

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD
TASK FORCE ON MENTAL HEALTH

Arlington, Virginia
Wednesday, December 19, 2006

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3 LTG KILEY: Good morning and welcome to
4 this session of the DoD Task Force on Mental
5 Health. For those of you who have not been here
6 before, we're a Congressionally mandated task
7 force, asked to look into the current military
8 mental health system. The overall intent of our
9 meeting here today is to gain insight into that
10 system and, ultimately, provide Congress with
11 recommendations for areas of improvement, but also
12 to acknowledge areas that are flourishing. We've
13 asked specific speakers to present to the Task
14 Force because we're particularly interested in
15 their programs and their experiences. Ms. Ellen
16 Embrey, the designated Federal official for the
17 Task Force's parent Federal advisory committee,
18 the Defense Health Board, had an unavoidable
19 conflict and will not be able to attend this
20 meeting. In her absence, she has appointed
21 Colonel Jeffrey Davies, the Army Surgeon General
22 Executive Officer as the Alternate Designated

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1 Federal Official. Colonel Davies, would you like
2 to call this open session of the Task Force to
3 order?

4 COL DAVIES: Thank you, Lieutenant
5 General Kiley. As the Acting Designated Federal

6 Official for the Defense Health Board, a Federal
7 advisor committee to the Secretary of Defense,
8 which serves as a continuing scientific advisory
9 body to the Assistant Secretary of Defense for
10 Health Affairs and the Surgeons General of the
11 military departments, I hereby call this meeting
12 to order.

13 LTG KILEY: Thank you, Colonel Davies.
14 I'd like to go around the panel here with
15 introductions first, please.

16 COL CAMPISE: Good morning. I'm Rick
17 Campise. I'm a pediatric psychologist, and I work
18 with the Air Force Surgeon General.

19 MS. FRYAR: Good morning. I'm Debra
20 Fryar. I'm the Family Member Representative on
21 the Task Force.

22 COL DAVIES: And I'm Jeff Davies. And

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1 I'm the Acting Designated Federal Official for
2 today.

3 LTG KILEY: I'm Dr. Kevin Kiley, the
4 Army Surgeon General Commander of Medical Command,
5 and a co-chair of this committee.

6 DR. MacDERMID: I'm Shelley McDermid.
7 I'm co-chair of the committee. I am an associate
8 dean in the College of Consumer and Family
9 Sciences at Purdue University.

10 DR. McCORMICK: I'm Dick McCormick. I
11 retired a few years ago as the director of mental
12 health for the VA Health Care System of Ohio, and
13 I do health care research (off mike)

14 MR. DOUGLAS: Jon Douglas. I'm
15 headquartered with Marine Corps Manpower Reserve
16 Affairs.

17 DR. McKEATHERN: Good morning. I'm Dr.
18 Margaret McKeathern, a Navy child analyst and
19 psychiatrist.

20 DR. ZEISS: Good morning -- Dr.
21 Antoinette Zeiss. I'm the Deputy Chief Consultant
22 in the Office of Mental Health Services at the

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1 Department of Veterans Affairs, and I represent VA
2 on the Task Force.

3 DR. ORMAN: I am Dr. Orman, a
4 psychiatrist. I travel full time doing site
5 visits in support of the Task Force.

6 DR. WERBEL: Good morning -- Dr. Aaron
7 Werbel. I'm a clinical psychologist and a
8 behavioral health affairs officer at Headquarters,
9 Marine Corps.

10 DR. KLAM: Good morning. I'm Dr. Warran
11 Klam. I'm a psychiatrist -- I'm a Navy
12 psychiatrist (off mike)

13 COL PEREIRA: Good morning, I'm Dr.

14 Angela Pereira, the social work representative to
15 the Task Force.

16 DR. McCURDY: I'm Layton McCurdy, adult
17 psychiatrist, recently dean of the medical school
18 at the Medical University of South Carolina in
19 Charleston.

20 DR. BLAZER: I'm Dan Blazer,
21 psychiatrist/epidemiologist; former dean of the
22 medical school at Duke University; also a member

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1 of the Defense Health Board; and I am the liaison
2 from the Board to this Task Force, as well as
3 being a member of the Task Force.

4 LTG KILEY: Thank you all very much.
5 Dr. Burke, do you have any administrative
6 comments?

7 DR. BURKE: Yes, sir. Thank you,
8 General Kiley. Good morning, ladies and
9 gentlemen. For all attendees, if you have not
10 already signed the attendance roster on the table
11 at the front entrance, please do so. We will be
12 transcribing this open session, so please use the
13 microphones when speaking, and clearly state your
14 name. The transcripts will be published on the
15 Task Force website within 90 days of this meeting.
16 We would also like to ask you to be respectful of
17 your fellow attendees and allow those who are

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18 speaking due courtesy. For members of the press:
19 the morning sessions are primarily for information
20 gathering for the Task Force. If you could please
21 hold any questions for the speakers until after
22 their talks, they will be available to take

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1 questions. Restrooms are located outside the main
2 entrance, to the right. And for any
3 administrative requirements, please see Ms.
4 Bennett at the front entrance, or Ms. Ferrell,
5 who's working audio-visual. Thank you, General
6 Kiley.

7 LTG KILEY: Thank you very much. Dr.
8 McDermid?

9 DR. MacDERMID: Our first speaker this
10 morning is Mr. Steve Robinson, who will speak on
11 behalf of the Veterans for America. Welcome.

12 MR. ROBINSON: Good morning. Thank you
13 for having us. We're honored to be here, and
14 we're very proud of the work that you're doing,
15 looking at the issues related to the returning
16 veterans and their health care needs. We decided
17 to take our 30 minutes and break it up into five
18 different presentations -- very short
19 presentations. But we wanted to give you a
20 breadth of experience. I'm going to do a big
21 view, and then the veterans will do their personal

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22 stories, or soldiers they have worked with. My

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1 name is Steve Robinson. I'm the Director of
2 Veterans Affairs at Veterans for America, formerly
3 Vietnam Veterans of America Foundation, an
4 educational and humanitarian organization that
5 addresses the causes, the conduct, and the
6 consequences of war. For a generation, VVAF and
7 now VFA, has been concerned about the issues
8 affecting the men and women in uniform, as well as
9 our nation's veterans. One of the issues that have
10 been at the forefront of our concern is the mental
11 health care problems in which vets returning from
12 the war. Our founder Bobby Muller worked hard to
13 ensure that Viet Nam era veterans suffering from
14 what we now know as PTSD were properly treated,
15 and that the generation of Americans took care of
16 them when they came home. They were responsible
17 for establishing the Vet Centers. Today I have
18 several colleagues with me that will come up and
19 introduce themselves and tell you a little bit
20 about their personal experiences. Some of them
21 have served in Iraq, others are Gulf War veterans
22 like myself. And I also want to acknowledge one

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1 of my colleagues, Andrew Pogany, who also I've
2 been working with as an outreach coordinator. Let
3 me start by praising the military for the care
4 they deliver on the battlefield and at the
5 hospitals and the clinics worldwide during the
6 war. The injuries our soldiers suffer from that
7 are the result of bullets and bombs are treated
8 with the greatest of care, state of the art
9 equipment, state of the art processes. We are
10 extremely proud of the military. You are saving
11 lives. This meeting today, however, is going to
12 discuss the unseen psychological wounds of war.
13 VFA wants the same thing you do: the healthiest,
14 best trained, best equipped warrior on the
15 battlefield, protecting our freedom and defending
16 our Constitution. We also want our veterans to
17 have prompt access to robust mental health care
18 systems. There have been many positive statements
19 in the process from DoD on the success of its
20 mental health care system. However we are here to
21 tell you that our soldiers and our veterans, and
22 some of their families, are falling through the

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1 cracks. I ask you this: if I could show you one

2 soldier that honorably served this nation in war,
3 and that soldier was improperly discharged without
4 receiving mental health care, and subsequently
5 lost access to his VA health care, would we be
6 angry and want to fix it? What if I could show
7 you two soldiers, in excellent health before they
8 entered into the military, and during their
9 military career they had stellar wartime service,
10 surviving IED blasts, yet they were discharged
11 without receiving a mental health care treatment
12 plan and were discharged improperly, given the
13 diagnosis of personality disorder -- would we be
14 angry? What if I told you that hundreds, and
15 potentially thousands of soldiers are facing
16 barriers to mental health care, and are receiving
17 improper discharges? Yet the military is failing
18 to correct this, even when the evidence is
19 presented to commanders. What if that soldier was
20 your child? A fellow officer? Or your driving
21 during war? Would you fight for them -- for their
22 honor and their future as a repayment for their

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1 sacrifices? I know you would. Of course we
2 would. I'm a Ranger. I was taught to never leave
3 a fallen comrade on the battlefield. We would
4 rather risk more lives than to let the enemy drag
5 one of our own through the streets. Surely you

6 agree that this is something that we need to
7 tackle for their honor. We have trained our
8 soldiers based on these principles of the Warrior
9 Ethos. They've lived it now, and they are asking
10 that these same principles apply to their needs
11 when they come home -- no exceptions. I'd like to
12 paint a picture describing what our soldiers face
13 upon returning from war from our perspective.
14 Nearly all the soldiers who we have dealt with
15 have served honorably in war. Yet, our soldiers
16 fall through the cracks due to a lack of mental
17 health care providers; they fall through the
18 cracks due to a lack of understanding about war-
19 related mental health conditions. They fall
20 through the cracks due to ignorance about the
21 consequences when soldiers are untreated. They
22 fall through the cracks when leaders don't take

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1 time to plug them into the existing health care
2 system. I know what I'm telling you is hard to
3 believe, and you're saying to yourself: "Not in my
4 military; not under my watch." But, ladies and
5 gentlemen, it is happening. And we are meeting
6 those soldiers. Recently in the news we've heard
7 statements about the strain on the military. Some
8 have predicted that the military will break if
9 action is not taken immediately. We are raising

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10 that same red flag. We are raising that red flag
11 about the needs of veterans when they come home
12 from war. How do we improve the situation? We
13 help soldiers understand that the stress they
14 experience is a continuum of the body, brain and
15 nervous system. Combat-operational stress comes
16 home in the form of a changed brain and nervous
17 system. These stresses end up in the soldier's
18 body and mind. We need to operationalize mental
19 health care as a regular part of our duties. We
20 need to put mental health care in our smart books
21 and teach soldiers about it during basic training.
22 We need to give them tools to understand the most

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1 important but least discussed weapon system on the
2 battlefield. We teach them about the brain and
3 body and how it functions in war. We make it a
4 standard part of military training. We make it
5 part of our leadership training. Here's what
6 "operationalizing" means: when a tank breaks down
7 in Iraq because of poor maintenance we don't
8 abandon it. We train our soldiers in mechanics to
9 maintain and repair it. We hold the soldier and
10 the chain of command responsible for the proper
11 maintenance and the combat readiness of the
12 vehicle. We provide the soldier with manuals,
13 checklists and reports. We audit and follow up

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14 with inspections. However, right now, there is no
15 field manual or training manual that's written and
16 enforced at the lowest level for leaders to use to
17 train our new recruits. There is no doctrine that
18 informs leaders that PTSD and combat stress are
19 integral factors of war that must be understood
20 and planned for during war and when soldiers come
21 home. This is the big picture idea that I want to
22 present to the Task Force. There are tools we can

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1 give our leaders. I want to talk about a cultural
2 mind-set in the military towards discussing,
3 training and planning for the realities of war,
4 then providing the tools for the soldiers and
5 leaders and the families to deal with these issues
6 when they come home. We've taught our soldiers
7 about heat stress and what to do when the signs
8 and symptoms present themselves. We should
9 provide similar training to our soldiers and
10 leaders and ensure they have these required skills
11 to operate where traumatic psychological events
12 occur. We believe addressing this idea head on
13 will reduce stigma, give the soldiers a way to
14 normalize their feelings and find themselves
15 supported by a chain of command that understands
16 their issues and will support them in recovery.
17 Moreover, we believe this approach will lead to a

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18 more resilient soldier who is better prepared for
19 the combat environment and the reintegration home.
20 I work with communities around the country who are
21 developing free community-based reintegration
22 programs for soldiers and families that go well

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1 beyond the services currently offered by the DoD
2 or the VA. These communities have responded
3 because our veterans are returning home, and they
4 are desperately in need of care. These
5 communities are willing to partner with the DoD.
6 These are the trauma experts of the world. They
7 are willing to partner with you to augment your
8 current programs. Please work with me and
9 Veterans for America to discuss these successful
10 programs and see if there is any way we can do
11 more in public and private partnerships. The
12 soldiers have earned the right to the most
13 comprehensive and tailored care this nation can
14 deliver. And the mission in Iraq and Afghanistan
15 will not be over until we have delivered it. I'd
16 like to introduce now Paul Sullivan who will talk
17 about how the war in Iraq is impacting the
18 Department of Veterans Affairs. Thank you very
19 much.

20 LTG KILEY: Thank you Mr. Robinson.
21 Will you be back for some questions -- I hope.

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1 General, and thank you Dr. McDermid, and members
2 of the Mental Health Task Force. My name is Paul
3 Sullivan. I'm the Director of Research and
4 Analysis at Veterans for America. Any my
5 testimony today will focus on the impact on the
6 Iraq and Afghanistan wars on veterans, and on the
7 Department of Veterans Affairs. You may have
8 received briefings from VA before, but I'll
9 present it in a little different light. First and
10 foremost, we're doing this because Veterans for
11 America is committed to ensuring that the care our
12 veterans receive is prompt, it's adequate and it's
13 comprehensive; and that the systems and programs
14 in place reflect the specific needs of these
15 veterans so that we can best assist them. No
16 organization or agency can assist veterans and
17 deliver quality care without first understanding
18 the unique readjustment needs of our newest
19 generation of veterans. For us at VFA the need is
20 most urgent. However there are some other urgent
21 needs that need to be addressed. When a service
22 member is discharged to civilian life, their

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1 mental health care needs related to their military
2 service become VA's responsibility. Further, when
3 there are problems with how the military handled
4 the service member's mental health care, then the
5 problems are often exacerbated between the gap
6 between leaving the military and being picked up
7 by the Department of Veterans Affairs. When I'm
8 done with presenting some of the comments about
9 the caseload and workload at VA, then I'll offer
10 some practical solutions about what VA can do
11 based on possible recommendations from this Task
12 Force. Right now, VA faces a very severe capacity
13 crisis if VA does not begin to properly plan for
14 the influx of returning veterans -- especially for
15 mental health care. Quality of care is dependent
16 on increasing VA's capacity soon. First, here are
17 the facts about the Iraq and Afghanistan war
18 workload at VA. As of September in 2006, we know
19 about 1.5 million of our service members have
20 deployed to the two wars in Iraq and Afghanistan.
21 Of those, about 630,000 are now eligible for VA
22 health care and benefits. Just of those eligible,

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1 more than 205,000 have already been treated at VA

2 hospitals. Of those treated, about 73,000 were
3 diagnosed with a mental health condition,
4 including about 34,000 with PTSD, and another
5 28,000 for non-dependent drug abuse. Of the
6 eligible veterans, 144,000 were already treated
7 and counseled at VA's Vet Centers for mental
8 health readjustment problems. The numbers are
9 really staggering. Of the eligible veterans,
10 153,000 are claiming they are disabled. And right
11 now the situation at VBA, where they process the
12 claims is also having a capacity problems. All
13 veterans are waiting six months for an initial
14 decision. All veterans are currently waiting
15 about two years for a decision on an appeal.
16 Unfortunately, VA doesn't provide any statistics
17 on mental health care claims for the Iraq and
18 Afghanistan war veterans, even though a lawsuit
19 was threatened to try to get the information from
20 them. Unfortunately, VA doesn't produce any
21 claims statistics on TBI either, which may be
22 related to other mental health problems. What I'd

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1 like to do is give you next a projection of the
2 devastating trends in VA health care and
3 disability claims use and caseload among Iraq and
4 Afghanistan war veterans. Based on current
5 trends, VA medical centers may treat up to 750,000

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6 or more recent war veterans. This is based on the
7 50 percent health care use among Gulf War
8 veterans. We expect about 200,000 of those to be
9 for mental health. VA's Vet Centers may treat
10 upwards of 525,000 or more recent war veterans,
11 based on their statistics and a recent Army study
12 showing about 35 percent mental health care use
13 after their return from war. VA's Regional
14 Offices that process claims may expect to receive
15 upwards of 650,000 compensation claims based on
16 the Gulf War claims- filed rate of 45 percent.
17 Let me use some of VA's own words to describe
18 their problems. In May 2006, Dr. Frances Murphy,
19 the Undersecretary for Health at VA, said the
20 growing numbers of veterans seeking mental health
21 care has put emphasis on areas where improvement
22 is needed. She noted that some VA clinics do not

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1 provide mental health or substance abuse care or,
2 if they do, she said: "Waiting lists render that
3 care virtually inaccessible." In an October 2006
4 report by the House Veterans Affairs Committee,
5 Vet Center managers reported that their increase
6 in workload has affected the Vet Centers' ability
7 to treat their existing client workload. Of the
8 Vet Centers the Congress sent questionnaires to,
9 40 percent have sent veterans for whom individual

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10 therapy would be appropriate to group therapy
11 instead. The Vet Centers said roughly 27 percent
12 of the affected Vet Centers have limited to plan
13 to limit veterans' access to marriage and family
14 therapy. Nearly 17 percent of the workload
15 affected Vet Centers have or plan to establish
16 waiting lists. As of November 2006, VA's claims
17 backlog of incomplete and pending disability
18 compensation claims hit a staggering 400,000 --
19 including 34,000 claims among Iraq and Afghanistan
20 war veterans. We believe that it's not too late,
21 but we must do something now. We have been
22 working with a number of House and Senate offices

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1 on these and related issues, including Senator
2 Obama, Senator Leahy, Senator Murray, Senator
3 Boxer and Senator Bond; as well as Representatives
4 Filer, Moran, DeLauro and LaHood -- in a
5 bipartisan effort to get results. We feel
6 confident that the 110th Congress is ready to work
7 with veterans advocates like Veterans for America
8 to help address these needs. We have some
9 immediate practical suggestions I'd like to offer.
10 First, DoD could and should promptly use Reserve,
11 National Guard, VA and/or qualified and screened
12 civilian mental health care professionals if
13 demand continues to exceed capacity. DoD should

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14 work with VA to provide Benefits Delivery at
15 Discharge to all deployed service members,
16 especially National Guard and Reserve. VA should
17 obtain real-time, robust medical and service
18 information from DoD on all service members, with
19 special identifiers about those deployed and
20 injured. DoD should create a joint statistical
21 office to prepare reports detailing the costs and
22 activity among these new war veterans. Next, DoD

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1 and VA should launch a nationwide anti-stigma
2 campaign for mental health. And VA should work
3 together with DoD to identify and monitor deployed
4 and non-deployed military cohorts for research and
5 to determine the best treatments for mental
6 health. Since I'm going a little long, what I'd
7 like to do is turn it over next to Jonathan
8 Powers, our vice president at Veterans for
9 America. Thank you.

10 LTG KILEY: Thank you. We have plenty
11 of time, though. There's plenty of time.

12 MR. POWERS: Thank you, members of the
13 panel, for the opportunity to testify today about
14 the case of Army Staff Sergeant Michael Goss. My
15 name is Jonathan Powers. I'm the Vice President
16 of Policy, Veterans for America. I spent over 14
17 months in Iraq deployed to fight in both Baghdad

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and Najaf, as a Captain of the First Armored
19 Division. I worked closely with the soldiers
20 during our time in Baghdad's most volatile sector,
21 both as platoon leader and later as Battalion
22 Commander's Adjutant. I also spent in Najaf,

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1 battling Moqtada Al-Sadr's uprising in the spring
2 of 2004. While I feel blessed for coming home
3 from this deployment physically unharmed, I do
4 know that my experiences have changed me as a
5 person. As a 24 year old man I led men into
6 battle and understand the horrors of war. At the
7 same time I also understand that my experiences
8 were much less violent than some of my soldiers',
9 and whatever adjustment anxieties I learned to
10 work through, many suffered much worse. One of my
11 soldiers in particular has undergone enormous
12 mental suffering from the combination of our first
13 tour together, and then his second -- the Fourth
14 Infantry Division -- and he has fallen through the
15 cracks. We need to prevent this from happening
16 again. I'm going to read to you from an e-mail
17 that I received last week: "Hi. It's me. I'm
18 sorry for what happened. When I decided to kill
19 myself, I had no idea how it would impact you. I
20 had no idea it would hurt you so badly. I never
21 realized that my decision would hurt so many

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1 pain. I was just so blinded by my own pain that I
2 couldn't see anything else. I could see how much
3 I was loved. I can see it now though. "Don't
4 think that you missed all the warning signs or
5 that you could have done something different
6 because I tried so hard to keep anyone from
7 finding out. I guess maybe I did keep it secret
8 that time. I didn't want you to know what I was
9 planning. I know you're hurting and I'm sorry. I
10 know you want the pain to stop, and I know what
11 you might be thinking. I can't be sure, but you
12 might be thinking that you want to kill yourself
13 too, like I did. Just think about that for
14 minute. I want you to be happy again, so please,
15 if you don't do anything else, please go to some
16 kind of support group to help yourself feel better
17 for me. "I love you very much and I never meant
18 to hurt you. I just didn't realize that what I was
19 doing would impact so many lives so much. "I'm
20 sorry. I want to ask you to do something for me.
21 I want you to do something to help others when you
22 feel you're ready. You could help others who have

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1 had friends or loved ones kill themselves, or you
2 could help people who are suicidal now. Whatever
3 you do, please help the hurting stop. "I wish I
4 could turn back time and make things different,
5 but I can't. I want you to remember that you
6 didn't do anything wrong. I chose this on my own,
7 so don't blame yourself. Please don't live in the
8 moment of my death because it will only hurt you
9 more, and I don't want to cause any more pain. I'm
10 sorry for all the pain that I've caused. I guess
11 I should be going now, but tell everyone what I
12 said. I'm depending on you to spread the word.
13 Bye for now." This e-mail was sent to myself and
14 a couple others by Michael Goss, a man who proudly
15 served the Army for nearly nine years. He rose to
16 the rank of Staff Sergeant in six years, which is
17 uncommon in the Field Artillery. He gained
18 numerous accolades, to include three Army
19 Achievement medals and one that's dearest to his
20 heart, the Combat Action Badge. It was during
21 Mike's second deployment to Iraq that he was
22 diagnosed with post traumatic stress disorder. He

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1 became obsessed with defeating the enemy. He woke

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2 up constantly from nightmares. He saw his friends
3 die. He unloaded an M-16 magazine into a car at a
4 checkpoint, only to discover, to his horror, that
5 it was filled with a father and three daughters,
6 and they all died. Mike wrote this on July 14,
7 2006: "As soon as we cleared the tall brush all
8 hell broke loose. RPGs and automatic fire. Now
9 I'm scared. I look past the humvees with the
10 soldier crouching behind and see that he's firing
11 at multiple men in the street. It's later that I
12 know what insurgents are. We fire back when I see
13 something disturbing. Soldiers scattered all over
14 the street and blood running down the street fast.
15 I panic, I'm not gonna lie, but I also snapped.
16 Fire back, I tell myself. I start firing when my
17 battle screams out the most obvious thing in the
18 world. 'Are they shooting at us?' 'Shit, they
19 are shooting at us.' And I said, 'Oh, shit,' and
20 ran to the humvee. "The Humvee had been attacked
21 by an IED. Destroyed the whole Humvee and it had
22 a soldier still in it. It was on fire. It was

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1 hot and it was quiet for some reason. I looked
2 around to see men in white running through the
3 brush, and I fired back one whole magazine into
4 the brush. Killing one. "I look over at the
5 burning Humvee and see a soldier moving, and I run

6 over and find Corporal Bibby, but his rounds are
7 cooking off in the Humvee. I run in anyways and
8 pull him out. I hand him over to a soldier on the
9 back of the Humvee. The soldier was sitting on a
10 tailgate. He cradles Bibby from under his arms
11 and they drive off fast. I know he's dead, I tell
12 myself. I look away as his face seems to look at
13 me. I feel sick now." These experiences haunted
14 Mike and led to his PTSD. Mike's commander in
15 Iraq reacted to his diagnosis by placing him on
16 security details guarding the unit's base. It was
17 on one of those details that his command accused
18 Mike of being in violation of the UCMJ for
19 providing a group of children construction
20 materials that he had found in a trash bin. Mike
21 thought he was helping the children, but his
22 command saw it another way, and soon he was sent

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1 back to the States to receive an Article 32
2 hearing. After nearly nine years of service,
3 Staff Sergeant Michael Coss received and
4 other-than- honorable discharge and was being
5 rushed out of the military at Fort Hood and dumped
6 into the civilian world. During the Army's
7 efforts to push Mike through the system they
8 neglected to address the one core issues that
9 surrounded all the others: his combat-related

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10 PTSD. Just prior to him clearing the military,
11 Mike me with a mental health NCO, who wrote: "' I
12 only have 15 minutes today. They're trying to get
13 me out tonight.' The Service Member seen as a
14 walk in. The Service Member states that he is
15 receiving a Chapter 10 discharge. Other than
16 honorable conditions. The Service Member is very
17 upset about this and concerned about what the
18 consequences will be for receiving VA benefits.
19 The Service Member feels Betrayed 'I've given them
20 nine years of service. I've been in combat and
21 this is how they repay me?' "The Service Member
22 endorses fear that he will be emotionally cut off

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1 from his family upon discharge. The Service
2 Member states that he is desperate to receive
3 counseling, but fears the VA will deny him access
4 to services because of the dishonorable
5 discharge. " The mental health NCO noted as a
6 diagnosis post-traumatic stress disorder. All of
7 Mike's fears came true, as he was improperly
8 denied medical care at a Department of Veterans
9 Affairs hospitals because of his other-
10 than-honorable discharge. VA ignored their own
11 rules by overlooking the fact that Mike received
12 two honorable discharges from previous
13 enlistments, thus entitling him to VA care. This

14 left Mike, his wife, and his three young children
15 on their own to deal with his invisible Iraq war
16 injury. The following is from another of Mike's
17 blogs, dated August 1, 2006: "Lately my wife and I
18 have been on bad terms. We don't communicate as
19 much. Our lives and love is more distant. I need
20 a job. I need security. I need PTSD counseling.
21 I need VA. I need a home. I need so much shit,
22 and the only think I think I'm losing my family is

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1 due to this discharge. I don't look for pity, or
2 have I ever. Just wish I knew the answers. She
3 might leave me soon. And then I'll be lost
4 again." These are the events that led Mike Goss
5 to send the e-mail that I received last week. But
6 Mike's lucky. His family and friends have pulled
7 together to help him through this time. It's a
8 continual struggle. But from the guidance of
9 heroes like Steve Robinson and Paul Sullivan, they
10 helped guide Mike through the maze of the VA, so
11 he's still alive today. So I asked Mike's
12 permission to use his story here today, and these
13 are the words I received back: "sir, asking me
14 shouldn't even have crossed your mind. You WILL
15 speak specifically about me today. We need to fix
16 what's broke. And I have no problem letting
17 people know that I am an example of a broken

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18 government and the way they treat their own.
19 Don't let them do another soldier like this
20 again." I'd like to introduce Andrew Pogany,
21 who's also a member of Veterans for America.
22 Thank you.

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1 LTG KILEY: Thank you.
2 MR. POGANY: Good morning, Lieutenant
3 General Kiley and distinguished members of the
4 panel. I welcome the opportunity to speak before
5 you today about the barriers to treatment on the
6 ground, in the companies, at the battalion level,
7 and in the barracks. My name is Georg-Andreas
8 Pogany, and I'm an Iraq war; served with the
9 Special Force Group. I'm also a member of
10 Veterans for America. I routinely meet with
11 service members and their families when they are
12 in the process of getting out of the military.
13 During the past two years I have worked with
14 active duty National Guard members during the
15 MEB/PB process, during their Chapters, and during
16 their UCMJ phases -- all associated with their
17 wartime service related injuries, reintegration
18 and readjustment needs. Soldiers contact me on a
19 regular basis and report that they are unable to
20 get comprehensive, adequate and
21 individually-tailored mental health care services

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for their combat-induced psychological injuries.

