. Can't answer that right now, but good
17 question.

18 We do not have mental health resources.
19 A slight exaggeration. We've got a few
20 psychiatrists who deploy with -- we have a certain
21 core structure that we -- approximately eight
22 battalions that have a psychiatrist with them

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1 Obviously with almost 350 soldiers, that's
2 inadequate for -- oh, thank you -- eight
3 psychiatrists just isn't going to be able to do
4 very much.

5 We recognized early on that -- and
6 certainly our states recognized early on -- that
7 mental health was a huge issue for our deploying
8 forces. At the time, there wasn't -- Military One
9 Source or Army One Source at the time was in
10 place, but there wasn't a whole lot of
11 programmatic things out there, so the Army
12 National Guard Surgeon posted a memo to the states
13 and told them to be very proactive and develop
14 their local resources, their local networks, and
15 agreement with the Veterans' Administration,
16 employment services, whatever, just to start
17 taking care of their soldiers at that point. And

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some states -- not all, but some states did in

19 fact go out and hire mental health coordinators to
20 work with both their soldiers and their family
21 members.

22 In terms of infrastructure, we think of,

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1 you know, access to care and some of the tracking
2 databases and so on, but the reality is to do the
3 case management of soldiers who report a problem
4 is very time consuming and very, very intensive,
5 and that's just not something that we currently
6 have in place as well as we would like. So,
7 again, once a soldier comes out of the Post-
8 Deployment Health Reassessment and is referred for
9 a follow-on evaluation, we don't have adequate
10 resources to do the intensive management of the
11 soldiers to find out if they went to the referral,
12 what came out of that, and so on and so on.

13 We also have Family Assistance Centers
14 in the National Guard, which are very active in --
15 again, primarily a resource for the family if
16 they're having trouble. It's another one-stop
17 shopping, and they also have a very nice Web page.

18 Next slide, please. And the next slide.
19 If you haven't -- I'm sure that you've seen some
20 of the -- if you haven't already, I'm sure you
21 will see some of the data that has come out of

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some of the surveys that have been accomplished,

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1 and what we consider to be good news is that Army
2 National Guard soldiers have the same reactions to
3 stress as do their Active component counterpart in
4 the same incidents of stress and post-traumatic
5 stress, and that holds up pretty well in all the
6 surveys that have been accomplished, as well as
7 the hospitalization data coming out of theater for
8 the mental health issues in theater itself.

9 However, the PDHRAs do indicate that
10 Army Reservists check positive responses for
11 mental health, behavioral health, and physical
12 health at a greater rate than do their Active
13 component counterparts. Why is that? Don't
14 really know. We've got some good ideas, some
15 things that probably need to be looked at. For
16 instance, we run our screening a little bit
17 differently than the Active component does. The
18 entire unit goes in at once. The leadership is
19 right there with their junior soldiers. The
20 referrals are done a little bit differently.
21 Again, our referrals are going toward -- referrals
22 for follow-on evaluation is done primarily via the

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1 Veterans' Administration as opposed to an Active
2 component MIF, and remember access to care is very
3 different. These soldiers don't have an Active
4 component MIF to go to, and oh, by the way,
5 they're about to lose their TAMP benefit by the
6 time the Post- Deployment Health Reassessment is
7 done. So, they may be thinking oh, this is kind
8 of my last chance. But we don't have data, so we
9 don't really know at this point why they are
10 checking it at a higher rate.

11 Next slide. As I mentioned earlier, we
12 don't have a centralized mechanism to track how
13 many soldiers who -- and we know how many soldiers
14 get an evaluation after the Post-Deployment Health
15 Reassessment. We don't, right now, have a good
16 way to look at the referral and what their
17 diagnosis and treatment data is.

18 An important point here, soldiers who
19 seek care at the Veterans' Administration do so as
20 a civilian, not as a soldier. So, we don't have
21 access to what the VA is doing for them. We don't
22 have the ability to track that at this point or to

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1 do the case management if they're going out.

2 They're not our responsibility. They are
3 civilians at that -- not our -- we take them very
4 seriously, but we don't have everything in place
5 to do that, again, that intensive case management,
6 nor do we have the access to the data.

7 Next slide. And that concludes my
8 presentation. Are there any further questions?
9 Ma'am.

10 MS. POWER: Do you have any plans for
11 picking up on any of those issues relative to the
12 evaluation of data?

13 COL FORTUIN: Yes. We're implementing a
14 centralized database for the line of duties, so
15 we're implementing that within the Army National
16 Guard, so we'll have a really good way -- (off
17 mike) the ICD-9 code, and we'll know exactly.
18 It's a centralized Web-based database, and so
19 we'll have access to all of that type of data.
20 And we work closely with Dr. Hogue and Company
21 when they're doing the research that they do.

22 MS. POWER: And that will come online in

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1 what fiscal year or what calendar year?

2 COL FORTUIN: It's January -- next month
3 is when we're directing its implementation through
4 all the states. It's been in development. It's
5 been piloted. It works, so we'll start using it.

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6 MS. POWER: Thank you.

7 COL PEREIRA: You have line-of-duty
8 claims for illness and injury. Are their
9 line-of-duty claims for exposure to emotional
10 trauma and, if so, how are those handled?

11 COL FORTUIN: Yeah, good question. And
12 as best as I can answer it, there are soldiers
13 that I know that come back and want to comeback
14 into the MRP2 -- the Medical Retention Processing
15 2 -- status, that after a month or whatever they
16 come back and they realize they're just not coping
17 and attribute it back to something that happened
18 in theater. And I do know that efforts are made
19 to get back to the commander that they were under
20 in theater and to document whatever incidents
21 occurred to find out if they are in fact qualified
22 if it does -- if the exposure or the incident

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1 occurred to attribute it to a line of duty to
2 bring them back on. So, yes, it is happening. A
3 lot of research goes into that.

4 COL PEREIRA: How difficult is that to
5 do after the fact?

6 COL FORTUIN: You'll have to tell me
7 that. The clinician -- it's the -- when the
8 soldiers are back in the state, they have to put
9 together a packet to document what they can. It

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10 is seen by a board, a board that is -- or a panel
11 that is made up of three clinicians who then look
12 at the packet to determine if it was a
13 deployment-related incident. And after that I
14 can't tell you how challenging it is to go back to
15 theater or to document all of that. I don't know
16 the answer to that.

17 COL PEREIRA: One more follow-up
18 question. How difficult would it be to document
19 during the deployment that kind of an exposure in
20 case it came up as an issue later instead of
21 having to go back and then try to re-piece the
22 occurrences after the fact?

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1 COL FORTUIN: Great question. I don't
2 feel qualified to answer that. The folks who are
3 actually treating folks in theater and dealing
4 with the information, the records, and so on in
5 theater would have to answer that question.

6 LTG KILEY: Yeah, I think the -- I think
7 soldiers that are seeking health care based on,
8 you know, emotional, traumatic events -- that's
9 probably documented. We'd like to have it all
10 electronic, but I think it's being documented in
11 the records.

12 The issue for line of duty as I
13 understand it is a soldier -- you know, many

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14 soldiers, Active and Reserve, have significant
15 emotional events, you know, trying combat
16 operations. It's -- when you get into the process
17 of having symptoms or beginning to get the
18 diagnosis of PTSD, for example, and you start
19 talking about medical boards and then the
20 disability system, I think that's where, in my
21 experience, you see the issues about getting a
22 line of duty, you know, was -- maybe Dave could

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1 expand on that a little bit, too, in terms of, you
2 know, what happened to you? Where were you? What
3 was the nature of the combat operation? Or what
4 was it you saw? And then the soldiers will go
5 back and give, you know, who their first sergeant
6 was and their company commander, and often -- and
7 this is very difficult to do sometimes, but back,
8 okay, on the 15th of April in 2006, you know, SGT
9 Smith was in a firefight, a complex attack as part
10 of the convoy operation, yes or no, and then
11 you've got to start validating.

12 Dave, what do you think?

13 COL ORMAN: I'll tell you what we
14 recommended for people that were deploying out of
15 Hood before I left, that they keep a journal and
16 record day to day their experiences with who was
17 there, etc., if there was a significant traumatic

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18 event, because I think the complexity of trying to
19 run down first sergeants and commanders well after
20 the fact and placing the burden on the soldier to
21 document all that stuff is where we're probably
22 going to have some difficulties in the future.

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1 COL FORTUIN: Question.
2 DR. MacDERMID: I'm curious about what
3 your wish list would be if we were going to make
4 recommendations about the infrastructure and
5 mechanisms that would be needed to ensure quality
6 of care for National Guard members as they return
7 from deployment and move back to into the civilian
8 world. What's not there that's -- well, you've
9 told us what's not there. Tell us what you would
10 hope we would recommend would be there.
11 COL FORTUIN: Yeah, the -- excuse me. I
12 think we do right now a very good job of the
13 soldiers that stay on active duty in the MRP
14 status. There's a very comprehensive process
15 that's put in place. My biggest concern that we
16 have the least visibility over is those soldiers
17 that either don't know that they had an injury or
18 illness or just want to go home really fast and
19 therefore don't report it and then they're very --
20 they're just very difficult to manage. So, we
21 tried to implement more case management, but I

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would say associating a much more robust case

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1 management process, as well, with PDHRA that is
2 now accessible for the Reserve components, as well
3 that we don't have to pay for -- that's quite a
4 wish list -- as well as getting data and
5 assistance from the Veterans' Administration when
6 these soldiers are seen at the Veterans'
7 Administration so that we get that data, even if
8 it's not at the individual level at the aggregate
9 data that we've got a better sense
10 programmatically of what's happening.

11 DR. MacDERMID: Do you think it would be
12 wise to have a drill weekend inside the 60-day
13 window following deployment for the purposes of
14 reintegration, training, assessment, whatever?

15 COL FORTUIN: We are definitely looking
16 at whether it's within the 60 days or later at
17 (off mike) to just look at overall health concerns
18 to include mental health, so, yes, it's -- you
19 know, there are so many priorities on the
20 commander's plate, and then you take another
21 couple of drills out of that access to the soldier
22 is very challenging.

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1 DR. McCORMICK: We did hear from one of
2 the National Guard in California where they had a
3 mental health representative hired by the Guard.

4 COL FORTUIN: Yeah.

5 DR. McCORMICK: I have two questions.
6 First of all, do you have any idea approximately
7 how many of the 52 have such a person? And then
8 what is the barriers -- what are the barriers to
9 the rest of them getting them? Is it resources or
10 beliefs or attitudes or what?

11 COL FORTUIN: Primarily resources, that
12 we've had states come to us looking for money to
13 hire somebody like that, and we just don't have
14 the ability to fund them, so -- for a whole
15 separate program like that. We encourage them to
16 take what resources we do give them, which of
17 course are earmarked for particular programs, and
18 then they of course have to prioritize what's
19 important to them and take things like that out of
20 (off mike). I would say at least a handful, but
21 don't know exactly how many have actually done
22 that. But, yes, it's absolutely resources that

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1 are withholding them; it's certainly not

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2 attitudes. We have tremendous interest from state

3 leadership -- state leaderships on how to better
4 care for their soldiers and are looking for ways
5 to do it.

6 DR. ZEISS: What are the policies in the
7 National Guard -- Army National Guard -- about
8 redeploying those who have a mental health
9 diagnosis?

10 COL FORTUIN: The standards are laid out
11 in the Personnel Policy Guidance -- the PPG -- so,
12 the deployment standards are laid out and every
13 time you deploy you have to go back through what's
14 called an SRP -- a Soldier Readiness Processing --
15 and you are evaluated against a certain standard.
16 If you do not meet that standard, then you will
17 not deploy. So, it's basically what's in the PPG
18 AR40-501 -- Army Regulation 40-501. You're always
19 independently assessed against that.

20 Okay, thank you very much.

21 LTG KILEY: All right, Col. Fortuin
22 thank you very much. Good presentation.

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1 COL FORTUIN: Thank you.

2 (Applause)

3 LTG KILEY: Go ahead, Shelley. Shelley,
4 do you want me to -- Shelley, are you going to
5 introduce the next speaker?

6 DR. MacDERMID: Sorry, I'm hearing in
7 stereo. Is our next speaker here?
8 LTG KILEY: Yes.
9 DR. MacDERMID: Oh, great. I actually
10 know our next speaker, Barbara Thompson, who is
11 now overseeing the Family Policy operation in the
12 Office of the Secretary of Defense, and we are
13 very happy to have here her, and we look forward
14 to her comments.
15 MS. THOMPSON: Thank you. I have some
16 folders that will be distributed to you that
17 contain some information about MilitaryHOMEFRONT
18 that I'll be talking about, but first of all,
19 General Kiley, Dr. MacDermid, and Dr. Burke in the
20 back and members of the Task Force, thank you for
21 the opportunity to meet with you this afternoon.
22 In the next few minutes I'll discuss with you some

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1 of the policies and programs in place to support
2 Service members and their families.
3 Military Community and Family Policy is
4 a part of Personnel and Readiness, led by
5 Undersecretary of Defense Dr. David Chu, and one
6 of our sister organizations in Personnel and
7 Readiness is Health Affairs. We recognize the
8 direct role Health Affairs plays in providing
9 mental health services for Service members and

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10 their families. We are also just as clear in

11 MC&FP that we provide an undergirding of support
12 through programs and services that impact and
13 strengthen the quality of life for Service members
14 and their families and indirectly support the
15 emotional well-being of the total force and their
16 families.

17 The integrated network of programs is
18 quite complex, so the intent of this presentation
19 is not to make you experts; rather, this will be a
20 very broad overview with time for a brief
21 discussion following my remarks.

22 Today more than 2.5 million volunteers

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1 serve our nation. 1.3 million are on active duty
2 and 1.2 million in the Reserves. They serve here
3 in the United States and in more than 150
4 locations around the globe. This force is young.
5 Almost half are under the age of 25. They are
6 well educated. Slightly more than half are
7 married, mostly with dual income, and have
8 children. Approximately two-thirds of our active
9 duty force live outside the confines of a military
10 installation. And they all learn very quickly
11 that military life comes with unique rewards and
12 challenges. It is a world with a language of its
13 own, a new way of doing things from shopping for

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14 groceries at the commissary to deploying in harm's

15 way and defending our nation.

16 A myriad of support systems are in place
17 to ensure good physical, emotional, spiritual,
18 educational, and social health for our Service
19 members and their families. These programs and
20 services can be accessed to meet the individual
21 needs of a particular individual at the time they
22 are needed. So, for example, our childless

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1 Service members are not consumers of the military
2 child development system, but when they become a
3 parent, that support system is available to them.

4 In the business world perhaps the most
5 comparable support system is the Employee
6 Assistance Program. These services are provided
7 in an effort to strengthen the health and
8 productivity of employees in the workplace. The
9 programs in the military, too, are interested in
10 supporting the mission.

11 However, as many of you know, military
12 life is more than just employment. It's a way of
13 life. It's a commitment to 24 hours, 7 days a
14 week of service to this nation. Along with the
15 common stressors of daily living, there are
16 stressors unique to military service, such as
17 increasingly frequent deployments of unknown

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duration to hostile environments; long
19 separations; recurrent moves; distance from
20 extended family; inconsistent quality of housing;
21 and sporadic opportunities for spousal employment.
22 And if you add in the various personal and

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1 financial challenges that confront any family, it
2 becomes quite apparent that support to military
3 families is critically important.

4 Since the advent of the all-voluntary
5 force in 1973, anecdotal reports and research have
6 shown that the decision to enlist is very
7 individualized, personal, and personal. The
8 decision to remain in military service, however,
9 is more frequently a family decision. As our
10 leaders describe it, we recruit individuals but we
11 retain families.

12 In response over the years,
13 quality-of-life programs to support families have
14 evolved, and today the Military Community and
15 Family Policy Office is composed of eight
16 directorates that oversee family support, such as
17 support during the deployment cycle; transition
18 assistance for separating Service members;
19 relocation assistance; nonmedical counseling
20 services; financial planning; military spouse
21 training, education, and employment; children and

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1 Education Activity Schools both here in the United
2 States and overseas; educational transition
3 support for military children; family advocacy,
4 such as support for victims of domestic violence
5 and new parent support programs; the Exceptional
6 Family Member Program; commissary and military
7 exchange services; morale, welfare, and recreation
8 activities; tuition assistance for voluntary
9 education; and we also have a state liaison office
10 dedicated to support military-friendly policies at
11 the state level in collaboration with the National
12 Governors Association.

13 What does this mean in practical terms?
14 I'll highlight some of the programs. Thirty years
15 ago, family separations were common, but little
16 support was provided. I am pleased to tell you
17 that much has changed for the better since then.
18 The attitude of if the Army, Navy, Air Force, or
19 Marines had wanted you to have a family, they'd
20 have issued you one is gone. Many new programs
21 are in place, and many good programs have been
22 enhanced and sustained.

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1 Let me tell you about some of the
2 programs that fall under my purview in the Office
3 of Family Policy, Children, and Youth. As noted
4 in the 2004 Quadrennial Quality-of-Life Review,
5 the cornerstone of the support systems is a
6 worldwide network of installation family centers
7 and local family readiness centers that are
8 established as needed.