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1 After careful and thorough review of each
2 soldier's medical and military service record, I
3 am faced with the sobering reality of the enormous
4 gaps in the systems of services and safeguards to
5 prevent service members from falling through the
6 cracks. My brief presentation today is a
7 snapshot, in the context of my ongoing fact
8 finding to seek to reveal and tear down the
9 barriers to appropriate care for those we have
10 sent to war. R. Winkenwerder told Congress in
11 October 2005: "No one who goes to war remains
12 unchanged." Dr. Winkenwerder is correct. Every
13 soldier I encountered during my work has come home
14 from the a changed person. They also sought
15 medical care for their serious psychological;
16 practically begging their chain of command to help
17 them with their problems. But their cries went
18 unheard. It is our duty and obligation to ensure
19 that they get the maximum care, which they have
20 rightfully earned by serving this nation during
21 time of war. I recently met with Major General
22 Pollock, and I presented her with nine thoroughly

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1 documented cases of soldiers who fell through the
2 cracks. Here are 10 serious problems describing
3 barriers to prompt and adequate treatment, many
4 validated by Army research studies: stigma against
5 mental health treatment, to include
6 self-stigmatization; lack of honest education of
7 the effects of combat stress and PTSD; failures to
8 refer soldiers to mental health after the soldier
9 indicated on their DD Form 2796 that they were at
10 risk; waits as long as four to six weeks when
11 mental health care is finally sought; lack of
12 training on how to assess the psychological cost
13 of war for the non-commissioned officers and
14 junior officers; hazing and abusing of soldiers by
15 their peers and chain of command; unjustly blaming
16 combat survivors, and faulting them for the
17 symptoms they experience as a result of combat by
18 labeling them and treating them as men of weak
19 character and being categorically defective; lack
20 of resources to promptly and adequately provide
21 mental health care, especially for PTSD and drug
22 abuse; lack of comprehensive and

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1 individually-tailored care; lack of the proper

2 environment conducive to promoting mental health
3 care in the best interests of soldiers, families
4 and national security. Here are 12 practical
5 solutions DoD can take right now to assist service
6 members who are most in need of treatment,
7 reintegration and recovery. For time purposes, I
8 will only read four of them. First, launch a
9 massive anti-stigma campaign for PTSD that
10 emphasizes combat stress and operational stress as
11 an operational element; bring service members who
12 are suffering from psychological injury to the
13 Capitol or the White House and publicly honor
14 their service and sacrifice, and acknowledge that
15 their condition is related to combat stress and is
16 a combat-related injury; bring combat veterans and
17 civilian trauma experts into the post-deployment
18 screening process, and into the delivery of
19 treatment and follow-up; consider alternative
20 programs, such as Native American Warrior
21 Cleansing Rituals. In conclusion: an open and
22 honest examination of the psychological effects of

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1 combat must begin by acknowledging that we are a
2 nation and an Army at war, with leaders whose
3 wartime skills are finely tuned and honed.
4 However, these positive aspects are being over
5 emphasized and exaggerated in order to protect the

6 self-image of combatants, and to honor the memory
7 of the fallen and rationalize their deaths. On
8 the flip side of that coin, we are failing to
9 incorporate combat stress as an operational
10 element in all aspects of military training and
11 leadership development. There is no honor in
12 denying and repressing the truth about this
13 extraordinarily traumatic and psychologically
14 costly endeavor that profoundly impacts all who
15 participate in it. The war missions in Iraq,
16 Afghanistan and here at home remain incomplete
17 until we fully mobilize every possible resource to
18 assist our returning combat veterans with their
19 reintegration and recovery needs. We must
20 acknowledge that the psychological cost of war is
21 borne by those who survive and come home. We must
22 recognize and address the psychological cost at

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1 the individual level. The effects of combat and
2 the profound psychological cost is irrefutably
3 great and tragic. We don't, you don't -- nobody
4 has the right to condemn our returning combat
5 veterans to a life without peace of mind. Put
6 into the words of President Abraham Lincoln: "How
7 costly a sacrifice to have laid upon the altar of
8 freedom." The only way to heal the injury to the
9 mind resulting from the most grotesque and

10 incomprehensible environment, the only way to heal
11 from the worst of what humanity has to offer, is
12 to stand face to face with the reality of combat
13 and to fully comprehend the magnitude of the
14 inevitable psychological cost. Every soldier,
15 marine, airman and sailor deserves to be listened
16 to and deserves to be understood, and not shoved
17 off into some fringe group of society labeled "the
18 mentally ill" or "the personality disordered." In
19 his book, Achilles in Vietnam: Combat Trauma and
20 the Undoing of Character, Jonathan Shay, a
21 psychiatrist writes that recovery from combat
22 depends on communalization of that trauma -- on

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1 sharing it; sharing it with a community that can
2 be trusted to listen, hold and retell the story in
3 an honest way. We must fully engage all of our
4 returning combat veterans wherever they stand in
5 life after coming home, and not hide from their
6 experiences or try to control it, but rather be
7 present with it. Thank you.

8 LTG KILEY: Thank you.

9 MR. REPPENHAGEN: My name is Garrett
10 Reppenhagen. I'm the Vice President of Public
11 Affairs for Veterans for America. I served as a
12 sniper in the Big Red One 1st Infantry division
13 for one year in Iraq. During that long year I

14 wrote a poem to try to express the difficult
15 emotions that I struggled with -- Ghosts.
16 What is left of a man after the war's
17 toll has broken him? After the blood of an enemy
18 and ally mixes on his hands And the sight of
19 twisted death burn white hot images in his mind,
20 how does he carry on? When his nerves are frayed
21 and cut as if exposed to the painful air, How does
22 he calm his startled heart? He stares into the

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1 darkness as if ghosts of his fallen friends were
2 haunting him. However, to his own sorrow, there
3 is no one there, No one to comfort him, no one who
4 understands, no one to forgive him. He is left
5 withered, beaten and alone, Until he becomes a
6 ghost himself. In that poem I tried to describe
7 my wishes to be haunted by my friends who had died
8 because I missed them. Because they were the only
9 ones who understood the horror of my experience at
10 war. Because they were the only ones that can see
11 the evidence of my actions and inaction, they
12 would be the only ones would can forgive me fully.
13 Because I cannot forgive myself. Perhaps if
14 psychological injury was more accepted by society
15 and the institution I would have an easier time
16 coping with my emotional and mental stress. Post
17 traumatic stress disorder and psychological injury

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18 should be addressed like physical injury. In
19 basic training, a soldier learns how to treat the
20 wooded, to treat bleeding, burns and shock. When a
21 recruit suffers from mental or emotional stress in
22 training he is alienated and he is isolated. His

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1 belt and bootlaces are taken from him so he cannot
2 commit suicide. He is given a bright orange vest
3 with "LOS" written on it, meaning he cannot leave
4 the line of sight of others at any time. He must
5 be watched by other recruits and even guarded
6 while he sleeps. The intent isn't to help the
7 soldier become well, but to intimidate him and
8 others so they do not show that they have mental
9 health conditions. In fact, even while on active
10 duty emotional and mental stress is seen as a sign
11 of weakness or considered malingering; feigning
12 illness or injury to avoid duty. While I was
13 deployed, a soldier, Specialist Thom, was nearly
14 killed by incoming mortar fire and began to suffer
15 from various mental health symptoms. When he went
16 for aid he was sent to his chaplain, who explained
17 that his problem was a lack of faith in God and
18 country. He pressed the issue when his symptoms
19 worsened, and he was told to seek help at a nearby
20 base -- Anaconda -- that had mental health care
21 professionals. Anaconda was still a 45 minute

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22 humvee ride away. So a scout squad who had

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1 already performed a 10-hour mission that day was
2 tasked to escort Specialist Thom. After risking
3 the journey and avoiding possible IEDs and
4 ambushes, Specialist Thom was given a stack of
5 paperwork and told to return the next day. The
6 scout squad again escorted Specialist Thom in
7 addition to their daily duties, this time being
8 struck by a vehicle car bomb on route. The scouts
9 quickly blamed the Specialist for their increased
10 mission load and the injuries to their friends.
11 Since Thom was not a combat arms MOS he was looked
12 upon as a faker and a coward. Feeling pressure
13 from command and his fellow soldiers, Specialist
14 Thom withdrew his request for help, and his
15 condition became dangerously worse as deployment
16 went on. Combat trauma is something that is well
17 documented in previous wars, and the DSM clearly
18 defines mental health injury as a reality of
19 combat. Combat stress has evolved from "shell
20 shock" and "battle fatigue" to "post traumatic
21 stress disorder." To claim that you can avoid
22 traumatic stress by having stronger nerve or being

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1 more courageous is as ridiculous as statement that
2 a stronger man with greater fortitude would not
3 have his leg ripped off by an IED. To claim that
4 disability from PTSD is a welfare program for
5 disgruntled vets is disgraceful. The men and
6 women I know who are struggling in the nightmare
7 of mental health injury would pay back tenfold
8 what they earned in compensation to not have to
9 live with this debilitating disorder. I have a
10 reoccurring dream that I am eating ice cream with
11 my daughter outside a Dairy Queen when we are
12 ambushed by insurgents. As RPGs whistle and
13 explode all around us, I scoop her up and hide
14 behind the building. Wedged between a dumpster
15 and a wall, I can see American soldiers rush from
16 the other direction. One soldier stops at the
17 edge of the building near us and is shot in the
18 throat. I yell at my daughter to cover her eyes,
19 and I drag the man out of harm's way and check his
20 vitals. Determining he is dead, I take his M-4
21 and swing around the corner. An Iraqi with an AK
22 is darting across the street, and I bring the

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1 weapon up to my check and put my nose against the

2 charging handle. I draw a bead through my
3 ironsights and my target blurs as my front sight
4 post focuses as I aim. My sweaty finger slowly
5 squeezes the trigger, and out of the corner of my
6 eye I see my daughter. She is staring at me in
7 curious terror, as I wrestle with the need to fire
8 and the inability to act in front of my child. A
9 flash of pain and gunshots follows, and I am
10 awake. Sometimes I am still in bed, sometimes I
11 am alone. The symptoms of trauma from war vary.
12 One common program and diagnosis will not cover
13 the range of illness effect of every veteran.
14 What doesn't vary is the responsibility to care
15 for these veterans. The men and women who chose
16 to serve their country gave an oath to the people
17 of this nation that they would sacrifice if their
18 democracy was in need of defense or there was an
19 injustice in the world that had to be stopped. We
20 willingly served with the trust that our society
21 and government would give us adequate health care
22 if we were injured in the line of duty. We

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1 sacrificed with the hope that when our service was
2 complete that we would have programs in place that
3 would place us on par with our peers that declined
4 to service. Currently our country is failing to
5 provide the needed care in the areas of mental

6 health. Right now in our nation, the promise that
7 we gave our service man and women is being broken.
8 Veterans for America is encouraged that this
9 important task force has been created. We urge
10 you to not only understand what needs to be done
11 for veterans and service members, but also be
12 reaffirmed on why proper care for veterans and
13 soldiers is a critical responsibility of our
14 nation. You all now have the position to fix this
15 crucial problem, and Veterans for America thanks
16 each and every one of you for taking on this
17 objective. I'm going to bring you back to Steve
18 and he can answer some questions for you.

19 MR. ROBINSON: So we'll all just kind of
20 stand right here, if there are any questions.

21 LTG KILEY: Sure -- have them all come
22 up, please. Thank you -- it's been very important

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1 testimony. Thank you very much. And now I'd like
2 to ask members of the Task Force if they have some
3 questions for any or all of these gentlemen.

4 DR. McCORMICK: One of the issues that
5 we're struggling with is trying to get a better
6 handle around returning National Guard and
7 Reservists. You made a few points about it
8 already. I wonder if you could share more --
9 especially with your outreach efforts -- to us

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10 about the unique challenges that they face?

11 MR. ROBINSON: There's a couple of ways
12 we could answer that. We know that the majority
13 of National Guard and reserve soldiers come from
14 rural America; towns and populations of less than
15 10,000. We know that when they return home they
16 do not have military facilities where they live,
17 and if there is a VA near them, it's usually a
18 community-based outreach center, or someplace that
19 is some extensive drive. I'll give you an
20 example: Ortenville, Minnesota; population 600; 42
21 soldiers deployed, seven were injured, two were
22 killed; the nearest VA was two hours. It was

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1 difficult for them to get the kind of care they
2 need. Fortunately, the FRG knew that they had
3 that problem and they called people in to be
4 present when the soldiers came home. Senator Kit
5 Bond and Senator Pat Leahy co-chair the National
6 Guard Caucus. They are aware of this problem and
7 they are trying to stand their programs to meet
8 the needs of the National Guard soldiers and the
9 Reservists.

10 CAPT KLAM: You've brought up some very
11 important points, and these are issues that we're
12 struggling with as a task force, to find out some
13 of the answer to some of the issues you've brought

14 up. My question is in regards to the barriers
15 that you're seeing from accessing mental health
16 from active duty members. What would you say are
17 the primary issues that are preventing airmen,
18 seamen, soldiers, marines from getting care when
19 they need it. And I'm talking right now primarily
20 while they're still in uniform.

21 MR. ROBINSON: Right. Andrew, if you'd
22 answer that. And, John, if you guys. One of the

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1 things we've worked on at Veterans for America is
2 ensuring that proper screening is taking place
3 when guys are coming home. Because as we talked
4 about before: when equipment comes back you check
5 the M-16s, you check the vehicles, but no one's
6 checking the soldiers. They're doing a screening
7 survey that you do in the field. I remember
8 sitting in the desert in Najaf and filling out a
9 check-box. That was my post-screening. And then
10 we got to the base and we had our 10 days before
11 we were actually released for leave, we had a
12 meeting in an entire room -- you know, the entire
13 battalion, 600 folks -- and someone stood in front
14 and asked: "If anyone's having any problems with
15 nightmares or their families, please come to the
16 front of the room." Who's going to do that? So
17 it's important that there's confidential,

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18 one-on-one screening that takes place when the
19 guys are coming literally off the plane -- not so
20 much to address whether or not they have PTSD
21 because we know that's going to show up later
22 sometimes -- just to inform them that this could

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1 happen and if it does happen, this is what you do.
2 And you're not going to get in trouble for doing
3 it. That's not taking place, and one of the
4 things we discuss is a 30, 60, 90-day screening
5 cycle. You come home, get screened; get screened
6 after leave; get screened 60, 90 days out. And
7 that's when you'll start seeing the trouble arise.

8 MR. POGANY: Thank you, ma'am. What
9 I've experienced -- I'm just going to give it to
10 you in a nutshell -- soldiers go through a
11 pre-screening before they come back from a
12 country, or from down-range. They check the
13 boxes. The screening questionnaire indicates a
14 referral. They come back to the station where
15 they deployed from. They go through SRP. They
16 indicate the same -- there's no checks for
17 referrals. The environment in which all this is
18 presented -- as soon as they come home they get
19 presented with these questionnaires. They're
20 around they're peers. Soldiers don't answer these
21 questionnaires truthfully. I think it has to do

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1 presented by either trauma experts or other
2 veterans who have been through this process;
3 people that have experienced the effects and
4 psychological costs of combat, that can
5 intelligently and honestly speak to them about
6 what's going on. Then when they do go to mental
7 health they come back to their units and they get
8 hazed. I've encountered soldiers who have been
9 physically beaten. I've encountered soldiers who
10 were disciplined with a bebe gun to become men.
11 When they come back, for example, with a profile
12 that says that they're not to go to the range or
13 carry weapons, they are literally -- and I quote
14 -- they're being put into what is called in units
15 the "Fuck-up platoon." They're being called
16 "shitbags." That platoon stands 20 feet back from
17 the rest of the company. And then when the other
18 soldiers see this type of treatment and this type
19 of behavior, they say to themselves, "I'm not
20 going to Mental Health." And then they start
21 drinking. And then they start doing drugs. And
22 then, sooner or later, it is inevitable that they

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1 have to either go self-refer or they will be
2 referred because they come up hot on a UA. And
3 these are the barriers that I've seen are being
4 encountered. And then once -- as soon as the
5 effect of combat which results in either drug use
6 or some sort of disciplinary problem -- going
7 AWOL, drug use, alcohol -- is seen, the unit
8 immediately resorts to disciplinary action.
9 Medical care and mental health care falls away,
10 and the soldiers are being disciplined and, for
11 lack of a better word, kicked out of the Army.
12 Their peers see this and it drives them to not
13 come forward and seek mental health care. And it
14 is not being addressed appropriately. On top of
15 that, they go to Mental Health. They go up, for
16 example -- the ones that I've encountered, and
17 this is time and time and time and again -- they
18 go up to CitCorps mental health because they need
19 the treatment. They go up, and they say, "Well,
20 come back. We'll give you an appointment --
21 three, four, five, six weeks. Well, what happens
22 in that six weeks? They do drugs. They drink.

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1 They get into trouble. When they do finally get

2 their appointment, it's potentially a half-hour
3 appointment. And this is what a half-hour
4 appointment looks like -- and this has been
5 presented to me by mental health care providers on
6 the inside that have come forward and spoken up.
7 They come in "Hey, how are you? Hang in there.
8 Please don't kill yourself. Make sure your meds
9 are updated. We're working on your Chapter; we're
10 working on your discharge -- you know, "Come back
11 in about six weeks." They're being heavily
12 medicated -- although the information that we're
13 receiving from Command is that they're not being
14 heavily medicated. I've encountered soldiers
15 who've had nine, 12, 15 different types of
16 medications. Those are the barriers to treatment,
17 ma'am. Thanks.

18 MR. ROBINSON: If I could add that the
19 base barrier treatment is operationalizing the
20 idea that this care needs to be delivered at the
21 lowest level. I talked to a command sergeant
22 major the other day who said: "We are an army at

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1 war. We are awesome at kicking down doors. We
2 know our mission on the battlefield. But our
3 soldiers aren't going to leadership schools.
4 They're not getting training. They're not getting
5 the most up-to-date information. So when they

6 come home they're in that war mentality. They
7 have that war mind-set. They don't have the
8 skills or the knowledge to understand how to
9 reintegrate their buddies who come home. And the
10 easiest thing for them to do is to see them out of
11 the military rather than help them." That's what
12 we see is happening.

13 MR. POWERS: For the soldier coming back
14 from Iraq, it's key that when you guys implement
15 your programs for the soldiers coming off the
16 planes -- for instance the screens: do it before
17 they get on the plane. Do it when they're in
18 theater, not when they have to choose between
19 seeing a doctor or seeing their family who they
20 haven't seen in 15 months. Because there's no
21 doubt about it: the soldiers are going to sit
22 there and want to go home right away. So, as

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1 Steve says: operationalize it, make it part of --
2 you clean your vehicles in Kuwait, well maybe you
3 should be cleaning your head a little bit, too,
4 there.

5 DR. McCURDY: I have a question: does
6 your organization have any numbers of, in this
7 war, how many have been discharged in a category
8 that would preclude veterans health care.

9 MR. ROBINSON: We've had a difficult

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10 time obtaining the information. It looks like
11 what we're going to end up having to do is to
12 request that the GAO investigate. We have an
13 extensive FOIA campaign. We have asked for the
14 data. We have data on a few installations that we
15 have obtained. And at those installations it
16 appears very problematic that people are getting
17 chaptered out; people are getting administrative
18 discharges for drug and alcohol abuse, domestic
19 violence, reckless driving, DUI. Also
20 "personality disorders" seem to be being handed
21 out like candy, which makes me believe that we're
22 either recruiting people that shouldn't be in the

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1 military, or the diagnosis is being improperly
2 used to release people from the military. But,
3 sir -- no, we don't have the data. It has not
4 been released yet. It is one of our
5 recommendations. We also have a Bill that we have
6 dropped with Congress that addresses that issue,
7 to collect data. We can't know the extent of the
8 problem until the data is collected and analyzed.
9 But we do have anecdotal evidence that it seems to
10 be on the rise.

11 DR. McCURDY: Does your organization
12 include Marines?

13 MR. ROBINSON: We do. We look at all

14 forces. And, you know, we have recently had some
15 breakthroughs. I want to report those
16 breakthroughs. We've had the opportunity to meet
17 with the Surgeon General, the Deputy Surgeon
18 General, and discuss these important issues with
19 them. We've also had the door open up to
20 different military installations where we're
21 working, and those people are talking to us now.
22 And we're partnering with them to try to help

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1 them. If we identify something we would much
2 rather bring it to the chain of command than see
3 it reported in "60 Minutes." We want the chain of
4 command to handle these issues, and we want to
5 give them the opportunity.

6 COL ORMAN: This question is directed to
7 Mr. Sullivan: Could you speak a little bit about
8 the source of your VA data in terms of -- is it
9 gleaned from secondary sources or is the VA
10 sharing this with you? Or could you perhaps
11 address that?

12 MR. SULLIVAN: Yes, sir. First, a
13 little background: I was the project manager at
14 the Department of Veterans Affairs who monitored
15 Iraq, Afghanistan and Gulf War veterans, so I knew
16 where the reports were. The information here was
17 obtained from the Department of Veterans Affairs,

18 Washington DC 20061220 TF meeting transcripts FINAL.txt
drilled down to the Vet Centers, the Veterans
19 Health Administration and the Veterans Benefits
20 Administration. I do want to let you know that
21 they were extremely hesitant in providing this
22 information that should be available to the

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1 public. And, in fact, they were threatened with a
2 lawsuit, and only provided redacted reports --
3 specifically deleting the information on mental
4 health care claims. They've sent us one answer.
5 They wanted several million dollars to answer one
6 FOIA. So it's getting a little ridiculous. But
7 all of the information that we've presented here
8 came from the Department of Veterans Affairs.

9 COL ORMAN: Thank you.
10 DR. McCORMICK: Could I just ask one
11 follow-up question on the earlier question? One
12 of the challenges for us is -- going to your
13 example of a small town in Minnesota -- of how to
14 "up-educate" -- I guess I'd use that word -- the
15 community providers in the specific expertise of
16 combat and stress experiences; whether they're
17 Tricare providers or now -- recognizing that when
18 you only treat a few cases like that, it's
19 different than being a psychologist or
20 psychiatrist outside the gates of Fort Hood. Do
21 you have any suggestions on what would be a

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1 MR. ROBINSON: Absolutely. I have been
2 to California, Colorado, Ohio, Florida and North
3 Carolina, and I have identified community-based
4 providers; in many cases -- 100 near Fort Bragg,
5 or in Sergeant Pogany's case, he established a
6 program in Colorado that identified providers and
7 tried to connect them to Tricare as people who
8 would provide free -- absolutely free to the
9 soldiers and their families any reintegration
10 needs. Obviously the returning war veteran has a
11 unique set of needs that perhaps not every
12 traditional psychiatrist may understand, but the
13 people that we identified are trauma experts;
14 people that understand trauma and wartime trauma.
15 My suggestion would be that if those people exist
16 in your community, and your military treatment
17 facility, for example, is being met with a
18 capacity issue, that you could identify -- harness
19 this resources, provide them some training -- some
20 information; talk to them, screen them, validate
21 them -- but utilize them. They're willing to do
22 more than put a yellow ribbon on their vehicle.

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1 They're offering their services for free. So
2 there could be some training programs that would
3 help bring them in and augment the current medical
4 treatment facilities.

5 LTG KILEY: I know we've gone over a
6 little bit. First, I'd like to thank all of you
7 very much for very insightful and moving
8 presentations. We appreciate your taking time to
9 come and talk to us. I do have a couple
10 questions. I may have missed a little bit of what
11 Layton was asking, in terms of data. I, too, am
12 very interested in data on this, because I concur
13 with you that just anecdotal reports doesn't
14 generate the same lift as saying: "Look, we've got
15 10 percent of the soldiers that have a diagnosis
16 of PTSD -- you know, "10 percent of the group that
17 have already diagnosed with PTSD that are landing
18 up with Chapter 10s, and getting
19 other-than-honorable discharges -- that concerns
20 this group. We've already identified that as an
21 issue we want to look at. It may be an issue of
22 educating warriors and commanders that: look,

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1 you've got to understand this is a new paradigm on

2 that. So the more data that you can give us would
3 be very much appreciated. I'm curious if any of
4 you have had any experience in terms of some of
5 the discussions and the presentations about the
6 Battlemind training, both pre-deployment and
7 post-deployment, what your perception is of that:
8 is it effective? Is it part of the solution for
9 commanders, you know, from brigadier general to
10 private, in terms of helping us solve these
11 problems? What are your thoughts?

12 MR. ROBINSON: We're very interested in
13 Battlemind. Right now it is not developed in the
14 pre-deployment phase. Battlemind only currently,
15 right now, is videos showing soldiers what not to
16 do, and giving them examples of bad behavior and
17 how you should correct it. We believe
18 operationalizing this, sir, just in the same way
19 that you do a PMCS on a humvee, we believe that
20 operationalizing this at the lowest level in basic
21 training, and going all the way incorporating it
22 in the metal tasks, doing it in your training

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1 exercises -- I mean, please, sir, tell me when the
2 last time a training exercise was conducted where
3 there were people that had PTSD and they had to be
4 evacuated off that battlefield. I know that we're
5 starting to do that. I know that the Mental

6 Health Care Advisory Teams are starting to
7 incorporate that. But operationalizing this is
8 the big thing. We like "Battlemind." I think it
9 needs to be -- right now it appears a little bit
10 light on the reality of war, because there are
11 some real things that we can talk about. We can't
12 be afraid to talk about the reality. That's the
13 biggest thing. And I think when we do that, we
14 normalize it. Anybody else?

15 MR. POGANY: Sir, I can report to you
16 that every soldier -- 100 percent -- that I've
17 interacted with at several installations that I
18 visit to gather information, nobody has heard of
19 Battlemind. Nobody has accessed or had an
20 opportunity to access Army One Source, or Military
21 One Source. Nobody has heard of the Army Wounded
22 Warrior Program. Large amounts of soldiers have

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1 very extremely limited access to the internet.
2 When you go down to the units and you ask this
3 question they'll say: "Hey, yeah, there's a
4 computer right there in the orderly room." But
5 then when you leave and the soldier goes in and
6 says, "Can I use the computer to get on the
7 internet?" I believe you already know what the
8 answer is to that, sir. And what I would like to
9 add to this is: when you are faced with

10 individuals -- and this is what I deal with on a
11 daily basis; I get the calls at two o'clock in the
12 morning from the mother asking me to find her son
13 because she fears that he's going to kill himself
14 -- the soldiers that are being pushed into the
15 reality of the fact that their combat-related
16 mental injury is not acknowledge, they are
17 becoming dysfunctional; they're giving up; and
18 they need individual care. They need somebody to
19 come in and say to them: it is okay. It is okay
20 to hurt. It is okay to grieve. It is okay to
21 have an injury to the mind. And we will do
22 everything that we possibly can to rebuild your

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1 life and give you an opportunity to participate in
2 normal life, just like everybody else that is
3 still back here. Thank you.

4 LTG KILEY: Okay. Thanks.
5 MR. ROBINSON: If I may add -- we had a
6 really academic discussion with a staff judge
7 advocate the other day, and the academic
8 discussion was this: at what point -- where do we
9 draw the line between providing health care --
10 mental health care -- and punishing the soldier
11 for inappropriate behavior that is inconsistent
12 with the good order and discipline of the
13 military? And I said, "Well, sir, I would draw

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14 the line -- myself, personally -- if a soldier
15 commits a crime that involves the death of
16 another, the beating of another, abusing of
17 another, that soldier's going to get punished. If
18 the soldier is abusing drugs, I can tell you that
19 the science tells us that that will happen. And
20 the question you have to ask yourself is this:
21 before you punish him for using drugs after
22 returning from war, did he indicate on the DD Form

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1 2796 that he needed help? Did he receive that
2 help? Was he allowed to go to the ASAP program
3 and complete the program, or was he given
4 residential treatment? Did you provide him the
5 maximum opportunity to recover from his wartime
6 experience? And if the answer is yes, and they
7 continue to use drugs and alcohol and be a
8 discipline problem, then we can all go to sleep at
9 night knowing that we gave them the opportunity to
10 recover but they did not conform. But if the
11 answer is the opposite -- that you did not give
12 them mental health care, and they did not go to a
13 drug and alcohol rehab program ever -- and then
14 you kick them out for that problem, that we have
15 let them down. And that's where I would draw the
16 line.

17 LTG KILEY: We are running out of time

18 Washington DC 20061220 TF meeting transcripts FINAL.txt
18 here, and I just had a couple more quick
19 questions: whether you all have had any experience
20 reference your comment which was apropos, about
21 putting a whole battalion into an area and saying,
22 "Okay, all of you that need to see the

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1 psychiatrist -- no offense -- "you guys get in the
2 short line and go over and see the psychiatrist."
3 Nobody stands up for that. Have you had any
4 visibility on recent redeployment exercises where
5 individuals, in fact, are getting face-to-face
6 counseling, person by person as they come back.

7 MR. REPPENHAGEN: We are seeing that
8 there's a little bit more of an effort to see
9 individuals. However the peer society of the
10 military still prevents a lot of soldiers from
11 seeking help. It doesn't seem like it's spread
12 entirely. You don't have your lieutenant colonel
13 going in to seek treatment as well as your
14 enlisted soldier. I think if everybody had to go
15 and see a doctor, no matter what your rank, no
16 matter what your position, then there would be a
17 little less hesitation by some soldiers to seek
18 treatment, and the hazing would be a lot less once
19 that soldier did seek treatment.

20 LTG KILEY: Well, I agree completely
21 with you, and we're attempting to do that. If the

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1 major goes through the mental health counselor
2 first, there's no reason everybody else can't fall
3 in behind them.

4 MR. REPPENHAGEN: I think a lot of the
5 problem also has to do with follow-up after that.
6 You've got a soldier that comes to his first
7 sergeant saying that -- you know, "First sergeant,
8 I need to go back to mental health tomorrow to
9 seek an appointment." And there's instantly flags
10 that go up. There's no anonymous way to go seek
11 treatment. Your chain of command is always going
12 to know; they're always going to know there's a
13 problem. And right now I think we're facing a
14 military manpower problem versus having actual
15 adequate care for soldiers. And those two are
16 competing now.

17 LTG KILEY: I'm not sure I understand
18 that. What are your thoughts on that. Do you
19 mean because there's a sense that we're short of
20 manpower for combat maneuver units, commanders are
21 reluctant to allow soldiers to go to Mental Health
22 for counseling because they've got to get back to

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1 the JRTC or the NTC --

2 MR. REPPENHAGEN: Down to the lowest
3 battalion level, to the company level -- all the
4 commanders, you know, are very interested in
5 keeping their soldiers on the battlefield, in
6 theater, in the battalion. And there is a
7 challenge there of: do we create a system where
8 there are going to be fraudulent cases, where
9 soldiers are going to sneak through, and there's
10 going to be con artists that get care that don't
11 need it, that get disability benefits that don't
12 need it; or do we create a care that's lenient
13 enough that some of those people sneak in, but at
14 least we don't have veterans or soldiers that are
15 falling through the cracks and committing suicide
16 and injuring themselves and their families.

17 LTG KILEY: Another question that has to
18 do with this post-deployment screen and your
19 comment, I think, about "the do it on the plane."
20 We were briefed the other day that divisional
21 units coming back are doing a decompression
22 process and that, in fact, if you say "yes" to a

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1 question, that doesn't mean you don't get to go

2 home for a couple days' pass, it means we're going
3 to give you an appointment to go see somebody --
4 unless you're in absolute dire straits; unless you
5 said, "Listen. I'm going right home and shoot
6 myself -- God forbid. Any thoughts on those
7 processes? The decompression process?