9 Installation family centers provide a
10 network and delivery system for a wide range of
11 services supporting commanders, Service members,
12 and families. These include information and
13 education on and assistance with key family
14 well-being issues such as financial readiness;
15 explanation of benefits; contingency care plans;
16 assistance for families with special needs;
17 printed materials; deployment kits; training
18 materials; and assistance to unit-based support
19 groups and command-supported volunteer networks to
20 ensure accurate, timely information is
21 communicated from the commander to spouses and
22 family members, including parents; and

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1 post-deployment support addressing a range of

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2 issues of interest to both married and single

3 Service members.

4 Local readiness centers are tailored to
5 meet the needs of a particular unit. For example,
6 at Fort Hood, Texas, the 13th Sustainment Command,
7 held a ribbon-cutting ceremony to officially open
8 its new Soldier Family Readiness Center last month
9 on the eighth of November. This facility, an
10 existing building remodeled and reconfigured to
11 support this mission, will provide space for
12 conference and family readiness group functions.
13 Two rooms have been set aside and prepared to
14 offer daycare for children. It also has a
15 resource center with donated literature; a video
16 teleconferencing center; and equipment with
17 capabilities to send and receive faxes and make
18 copies. The unit has been deployed consistently
19 since 2001. The commander says this Readiness
20 Center is vital to creating a resource area for
21 the latest information relevant to family
22 readiness. The facility will enable the command,

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1 its soldiers, and their family members to maintain
2 closer communication, a key element to managing
3 stress.

4 One of the most significant initiatives
5 to support Service members and their families,

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6 regardless of their location, was introduced in

7 2002 when the Department of Defense implemented a
8 toll-free family assistance program known as
9 Military One Source. I'll be discussing this
10 program, as well as the Military Family Life
11 Consultant Program, in greater detail on Wednesday
12 morning. Until then, in a nutshell, Military One
13 Source is available by phone, by mail, online, and
14 through face-to-face counseling sessions to
15 provide support to Service members and families at
16 no charge. Whether it's help with child care,
17 personal finances, emotional support during
18 deployments, relocation information, or resources
19 needed for special circumstances the program is
20 there for military personnel regardless of their
21 activation status and their families every day
22 24/7, 365 days a year. Access to this type of

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1 support is particularly important for family
2 members of those who are serving in the National
3 Guard and Reserve units who may live far from any
4 military installation and related programs and
5 services.

6 Another program that provides direct
7 support services is the Military Family Life
8 Consultant Program. Military life consultants can
9 be made available at locations where there is a

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10 need. They are licensed professional counselors
11 available to provide short-term consultation, life
12 coaching, and problem- solving support, if you
13 will, on a confidential basis. Their method is
14 sometimes described as preventive social work by
15 walking around, because consultants meet with
16 Service members in their environment, such as the
17 motor pool or at the Burger King, in a
18 non-intrusive way. These professionals provide
19 conversation and have the skills to make this
20 transition time easier and less stressful for
21 everyone involved.
22 Services the consultants offer include

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1 workshops, group discussions, personal
2 consultations, activities, and organization tips.
3 These services are confidential and free to the
4 individuals and family members. As with Military
5 One Source master's-level consultants,
6 consultation is provided on a confidential basis
7 with the exception of duty to warn. Issues such
8 as intent to harm, child abuse, and domestic
9 violence are referred.

10 Often the primary need for daily problem
11 solving is simply information. Technology, the
12 internet in particular, provides an incredible
13 opportunity for reaching people at a time

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14 convenient to them. The challenge, as I'm sure
15 you have seen, is locating accurate, timely
16 information. So, you have information about
17 MilitaryHOMEFRONT. That's the official Department
18 of Defense website for reliable quality-of-life
19 information.

20 With the focus on news you can use,
21 information is tailored for three specific groups:
22 Service members and their families; their leaders;

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1 and service providers. Information for Families
2 addresses a full range of topics from the first ID
3 card to transition to civilian life. For leaders,
4 this site provides official quality-of-life
5 program information and resources for troops and
6 families.

7 For service providers, MilitaryHOMEFRONT
8 provides desk guides, policies, instruction,
9 legislation, references, forms, and other
10 information from the Service branches and the
11 Department of Defense all to ensure Service branch
12 and installation program managers have the most
13 up-to-date, accurate resources.

14 Frequent family separations and their
15 requirement to move on average every three years
16 places military families in situations not often
17 experienced in the civilian world. For this

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18 population, finding affordable, high-quality child
19 care is paramount if they are ready to perform the
20 mission and their jobs. It is also important to
21 military personnel that child care services be
22 consistent and uniform at installations throughout

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1 the military. Service members tell us that they
2 are better able to do their jobs when they know
3 their children are receiving high-quality care.

4 There are four main components that
5 comprise the Department of Defense's model for the
6 nation, Child Development System. These are child
7 development centers, family child care homes,
8 school-age care, and resource and referral
9 programs. Through these four systems of delivery,
10 the DoD serves more than 200,000 children ages 6
11 weeks through 12 years each day.

12 Commands and installations also use
13 creative problem solving to meet the needs of
14 families not yet using these programs. At Fort
15 Lewis, Washington, for example, a special program
16 for spouses and deployed Service members, called
17 Rainbows and Raindrops, offers a structured play
18 setting for children. Parents have an opportunity
19 to play with their children alongside other
20 adults. The program connects young children not
21 receiving care in the child development system

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1 of isolation often felt by the sometimes single
2 parent.

3 Another program at Fort Campbell,
4 Kentucky, offers a fitness program for the spouses
5 of deployed Service members. Fitness equipment is
6 provided on one side of the building and
7 short-term child care is available while Mom or
8 Dad exercises. The program offers stress
9 management activities for parents and quality
10 child care for their children.

11 Neither program required a great deal of
12 startup funding. Both used existing resources to
13 match a program with a need. These are two
14 programs recently brought to my attention. I'm
15 sure that there are many others like them out
16 there, because each of the military departments
17 has built highly responsive family support
18 systems.

19 As you visit military installations, I
20 behoove you to take note of innovative approaches
21 to support Service members and their families
22 across disciplines. These best practices can be a

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1 rich resource for policymakers, as well as those
2 who are on the front line at the installation
3 level.

4 Our work will not be effective if it is
5 done in a vacuum. It requires integration,
6 collaboration, and communication with all
7 resources, including a partnership with a clinical
8 component. What we offer through the delivery of
9 services, education, and promotion of healthy
10 choices is part of a responsive continuum. If
11 those actions fail, we are responsible for
12 reporting to the appropriate entity so that
13 clinical intervention can take place.

14 Collectively, we are working hard to
15 better understand, prepare for, and respond to the
16 needs of Service members and their families inside
17 and outside the traditional military community.
18 One such effort is joint agency work with the
19 Center for Study of Traumatic Stress at the
20 Uniform Services University and Health Affairs.
21 In October we identified specific action items
22 aimed to impact educators, child and family

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1 programs, DoD, and community leaders and health

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2 care organizations. The work is organized under
3 three main initiatives -- education and
4 consultation, knowledge acquisition, and community
5 development. The group members recognize the
6 importance of using those resources that are of
7 high quality rather than developing new materials,
8 identifying public and professional messages, and
9 using best practices of information distribution.
10 This includes partnering with established systems
11 within military communities, as well as through
12 federal, state, and private sector agencies. We
13 look to continuing this effort to deliver services
14 that are responsive. When we take care of the
15 children of the total force, we really do take
16 care of the total force.

17 The criticality of this need is
18 reinforced by a comment made several years ago by
19 Charles Moskos, Professor Emeritus of Sociology at
20 Northwestern University. He said, "While many
21 civilian occupations share some of the demands
22 that are typical of a career in the armed forces,

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1 including geographic mobility, residence in
2 foreign countries, risk of injury or death,
3 frequent separation from family, and role
4 pressures, the military is unique in that all of
5 those demands can be asked of a Service member at

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6 the same time."

7 Change is difficult, and we have a lot
8 of it via joint basing, unpredictable world
9 circumstances, transformation that is currently
10 underway, and the global war on terrorism. We in
11 the Military Community and Family Policy Office
12 are committed to doing all that we can to mitigate
13 the stressors associated with military life --
14 empower our troops and families to facilitate
15 resilience and to move forward. It's not only the
16 right thing to do for our people, it's essential
17 to military readiness and our national defense.

18 Thank you again for the opportunity to
19 share with you some of the programs and policies
20 currently underway. I'm happy to take your
21 questions.

22 Yes, sir.

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1 DR. McCURDY: MilitaryHOMEFRONT -- how
2 long has that been --

3 MS. THOMPSON: In -- I think it's been
4 -- we've been working with MilitaryHOMEFRONT I
5 would say since 2005, so it's a recent initiative.

6 DR. McCURDY: Numbers of hits do you
7 have --

8 DR. MacDERMID: Can you use the
9 microphone, please?

10 DR. McCURDY: Yeah. Just curious about
11 -- I learned that the MilitaryHOMEFRONT has been
12 operating more than a year I guess.
13 MS. THOMPSON: Year and a half.
14 DR. McCURDY: I'm curious to what extent
15 it's being used.
16 MS. THOMPSON: I can find that out and
17 bring it to me when I come back -- I can bring it
18 to the group on Wednesday.
19 DR. MacDERMID: Rick?
20 LTC CAMPISE: I'm familiar with Military
21 One Source and how it's access by the active duty
22 forces. Is there any difference between how the

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1 Guard and the Reserve access it and their rights
2 to it?
3 MS. THOMPSON: I can find that out. I
4 don't know if there's a difference, but I do know
5 -- I wanted to respond to your question that
6 regardless of their activation status, Guard and
7 Reserve and their family members have access to
8 Military One Source.
9 DR. McCORMICK: I had a question on --
10 having visited a number of bases, I've been struck
11 by the variability of the family services that are
12 available. My question really goes -- for
13 example, I've seen and I've heard from you good

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14 examples of child care. On the other hand, some
15 of us were at a base last week where there had
16 been a child care program and it was stopped
17 because of a lack of funding and, for example, the
18 attendance at the women's group went down from 13
19 to 2 because they didn't have anybody to take care
20 of their kids. Similarly, in some bases you'll
21 find the family services providing marital
22 counseling; other places they don't do counseling

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1 at all.
2 MS. THOMPSON: It depends on the
3 service.
4 DR. McCORMICK: Right.
5 MS. THOMPSON: Um-hmm.
6 DR. McCORMICK: So, my question is -- is
7 there any policy that there is a set of expected
8 services at any base regardless of which service
9 they're in or regardless of local option?
10 MS. THOMPSON: I wanted to clarify your
11 question on the child care. Is that respite care
12 above and beyond the normal duty day -- is what
13 you're talking about?
14 DR. McCORMICK: No, this was child care
15 -- at this particular base they had had a program
16 where they had money, actually trained some of the
17 wives on post to become certified child care

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18 people, and then if a wife happen to be Marine,
19 the Marine is deployed, the wife needs counseling,
20 she could drop the child there and go get
21 counseling.
22 MS. THOMPSON: Um-hmm, um-hmm.

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1 DR. McCORMICK: That was -- we were told
2 that was dropped recently because they lacked
3 funding to continue. So, it was very time
4 limited.
5 MS. THOMPSON: So, that was an
6 additional -- I mean, I'm trying to figure out is
7 this an additional --
8 DR. McCORMICK: I don't know that.
9 MS. THOMPSON: Yeah.
10 DR. McCORMICK: I'm just saying -- I'm
11 just looking at it from the point of view -- I'm
12 not looking at it from the point of view of the
13 bureaucracy and its programs. I'm looking at it
14 from the point of view of the E-2 Marine's wife --
15 MS. THOMPSON: Right, right, right.
16 DR. McCORMICK: -- who needs to drop the
17 kids off to get services.
18 MS. THOMPSON: Because we're looking
19 child care as an employer -- you know, as -- for
20 them to do their jobs, and this would be an
21 additional resource and so when you say the child

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care was stopped, I really wanted to clarify that

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1 it's -- that it was the additional respite care
2 that was offered to deployed Service members'
3 families.

4 DR. McCORMICK: Right.

5 MS. THOMPSON: Okay.

6 DR. McCORMICK: But, again, my basic
7 question is -- is there any set expected array of
8 services across facilities and across services
9 and, if not, why not?

10 MS. THOMPSON: The way the family policy
11 works is that as long as it's provided we're not
12 dictating where it's provided. Right now we're
13 going through this whole issue with joint basing,
14 and we've -- you know, we're seeing that depending
15 on the service we -- they all offer, let's say,
16 counseling, but some -- like, for example, the Air
17 Force offers it in the hospital versus the Navy
18 offers it in the Fleet and Family Support Centers.
19 So, what we're seeing is that everybody is
20 offering these services. Where they're delivered
21 can be different.

22 DR. McCORMICK: Well, I have to tell

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1 you, there are Air Force installations where
2 there's marital counseling, no marital counseling
3 offered at all.

4 MS. THOMPSON: In the hospital.

5 DR. McCORMICK: On the base.

6 MS. THOMPSON: Okay. You know, and that
7 -- you know, that's -- it's not a family policy to
8 dictate that counseling is offered.

9 LCDR WERBEL: If I might follow up on
10 that.

11 MS. THOMPSON: Um-hmm.

12 LCDR WERBEL: You'd mentioned that there
13 are the four systems of child care available.

14 MS. THOMPSON: Um-hmm.

15 LCDR WERBEL: Is it policy that those
16 four systems be offered everywhere, or those are
17 just four options that different installations can
18 choose from?

19 MS. THOMPSON: You know, it's really --
20 that's a -- it's service specific. We say you can
21 offer it. It depends on, like, if there's housing
22 to be able to have a child development home

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1 program. There are reasons that may preclude SOFA

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2 agreements. For example, in Italy, we can't offer
3 child development homes or family child care
4 homes, so a lot of it is not just that it's a
5 policy to say you have to have the four delivery
6 systems as how do you maximize the availability of
7 space through the best methods that you can at
8 your installation. So, some of the issues are not
9 dictated by policy; they're dictated by the local
10 circumstances.

11 DR. MacDERMID: One of the things that
12 you talked about was coordination between the
13 folks who provide all of these support services
14 for families and clinical mental health providers.
15 Our sense has been that there's also variability
16 there and sort of how that happens and who does it
17 and when it happens. If you were going to design
18 what the relationship should be between the family
19 support arm and the clinical mental health arm,
20 what recommendations would you hope that we would
21 make or what policies would you like to see put in
22 place with regard to that?

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1 MS. THOMPSON: Well, I -- you know,
2 going through the recent work that we're doing on
3 joint basing, I think all of the Services agree
4 that we need to have a non-medical, clinical
5 support service in our Family Centers, so the Air

6 Force has mentioned it to me that it's because of
7 lack of resources that they do not do that but
8 they would love to see the possibility of having
9 the military family life consultants be available
10 in Air Force programs. We all recognize that
11 early prevention is critical and may preclude the
12 escalation of the intervention if we can get to
13 families at an earlier stage, so I don't think
14 there's any doubt in all of the Services' program
15 managers that the Services really need it.

16 My recommendation is how do we
17 consistently provide it in family programs that
18 kind of mirrors what we've done in children and
19 youth programs, that, you know, when you're on an
20 installation you can basically expect to see a
21 certain level of child care availability,
22 affordability, and quality. I think the family

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1 programs are very disparate in that regard, and
2 we're working to -- we're in the process of
3 rewriting the directive, which is going to become
4 an instruction in trying to provide more systems
5 and more stability across the services so that it
6 is a service that families can achieve wherever
7 they're located so that they know the services are
8 available.

9 DR. MacDERMID: Angela?

10 COL PEREIRA: The six prepaid counseling
11 sessions for National Guard and Reserve troops and
12 their families -- are those associated with
13 Military One Source?

14 MS. THOMPSON: No. There's two delivery
15 systems for the Guard and Reserve. One is through
16 the Military Family Life consultants, and one is
17 through Military One Source. So, there are
18 different contracts.

19 COL PEREIRA: This is through the Family
20 Life?

21 MS. THOMPSON: Family Life consultants.
22 We will actually deploy consultants to go to a

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1 unit. Let's say you're having a drill weekend or
2 -- for example, we just sent two grief counselors
3 to Minnesota because they had three deaths in
4 Minnesota, so we sent two counselors to attend the
5 funerals to be there to support the families and
6 other members of their unit. So we'll respond to
7 unusual circumstances or just reintegration or
8 reunion kinds of things.

9 COL PEREIRA: Okay, I'm speaking
10 specifically of the six face-to-face sessions.
11 Are those available at any time for members?

12 MS. THOMPSON: Yes.

13 COL PEREIRA: Regardless of how long it

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14 was since they'd been deployed?

15 MS. THOMPSON: As long as -- you know,
16 as long as they haven't been discharged from the
17 Service. As long as they're still in an
18 activation -- they don't have to be activated, but
19 they're still a member of the Guard and Reserve --
20 you can provide those services.