8 MR. ROBINSON: Yes, sir. And I'd like
9 to go back to your first -- there are bright spots
10 at different installations. Fort Lewis,
11 Washington, for example, is doing a new program
12 that looks like it's really helping dramatically.
13 We know that that is a pilot program that is not
14 force-wide. This is always an issue about
15 leadership, sir -- leadership and knowledge.
16 There are good commanders in the military that
17 understand this issue. And in those particular
18 units they do a good job. There are others that
19 are operationally challenged and don't have time
20 to do this work because they're going to rotate
21 back to Iraq. But, yes, sir -- it's a great
22 analogy to remember -- and Paul Sullivan likes to

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1 tell a long story about this -- that in World War
2 II we came back on ships, and it took forever to
3 get back. And the VA was there with them, and
4 they were decompressing. They were telling their
5 war stories, they were getting it out of their

6 system, and they were being educated about where
7 there benefits are. We know that that is not the
8 same today. So, yes, sir -- if we can figure out
9 a way to decompress; if we can figure out a way --
10 by the way, sir, please: if they have loved ones,
11 or those that care about them, they have to be
12 involved in this decompression process. Bring the
13 family in with the soldier. You know, even if we
14 can boil it down to like a week, or maybe even two
15 weeks -- whatever -- an intensive program that
16 allows them to decompress will mitigate a lot of
17 these problems in the long term.

18 LTG KILEY: Last question, and then I do
19 have to -- in deference to the other speakers that
20 are standing by -- I am -- I think we're all
21 concerned -- we've talked about this in closed
22 session, also -- we're very concerned,

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1 particularly with the presentation this morning,
2 about the VA's ability to pick this mission up.
3 And while that's not central to our role, because
4 it's the military -- presumably active duty but
5 not exclusively that -- we are going to look at
6 and have been visiting Vas. But I guess my
7 question is: as you articulate these concerns
8 about the numbers, other than Dr. Murphy's
9 comments, do you get any response from the VA in

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10 terms of -- with deference to your VA member here
11 who doesn't need to jump up and defend them -- but
12 what is your sense about -- does the VA recognize
13 the same concerns you have? And are they
14 concerned about resourcing in the future to handle
15 this? Or do they just -- because I know the
16 Acting Assistant Secretary for Health, Dr. Kusman,
17 and Dr. Cross, and Drs. Duncan and Hayke and the
18 rest of that crew. They're high quality people.
19 Have you had any opportunities to talk with them?
20 Do they give you feedback on these issues?
21 MR. SULLIVAN: Let me give you a little
22 bit of background if I could. I sat on the

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1 Secretary's Seamless Transition Task Force. I
2 also prepared the report by the Department of
3 Veterans Affairs for the Secretary on Seamless
4 Transition. I'm the person who designed the
5 Seamless Transition Office to be created. Those
6 are all my brain-children. I also briefed political
7 appointees and senior VA leadership on what was
8 happening at VA. And I can tell you, quite
9 assuredly, that they are blind to the problem. I
10 can tell you from the meetings, where I was
11 briefing them on the statistics of the number of
12 claims from Iraq and Afghanistan war veterans --
13 and this might be offensive to some of you -- I

14 was told: "God doesn't like ugly. You need to
15 make the numbers lower." I was told at another
16 briefing that I was giving to senior executives:
17 "Let's see if we can withhold this from Congress."
18 I was told at another briefing by a senior
19 political appointee, when I was describing the
20 number of mental health disability compensation
21 claims that it was "too many," they were "too
22 young," it was "too fast," and it was "costing VA

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1 too much money." That was highly offensive. As a
2 Gulf War veteran -- I was a scout in the First
3 Armored Division -- I was the only combat veteran
4 in the room. Then the political appointee, who
5 had never served in combat, slammed their hand
6 down on the table loudly and said: "If they just
7 believed in God and country they wouldn't come
8 home with mental health problems." So you
9 actually have problems within VA where they not
10 only want to downplay the mental health because
11 they don't believe in it, they want to downplay it
12 because of the costs; they want to downplay it
13 because of political considerations. It's not a
14 very good recipe for a seamless transition between
15 the Department of Defense and the Department of
16 Veterans Affairs. This is a very serious problem
17 right now, and those who are going to be the most

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18 impacted will be those with mental health problems
19 waiting to get in to see a VA doctor, or waiting
20 for that VA claim to get adjudicated. Because in
21 most cases, that VA claim -- that
22 service-connection you may have heard about, that

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1 status -- that's going to be their key to be able
2 to get mental health care. And what we're trying
3 to ask for -- and this is one of the keys -- is:
4 let's bring VA and DoD together. I would like to
5 see more VA in this room -- really; especially the
6 benefits folks. It's great that the VA health
7 care people are here, and the VA health care is
8 great if you can get in. But if that service
9 member -- especially Guard and Reserve -- is met
10 with benefits delivery at discharge when they come
11 home, and they know about their VA benefits, sir,
12 and the paperwork is filled out -- the day they
13 leave the service all of the paperwork is done,
14 they can walk right into a VA hospital, or have
15 their disability check paid in 30 days. That's
16 the kind of stuff that can happen.

17 LTG KILEY: Gentlemen -- yes, go ahead.
18 One quick comment.

19 MR. POWERS: Sir, just an anecdote from
20 someone who just got out of the service recently.
21 (off mike) transition is happening, where (off

22 Washington DC 20061220 TF meeting transcripts FINAL.txt
mike). Speaking two different languages; the

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1 military speaks its own language, so does the VA.
2 I didn't understand it almost 12 months after I
3 got out (off mike). Education needs to happen.

4 LTG KILEY: Gentlemen, thank you very,
5 very much. Very good. Appreciate it.

6 (Applause)

7 LTG KILEY: My apologies to the
8 follow-on speakers who we are equally interested
9 in listening to.

10 DR. MacDERMID: Our next speaker is Ms.
11 Barbara Thompson, who's going to present a
12 briefing on Military One Source. Welcome back.

13 MS. THOMPSON: Good morning, everybody.
14 I'm going to be as concise as I possible can, to
15 talk about Military One Source, and to talk about
16 the Military Family Life Consultant Program. Two
17 things -- you'll be getting some handouts. I
18 wanted to answer a couple of the questions that
19 came up on Monday. One was: what is the
20 difference between how the Guard and Reserve
21 access Military One Source versus active duty.
22 And the one bit of information that I can share

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1 with you is that: active duty use either Google or
2 Yahoo to reach Military One Source, and Guard and
3 Reservists use MSN. And they said it's an age
4 issue; that Guard and Reservists may be a little
5 bit older and not as young as the active duty
6 service members, so that was their twist on that.
7 And, second, you asked how many hits Military Home
8 Front had. In the month of November we had
9 3,092,656 hits; of those, 2,549,000 were actually
10 on Home Front. And then we have different
11 portals, like the Commanders Page, the
12 Transportal, Military Students, and they all added
13 to that 3 million hit.

14 VOICE: (off mike) Home Front -- give me
15 that number again?

16 MS. THOMPSON: 3,092,656. Now that's
17 hits. One of your handouts that you'll be
18 receiving is a more intense package of information
19 on Military Home Front. And there are screen
20 shots to show you the kind of information that can
21 be accessed at that website. (Slide) This is not
22 the brief. This is a child-care brief, so I

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1 don't think you have the right one. It should be

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2 called "DoD Task Force MOS." (Pause) There you

3 go. Great. I really wanted to share with you a
4 couple of really good news stories about Military
5 One Source. And one was at the latest Army Family
6 Action Plan meeting held this fall. Military One
7 Source was named the number one strength for
8 mobilization and deployment. And a second venue
9 we had with the Deployment Health and Family
10 Readiness Library, they had focus groups this
11 fall, and they were comprised of family members of
12 Guard and Reservists. And they commented that
13 they normally get military-related information
14 from One Source. And they said: "Please don't let
15 that go away." So those are two good news stories
16 about Military One Source. Next slide, please.
17 (Slide) I'm going to do a very quick overview,
18 because I think what you really want to hear about
19 is the counseling. But it is our answer to an
20 employee assistance program. It's an extension of
21 what are already Family Readiness resources exist
22 at installations and in Family Readiness Groups

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1 for the Guard and Reserve. It is available
2 through phone, e-mail or mail 24 hours a day,
3 seven days a week, 365 days a year. And people
4 who answer the phone -- 90 percent of the calls
5 are answered within 20 seconds, or five rings, by

6 a master's level consultant. And I think that's
7 really important today, because you know the
8 frustration as well as I do when you get on the
9 phone, and you have to punch number 1, and number
10 3, and it takes you forever to get an answer, and
11 you probably don't even get the right answer at
12 that point. It's no cost to service members and
13 their families. It's confidential. It's
14 solution- focused. And we look at it "high tech
15 to high touch." We realize that using the
16 internet and the phone service is high tech and
17 offers opportunities for answers, but we also
18 realize that if we're not partnering with the
19 services that we have at our family centers and
20 our installation level, there's no high touch.
21 And we realize when people are looking for
22 solutions to their problems, that high touch is an

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1 also critical component. Next slide, please.
2 (Slide) One Source is committed to delivering a
3 high quality of service. And so what they will
4 find is that when you have a caller and you
5 mutually agree to receive a feedback call, they
6 check to see if the information that was received
7 met the person's needs and provided the
8 information that they needed; and, if not, they
9 have an entire system of trying to figure out what

10 they can do to improve on that process. Next
11 slide, please. (Slide) You asked about the
12 eligibility. One of your handouts is the list of
13 who is eligible. But this gives you in a
14 nutshell: active duty and their family members --
15 and I think it's really important for the helping
16 agencies to realize even if you're not active duty
17 that you can access Military One Source for your
18 personal needs, because we feel it's really
19 important to nurture the helping agencies. So we
20 stress that in all of our briefings when we go out
21 to the different conferences that helping agencies
22 also have access to Military One Source. And also

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1 for the Guard and Reserve, regardless of their
2 activation status, they can use Military One
3 Source. And the IRR eligible and retirees up to
4 six months at the end of that commitment. One of
5 the participants last month asked about parents.
6 Parents and siblings can access the Military One
7 Source if they're working on behalf of the service
8 member. So let's say a sibling is taking care of a
9 single parent's child and they have a child-care
10 question, they can access Military One Source for
11 support. Next slide, please. (Slide) This kind
12 of gives you an overview of some of the issues
13 that are touched upon in Military One Source. I'm

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14 going to go a little bit more in depth about
15 counseling. But I wanted to bring up the "money
16 matters." Right now we're in the throes of a very
17 intense financial readiness campaign for the
18 Department. One of the reasons is we're seeing
19 that financial issues impact a lot of other family
20 issues, and that also impacts security clearances
21 and the appointment availability for our service
22 members. So through Military One Source you can

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1 actually receive financial counseling on the
2 telephone. And I think that's an important
3 component and support. Next slide, please.
4 (Slide) This is a screen shot of Military One
5 Source. It's both branch-specific as well as DoD
6 and community resources are located there. You
7 can e-mail and talk to somebody live. I think the
8 webinars are really handy. They can be accessed
9 on line and then through a telephone, when you can
10 actually be actively involved in the presentation.
11 And if the time is not suited for you, you can
12 access it later on because they're archived. And
13 so they do things -- subjects -- about deployment,
14 or they do information about financial assistance.
15 The on-line locators -- you can find child care,
16 elder care, smoking cessation -- all those things
17 in your community. And on the left-hand side you

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18 see the different categories of topics. They have
19 over 1,000 articles, and they have CD-ROMs and
20 also booklets on those topics. And you'll get a
21 sampling in the materials that you'll be getting.
22 Next slide, please. (Slide) For the helping

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1 agencies, if you're doing a presentation you can
2 also order these materials to be used in your
3 presentation. We feel that that's really
4 important; that it supports the family centers,
5 child development programs, etcetera, as they're
6 supporting families with materials for them to
7 share. And you're actually going to get the CD on
8 the spouse -- "These Boots are Made for
9 Deployment." And I don't know if you've all seen
10 the DVD that we've done with Sesame Street and the
11 partnership with WalMart. Our partnership with US
12 UHS, we're working on another CD-ROM that can be
13 used by adults who are working with children so
14 that they know how to use the DVD to get the most
15 out of it. So that's going to be forthcoming.
16 Next slide, please. (Slide) This is really an
17 important benefit for those of us who've been
18 overseas and know how difficult it is to work with
19 people who speak another language. So, for
20 example, if you're stationed in Germany and you
21 don't understand your landlord, you can have a

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three-way conversation, so the interpreter on the

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1 phone can help either get over a bump, or
2 translate the rental agreements to make sure that,
3 again, you are getting the best service you
4 possibly can. We are also doing a lot of
5 translation with immigration and naturalization
6 services for so many of our service members have
7 different nationalities, or family members with
8 different nationalities, and so it helps translate
9 those marriage certificates or adoption papers so
10 that -- again, these are life challenges when
11 you're trying to do your job and you don't need to
12 think about where can I go get a translation of a
13 document? It really helps to have the service
14 available. (Slide) We had a question about
15 marketing. We use a variety of methods to get the
16 word out. I know it's a never-ending challenge.
17 And word of mouth, and people who use this
18 opportunity to share why it's worked for you, it's
19 very helpful. We behoove our helping agencies to
20 be that conduit of information. You know, we hear
21 a lot about it through the Military Times, where
22 it's advertised. And we hope -- I don't know if

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1 you've seen the posters with our senior enlisted
2 advisors all endorsing Military One Source as an
3 avenue for families and service members to use.
4 (Slide) And a little bit about usage on the next
5 slide. We track usage. As I said on Monday the
6 Marines piloted this program in 2002. The other
7 services got on board in 2004. And we've seen a
8 dramatic, tremendous growth in the use of Military
9 One Source. We want to embed this in military
10 cultures that it becomes a household word; that
11 people turn to it as their first source of
12 information and support. And so we're seeing that
13 -- again, we're getting on-line visits. They've
14 increased six times since Fiscal Year 2005. Our
15 face-to-face counseling sessions are doubled. And
16 we're seeing that we're doing follow-up, once
17 somebody is referred to a counseling session, that
18 70 percent of the people are attending them. And
19 the average time -- they have up to six sessions
20 per issue, they're averaging 4.5. (Slide) We
21 appreciate the emphasis that the National Military
22 Family Association, Ann Dakowitz, has placed on

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1 Military One Source. And they provide feedback

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2 information to us and that's very helpful.

3 (Slide) Those are the numbers to call. If you
4 haven't had the opportunity to use Military One
5 Source, I'd love for you to try it out. And if
6 you have any issues with it, or concerns, or
7 feedback we'd love to hear it. That's the only
8 way we can improve upon the service. (Slide) Now
9 I'm going to talk about counseling. We in
10 Military Community and Family Policy provide two
11 arms of non-medical counseling, and that is
12 through Military One Source, and through Military
13 Family Life Consultants. Both of those
14 organizations offer the face-to-face six sessions.
15 The Military Family Life Consultant program
16 differs from Military One Source that it offers
17 two other arms of counseling services. But,
18 again, I want to explain those differences to you
19 so that you understand them and what is offered at
20 our installations and at Guard and Reserve units.
21 So when a call for a referral is received, the
22 consultant has an access to a network of licensed

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1 professionals. And what they do is they match the
2 need of the caller to the skill set of the
3 counselor who is available within 30 minutes of
4 where the family lives, or the service member
5 lives. And they also check on that availability.

6 They just don't give you a name to call and that
7 person may not have any openings. They try to
8 make it as easy as possible to connect the caller
9 with the service. And in cases, as you're
10 receiving the intake about what this person needs,
11 if the operator, the consultant on the other line,
12 sees that there needs to be a referral to a
13 military treatment facility, or to Tricare, they
14 do a warm handoff at that point, because they are
15 not going to hook somebody up with non-medical
16 counseling services if, in fact, this is what they
17 need; if they need intervention versus life
18 coaching and prevention. And we do keep a
19 duty-to-warn log. We don't keep records, but if
20 somebody is referred to an MIF or Tricare because
21 of suicide or abuse, we keep a log of that
22 information. (Slide) So these are the three

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1 types: the Family Assistance, which is the
2 face-to-face, which could be done individually, it
3 can be done as a couple, or it could be done as a
4 family or a small group. And that can be received
5 either through Military One Source or through the
6 Military Family Life Consultant program. This is
7 where it differs -- Next slide, please. (Slide)
8 -- the outreach and the psycho-educational
9 presentations are exclusive to the Military

10 Family Life Consultant project. And that means
11 that the counselors are embedded in the community.
12 As I mentioned on Monday, they walk around the
13 community -- whether they're at the Burger King,
14 or meeting the planes coming back from deployment
15 -- they are there just to listen and talk and be
16 there available for someone to talk to. They are
17 intended to augment existing military support
18 systems. The delivery of their service can be
19 both on and off the installation -- so it's not
20 exclusive to military installations. And they do
21 what Tricare does not do: they provide counseling
22 in areas that are non-medical V-code, and they are

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1 done with confidentiality. And we feel that this
2 promotes prevention and problem-solving for those
3 life events that are normal reactions to what the
4 soldier and the service members and the family
5 members are experiencing. We feel that we partner
6 with health Affairs in addressing counseling
7 needs. We just do non-medical counseling, and
8 Health Affairs does medical counseling. But both
9 are needed. (Slide) These are some of the topics
10 that are addressed, both in the face-to-face
11 counseling, as well as in the psycho-educational
12 classes or in the outreach. You're looking at
13 anger management, you're looking stress

14 management, you're looking at how to talk with
15 your children, how to communicate with them while
16 the parent has been deployed. These are some of
17 the areas that they touch. Next slide, please.
18 (Slide) My office has the oversight for the
19 contract. And, again, our goal is to make sure
20 that the support is provided to service members
21 and their families, and that these resources are
22 used effectively. As I mentioned on Monday, we're

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1 in the process of developing an evaluation piece,
2 a quality assurance piece, to make sure that this
3 is meeting the needs of what we're supposed to do.
4 And these services, although at the beginning were
5 exclusively used by the Army, we are now branching
6 out and they are provided for all branches of the
7 services. And each one does it a little
8 differently, because their culture needs it a
9 little differently. Now we do go to Guard and
10 Reserve units at their request; at events --
11 whether they're a family readiness group issue,
12 whether it's a drill weekend, or whether, again,
13 it's a reunion and reintegration event. It is
14 done through the National Guard Bureau, and we
15 each have a service POC, and we coordinate all of
16 these deployments, if you will, of our Military
17 Family Life Consultants. Next slide, please.

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18 (Slide) We purposefully make this rotational so
19 that we can meet the needs of the deployment
20 cycle. So they are not going to be located at
21 every military installation or every Guard unit.
22 It's where they're needed at the time that they

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1 see that the need exists. And so whether it's --
2 like I said on Monday -- whether it's a unit has
3 been extended, a unit has experienced death, a
4 unit has experienced an early deployment, those
5 would be flags to us to say: we need to send a
6 team to these places to support the current
7 delivery of services that the installation or the
8 unit is offering. And we've partnered across
9 Military Community and Family Policy, too, with
10 our school system and our Children and Youth
11 Programs during the summer, where we actually
12 embed counselors to support children of the
13 deployed so that they have somebody to talk to and
14 to figure out to share those feelings of what it's
15 like to have a deployed parent. Next slide,
16 please. (Slide) We're working on our
17 communication and cementing how we get the
18 information where the consultants are needed, how
19 do we get them quickly to that location. And so I
20 have to say, you know, we're working on protocols
21 and communication issues between the service POCs,

22 Washington DC 20061220 TF meeting transcripts FINAL.txt
our office and the contractor to make sure that

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1 delivery of service is timely and where needed.
2 And we have a couple of new initiatives that we're
3 working on. One is called "Coaching for Young
4 Families." And we've asked each of the services
5 and the Guard and reserve to give us a new way of
6 using the service to support families. And so,
7 for example, one of the initiatives is we're
8 providing counselors, or consultants, at Fort Hood
9 to actually work with surviving spouses who have
10 young children. Another coaching for young
11 children is building a shaken-baby-syndrome
12 curriculum to be used across the services. So
13 we're looking at different approaches and how we
14 use the consultants to best meet the needs of our
15 families. (Slide) And I just want to share one
16 thing yet, very quickly, of how the consultants
17 are used, to give an example. A soldier was going
18 through the Reserve SRP at the Soldier Readiness
19 Center at Fort Dix, New Jersey. He was there for
20 six days of processing after a year in Iraq, and
21 then will return home to his family in New
22 England. He told the Military Family Life

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1 Consultant that he was very anxious about
2 returning home. Prior to his deployment his wife
3 was a stay-at-home mom, and now she is working
4 part-time for a law firm and enjoys her new job.
5 About three-fourths of the way into his tour of
6 duty, his six-year-old son started to refuse to
7 speak with him on the telephone, and he did not
8 understand why. He was also concerned that his
9 old job may not be available because his
10 replacement, who he trained, has been doing a
11 great job, and business in general has slowed
12 down. He has not wanted to talk to his buddies
13 about his fears, because they all seem so happy
14 about returning home. He, of course, is happy
15 that he survived, but is scared what might await
16 him. The consultant listened to all his concerns
17 and reinforced that it is normal to have
18 reservations about returning home after being away
19 a year in a war zone. The consultant educated the
20 individual about six-year-old children's behavior,
21 and why children may withdraw after a period of
22 time; and also offered some suggestions on how to

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1 approach the child upon his arrival at home. The

2 consultant addressed how both he and his wife had
3 had different experiences, and also reiterated to
4 the soldier how he coped in Iraq, and reminded him
5 that he could also use those same skills to cope
6 with whatever happened with his employment. The
7 soldier was informed about Military One Source and
8 other resources for support. He said that he was
9 greatly relieved and he was glad to know that he
10 was not crazy for thinking these things, and
11 thanked the Military Family Life Consultant. And
12 I know after listening to the testimony this
13 morning, we have a lot of work to do to make sure
14 that these services are available when they are
15 needed. And it is a major challenge to provide
16 them at the right place and at the right time. So
17 -- any questions?

18 DR. McCURDY: I have a question: the
19 counseling program -- are these counselors
20 employees of the contractee?

21 MS. THOMPSON: Yes.

22 DR. McCURDY: And are there multiple

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1 contracts?

2 MS. THOMPSON: Two contracts.

3 DR. McCURDY: Only two in the country.

4 MS. THOMPSON: Well, there are two
5 contracts that we manage, and then they contract

6 -- they sub- contract with their network of
7 providers.

8 DR. McCURDY: Right. Is there any
9 method of quality checking, or quality
10 accountability? It seems like it would be
11 difficult to track that.

12 MS. THOMPSON: We're starting to embed
13 that right now, and we're actually sending one of
14 my employees, who's a clinical counselor, out to
15 the installations to see -- you know, to meet with
16 the consultants, see what they're doing, getting
17 feedback. So we're starting to increase that
18 level of oversight at this point in time. The
19 last two years we've been just getting the program
20 going and moving out where the need was there.

21 DR. McCURDY: Right. I understand.

22 MS. THOMPSON: And they all have to be

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1 licensed clinical counselors.

2 DR. McCURDY: They do have to be
3 licensed.

4 MS. THOMPSON: Yes -- they have to be
5 licensed.

6 DR. McCURDY: And are they employees of
7 the contract holder? Or are they fee-for-service?
8 How does that work?

9 MS. THOMPSON: They are part of a

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10 network, and they can call on them at any time to
11 move to whatever location. Depending on the
12 delivery system that we have, some of them are
13 employees. But I think for the most part they're
14 in a network of available providers.

15 DR. McCURDY: So, sort of "all of the
16 above." Yes. Thank you.

17 DR. McCORMICK: A follow-up question to
18 that, maybe -- going back to the question that I
19 asked one of the gentlemen earlier -- the reality
20 is the National Guardsmen or Reservist may be a
21 onesie and twosie in a very small town. And the
22 counselor may have very little other experience

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1 with combat. Does the contract require that the
2 counselors have any training or specific
3 experience in military and combat-related issues?

4 MS. THOMPSON: Yes. We use
5 myarmylife.com as like an overview of what
6 military life is all about. And many of our
7 counselors -- we always ask that they first try to
8 find someone who has a related affinity to the
9 military; so a military spouse, we try to touch
10 base with them first for employees, or for
11 counselor.

12 DR. McCORMICK: Let me just ask a quick
13 eligibility question: survivors -- how long are

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14 they allowed to, or able to, access Military One

15 Source.

16 MS. THOMPSON: There's no time limit.

17 DR. McCORMICK: So -- forever. Okay,
18 great. The last comment is that in visiting many
19 bases we often have a group of NCOs. And one of
20 the questions we ask them is do they know about
21 Military One Source. And I'm sorry to say that,
22 quite frankly, the number of hands that shoots up

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1 isn't what you might hope. And they are key,
2 obviously -- the NCOs -- to the troops. Is there
3 any specific outreach or education effort that
4 you're building to direct at NCOs?

5 MS. THOMPSON: I know we're looking at
6 addressing the senior enlisted advisor group that
7 meets in the Pentagon. And, again, you know, I
8 think through the senior enlisted advisors that
9 information should flow down. You're right: we
10 need to do a much better job in marketing to the
11 people who provide the resources to the service
12 members. And I know not everybody has access to a
13 computer, but people do have phones. And so
14 that's one reason we want to make sure that
15 Military One Source is not just on-line. But --
16 yes, we have to do a better job in getting the
17 information out to the right people. And, you

18 know, when you're out in the field I hope that if
19 you need information, you know, the magnets, the
20 brochures to take with you to share with the
21 people you meet, I'd be happy to supply you with
22 that information.

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1 DR. McCORMICK: Well, just one
2 follow-up, and that is that I understand that part
3 of the reality, of course, is that you guys are
4 confidential. And I think some of the work you
5 need to do with the NCOs is to realize you're not
6 the enemy.

7 MS. THOMPSON: Right.

8 COL CAMPISE: I have two separate but
9 related questions. The first one is: in regards
10 to the translation services, are those available
11 for therapy? And second: do you have a list of
12 Military One Source providers who speak something
13 other than English as a master list?

14 MS. THOMPSON: Yes, we do. And I will
15 tell you: I just worked with, not only in
16 languages, also in sign language, where we got an
17 interpreter to work with Henderson Hall to help
18 with marriage therapy. I know it's 150 languages
19 with translation, and 160 languages with
20 interpretation. And I think you could ask for
21 that special request, as a special need. This is

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1 translator.

2 DR. MacDERMID: Barbara, would it be
3 possible for you to provide us with a breakdown of
4 the top issues that people call about? I know you
5 get those reports --

6 MS. THOMPSON: Yes.

7 DR. MacDERMID: -- and I believe that
8 was on the Data Call -- right? -- what people call
9 One Source about? We had prepared a list of
10 information that we were hoping to get from
11 various places. And we'd appreciate knowing the
12 top issues if that's possible.

13 MS. THOMPSON: Yes. Sure.

14 DR. McCURDY: One more comment: one of
15 the things in traveling around, the site visit --
16 universally, when asked, I hear positive things
17 about Military One Source. I don't think I've
18 heard a single negative comment. And rarely do
19 you find a group where people don't know about
20 Military One Source. So whatever you did with
21 that, it seems to be working, and those that have
22 had experiences speak very positively about it.

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1 MS. THOMPSON: I'll take that feedback
2 back. Thank you.

3 MR. WERBEL: Ms. Thompson?

4 MS. THOMPSON: Yes, sir.

5 MR. WERBEL: Certainly officials in DoD,
6 we have a tendency to define "family" as
7 dependents.

8 MS. THOMPSON: Mm-hmm.

9 MR. WERBEL: The vast majority of our
10 service members are single service members, and
11 they would probably tell you "family" means mom
12 and dad, fiancée, siblings. What type of active
13 outreach and/or passive access are you aware of in
14 these programs to those types of family members.
15 They aren't officially recognized dependents in
16 DoD.

17 MS. THOMPSON: Right. I know we talked
18 about that on Monday. As I said, they have access
19 to Military One Source if they're acting on behalf
20 of the service member. And I think -- I know we
21 always show this book that Mrs. Cody wrote for
22 parents as a possible resource so that they

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1 understand what their child may be going through.

2 I think it's really hard for the family readiness
3 groups to stay in contact with parents. And I
4 think we just need to do a better job in doing
5 that. I know working with the Military Severely
6 Injured Program, we look at parents as our
7 partners, and recognize how important it is for
8 them to be a part of the resources that we have
9 available.

10 MR. WERBEL: Is there any active
11 outreach that you're aware of to reach those
12 family members? Or is it more passive: when they
13 find you --

14 MS. THOMPSON: When they find us.

15 MR. WERBEL: -- they get access.

16 MS. THOMPSON: Right.

17 MR. WERBEL: Thank you.

18 COL PEREIRA: I have a question about
19 the level of counseling provided. For the six
20 sessions, you mentioned that that is a non-medical
21 counseling with a focus on problem solving.

22 MS. THOMPSON: Exactly.

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1 COL PEREIRA: That's correct? But you
2 also mentioned credentialed providers. Could you
3 talk about the credentialing process?

4 MS. THOMPSON: Sure. We built this into
5 both Military One Source and into the Military

6 Family Life Consultant program. We wanted to make
7 sure that the person who was providing the
8 non-medical counseling had the experience and the
9 expertise to recognize when it needed to go to the
10 next level. And so, you know, it's part of our
11 program to really explain to them that they do not
12 wear their counseling hat. They're wearing a life
13 coach hat. And once it goes into that next area,
14 they need to refer it to the proper channels. But
15 we felt that if they did not have that experience
16 and that expertise. They may not know that that's
17 where it needed to go next. And so that's why we
18 require licensed clinical social workers or
19 psychologists or marriage/family therapists.

20 COL PEREIRA: But you also mentioned
21 "credentialing," and that's my specific question.
22 What's the credentialing process?

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1 MS. THOMPSON: The contractor does that.
2 That's part of their contract. The contract says
3 that they will only employ -- well, that's not the
4 right word, because they're not employees -- but
5 they will only contract with licensed clinical
6 social workers, psychologists -- credentialed
7 people.

8 COL PEREIRA: So they're actually
9 licensed.

10 MS. THOMPSON: Yes.
11 COL PEREIRA: Not necessarily
12 credentialed.
13 MS. THOMPSON: Not credentialed like you
14 do in the hospital.
15 COL PEREIRA: Thank you.
16 LTG KILEY: What checks and balances do
17 you or the contractor use to ensure that when
18 soldiers are in some kind of life counseling and
19 it begins to transition into medical counseling
20 that the counselors, in fact, do disengage from
21 medical counseling and refer them back; versus --
22 particularly if the soldiers don't want to go back

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1 into the mental health, behavioral health,
2 community. How do we know if there's a system
3 that ensures that that happens?
4 MS. THOMPSON: There's not a system that
5 ensures that that happens. What we do is try to
6 -- I know the thrust is to try to convince and
7 encourage the service member to seek those
8 services in the medical treatment facility or
9 Tricare. And they actually will help try to
10 transition that with a three-way call. But then
11 once that person is transitioned over, that's what
12 happens.
13 DR. MacDERMID: I think this will be the

14 final question. One of the things that we've
15 really been struggling with is how far-flung all
16 the different elements of the mental health
17 landscape in the military are. And the reason
18 it's a concern is that there seems to be great
19 variability in the allocation of helping
20 professionals across installations, with the
21 result that the continuum of care is often not
22 there. There are gaps in it at different places.

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1 And we've been trying to figure out: how do you
2 make sure that there are the right kinds of
3 people, and the right numbers of people in place
4 to provide members and families all the services
5 that they need? Do you have any suggestions for
6 us about what we should recommend?

7 MS. THOMPSON: Well, again, Colonel
8 Ireland is going to be on next, and we feel that
9 we've really started to reach out, in Military
10 Community and Family Policy, to work with Health
11 Affairs because it is that continuum of care.
12 It's where we see that our family support programs
13 are in place to provide that prevention and
14 problem-solving and building and strengthening
15 resiliency so that their resources are available
16 to meet the needs when they go beyond that. And I
17 think that's the big issue is: how do we

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18 communicate across disciplines to really see what
19 we each bring to the table, and what we each
20 offer, and to build on those strengths and fill
21 those gaps -- if they're there. And I think
22 bringing the installation teams to the table to

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1 say: what can we all do to support the emotional
2 well-being of service members and families? And
3 it's above mental health. We would like to see
4 that we would do something that would prevent that
5 even having to kick in. That's the idea.

6 DR. MacDERMID: Thank you very much for
7 a great presentation. Thank you.

8 (Applause)

9 DR. MacDERMID: Our next speaker will be
10 Colonel Robert Ireland, presenting on DoD's mental
11 health policies.

12 COL IRELAND: I did not get a specific
13 topic, so we can go where we need to go here.
14 I've been ask to sort of help the group catch up
15 by truncating my time to 50 percent, to sort of
16 get caught up with the breaks. I've prepared some
17 remarks, and I've thought of remarks that would
18 take two days to actually bring to you. And,
19 obviously, there's some pathos involved in coming
20 to grips with that. I think the primary priority
21 to me, right at this moment, is to thank you from

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22 the bottom of my heart, and on behalf of Dr.

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1 Winkenwerder, for doing this. Many of you have
2 set aside incredibly busy professional lives --
3 and at this time of the year you've set aside the
4 time that might normally be spent with your
5 families. And you've made great personal
6 sacrifices in travel and in living in various
7 kinds of conditions and encountering, I think,
8 sometimes very difficult situations, events; asked
9 to solve almost impossible dilemmas; to look at
10 conflicting information on the same issue; to have
11 philosophical and medical clinical differences
12 that seem irreconcilable. And you've had to
13 engage in a topic that is bigger than any one of
14 us can do, and that's why you're here; bigger than
15 any service can do, that's why you're here; bigger
16 than the military and the civilians and the VA can
17 do alone -- that's why you're all here. And I'm
18 just deeply grateful for your doing this. And I
19 can't thank you enough, the support for DoD, and
20 how that ripples out to our other departments is
21 just amazing. And thank you very much. So that's
22 mission one. My other plan was to briefly go

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1 through some of the dialectics of what you're
2 about, and some of the maybe more high visibility
3 ones. Because I think in some ways -- and we can
4 get to policy and structural issues, too, if you'd
5 rather -- but in some ways solving the dialectical
6 issues is really going to be where it comes down
7 to in your final work. But we can go either way
8 you want. I can knock that off, because they'll
9 just pop up anyhow. And we can go to some other
10 questions that you might have of me in my role.

11 DR. MacDERMID: Well, let me say first
12 that we would be happy to receive whatever you
13 would like to tell us. I mean, we're happy to
14 have the two-day version if you'd be willing to
15 submit it in writing. We'd love to read it. So
16 don't let this truncated time stop you. Let me
17 check with Task Force members: would you like to
18 just have open question-and-answer? Or would you
19 like to have Colonel Ireland make a few remarks
20 and then --

21 VOICE: Open question-and-answer is my
22 vote.

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1 COL CAMPISE: I'd like him to start off

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2 with some remarks; find out what he wanted to say.

3 DR. MacDERMID: Well, let's see. We've
4 got two colonels who each want different things.
5 Why don't you take just a couple of minutes to
6 sort of list these dialectics.

7 COL IRELAND: Sure. I'll do that. And
8 they're examples. But the bottom line is -- and
9 so much of what you do with any large
10 organization, and especially ones that are
11 involved in many areas of life across the world,
12 and culturally challenged in terms of what they
13 have to do -- you're damned if you do, and you're
14 damned if you don't. If you choose one side or
15 the other, and if you dig your heels in, you're
16 going to lose from the other side. And those
17 conundrums are appearing all over the place. And
18 so your task will perhaps be, then, through your
19 collective wisdom -- and we're saying: hey, get
20 these smart folks together, representing these
21 various perspectives -- your task is to perhaps
22 find a position on the notch between those

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1 dialectics; or perhaps synthesize and, say, in
2 some way to come up with a new statement of truth
3 to recognize perhaps the truth in both; or to
4 somehow matrix how you'd relate to them. And
5 there's ways of doing that. We've done it in Air

6 Force psychiatry profiling. But how do you
7 approach them. And so I think sometimes in these
8 kinds of settings here, we can sort of find
9 polarities get accentuated, and it would sometimes
10 make it feel impossible to find a solution that
11 would be satisfying to all. And if it was
12 satisfying to all it would be realistically
13 accomplishable. So those are some of the big
14 pictures. Some of the areas that I see
15 significant dialectics emerging and have been
16 debated for awhile, and sometimes in various
17 settings, would be new accessions mental health
18 standards; mental health screening; assessing
19 mental health fitness to deploy; acute responses
20 to psychological trauma -- from the clinical side,
21 let's say; psychiatric treatment in combat
22 theaters; the nosology of PTSD; diagnosing PTSD;

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1 military providers versus outsourcing to civilian
2 mental health providers; and approaches to
3 managing stigma regarding care. I was just going
4 to say a few quick words about each. I can
5 proceed, or we can stop and go wherever you'd like
6 to go.

7 DR. MacDERMID: I think, given the
8 shortness of time, we should probably open it up
9 to questions. My sense is that we probably have

10 some of those same concerns as you about each of
11 these issues. So -- Colonel Orman, do you want to
12 start?

13 COL ORMAN: Colonel Ireland, good to see
14 you again. Thanks for coming. I'm going to kind
15 of put you on the hot seat, not because I think
16 you have all the right answers, but just so
17 there's awareness of some of our concerns and the
18 issues involved. One of the things I've been
19 concerned about during the entirety of my 30-year
20 career in the Army is my perception -- that I
21 think perhaps is shared by others -- that there's
22 really not high-level advocacy for mental health

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1 care, for behavioral health issues, within HA, as
2 well as within the services Surgeon's office. I
3 know you work somewhat in that capacity at HA.
4 And having seen many of your predecessors in that
5 role, my sense is you're sort of caught up in the
6 day-to-day reacting to the latest fire drill that
7 inevitably comes your way. So my own question to
8 you is: what suggestions do you have, based on
9 your own experience, based on your own long
10 career, as to what the Task Force might recommend
11 to create more advocacy, more of a proactive
12 vision of what mental health needs to be, both in
13 time of war, follow-on to war, and during peace

14 time, so that we don't find ourselves behind the
15 curve like I think we're currently at? So perhaps
16 you could address that a bit.

17 COL IRELAND: I think advocacy, no
18 matter how well it's done -- and certainly it's
19 been done well in some branches, in terms of
20 suicide prevention for example -- classic example;
21 no matter how well it's done, if it's not grabbed
22 ahold of by the horns by the line leadership, for

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1 which we are merely a support group -- okay? -- if
2 it's not grabbed by the line -- and I would say
3 right up to the very top of our structure, and
4 advocated, in no paternalistic or condescending
5 way, but -- no kidding -- owned and advocated, and
6 then that penetrates down, then we'll see a
7 cultural change, no matter what we do in our
8 little cubes somewhere in a small office. So I
9 think it's really got to come from the top. And
10 that crosses so many boundaries. And it's a
11 philosophy about what PTSD is, is one way, and
12 what the clinicians are saying is another, and
13 there's no meeting in the middle. You can
14 advocate all you want, but you're just going to
15 piss off somebody else. So the bottom line is: we
16 have to get everybody on the same sheet of music,
17 from senior civilian leadership, political

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appointees, line leadership, and then the support.

19 The structure has to allow it.

20 COL ORMAN: How do we do that?

21 COL IRELAND: I'm not sure we do it from
22 our level. I'm not sure that the medics do it.

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1 DR. MacDERMID: Well, but I think what
2 he's asking is exactly what I want to ask, which
3 is: can you operationalize that for us? If you
4 could reorganize lines, if you could create
5 positions, if you could create a structure, what
6 would you create that would provide adequate
7 advocacy for mental health in DoD.

8 COL IRELAND: You know, the House
9 Appropriations Committee has asked us to do just
10 that -- just that. They said: if you had \$25
11 million to start something, where would you start?
12 And then figure that out, and then let us know
13 what the follow-on costs would be. I think the
14 first thing you would have to do is start at a
15 level that was pre-pathological or pre-clinical.
16 And what you would need to do is integrate, I
17 would say, mental-health-informed ways of doing
18 business at the lowest affordable levels. And it
19 wouldn't be a division, for example. It would be
20 as low as you could afford to go with it. And
21 what would it look like? It would probably not be

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22 providers in a provider role. They would probably

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1 be providers integrated into organizations in more
2 of a consultation role -- but with an eye of a
3 provider, as well. What kind of specialty might
4 be the best? It could be those with maybe
5 occupational and prevention expertise, and also a
6 deep interest in the military and its culture, and
7 maybe some participation in it and specialized
8 training. Are all those people available now?
9 There not. Do we have models of it? Yes, we do
10 -- to a limited extent, in some special operations
11 groups, in some specialized training situations.
12 We have integrated neuropsychologists who
13 established customized stress inoculation, who do
14 work with individuals after particularly stressful
15 training episodes to process how it went, and then
16 how they might handle it a little bit better going
17 through it again. And they go through it again.
18 And they practice those techniques and this type
19 of thing. They stay in consultation with
20 leadership about how to design the flow of
21 operational movement, let's say, in terms of
22 fatigue-rest cycles, and in terms of how to

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1 monitor folks, and do it in a way that's not like
2 the providers sitting around with their checklists
3 saying: "Well, fit the criteria. Go to the clinic
4 and get a diagnosis," but more in the model of --
5 forgive me if I say this -- Yoda; sort of the
6 shadow warrior, wise person, who is there to sort
7 of help them be at the top performance they want
8 to be, and shift gears into sort of a high level
9 wellness model that covers a lot of domains of
10 life. But I think if we're going to start over,
11 we have to sort of get ourselves -- and this is
12 done to a certain extent with medics already. I've
13 been a flight surgeon most of my life, integrated
14 with squadrons and travel around with them, where
15 you sort of become one of them, and they learn to
16 trust your judgment and rely on you, and come for
17 guidance on different type of things to you for
18 medical things. So I think there's ways of doing
19 that. It's a large model. It would take years to
20 implement and a fair amount of money; maybe
21 setting up centers of excellent for training and
22 growing and retaining and incentivizing, let's

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1 say, psychologists to stay. So that's one model

2 -- rather than just have the medical model and try
3 to jam that, perhaps, inappropriately into the
4 whole system, making everybody pseudo-patients.

5 DR. MacDERMID: And what about at the
6 top -- at the other end of the continuum? What
7 would the top of that structure look like?

8 COL IRELAND: Well, I think -- in terms
9 of medical care? Or --

10 DR. MacDERMID: Well, no, who -- if you
11 were going to create an advocate for mental health
12 within DoD, to whom would that person report, who
13 --

14 COL IRELAND: Well, it would be
15 non-medical primarily, at that level. So would it
16 would be personnel readiness. It would have to be
17 owned by the Pentagon. I mean, it would have to
18 be taken on as part of how you do your mission.

19 DR. MacDERMID: And to whom would they
20 report, then? Would they report to the
21 Undersecretary for Personnel and Readiness? Would
22 they report to the Surgeon Generals of the

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1 services?

2 COL IRELAND: Well, I think that has to
3 be thought out. It has to be thought out.

4 DR. MacDERMID: Well, we're trying to do
5 that.

6
7 going to have a roundtable on this coming up,
8 where we're going to bring a lot of folks
9 together. You know, I think this is new thinking.
10 I think we're dealing with an institution that has
11 the inertia of, you know, three Titanics bundled
12 together. I mean, how do you go about these
13 things? And I think it's going to take a lot of
14 brainstorming. I know there's a lot of people
15 interested in this type of things from various
16 domains; perhaps the VA, and our system, perhaps
17 legislative affairs. I think there's a lot of
18 folks who are interested in a way that is
19 non-pathologizing, that doesn't create stigma,
20 that gets your sensors into the daily lives of
21 folks and acts on the low threshold of mental
22 health distress.

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1 DR. BLAZER: Let me ask a question -- I
2 want to go back to one of your dialectics, namely
3 the diagnosis of PTSD. Because PTSD has become
4 sort of the lightning rod diagnosis for this
5 particular era. The Institute of Medicine
6 recently issued a report that was commissioned by
7 the VA on the diagnosis of PTSD. That report was
8 pretty straightforward, and basically endorsed
9 more or less what's in our DSM-4 manuals; endorsed

10 the traditional ways that PTSD diagnoses were
11 made. And my understanding is: that created
12 considerable consternation and debate within the
13 VA. I'm curious about -- you listed that, the
14 diagnosis of PTSD -- what you're thinking is in
15 terms of are there problems with the diagnosis
16 now? Are there issues that you feel like are
17 really are top items that need to be addressed,
18 etcetera?

19 COL IRELAND: The same issues that
20 probably the nosology folks who are working on
21 DSM-5, and dreaming about DSM-6 are, sir. My
22 guess is we're in sort of an era of making

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1 psychiatric diagnoses, for example, by observing
2 particular phenomena that are criteria, and so you
3 have a checklist, and you get to someone and you
4 sort of run the checklist off. And if they meet
5 the criteria -- I even had a psychiatric
6 epidemiologist Ph.D. tell me this: if you meet the
7 criteria, you've got the diagnosis. So that's
8 what you might call a phenomenological approach.
9 It's very different from, let's say, the model in
10 which most psychiatrists train, where you sit down
11 with someone and you take a pretty good history --
12 a developmental history, a psychiatric history, a
13 medical history; you learn about their traits and

14 character development and how they sort of look at
15 things, and how they approach life; how they
16 appropriate -- the involvement of relationships in
17 character development -- that type of thing. And
18 then, in the context of that person, that person's
19 development, you look at how they respond to
20 particular challenges or traumatic events, and
21 then what you're dealing with at that point in
22 time -- so sort of what some would call a

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1 "bottom-up" approach to building a life story and
2 sort of the history of how that person comes to
3 the issues that are challenging them. And it may
4 be you're dealing more with existential crisis;
5 more with what some might call a transcendent or
6 spiritual crisis. And it has the symptoms of
7 PTSD, but the primary issue may not be this
8 medical problem of amygdala being hyperactive and
9 not learning safety and cooling off the system.
10 It may be this other problem. It may be --
11 Jonathan Shay would talk about -- issues of maybe
12 betrayal or something like that that tend to
13 produce chronicity. So is that captured by DSM-4?
14 Maybe not. Does that capture fully dissociation?
15 Does it capture things like personality change?
16 Does it capture identity change? Does it capture
17 those other kinds of things that are associated

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18 with it? Maybe not.

19 DR. BLAZER: Okay, let me just follow it
20 just briefly. I think I hear you saying that
21 rather than just simply labeling somebody with
22 PTSD, "yes" or "no," like DSM-4 does, what you

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1 would like to see is a more thorough evaluation,
2 sort of like what we used to do with a psychiatric
3 formulation of what goes into that diagnosis. But
4 let me be sure I also understand: I don't think I
5 hear you saying that you think the diagnosis is
6 necessarily being overused. Or are you?

7 COL IRELAND: Well, I think that would
8 require data to generate. And if you're looking
9 at, let's say, tens of thousands of patients in, I
10 don't know, whatever organization you're in, the
11 only way you can make a conclusion about that is
12 to analyze the detail on the charts. And if the
13 charts are very sparse, then you can't answer the
14 question. But if the chart not just sort of
15 checks off the criterion checklist, but actually
16 goes into how that criterion was actually met, and
17 gives you some sense of it, then I think one could
18 begin to do that analysis. I think it would cost
19 hundreds of millions of dollars to do it. (Laughs)
20 You'd really have to find a lot of experts, you'd
21 have to locate a lot of charts, and you'd have to

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sit down and do some serious work.

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1 COL CAMPISE: Is there anything that you
2 would recommend that we recommend in regards to
3 changes that need to happen in Health Affairs for
4 us to be more effective?

5 COL IRELAND: I think the role of how
6 Health Affairs functions probably would benefit
7 from being defined in a way that others could make
8 sense out of it. My understanding, in my role,
9 that it's sort of a policy shop, develops sort of
10 policy that allows room within it for specific
11 development and specifications that the service
12 branches create their rubric under, that more
13 specifically outlines what policy out to be. So
14 it's sort of a floor, so to speak; or sort of the
15 basic outline that is filled in by the services.
16 The services get their money, their funding
17 separately; they determine how to spend it; and
18 they determine what policies they will execute the
19 mission they've been handed. And each branch has
20 challenges that are quite unique from the other in
21 how they do business, and even cultural kinds of
22 traditions that go along with it. So I think the

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1 branches really own the application of how you do
2 business, and they are funded to do so. And then
3 they make decisions. And I'm not an expert in
4 that area. So I think Health Affairs -- I mean
5 some folks would look at -- "Well, why don't you
6 do this -- and do this, and make this happen, and
7 "Go down and make them fix that. We're not that
8 kind of organization. When the service branches
9 are empowered to take care of themselves and to
10 administer their own policy. So unless there was
11 a structural change in that -- which is far above
12 my pay-grade to even think about -- I don't see
13 health Affairs as taking on the kind of authority
14 some people have talked about.

15 COL ORMAN: Colonel Ireland, one of the
16 things -- I've visited probably 25 different
17 installations in all four services now -- one of
18 the things I hear, and the people that travel with
19 me hear with some frequency, from a variety of
20 constituencies, whether it be family member,
21 beneficiaries, active duty members, hospital
22 commanders, behavioral health providers, is the

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1 sense that we've created a culture of a business,

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2 if you will, for medical care during time of war.

3 And in many people's minds there's a disconnect
4 between trying to run an efficient let's-
5 count-the numbers, let's-count-how-many-widgets-
6 flow-through-the-factory sort of thinking versus
7 "The nation's at war, we've got a lot of
8 individuals sacrificing for the nation. We've got
9 their family members left behind." And yet
10 they're told "Sorry, you can't access services for
11 eight weeks because we don't have the money to buy
12 the providers it would take to increase your
13 access." Realizing what you just said with HA
14 delivering budgets down to the services to
15 operationalize, I kind of wonder, though, about
16 the role of HA sort of pushing the business model,
17 particularly during time of war. It's one thing
18 to try to do a transformation of the sorts of
19 thinking during peacetime, but to sort of be
20 pushing that model in a time when -- war is a very
21 expensive business that's not designed to be
22 efficient and thrifty with the dollar. It's

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1 designed to spend lots of dollars. Can you speak
2 to --

3 COL IRELAND: (off mike) has put out
4 millions of dollars for providers. There's more
5 than one service that was returned from mental

6 health providers. So, I mean, there have been
7 situations where it's not just money. I think the
8 dialectic you're referring to is the tension
9 between the priorities to conduct a war and
10 sustain it, and the medical care for optimal
11 health -- which is always a dialectical struggle;
12 and do we want to eliminate that? Should they
13 always be in tension? Probably so. Should people
14 be waiting eight weeks? Absolutely not. That's
15 not a Tricare standard.

16 COL ORMAN: Well, let me tell you what
17 the reality is on the ground. You're a
18 psychiatric provider at a fairly small clinic in a
19 non-urban, geographically isolated post. You've
20 deployed. You've got maybe two other people in
21 your shop. And you're told if you want more people
22 to support the fact that one of your staff members

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1 is deployed, you've got to put together a
2 business-case analysis, etcetera, etcetera,
3 etcetera. And meanwhile you're already working
4 80-hour weeks. This doesn't make sense to the
5 provider community. And there are hospital
6 commanders who'll validate this. Yep -- that's
7 the nutroll we put these guys through. And the
8 beneficiaries don't get it. Where are the dollars
9 to fund the care that is in demand?

10 COL IRELAND: Yes. I'm not here to
11 address budget issues.
12 COL ORMAN: I know.
13 COL IRELAND: But I think the services
14 have a fair amount of latitude in how they
15 prioritize. And Health Affairs does not tell a
16 service how to do that business.
17 DR. MacDERMID: I have a couple of
18 questions. Although we are a task force on mental
19 health, we spend a lot of time talking about
20 mental illness. And there's a dialectic about
21 where on the continuum between the best possible
22 mental health and the worst possible illness,

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1 what's the military's target? What should its
2 target be in terms of placing itself on that
3 continuum for members and their families? Can you
4 talk a little bit about that? Where do you think
5 that line is?

6 COL IRELAND: I think we can set the
7 target very high. I mean, you may not hit it in
8 every case. I've authored a little notional
9 chapter on optimization of the human weapon
10 system. It really incorporates about seven or
11 eight dimensions of wellness, and how we could
12 implement those wellness improving measures even
13 while deployed in a field of battle; that there

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14 are just certain things you can do that can help
15 people meet some of these dimensions -- for
16 example training and education. We're getting
17 front coverage stories in Air Force Times about
18 senior sergeants who are getting their degrees in
19 theater, using every minute of extra time they
20 have to do some on-line stuff. But that's just
21 one wild example. But the bottom line is: I think
22 we need to have no short of the highest mark we

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1 can envision as humanly possible to set for
2 ourselves. If we don't hit it, we can sure try
3 getting there. And, analogously, the Department
4 of Defense and its association with the VA and the
5 other government agencies that are paid for by the
6 taxpayers are analogous to our human body. I
7 mean, I'm noticing as I age, all the things that I
8 would be so for my body and what I can do are not
9 true. And I think as a body together, all of us
10 working sort of analogously as cells and organs,
11 lets say -- we have visions that should be just as
12 high as we can set them, recognizing that part of
13 us won't be able to pull it together in that
14 particular location or at that particular time,
15 and that we do the best we can all the time, and
16 not abandon hope that we can get to high-level
17 wellness in the midst of all our challenges, and

18 sometimes not the amount of care and support we
19 would like to have.
20 DR. MacDERMID: Can you talk a little
21 bit about DOD's obligation with regard to the
22 mental health of dependents -- spouses and

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1 children -- of active duty members and Guard and
2 Reservists? What is the military's obligation to
3 them, and where are we at? Where should we be at?
4 COL IRELAND: Family members are that
5 without which, I think, a service member can be
6 focused on whatever it is they're supposed to do
7 in the service. So it's an incredibly high
8 priority. My understanding, and what I've
9 observed over the years is that we've shifted a
10 great deal of their care to the civilian
11 community. Now, at the same time, we have a
12 civilian community where providers -- I go to
13 these conferences, and they'll sit around for
14 lunch, and they'll brag about it took them only a
15 year to get on a cash basis. And I'll be looking
16 at people that are former military. And I'm
17 thinking in my mind: how could you not continue to
18 support your culture? Why would you get rid of
19 Tricare? And I know that historically there were
20 some challenges. But now lot of those have been
21 met I understand. But I think what we do is we

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1 their patriotic duty, to not just go on a cash
2 basis at triple, you know, whatever the highest
3 payer can give them in an insurance industry. So
4 my sense is -- the brass tacks is: we're competing
5 in the VA, let's say, and in the DoD for mental
6 health assets and providers. There are major
7 cities in the United States where you call
8 anywhere and you're not going to get an
9 appointment in eight weeks to see anyone -- major
10 cities -- under any circumstances. So I think
11 we're in that competitive market. And so what
12 we're going to do is we're going to give you a
13 government-limited tally, and some illness, and
14 you'll have an opportunity to visit exotic places
15 and have unbelievable challenges. You know, some
16 people respond to that, but not everybody.

17 DR. MacDERMID: Anybody else? (No
18 response) We're going to take a break now until
19 10:30. I want to thank Colonel Ireland very much
20 and encourage him, once again, to present anything
21 that you would like to in writing to the Task
22 Force. We're happy to have it. I'm really

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1 interested in this chapter on the optimization of
2 the human weapons system. And thank you very much
3 for taking the time to speak with us today.

4 COL IRELAND: Thank you very much.

5 (Applause)

6 (Recess)

7 DR. MacDERMID: Back on the record.

8 COL COX: Good morning. I'm presenting
9 on behalf of Colonel Atkins, who I know was your
10 first request. But unfortunately she was out of
11 town this week. And so this program involving the
12 Post Deployment Health Reassessment has
13 transferred from her section to mine anyway, it
14 made sense to have me come and talk to you. But
15 although the original request was to discuss the
16 Post Deployment Health Reassessment -- and I will
17 -- I feel compelled to outline the set of
18 assessments that we use in the military, as many
19 of you know, already, because really what's
20 critical is that we don't rely on a single point
21 in time to somehow capture and magically address
22 everything that may have gone wrong. What we need

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1 to do is establish the culture of much of what

2 you've talked about already, that promotes
3 individual responsibility, individual knowledge,
4 of what steps are available; training for the
5 kinds of tools that give them personal resiliency
6 and the abilities to deal with issues; as well as
7 the community around them to provide the support
8 that they need and, when required, of course,
9 actual medical care and specialty attention as
10 well. So we will do a brief dash through the
11 overall aspects of our continuum of care and
12 assessment milestones, and then focus on the
13 results and our experience to date with the newer
14 Post Deployment Health Reassessment. (Slide) So
15 this is just a schematic of the overall cycle.
16 And it starts in the lower left-hand corner at a
17 session. We want to systematically gather much
18 more information than we have in the past, not
19 just focusing on physical issues and whether
20 people are up to the standards we require for them
21 to enter service and expect them to be able to
22 perform well, but to also look at their

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1 background, what their life experiences have been
2 prior to entering the service, and to capture
3 those; be able to review those over time and see
4 how things change. Then once they've completed
5 some form of initial training and are now at least

6 at least a minimal level of competency at some
7 occupational specialty, then they go into their
8 military service. And this applies -- just to be
9 clear -- to total force; it's active duty and
10 Reserve components, but there are obviously some
11 differences in how it's implemented. But once
12 they're in their military career, then there's
13 this repetitive cycle of things that either happen
14 in the garrison setting, or that occur related to
15 a deployment of some operational support nature.
16 And so we're going to just look at each of those
17 little steps, as far as the Annual Preventive
18 Health Assessment, and then the pre-deployment,
19 the re-deployment and the post-deployment health
20 reassessment. And then obviously there comes a
21 point when people leave military service, and they
22 either have a separation exam if they're not going

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1 to be eligible to retire, or they have the same
2 equivalent approach but it's a retirement exam
3 (Slide) So -- not to spend time on this, since
4 it's not your key issue -- but we do want to --
5 we're missing currently this baseline, the initial
6 baseline of information. There's been work done
7 for several years now to create a self-reporting
8 tool to use for that. It's been approved. It's
9 in the process of being implemented. And then we

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10 will electronically have that first data point, or
11 set of data points, in each person's record.
12 (Slide) The key to both medical readiness, as well
13 as installing and promoting this preventive
14 medicine culture and overall preventive culture,
15 period, is the periodic health assessment. And it
16 replaces the older every-five-years exam. This
17 one is once a year. It is tailored, based on the
18 individual's age, gender, using United States
19 Health Preventive Services Task Force
20 recommendations, as well as that individual's past
21 history, their family history, and their responses
22 on a consistent self-reporting tool that's going

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1 to be part of each visit that let's the provider
2 then focus on what that individual needs; whether
3 it be tests, whether it be specialty referrals,
4 whether it be education, brochures -- whatever.
5 (Slide) So then we start to talk about the
6 deployment-related assessments. And we're not
7 going to spend time on the pre-deployment --
8 that's a last-minute, just-before-you-go, within
9 30 days kind of thing that checks to make sure
10 there haven't been interval changes since your
11 previous periodic health assessment which, again,
12 is that consistent linchpin. Once you are
13 deployed, you're in the field, then of course we

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14 don't have the same access, we don't do the same
15 things. But just prior to coming back, or shortly
16 after -- depending on the logistics and the timing
17 -- there is what's called a "Post Deployment
18 Health Assessment." And the individual answers a
19 set of questions dealing with both physical,
20 psycho-social, as well as environmental concerns.
21 In the guidance it's to be accomplished as close
22 to the date of redeployment as possible but no

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1 more than within the boundaries of 30 days on
2 either side of the deployment. In actuality,
3 because of the previous policy being to do them
4 within five days, the great majority of them are
5 done within five days of departing the theater.
6 In some cases services have chosen to do them
7 again as soon as they get off the plane back in
8 the States. So they certainly have a number of
9 opportunities to complete those. (Slide) And then
10 the newest one is the Post Deployment Health
11 Reassessment -- which we're going to go into in
12 more details and see some of the results of, and
13 we'll talk about why we switched to that, or added
14 that, I should say. So the concern, as we know,
15 is that things develop over time. And when you ask
16 people questions just before they get on a plane,
17 when they're anxious to come home, when they're in