21 COL PEREIRA: Is there a limit to the
22 amount of times they can access that service?

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1 MS. THOMPSON: No. The issue is that
2 we're saying they can have six sessions per issue,
3 so there could be a variety of times that you
4 might seek counseling. For example, let's say
5 you're having parent/teenager communication
6 problems and you can receive six sessions on that
7 topic, and then let's say you're having financial
8 issues, so you can receive six sessions on that
9 topic. So, you can receive six face-to-face
10 counseling sessions on different topics. Now,
11 what we're finding is that with the Military
12 Family Life Consultant Program, is that it's
13 usually a very problem-solving situation, but most
14 people are not utilizing the six service -- it's
15 six times. There are usually two times and they
16 get their issues on track and a plan of action and
17 they move forward.

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LTC CAMPISE: So, these topics that they

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get counseling for, is this nonreimbursable
TRICARE diagnoses?

MS. THOMPSON: No, in fact, they are not
issues covered by TRICARE, so we're looking at

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1 them as life issues. So, like I said, in
2 communication with your children or communication
3 with your spouse or, you know, they are
4 nondiagnosable conditions. If they see that this
5 is not working, that it requires a higher level of
6 intervention, that's when they refer to TRICARE or
7 to the MIF.

8 DR. McCURDY: What's the difference in
9 that service and Military One Source?

10 MS. THOMPSON: There's no difference.
11 The only difference is we decided that we needed
12 an additional support for the Guard and Reserve
13 because of their geographic dispersity and because
14 of the level of activation. So, the Guard and
15 Reserve can access both systems. But we really
16 are using them to deploy to locations. For
17 example, we sent a group of eight to Fort
18 Wainright when they were extended. We've sent two
19 to Fort Hood when they found out that they would
20 be deploying early. And, like I said, we will go
21 to those Guard and drill Reserve weekends to

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1 issues.
2 DR. McCURDY: Good. Good.
3 DR. MacDERMID: Deb.
4 MS. FRYAR: You mentioned that family
5 life consultant counseling was confidential? Does
6 that mean there are any records kept or --
7 MS. THOMPSON: No records are kept.
8 MS. FRYAR: Unless it's a reportable
9 offense or reportable concern.
10 MS. THOMPSON: Then they do a handoff.
11 They don't keep records. They just hand it off to
12 the MIF. Each consultant has a protocol on how to
13 handle a referral at that installation, and that's
14 what they do. They'll call the MIF or they'll
15 call TRICARE.
16 MS. FRYAR: Okay, and second question in
17 regard to military life -- family life
18 consultants. As far as them going OCONUS, is
19 there a time limit for the amount of time they can
20 stay on station?
21 MS. THOMPSON: Yes. Because of the SOFA
22 agreements they cannot stay longer than 90 days,

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1 so they're rotational. In fact, we like the
2 rotational aspect across both OCONUS and CONUS
3 because we feel that it enhances the sense of
4 confidentiality, and it also gives a fresh
5 perspective on what can be offered and different
6 specialties can be brought into the picture. But
7 there are some issues with SOFA agreements in the
8 overseas arena.

9 DR. MacDERMID: Barbara, can you talk a
10 little bit about the tension between the lack of
11 keeping records and how it prevents -- it
12 preserves confidentiality and reduces stigma
13 versus the concerns that might be raised by not
14 being able to have good continuity of care because
15 there aren't records at the handoff and that sort
16 of thing? I'm sure you've talked about that.
17 What are your thoughts?

18 MS. THOMPSON: And, again, I think we
19 want to remember that these are life coaching.
20 We're trying to get people to think about their
21 issues, come up with a plan of action, and then
22 maybe have a subsequent meeting with them to see

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1 how things are going. It's not used as long-term

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2 intervention. That is not the purpose of this
3 program. And so you see a lot of times it's used
4 not only with individuals or with families, but
5 it's used in group situations, so there'll be
6 support groups going to family readiness meetings
7 or they're going to the Family Centers with a
8 group of new parents or, you know it's -- so, it's
9 more of a group approach, although the individual
10 capacity exists. We wanted to make it very clear
11 that there was a difference between what you would
12 you receive at an MIF or TRICARE and what this is,
13 and we look at this as family support, and so it
14 means that it can be anonymous.

15 DR. MacDERMID: Aaron?

16 LCDR WERBEL: I have two questions, one
17 regarding also the Life Consultant Program. One
18 is are those individuals sent out at the
19 initiative of the command organization requesting
20 that someone be sent or primarily, as it sounds
21 like we've heard from the examples so far, at the
22 initiative of the headquarters or DoD sending them

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1 to locations?

2 MS. THOMPSON: No, they come in with a
3 request. So, for example -- unless we know of an
4 unusual circumstance, such as we offered the Army
5 do you want additional support at Fort Wainright

6 when we heard about the extension. But for the
7 most part, the service -- we have service POCs who
8 come to us and say we need support at these
9 locations regarding these issues and how can you
10 support us? So, the Army has been the biggest
11 user of our program. We have placed counselors at
12 Katrina sites for the Navy, and we have what we
13 call On Demand for the Guard and Reserve where
14 they call up and say can you come for this week
15 and event or can you come to support this issue.
16 We've had two pilots with the Air Force -- one in
17 PACAF and one in USAFFE at small locations, and
18 we're evaluating the response that the Air Force
19 that it was working. So far it's been very
20 positive. And we're seeing how we can better the
21 services to make sure that we have sufficient
22 numbers at locations that need them.

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1 LCDR WERBEL: And the second question
2 you started to address, actually, a little bit
3 there with the Air Force, and maybe that's the
4 only example of it so far was the -- (off mike)
5 and appeal of a program like this is very good and
6 it sounds like a great program much in the way any
7 of the therapy-by-walking-around programs sound
8 great. Also when we -- when there's a crisis in a
9 school system we are inundated sometimes with

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10 counselors and you get problems, and then there

11 have been studies that have shown that some of
12 those interventions are a little counterproductive
13 and aren't so effective. So, I was wondering if
14 there have been some studies that have -- where
15 you've attempted to demonstrate the efficacy of
16 the Life Consultant Program

17 MS. THOMPSON: We're in the process of
18 doing that right now. We've awarded a contract to
19 Virginia Tech to do an evaluation of the program.

20 LCDR WERBEL: Is that a -- what stage is
21 that at? Just been awarded and they're going to
22 start doing it?

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1 LTC DOUGLAS: It just -- it's not even
2 been -- you know, it's just starting. I mean, the
3 Military Family Life Consultant is, let's see,
4 two, almost two years old.

5 LCDR WERBEL: Thank you.

6 LTG KILEY: This may -- you may be in
7 the process of answering that with the Virginia
8 Tech study, but my question is slightly different,
9 which is how do you document the quality of the
10 services delivered by these counselors? Is it
11 just it sounds like a great idea and we'll send
12 them up to Alaska? It's an outcomes-based issue
13 also.

14 MS. THOMPSON: Right. We get reports of
15 how many encounters we've tracked, the data, as
16 far how many people they've seen. We get feedback
17 from -- they're usually placed with the Family
18 Centers, so we get feedback from the ACS director,
19 and then we recently started a quality assurance.
20 We're actually sending a clinician out from my
21 office to go to the installations to do an
22 assessment of how well they're used, are they

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1 productive, are they meeting the intent, are they
2 -- you know, what we've said very clearly is these
3 counselors are not additional admin people in the
4 Family Centers. They are clinical counselors.
5 They are not to wear that hat, but they have that
6 skill set, and so they should be used effectively
7 in that regard. But that is just -- we -- the
8 last two years have been built in getting the
9 program up and out and moving forward, and now
10 we're kind of -- I guess the best mode is
11 assessing and evaluating and trying to figure out
12 what is the best approach to maximizing this
13 resource.

14 LTG KILEY: Thank you.

15 DR. MacDERMID: Anybody have anything
16 else?

17 MS. THOMPSON: Great. Well, I'll see

18 Washington DC 20061218 TF meeting transcripts FINAL.txt
you on Wednesday.

19 COL PEREIRA: Oh, I had one more. It
20 sounds like you've got some very -- we have some
21 very good policies and programs. What areas would
22 you see that we need to make improvements for

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1 families and mental health?

2 MS. THOMPSON: I think across the board,
3 even with our family programs, we have to do a
4 much better job in letting families know what is
5 available to them and how they can access it and
6 how we can tailor it, whether it's an issue of
7 child care. Because they don't have child care,
8 that means they can't go to the support programs
9 that are available. I am very excited for a
10 couple of reasons, working with COL Ireland and
11 Dr. Cozza at the Center for Traumatic Stress,
12 really synergizing our efforts between helping the
13 education and the family support side, work with
14 the mental health community so that we have best
15 practices in place; that we're training our people
16 with the best information; that we can be a
17 buffer; and that we can support families in a
18 different way than the mental health community
19 can. And I think that's -- the whole idea is how
20 can we collaborate across these disciplines to
21 share information and to say we are all in this

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together and if we work together we'll more

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1 effectively take care of our families. And I
2 think that just takes time and effort to sit down
3 at the table together to find out what is really
4 needed at a certain -- and whatever the
5 installation is; whatever the need is; what are
6 the strengths; what are the weaknesses; and how
7 can we build on each other's support systems to
8 make better delivery of care happen.

9 DR. MacDERMID: We've been struggling
10 with, actually, what term we should use to refer
11 to this landscape --

12 MS. THOMPSON: Right.

13 DR. MacDERMID: -- because it's clear
14 that mental health in the military does not just
15 get taken care of in MIFs. But we also know that
16 that term has become synonymous in some ways with
17 a certain part of the system, so we've been
18 debating about what language can we use to make it
19 clear that we're referring to the whole landscape.

20 MS. THOMPSON: Right.

21 DR. MacDERMID: Do you have any
22 suggestions for us?

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1 MS. THOMPSON: No. I'll leave that up
2 to the experts. I mean, it is. It's a continuum
3 of care. It's -- you know, and we see ourselves
4 at the very beginning of that support system that
5 can be the buffer, that it doesn't escalate to a
6 higher level of intervention. That's what we hope
7 to achieve with family programs and children
8 relief programs, quality- of-life programs.

9 DR. MacDERMID: Well, if you have any
10 brilliant ideas between now and Wednesday, we'll
11 be happy to hear them.

12 MS. THOMPSON: I'll put all our creative
13 people onto it.

14 DR. MacDERMID: Thank you.

15 MS. THOMPSON: We struggle with this
16 nonmedical counseling. What does that mean? You
17 know, I mean, you know, is that a confusing term
18 for families? You know, we're trying to make sure
19 that we stay in our lane versus our mental health
20 counterparts so that they don't confuse the two
21 systems.

22 DR. MacDERMID: Okay.

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1 MS. THOMPSON: Okay, great.

2 DR. MacDERMID: Thank you very much for
3 visiting us.
4 MS. THOMPSON: Thank you.
5 DR. MacDERMID: See you again on
6 Wednesday, yes?
7 (Applause)
8 DR. MacDERMID: In a moment we'll take a
9 break, but let me just announce that COL Engle is
10 stuck in traffic and will not be here in time for
11 his presentation, but MAJ Werner is here, so we're
12 going to flip-flop those two presentations and at
13 1430 MAJ Werner will speak and then hopefully COL
14 Engle will have extricated himself in time for
15 1500. So, take a 15-minute break.

16 (Recess)
17 LTG KILEY: Why don't we go ahead and
18 get started again, please.
19 DR. MacDERMID: Our next speaker, as I
20 announced just before the break, will be MAJ
21 Christopher Warner from Army Operational Mental
22 Health.

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1 LTG KILEY: It's you, MAJ Warner. Why
2 don't you come on up here to the podium. Why
3 don't you go ahead and introduce yourself and tell
4 us who you are and what you've been doing.
5 MR. WARNER: Yes, sir. Good afternoon,

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6 everyone. I'm MAJ Chris Warner. I'm the division
7 psychiatrist for the Third Infantry Division out
8 of Fort Stewart, Georgia. I'm going to talk you
9 here very briefly about operational behavioral
10 health in the lessons we came up from Task Force
11 Baghdad during our deployment to Operation Iraqi
12 Freedom III. This briefing was prepared by myself
13 and the division surgeon, LCOL George Appenderer,
14 who is not here today.

15 Next slide, please. We'll cover here
16 during the course of this briefing just a brief
17 overview. I know a lot of your focus so far as
18 part of this has been in reference to what happens
19 with MIF care. Operational behavioral health for
20 the Army is a different aspect. We are -- I do
21 not belong to the Medical Command. I do not
22 belong to the hospital. I am under the command of

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1 an infantry line commander, and that's where I
2 work, so we're going to talk about a little bit of
3 the nature of that. We're going to go through
4 some of the lessons of what we saw during our
5 deployment to Operation Iraqi Freedom and really
6 emphasize our redeployment efforts coming back in
7 late 2005, early 2006, including some of the
8 statistics of what we saw and some of the
9 interventions that we made and then close out by

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10 talking about the lessons learned and where we

11 think we did well and what we need to work on in
12 the future.

13 Next slide, please. So -- just so you
14 understand, we have a two-

15 Part mission. We are not a -- we are
16 not just in the business of providing care. We're
17 also in the business of advising commanders. We
18 are responsible -- next slide, please. If you
19 look at the structure here, each brigade -- and,
20 of course, the Army has become very
21 brigade-centric. They're what's called brigade
22 combat themes, which are normally 2500 to 3500

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1 soldiers that design to deploy in this type of a
2 modular format. Each of those brigades is
3 equipped both with a behavioral science officer as
4 well as an NCO or mental health technician.

5 Thank you, sir. Each brigade has that
6 capability, and then each division has a
7 psychiatrist and NCOIC that provide overview. And
8 this is the structure of what we took with us to
9 deployment to Iraq. Two things to consider --
10 number one, the Aviation Brigade, as you see, has
11 no assets assigned to it directly, as well as a
12 change that's occurred since our return is in the
13 new structure, the Division Support Brigades.

14 These have evolved to Support Unit Activity or a
15 Sustainment Brigade, and these units now have no
16 units when they're in CONUS, but they are plussed
17 up with mental health teams once they deploy.

18 Next slide, please. So, as part of our
19 prep in getting ready to deploy -- and this was
20 before I joined the unit -- I think the first and
21 foremost and the one thing I can cover enough
22 times -- I can't say enough here -- is the

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1 importance of commander emphasis and getting
2 commander buy-in. Our previous commander, MGEN
3 William Webster, gave a great amount of emphasis
4 to mental health care and to behavior health,
5 readiness of the soldiers, as well as the
6 commanders, and he put great emphasis on educating
7 commanders all the way down to the company level
8 to make sure they understood what expectations and
9 stresses are going to be placed on family and on
10 soldiers and how to deal with them, as well as how
11 to access resources. They not only went there,
12 but they went to the senior family readiness group
13 leaders, too, who are the people that are going to
14 be encountering the front lines of the home front
15 stress. As you'll see, that's an issue coming up
16 -- also, put together programs for leaders
17 encountering stress during command and during

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18 their deployments to make sure they understand how
19 to cope and alleviate stress and deal with it.
20 And then the last thing is with the new
21 brigade-centric Army and being the first division
22 to convert to the brigade combat team structure,

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1 this makes a little more of a challenge of
2 integrating, coordinating resources, as you're not
3 going out as a division as a whole.

4 Next slide, please. As you can see very
5 briefly here, this was the structure of Task Force
6 Baghdad, which was under MGEN Webster's command.
7 Specifically, our first and third brigades did not
8 deploy with us. They were under the command of
9 the 42nd Infantry Division, but we also took on
10 units that did not belong to us and were not with
11 us at Fort Stewart or Fort Benning. In all, we
12 had approximately on average 25,000 soldiers
13 deployed. They came from nine different duty
14 stations, and we also had two reserve units,
15 including the 48th Brigade Combat Team and the
16 256th National Guard Unit out of Louisiana.

17 Next slide, please. During the course
18 of the 12-month deployment, you can see this was
19 our overall utilization. We had over 22,000
20 encounters from our team that was out there. Now,
21 this includes all forms of care. This includes

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1 education, and sensing sessions, as well as any
2 referrals that were done during our
3 post-deployment health assessment process in
4 coming home. As you can see, there's definitely
5 an increase going through the first couple of
6 months.

7 There are a number of explanations.
8 First of all, a soldier's -- it takes them a
9 little while to learn where and how to access the
10 resources once they get into theater, as well as
11 it takes the behavioral health resources a little
12 bit of time within the division to get stood up.

13 Secondly, the first 90 days soldiers are
14 just trying to learn how to do their job and
15 accessing medical resources, and taking time out
16 for themselves is a little more difficult versus
17 once they're into a little bit more of the
18 sustained deployment phase. The large spike in
19 the last month is twofold. Number one, there's
20 lots of education going on for all the soldiers as
21 part of the post-deployment -- as part of the
22 redeployment process, as well as there are a

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1 number of soldiers that are being consulted and
2 evaluated before they're coming home.
3 Next slide. Here you can see this
4 breaks down our clinical contacts. In total we
5 had approximately 5500 total clinical contacts
6 with the soldiers during the course of the
7 deployment. Approximately 80 percent of them were
8 for combat operational stress reactions. Another
9 20 percent were for diagnose psychiatric
10 disorders. Again, what you can see here is the
11 first couple of months, not large numbers, and
12 then it does stabilize out. A couple of key
13 things about near the end of the deployment.
14 Third Infantry Division and Task Force Baghdad
15 were responsible for three elections over the
16 course of 2005 --
17 Yes, sir.
18 DR. McCURDY: Remind me of the
19 denominator here -- 25,000 (off mike)?
20 MR. WARNER: There was a total on
21 average of 25,000 soldiers. That's correct, sir.
22 So, approximately 20 percent we had

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1 seen. All right, next slide, please. We also

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2 took these numbers of the soldiers we saw for

3 combat operational stress reactions and looked at
4 what is the primary stressor that they're being
5 affected by. The blues represented by home front
6 stress -- that can be anything from having a
7 family marriage to kids having problems in school
8 to spouses having difficulty or financial problems
9 at home. By far, that was the number one
10 stressor, and as you can see over especially the
11 latter course of the deployment, there definitely
12 is a rise in the stress that our soldiers are
13 experiencing from the home front. As we prepare
14 to redeploy to Iraq, this is one of the areas
15 where we are very much focusing on what can we do
16 on division side to help decrease this stress, and
17 it's an area that our leaders are focusing on what
18 can they do as the line leaders to help decrease
19 stress that's placed on our soldiers and decrease
20 stress placed on our families, because our belief
21 is if we decrease the family stress, it's going to
22 make our soldiers more combat effective, because

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1 there's going to be less stress on them. As you
2 see, the combat stress represented by -- or the
3 combat exposure represented by the yellow is due
4 to a large amount of operations near the end. We
5 had two elections within the last three months,

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6 including one within three to four weeks before we
7 redeployed.

8 Next slide, please. This just gives a
9 brief overview of the treatments that were
10 provided by the division behavior health team in
11 theater. Obviously, the combat operational stress
12 control principles, including the implementation
13 of the PIES or the BICEPS, depending on which
14 literature you look at -- the PIES -- principles
15 of proximity, immediacy, expectancy, and
16 simplicity -- those basic principles that have
17 been around since World War I and World War II --
18 but one of the abilities we have in the current
19 structure, especially having FOB based where we
20 now have established positions where we can set up
21 hardened clinics is to be able to provide more
22 follow-on care, be able to do more follow-up, be

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1 able to actually do some short-term therapy,
2 including some cognitive inproaches(?), some
3 supportive therapy as well, and of course
4 pharmacological management when indicated also
5 with appropriate monitoring.

6 Next slide, please. This slide looks at
7 just our mission noncapable soldiers for mental
8 health reasons. As you can see, we talked about
9 the fact that 5,000 soldiers were seen over the

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10 course of deployment for behavioral health issues.
11 However, a very small percentage of them were
12 mission noncapable. Mission noncapable is
13 represented by the blue. These were soldiers that
14 were incapable of doing their job, be it they
15 weren't -- they had to be restricted from carrying
16 their weapons; they potentially couldn't handle
17 ammunition; or they weren't able to go out and
18 function in their duties. Many times, these
19 soldiers were returned to duty. It was less than
20 20 percent of those who returned to duty as
21 mission noncapable that were mission-- deemed
22 mission noncapable a second time. If deemed

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1 mission noncapable a second time, they were
2 evacuated from theater. In all, we had 16
3 soldiers from Task Force Baghdad evacuated from
4 theater for mental health reasons.

5 Next slide, please. I'm going to
6 transition here, talk about our redeployment plan.
7 This was probably one of our biggest endeavors as
8 we began to look at things, and the first and
9 foremost thing that we did was we got all of our
10 behavioral health resources in theater together to
11 develop a plan of how could we effectively
12 transition this unit home and minimize the stress
13 and also best set our soldiers and their families

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14 up for success as part of the reintegration

15 process in coming home. We looked at the assets
16 that we had both in theater and at home, and of
17 course in theater you have not only your chaplain,
18 your medical, and your mental health resources,
19 once you get home there are there are a lot of
20 other support resources.

21 Next slide. Those I'm sure that you're
22 talking about over the course of your

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1 investigation, including such organizations as the
2 MEDDAC, the MIFs, the Military -- the Army
3 Community One Source and the Military One Source
4 programs, as well as many others. One that we
5 honed in on that we thought we could effectively
6 use was the Military One Source program, and I'll
7 mention that a little bit more here as we go.

8 Next slide, please. From our focus, we
9 wanted to look at a three-

10 Tiered approach. We wanted to make sure
11 we were properly educating our soldiers, their
12 families, the providers. We wanted to do
13 everything we could to early -- to identify early
14 any ongoing issues so that we could address them,
15 and we wanted to get appropriate treatment out to
16 these soldiers, and our goal to the commanders,
17 our goal to the soldiers all along was we are --

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18 the stigma that comes with mental health many
19 times is this concern that it's going to end their
20 career, it's going to have some impact on them,
21 and the goal -- we always sold it to the
22 commanders as was we want to get your soldiers up

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1 to continue doing what they're doing, continuing
2 to be good, strong soldiers -- as well as we want
3 to minimize the impact on the soldiers, their
4 families, and their community in terms of
5 potential long-term impact from these deployments,
6 and we felt the best way to do that was getting
7 these conditions identified early.

8 So, from the standpoint of education --
9 next slide, please -- from the standpoint of
10 education we had multiple initiatives. The first
11 was we developed a theme for the redeployment, and
12 that was called the Mission of the Battle Buddy.
13 Our feeling was these soldiers had spent the last
14 year emphasizing that the Battle Buddy was there
15 to look out for each other. You made sure, you
16 know, you watched somebody's weapon when they went
17 into the latrine; you took care of each other; you
18 were looking out for each other over there. Why
19 did that end just when you come home? We felt it
20 doesn't. We felt that it's the Mission of the
21 Battle Buddy to keep looking out for each other

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throughout this redeployment process.

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1 We had some grand visions that did not
2 go through that included things such as soldiers
3 who were going to be moved from one unit to
4 another or that were going to be PCS. Ideally, we
5 would have liked to see them do that in their
6 Battle Buddy team still. The logistics of that
7 and the nightmares that that would created for G1
8 and our personnel folks was a little bit too
9 difficult, but this was the general focus, and it
10 went in terms of advertising. The poster that you
11 see the left -- on your right -- is the -- was a
12 poster that was displayed throughout the post and
13 talked about resources, gave some standard quotes.
14 We also made a similar one for the mission of the
15 military family, and again it was putting
16 advertisement out there. We advertised on the
17 local TV -- what we call Marne TV -- and we also
18 looked at other in initiatives. GEN Webster
19 created the Dogfaced Soldier Promise. Third
20 Infantry Division, the division motto is "Rock of
21 the Marne" dating back to their history in World
22 War I, and they were nicknamed at that time as GEN

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1 Pershing's dogfaced soldiers, and since that's
2 been part of our division history, so hence the
3 name. The Dogfaced Soldier Promise was an
4 initiative, a contract between the soldier, his
5 Battle Buddy, his commander, and his first
6 sergeant, where they pledged six things of I will
7 not drink and drive; I will not harm myself; I
8 will ask for help if I need -- basically a
9 contract for safety but that the soldier signed,
10 his Battle Buddy signed with the responsibility to
11 look out for the soldier and that the command
12 signed that they would not punish the soldier if
13 they came asking for help. Obviously, if the
14 soldier gets the DUI it's a little bit late to be
15 asking for the help, but that it was -- and it
16 continued -- numbers and the resources for the
17 soldier to contact, including phone numbers to
18 call, and if there was a problem, if they got
19 themselves intoxicated and did not feel
20 comfortable driving, this was a place to call.
21 The cards were drilled down to where it was
22 company specific, so each company had their own

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1 cards and their own contract and we made a big

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2 presentation of each signing and sitting down and

3 having the commander sign that with the soldier,
4 and these were done during the first few weeks of
5 the redeployment.

6 We developed a number of handouts also.
7 Probably our most successful one was a trifold
8 that talked about -- on one side gave 10 basic
9 questions on what to expect; what are the common
10 things encountered; when should you get access to
11 resources; and how do you get to them on the back.
12 We put all of the specific resources to that post
13 and the phone numbers and how to access them and
14 then one for national resources, including
15 websites. We made this for all nine installations
16 for the soldiers coming back.

17 This is where we utilize Military One
18 Source. I only go to Fort Stewart and Fort
19 Benning. I can't get to Fort Lewis, to Fort
20 Bragg, to Fort Campbell very easily, so we
21 incorporated Military One Source to actually take
22 on the cost of producing the pamphlets for us. We

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1 let them put their name on it, and then we had
2 them, as part of our reintegration process there,
3 handing these out and giving them out, so they saw
4 the active duty military side of the presentations
5 while they were still in theater, but they also

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6 saw the Military One Source folks and the civilian

7 side coming in and offering resources and all of
8 us saying the same things: We don't care where you
9 get the help; we just want you to get the help
10 because we want you to be good dogfaced soldiers.
11 And that was our ongoing motto.

12 And then lastly was our teaching and our
13 initiatives. We put together presentations for
14 the soldiers. We incorporated the Battle Mind
15 training, which I'm sure you're going to hear
16 about. We also really focused in on continuing to
17 educate the commanders and the unit leaders. I
18 think if we really want to make a difference in
19 decreasing stigma of mental health care, we've got
20 to get command buy-in, and one of the things we've
21 been most successful with at 3rd Infantry Division
22 is having the commanders buy in from the top down,

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1 and that makes a difference in terms of the whole
2 attitude of -- the soldiers are going to be less
3 concerned about seeking the mental health care if
4 they don't think the commands are going to punish
5 them or they're going to be labeled as having a
6 problem

7 And then we also pushed out education to
8 the providers. I'm only one psychiatrist for an
9 entire division of 20-25,000 soldiers. As much as

10 I'd like to, I cannot take care of all of them at
11 all times, and so making sure we're providing the
12 best education to our family physicians, to our
13 unit providers was one of our key goals also.

14 Next slide, please. I'm going to
15 briefly talk about the PDHA.

16 I'm sure you have heard about this. One
17 thing that we did a little bit unique was we
18 actually used it as a restratifying tool. We
19 evaluated the soldiers while they were in theater,
20 and they went through there face to face. At each
21 location where they did their face- to-face
22 encounter with their provider, we put a behavioral

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1 health team on site. We developed standardized
2 criteria that if the soldier answers these
3 questions in this way, they must have a referral,
4 and we made it so that this was just the way it
5 was. It wasn't a big deal. Look, you just need
6 to go talk to someone and we've got them right
7 there on site, and they went in and talked with
8 our providers that were there. The process was
9 completed before they ever left the building, and
10 during that the goals of the consults were not to
11 do full history and physicals but, rather, do a
12 safety evaluation, make sure the soldiers were
13 aware of what resources we think would help them

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and how to access them once they got home.

15 Next slide, please -- as red, yellow, or
16 green. Red were the soldiers we were most
17 concerned about as potential risks to harm
18 themselves or harm someone else when they got
19 home. For these soldiers that we deemed as red,
20 we actually prepared command-directed packets, and
21 we had set up that when they landed, before they
22 ever went through their homecoming ceremony they

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1 were evaluated by a behavioral health provider
2 before they went home on day one.

3 For the yellow soldiers, these were
4 soldiers that we thought -- these are guys that
5 were having some problems -- there's a lot going
6 on, we'd like them to really get engaged in care.
7 And so what we developed was for these soldiers,
8 their home station mental health resources would
9 contact them and offer them an appointment within
10 the first 14 days of being home.

11 And then, lastly, were our greens.
12 These were the people that we thought were having
13 some normal responses to ongoing effects of their
14 deployment. We recommended services; we educated
15 on them but we did not do any further outreach.

16 Next slide. So, what you can see here
17 is a breakdown of what our -- overall we had an 11

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18 percent consult rate, which was about 2,000 of our
19 soldiers -- required behavioral health consults.
20 Of that 11 percent, approximately 10 percent were
21 deemed yellow, which was an overall division rate
22 of 1 percent. Of those -- they got the 14-day

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1 callback. Of those, more than 72 percent actually
2 came in and saw a mental health for at least one
3 follow-on visit during their post- deployment
4 phase. We did not track out further to see how
5 many stayed for six sessions or ten sessions, but
6 one of our initiatives is to go back and look at
7 those soldiers at a six-month time frame and see
8 were they still having problems; how many of them
9 are still in the military; and what their -- are
10 they still able to perform their duties. But we
11 have not done that initiative at this point.

12 And then of the soldiers that we deemed
13 as red, there were 16 soldiers in all, which
14 accounted for about .1 percent of the division.
15 Many of these cases were family advocacy cases,
16 known cases of family violence or ongoing family
17 issues where we were concerned there were
18 potential issues for family violence. So, you're
19 aware our division had a double homicide after
20 OIF1, so it was an issue that they were very prime
21 for and very concerned about.

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1 did, and this was taken from U. S. Army Europe, who
2 had done this the year prior -- was a
3 decompression phase. I think this has been copied
4 or taken now from just about every division that's
5 been becoming home since, but as far as I can
6 look, it started with the U. S. Army Europe group,
7 but a -- some form of decompression. Now, it
8 varies from unit to unit how they do it. We did a
9 10-day phase. What happened when the soldiers
10 came home was on Daisy Row. They landed at the --
11 they landed at the airstrip, they walked off, they
12 turned in their weapon, they went -- they got
13 loaded on the buses about -- they sat there for
14 about 45 minutes to get everything organized. The
15 USO were there handing out cookies and all this
16 type of stuff. They got on the buses, they went
17 back to Fort Stewart, there were normally parades
18 and signs as they're coming in, then they went to
19 the field, they marched across the field to the
20 homecoming ceremony, the garrison commander gave a
21 speech welcoming them home, we all sang the
22 division song, we sang the Army song, and

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1 everybody broke and they got to go home. And they
2 went home for the next 48 hours. They were on a
3 48-hour pass at that time with their families.
4 After that 48 hours passed, they returned and they
5 started their day one activities. Day one
6 activities included a medical review. Their PDHAs
7 were reviewed by a provider again to see if they
8 wanted to change any of their answers. They went
9 through legal. They went through all the other
10 things. What you can see on the list is the
11 mandatory tasks, but a number of briefings,
12 including many of, again, the post- deployment and
13 suicide prevention briefings were integrated again
14 by providers so that the soldiers again received
15 that education.

16 Some of the feedback we got from the
17 soldiers is this was very good. They liked the
18 fact that they weren't just suddenly thrown to the
19 wind, they got time again -- oh, the other thing
20 is that these ten days were half days. These were
21 half days and they got weekends off, so -- and
22 then after this they were free to go on their

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1 block leave, which is normally anywhere from two

2 to four weeks. But it was a time that they were
3 going to spend with their unit before going away
4 for a month. It was a time to see how they were
5 adjusting and have an internal support group again
6 with their Battle Buddy but also have them
7 accessing resources. The one piece of feedback
8 we've had so far just in general was these needed
9 to be more activities that were designed for team
10 building and family fun and less "okay, let's sit
11 through another briefing" type of activities. And
12 that's one of the things we're considering -- what
13 can we do for that as we prepare for the next
14 deployment.

15 Next slide. So, all of these things --
16 did they make a difference? We don't know for
17 sure, but what we can say is between -- as we were
18 the first division to go for a second time and
19 preparing to be the first division to go for a
20 third time, we're looking at between OF1 and OPF3
21 some significant reductions in family violence, in
22 crime, as well as some other activities, including

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1 positive drug screens and such. So, with those in
2 mind, we feel like we're moving in the right
3 direction. Can we directly attribute any of these
4 numbers to these specific initiatives? No. But
5 we think all of these things combined are making a

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6 difference and are moving in the right direction

7 to help set our soldiers up for success and help
8 set our community up for success.

9 Next slide, please. As I get ready to
10 close out here, I just want to cover a couple of
11 things in sum of what we thought some our
12 successes and where we can continue to improve.

13 From the idea of soldier care, number
14 one, we thought a great success was the fact that
15 99 percent of our soldiers were returned to duty.

16 Debriefings, diffusings -- one of the
17 things we did I know that was brought up during
18 the last -- you know, is critical incidents.
19 Stress debriefing's the appropriate thing.
20 There's a lot of mixed literature on it. We used
21 our own sort of diffusing method after each
22 critical event, but the big thing we did was we

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1 worked in conjunction with the chaplains, and
2 after every soldier death, for those who were
3 directly involved, we had some sort of voluntary
4 session. We made sure our mental health folks
5 attended every memorial service so that they were
6 there, and our soldiers knew how to access. We
7 tried to identify those that we were concerned
8 about during those sessions, and what we found by
9 the end of deployments was many of the battalion

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10 commanders were following us around to see who we
11 were talking to. So, as soon as we walked away,
12 they went and checked on them. And that, to me,
13 is the bigger issue, because if the command is
14 taking care of them, if the command is looking
15 after these guys, they're going to be set up for
16 success. So, we thought that was the broad
17 variety of treatment that we could get out there,
18 as well as a lot of this data that you see? We
19 use this on a monthly basis. We are able to take
20 this back and we brief commanders on a monthly
21 basis of what was the -- to give them a finger on
22 the pulse of the behavioral health in their unit.