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18 a certain state of feelings and perspectives about
19 what they've survived, what they've done, and what
20 they have to look forward to they're answers
21 aren't necessarily the same about psycho-social
22 questions as they may be three or six months

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1 later. And on the physical health side, certain
2 diseases take time to manifest themselves,
3 including some of the exotic and unusual things
4 that people can be exposed to in our current
5 operations. So rather than just checking at the
6 exact time of redeployment it made sense to make
7 sure we were reaching out and finding out if there
8 were things that people needed, or had concerns
9 about, that had developed over time. So the
10 decision was to implement a Post Deployment Health
11 Reassessment milestone. Now I should mention that
12 although we're saying we wanted that three to six
13 month check, if you'd go back to that concept,
14 paradigm, of the preventive health assessment,
15 that's supposed to occur every year. And
16 depending on the average length of deployment,
17 which does vary with the service, a number of
18 people are going to be due for that when they come
19 back. If they've been gone for a year, well then
20 they have to already be in the window to have it
21 done. Well, we usually give them about 90 days'

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1 integrate with their family, their community,
2 their society; if they're Reservists, to get back
3 into their job. So they probably come due for
4 this at the same time. And that is one of the
5 efficiencies we expect, is we will combine this
6 health reassessment with the PHA, do them
7 simultaneously. And the Army has put out policy
8 that promotes that approach to streamlining it.
9 However for other services, who have maybe an
10 average deployment of 120 days it's not exactly
11 the same. And so this may not come out as being
12 due at the time as a PHA, in which case they'll be
13 handled as separate events. But the point is that
14 they're both accomplishing the same kind of goals,
15 in that we want to look at the spectrum, all the
16 domains of health. I have to say up front: the
17 PDHRA was not designed to be a mental health
18 assessment. It was designed to be part of a total
19 health assessment, of which mental health is a
20 critical portion that we want to pay just
21 attention to. (Slide) So -- more specifics about
22 who gets it. Well, anybody who deployed under the

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1 guidance of DODI 6490.03 defines what a deployment
2 is which requires the post deployment Form 2796 to
3 be filled out. If you were required to fill out
4 one of those forms, that's the automatic trigger
5 then that you will also be notified and offered
6 the opportunity to have a Post Deployment Health
7 Reassessment at that 90 to 180 day period after
8 you've come back home. It applies to total force.
9 It's not just for combat operations. And under
10 that same DODI I referenced there is the option
11 for commanders to choose to add those assessments,
12 even though it might not normally have been felt
13 to qualify. So things like Katrina, where people
14 were saying: "Oh, well, this is CONUS. We're at
15 home. We don't need to do any of this. There's
16 no necessity to do either serum samples, or to do
17 these pre and post- deployment assessments." But
18 based on the expected exposures, or things that
19 you find out while you're there, commanders can
20 require that to hold it to an even stricter
21 standard than what's in the DODI itself. (Slide)
22 Where are these accomplished? It is at the unit

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1 level. That varies sometimes with travel and

2 armories and the Reserve components, but it's
3 focused at the unit level. It is a commander's
4 program, as is all of medical readiness. And
5 we've already explored the reasons for why we want
6 to contact people. (Slide) So, just to give you a
7 little overview of what we've seen so far: as of
8 just a few days ago we have completed almost
9 180,000 of these. By now it's past 180,000. It's
10 a continuous program. What we're seeing -- the
11 next few bullets summarize what the members
12 answered on their portions of it. And then we'll
13 see what the providers thought as they finished
14 their interviews and came to a clinical
15 assessment, on the next slides. But this one
16 shows that a little more than a third of them did
17 not express any concerns -- and, of course,
18 there's always the question about whether they're
19 answering openly and honestly, and we have to take
20 that into effect. But certainly there are plenty
21 that do express concerns, so it's not like it's
22 seen as some totally oppressive thing that you

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1 must lie and not give any honest responses to.
2 But we have a third who also mention having mental
3 health concerns; and a greater degree of people
4 who are worried about some kind of physical injury
5 or other medical condition that isn't strictly in

6 the realm of mental health, although obviously
7 there's a great deal of overlap and relationship
8 between those two issues. And a significant
9 number who report some of each. Of these
10 individuals -- they have the opportunity on the
11 form to specifically say whether they would like
12 to have a referral to address something. And
13 there are several kinds of referrals. There can
14 be referrals for medical care, there can be
15 referrals for things like One Source, which you
16 received a briefing on earlier today. (Slide) So
17 the next stage is that after the individual has
18 answered their questions, then a provider has to
19 review those responses. And they then gather
20 additional information through history, talking to
21 them on the phone, talking to them in person.
22 We'll see that there are several venues by which

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1 this happens, to try and meet the needs of all the
2 different components, which are not identical.
3 But once they have talked to them they determine
4 clinical significance, and they label things as
5 either a major concern or a minor concern from the
6 provider's perspective. And then they make a
7 decision on whether to refer them or not for
8 additional evaluation and/or treatment. So you
9 can see that for the people who expressed a health

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10 concern, almost half of them ended up getting a
11 referral; and that for the people who received
12 referrals, the most common symptoms that were
13 mentioned were sleep and fatigue issues, back pain
14 and joint pain. So we get a heavy emphasis on
15 musculoskeletal. Of the people -- and I'm afraid
16 one of these bullets got indented inappropriately
17 -- but the next one should have been at the same
18 level as the "physical," but referred 53 percent
19 of those with mental health concerns. So again
20 about half of the people who have concerns end up
21 getting referred. When you look at it closely
22 it's not a one- to-one match by any means because,

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1 as it shows down here, 28 percent of the people
2 received at least one referral. On the previous
3 slide you'll notice that 18 percent of the people
4 requested referrals. So it isn't like it's just a
5 rubber stamp: if a person asks it they get it.
6 And if you look at the 18 percent who asked for
7 it, not all of them get it. Because as part of
8 the clinical process, when you work with people, a
9 lot of time what they're missing is some
10 information, some education, some health- risk
11 communication. And when you get through that you
12 come to a mutual agreement that at this time, at
13 least, there is no reason to refer. And other

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14 people, who didn't ask for a referral --

15 clinicians, after they talk to them, sometimes
16 decide that: yes, you should have a referral. So
17 that's part of what medicine should do. That's
18 the art of being a physician. (Slide) So, to
19 finish out the mental health concerns: they are
20 divided among issues. There are sort of several
21 miniature scales on the DD Form 2900. And it
22 looks at PTSD, it looks at depression, it looks at

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1 interpersonal issues. And it gets split almost
2 equally amongst those as to reasons for why people
3 end up with referrals. They do provide a great
4 deal of education, guidance, access, brochures,
5 information, websites -- whatever fits that
6 individual's needs, their preference for obtaining
7 information. And then the referrals are made.
8 And, as you can see, a fair number -- most -- go
9 to primary care. The military has a primary care
10 manager approach. We expect people to serve as
11 generalists when it's appropriate, and to know
12 their limits, and to refer to specialty as they
13 need to. About 30 percent do go directly to
14 mental health professionals. And a very
15 substantial portion of the people either request
16 or, when offered, accept the more broad-based,
17 community-based types of consultative services

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18 such as Military One Source. (Slide) Now, this
19 shows we're starting to link and looking at
20 things. Because the question is -- this is an
21 extra assessment; we need to show that we're
22 providing service. We would like to know if we're

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1 finding the things that need to be found, or that
2 we're just identifying additional things that are
3 already known about, and that we're not actually
4 providing a valuable service. So we're starting
5 to compare the results between the questions and
6 the decisions made at the point when people are
7 just coming back, around the time of redeployment,
8 with what we're seeing at the three to six-month
9 point later. And I'll just mention that the
10 six-month point was not something magical to begin
11 with, that we said "Oh, we know this is clinically
12 the best time to ask these questions." It really
13 had to do with entitlements. And so the TAMP --
14 the Transitional Assistance Management Program for
15 Reserve component people -- expires at the sixth
16 month, and so they lose some of the flexibility
17 they would have to seek care if it's needed. So
18 at least starting out looking at this before six
19 months, we knew that we could give them every
20 opportunity for quick access for care, in addition
21 to the VA services which then continue for two

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22 years. And so we focus on the two-year point

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1 overall. But we'll talk in the validation program
2 about: we want to look -- is three months the
3 right time to ask? Is that the best time? Is six
4 months? Should it be nine months? We're not
5 sure. And so that's part of our ongoing
6 validation study, to figure that out. But if you
7 look at the responses on their own health, you see
8 that there is a general decrease in that three to
9 six-month period; that people self-report that
10 they think their health isn't quite as good as it
11 used to be. If you look at the provider
12 assessment to the concerns, though, it's
13 relatively consistent. Now I have to say that the
14 PDHA, the questions and the structure by which
15 it's done are not identical to the PDHRA. So I'm
16 not convinced that that's a legitimate comparison.
17 But it's what we have at this point, until we can
18 dig deeper. And certainly you see that they seem
19 to endorse, as providers, a relatively similar
20 amount of concerns for either physical or mental
21 health. Exposure concerns are dramatically
22 different. And we don't have proof yet, until we

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1 can get more data and come back in, but I'm
2 suspicious that that, to me, makes some sense.
3 Exposure concerns usually are brought up by
4 individuals right when they're coming back,
5 because they've been there, they've heard about
6 it, the rumor was all over camp that this spot had
7 depleted uranium, that spot had airborne particles
8 of fecal matter floating all the time -- whatever
9 it was; they've heard that, and now they want to
10 ask questions about it. Three to six months
11 later, they're back in a new environment, the
12 concerns are more remote historically, and from
13 memory. They may have been offered material, they
14 may have read things in the paper. Of course it
15 could go the other way, too. But it may be that
16 -- and from a clinical standpoint a provider is
17 going to be less concerned about environmental
18 concerns if they're not supported by symptoms and
19 signs and things that lead them toward a medical
20 diagnosis. So we're interested to follow that and
21 see what it means in the long run. For overall
22 referral for care -- again, not dramatically

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1 different; about 22 percent right at the time

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2 they're coming back; 28 percent a few months
3 later -- but in that same kind of mix of
4 predominantly physical concerns, and a significant
5 portion of mental health concerns. (Slide) And
6 this is just one interesting slide to try and show
7 how clinicians use the information they have to
8 determine when they refer or don't. There is a
9 four-question PTSD scale on the form. And a
10 significant number of people answer two or more of
11 those questions with a positive. And then, of
12 course, the clinician has to talk to them and
13 decide: well, is it now? Is it persistent? Is it
14 old and they're just mentioning that they had it
15 when they first came back but it's actually
16 resolved now and isn't an issue? And one of the
17 ways that we expect them to differentiate is by
18 impairment. And there is a question -- a general
19 question -- about impairment; interaction with
20 daily activities; doing your job. And as you
21 would hope and predict, if the individuals say
22 that they are impaired, as well as answering these

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1 PTSD questions in a positive manner, then they are
2 far more likely to be referred. But a significant
3 number who also don't say they're impaired also
4 get referred. So, again, it comes back to
5 clinical judgment. (Slide) I mentioned the

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6 validation test -- again, this is a new system

7 Even the older tool -- the 2796, which has been
8 around for a number of years -- has never been
9 formally validated. The questions were designed
10 under duress to prepare for operations. They were
11 expanded in 2003, as we prepared to go into OAF.
12 We need to really look at them and see if they're
13 doing what we expect, and try and assess
14 sensitivity, specificity. It's not a diagnostic
15 tool. It is meant to be strictly a screening
16 tool, and we have to assess it from that
17 standpoint. But adding this new one gave us the
18 opportunity to do that closer to the start. And
19 so we do have a study that's underway. And the
20 IRB is getting approved now. There are several
21 sites involved, especially Madigan Army Medical
22 Center in Fort Lewis, as well as some supporting

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1 from the Corps, the Navy in Bremerton is going to
2 support it. We've had some work in Kedina -- not
3 Kedina, but Okinawa, with the Marines, and Hawaii;
4 and also Alaska. So we're getting a fair number
5 of groups to participate. Because one of the
6 challenges is that the services interpreted the
7 policy implementing this in different ways. So
8 it's being done differently. And the question is:
9 is one way better than another. So the original

10 expectation is that every individual would have a
11 discussion with a provider, which is what we do
12 with the post- deployment assessment. But one
13 service decided that there was a question, that
14 responses, it should be only if it was significant
15 responses. If nobody said they had any problems,
16 well what was the point of discussing it? So they
17 went off and only had the interactions if there
18 were worrisome responses. Other services,
19 everybody gets one. Some sites decided, in
20 addition to having a primary care person,
21 provider, review these results and interact with
22 the service member, they would all see a mental

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1 health provider, because maybe that would have
2 some effect on stigma and a willingness to answer
3 questions. Again, you can go in both directions.
4 And until we do the validation study we're not
5 sure what difference that's making. Are they
6 finding a greater number of clinically significant
7 cases? Is there a better sensitivity and
8 specificity balance because of that? So the study
9 will look at each of those primary approaches to
10 handling this assessment that we've discovered.
11 And they expect to start collecting data,
12 actually, in January of 2007. And if they stay on
13 schedule, the final report would be expected in

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14 later fall of 2007. (Slide) So that's sort of the
15 overview of generic approach to this Post
16 Deployment Health Reassessment and its place
17 within the greater continuum of health assessments
18 that cover a service member's entire career. And
19 a lot of the work right now has to go towards
20 refining the business process. It's complicated.
21 We have telephone centers handling it for Reserve
22 component people who don't have the same ready

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1 access to come in and be brought together. And
2 you don't want to conflict with training time.
3 And we have on-site approaches: we have on-site
4 traveling teams; we have active duty using their
5 own medical staff. And so all of those different
6 approaches, each one has to be tuned and get our
7 capacity up. Right now we've accomplished about
8 50 percent of what we should have accomplished
9 since it started. So we're behind. And, of
10 course, there's new people coming back each month,
11 and we have to get to where we can keep up with
12 the current and catch up on the past. So -- lots
13 of work on the logistical side. And then we want
14 to validate what we're doing, and then make
15 changes if it's not working as we had intended.
16 That includes refining the practice guidelines,
17 assessing how the providers deal with these issues

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18 and, of course, continuing our work with the VA,
19 because this is a split support with them, as
20 well. And actually most of the referrals for the
21 Reserve component at this time are going to the
22 VA, as opposed to into the Tricare network, or

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1 being handled by military treatment facilities.
2 So I think that's as far as I had intended to go
3 with the overview, and would like to take this
4 opportunity to answer any questions you might
5 have.

6 DR. McCORMICK: I have a question. I'm
7 glad you did include the early part -- the
8 baseline, if you will; and you mentioned the
9 practice guidelines. The practice guidelines --
10 the DoD practice guidelines for depression and
11 PTSD actually call for regular screen during the
12 annual physical for those conditions, which would
13 provide a baseline. But my understanding is that
14 is not policy in DoD to do that. Could you
15 comment on why that isn't policy? And would not
16 be a reasonable thing to do?

17 COL COX: Well, I'm not sure that it
18 isn't policy. It may be that it's not culled out
19 as a separate policy. But what we have right now
20 with the PHA that I mentioned, there is a tool --
21 a self-reporting tool. It used to be called the

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22 "HEAR." It never really got fully adopted. Now

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1 it's new name is the "Health Assessment Review
2 Tool" -- the HART -- and the HART is part of every
3 PHA. The HART includes the mental health-related
4 questions that you find on these other forms that
5 we're talking about. That's one of the issues,
6 and one of the key things that we're doing, is
7 making sure that those match up with the questions
8 so that over time we can follow people's changes
9 in responses in a meaningful manner, starting with
10 accession, through their PHAs, and then every
11 deployment cycle that gets layered on top of that.
12 So when they use the HART they are assessing for
13 PTSD, they are assessing for depression, using
14 those questions that are in that self-reporting
15 tool. Now, not everybody is using that tool yet,
16 because there's issues about implementing it --
17 especially for the Reserve component who doesn't
18 have ALTA, it doesn't have all these other things.
19 Now, the Air Force has been using a HEAR for a
20 number of years, and they're ready to move to the
21 HART. The Army has come on line with their
22 implementation guideline, and they're in their one

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1 year implementation period now. So it's more or
2 less in the coming-on-line form, and it will
3 become much more consistently available than it
4 has been to this point.

5 DR. McCORMICK: So you're saying it will
6 be. Because on site visits, quite frankly, I
7 don't see it happening. So you're saying it is
8 policy and it will happen?

9 COL COX: Right. The PHA policy was
10 released last year. It's been out. February of
11 this year, excuse me. And implementing policy by
12 the services has followed since then. And, no --
13 right now you'll find, from your visits, many of
14 the sites who hadn't adopted the PHA earlier are
15 still in the every-five-year cycle, and so you
16 don't see that. Each of the services had their
17 own other screening tools, too. The Navy had a
18 fleet health readiness kind of questionnaire, the
19 Army had an HRA questionnaire. The Air Force was
20 an early HEAR adopter. They all included mental
21 health questions, but they weren't systematic and
22 they weren't identical across the enterprise

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1 which, of course, made it very hard to do

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2 comparisons. But the policy is out there, and

3 implementation is in process.

4 DR. MacDERMID: Angela?

5 COL PEREIRA: One of the other issues
6 that we're hearing on our site visits is that the
7 way that the screening tools are being
8 administered may be getting in the way of its
9 effectiveness and the accuracy of information and
10 willingness to get mental health follow-up. In
11 one of the examples we heard this morning from
12 Veterans for America is the situation in which you
13 have a room full of people sitting there filling
14 out the PDHA or PDHRA -- well, normally, PDHA --
15 and then after that has been done, the
16 announcement made: "So if you want to see a mental
17 health professional, come up to the front of the
18 room." Now, it may not be that bad anymore, but
19 we're still seeing situations where there's not a
20 one-on-one, or that information is somehow
21 conveyed to the entire group. And because of the
22 stigma about mental health there's an

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1 unwillingness to go and see that one-on-one
2 provider. Has there been any further guidance put
3 out to leadership about how the tool should be
4 administered in order to be effective?

5 COL COX: I would say no, and the reason

6 is along the lines of what Colonel Ireland was
7 mentioning before, as well, is that much of this
8 comes under service-specific prerogative about how
9 they execute a policy, a program, that's been
10 designed. The intent was to always follow
11 appropriate levels of privacy when dealing with
12 medical information. I mean, it doesn't matter
13 whether it's mental health or whether it's other
14 issues; sexually transmitted diseases -- whatever
15 -- we're supposed to always be concerned about
16 privacy when we're dealing with our patients.

17 COL PEREIRA: Well, we are, but that
18 doesn't necessarily mean the leadership is.

19 COL COX: Well, when it comes to this,
20 though, the medical has to drive that with the
21 commander at the local level. If the commander is
22 saying, "Oh, well, I just want my people put into

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1 a room and administered in a group, " the medics
2 have to stand up and say, "No, that's
3 inappropriate under Privacy, and you're not going
4 to meet the intent of this program " But I
5 certainly that we've heard of situations like you
6 describe, and we've heard it go in multiple ways,
7 as far as what that means. Some people seem to
8 think it's better having the noisy group, and
9 everybody sitting around, because there's so much

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10 background noise nobody can hear what's going on;
11 as opposed to having to walk out because -- I tell
12 you, I think humans have a streak of perversity in
13 them that you just can't get rid of. But if you
14 try and de-stigmatize it by saying that
15 everybody's going to see a mental health person,
16 which is one of the approaches that's been taken
17 to your situation you mention, well, we already
18 know that there's people sitting out there timing
19 it. And they say, "Well, he spent 20 minutes in
20 there, and everybody else only spend five minutes.
21 So we know he has a problem." You know, people
22 will look for that. That's just the way they are.

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1 And I don't know how you stop that -- you know,
2 put a maximum time limit on how many minutes you
3 can stay with a mental health provider? So I
4 think the point is that we need a lot of different
5 ways to try it. We do need some feedback from the
6 validation study to see if that makes a
7 difference. Does it de-stigmatize it to say you
8 have a mandatory requirement to sit with a mental
9 health person, a specialist? Or are generalists
10 trained adequately to do this, and do they
11 recognize their limitations and they hand them off
12 appropriately, and that's better done where they
13 call a week later, if it's not an urgent issue,

14 and they can go into some back door and not seen
15 associating with mental health people. I think
16 that's the wrong answer, to me. We have to get to
17 the point where people accept this as part of the
18 culture: at one time we go see a nutritionist; at
19 one time we see an optometrist, because they're
20 eye people; and one time we see a generalist; at
21 other times we need to go see a mental health
22 person. There shouldn't be any issue with that.

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1 And for, I think, a growing percentage of our
2 people there isn't. It's a generational thing
3 that is changing. But we're obviously not done
4 changing yet. And I think the real question is:
5 what can we do to accelerate that transformation.

6 COL ORMAN: One question: with regard to
7 the frequency that these instruments are
8 administered, one of the things we hear about on
9 our site visits quite often is that the frequency
10 makes no sense. And let me give you the Marine
11 example I heard most recently. The Marines have
12 sort of a policy of six, seven months out bring
13 them back in, do their block leaves etcetera, and
14 then spend roughly five to six months training up
15 for the next deployment. So this idea that
16 somehow we're going to time a 90-day assessment
17 after they come back from a deployment makes no

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18 sense to them. The Air Police in the Air Force
19 have some similar sort of thing. And I'm
20 wondering if this feedback isn't getting up to HA,
21 because I think it causes no end of trouble, and
22 it really defeats the purpose, I think, of this

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1 well-intentioned effort. This idea that somehow
2 we're going to give these things continually --
3 ultimately the soldiers, the Marines, start pencil
4 whipping, because they're happening too
5 frequently, they're not making sense in their
6 train-up cycle, the deployment cycles; and,
7 furthermore, they're not clear what the outcome
8 is. They may endorse things, but if a follow-up
9 doesn't happen, then it becomes meaningless to
10 them. So I worry a bit -- I worry a lot,
11 actually -- that we're trivializing what we're
12 trying to accomplish here by using
13 pencil-completed self-report surveys, versus
14 something that I think is meaningful to people,
15 which is to sit down with a mental health provider
16 and talk about what the current stresses in your
17 life are.

18 COL COX: Well, I can't answer for all
19 the services. I can say that the encouraging
20 signs, I think, are that a significant number of
21 people are getting referred; a significant number

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of people are getting seen; they're filling out

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1 the forms, they're having an interaction with
2 providers. And of those a number get referred.
3 And of the ones who get referred, they're getting
4 seen. We checked that. So from that standpoint a
5 lot of people are having an opportunity to benefit
6 from this. We haven't proved if they benefit or
7 not. That's one of the things we have to look at.
8 As far as the timing goes, we agree that there's
9 too many assessments for people who are frequent
10 deployers, such as Special Forces and such. And
11 we're considering it in the midst of coordinating
12 it a change to policy that would say: frequent
13 people that go and come back -- say they go for
14 30, 60 days, do that two or three times a year --
15 well, they're going to do this once a year.
16 That's what the PHA is for. And you can't keep
17 chasing them and drawing more blood and all the
18 rest, because all you do is make them mad. And as
19 I mentioned, we do want to combine these. If the
20 90 days doesn't work, well that's why it's 90 days
21 to six months. And so that unit, that
22 organization, has to fit into that 90 day period,

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1 and they're going to have to fit with the PHA
2 anyway, because that's an annual requirement. If
3 the two are within 60, 90 days of each other, they
4 should be combined. That's the efficiency
5 approach that the services need to build into
6 their support systems so that they make it easier
7 for the line commanders to get this done and to
8 get whatever the benefits are. But we definitely
9 haven't resolved that within each of the services
10 down to the unit level.

11 LTG KILEY: The Marines, you're just
12 going to "get with the program," Dave. That's
13 what you should be telling them every time you go
14 visit: "Get with the program."

15 DR. MacDERMID: We're getting short of
16 time here. Do you have a quick question?

17 MS. FRYAR: (Off mike) -- on your slide
18 about the effect of the preventative -- I think it
19 was "perceived impairment," three slides back? On
20 the graph it looks like (off mike) address this
21 somewhat. But on the referrals, have those gone
22 down because of the face-to-face screening of

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1 those that are actually not referred?

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COL COX: I'm not sure -- this is just

2
3 showing that anybody who answered three or four
4 symptoms with a yes, that some get referred and
5 some don't. And so I'm not sure -- I'm not saying
6 they go down, it's that if they also said they
7 were impaired, well then 70 percent of the
8 individuals who had three or four symptoms and
9 said they were impaired -- 70 percent of those
10 individuals received a referral. Then on the
11 other side, they could answer three or four yes,
12 but if they weren't impaired, then a provider was
13 far less likely to refer them. Only 55 percent of
14 them got referred.

15 MS. FRYAR: And this is based on a
16 face-to-face with a health professional.

17 COL COX: Not necessarily face-to-face
18 -- it's a personal interview, remembering that
19 many Reserve component people use a call center to
20 accomplish these. On the active duty they're all
21 face-to-face at this time, although some services
22 are entertaining using the call center to

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1 supplement their capacity. But for the Reserve
2 components, they use a mix of call center versus
3 on-site teams. So in those cases it's not
4 literally face-to-face, but it is talking to a
5 provider on the phone. And then the provider

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6 comes to their decision whether to refer or not.

7 MR. WERBEL: Shelley, this won't take
8 but a second because it doesn't require a reply.

9 DR. MacDERMID: Okay.

10 MR. WERBEL: Just a request for another
11 one piece of data -- if you could go to slide
12 number nine, where you broke out the 18 percent
13 "requested a referral." I wonder if you could
14 provide the Task Force with what percent of those
15 who reported a mental health concern requested a
16 referral, compared to what percent who reported a
17 health or injury concern requested a referral?

18 COL COX: You can do that -- the trouble
19 is that there's only "request referral" question.
20 And so for those people that ask for mental health
21 and physical, you can't separate out which one
22 they wanted it for. So you're going to have a big

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1 gap, since 27 percent of the people asked for
2 both.

3 MR. WERBEL: Right -- maybe you could
4 just provide it for those three groups.

5 MS. ZEISS: On that same slide, it would
6 be very helpful also to have it split out so that
7 it would add to 100 percent; so that the
8 categories would be "no health concerns," "only a
9 mental health concern," "only a health or injury

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10 concern," and "both" -- would be more helpful than

11 having it the way it's laid out at the money.

12 COL COX: Two groups of people -- some
13 who think there's two groups of people and some
14 that don't. There's the people that like to be
15 able to see all of them separately and they don't
16 care if it adds up to more than 100 percent, and
17 some that only like things to add up to 100
18 percent. So -- we can do it either way.

19 LTG KILEY: Okay -- thank you very much,
20 Colonel Cox. Great presentation.

21 (Applause)

22 LTG KILEY: Our next speaker, we're

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1 honored to have with us presenting, is former
2 Chief of Staff of the Army, and now the Executive
3 Director of the Association of the United States
4 Army, our professional organization for the Army
5 -- General Gordon Sullivan. Sir, thanks for
6 joining us, taking some time out of your very busy
7 schedule. The Mental Health Task Force is
8 awaiting, with great anticipation, your comments.

9 MR. SULLIVAN: Thanks a lot, Kevin. I
10 appreciate it very much -- and I certainly
11 appreciate everything that's going on here today.
12 Frankly, I hear some of the specifics of your
13 questions, and it's kind of interesting sitting

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14 there. I think Congress, the DoD, the service
15 medical departments, need a real pat on the back
16 for this endeavor. And while I understand the
17 desire to reach perfectness and Nirvana, with
18 chartology and so forth and so on, this hearing
19 right here, during the course of a war, and
20 actually the involvement of mental health people
21 since the very beginning I think is to be
22 applauded since in my memory this kind of

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1 attention has been woefully lacking in previous
2 endeavors. So, to all of you -- and to some of
3 you in the audience who represent other
4 institutions involved in this subject, thanks a
5 lot for what you've done, and what you are doing,
6 and what you plan to do. Now, it certainly goes
7 without saying that I view mental health -- the
8 mental health of our soldiers and their families
9 -- to be a part of readiness. It's an integral
10 part of readiness. And without people who feel
11 good about themselves and what they're doing, and
12 feel confident, and their families feel that
13 they're appreciated, this thing is going to start
14 coming unraveled. And I think that the longer it
15 goes the more we're going to see issues come up
16 related to well-being which are not only physical,
17 it's mental. This long war -- and it is indeed a

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18 long war. After all, it's gone on since November
19 of 2001. I know some people like to count the war
20 from '03 -- March of '03 in Iraq -- but it really
21 began in the winter -- the late fall, early winter
22 -- of 2001 in Afghanistan. And we have people who

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1 have gone back and forth since '01. That's a long
2 time. That really is more combat than most people
3 saw in World War II of any service. And in the
4 case of the Army and the Marines, it's much more
5 than the average person saw. So I think it is a
6 long war, and it's stressing both the force and
7 their families in ways that had never been
8 anticipated before. I applaud, as I said,
9 everything that you are doing. But we are
10 beginning to see what have been enduring issues,
11 traditional issues of mental health -- and some of
12 them go all the way back to the American
13 Revolution, and probably before. This profession
14 that we're in is very stressful. And mental
15 health of these young people who serve, and their
16 families, will continue long after this conflict
17 has ended -- whenever that might be. But these
18 issues will still be there. And we cannot allow
19 the armed services to regress, or our soldiers to
20 regress, to lower levels of mental health care
21 just because they are no longer on active duty.