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1 It made impacts in how they apply their resources
2 to the extent in one brigade they actually went in
3 and changed out the battalion's area of
4 operations, because we showed: Look, sir, your
5 combat stress in this particular battalion is
6 going up; it's gone up the last three months. We
7 also can look at the safety data and say
8 safetywise you're having more accidents. They're
9 being less effective in what they're doing. And
10 in that response he said we need to move that
11 battalion out of that area, and he switched two
12 up. We saw combat stress drop. We saw their
13 effectiveness increase, and in all we were able to

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14 apply behavioral health data to help support the
15 ongoing combat mission and help protect soldiers
16 at the same time. And so I think using that type
17 of information and integrating with the commands
18 is what is unique about our role in a division
19 mental health function and what we need to
20 continue to do, but I think it was one of our
21 definite successes. I think our decompression and
22 redeployment plan definitely helped play a role

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1 and play some success but definitely continues the
2 need to be an area for continued reworking and
3 looking to find what's the best practice out
4 there.

5 Areas for improvement. Combat stress
6 detachments versus division behavioral health.
7 There sometimes can be some relationships where
8 people are butting heads. How's the proper way to
9 do it? Who's the proper people to be seeing
10 each individual? And the bottom line -- it goes
11 back to my statement: I don't care where soldiers
12 get help, as long as they get help. But I think
13 one of the things we have to continue to work on
14 is developing a good integral relationship between
15 those types of units.

16 Record keeping. I heard some comments
17 during the last briefing about that. Certain

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18 units see soldiers in theater, do not keep
19 records; certain units do, depending on the type
20 of contacts, the nature of it. Depending on where
21 that unit redeploys and where they were seen
22 depends on where the record goes to, so one of the

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1 things that we've done and how we've already
2 adjusted this is when we redeploy, all of our
3 division behavioral health units are now equipped
4 with the MC4, which is the electronic medical
5 record in deployed format. We will keep records
6 over there so that each soldier that comes back
7 will have a record from their mental health care
8 during their deployment. We'll use the same
9 standards we use for (off mike) in the electronic
10 medical record and the home station so that we're
11 able to track what was going on, what care was
12 delivered, and what the soldier had going on at
13 that point in time. I think that's vitally
14 important, because having been a doc over there
15 with them and then dealing with the
16 post-deployment effects after, one of the biggest
17 frustrations is having them come in and say well,
18 I got seen over there. Well, what did they do?
19 What happened? What was going on? I don't
20 remember. And so now you're reinventing the
21 wheel. You're having to restart. If we can

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1 we make it just like every other medical care,
2 then I think we're decreasing the stigma at the
3 same time. If I bust my knee and I go in, I
4 expect there to be a document. Why should it be
5 different from when I'm going in because, you
6 know, I'm having problems sleeping or I have
7 something going on.

8 And then also as I mentioned, the
9 decompressions in the area need to be worked on.

10 Supervision requirements of our
11 behavioral science officers. This is an issue
12 that's been resolved already. Our psychologists
13 were going over before they had their
14 unrestricted license, which meant we had to
15 arrange supervision for them while they were in
16 theater. It put our providers at risk. I can
17 personally say I got engaged in two combat
18 situations where it was because I was traveling to
19 go and supervise a psychologist. This has been
20 addressed and is being taking care of. The
21 problem with that is that now we're sitting where
22 we're not necessarily at full fill of our

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1 psychologists because we have many that are not
2 deployable at this point. So, it is a transition
3 time for the Army and is an area where we're going
4 to have to adjust, because as a result our
5 division right now is down two psychologists and
6 we're only at 50 percent strength within -- with
7 expecting a deployment in the next six to nine
8 months.

9 Next slide. From an advisory
10 consultative standpoint -- and I'm going to blow
11 through these last three -- you can see why this
12 is important to be able to consult the commands,
13 why to serve as an advisor from them. We
14 regularly were involved in the battalion update
15 meetings and the company update briefs. Those are
16 the cubs and the bubs. This is where the
17 commander's getting all this information about
18 what's going on, and we need to be part of that
19 group just as much as everybody else and working
20 with our battalion, our brigade, and our division
21 surgeons as part of the key resources for them if
22 we want to be taken seriously when things are

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1 going on. We need to be paying attention to their

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2 ongoing mission and show that what they're doing

3 is important to us.

4 Definitely getting out and doing the
5 education and involving the commands. Again,
6 areas for improvement. I can't say enough about
7 the combat stress detachments and the division
8 behavioral assets working together and the
9 recordkeeping and the supervision requirements.

10 Interdisciplinary -- next slide, please.
11 Command support was so vital. I cannot emphasize
12 enough times. That was - the number one success
13 for us as a behavioral health unit was having
14 command buy-in, and I've been very lucky. I've
15 been division psychiatrist for two years and I
16 have had two commanders who placed great emphasis
17 on their soldiers' behavioral health and looking
18 for it, and I love the fact that I get yelled at
19 for not doing enough, because I'd much rather have
20 that than have a commander who doesn't care about
21 the behavioral health of their soldiers or it's
22 not a priority to them. So, I think that's one of

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1 the things that are going very well. The
2 coordination and the integration with the
3 resources and the PDHA, as well as a planning
4 conference to get this all together so that we had
5 buy-in and everybody understanding what we were

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6 doing instead of me sitting back at the division

7 level coming up with this grand plan and then my
8 brigade officers not completely understanding.
9 Getting them involved in the initial planning,
10 they took ownership of it just -- as well as our
11 91 X-rays. Our enlisted techs were involved in
12 saying we need to do it this way, that won't work,
13 and getting them involved got buy-in and that made
14 a big difference.

15 Again, coordination with resources and
16 the coordination with the theater behavioral
17 consultant can be an area for improvement, and I
18 know that's been addressed already by COL Richie.

19 Lastly, from a logistical standpoint,
20 successes. Using the PDHA as a restratification
21 process helped to make a smooth transition; helped
22 us to make sure soldiers weren't falling through

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1 the cracks that needed care.

2 Getting Military One Source involved.
3 We're all very limited in what we have. From a
4 division standpoint, we're significantly limited
5 at times, and I was looking in the environment --
6 when we were coming home and I didn't want my
7 providers to be working. I wanted them to be
8 going and getting a chance to decompress. I
9 wanted them to have a chance to go spend time with

10 their families after spending 12 months in Iraq
11 away from them, that this was a chance for where
12 we could use resources that are there and take
13 advantage of them, and I think that's one of the
14 biggest issues where we have a lot of resources
15 there but we've got to do a better job of making
16 the link between the resources that are there and
17 the soldiers and their families.

18 Pharmacy I mentioned is a success. This
19 was an issue from MHAT-I, that there was not
20 availability of things. I had everything under
21 the sun. As a matter of fact, I mentioned as an
22 area for improvement I had too much. I had things

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1 that I don't have when I got back home. I had
2 soldiers who were being treated with medication,
3 such as Lexapro, that are not available on our
4 core formularies, and we had to deal with making
5 sudden transitions in medications or going through
6 special purchase request processes when soldiers
7 came home. Again, this is an area that I believe
8 has been addressed but was one key issue.

9 Facilities I also bring up. The bottom
10 picture on the slide there -- that was our clinic,
11 so whenever we can have -- opportunities to get
12 secure areas are good. It took us six months to
13 get that trailer. For the first six months we

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14 were working out of one room with literally
15 providers in each corner of the room. My opinion:
16 not effective; not appropriate. And so we've got,
17 again, to get our medical company commanders and
18 our medical resources working and helping us to
19 make sure we're getting the appropriate places,
20 and that's not at the large level; that's at the
21 medical company level when we're setting up these
22 facilities at the local files.

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1 All right, last slide, please. The
2 follow-on issues. We've continued to do these --
3 we've continued the monitoring; we've continued to
4 utilize following the last 12 months since we've
5 been home, utilizing updates, again advising
6 commanders, keeping them with a finger on the
7 pulse. I don't think this is something that
8 stopped with just the deployment. We need to keep
9 doing it.

10 Some of our other initiatives -- the
11 PDHRA -- we were the first large-scale
12 implementation of a division. Over 90 percent of
13 our division has completed the process, and,
14 again, we saw about 11 percent consult rate. We
15 did, again, use the same restratification process.
16 The one thing I'll say is we saw a lot more
17 yellows this time, which is appropriate. At this

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18 point, you're 90 days out. Having problems

19 sleeping, having other issues is no longer a
20 normal response to abnormal stressors.

21 And then lastly is our preparation, and
22 I think I've talked about a lot of these things

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1 already over the course of this, but incorporating
2 our lessons learned and better setting up our
3 units, our commands, and our soldiers for success
4 over the long haul with these multiple deployments
5 is vital. We have soldiers that are going back
6 for their third time to Iraq here in the 3rd
7 Infantry Division and here in many of these other
8 divisions also. We need to make sure we're
9 preparing them and giving them all of the best
10 resources so that we can take care of them and
11 make sure that they're -- that we can also give
12 the best care to their families as they're facing
13 the stress of being single parents and being
14 separated -- geographically separated spouses for
15 potentially a third time also.

16 And one of the things I think is great
17 with that is the new transition to the Battle Mind
18 training. We're no longer focusing on hey, here's
19 what's going to happen, here's what you can
20 expect, here's how to get to it. It's now let's
21 view the strengths, let's empower, let's develop

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resiliency, let's give people the ability to

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1 handle these things. And we're doing many
2 initiatives to decrease the home front stress, but
3 I don't think that's the purview at this point in
4 time, and we can talk to you when you come down to
5 Fort Stewart as part of this committee in
6 February.

7 This concludes my portion. Are there
8 any questions at all?

9 Yes, ma'am.

10 DR. MacDERMID: Could you go back to
11 your behavioral indicator stats for a moment, the
12 DUIs and etc?

13 MR. WARNER: Sure.

14 GROUP: That was it. You went by it.
15 Forward. One more.

16 MR. WARNER: Sure. It's the slide
17 labeled Impact of Changes.

18 DR. MacDERMID: Those are very
19 impressive stats. Congratulations on a job well
20 done. I assume because it was the same division,
21 the end is pretty much the same.

22 MR. WARNER: Yes, ma'am, and

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1 approximately -- I'd have to get with G1 to get
2 the exact numbers, but approximately 70 percent of
3 the soldiers that deployed to OIF-1 also deployed
4 to OIF-3, so you're looking at largely the same
5 group. Obviously there has been some change, some
6 newer recruits also, but generally a similar
7 population.

8 DR. MacDERMID: Those are wonderful
9 successes. Now, assuming that you aren't able to
10 run a regression analysis on it because you
11 probably weren't able to collect the statistics,
12 intuitively what would you say were the components
13 of your program that were most responsible for
14 these successes?

15 MR. WARNER: I think there are several
16 things. Number one, I think the decompression
17 phase is by far one of the biggest differences.
18 When they came home the first time, they still had
19 the education; they still had the briefings. But
20 getting them the time to still be around the post,
21 still be around the resources, and actually making
22 them sit through some of this -- I know some posts

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1 are doing where a hundred percent of people are

2 seeing a behavioral health provider. I know some
3 facilities are making everybody go through these
4 various aspects. But getting them into some
5 process where they have time with their units,
6 they have time to spend, and yet they're not
7 completely just -- because I think we'd be doing
8 them a disservice -- bring them home and five days
9 later they're just -- they're gone to the winds
10 for two or three weeks, two to four weeks.

11 I think the other one was using the PDHA
12 as a restratification program. By seeing all the
13 soldiers, identifying them before they came home
14 -- and we did it about two weeks before they came
15 home, so we tried to minimize how much of this
16 "well, if I tell the truth here they're not going
17 to let me on the plane." We made that very clear,
18 and during the in-brief it didn't matter what they
19 said. Everybody was going to home at the same
20 time, but it gave them a chance where it wasn't
21 we're talking to them and their spouse is waiting
22 outside the door, as soon as they're done they get

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1 to home. And at the same we put the behavioral
2 health right there. So, it wasn't "okay, we have
3 to move you to someplace else." It was just part
4 of the process, and using that, then, as a tool to
5 say here are the people that we most need to focus

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6 our efforts on I think really allowed us to

7 identify them and get them into care and get them
8 the resources before they got into trouble,
9 because many times types of things may be -- these
10 are soldiers that need help, that are unwilling or
11 don't know how to access it, and it comes out in
12 some of these behaviors and then we get them into
13 care. So, if we can make the step back and catch
14 it earlier, then I think a restratification
15 process is allowing us to do that.

16 LTG KILEY: If I can make a couple of
17 comments before we move on with more -- first of
18 all, thanks for your service over there, Chris.
19 We're real proud of you.

20 DR. MacDERMID: Can I ask a follow-up --

21 MR. WARNER: Yes, sir.

22 LTG KILEY: Additionally, thanks for

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1 coming up here, because I understand you're on
2 block leave of some kind anyway.

3 MR. WARNER: Yes, sir.

4 LTG KILEY: Please thank your general
5 for doing that.

6 And I have some other questions in a
7 minute. I wanted to just make one cautionary note
8 on these numbers published here on the slide.
9 Until you do some analysis, your kind of

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10 score-type stuff, we don't know whether those are
11 statistically significantly different numbers,
12 number one.

13 MR. WARNER: That's correct.

14 LTG KILEY: Number 2, if 70 percent of
15 the population is the same, the individuals in
16 post-OAF1 who had all of these things happen to
17 them may well have been off the roles, and so OAF2
18 may have been, in many respects, a much different
19 population of troops, so I wouldn't want anybody
20 leaving here thinking well, by gosh, this
21 decompression is, like, you know, the golden
22 bullet, as they say, you know, the golden BB that

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1 solves all the problems. But it clearly begs for
2 more analysis, because I think it's very
3 encouraging at least. Maybe that will make a
4 difference for us.

5 I had some questions, I'd like to let
6 the rest of the members -- yeah.

7 DR. MacDERMID: Can I ask a follow-up
8 first?

9 LTG KILEY: Yeah, sure.

10 DR. MacDERMID: And that is that since
11 you think that the decompression phase is vital to
12 the overall success of your program, how would you
13 recommend that we provide each individual

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14 augmentee's IAs the same kind of a decompression

15 period, given the fact that they're not with the
16 peers that they deployed?

17 MR. WARNER: This actually brings up a
18 good point. We were having this discussion this
19 morning between myself and the division surgeon
20 looking at not individual augmentees but what
21 about soldiers who were very seriously injured who
22 don't come home at the same time as the division;

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1 who don't go through this; and who potentially
2 have spent six to nine months at a facility like a
3 Walter Reed.

4 I don't have a clear answer for you yet.
5 It's an area that we're trying to develop
6 something at our level of how can we take care of
7 our soldiers in that respect, because it's
8 something that we've identified as an area for
9 improvement.

10 I think we've got to look at some way to
11 allow them to decompress. One of the biggest
12 areas that we saw was our docs. I mean, some of
13 our biggest statistics have been -- and I don't
14 have the exact numbers, but I can see some of
15 those who have been most affected by their
16 experiences in combat are medics and are docs, and
17 that's not surprising. They're seeing a lot of

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18 it, and in our case most of our PROFIS docs did
19 not get a chance to participate in this. They
20 came home, and there was a big pull to get them
21 right back to their MTS and get them working
22 again. So, I think it's an area we've got to look

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1 at. I don't have a good answer for you on how to
2 do it yet, but --

3 LTG KILEY: But they did get block
4 leave, those PROFIS positions.

5 MR. WARNER: Yes, sir, they did.

6 LTG KILEY: Yeah, okay. Question.

7 COL PEREIRA: Sir, go ahead, Layton.

8 DR. McCURDY: No.

9 COL PEREIRA: Go ahead.

10 DR. McCURDY: Okay, thanks. If you had
11 your way, what would you have this committee --
12 Task Force -- recommend as far as resources or
13 policies or whatever to make your job more
14 effective, make this operation more effective?

15 MR. WARNER: Okay. I think, first of
16 all, I'd love to have my full complement of
17 resources.

18 As I said, we've been -- since we've
19 been home we've been at 50 percent strength at
20 best. Now, we are great in the fact that our
21 enlisted population -- our enlisted technicians

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are at 200 percent strength now. Each brigade

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1 that we send out the door this time will have
2 twice as many as they're allowed, which is, I
3 think, outstanding because a lot of our soldiers
4 are more comfortable talking to another enlisted
5 soldier than they are talking to a major or a
6 captain. So, getting us the resources out there
7 is issue one.

8 I think issue two is we've got to really
9 hone in on the commander still. I think there's
10 been a great deal of emphasis on the senior-level
11 commanders. You know, the general staff from all
12 the general officers that I've encountered now are
13 very in tune and understand the importance of
14 behavioral health. The company commanders aren't
15 always getting the message, and I think if we can
16 find programs and abilities to get it down to that
17 level, and especially to our NCO leadership
18 chains, such as our first sergeants, that's going
19 to make a big difference, because those are the
20 people that are -- if you want to talk about where
21 the stigma is going to get impacted, it's not that
22 -- okay, we're not going to give you this job;

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1 it's the comment the first sergeant's going to
2 make when he finds out where you're going and all
3 the ribbon or hey, we can't have him on that
4 detail, you know, he can't be the armor anymore or
5 something like that, because we can't trust him.
6 So, I think that's -- if we can put resources
7 towards changing the environment and the attitude
8 of those individuals, that will be the number one.

9 Number two is we've got to concentrate
10 and focus on our families. If we decrease the
11 stress that's placed on our families and we
12 provide them -- and I think there's a lot of
13 resources out there. I think the problem is we
14 haven't always done a good job of linking the
15 families to the resources.

16 While we were deployed, there were a lot
17 of articles written in the local papers in Georgia
18 about this, of hey, this is going on, this is
19 going on, and only two people are participating
20 and only this, and I'm seeing it now as we prepare
21 to deploy, they come to these briefings and these
22 spouses are being handed 25 different flyers of

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1 this great program and this great idea.

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2 So, which one do you choose? I think

3 we've got to find a way to centralize it, drill it
4 down, and link them up with it so that we can best
5 put them -- set them up for success. But the
6 problem is when we have all these different
7 programs -- and I think it's -- everybody wants to
8 help, everybody's got the right idea, but
9 everybody's coming up with their own programs and
10 then we're just not getting good participation and
11 it's hard to sustain those.

12 I think you also have to look at what
13 resources you have to do it, because a lot of
14 times people are focusing on using GWOT funding so
15 they get great success out of these things, but
16 then if they're relying only those dollars, then
17 it may not be able to be a sustained program
18 either, and that I think is one other key to
19 success, something that we can keep continuing
20 down the road.

21 DR. McCURDY: Thank you.

22 DR. MacDERMID: Can I ask one last

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1 question? One of the concerns that I think
2 created -- was partially responsible for creating
3 this Task Force is concerns and questions about
4 how services are delivered to people during
5 deployment, and so my question to you is what do

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6 you think are the indicators that we should be

7 looking at to tell us how good the services are
8 that are being delivered to people overseas?

9 MR. WARNER: Could you define a little
10 bit more for me what you mean by "the services
11 that are being delivered overseas"?

12 DR. MacDERMID: Well, people are
13 receiving mental health care overseas, and so for
14 example one of the statistics you gave was a very
15 high percentage of people who have returned to
16 duty. That's one indicator of the quality of
17 mental health care delivered to someone during
18 deployment. What do you think the other best
19 indicators are?

20 MR. WARNER: I think we need to find
21 ways to get reports back from commanders as to how
22 effective those soldiers are. There was a very

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1 good article that was written -- I think it came
2 out about 18 months ago that really looked at
3 return-to-duty rates and said is that really a
4 good stat to look at, because obviously I work --
5 you know, who's my boss? My boss is the division
6 commander. He wants to keep his soldiers up
7 there. They want them out there. What are --
8 where are the areas that we need to be looking at?
9 Is there a way of a scale to assess, number one,

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10 their level of symptoms. Frequently when we were
11 looking at soldiers with depression, we were
12 implementing scales such as the patient health
13 questionnaire 9 to be able to gain an assessment
14 and be able to track out monitoring. I think also
15 if there were some way to get feedback from
16 command as to are these guys effective in doing
17 their performance and how we've tried to do that
18 is by incorporating more what are called
19 chain-of-command meetings where we sit down with
20 the soldiers' commander and their first sergeant,
21 almost like a treatment team meeting, and get them
22 more integrated. As for the aspect of our care

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1 versus CONUS versus during deployment, my SOPs are
2 very clear, and what I told all of my providers --
3 my expectation is it doesn't change. It should be
4 -- we should be striving to deliver the same
5 quality of care whether it be out of the back of a
6 Humvee or, if it's sitting in a nice office, and
7 that's why we've tried to do everything we can
8 from putting the resources as much on electronic
9 media and equipping them with things such as just
10 a simple laptop computer to be able to maintain
11 the resources as opposed to trying to drag two
12 chests of records around with them wherever they
13 go, because it makes things easier for them so

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14 they can focus on doing their number one priority,

15 which is taking care of that soldier.

16 DR. MacDERMID: Thank you.

17 LTG KILEY: Chris, let me follow up on
18 that --

19 MR. WARNER: Yes, sir.

20 LTG KILEY: -- and go at it a slightly
21 different direction, because I think -- I agree
22 with Shelley. Some of this discussion strikes to

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1 the heart of the rationale for the Task Force to
2 examine what it is we're doing with and to and for
3 soldiers.

4 I was struck by the number I think on
5 one of your slides where you only Medivacced out,
6 for psychiatric reasons, 16 soldiers out of
7 20,000+ --

8 MR. WARNER: That's correct, sir.

9 LTG KILEY: -- which is a pretty --
10 that's a phenomenally small number. When we look
11 at some of the data, like Hogue's data, and we had
12 our mental health summit -- our Army mental health
13 summit a while ago, the walk-around number we use
14 is 10 to 15 percent of the soldiers got a
15 diagnosis of PTSD and you've got another 10 to 15
16 percent looking at you two psychiatrists here now
17 that have PTSD-type symptoms, and I think you

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18 recognize that you may have talked about it in a
19 different term on your slide. So, I guess the
20 question is it would strike me that either the
21 soldiers are more resilient; your therapies are
22 very effective; Battle Buddies make a difference

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1 or they don't. So, as we work our way through
2 solution sets and recommendations, do you think
3 assigning more combat stress control teams into
4 the theater of operations would have helped or
5 hurt or been neutral?

6 And I'm going to ask you another piece
7 of this, which is the use of medications in
8 theater and whether, you know, that helps, hurts,
9 or is neutral. What are your thoughts in that
10 area?

11 MR. WARNER: Sir, on the first half of
12 that question, the idea of more combat stress
13 units, initially we definitely had a need for
14 more. If you're familiar with all around the
15 Baghdad area, you'll know that the south area --
16 the area south of Baghdad is one of the more
17 highly conflicted zones, especially around
18 Mahmoudiya and that area. Because some of our
19 units had not converted to brigade combat teams
20 yet when they deployed, we had certain brigades
21 out there without resources, without a behavioral

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1 We did not have enough from our local CSC to cover
2 all of that, and we did actually go and request
3 from Col. Brant and his CSC to actually provide us
4 support and coverage and did receive that.

5 Other than that, other than that region,
6 though, I think we had very good coverage between
7 ourselves and the CSC, and we -- probably the
8 biggest issue, again, goes back to that
9 coordination, sir. We had one particular FOB that
10 had the main body of our division mental health,
11 so it had the division psychiatrist, the division
12 -- one psychologist and one social worker, as well
13 as three techs, as well as you had a CSC team on
14 that same FOB that had a psychiatrist, a
15 psychiatric nurse, and two social workers. So,
16 that one FOB had quite a large amount, and I think
17 that goes back to the theater consultant being
18 able to provide some sort of overview in that
19 respect.

20 Other than that, from my perspective and
21 my experience, sir, we had very good support and
22 had enough assets to be able to cover the demand

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1 and cover the need. Our guys are definitely
2 working hard. They're definitely doing a lot, but
3 what else are they going to do while they're over
4 there, so --

5 LTG KILEY: How about the use of
6 medications over there? Were you comfortable that
7 the soldiers that were on medication were on it
8 for appropriate reasons and were appropriately
9 monitored while they were taking it?

10 MR. WARNER: Yes, sir. First of all, we
11 stuck to pretty much common antidepressants, such
12 as -- and (off mike) our most prescribed one was
13 Prozac. Prozac of its longer half life decreases
14 the incidence of serotonin discontinuation
15 syndrome, which of course these guys are going to
16 go out on four-day patrols and forget to take
17 their meds that are with them. We established
18 very clear expectations of when soldiers should be
19 holed up, and this is a basic - you know, I'm also
20 a family physician. I'm family-practice trained,
21 and I'm very comfortable doing antidepressant
22 management as a family physician. Each battalion

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1 has a primary care physician with them who has

2 eyes on who's going to be local, and we've put a
3 great deal of emphasis and actually sent out many
4 messages to them that they needed to be doing
5 appropriate monitoring. The expectation is they
6 shouldn't -- or their first prescription should
7 not have been getting more than a two-week supply
8 of the medication. They needed to be following up
9 with the soldier and reassessing, as well as doing
10 clear safety assessments with each encounter.

11 Beyond that, sir, we stuck to very
12 little use other than some mild sleep assistance,
13 such as Ambien was our most prescribed. We did
14 also occasionally use Trazodone, although its long
15 half life and the fact that the orthostatic
16 hypotension, as well as the sedation, was not real
17 effective for guys that might four hours later
18 have to be getting up to go out and drive a tank,
19 and we would occasionally use Seroquel at very low
20 dose to help with sleep and to help with those who
21 were having nightmares. My general opinion is
22 that I'd rather see us using that there. Again,

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1 it's the idea of early intervention, early
2 treatment. We are making soldiers more effective,
3 and we're -- if we're not treating them are we
4 withholding treatment from them that could help
5 improve and make them better. So, I think we're

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6 doing them a service to push those types of

7 medication forward with proper monitoring, which I
8 felt was there through our primary care providers
9 and then with oversight from myself and the other
10 psychiatrists that we're with in the region.

11 LTG KILEY: In the predeployment
12 screening, did you identify soldiers in 3rd ID
13 that had had or had a diagnosis of PTSD and
14 deployed with that diagnosis?

15 MR. WARNER: Sir, I was not there for
16 the predeployment of the -- with the last time.
17 We have our first brigade combat team, which is
18 leaving very shortly, and as part of that we have
19 been a -- we -- any soldier who has seen mental
20 health in the last 12 months or who has been on
21 any psychotropic medication is seeing me for
22 clearance as part of that, and any soldier -- my

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1 opinion is any soldier who meets the criteria or
2 diagnosis for PTSD needs a formal review to ensure
3 that they are still able to do it, and we will
4 refer them for a medical board evaluation to
5 determine.

6 My experience has been, at least with
7 this division, that we don't have a large number
8 of people with formal PTSD. They're not meeting
9 the four criterion. More of what I'm seeing are

10 soldiers who are having what we're terming anxiety
11 disorder -- NOS is the appropriate diagnosis --
12 who are having potentially some difficulty with
13 sleeping, who might be having some reliving or
14 reexperiencing symptoms, and we then assess those
15 on a case-by-case basis to see do we feel that the
16 soldier is able to do their job? Are we putting
17 them and setting them up for potentially getting
18 worse? How have they responded under stressful
19 situations? And do we feel comfortable that
20 they're going to have appropriate monitoring and
21 access to care during the deployment. And if the
22 answers to those questions are no, then we're not

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1 going to send them, sir.
2 LTG KILEY: Okay, thanks. By the way,
3 you'll get the mental health assets you need to
4 deploy.
5 MR. WARNER: Yes, sir.
6 MS. FRYAR: I have a question.
7 MR. WARNER: Yes, ma'am.
8 MS. FRYAR: In your experience, have you
9 noticed any Service members showing up in theater
10 with their own supply of medications that were not
11 identified perhaps so it would go on the medical
12 record?
13 MR. WARNER: Yes, ma'am. We definitely

14 -- well, what I've seen is a number -- and this
15 has decreased significantly from my experience of
16 where we were before.

17 My wife is an active duty family
18 physician. She ran one of the first soldier
19 readiness centers for -- or mobilization centers
20 at Aberdeen Proving Ground back in 2003 when this
21 was all standing up, and the horror stories you
22 had of guys who were showing up in theater asking

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1 for their chemotherapy meds, their refills on
2 Lithium. I think we definitely improved over
3 that.

4 Do I still see guys that are showing up
5 saying hey, doc, I'm on my Depakote now for six
6 months, and I'm thinking has anybody checked your
7 levels? Where are things at? Those types of
8 things? Sure, and you start -- I've even
9 encountered some that go and see their civilian
10 provider. They're doing it at their own expense.
11 They're doing it at their cost. They're hiding it
12 from the military. And they're spending -- you
13 know, they're paying for the meds. They're
14 getting six months. They come on their R&R, they
15 get their refill and come back, and we didn't even
16 know about it the entire deployment. Is that a
17 problem? Yes. Is it a major problem? I don't

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18 think so. I think it's only a handful of cases.
19 I can probably count five or six that I saw like
20 that, both in the -- during the deployment and our
21 post-deployment phase.
22 I think that comes back to we've got to

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1 decrease that. We've got to make it okay for
2 soldiers to get the help so that they're not
3 afraid and they don't want to spend all that money
4 out of their pocket and put themselves at risk
5 like that, because I think at the same time our
6 civilian counterparts are becoming attuned to the
7 environment that these guys are going into now,
8 that they're going to be a little more -- they're
9 not going to be using Lithium and other such
10 medications that may put them at greater risk.

11 DR. MacDERMID: Great. Thank you very
12 much.

13 LTG KILEY: That's good.

14 MR. WARNER: Thank you.

15 (Applause)

16 DR. MacDERMID: COL Engle.

17 MR. ENGEL: Well, it's great to be here.

18 My name's Chuck Engel. I'm the director of the
19 Deployment Health Clinical Center at Walter Reed.
20 I have been running the Center for about the last
21 ten years. Started out as the Gulf War Health

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1 with medically unexplained symptoms.
2 We've shifted gears. We've taken care
3 of folks post-9/11, and what I'm about to tell you
4 a little bit about today really had its genesis in
5 the post-9/11 period when we were thinking hard
6 about how we could reach into primary care and try
7 to help soldiers earlier and their family members
8 earlier after traumatic events to get the
9 assistance that they need, and at that time what
10 we did was we put care managers, facilitators of
11 care, into eight primary care clinics in the
12 national capital region, and in the course of
13 presenting that work to -- at the national meeting
14 ran into others who were thinking in similar terms
15 for depression and other ailments using a care
16 manager.
17 One particular group with the MacArthur
18 Foundation -- funded by the MacArthur Foundation
19 who'd been working on depression approached us and
20 we linked up with them, and out of this
21 RESPECT-MIL was born. The RESPECT stands for
22 Reengineering Systems of Primary Care Treatment.

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1 The original effort was called RESPECT-Depression
2 -- involved these MacArthur Foundation-funded
3 investigators to the very large multi-center trial
4 of this approach of primary care treatment for
5 depression, which was published in the British
6 Medical Journal.

7 This is sort of awkward, but I can't
8 really see my slides, and I can't tell exactly
9 what you're looking at, and I don't have a switch
10 to flip them. Hopefully -- and I actually
11 switched my slides out, so I'm not even sure that
12 the handouts that you have are exactly the ones
13 that are going to come up here. So, we'll sort of
14 wing it here. If I'm on the wrong slide as we go
15 along, let me know.

16 So, you can see this is a partnership
17 involving not only these investigators from the
18 MacArthur -- funded by the MacArthur Foundation,
19 but Uniform Services University, the Surgeon
20 General's office, the Army Medical Department, my
21 Center; and where we're running a Center of
22 Excellence which is sort of implementing the whole

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1 program is operated out of Fort Bragg, so the

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2 Womack Health Care System is also engaged with us.

3 You're looking at pictures of two of the
4 pioneers of the original RESPECT-MIL demonstration
5 project -- Chris Yamamoto and Daren Gould. Chris
6 is a family practice doc, and CAPT Yamamoto was
7 practicing -- was a brigade surgeon with the 82nd
8 Airborne. He's deployed twice now. He's on his
9 second deployment. The picture that you see in
10 the upper left is him during the current
11 deployment. Daren Gould was the division
12 psychiatrist for the 82nd Airborne, and he is also
13 -- he deployed about the same time as Chris did,
14 so as this thing really started to take off
15 unfortunately they took off, and we're hoping that
16 they can join us as the effort ramps up.

17 Next slide. This is a slide that
18 imagine you've probably seen several times. This
19 is Charles Hogue's data, which shows that
20 essentially of those troops, those combat elements
21 from OIF-1 who are coming through Fort Bragg, the
22 20 percent of veterans who are screening positive

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1 for moderate or severe mental disorder on their
2 measures, they found that about 80 percent of them
3 acknowledged on a survey question that they had a
4 problem with which they needed assistance -- a
5 mental health problem. Interestingly, only about

6 half of those -- about 40 percent -- said that
7 they wanted help with that perceived problem, and
8 the numbers that you see below that are those that
9 actually had received help within the previous
10 year and those numbers go down from there. So, as
11 few as, really, as a quarter had received any
12 mental health treatment, any specialty mental
13 health treatment, over the preceding 12 months.

14 The next couple of slides also review
15 Charles Hogue's data where he did the right thing
16 really -- anticipated that we might see something
17 like this and asked questions about why folks
18 might be hesitant to seek assistance. And, again,
19 I think you've seen these before -- the idea that
20 unit leadership might treat folks differently;
21 that, you know, if you heard the NPR report
22 recently, you know, peers and/or immediate

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1 supervisors sometimes may not be in touch with the
2 big organizational message around all this. They
3 may feel that they'll be judged by those folks --
4 could have an adverse impact on their career.

5 And then the next slide shows difficulty
6 getting time away from work -- not sure where to
7 get help.

8 Then the last one, being a psychiatrist
9 I can't imagine that's true that anybody wouldn't

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10 trust a mental health professional, but I hear

11 that some people actually report that.

12 These are -- in a lot of ways these
13 reasons that might cause people to hesitate in
14 seeking care are more similar than you might
15 imagine in the military to what have been reported
16 in the civilian world. Ron Kessler at Harvard has
17 done -- has asked similar kinds of questions.
18 Obviously, many of these questions are military
19 specific, but what's remarkable to me is the
20 similarities that agree and stigma.