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1 challenge for the families, too. I don't think
2 any of us -- and, by the way, as I said, my
3 disclaimer is: I am not a mental health person --
4 okay? So some of what I say is an assertion on my
5 part. But I think some of the children of these
6 young men and women who are serving will carry the
7 burdens of this conflict for years to come. So
8 mental health care, from recruitment through
9 retirement -- through retirement to what
10 ultimately happens to all of us -- is an issue
11 that the United States of America needs to come to
12 grips with, in both an institutional, a financial
13 and a legitimate way. I've been associated with
14 the Army for 50 years. I took my oath as a cadet
15 in 1955, and served for 36 years on active duty.
16 And I've been intimately associated with the Army
17 since I have been retired. That's actually about
18 51 years of being a soldier. And I am pleased to
19 see -- and I am really pleased to see -- that the
20 nation and the institutions of our nation are
21 paying attention to mental health, and you have
22 brought this issue out of the closet. I would

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1 like to think that what I saw at Fort Lewis and
2 some of the other places I've been, where
3 everybody gets to see a mental health person --
4 everybody gets to actually sit down and talk, and
5 not 50 guys and gals in a room: "Okay, listen up
6 everybody -- boom, boom, boom; and "Anybody want
7 to see a doc?" We've got to do better than that.
8 We have to do better than that. That just happens
9 to be my editorial comment as a guy who has hung
10 around this institution for a long time. And I
11 don't believe there should be a stigma to getting
12 to see face-to-face -- face-to-face -- a caring,
13 knowledgeable, professional mental health care
14 provider. And that means sitting down and have
15 them look in my beady eyes and say, "Wait a
16 minute, buddy -- you need some help." And I don't
17 care whether you are a colonel, a general or the
18 newest PFC. There's an article in this week's
19 Army Times about a young soldier in the 26th
20 Infantry, who smothered a hand grenade so that the
21 other three people in the humvee would walk away.
22 He did what that young Marine who was awarded

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1 posthumously the Medal of Honor did. And he had a

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2 choice. Read this article, and think about what
3 you're doing here today, and think about the
4 burdens that those three people will carry with
5 them -- the psychological burdens, the three
6 survivors and the others who were involved, and
7 think about what they will carry with them for the
8 rest of their lives. This combat we are involved
9 in is searing. This is non-amateur sport, gang.
10 And it's too easy to talk about it here in
11 Washington and disassociate yourself from the
12 reality of what these young people are doing each
13 and every day. And you've got to suck it up every
14 day and sublimate a lot -- a lot -- of personal
15 characteristics to go out on those roads. And we
16 owe it to them. Thanks for taking it out of the
17 closet. Now, I'm pleased to see the energy and
18 commitment to deal with battle fatigue, what used
19 to be called "shell shock," now PTSD -- same
20 stuff. I'm pleased to see that it's now getting
21 out to the American people. It is an area of
22 constant attention by commanders and mental health

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1 professionals. And I think what you're doing is
2 talking about it in a way that will improve what
3 we are doing. I'm pleased to see this DoD,
4 Veterans Administration and civilian community
5 treatment symbiotic relationship improving. Still

6 much to be done, to be sure. And I certainly --
7 when I say the "civilian community," I am not
8 qualified in any sense to even imagine what the
9 robustness is of the civilian mental health
10 community. I don't know. Is it large? Is it
11 small? Do we produce psychiatrists,
12 psychologists? Mental health people? I don't
13 know what the medical schools in America are
14 doing. But God knows there's enough here to keep
15 a lot of people busy for a long time, so that we
16 don't wind up with these veterans wandering on
17 down here on the Mall or other places, homeless or
18 damaged for life. In today's long war our troops
19 are engaged in what is truly a much different
20 situation. Certainly, from my perspective as a
21 former commander, access to the internet, cellular
22 phones and instant messaging technology while

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1 great -- while great -- does have challenges.
2 Because young people, young leaders on the
3 battlefield, are being faced with challenges from
4 home. And they are immediate challenges which the
5 spouses are transferring to their loved one who's
6 forward, looking for an answer. And in some cases
7 there's not an immediate answer. But they carry
8 that burden with them as they perform their other
9 duties. This brings the family onto the

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10 battleground. And there are stresses and strains.
11 It can be comforting, it can be outreach --
12 certainly from the family to the service member;
13 and likewise back and forth. But what's really
14 being communicated one way or the other, and can
15 problems be solved? I don't know. But I can tell
16 you that barracks telegraph, and the rumors, all
17 of that is fueled in a much different way than it
18 was when I was a young officer. I served in
19 Vietnam in 1963. I went there in January of '63;
20 came home in December of '64. I had been in Korea
21 before that; spent about three years in the Far
22 East as a young officer. I don't think I called

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1 home -- I was not married at the time -- I don't
2 think I called home five times. It was hard. It
3 was hard to do. It was a big deal. You had to go
4 to Seoul, or you had to go to Saigon to do it.
5 You had to make all sorts of arrangements. And
6 then I never knew what to say, because it was sort
7 of like unique. It was a big deal to call from
8 Saigon to Quincy, Massachusetts. What do you say?
9 Well, "What time is it?" "How's the weather?"
10 (Laughter) You know. But the point is -- my point
11 is -- I didn't have that. It was all done by
12 letters. So it was detached. I mean, what
13 happened when my mother wrote the letter, or what

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14 was happening when I was writing the letter is I
15 was probably sitting down and not getting shot at
16 -- in all likelihood. Anyway, this information
17 age that we live in puts stresses on people. And
18 I don't think -- I really don't think it was there
19 quite as -- even during the first Gulf War it
20 wasn't there. Today's fight, with the more
21 frequent rotations, and the earlier wars, has a
22 place where it's go, go, go, go, go, go -- and

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1 then come back and go again. It's placing a lot
2 of stresses and strains on people. And I am
3 starting to pick up, as I travel around with my
4 people throughout the United States -- "Hey, sir
5 -- " -- the questions go something like this -- "
6 -- how come we're at war and the rest of the
7 nation isn't?" Now I think the headlines in the
8 New York Times today, by the way -- the headlines
9 in the New York Times today -- if you have the
10 paper with you, you might look at it. What it
11 says is: the President has said he's going to
12 essentially raise the manpower of both the United
13 States Army and the United States Marine Corps. I
14 think for the troops over there that's a pretty
15 good -- the troops back here in the States, that's
16 a very good indicator that the President
17 understands the relationship of increased manpower

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18 to tour lengths and dwell time. The more
19 manpower, the more time you will have from the
20 time you come home to the time you go again. And
21 that is important. That's very important, in my
22 view, for the health of the troops. Now, my

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1 knowledge of the challenges the leadership faces
2 today comes from my travels, as I have mentioned.
3 And, frankly, I am remarkably positive about what
4 I am seeing. The troops are reenlisting -- at
5 least the Army troops I see are reenlisting. They
6 feel good about themselves. And they are ready to
7 go back -- in most cases. I am aware, though,
8 that many of these casualties that you're talking
9 about you can't really see it. You can't really
10 see it. It's something that's there that you
11 can't see, and professionals have to talk to dig
12 it out. Which is why I think what you're doing is
13 so important. Instability, sleeplessness, bad
14 dreams; the issues of reconnecting with families
15 -- as somebody who's done that a lot, reconnected
16 with my own family as a younger officer, it's
17 tricky. It's tricky stuff. And it's not quite as
18 easy as all going to Disney. It's not that. It's
19 the quiet moments, it's the not-so-quiet moments.
20 And it's these moments when you really don't feel
21 like talking about it. And I think all of us need

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1 someone who has served on the ground in combat,
2 driving from here to Gettysburg, Pennsylvania, you
3 will pass a lot of great looking country. But to
4 somebody who has served on the ground in combat,
5 it's not scenery. It's no longer scenery. It's
6 terrain. Somebody who has served over there will
7 never, ever pass trash on the road and stuff on
8 the roadside and feel the same way. That will
9 mean there will be blank spots in the
10 conversations. And that has something to do with
11 reconnecting with your family. And I think what
12 you are doing is very, very important. And it
13 must be funded robustly. I am particularly
14 impressed with the cycle -- the preparation cycle,
15 the prevention cycle -- from pre-deployment,
16 through deployment, through post-deployment. If
17 you read -- read some of the publications where
18 companycommand.com is publishing articles about
19 how commanders, non-commissioned officers, handle
20 death in their units in very positive ways. We
21 are talking not euphemistically about the
22 realities of combat. The troops are talking

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1 realistically about the facts -- the cold, hard
2 facts -- of what our profession is all about. And
3 this, in my view, is very positive. You've got to
4 talk about it. And I think what you are putting
5 in place is very, very important. However it must
6 be funded in the long run. It must be funded
7 forever. Try that one on for size: forever. And
8 I'm not sure that everybody in the Veterans
9 Administration or in the civilian health care
10 community, or in the Congress of the United States
11 is fully up to speed on what this is going to
12 cost. I'm not sure I am. I know I'm not. But
13 it's not cheap. But we owe it to these young
14 people. You know, this is a country of 300
15 million people -- 300 million people -- and we are
16 fighting this with a handful; with a handful. And
17 we owe it to them, and to you, by the way -- those
18 of you who are sitting here. And the health care
19 providers on the battlefields, the chaplains, the
20 medics -- you know, all of the people who are
21 there; the mortuary people. I mean we can talk
22 about this, right? I mean, you're all health care

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1 providers. We can talk about the realities of

2 this. The people who are touching our young
3 people when they are, in fact, being carried off
4 the battlefield, they need care. And they will
5 need care. And someone must fund that, and
6 someone must be attentive to that. The Army,
7 Navy, Air Force and Marines, and the Coast Guard
8 -- we are learning organizations, and we are
9 learning. But what we are learning is that this
10 is not inexpensive, and it is enduring. The
11 current challenges I see, obviously -- and this is
12 redundant -- are these repetitive tours, the loss
13 of connectivity with people who count: families,
14 obviously; employers; communities -- as a result
15 of these multiple tours. And people start
16 becoming detached. And the health care system in
17 America is overloaded. It's overloaded. And we
18 can't kid ourselves. And I think sometimes people
19 have old-think on mental health issues. You know,
20 they read about World War II and so forth and so
21 on, and then sometimes we blow out of proportions
22 issues related to battle fatigue and whatever the

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1 buzz words are that are used. I think we all need
2 to take a more realistic view of this. This is a
3 reality of combat, and we can't have old-think. I
4 think there's a lot of new-think going on in this
5 community. And there are obviously certain high

6 risk populations, so I've been concerned
7 personally from the very outset of this with the
8 Guard and Reserve community. What I worry about:
9 are the Guardsmen and Reservists returning back
10 and winding up out in Kingman, Arizona; they live
11 check-to-jowl with their buddies for 12 months.
12 They're in this tough environment. Then they wind
13 up in some double-wide out in Kingman or some
14 other place with loved ones who are very happy to
15 have them home, but they can't connect. It's hard
16 to connect. "What did it all mean?" And, by the
17 way, anybody who thinks, even in Vietnam, that
18 there was an experience that everybody had --
19 everybody had a different experience. War is
20 unique. It's unique unto the soldier, sailor,
21 airman and Marine. It's not the same. So when
22 somebody is listening to you, they really have to

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1 listen, and they really have to listen. And is
2 everybody prepared to listen to these stories?
3 Just think about it: you take a trip to Paris and
4 you come home, and you try to talk to somebody
5 who's never been in Paris about Paris, and they
6 say, "What the hell's this guy talking about? I
7 want to talk about what's going on with the Red
8 Sox, or the Yankees or something. I don't want to
9 talk about this guy's trip to Paris." You think

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10 it's any different with combat? "Look, I'm happy
11 to have him home. I'm going to put my arms around
12 him, and give him what he used to like to eat, and
13 everything's going to be great." Forget it. This
14 is serious, long-term stuff. And there are
15 high-risk populations: wounded soldiers, isolated
16 Reserve component soldiers, highly exposed people
17 such as the mortuary affairs, casualty assistance
18 officers -- you know, showing up on somebody's
19 doorstep to tell them that their son or daughter
20 has been killed, that's a high stress occupation.
21 And I think the isolated Reserve component
22 soldiers need particular care. Okay -- what are

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1 the specifics here? Access the full range of
2 mental health care services, regardless of the
3 beneficiary location in States. It's going to be
4 long-term in some cases. Somebody needs to take a
5 look at this. Improve access, transferability:
6 "Gee, I'm on active duty and all of a sudden I'm
7 out." Look at the picture on this month's
8 Esquire magazine; the young soldier holding the
9 Purple Heart. And read that article. And this
10 guy is a squared-away guy. It's worth reading for
11 all of you how, here's a triple amputee, looks
12 good -- boom, there he is, robust. And that's the
13 way he's living his life. That's one kind of

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14 person. But he's gone from one system to another.
15 I think he's in the VA system now. He looks like
16 he's doing fine. It sounds like he is. But how
17 did he transfer? What confidentiality -- he's
18 obviously waived a lot of confidentiality to be on
19 the cover of Esquire, and to tell everybody how he
20 feels about all of this. But some people don't
21 want to do it. Now, we have to ensure increasing
22 emphasis on PTSD awareness, treatment

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1 opportunities, and how we take care of people;
2 ensuring that certified marriage counselors are
3 working with our young people. As I say -- and
4 I'm going to stop talking. I'll try to answer any
5 questions you might have, although I'm not a
6 health care provider to be sure; I don't know much
7 about medicine either. You know, this has been
8 around since Von Steuben and Washington at Valley
9 Forge, and I'm sure some of those people came out
10 of that war screwed up, too; needing health care.
11 Some of them get a little bit of intervention,
12 they're okay. Some of us okay -- boom, boom. But
13 some of us have trouble unscrewing ourselves from
14 the war. And as somebody who did it -- not much
15 of it, thankfully; not as much as some of these
16 people are doing -- you never forget it. And
17 don't kid yourself. You never forget it. And you

18 need people around you who are willing to listen
19 to you as you talk through your experiences. And
20 you have to be willing to listen to them. And
21 looking at my own life, I think that there was
22 that going on, which is -- for me, because I was a

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1 regular Army officer, I had that opportunity to
2 listen to my buddies, and they would listen to me.
3 And it was apparently therapeutic. But we weren't
4 docs or anything like that. But at any rate, this
5 is an enduring problem, and the country must fund
6 it. And I will do anything in my power to ensure
7 that these young people who serve today are taken
8 care of for their lives. Thanks a lot.

9 (Applause)

10 DR. MacDERMID: Thank you very much for
11 your contribution, sir. I have a question -- and
12 it might be an outrageous question, and if it is,
13 I apologize. We have talked a lot about how to
14 prepare people for war. We've talked a lot about
15 how to catch problems early, and how to treat and
16 how to refer. But all of that is really about
17 sort of fixing the soldier or preparing the
18 soldier, or airman, or Marine; helping their
19 families. But I'm sitting here wondering: are
20 there things that we should be thinking about,
21 about recommendations about how we wage war that

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22 would make it easier for soldiers? Are there

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1 things that could be done without compromising the
2 mission that would reduce the psychological cost
3 that you can see in your experience?

4 GEN SULLIVAN: That's not an outrageous
5 question. Look -- the theory -- there's two
6 measures of effectiveness of an army or a Marine
7 Corps, or any of the services. There's two
8 measures of effectiveness: one is lethality, the
9 other is to be able to control something. The
10 paradox is that the armed forces can be more
11 lethal -- and, by the way, I think we are probably
12 the best in the world in this -- we can be more
13 lethal with less manpower than we've ever been.
14 And I think we demonstrated that in the first
15 three weeks of this conflict. But that's clearly
16 -- it was never going to be effective because
17 "victory" or "success" in this particular war, and
18 in Afghanistan, is not related to lethality, it's
19 related to the other characteristic of an armed
20 force -- especially an armed force for the United
21 States of America: that is, the ability to control
22 and to assist others in the political -- to set

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1 the conditions for political success. And that
2 requires men and women on the ground, and exposing
3 them. So -- yes, if you can conjure up a conflict
4 in the 21st century that looks like it would only
5 be boom-boom -- I have trouble doing that now,
6 frankly. We know the answer to that. You know,
7 Panama was like 27 objectives midnight until
8 daylight. We went in with all of the capability
9 -- Army, Navy, Air Force and Marines, and I think
10 there were even some Coast Guard people -- and we
11 took everything down in about eight hours. That's
12 modern war. That's the first indication we saw of
13 that. Then the Gulf War when you go at them very
14 quickly. And there's actually very few casualties
15 on both sides as a matter of fact. But you shut
16 the country down. But it's becoming much more
17 complex. It's a good question. It's a good
18 question. But I don't see it anymore. Yes,
19 Doctor.

20 DR. McCORMICK: General, you have
21 tremendous experience both within the institution
22 of the military, and then also in interfacing with

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1 the political realities, the political people.

2 Clearly we're going to come up with some
3 recommendations. Do you have any advice? But
4 then somebody's going to have to pick them up and
5 give them traction, and give them advocacy. Do
6 you have any advice to us on how we can best do
7 our job to make the important work that people
8 like you are going to have to do after we're done
9 successful?

10 GEN SULLIVAN: I think one of the things
11 you are doing -- and I don't know who's here. I
12 mean, I know the uniformed people are here, but I
13 don't know what communities are represented on the
14 panel. I presumed DoD? VA? One, two? One VA.
15 Any civilian?

16 LTG KILEY: Yes, sir -- private medical,
17 psychiatric --

18 GEN SULLIVAN: Okay -- well, see, I
19 think that relationship, I think making that point
20 apparent to members of Congress and to the
21 American people, that there is a symbiosis and
22 there is a continuum here between the military --

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1 the more immediate health care providers who are
2 involved with the preparation and the care while
3 the troops are in combat, and then pick it up; and
4 that there is this continuum. This is a national
5 issue. And we must return these people to

6 productive lives. Look, I don't know what
7 "happiness" is. So, I mean -- whatever. I don't
8 even know what "love" is. But I know how people
9 have defined some of these things. But you know,
10 because you worry about those things. But
11 productive lives where people are not so impaired
12 that they can't function. We're looking for
13 people who are relatively happy with their lives.
14 And that's what I would say, Doctor. If it's
15 coming over to me and people like me -- I think
16 some of them have been here, and have been in the
17 audience, from other service-related
18 organizations, so that we don't have to go to
19 Congress or to the American people and establish
20 that there is this link between the civilian
21 medical community. The medical community --
22 uniformed and civilian -- we're all in this

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1 together.

2 LTG KILEY: Sir, thank you very much.

3 GEN SULLIVAN: Okay, thanks a lot,
4 folks. Thanks for what you're doing.

5 DR. MacDERMID: Our next speaker is Ms.
6 Anna Smythe, who is here to speak on behalf of the
7 Military Officers Association of America.

8 MS. SMYTHE: Boy, that's a hard act to
9 follow. And I know the time is truncated because,

10 obviously, everybody's dying to go to lunch and
11 it's been a long morning. I have provided a
12 statement to each of you, but here I will kind of
13 synopsise, to try and bring it into a little more
14 clarity, and without droning on. But I would hope
15 that the text will be, for the record, the full
16 proceeding. Thank you very much. Again, my name
17 is Anna Smythe. A little background: I have been
18 in the Marine Corps for 31 years, just recently
19 retired. Have commanded at all kinds of places,
20 most recently out in San Diego. So I bring with
21 that a little bit different view than just an
22 average person. Our view, from MOAA, tracks

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1 pretty much with the Mental Health Task Force
2 elements as expressed in the charter of the body.
3 First and foremost, the Defense and Veterans
4 Affairs leaders need to work in concert to ensure
5 implementation of a unifying strategy and
6 consistent guidance, coordination of effort and
7 cross-feed of results among the various segmented
8 studies, task forces and programs addressing the
9 issue. All of you know -- as we've seen, and I've
10 spent at least most of the last few days with you,
11 and there have been and I have read study upon
12 study upon analysis of this issue. For example,
13 I'd note that the recently passed Omnibus Veterans

14 Bill, as amended, the Veterans Benefits, Health
15 Care and Information Act of 2006, which was passed
16 on 9 December says: "Requires VA's National Center
17 on PTSD to collaborate with the Secretary of
18 Defense for the purposes of enabling DoD mental
19 health care providers and clinicians to benefit
20 from the unique and comprehensive expertise that
21 VA has in the area of PTSD diagnosis and
22 treatment; further, direct the two Departments to

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1 develop joint training and protocols to ensure
2 consistency, and authorize to be appropriated \$2
3 million for the purpose of carrying out the
4 collaborated PTSD requirements." Hence MOAA
5 recommends that the DoD, VA, the Joint Executive
6 Council -- JEC -- and the Health Executive Council
7 -- the HEC -- include this issue as a priority, if
8 they have not already done so. We also believe
9 that the JEC and the HEC report out to the
10 stakeholders how they plan to oversee DoD/VA
11 collaboration on this issue. Second, MOAA
12 believes there is a need to get a better handle on
13 the extent of the problem. A variety of
14 government and independent medical studies would
15 suggest that operations-related mental health
16 illness is significantly greater than is being
17 officially reported. And I think we all agree

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18 with that. For example, the FAO May 2006 report
19 on PTSD said that 9,154 individuals, 5 percent of
20 the 178,664 OIF/OEF service members may have been
21 at risk for developing PTSD. Of that 5 percent at
22 risk, the GAO said that only 22 percent -- 2,029

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1 -- were referred for further evaluation. That's
2 just one report that's out there. There are
3 numerous reports out there. And then following up
4 on such high-profile government reports, media
5 coast-to-coast have produced stories that add to
6 the confusion. The Hartford Courant ran a series
7 on exposed gaps in the military mental health care
8 system, while the Associated Press reported that
9 64,000 out of 180,000 OIF/OEF vets have sought
10 care from the VA. All of this media exposure
11 raises anxieties, both among service families and
12 the public, about the true extent of the problem
13 and the effectiveness of ongoing efforts to
14 address it. MOAA recommends that the Task Force
15 endorse a consistent framework for reporting
16 statistics on this issue -- at least within the
17 government. Until now there appear to be a
18 variety of field reports based on differing
19 factors, which can only add to a loss of
20 confidence on the extent of the problem. Here, in
21 the last two days, we've had different DoD

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officials, and VA and other individuals, bring up

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1 completely different statistics, completely
2 different -- off different sheets of music.
3 Third: PTSD is real and directly impacts military
4 members. We're all aware of that. It affects the
5 ability to work, cope and succeed in all aspects
6 of lives, not only for the member but the
7 families. You know, we're forced to use numbers
8 in an effort to measure and address the problem.
9 But we can take the words of service members to
10 put a personal face on the severity of the
11 condition. General Sullivan brought a face. And
12 you, I'm sure, as you go out to all of these
13 activities, have talked to individuals. So I
14 won't go on. I've put a couple in my text, of
15 individuals that -- you know, hey, anyone that
16 goes to this kind of war comes back with different
17 scars, different wounds, and will handle them
18 differently. The key word here is the trauma that
19 you experience, or that any individual
20 experiences, in Iraq will be with you for the rest
21 of your life. These are the cries for help and
22 healing that all in this room have already heard.

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1 You're more aware than I could ever be. I know as
2 a commander, I must admit when I was in San Diego
3 less than a year ago, I had an awful lot of
4 servicemen -- Marines, in my case -- come back
5 from Iraq, and because I was a woman, maybe, and
6 as I did my in-call with every single one of
7 them, every single one of them, once we got
8 through the "Yes, ma'am," "How are you?" And, you
9 know, "I'm fine. Everything's good. My family's
10 great. Great to be home -- blah, blah, blah.
11 "Okay, take off the hardcore, Gunny, and tell me:
12 how are you doing? Are you sleeping?" And once
13 they felt comfortable that I wasn't going to go
14 into the attack, or look at them with that same
15 stigma that so many leaders do because we first
16 and foremost have to promulgate the war. That
17 mission is paramount in every commander's thought.
18 When we got through that, I can honestly state
19 that every single one of those individuals that I
20 touched had residuals. And as recognized by Army
21 Chief of Staff, Peter Schoomaker, and Marine
22 Commandant James Conway before Congress very

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1 recently, the pressure and stress on the service

2 members and their family is not easy but, rather,
3 intensifying. There must be a standardized pre-
4 and post- deployment mental health screening
5 process, and that means across all the services.
6 Everybody has their own stovepipe, their way of
7 handling it. That process has to ensure that
8 members and their families are referred to and
9 receive appropriate intervention services --
10 however you decide to handle that. It just needs
11 to be accomplished. So MOAA recommends that a
12 standardized education program be developed and
13 introduced during entry level training, and
14 reinforced throughout an individual's military
15 career; a proactive approach to prevention. I
16 hear so often -- as we tend to do, we react. We
17 are currently in a reactive phase. And we have
18 to be. I mean, we have to react to what has
19 happened. But how can we -- we prepare so well:
20 we provide the gear, we ensure they've got the
21 right weaponry; they're physically fit. And yet
22 we do not prepare them mentally. We do a

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1 pre-deployment assessment when he's in the middle
2 of training, getting ready to work, getting ready
3 to go forward. All of the issues -- leaving their
4 families -- this is when we introduce this issue.
5 We're wrong. We need to introduce this issue from

6 the day they enter -- at whatever entry level,
7 whether it's OCS, entry level training. And it
8 has to be standardized. Because if you leave it
9 up to the company Gunny to provide that
10 instruction, every company Gunny's going to do it
11 differently and it will become pablum. We don't
12 necessarily have the expertise inside the
13 services. We need to look to trauma specialists
14 to develop that curriculum. And we need to ensure
15 that it gets into every entry-level program and
16 then is followed throughout the career. That's my
17 personal feeling on this. Fourth, MOAA recommends
18 the Task Force address the need for additional
19 resources; obviously, including more mental health
20 care professionals -- we've heard it the last few
21 days, and I know you've heard it ad nauseam; and
22 intensified, focused training for those

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1 individuals, because most of them have no
2 background in coping with the stress, PTSD and
3 other mental health conditions post-war, post
4 combat. We must train and sustain -- which is
5 also going to cost money -- more trained mental
6 health professionals with the special skills
7 needed to work through the range of mild to severe
8 PTSD veterans who experience being shot at, seeing
9 bodies, or human remains; have been attacked or

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10 ambushed; had someone in their unit killed or
11 seriously injured; or have seen women and children
12 that they couldn't help, they couldn't reach out
13 to. Each of these experiences is a searing wound
14 to the psyche. It cannot be left untended. We
15 must also recognize -- and it's been stated, again
16 -- that many cases will require long- term
17 treatment and services. And, bottom line, without
18 an overarching strategy -- and that's what I look
19 to you for, is to provide an overarching strategic
20 plan, and integrated organizational lead --
21 nothing can happen effectively. MOAA recommends
22 the development of a coordinated plan to maximize

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1 the positive effect of additional resources for
2 mental health care and rehabilitation. The plan
3 must provide joint cooperative oversight by DoD
4 and the VA, ensure coordination of authorities and
5 funding requirements with Congress. And
6 associations like MOAA can help in that vein. If
7 there are statutes that need to be changed, like
8 that one yesterday that was written in 1993 for a
9 purpose, then we can help advocate; we can work
10 with you as advocates to ensure that this care is
11 received. Establish standard factors of
12 evaluation -- standard factors of evaluation;
13 bring synergy to uncoordinated efforts in the

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14 military, VA and private sectors. Everybody wants
15 to help. Let's get on the same sheet of music.
16 And provide for a clearinghouse for
17 lessons-learned, best practices, and education
18 programs centered on prevention and mutual
19 awareness and acceptance by service members,
20 military family members, commanders and health
21 care practitioners. Thank you again for the
22 opportunity to address this august group. And we

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1 pledge our full support in MOAA for these efforts.
2 And I would be happy to address any questions at
3 this time, and you may go to lunch.
4 DR. MacDERMID: Well, actually not --
5 (Laughter) -- but -- go ahead, Colonel.
6 COL ORMAN: Ma'am, thank you so much for
7 your suggestions. But I want to draw on your
8 expertise as a former Marine Commander. You
9 mentioned something that I think is very
10 important, that's hard for people who are not on
11 the inside to quite grasp, which is this whole
12 issue of your role as a dual agent as a commander.
13 On the one hand, you're responsible for the
14 mission, and that's your primary goal and reason
15 for existence. On the other hand, you want to
16 take care of that Gunny. And I wonder if you
17 could think a bit about how we need to address

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18 that issue inside a report, in terms of a
19 recommendation, or series of recommendations, to
20 help commanders resolve what I know is a very hard
21 issue in their mind, which is: I'm getting ready
22 to take my guys to the war. And yet I've got this

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1 Gunny whose wife's leaving him. And he's a mess.
2 And yet he's a great Gunny; you know, if his life
3 is intact personally, he's doing great. How do
4 you address that? And how do we help commanders
5 take care of their people, at the same time
6 feeling like they can execute their mission?
7 MS. SMYTHE: Empathy is a great word
8 that I've learned as I've gotten a lot older. And
9 I think that what a leader brings to the table is:
10 yes, the strength and the knowledge and the
11 commitment to the mission. And that is so
12 paramount. And I think it's ingrained in every
13 single leader's brain. But what happens, I've
14 found, is too often that is all that is ingrained.
15 And they lose sight of the human side, and the
16 human factor in every relationship. Leaders
17 should not be afraid to get to know their Marines
18 or their soldiers. Because I think the
19 relationship, if you are respected -- and respect
20 does work both ways, and it is earned -- if you
21 are respected by your subordinates, your peers,

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22 that's the key in my mind. It's being empathetic

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1 yet strong. Empathy doesn't mean weak. You have
2 to take that. And, you know, I think every person
3 in combat comes back and will say that they didn't
4 do it for America, they did it for the guy
5 standing next to them. Those relationships are
6 key. I had a young lieutenant just write me from
7 Iraq, who was a sergeant when I was an MSG
8 commander, and he got promoted to lieutenant. And
9 he wrote me and he said, "Ma'am, I'm so
10 frustrated. My Captain, my Colonel with the MU
11 have come over, and they've got only a few months
12 to get their recognition. They don't see what
13 we've been doing for the last seven months, and
14 I've done on my two previous deployments to Iraq.
15 They only see this mission, right now. And
16 they've lost sight of their Marines." Okay?
17 That's exactly what I'm talking about. We need to
18 instill in the leadership the understanding and
19 the oversight. That's why we get what we do --
20 the big bucks -- for what we wear on our collar.
21 I don't have a simple answer. But I do think it
22 has to be stressed from the top down that, yes,

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1 the mission is critical but, simultaneously, know
2 your Marines and your soldiers, and take care of
3 them along the way. And don't be afraid to reach
4 out to them and make sure that you're meeting
5 their needs. Because they'll take great care of
6 you if you take care of them.