21 The point of all this, really, is that
22 many folks aren't getting care, that many folks

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1 are hesitant to seek specialty care, and if they
2 are hesitant to seek specialty care we have to
3 find ways to reach out to them.

4 The next slide I think -- yeah, these
5 are data from the Walter Reed battle-injured
6 cohort. These were published just recently in the
7 October American Journal of Psychiatry -- Tom
8 Grieger, myself, Charles Hogue, and Steve Cozza
9 and others published this -- and the main point
10 I'd like you to get from this as it relates to the
11 important of primary care is the importance of
12 continuity -- that it's not enough to screen once.
13 Arguably, it's not enough to screen twice.

14
15 these symptom presentations, particularly in the
16 early going. This is a cohort of folks who were
17 injured in battle, came back to Walter Reed.
18 Obviously, they're unique and have unique needs,
19 but I've seen at least two other datasets that
20 show a very similar sort of curve qualitatively
21 arising rate over time in returning troops. This
22 has the advantage of showing that in the first

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1 wave where -- I think the purple-colored are -- am
2 I looking at the right thing? Yeah, in the first
3 wave, you can see the purple-colored bar are all
4 those that were recognized in that initial period.
5 The second wave you can see that about half of
6 those have gotten better at that point. But
7 there's a whole new set of folks who weren't --
8 who didn't have PTSD by the case definition
9 applied who now have it at wave two, and of those
10 folks, by wave three, that a sizeable proportion
11 of them have also gotten better, and then others
12 who have persistent symptoms. So, in some fashion
13 the only way to really know who is going to have
14 troubles is to monitor over time, and we looked in
15 this cohort at a number of different predictors of
16 who went on to have difficulties. What we found
17 was in this battle-injured cohort that somatic

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18 symptoms, including pain, were really the only
19 major predictors, but unfortunately from a
20 clinical standpoint, they don't offer great
21 benefit. So, the main -- the bottom line point
22 there is that we have a lot of folks out there

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1 with needs, a lot of folks who are not seeking
2 care for those needs, and that one-time care is
3 arguably not enough, that we have to have some way
4 to ensure some continuity of monitoring.

5 The next slide really illustrates --
6 make sure we're on the same page -- really
7 illustrates what has been the focus my Center's
8 work for quite some time, and that is trying to
9 find ways to assist soldiers at several different
10 levels. Now, you've I'm sure heard a lot about
11 PDHA, about PDHRA -- which are preclinical efforts
12 to mitigate -- and I'm sure you've also heard
13 about a lot of sort of champion programs in
14 specialty care doing what they can at secondary
15 and tertiary prevention of distress after combat
16 service. What we've wanted to do, what we have
17 been doing is focusing on this middle level of
18 care where people are coming into primary care and
19 there's an opportunity to frontload care for them
20 from a mental health standpoint.

21 Next slide. Okay, so, you know -- I'd

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1 care is -- this is where soldiers are seeking
2 their care. Again, this is a similarity to what's
3 happening in the civilian world since the --
4 really the late 1970s. We've been aware that most
5 mental health care has been delivered out of
6 primary care settings, and increasingly we have
7 automated data from our own system to reinforce
8 the notion that our soldiers are seeking primary
9 care. I think that sometimes there's a hesitance
10 on the part of command to, you know, encourage
11 everybody to go to see a mental health
12 professional in specialty care, and sometimes
13 there's even a hesitance about any level of
14 medical care, seeing, you know, the medical care
15 system as, you know, a marker of -- it's a failed
16 outcome. But I think, really, what's important to
17 recognize is that most of our soldiers are already
18 seeking primary care at a high rate -- about three
19 and a half visits per year -- and even in the
20 lowest-using demographic groups, males under 40,
21 the rate is approaching 90 percent are using one
22 or more visits per year. So, although we don't

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1 know for sure, I think that there's reason to
2 believe that if we can deliver mental health
3 services in primary care, there's an opportunity
4 to reduce stigma, and certainly there's the
5 opportunity to bring care to many of those who are
6 in need who are not currently getting it. And
7 there is, fortunately, a number of interventions
8 which can be delivered in primary care. There's
9 an increasing literature that's demonstrating this
10 -- next slide -- where these are very solid,
11 randomized, controlled trials done in multiple
12 sites using effectiveness designs so we get a
13 sense of what their impact is in real life that
14 shows that essentially a collaborative care model
15 -- which I'll say a little bit more about here in
16 a minute as it relates to our program -- can
17 effectively improve outcomes for a wide range of
18 mental illnesses, some of which are highly
19 relevant in our population, and maybe others,
20 arguably, are less relevant. But we see
21 consistency in this literature that it helps.

22 Next slide. So, when we decided to go

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1 forward with this kind of approach in pilot

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2 fashion at Fort Bragg, which was where Charles

3 Hogue had done their New England Journal work, and
4 we felt that this was an ideal place to initiate
5 the work, because there's also a residency program
6 and family practice at Fort Bragg, so there's, you
7 know, very active interest in looking at novel
8 ways of caring for the troops when they come back
9 and obviously a lot of combat elements and
10 demobilization platform and so on. We asked first
11 what do we know, what are the elements that we can
12 deliver that will improve primary care? And
13 there's been some work to help us to understand
14 this.

15 One, I'd say, that's very clear is that
16 education is not enough. It's one piece, but it's
17 not all about just educating primary care docs,
18 that primary care docs by and large -- you know,
19 they vary in their skill level and their
20 motivation, but by and large they're very
21 knowledgeable about what to do.

22 The difficulty is that the system in

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1 which they practice is not always set up to
2 support them in the delivery of mental health
3 care.

4 So, education is a piece, but a system
5 focus needs to be, really, adopted and multiple

6 modalities need to be used, not just any single,
7 and the main components and trials that have been
8 done in depression, where the most work has been
9 done, suggest that education, a prepared practice
10 where you have screening tools and automated
11 information systems, and other mechanisms for
12 setting up doing the right thing exist where there
13 is a care management resource -- someone, sort of
14 an extra person there who's really focusing on the
15 continuity piece as a go-between between specialty
16 care, primary care, and the patient -- and then an
17 enhanced specialty care interface, the opportunity
18 through this care manager resource to make
19 specialty services more accessible to the soldier,
20 and in some cases to allow the soldier, allow the
21 patient to derive benefits akin to what they would
22 get in specialty care without ever actually

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1 necessarily coming face to face with a primary --
2 with a mental health care provider, you know,
3 keeping in mind that many folks, for their own
4 reasons, would prefer that that not happen, and as
5 much we might like to persuade them, cajole them,
6 order them, whatever, to specialty care, there's
7 not always the opportunity to do that and,
8 arguably, would not always be the best judgment to
9 do that.

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10 Next slide. This is really just showing

11 you the paper that the original RESPECT-Depression
12 investigators published in the British Medical
13 Journal. Again, this was a multi-site clinical
14 trial focusing on depression.

15 Next slide. This is introducing you to
16 the Fort Bragg work that we've been doing, which
17 is kind of the launching pad for more work that
18 I'll tell you about. We started about two years
19 ago at Fort Bragg, and our main goal -- after
20 talking with the command at Fort Bragg, the
21 medical command, WOMACK in the health care system
22 there, with the medical folks operating within the

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1 82nd Airborne -- our main goal was not to look at
2 efficacy or even effectiveness. Our main goal was
3 to look at feasibility, because as we talked with
4 the primary care docs there -- I'm talking about
5 PAs and nurse practitioners as well as family
6 medicine docs -- one of their main concerns was
7 that this was going to turn their clinic on its
8 ear, and so, you know, in some respects what we
9 had to do first and foremost was show them that
10 this seemed to be doing the right thing in their
11 eyes, as well as in the patient's eyes. So, we've
12 actually -- this says "Data collection is nearing
13 completion." It's actually completed at this

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14 time.

15 Next slide. So, this tells you what the
16 main ingredients of RESPECT-MIL are kind of in a
17 simplified way. First I'd like to emphasize that
18 these -- that the approach is manualized. We have
19 a clinician manual for the primary care doc. We
20 have a RESPECT-MIL facilitator manual for the
21 facilitator that tells -- particularly --
22 especially in the case of the facilitator, this

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1 manual tells them not only what they're supposed
2 to do but sometimes what they're not supposed to
3 do, sort of how to "stay in their lane," as we say
4 in the military, and make this all work, and I
5 think codifying it in that way is very important
6 from a fidelity perspective -- you know, ensuring
7 it's being rolled out the way it was intended --
8 and from an accountability perspective, going back
9 and monitoring and measuring whether it's actually
10 being rolled out as it was designed and whether
11 that's related to outcomes and so on.

12 So, primary care docs will undergo two
13 hours of training. So far we've done this in
14 person. We're developing automated versions of
15 training with hopefully some interactive video
16 that give them a chance to practice with "real
17 live patients," sort of standardized patients in

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18 some fashion. There is routine clinic-based
19 screening, which I'll tell you a little bit more
20 about, and I think actually in the slides at the
21 end there are some backup slides in there and you
22 kind of see some of the measures that we're using

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1 or pieces from some of the measures that we're
2 using.
3 So, all patients coming in get screened
4 for PTSD and depression, that positive screens are
5 followed by what we've been calling a presumptive
6 diagnostic tool, so this is essentially a longer
7 screening measure that adheres to DSM criteria and
8 in relatively short order can give the clinician
9 some sense -- the primary care clinician some
10 sense of whether this patient meets the symptom
11 criteria for depression, and then with a -- you
12 know, some clarifying questions they can move from
13 there to a presumptive diagnosis. It's not as
14 good as a specialty care diagnosis but it's a way
15 forward for the primary care doc. And then if
16 they meet presumptive criteria for depression or
17 PTSD, then there is a referral made to the
18 RESPECT-MIL facilitator with follow-up done
19 ideally until there is remission of symptoms. The
20 RESPECT-MIL facilitator undergoes weekly
21 supervision with a local specialist, usually a

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1 lot, and the facilitator actually isn't making
2 treatment decisions. The facilitator is really
3 going -- is assessing the patient over time using
4 these same standardized diagnostic measures to see
5 that symptoms are getting better or getting worse;
6 is delivering the recommendations of the
7 specialist to the primary care doc so they can
8 tailor treatment to the patient; and staying in
9 touch with the patient so that they don't drop out
10 of care or if they have questions about side
11 effects. But those are addressed and don't fall
12 by the wayside.

13 Next slide. This may be somewhat
14 difficult not seeing exactly what I'm looking at
15 here, but this really sort of summarizes what goes
16 on in each of the steps here.

17 If we hit the button one more time. In
18 fact, you can hit it, like, about three more
19 times. Oh, it does go from one to another.

20 So, there's -- but at the first step in
21 the recognition and diagnosis, there's screening,
22 and there is a suicide assessment. There's a

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1 suicide item that's asked, and we work with the
2 primary care docs so that they understand how to
3 do a very basic sort of structured suicide
4 assessment if they need to do that, if there's
5 some indication from the survey that questions
6 need to be asked. We actually find that that
7 happens in about one in a hundred primary care
8 patients that are seen, that there is -- that the
9 suicide item is endorsed, and then about maybe a
10 third of those that there's some sort of active
11 suicidality that once the patient is recognized
12 and treatment options are presented to them, a
13 choice on the part of the patient is made with
14 regard to treatment options, which is not
15 necessarily just medicines, that that can be the
16 most immediate treatment in a primary care
17 setting, but part of the job of the facilitator is
18 actually to help the patient get engaged in
19 specialty care if that's the level of care that
20 they're interested in.

21 And then they initiate treatment. There
22 are patient education messages given. Again, in

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1 the backup slides there's -- I think it shows you

2 some examples of some coping strategies that the
3 facilitator works with the patient on setting --
4 on goal setting around. You might see this as low
5 intensity psychosocial intervention. It's not
6 really therapy. There's some problem solving that
7 the facilitator helps the patients to do. And
8 then probably the most important part -- I've
9 already emphasized the continuity part, but it's
10 very hard to generalize what the right treatment
11 is for every patient, and in the continuing and
12 changing of treatment the idea that monitoring is
13 going on; that we see whether symptoms are
14 improving, staying the same, or getting worse; and
15 that those get -- that information gets relayed
16 back to the primary care doc, who can adjust
17 treatment as indicated. This is probably the most
18 common failure of mental health care, I think, in
19 both the specialty care setting and in primary
20 care setting -- is that there's inadequate
21 follow-up, that people are put on medications or
22 on some other form of therapy, and monitoring does

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1 not occur. So, this is a key element within
2 RESPECT-MIL.

3 Next slide. I won't belabor this one,
4 but this really tells you what the facilitator
5 does -- I think I've kind of already given you a

6 sense of that -- encouraging adherence to the
7 treatment; some psychosocial intervention
8 involving problem solving; measuring treatment
9 response and monitoring remission; ensuring
10 continuity.

11 The next slide. We're still on the same
12 -- yeah.

13 This is what the specialist does.
14 Really they supervise the facilitator. These are
15 familiar elements of care for most specialists.
16 It doesn't require a large adaptation on the part
17 of the specialist to learn this model. As a
18 specialist myself, I found it to be really,
19 actually, very fun to work with the facilitators.
20 You feel like you're being quite effective,
21 because there's the opportunity to sort of reach
22 out and touch the care of a lot of patients who

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1 would normally never come to your attention. So,
2 it improves the specialists' efficiency quite a
3 bit.

4 Next slide. Now -- yeah, we're looking
5 at some of the preliminary data. I want to
6 emphasize right up front what we are looking at
7 here is, you know, is this model feasible? Can we
8 do this? Can we roll this out in a busy troop
9 medical clinic at Fort Bragg that's taking care of

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10 82nd Airborne soldiers coming to and from

11 Afghanistan, Iraq, the Gulf Coast, and a number of
12 other different places where they get sent, along
13 with their providers who are doing this, and so
14 that's the general thrust here.

15 We trained 30 clinicians total in this
16 one clinic. Twenty-three of them are active duty.
17 Actually, as sort of an indication of feasibility
18 I'll call it, or at least acceptability on the
19 part of the primary care community after he'd been
20 doing this for a couple of months, the rest of the
21 clinic staff, you know, approached the clinic
22 chief and asked to have this training. They

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1 wanted the training. So, there's a number of
2 civilian providers that we also trained in the
3 model that we originally hadn't anticipated doing.
4 This was all done under protocol. Actually,
5 providers had to sign informed consent to
6 participate. It was all done voluntarily.

7 As you can see here, there was a mix of
8 primary care clinicians that we worked with and a
9 number of screenings that approached 5,000,
10 actually, by the time that data gathering closed.

11 Next slide. What we found essentially
12 was that about 10 percent screened positive for
13 depression, PTSD, or both. This was 10 percent of

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14 the primary care population, all comers coming in,
15 and all of those folks received primary care
16 follow-up. About 20 percent of the
17 screen-positive soldiers -- this is -- you know,
18 they screen positive on the initial screen --
19 again, in your backup slides you can kind of see
20 what the depression questions are, and I believe
21 the PTSD screener is in there as well -- that only
22 a subset of those actually come up with

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1 presumptive diagnoses. About 20 percent end up
2 getting referred to the RESPECT-MIL facilitator,
3 and after about -- after 12 weeks of case
4 management, we found that about two-thirds with
5 depression are improving and even a higher percent
6 of those with PTSD are improving.

7 Again, this is not a randomized,
8 controlled trial. We're just looking at pre-post,
9 you know, regression, and the mean would suggest
10 we're going to go in that direction, but it's
11 reassuring that things are headed in that
12 direction, and, again, I think we have clinical
13 trial evidence from other settings to suspect that
14 this will benefit.

15 Next slide. So, what we've -- what I
16 believe that we've learned so far is that the
17 program is acceptable both to soldiers and to

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18 their providers, that it's feasible. What we have
19 found, actually, is that more people are screening
20 positive for depression than are for PTSD, and
21 we're finding that perhaps more than in the
22 civilian population that marriage and family

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1 problems are more frequently a complicating
2 factor. This is feedback that we're hearing from
3 our RESPECT- Depression, you know, civilian
4 colleagues who've been doing the depression work
5 across a number of different health care systems
6 over time. This is the feedback that they give
7 us.

8 Challenges that we face are -- next
9 slide -- okay, here's where I deviated a little
10 bit. These are vanity slides. I sort of -- my
11 message here, really, is that once you create a
12 sort of system, an approach to improving primary
13 care for depression and PTSD and other behavioral
14 health issues, other mental health issues, there's
15 the opportunity to improve it, and this is -- I'll
16 give a couple of quick examples here.

17 This is a tool that -- we just finished
18 an NIMH-funded study called DE-STRESS, which is a
19 computer self-management tool with a therapist
20 assist for patients where we initiated it in the
21 post-9/11 era and had some folks enter into it

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1 compared, in a randomized, controlled trial, a CBT
2 online version of this with a supportive care
3 online version. We actually found that the CBT
4 did significantly better. We took the data from
5 that -- you know, we're writing this up for
6 publication, but we took the data from that and we
7 went to NIMH with this idea, which is essentially
8 the primary care version of DE-STRESS where we
9 made it shorter. Instead of using a therapist for
10 assistance, it uses a nurse. It's much more
11 within the model of, like, diabetes care. If
12 you're diagnosed, then you go out and see the
13 diabetic nurse and you learn how to monitor your
14 sugars and so on. In this case, if you screen
15 positive and the patient isn't interested in a
16 medicine, you know, without going to specialty
17 care, a patient might not have any options, but
18 with DESTRESS-PC they could -- there's an active
19 self-management approach that they can engage with
20 and get assistance from the nurse. So, actually
21 we now have funding from NIMH and DoD to study
22 this model, which eventually could be, you know,

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1 brought right into this kind of RESPECT-MIL model.
2 Next slide. This is -- you know, as
3 many of you know, there's a four-question PTSD
4 screener that's used for -- that is used in the
5 PDHA. It originated in the VA. You know, while
6 there's lots of different screening methods for
7 depression in primary care, there's much less of a
8 literature on this on PTSD. We decided to sort of
9 go for the job learn and say let's see if we can
10 invent a one-question screener that works. This
11 is the -- and, you know, we -- the idea here was a
12 question that, you know, oftentimes these are
13 efforts that are sort of factor analyzed, bigger
14 surveys, use fancy statistical techniques. What
15 we wanted was a question that a primary care doc
16 could remember, could commit to memory that made
17 sense to them, and this is what we came up with.
18 It rolls out about the sixth- grade level if you
19 tested the grade level on Word.
20 Next slide. And I can't see the data.
21 I don't have it in front of me and I can't see
22 around the corner, but the bottom line is about 75

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1 percent of folks say they're not bothered by a

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2 recent event in which they thought they'd be

3 injured or killed, and in that population about 2
4 to 3 percent meet structured diagnostic criteria
5 for PTSD.

6 At the other end of the spectrum, a
7 small subset -- about 6-1/2, 7 percent in the
8 three clinics that we studied say that they're
9 bothered a lot. About half of those folks on
10 structured psychiatric interview have PTSD. And
11 then the middle group -- it's about 20 percent of
12 the overall sample. About 20 percent of that 20
13 percent meet structured interview criteria for
14 PTSD. So, this -- it's like a -- I've often
15 described it -- you know, in the culture of
16 primary care, you're always trying to figure out
17 which people you can put in the express lane and
18 which ones you've got to put into the -- you know,
19 into another cue. This is a way that a primary
20 care doc can say, you know, if they're bothered a
21 lot, you've got right to the front of the PTSD
22 line. They're not -- you know, they're bothered a

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1 little if they've got a broken leg. We can defer
2 that till later. If they say not bothered, then,
3 you know, unless there are some other red flags
4 going on, you can kind of set that aside as a
5 problem, and it's one logical question. So, we're

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6 doing some further work on that.

7 Again, the whole idea here is to say,
8 you know, we can go from four questions to one
9 question; we can add psychosocial interventions in
10 primary care. There's ways that we can gear up
11 the setting to do more intensive approaches for
12 soldiers and their family members coming through
13 primary care.

14 Next. Okay, the -- I think I have
15 already talked my way through this one without
16 really realizing -- no I didn't talk my way
17 through this one. I've already mentioned the big
18 challenge of soldier and provider rotations. You
19 know, trying to preserve continuity in an
20 environment where both providers and patients are
21 on the move is a daunting task, making this kind
22 of a model, I would argue, all the more important,

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1 maybe even more important than in a routine
2 primary care setting, something that tries to
3 preserve continuity, to provide a stable face for
4 the soldier.

5 The provider training and retraining --
6 I mentioned that, you know, we're working on
7 automation. GEN Kiley has actively -- you know,
8 he's funded an initiative to disseminate this
9 much more broadly, and part of that is to train

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10 every primary care clinician within the Army in

11 PTSD and depression care and in a subset who are
12 more engaged in this implementation project of
13 RESPECT-MIL in that model specifically.

14 Next slide. So, the directive from the
15 surgeon general is, as I mentioned, universal
16 primary care provider training and 15-site
17 RESPECT-MIL dissemination. This is 15
18 high-deployment sites carefully selected because
19 of a large nearby indigenous troop population
20 receiving primary care services, and we -- in
21 these 15 sites there's between about 15 and 60
22 primary care clinics, and the training package is

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1 in development. The roll-out is beginning. As
2 of December 1 we started hiring people in the
3 first wave of implementation sites.

4 Next. This just kind of shows you where
5 we're rolling it out. We're working from near to
6 far. The phase I sites are all largely East Coast
7 sites, and the phase III sites are by and large
8 overseas sites: Scofield Barracks in Hawaii and
9 three in Europe -- one in Italy, two in Germany --
10 and Fort Lewis just outside of Seattle. And then
11 the phase II sites are in the middle. We're
12 taking about three to four months in each of these
13 waves to do intensive train-up of personnel at the

14 Washington DC 20061218 TF meeting transcripts FINAL.txt
clinics, hiring of care managers, and so on.

15 Next slide. And this is all run out of
16 the central site at Fort Bragg, a Center of
17 Excellence where we have a psychiatrist due to
18 arrive in the next few months. We already have,
19 actually, two primary care docs there that are
20 actively being the primary care face of the
21 program. Mike Laska really is the lead guy down
22 there, a lieutenant-colonel family practitioner.

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1 The command at Womack has been very supportive.
2 Each of the RESPECT-MIL sites will receive one to
3 two nurse facilitators along with an
4 administrative assistant from Program Funding, and
5 we will be bringing these folks initially to Fort
6 Bragg in waves to train them up, help them to
7 develop implementation plans for their sites.
8 Will do distance supervision of each of these.
9 You know, there will be a primary care champion at
10 each site, which will be another duty as assigned.
11 There will be a behavioral health champion at each
12 site, which is another duty as assigned, for those
13 folks, and then the other personnel -- the one to
14 two care managers and the administrative assistant
15 -- are funded out of the program, and we'll be
16 working closely with them to get this stood up and
17 then eventually we'll go out and do site visits

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and make sure that the model is being implemented
19 as we would hope that it would. We'll be
20 monitoring metrics.
21 We've developed with the operations
22 community support an op plan, which is currently,

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1 you know, I think going through final signatures,
2 and we expect that to be disseminated here
3 shortly, so that is -- that's where we're headed
4 with this. It's a big project. It's an enormous
5 endeavor. I'm actually really pleased that the
6 folks who are collaborators who were once funded
7 by the MacArthur Foundation, actually funded for,
8 like, a decade, and no longer funded but are
9 really sticking with us, and these are academics,
10 career academics -- one from Duke, John Williams,
11 a general internist; another from Dartmouth, who
12 is a family practitioner, and they are completely
13 dedicated to see this thing rolled out in some
14 sort of effective way. So, we've got, you know, a
15 lot of folks who are working very hard who in the
16 coming 18 to 24 months are going to be making this
17 work.

18 Thanks very much.

19 (Applause)

20 LTG KILEY: Anybody have any questions?

21 DR. McCORMICK: Yeah, just one question.

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22 Thank you very much. It was an excellent

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1 presentation.

2 I'm familiar with the literature and the
3 studies on depression treatment in primary care,
4 which obviously you rest on here. I'm less
5 familiar with any studies showing that PTSD can be
6 treated in primary care. Are there such things?

7 MR. ENGEL: The -- well, there are
8 studies -- it depends on -- you know, there are
9 not studies of a model like this, like I showed
10 you the list of different conditions, mental
11 health conditions, or behavioral health problems
12 for which randomized, controlled trials have been
13 done. PTSD is not among them.

14 There is a -- the VA has funded Paula
15 Schnurr and Matt Friedman from the National Center
16 to do a multi-site trial in Texas in multiple
17 sites, and I've been consulting with them and
18 they've been consulting with us around this.
19 They're using this exact same model with the same
20 collaborators. The way I would put it is, you
21 know, that most of the folks really have
22 depression and not PTSD, so there's -- from that

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1 perspective, you know, we're not inventing
2 anything new here, and then even as it pertains to
3 PTSD I'd say the research in other mental health
4 conditions is compelling such that I would say
5 it's worth a try, and I think we've tried to go
6 forward responsibly, piloting it for, you know, on
7 the order of 18 months at Fort Bragg to make sure
8 that, you know, we're not going to sort of turn
9 things upside down.

10 So, there is also -- I'm aware of --
11 Peter Royburn in Seattle is doing a collaborative
12 care treatment trial funded by NIMH of anxiety
13 disorders of which PTSD is one of the anxiety
14 disorders that they're working on. It has been
15 done for panic. Peter Royburn actually has done
16 that work. So, there's precedence for doing it in
17 anxiety disorders, but PTSD, no.

18 DR. McCURDY: Question.

19 MR. ENGEL: Yes.

20 DR. McCURDY: Two questions. I may have
21 missed it. The facilitators are nurse clinicians
22 or just nurse -- regular nurses?

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1 MR. ENGEL: They are nurse clinicians.

2 I mean, I don't know what you mean by nurse
3 clinician versus regular --
4 DR. McCURDY: (off mike)
5 MR. ENGEL: No, they're not actually.
6 They are regular nurses, and, you know, this is
7 something that, you know, we've discussed at some
8 length with, you know, our RESPECT-Depression
9 collaborators, and what becomes -- you know, there
10 -- let's put it this way. There's not clear
11 evidence around, you know, what the discipline of
12 the care manager or facilitator should be. There
13 are models that use, you know, a psychologist down
14 to the nurse, and what we didn't want to create
15 was an independent level of care in primary care.

16 DR. McCURDY: Right.
17 MR. ENGEL: The concern that we had,
18 frankly, is that the more skilled the person is
19 often they're skilled enough to run amok, and so
20 what we wanted -- what we really wanted was
21 someone who was not, you know, was not devising
22 treatment plans but was, you know, implementing

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1 surveys of symptoms, calling people up, seeing if
2 they had side effects. You know, they do -- when
3 I say problem solving, really this is the kind of
4 work that you would do with your son, you know.
5 It's, you know, what are the difficulties that

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6 you're having? You know, how I can help you to get

7 an appointment? That sort of level of problem
8 solving.

9 DR. McCURDY: Second question. You
10 didn't mention patients who -- from whom this
11 didn't work who then would have to get referred to
12 specialty clinics.

13 MR. ENGEL: Yes.

14 DR. McCURDY: What's the story on that?

15 MR. ENGEL: Well, actually, one of the,
16 you know, key ingredients here is the enhanced
17 specialty interface, which happens through weekly
18 supervision by an on-site specialist with the
19 facilitator. This is an opportunity where if
20 patients -- for a variety of different reasons,
21 patients can be, you know, escorted into specialty
22 care if they're not getting better, if they prefer

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1 specialty care treatment -- you know, they're --
2 and if they're not taking their medicines, if
3 there's concerns that, you know, the problem is
4 more complicated, suicidality, you know, any of
5 those kinds of issues in the supervision setting,
6 which can take place over the telephone. It's
7 sort of sometimes in person, sometimes by
8 telephone, that there is then the opportunity to
9 facilitate specialty care. So, you know, by the

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10 same token, what we're experiencing at Fort Bragg
11 is this doesn't create a, you know, mad -- there's
12 -- people come in two groups, it seems like, you
13 know, and in fee-for-service medicine the fear is
14 that their patient population will dry up, you
15 know, and in military medicine where you don't get
16 paid extra the fear is that they're going to get
17 swamped. You know, neither seems to happen. I
18 would say it's more of a patients who are more
19 appropriate for specialty care get to specialty
20 care; those who, for often their own reasons,
21 prefer not to do it that way or are getting better
22 in primary care -- they're able to stay there.

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1 DR. McCURDY: Do you have any notion of
2 numbers that start out in primary case but then
3 require specialty referral?

4 MR. ENGEL: Yeah, I don't have those
5 numbers for you. Part of the challenge was -- in
6 the demonstration project -- was that we had to --
7 you know, we had to do -- we had to please an IRB.
8 You know, we --

9 DR. McCURDY: Right.

10 MR. ENGEL: So, we didn't want to
11 consent every patient. If we did patient-level
12 consent, then we'd be able to collect identifiers
13 and follow them longitudinally and report that

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14 data, that if we consented the providers for their

15 participation and then didn't collect identifiers
16 with patients, the problem is we -- you know, we
17 lose the longitudinal part, but it allows us to
18 preserve the model. You know, if we had -- it
19 would be very artificial if we had to sit down and
20 do an hour-long informed consent with each of
21 these primary care patients before they -- so.

22 DR. MacDERMID: I'm not a clinician, so

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1 I'm wondering if you could educate me a little bit
2 about the level of training that primary providers
3 in your model are receiving to do mental health
4 assessment and treatment versus some of the other
5 specialties that they have to be the front door
6 for, like neurology or other -- OB or other
7 specialties.

8 MR. ENGEL: Are you -- you're asking
9 relative to those other specialties how much
10 training are they getting in mental health?

11 DR. MacDERMID: Um-hmm.

12 MR. ENGEL: It's a good question. My
13 sense is that, you know, probably over, you know
14 -- and Dan Blazer knows this as well as anybody,
15 but probably over about the last 10 to 15 years
16 there's been an intense focus on depression, and
17 they've gotten a lot of training in depression,

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18 and it's sort of reassuring, actually, I sort of
19 grew up in this primary care mental health stuff
20 over that period, and I really do think that I've
21 seen an emerging level of comfort for primary
22 cares with the screening, making the diagnosis,

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1 and so on, you know, and it goes back to your
2 question about can we generalize these findings to
3 PTSD. PTSD is a bit more complicated. You know,
4 depression is a one- symptom domain. Nine
5 symptoms -- you know, PTSD has 17 symptoms across
6 -- if you count the trauma, you know, and the
7 inability to function -- you know, five separate
8 domains. So, you know, I think that this is an
9 area where it's a pretty steep learning curve for
10 them. There's no question about that, and through
11 the tools that we use, through the presumptive
12 diagnostic tools -- you can see some examples of
13 those in your packet and I'd be glad to provide
14 the Task Force with more information about this --
15 I'd be happy -- in fact, I have an electronic
16 version of the manuals. I could provide the whole
17 Task Force the manuals and so on that, you know,
18 the clinician and the primary care provider
19 manuals, so. But the idea is to make the sort of
20 visually -- something that at a glance they can
21 take in and come up with a presumptive diagnosis.

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1 which is in primary care, you know, you rarely
2 have the luxury of making a definitive diagnosis
3 in any area, that, you know, what you're trying to
4 do is take a first crack at identifying a problem,
5 a first crack at treating it, maybe a second, and
6 learning more about the patient over time. And so
7 this -- you know, this facilitates that. But, you
8 know, I think in direct answer to your question
9 they -- my sense is they get more mental health
10 training overall than some of the -- you know, the
11 mental health community has been pretty big on
12 reaching out to the primary care community, and I
13 think other disciplines over time have seen that
14 and tried to copy it. But I think, you know,
15 we're still using up a large amount of their time
16 to train them.

17 DR. MacDERMID: Do you have any worries
18 that physicians may over-prescribe medication and
19 under-prescribe talk therapy?

20 MR. ENGEL: I think that -- well, what I
21 believe about this is that it really boils down to
22 patient choice, that, you know, the important

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1 thing is to ensure that patients have the
2 opportunity to hear what the options are, and then
3 they -- you know, in -- depression care meds and
4 psychotherapy are about equally effective in -- in
5 PTSD care, there's some evidence that talk
6 therapies are probably at least as effective,
7 maybe a little more effective, and medicines are
8 less effective, but there are FDA-approved
9 options.

10 So, it's hard for me to answer your
11 question directly. I would say that I -- you
12 know, as much as possible, this model attempts to
13 match the treatment for the patient. You know, it
14 attempts to make sure that patients understand
15 what their options are with the help of a
16 facilitator and that at any point if they change
17 their mind through the facilitator, you know, that
18 could be arranged for them. So, I think it
19 provides quite a bit of flexibility. I guess the
20 other way of responding to your question is that
21 the more we talk with PAs and nurse practitioners
22 and family practitioners and general internists,

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1 particularly in MD, DO groups, you know, the more

2 we understand that they're actively prescribing
3 for these things already, but they're doing it
4 without these tools, and so the idea is to make
5 the prescription of treatment more appropriate.

6 DR. McCURDY: Interestingly, when it
7 comes to antidepressants, there are some good
8 studies that indicate that primary care doctors
9 under-prescribe antidepressants. I know less
10 about the PTSD part, but traditionally, to the
11 rate of like 85 to 90 percent they will
12 perennially under-prescribed. Interesting.

13 LTG KILEY: Chuck, thanks very much for
14 a great presentation, okay?

15 MR. ENGEL: Yeah, thanks for having me.
16 I appreciate it, yeah.

17 (Applause)

18 LTG KILEY: Okay, I'd like to thank all
19 the speakers for this afternoon's presentations,
20 all of which were outstanding, and I'd also like
21 to thank everyone who's attended these open
22 sessions. I'd like to see all of you back here

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1 again tomorrow, particularly the Mental Health
2 Task Force -- we'd like to see you back tomorrow
3 at 8 o'clock. We have another full day tomorrow
4 with some presentations. So, at this point, I'd
5 like to turn it over to the Designated Federal

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Official, COL Davies.

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COL DAVIES: Thanks GEN Kiley. This
open session is officially closed, and we will
open up tomorrow at 0800.

(Whereupon, at 4:24 p.m., the
PROCEEDINGS were adjourned.)

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