7 DR. MacDERMID: I guess I'll just ask
8 one last question, and then we will break for
9 lunch. We've been talking a lot about some of the
10 ideas that you also have mentioned here, and I
11 wonder if you have any recommendations for us
12 about what the structure, or the people or the
13 arrangement would like of this joint, coordinated,
14 working- together sort of operation?

15 MS. SMYTHE: Which piece of the puzzle?
16 The education piece? Or the whole -- the JEC, the
17 HEC, or the VA? There are so many.

18 DR. MacDERMID: I guess what I'm most
19 interested in hearing you talk about is: at the
20 top, when you want this coordinated effort to
21 happen between DoD and VA, I mean who would head
22 that up? And who would they report to? And who

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1 would report to them?

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MS. SMYTHE: Who makes it happen? Well,

2
3 I do think that it may need to be Congressionally
4 mandated -- again, because people like to
5 stovepipe. DoD will come up with their answers
6 and the VA will come up with their answers. And
7 it's difficult to get them to cojoin in an effort.
8 I do think the Task Force has the opportunity to
9 find a group to build that. And I don't know --
10 if you can. I mean, is that do-able? Should it
11 be? I think it has to be a dual effort from the
12 top, so it has to be very senior in DoD that's
13 been by the Secretary of Defense has been
14 nominated. And somebody, the same thing, from the
15 Secretary of the VA, to work this issue from the
16 top down and has oversight. And I would think
17 that it would need to be a panel that is put and
18 left in place for the duration, until we feel that
19 all those tentacles that need to reach down have
20 been established enough. So I think it needs to
21 be a joint panel at the top that's directing the
22 effort within the services.

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1 DR. MacDERMID: Thank you.
2 (Applause)
3 LTG KILEY: Thank you, Colonel Smythe.
4 And thank you for delaying your presentation. If
5 you've got a copy of the schedule, Mr. Potter from

6 the Veterans of Foreign Wars is next. He has
7 graciously deferred to those of us that would like
8 a lunch. And he will be first on the agenda at
9 approximately one o'clock when we reopen our
10 public session. I would like to ask if there are
11 representatives from the American Gulf War
12 Veterans War Association, or the Vietnam Veterans
13 Association, that were invited to speak -- if
14 they're here, if you'll just make your presence
15 known to Dr. Burke in the back, we'll be having an
16 afternoon session, starting with Mr. Potter, and
17 then any other public statements that anyone would
18 like to make. At this time, Colonel Davies, can
19 you bring yourself to adjourn this public session?

20 COL DAVIES: General Kiley, yes, I will.
21 We will close this open session at this time. We
22 will open up the session again at 1300. And we

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1 will have Mr. Potter, as General Kiley said, and
2 then we'll have open public comment at that time.
3 Adjourned.

4 (Whereupon, at 12:12 p.m., a
5 luncheon recess was taken.)
6
7
8
9

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on behalf of the Veterans of Foreign Wars.

14
15 MR. POTTER: Good afternoon. I have a
16 mouth, so I probably won't even need the
17 microphone. My name is Mark Potter. I'm the
18 field representative from the Health Policy side
19 of the Veterans for Foreign Wars. We're located
20 just up on Capitol Hill, on Maryland Avenue. And
21 a little brief history of myself: I'm retired
22 Navy, Hospital Corpsman Chief, FMF; 22 years in

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1 the Navy, about eight years of the grunts. And I
2 was with the 1st Marines during OIF One, during
3 the initial invasion, or -- somebody told me don't
4 use that word "invasion," but that's what it was.
5 (Laughter) So, as I said, I spent a lot of time
6 with the Marine Corps.

7 And just a brief history of the VFW: Th
8 e Veterans of Foreign Wars, with its auxiliaries,
9 include 2.4 million members, and approximately
10 9,000 posts worldwide. It's the largest combat
11 veterans organization in the world. Its mission
12 is to honor the dead by helping the living --
13 through veterans service, community service,
14 national security and strong national defense.
15 The VFW traces its roots back to 1899, when
16 veterans of the Spanish American War and the
17 Filipino insurrection founded local organizations

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to secure rights and benefits for their service.
19 Many arrived home wounded or sick. There was no
20 medical care or veterans pensions for them, and
21 they were left to care for themselves. In their
22 misery, some of these veterans banded together and

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1 formed organizations that would later become known
2 as the Veterans of Foreign Wars of the United
3 States. After chapters were formed in Ohio,
4 Colorado and Pennsylvania, the movement quickly
5 gained momentum, and by 1915 grew to 5,000
6 members. By 1936, the membership was almost
7 200,000. Since then, the VFW's voice has been
8 instrumental in establishing the VA, creating the
9 GI Bill for the 20th Century, and developing a
10 national cemetery system, and the fight for
11 compensation for Vietnam vets exposed to Agent
12 Orange, and for veterans diagnosed with Gulf War
13 Syndrome or PTSD. The VFW has fought for
14 improving VA medical centers for women vets. We
15 primarily deal -- we're chartered with the VA.
16 And we do have some dealings with the DoD if we
17 get calls; we have active duty members also. If
18 they have any question, we try to point them in
19 the right direction. The U.S. military engagement
20 in Southwest Asia extends into its fourth year.
21 This is a difficult and dangerous campaign for

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1 active duty members, Reserve or National Guard.
2 Ground combat units have faced fierce fighting
3 when in close combat in the streets and buildings
4 of urban areas. And while transversing the rugged
5 mountain passes, danger is imminent even for the
6 military members working in support units.
7 Thousands are now injured -- some physically, and
8 some with wounds that are not physically apparent.
9 A recent study published in the New England
10 Journal of Medicine found that 17 percent of U. S.
11 combat troops -- they just included Marines and
12 Army, and that percent varies; it depends on who
13 you talk to. We had people who have said 80
14 percent. We kind of questioned that. But 17
15 percent is what was mentioned -- experienced major
16 depression and combat stress, the highest recorded
17 rate since the U. S. engagement in Vietnam. The VA
18 stats show that since 2002 to the present, a total
19 of 73,157 unique patients received a diagnosis of
20 possible mental disorders; among these, 33,754
21 PTSD cases. This does not include Vet Centers.
22 And if you know what Vet Centers are, they're VA

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1 storefront centers where basically vets show up,
2 whether they're in the VA system or not, if they
3 need counseling. It was mainly started for
4 Vietnam vets for PTSD. And that's not counting
5 the folks that visit those centers. And it also
6 does not include veterans not enrolled in VA
7 health care, and veterans who do not have
8 diagnosis of PTSD but had diagnosis of adjustment
9 disorder. The VFW and other VSOs are convinced
10 that these numbers will increase as the conflicts
11 wear on. And just on personal note: as I said,
12 I'm an OIF veteran. I served with the Marine
13 Corps. As the General was talking this morning,
14 combat is different for each person. For me --
15 for folks here who have never been in combat, or
16 been in that area -- this is how I always describe
17 it: it's like driving down I-95 on the beltway and
18 a tractor-trailer cuts you off. And you get that
19 feeling, your heart's pounding. Imagine that
20 24/7. That's what it's like -- for the most part.
21 And it's putting a lot of stress on the troops.
22 And the VFW's main concern is: when they return to

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1 the States, that the VA takes care of these

2 people. Because lot of time what the DoD says and
3 the VA are two different things. They're two
4 different entities. And they would say, "The Army
5 promised me this." Well, our answer is: "Well,
6 the VA didn't." But we help them navigate through
7 the VA system, whether it's putting in claims, or
8 standing as adjudicators for them in the Court of
9 Veterans Appeals. And that's our main mission.
10 And also, every year, I don't know if you guys
11 have seen this. It's the independent budget.
12 It's put together by the VFW, AMVETS, Disabled
13 American Vets, and Paralyzed American Vets. It's
14 a publication we put together every year, and we
15 pass it to Congress and the VA, basically giving
16 our interpretation of what the budget should be.
17 We're generally right. They're generally wrong.
18 And some of the recommendations that the VS0s are
19 considering, or they put forward -- the VA does
20 not have in place a needed arsenal of
21 rehabilitative services, from supported employment
22 housing assistance, to peer supports, and the

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1 veterans need to achieve the fullest possible
2 recovery from chronic mental illness. The VA and
3 the DoD have not perfected a systematic approach
4 to provide screening and intervention services to
5 help returning veterans or returning service

6 members transition from early veterans for
7 war-related mental health problems and sustained
8 support and care and leaving recovery. And I can
9 attest to that, because I filled out many
10 deployment and post-deployment forms, and I just
11 wanted to fill them out, and out of the room and
12 get home. And the main problem we're seeing are
13 Reservists and National Guard, because when
14 they're home, you know, they're civilians again.
15 And especially out in the western areas --
16 Montana, Wyoming -- it's hard to keep track of
17 those folks. So that's one of our main concerns.
18 And also veterans with substance abuse problems,
19 particularly those with co-morbid mental health
20 challenges do not have adequate access to the VA
21 treatment programs. The very definition of
22 integrated substance abuse and mental health

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1 services have to be promulgated throughout the
2 system. It's just the VA -- not so much today.
3 The word we've been hearing from folks at the VA
4 and the Vet Centers, they're not seeing too many
5 OIF/OEF vets coming in, one or two; they would
6 show up for the initial screening and then they'll
7 leave and they won't hear from them again.
8 They're worried about five years from now -- you
9 know, once they're all settled in and they start

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10 thinking about what happened to them. And that's
11 they're main concern. And funding. That's all I
12 have to say. Thank you for your time.
13 LTG KILEY: Any questions? (No
14 response)
15 LTG KILEY: Well, first, thanks for
16 pushing your presentation off until after lunch.
17 Thank you very much. We appreciate your being
18 here. And the work you do for veterans is very
19 much appreciated. And I think we've gained a
20 sense, not only listening to the presentations
21 today, but as we've talked in executive sessions
22 about the criticality of DoD and VA, that's really

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1 becoming a central theme in our discussions.
2 Thank you very much.
3 (Applause)
4 COL CAMPISE: He was kind enough to
5 bring the newest guide they have out. Can you
6 describe (off mike).
7 MR. POTTER: Basically, this is their
8 service officer guide. We have service officers
9 in all 50 states, including the Philippines and
10 Puerto Rico and Panama. And basically it's a
11 guide how to navigate through the VA system; put
12 in claims, different rates. We come out very year
13 with one. This is the 2006 one. We're currently

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working on a 2007 model.

15 COL ORMAN: It looks too skinny.

16 MR. POTTER: But it's not. It has a lot
17 of good information in there and a lot of good
18 contact numbers. And I'll just leave it with the
19 group here. And also I left a copy of our
20 independent budget if you want to look through
21 that. And we put a lot of work into it, all the
22 service organizations. And, as I said before,

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1 we're closer than the government. And we're just
2 a bunch of vets. (Laughs)

3 LTG KILEY: Thank you.

4 (Applause)

5 DR. MacDERMID: Our next speaker will be
6 Joyce Raezer from the National Military Family
7 Association. We have several speakers who have
8 indicated that we would like to address us this
9 afternoon, and we're conscious of time. So we'd
10 like to ask speakers to hold your remarks to about
11 10 minutes, and that will allow us about five
12 minutes for questions, and then we'll move along.
13 You'll also notice that some of the Task Force
14 members need to slip out early. That's because of
15 plane schedules and things like that, not because
16 you're not interesting and important. Joyce?

17 MS. RAEZER: Thank you. General Kiley

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and Dr. McDermid, and members of this Task Force,
19 I'd like to thank you on behalf of the National
20 Military Family Association for the opportunity to
21 talk to you a little bit about the mental health
22 needs of service members and their families. And

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1 we have prepared a written statement that you all
2 have. I'm going to summarize those points right
3 now. And to emphasize first that, just as family
4 readiness is imperative for service member
5 readiness -- and our military leaders say that --
6 the emotional well-being and mental health of
7 service members is linked to that of their
8 families. Family readiness and well-being affects
9 a service member's entire career, from recruitment
10 to retention to retirement. And we're asking DoD,
11 with your help, to continue to refine and improve
12 mental health support for families as well as for
13 service members, not only because it's the right
14 thing to do, but it's also necessary to retain
15 highly trained and qualified service members. In
16 the sixth year of the war on terror, no need is
17 greater for military family readiness than a
18 robust continuum of easily accessible and
19 responsive mental health services; from stress
20 management programs, and preventative mental
21 health counseling, through therapeutic mental

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1 elements for this Task Force clearly delineate the
2 many factors that must be addressed to enhance the
3 mental health of service members. And three of
4 those elements call attention to the importance of
5 addressing the mental health needs of the entire
6 military family. Several elements deal with
7 service member awareness and willingness to access
8 services. Family involvement is critical in
9 raising the awareness of the service member
10 regarding mental health services and in reducing
11 that stigma that you've talked about so much
12 today, that discourages some members from seeking
13 these services. That the well-being of the family
14 is linked with the mental well-being of the
15 service member is illustrated by this remark from
16 a returning sergeant first class of the 172nd
17 Striker Brigade: "It was rough when we were there,
18 and there were times you didn't think it would
19 end. But it was harder on the families than it
20 was on us. Being gone makes you look at your
21 family a little differently now." The Army's
22 recently released "Third Mental Health Advisory

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1 Team Report" -- there was a DoD news article about
2 this report yesterday -- even further links the
3 need to address family issues as a means for
4 reducing stress on deployed service members. The
5 team found that the top non-combat stressors were
6 deployment-linked family separation. They noted
7 that soldiers serving a repeat deployment reported
8 higher acute stress than those on their first
9 deployment. They found that, while multiple
10 deployers said they were better prepared due to
11 improved pre-deployment training, they also said
12 their families were experiencing more stress the
13 second or third time around. The study also
14 determined that leading suicide risk factors were
15 relationship issues at home and in theater. We
16 applaud the timely release of this report, and
17 know it will be of great value to this Task Force.
18 As service members and families experience
19 numerous lengthy and dangerous deployments, NMFA
20 believes the need for confidential preventative
21 mental health services will continue to rise. It
22 will also remain high for some time, even after

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1 military operations scale down in Iraq and

2 Afghanistan. In our written statement we've
3 provided some examples of areas where we've seen
4 progress in the provision of mental health
5 services; access to those services, and military
6 service member and family well being. In some
7 cases, the progress is ongoing, and so a
8 subsequent discussion of remaining barriers to
9 quality mental health care is also necessary. And
10 we list several recommendations for breaking down
11 those barriers. These recommendations are based
12 on our long-time study of this issue and what we
13 hear from military families. We look at how
14 military families adjust to the stresses of
15 multiple deployment, and what they believe to
16 better cope with the service member's deployment,
17 return, training to deploy again, and subsequent
18 deployments. We've found that DoD and the VA are
19 increasing their efforts to investigate issues
20 affecting the mental health of service members
21 exposed to combat and its aftermath, and to
22 provide appropriate care -- given the gaps that

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1 you've identified here today and in some of your
2 previous meetings. However we found there's much
3 less research on how family members are coping
4 with all of these issues, and what specific mental
5 health services families need. Coordination of

6 the services needed to facilitate the readjustment
7 and health of the entire family still needs
8 improvement. Access to services varies, based on
9 a variety of factors; and participation in family
10 programs remains voluntary. One of the issues
11 aimed at supporting service members and families
12 is Military One Source -- and you've heard a lot
13 about that today. NMFA has supported and marketed
14 Military One Source from its beginning, because we
15 believe One Source is a critical element in the
16 overall care of the military service member and
17 the family. It's especially important for those
18 isolated Guard and Reserve families who cannot
19 access services on a military installation. It's
20 also important for those folks who can't get to
21 the installation during work hours, when the
22 family support personnel are available. So it's a

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1 vital link. The information available on One
2 Source has improved, and we've been very pleased
3 to see the adoption of the counseling and the
4 funding of the counseling for all the services.
5 It's important to note, however, that this
6 counseling focuses on stress management and
7 relationship issues. It's not the medical mental
8 health care required by someone with PTSD, or some
9 of our families who are exhibited more severe

10 symptoms. On the medical side, we're concerned
11 that access to care is probably the greatest
12 barrier families face in getting the appropriate
13 care they need. Many uniformed professionals who
14 are still at the installations -- many, of course,
15 are deployed with the troops -- are focused solely
16 on caring for the troops: those who are getting
17 ready to deploy, those who've come back. Military
18 families are not going to criticize the deployment
19 of mental health providers to theater. They want
20 those resources available for their service member
21 in the combat zone. However they and their
22 service member are saying: but we have to watch

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1 out for the folks at home; we have to have the
2 resources in place to take care of them. We
3 desperately need more providers, both uniformed
4 providers and civilians; whether working at the
5 military facilities or in the civilian network.
6 I've been contacted by quite a few civilian mental
7 health providers -- and a couple organizations
8 have sprung up whereby civilian mental health
9 providers can volunteer their time to treat
10 service members and their families free of charge
11 to help them with some of these issues. It's a
12 wonderful spirit. However, when I talk to these
13 folks I say: you know, we really need you in the

14 Tricare networks, too. We need you to be
15 participating in Tricare. They say: no, that's
16 too much trouble. We'll see folks on a voluntary
17 basis, sometimes on a short-term basis, as
18 volunteers, but there's too many hassles,
19 reimbursement rates are too low for us to
20 participate in Tricare. That's something that has
21 to change. We have to get these civilian
22 providers into Tricare. There's a scarcity of

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1 some of these providers in some locations,
2 national scarcity of adolescent and child
3 psychology folks. But we need to get more of
4 those who are out there in the Tricare networks --
5 whether that's a combination of looking at Tricare
6 reimbursement rates, or some of the rules that
7 Tricare has. It's very important to have these
8 folks in the system, because we believe that
9 promotes continuity of care. We hear from
10 families that more must be done to link them and
11 the service members with the services they need,
12 and the information they need, about PTSD and
13 other mental health issues. And, as I said: they
14 need support across the whole spectrum of mental
15 health care, starting with that information,
16 leading into preventative care, and -- always --
17 the right kind of care to meet the symptoms and

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18 the needs of the families. What else have we
19 learned from families? To prepare for the reunion
20 with the service members, families want more
21 information on what their service member is
22 experiencing in the combat zone. They worry about

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1 PTSD and want to know what to expect when the
2 service member comes home. Families want to know
3 what are normal behaviors associated with the
4 deployment to a war zone, and what are warning
5 signs for something more serious. They want to
6 know how long it should take before the service
7 member gets back to normal. Family members also
8 need to know when "normal" post- deployment anger
9 morphs into abuse, and where they can go for help
10 if it does. Despite the much discussed military
11 stigma about seeking mental health services, many
12 families we've surveyed have said they've actually
13 sought counseling, either during the deployment or
14 after the reunion, and are encouraging their
15 service member to do the same thing. While our
16 surveys, and work done by the Army through its
17 Mental Health Advisory Team in combat theater,
18 indicates stigma is going away in some cases, and
19 that more service members are seeking counseling
20 and mental health support, families remain
21 concerned their service member is reluctant to

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1 of their leaders is critical in setting the
2 example for seeking care and refuting the stigma.
3 Families are also concerned that they and their
4 service members don't have enough time to adjust
5 before the service member must deploy again. They
6 worry the service member will not have access to
7 mental health services they need to monitor
8 medication and continue their care -- especially
9 when they deploy again. We believe the new DoD
10 policy on mental health and deployment that was
11 released the beginning of last month will address
12 some of these issues. Military parents -- both
13 service members and spouses worry about their
14 children. In many military communities, just as
15 in many civilian communities, as I said, there's a
16 shortage of child and adolescent mental health
17 providers. We've found the military has often
18 compounded that shortage by deployment its
19 uniformed child and adolescent psych providers to
20 the war zones. Schools must be engaged as
21 partners in the care of children and adolescents,
22 and we encourage this Task Force to investigate

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1 ways that could happen. Survivors of the fallen
2 ask for grief counseling -- which is not a benefit
3 under Tricare. And we asked DoD and the VA to
4 ensure those families who've made the greatest
5 sacrifice that they obtain appropriate care a the
6 first moment they need it. We often speak about
7 the slightly more than one-half of service members
8 who are married, but tend to forget that means
9 almost one-half are single. Parents' isolation
10 from the military mainstream becomes an even
11 greater problem if their son or daughter returns
12 with an injury or an illness, or is diagnosed with
13 PTSD. NMFA asserts that wounded service members
14 have wounded families. These families include
15 parents and siblings, as well as spouses and
16 children. Parents of injured or ill service
17 members need to know their child has access to the
18 mental health services they need, even if they are
19 no longer in the military or cannot access a
20 military installation. While most families, even
21 isolated National Guard and Reserve families, may
22 be aware of at least some DoD or military support

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1 services, most know nothing of what is available

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2 through the VA. This lack of knowledge puts these
3 families and their service members at a
4 disadvantage when the service member leaves active
5 service. While DoD and the Congress have worked
6 to increase the resources available to enhance
7 mental health care for service members and
8 families, the challenges seem to us to be
9 increasing at a faster pace. Families want to
10 know mental health services are available when
11 they or their service member need them. They want
12 to know how to recognize danger signs for
13 themselves, their children and their service
14 member. They want to know that seeking care will
15 result in improved health, at no danger to their
16 service member's career. They want to know that
17 care is available over the long time for PTSD and
18 other conditions related to military service.
19 Ensuring the strong mental health of service
20 members and their families is a readiness issue.
21 And the cost of ensuring that health is a cost of
22 war. Our nation must bear that cost. Thank you

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1 for this opportunity. Do you have any questions?
2 Yes, sir?
3 DR. McCURDY: (Off mike) You mentioned
4 (off mike) grief counseling. Does Military One
5 Source, is that a grief-counseling service?

6 MS. RAEZER: Yes, Military One Source
7 can provide some grief counseling if the survivors
8 call. The question is sometimes what's the
9 appropriate level of care? Some of these
10 survivors may actually need that medical mental
11 health care under Tricare. But when they say to
12 the Tricare contractor, "I need grief counseling,"
13 the response is: "We don't cover grief
14 counseling." So a provider has to work with the
15 family to make sure that family's at the
16 appropriate place for care. And that often causes
17 just a lot of additional stress on folks who are
18 already undergoing stress.

19 DR. McCURDY: Right. Just a word. I
20 don't think I've heard this or learned this: when
21 a person, a family member, gets the awful news
22 about they've lost their family member, what does

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1 the Department of Defense -- is there an action
2 that goes into place? Are there things that begin
3 to happen?

4 MS. RAEZER: Yes. Right away there's
5 this Casualty Assistance Officer, or the Call
6 Officer -- the services have different words --
7 that is a military person who is helping with the
8 notification. Chaplains are brought in. There's
9 somebody from the military who's with the family

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10 through that paperwork process and the funeral,
11 the burial -- and are supposedly on-call. What
12 happens sometimes is those folks end up being
13 deployed a couple months later, and the surviving
14 family's lost that link with the military so
15 they're looking for other places. Volunteer
16 networks step in. There are a lot of helping
17 resources, but they can vary. But the military
18 does have a protocol to follow.

19 DR. McCURDY: Thank you.

20 DR. MacDERMID: Do you have a suggestion
21 for us about what we should recommend to ensure
22 that all of the pieces of the mental health

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1 landscape are better coordinated? I mean, our
2 impression is that the allocation of resources is
3 very uneven across installations, and that one
4 site doesn't often know what the other is doing;
5 that there's not a lot of sort of high level
6 advocacy for mental health. And we're trying to
7 figure out what to do about that. Do you have
8 suggestions?

9 MS. RAEZER: I think the one thing I
10 would not want you to recommend is another
11 stovepipe, like a DoD mental health agency or
12 something. I think -- yes, it's problematic
13 because mental health services are in so many

14 different places, and controlled by so many
15 different entities. So what's needed, I think, is
16 to use some of the existing structures, advisory
17 groups, within the Department, within DoD, to look
18 at this issue. I think a lot of the oversight of
19 this issue probably would fall under the
20 Undersecretary of Defense for Personnel and
21 Readiness. I mean, that's the person in OSD who
22 has responsibility for family programs, for health

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1 care, for most of the personnel programs. So a
2 lot of the things that we're talking about --
3 whether it's Military One Source, or counseling
4 provided in family centers, or what's provided in
5 the health care arena -- whether civilian or
6 direct care -- comes under that person. That
7 person meets regularly with his counterpart in an
8 Executive Council with the VA, so there is an
9 opportunity to put in some directive. I think
10 there are also working groups and advisory
11 councils that involve the service leadership,
12 either at the Chief level or the Vice- chief
13 level. I know they've looked at health care,
14 they've looked at other issues. So having these
15 mental health cross- service, cross- component,
16 cross- agency issues addressed at that level could
17 certainly help. Because we do need the line

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18 leadership involvement in this. So I think that
19 using those existing councils. The other thing I
20 would do is start making cooperation with other
21 entities a requirement for these agencies. If
22 you're talking about a contractor, like the one

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1 for Military One Source, put in a contract
2 requirement that directs that contractor to
3 interface with key personnel on the Health Affairs
4 side, on Tricare, so there's an interaction. The
5 military services have accreditation standards for
6 their family centers and for many of their
7 programs. Put in requirements that they need to
8 interface on these issues with folks in the
9 military health system, or with local school
10 districts, or community resources -- and then
11 grade them on their performance on those issues.
12 There are a lot of things in the standards now, so
13 there are ways to encourage cooperation through
14 some of these measures, and using some of the
15 existing interactions that are already there. And
16 it may be that Congress will have to say:
17 "Undersecretary of Defense for Personnel and
18 Readiness, you've now got mental health
19 coordination as one of your tasks. Tell us how
20 you're going to do it." And then let those folks
21 figure out how to do it. But make it a

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1 doing this.

2 COL ORMAN: Ma'am, as I listen to that
3 I'm struck by what I hear as I go from
4 installation to installation about the sheer
5 fragmentation at the user level. And as you were
6 describing all the various pieces of the
7 bureaucracy that have a stake in this, have their
8 own proponency in terms of who's funding them and
9 what the issue is that's being funded, I can't
10 help but think that more of that is not good. And
11 yet I haven't heard you really respond to Dr.
12 MacDermid's question of: how do we tie it all
13 together, make it coherent at the user level? I
14 could care less if the bureaucrats are working
15 hard trying to get their acts together, but I care
16 a lot about what happens down there on the ground.

17 MS. RAEZER: And that's why we need some
18 kind of measures at that local level, that affects
19 that local family center.

20 COL ORMAN: No, ma'am -- I don't think
21 we need that. I'll tell you what I think we need.
22 I think we need somebody who's educating E- 2s,

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1 and their wives as they go into a new post, or as they
2 enter the Army, Marines, Air Force for the first
3 time, there's sort of this manual on how to use
4 the system is what we need. And that doesn't
5 exist -- just so you'll know -- anywhere. Because
6 I've asked for it every single site I've made, and
7 I've been about 25 different places now.

8 MS. RAEZER: There's some of that at
9 some installations. Both the Army and Marines --

10 COL ORMAN: There's brochures galore;
11 there's folders galore full of these brochures.
12 But if you're a 20-year-old E-2's wife, you don't
13 know how to use that stuff.

14 MS. RAEZER: Exactly -- and that's where
15 the families -- and remember what I said about
16 family programs being voluntary; this has been one
17 of the problems with the military is a commander
18 can force that E-2 to come to a session and hear
19 about Military One Source. That commander cannot
20 force the E-2's spouse to come to the session, nor
21 can the commander force that E-2 to take that
22 information home to his or her spouse. So that

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1 has been a traditional problem with the military,

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2 that communication piece. All of the services
3 have entry level orientation to the military
4 programs, installation- specific in terms of how
5 they get participation. We do see participation
6 in some of these through the units. A lot of
7 folks pay attention when their service member is
8 about to deploy, or is deploying. And so, for
9 example, on Military One Source -- we just did
10 survey on Military One Source -- and most of the
11 respondents said they found out about Military One
12 Source through their unit or their family
13 readiness group, because that's who touches them
14 when they need that information most. So that's
15 why I'm saying we need to engage the line
16 leadership in some of this, because the line is
17 who controls the rear detachments, who controls
18 that information flow during deployments -- and so
19 how do we get that information at those teachable
20 moments? But you start by: you have to hold
21 people accountable. If you're not going to hold
22 people accountable, if you're not going to make it

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1 a requirement, I've seen too many things where
2 people will say, "I don't have time to deal with
3 that." And we've heard of some of that today,
4 where folks --

5 COL ORMAN: I think the lack of

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6 accountability's up above.

7 MS. RAEZER: It has to be at all levels.
8 It has to be at all levels. And there have been
9 suggestions earlier that have talked about getting
10 more of this information into all cycles of
11 training, for all service members. That's one
12 start. We have talked a lot about outreach to
13 where the families are. If families have
14 school-age children, the last thing they're going
15 to give up in the stress of a deployment is their
16 involvement in that child's school. So how is
17 that local installation linking with the
18 children's schools to use that opportunity to
19 share information or offer support to the families
20 through the schools. Child development centers --
21 a lot of our folks are coming to the child
22 development centers. Or hospitals. Take a look,

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1 when you go out on your tours, take a look at the
2 lack of information about community resources
3 that's available in the waiting room for the
4 family practice clinic or the pediatric clinic.
5 Those places are prime spots for information to
6 touch families. But in many cases there's no
7 information there. So how do we encourage
8 hospital commanders to say: part of our education
9 job, and our health prevention task is getting

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10 good information to families where they are.

11 COL ORMAN: There's too much information
12 now.

13 MS. RAEZER: There's a lot of
14 information but it's not getting to people when
15 they need it.

16 COL ORMAN: There's no integrator of the
17 information.

18 MS. RAEZER: Right.

19 COL ORMAN: Okay.

20 MS. RAEZER: But sometimes you can
21 repeat. And the more you repeat the same
22 information -- I read somewhere where it takes

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1 seven times to tell somebody something before it
2 sinks in. So if you hit people seven times in
3 seven different places, maybe they'll start to
4 pick up the information that's most important.

5 DR. MacDERMID: We need to move on.
6 Thank you very much.

7 MS. RAEZER: You're welcome.

8 DR. MacDERMID: And please feel free to
9 submit. We're always happy to learn more. So if
10 there's more you want to tell us, please do.

11 (Applause)

12 DR. MacDERMID: The next speaker is Mr.
13 John Davis with the Fleet Reserve Association.

15 MR. DAVIS: Thank you. I'm John Davis
16 with the Fleet Reserve Association. I'm the
17 Director of Legislative Programs. I'd just like
18 to let you know that the Fleet Reserve
19 Association's been around since 1924. It's the
20 oldest and largest organization serving active
21 duty and retirees for the Navy, the Marine Corps
22 and the Coast Guard. It's a Congressionally

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1 organization, and is recognized by the Veterans
2 Administration as a veterans service organization.
3 FRA is a premier watchdog group, maintaining and
4 improving the quality of life for sea-service
5 personnel. In that regard, FRA has as one of its
6 top priorities full funding for health care --
7 which, of course, includes mental health funding
8 as well. And that funding should go across the
9 board with not just the Veterans Health
10 Administration, but also the Defense Health
11 Program. We think that that funding should meet
12 the growing health care challenge for all
13 beneficiaries, whether in the mental or the
14 physical realm. As you know, the 109th Congress
15 did not complete its budget before adjourning --
16 that's the FY 2007 budget. They're right now
17 operating under a current resolution which

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18 flatlines their spending. The new majority is
19 coming in next month and has let it be known that
20 they want to basically flatline or continuing
21 resolution for the spending on most of the
22 programs for FY 2007. They have made notice that

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1 they would like to try and add some money to the
2 CR for veterans health care programs, but I think
3 that is going to be very difficult for them to do
4 because it will simply be -- once you open up that
5 floodgate it will be "me, too;" all these other
6 groups and agencies will come in wanting their
7 funding changed and they'll be basically doing the
8 appropriations process again. So we see that as
9 one big challenge. Also, of course, Congress not
10 only does the appropriations but it does the
11 authorization, as well. And this year, as in most
12 years, the House and Senate had its versions of
13 the Defense Authorization Act. The House version
14 was H. R. 5122; the Senate version was S. 2766.
15 Both of these had provisions for mental health
16 care in various forms, but a lot of them got taken
17 out in the final version. I have a number of them
18 in my written testimony that I've given you, but
19 let me just give you a couple of examples. For
20 example, in S. 2766, it required the DoD to
21 establish an office to assist employers of Guard

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1 health care issues. That was Section 683 of the
2 Senate Bill. On the House version they included a
3 provision which was Section 705, which would have
4 allowed mental health counselors without prior
5 physical referral to supervise -- without referral
6 or supervision for Tricare beneficiaries currently
7 serving. That was also dropped from the final
8 version of the Bill. Conferees of the Bill did
9 include a requirement -- Section 738 -- for the
10 DoD to issue policy guidance for service members
11 with deployment- limiting psychiatric conditions,
12 and those who are prescribed with psychiatric
13 medications. So we thought that was a step in the
14 right direction. One of the biggest mental health
15 care conditions right now, of course, that's in
16 the news is PTSD -- that's post traumatic stress
17 disorder. And FRA believes that Congress should
18 provide more funding and oversight for this
19 problem; should help DoD -- or direct, really --
20 Congress should direct DoD and the Veterans
21 Administration to implement an awareness and
22 treatment program for PTSD. As you know -- as I

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1 was looking through this on this issue, I found an
2 October issue of the American Journal of
3 Psychiatry, a study that was done in 2005 on PTSD,
4 with over a thousand military men coming back from
5 Iraq. One month out they were surveyed to see how
6 many of these men had PTSD symptoms. About 4
7 percent did. Four months later the survey was
8 done again, and this time over 12 percent of the
9 respondents had symptoms of PTSD. Though this is
10 an elusive and difficult problem, it is not a new
11 one. This PTSD problem was experienced in
12 Vietnam, we've done a lot of study on that
13 problem. Despite that knowledge base, the
14 Veterans Administration just recently had no
15 clear, defined admission criteria for PTSD.
16 That's according to a VA Office of Inspector
17 General report that was just put out. And the VA
18 Office of Inspector General, which includes the
19 Office of Health Inspector, indicated that there
20 was no clear admission standards for people
21 suffering from PTSD; concludes that the VA should
22 immediately develop a standard for admissions

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1 across the board. FRA concurs with this, and

2 believes that a lot more needs to be done to
3 identify and treat this condition. The FRA
4 supports the Executive Order recently put out this
5 year that has standardized electronic health care
6 records for all Federal agencies. We think that
7 will help with the seamless transition program,
8 where someone goes from DoD to VA. It will help
9 smooth that transition. As far as I know, this
10 program is on schedule and will be fully
11 implemented by 1 January 2007. Just recently,
12 too, within the last few days there's been a GAO
13 report that's been put out that indicates that the
14 Veterans Benefits Administration can do a lot to
15 improve its procedures to reduce the claim process
16 time for PTSD and other mental health claim. FRA
17 was encouraged, even though the budget didn't pass
18 this year in Congress, we were encouraged by the
19 fact that the Congress did, on the closing days,
20 pass S. 3421, which allows the VA to have
21 outpatient clinics for mental health services on a
22 contractual basis. S. 3421 also calls for

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1 collaboration between the VA and the DoD to
2 improve clinical skills for diagnosing PTSD and
3 other mental health care problems suffered by the
4 military. This legislation, I think, indicates
5 that Congress is becoming more and more aware of

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6 the mental health care challenges being

7 experienced by service members coming back from
8 Operation Enduring Freedom and Operation Iraqi
9 Freedom. And we think that's a step in the right
10 direction. I'd like to thank you for the
11 opportunity to come and talk to you today. And if
12 there's any questions, I'd be glad to answer them.

13 DR. MacDERMID: Thank you, sir.

14 Questions? (No response)

15 MR. DUDAS: Thank you very much.

16 (Applause)

17 DR. MacDERMID: Our next speaker is Beth
18 Powell, of the American Mental Health Care
19 Association. Welcome.

20 MS. POWELL: Hi, I'm Beth Powell, and
21 I'm the Director of Public Policy and Professional
22 Issues for the American Health Counselors

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1 Association. And thank you for providing us this
2 opportunity to speak with you all. AMHCA is the
3 nation's largest professional organization
4 exclusively representing licensed mental health
5 counselors. Mental health counselors are
6 professionals with master's or doctoral degrees in
7 counseling or related disciplines, such as
8 counseling-psychology, and are licensed by the
9 states to diagnosis and treat mental and emotional

10 disorders. Clinical training for mental health
11 counselors is comparable to other master's level
12 Tricare providers, including clinical social
13 workers and marriage and family therapists.
14 However counselors are the only ones who cannot
15 practice independently. And currently
16 beneficiaries have to go see their primary care
17 physicians or another contact before going to see
18 a licensed mental health counselor. I know others
19 have talked about this issue this afternoon.
20 Congress recently passed legislation to allow
21 licensed mental health counselors to practice
22 independently in the VA. This was part of S. 3421

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1 that the previous speaker just talked about. This
2 legislation will increase the pool of qualified
3 mental health professionals available to serve our
4 nation's veterans. In addition, approximately 90
5 percent of managed care plans reimburse mental
6 health counselors directly for providing services.
7 Our members are also Medicaid providers, and are
8 reimbursed under the Federal Employee Health
9 Benefit Plan. Tricare beneficiaries should be
10 given the same type of access to our qualified
11 providers. The House of Representatives, in the
12 108th and 109th Congress, included in their
13 versions of the Defense Authorization Bills a

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14 provision to grant licensed mental health
15 counselors independent practice authority under
16 Tricare. CBO estimates that the cost of doing
17 this to the Federal government would be
18 insignificant. Groups such as the National
19 Military Family Association support our provision,
20 as well. So AMHCA encourages the Task Force to
21 recommend that licensed mental health counselors
22 be able to provide direct services to Tricare

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1 beneficiaries. Do you all have any questions?
2 COL PEREIRA: Are there different levels
3 of licensure available through states for
4 counselors?
5 MS. POWELL: There are -- in some states
6 there are tiered licenses, just like there are for
7 clinical social work. So -- yes. But all of our
8 licensees have at least a master's; have, you
9 know, 3,000 hours post-master's supervised
10 experienced, and have passed a national exam to
11 become licensed.
12 COL PEREIRA: What I'm asking is: for
13 most states, is there an independent-level
14 license?
15 MS. POWELL: Yes.
16 COL PEREIRA: In other words, it's
17 usually the third level of licensure.

18 MS. POWELL: Yes. Yes. And they're
19 typically called "licensed professional
20 counselors," in most of the states.
21 COL PEREIRA: Nothing about "independent
22 practice license?"

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1 MS. POWELL: No, we don't have -- like
2 "licensed independent clinical social worker."
3 Our title is "licensed professional counselor."
4 COL PEREIRA: Okay. And you're saying
5 not all states have that, though.
6 MS. POWELL: Yes, they do. Yes.
7 COL PEREIRA: All states --
8 MS. POWELL: 48 states are licensed.
9 COL PEREIRA: I'm not just asking about
10 licensed, it's the level of license --
11 MS. POWELL: Independent practice --
12 yes, ma'am. They can be directly be reimbursed
13 for providing services through Federal Employee
14 Health Benefit Plan, all types of outside vendors.
15 Yes.
16 COL PEREIRA: Okay.
17 DR. MacDERMID: Is that all? Thank you
18 very much.
19 (Applause)
20 LTG KILEY: I believe our next presenter
21 is Major Cindy Rasmussen -- is that correct?

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1 Davies, Dr. MacDermid, and all other distinguished
2 members of the Task Force -- thank you so much for
3 this opportunity to speak. I'm so excited that
4 I'm afraid I'm going to cause trouble. My name is
5 Cindy Rasmussen. I'm a mobilized Reserve soldier
6 in support of Operation Noble Eagle. I was
7 mobilized over two years ago. I am a psychiatric
8 nurse in the Army Reserves for 18 years. And in
9 civilian life, I'm a VA nurse practitioner in
10 primary care and psychiatric care. I am currently
11 also the sexual assault response coordinator for
12 the Army Reserve in the Midwest. I am also the
13 sexual assault response coordinator for 934th Air
14 Force Reserve in the Midwest, as they did not have
15 a sexual assault response coordinator so they
16 asked if I would also do that. And I am
17 absolutely privileged to be a Combat Stress
18 Control Officer, along with Lieutenant Colonel
19 Whittaker, an MSW, and Lieutenant Colonel,
20 promotable, Erickson, an occupational therapist.
21 These two lieutenant colonels initiated the
22 program in February of 2003 because General

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1 Beasley, the commander at the time of 88th
2 Regional Readiness Command. had a passion for
3 taking good care of his soldiers, including the
4 mental health. The 88th RRC is the only Regional
5 Readiness Command with a full-time combat stress
6 control program. Not only is it the only one, but
7 it's the only one that's been in existence for
8 over three years. And the reason I'm telling you
9 this is because the number of soldiers in the 88th
10 Regional Readiness Command had gone from 24,000 to
11 26,000. So we're responsible for the mental
12 health of 24,000 to 26,000 soldiers plus their
13 family members. And therefore the information
14 that I'm going to give you today is based on over
15 three years on ongoing, daily, sometimes 24/7
16 practice with these soldiers and family members,
17 including the Army, Navy, Air Force and Marines.
18 I'm here representing this program, and I'm
19 representing my Surgeon, Colonel Jimmy Browning,
20 who is my boss, who 100 percent totally supports
21 this program -- with funds and with his presence
22 and with his emphasis. But most importantly --

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1 most importantly, more than anything -- I'm here

2 to represent the service members and their
3 families, and the ones that I have promised, over
4 the last three years that: yes, there is hope; yes
5 there is somebody that cares. And the reason I'm
6 so excited to be here is because three weeks ago I
7 told someone: I think I'm losing hope. I've been
8 hitting so many brick walls that for the first
9 time in three years I'm actually losing hope. And
10 I'm not sure how much longer I can do this job
11 once I lose hope. And because of the last three
12 days here, I want to tell you that my hope has
13 returned; and that since I'm being extended for
14 another year that I feel like I have the energy to
15 go out there and continue to maintain that hope.
16 So -- Dr. MacDermid, you asked for suggestions to
17 improve the mental health of our armed forces and
18 their families. So, you're going to get what you
19 asked for. (Laughs) As Major Warner discussed,
20 command buy-in may be one of the most important
21 concepts to improving the mental health. Please
22 consider leader validation courses in combat

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1 stress, mental health, and resources; and support
2 the emphasis that people with mental illness --
3 soldiers, family members with issues related to,
4 as you heard this morning, combat stress issues
5 from being in this uniform and doing your mission

6 -- they're not crazy or broken. The program that
7 I am a part of does a complete deployment-cycle
8 program, starting from the day that the soldiers
9 join the Army Reserves. We do pre-mo briefings;
10 we do mid-cycle briefings out in the field to all
11 of the family-readiness groups whenever they ask
12 for it. Sometimes we go out two or three times.
13 One unit in Ohio I've been out to at least six
14 times personally. We've sent mental health
15 providers from the VA in Cleveland out there.
16 They lost four soldiers in some serious incidents,
17 and we continue to go out there. And, actually,
18 what's really cool is they were the first ones to
19 get the PDHRA last month in the Army Reserves in
20 our command. And I'm here to say that over a
21 hundred soldiers in that unit were referred for
22 appointment. And I've been out there six times

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1 trying to get these guys to go in for
2 appointments. So that is really exciting also.
3 We also do post-mo briefings for families and for
4 the soldiers. We do community orientation and
5 reintegration and education. We do CEU programs
6 at all the colleges in Minneapolis, and we're
7 working on CEU programming in the other six states
8 that we're a part of. Another suggestion is:
9 consistent availability of resources. And I think

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10 that was a big issue that you have, sir. I don't
11 think we need any more resources -- and I can give
12 suggestions. And we're going to put this all in
13 writing for you guys as soon as I get back -- is a
14 diagram, or a method to get that information out.
15 And we do have some of those methods, and I can
16 explain those to you. Combat stress control
17 resources at all levels, especially active duty
18 and NG/R positions at the new RRS season. I'm not
19 sure how many of you are familiar with, within the
20 Reserve command, with BRAC, we're going, I think,
21 seven or eight RRCs, which is the commands across
22 the country, to RRSCs. So our command, which will

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1 actually stand down and a new command will stand
2 up, will be responsible for 18 states instead of
3 just six. And my boss, Colonel Browning, who was
4 a Marine, by the way, during Vietnam, and is now
5 an Army Reserve Surgeon -- when I called him up
6 and said, "Sir, is it okay if I go to that?" He
7 said, "Okay, Cindy -- here's what I want you to
8 tell them: that they absolutely have to have a
9 position for a combat stress officer at all of
10 those RSCs." And at this time that's not in the
11 program. In fact they're going to decrease the
12 amount of slots available for those resources.
13 And I'm also going to suggest a first- responder

14 training for all soldiers and family- readiness
15 leaders. We have first-responder training. We've
16 run four of them. We've had over 90 participants
17 in each one that we've had. It's less than two
18 days long. We've had family-readiness leaders.
19 We've had Canadian soldiers, from the Canadian
20 Army come and attend. We've had National Guard,
21 Air Force, Navy, Marines and Air Guard members
22 come to our programming. We are hopefully

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1 planning in the next year to get this out to the
2 field and do on drill weekends during training,
3 the first-responder course. And basically what it
4 is: it's CPR, but it's mental health CPR for all
5 the soldiers. So it's buddy-aid. It's how do you
6 recognize in yourselves, your families and each
7 other -- family members, how do you recognize in
8 that wife that shows up for the meeting whether
9 she's depressed or having issues? So I'm
10 suggesting that that program be part of NCO DP and
11 ODP throughout the military. Also Battlemind and
12 respect. Now, mind you, we know Battlemind pretty
13 well, but what we've done is we've taken
14 Battlemind and we've made it work for the soldiers
15 and the families. We like the concept, but
16 there's a chaplain in Boston who wrote a paper on
17 "Battlemind issues," and we use his stuff because

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18 it's much more user friendly, and it's awesome.
19 And I'm sorry -- I can't remember his name right
20 this second. The 90-day return to duty needs to
21 change. Service members need to be available,
22 with their families, on a regular basis after

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1 getting back. For those of you who said that, you
2 notice that it takes a while for combat stress
3 issues and PTSD to show up. You'll also notice,
4 especially if you've worked in VAs and you've sat
5 in the halls with the Vietnam vets and the Korean
6 and World War II vets -- healing takes place in
7 the uniform. And I'm sorry for all those of you
8 civilians who are really active, and understand
9 and get along really well with the soldiers. But
10 the main healing for soldiers, service members,
11 takes place in the uniform. And so getting them
12 out, getting rid of them, kicking them out, or not
13 allowing them access is an issue to prevent
14 healing. Often alcohol and drug, family, job,
15 legal problems, etcetera, are out of control by
16 the time we see them back after 90 days. Clear
17 directives on the use of antidepressants. A very
18 recent directive came out, and just not clear at
19 all, for commanders, about what do you do if one
20 of your soldiers is on antidepressants? What does
21 that mean for you? Commanders can still do

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anything they want, basically. Also about alcohol

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1 and drugs: my command retains people. We have
2 soldiers who have dropped- hot for crack, and our
3 command has asked us: do an evaluation; what's
4 going on with this soldier? And if we say, "Sir,
5 this person is showing signs of combat stress.
6 They've been recently back from Iraq, and we think
7 they'll benefit from treatment. They're awesome
8 NCOs. And the only reason they're doing this is
9 because they were served with divorce papers in
10 Iraq; came back, had no home, no family, no
11 children, no spouse. And, you know, the easiest
12 thing to do is self-medicate." Our command will
13 actually give them the benefit of the doubt and
14 allow them to have care first. Consideration is
15 given to each and every service member and family:
16 I was a home hospice nurse in the inner city years
17 ago, and I believe that every person has only one
18 opportunity to die, so every person only has one
19 opportunity to get the best care. I feel the same
20 way about service members and family members. And
21 that sometimes is really difficult, because you do
22 run into a lot of people who look at it in a

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1 bigger picture, like it's a unit, or it's a whole
2 army, or it's a whole Reserve. So it is a little
3 challenging to try to get people to see that each
4 person is a person; each soldier and family is one
5 person. Consistent, immediate, available
6 resources to provide Reserve component service
7 members with income when unable to do their job
8 and having difficulty getting jobs. What I hear
9 on a regular basis -- and I get calls every day
10 and hear stories like what you guys heard this
11 morning -- is: "Well, the VA told me I can't work;
12 I'm 100 percent service-connected." "Well, what
13 are you doing?" "I'm not working." "What's going
14 on?" "Well, they just repo-ed my car yesterday,
15 and they're going to take my house away next week.
16 My wife's going to leave me because I can't
17 support her and she doesn't understand." "Well,
18 how come the VA told you you can't work? When are
19 you getting service-connected?" "I don't know.
20 They haven't even processed the papers yet."
21 "What are you getting from the Army Reserve, or
22 from the Reserve." "I'm not sure, because I have

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1 to fill out all these forms, and I'm not sure how

2 to do it." And on and on and on. I'm sure you
3 get the picture. We have CBHOCs, we have
4 Med-hold, we have ENCAP pay, we have this thing
5 called MPR2. And we have all these different
6 programs that have been put up to band-aid all of
7 this, but we're still seeing this on a regular,
8 daily basis. Military One Source is a great,
9 great program. We use it all the time. I
10 specifically only use it for family members,
11 partly because a lot of the civilian providers
12 will say, "Well, they've treated you pretty bad.
13 You need to get out of the Army." Well, that's
14 not the answer, because we're the ones that can
15 help them and support them; and because five or 10
16 years down the road, the VA's going to be the only
17 ones left to take care of us veterans. So -- the
18 one thing is: Military One Source, as of yesterday
19 or the day before when I called, they do not
20 provide care for parents, unless you're a
21 dependent parent. And I don't know if Ms.
22 Thompson is still here or not. She did say this

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1 morning they do. We need to talk about that,
2 because I've got tons of parents out there that
3 need you guys really bad. Oversee the VA. Please
4 make them put their money where their mouth is;
5 make them respond promptly to complaints of poor

6 care. I frequently -- weekly -- report the
7 messages I get from our soldiers and families
8 about poor care. Some of them are great, they
9 respond within 15 minutes, I get a call back.
10 Others never call me back. Case managers who help
11 with all the resources and follow up -- big one;
12 extremely important. I had lunch with a few
13 people I had never met before, and the whole
14 conversation was about how all of us get these
15 calls every day, and how we spend 24/7 working
16 with one family member and one soldier. But you
17 know what? There aren't enough of us out there.
18 I'm lucky. I know how to work the system; I know
19 how to work the VA system, I know how to work the
20 military system, I know how to work the civilian
21 system. But how many of us are out there? And I
22 don't have time to do it all. So people like us,

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1 that are invested, and have the energy, and know
2 how to do it -- it's like your supply sergeant.
3 If you know your supply sergeant -- man, you can
4 make anything happen -- right? Soldier care
5 in-country by commands -- and the reason I bring
6 this up is I sat and cried -- I'll tell you a
7 really quick story. This was a soldier I met; two
8 years ago I was out at a family readiness
9 gathering. The families called and said, you

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10 know: "Our unit just lost a few soldiers. All of
11 our families are freaking out. Can you guys come
12 out and do a mid-cycle briefing, stress
13 management -- all that kind of stuff. And I said,
14 "Yes, no problem." So I went out there, took a
15 chaplain, because we always work with chaplains
16 and family readiness folks everywhere we go. We
17 work as a team. And so that night they had a
18 cookout. And I was sitting at the cookout, and
19 there were a few soldiers from OIF-One. They'd
20 come back awesome NCOs. Kevin, who I know would
21 be very, very proud that I'm telling his story,
22 was actually Special Forces in OIF-One. He's an

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1 awesome NCO, wonderful man, wonderful soldier,
2 wonderful husband, wonderful father. Well, he was
3 cross-leveled in OIF-One to a unit -- he's an
4 engineer -- that he'd never been with. And I
5 didn't just hear this from Kevin, I heard it from
6 other folks across the country that were in this
7 unit: the cross-leveled soldiers were treated like
8 second class citizens while they were there by the
9 command of the unit that they were cross-leveled
10 to. Kevin looked in my eyes and said to me:
11 "Ma'am, I want to go back to Iraq. I want to step
12 on an IED. I want to die so that I don't have to
13 go through this pain anymore, so I die a hero, and

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14 so that my family gets the money they deserve."

15 And that was one of my very first interactions
16 with someone like Kevin, when I first started this
17 job. He meant it. And I will tell you that,
18 despite everything that I did, it took almost
19 eight months after that for the next time I called
20 Kevin for him to say: "You know what? I'm a
21 little better." Kevin had physical and mental
22 health issues that were not being treated. He was

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1 suicidal. I sent him to the VA, and his wife
2 called me on the way home from the VA and said,
3 "Cindy, they didn't do anything for him. They
4 said that they had no one to help." So then I
5 sent him to -- I said, "You've got to go to the
6 emergency room right there." So they went to the
7 emergency room and -- guess what? Tricare
8 wouldn't pay for it. But they did give him four
9 medications, which helped him sleep for the first
10 time. Anyway -- needless to say, there's a lot
11 more to that story. Let's see -- so, active duty
12 combat soldiers cannot be reassigned -- oh, this
13 is another one. A couple weeks ago we were asked
14 to do a weekend retreat for the recruiting
15 battalion in Wisconsin and Minnesota, because they
16 had so many problems with their active duty
17 recruit soldiers, including suicide and other

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18 issue. So we spent the weekend with over 20
19 active duty recruiters that had been immediately
20 assigned to recruiting after coming home from Iraq
21 and Afghanistan. And these were all combat --
22 let's see, the Airborne, and two of the combat

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1 units. And I sat in a room with 15 of these
2 soldiers for four hours; thought I was going to do
3 some education, and wound up doing a process
4 group. And every one of those 15 soldiers in that
5 room had been suicidal and/or homicidal within the
6 last, probably, month. Every single one of them
7 had been either split up from their family and
8 their support systems already, or were heading for
9 that. Every single one of them went home and,
10 basically, drank or did drugs. Every single one
11 of them was worried about hurting one of the kids
12 in the high schools that were -- or the parents
13 that were saying, "F -- - you, don't call my kid
14 anymore." And on and on and on. A lieutenant
15 colonel who was retired that was with me told the
16 Command: "You're lucky one of these kids hasn't
17 gone postal yet." I'm here to tell you that I
18 told Ryan that I would tell his story. Ryan was
19 one of the worst. We never expected him -- he
20 basically made fun of us through out whole first
21 day. We never expected him to ask for help. He

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22 showed up in my office Monday morning and said,

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1 "Ma'am, I need to get some help. Because if I
2 don't get help, I can't ask my soldiers to get
3 help." I need to tell you: I sent him to the VA
4 that day. I called ahead. I told everyone he
5 was coming, who he was, why he was coming.
6 Five-thirty that afternoon I got a call from the
7 woman who had accompanied him, and said, "You
8 know, Ryan's still sitting here. What do we do?
9 I've got to go home and see my kids." Luckily, I
10 was able to go over there and bust them out. But
11 I reported that to the VA. And you know what?
12 Nothing ever came of that. Ryan still hasn't got
13 help, but I did hear that Ryan's Command is now
14 going to send him for a fit-for-duty because he
15 mentioned to them that he was going to try to go
16 get help. Okay. Let's see. What else? VA needs
17 to support families, with education and marital
18 counseling. Basically the answer you get is: "We
19 don't do marital counseling; We just do the
20 soldiers."

21 DR. MacDERMID: Ms. Rasmussen?

22 MAJ RASMUSSEN: A couple more minutes?

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1 Can we get to questions.
2 All right. Thanks. I meant to say would
3 you mind stopping me, because I know I could ramble on
4 for days up here. I'm sorry. Okay -- so that's the
5 recruiters. In answer to the question that you asked
6 a few minutes ago, sir -- a flow chart with all
7 available resources for each different scenario -- I
8 did actually recently call a meeting of all of the
9 resources in our area, including all the veterans
10 organizations, and all of the Reserve units. Because
11 at Fort Snelling we have Marines, Army, Navy, Air
12 Force, and we are going to get together and do flow
13 charts. Because when I get a call sometimes I forget:
14 oh, did I have him apply for EN CAP pay? Did I have
15 him call this person or that person? So that's one
16 thing that would be easy, it wouldn't cost much, and
17 we could do it quick and get it out. Also, in regard
18 to the sexual assault victims, we need a special track
19 for sexual assault victims. We currently have a
20 couple sexual assault victims that recently were or
21 are on med-hold at various places, that are being
22 treated worse than you would even want your dogs to be

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1 treated. That cannot happen -- especially with the

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2 emphasis on the care of sexual assault victims. There
3 needs to be an evaluation of medical hold programs,
4 and mob sites, and how they treat the soldiers and
5 families coming and going. Encourage participation of
6 the family readiness groups, chaplains and CAS
7 personnel. And you know what? We had a great
8 program, but people need to let their personalities at
9 why they're there. Resiliency training -- on-going
10 units, soldiers and families. We have a program we're
11 putting together, and we are working with VA staff and
12 all organizations about an actual training. Because
13 what I hear from a lot of the company commanders is:
14 these kids are coming into the military without the
15 resources they need to be soldiers. So what we're
16 putting together is a program to incorporate into the
17 training of soldiers on a regular basis that won't
18 take away from their combat training, that trains them
19 on resiliency; things like goal-setting, financial
20 planning, communication and all that kind of stuff.
21 Support the PDHRA process, but not to the exclusion of
22 the human element. And on and on and on and on.

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1 There was one other question I wanted to answer. Oh,
2 yes. If you would, I'd like to invite you to come and
3 do a site visit, meet us and see our program, and see
4 what we've done. Because I will tell you that
5 everything that we've done taking care of -- and we

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6 personally have seen -- I don't have the numbers with
7 me. I'll get them to you -- but thousands and
8 thousands of soldiers and family members, without any
9 extra funds. I want you to know that all the funds
10 that have been used for us -- and we have carte
11 blanche to do whatever we need to do, fly wherever we
12 need to fly -- we have not had any extra funds given
13 to this program. Four weeks ago we went to Fort
14 Leonardwood, and Colonel Whittaker and I presented
15 this program to all the medical staff at Fort
16 Leonardwood. Believe it or not, they did not have a
17 program set up, and they had thousands of soldiers
18 coming in. They had recently had a suicide and
19 homicide, and wanted to be prepared. And we're still
20 getting calls from them all the time. We've been to
21 Texas. We've been to lots of other places. We don't
22 care who uses it. We give our slides away to

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1 everybody. They can change the name, they can do
2 whatever they want. So I'd love to invite you to do
3 that. And when you do come, the Minnesota National
4 Guard also has the "Beyond the Yellow Ribbon Program,"
5 which does an awesome job, and will do for the 4,000
6 soldiers coming back in the spring. But that's just a
7 reintegration program. It doesn't hit all the other
8 areas. And Ohio Cares -- someone asked about that.
9 Ohio Cares, we are on their board. We work closely

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10 with them And we also work with all the agencies
11 like Purple Heart, and Family Readiness and stuff.
12 DR. MacDERMID: And did I understand
13 correctly that you intend to send us written
14 materials?
15 MAJ RASMUSSEN: Yes. We have an
16 information paper we put together. Colonel
17 Whittaker and Colonel Erickson did a presentation
18 here in Washington to -- I want to say it was 05s
19 and 06s about a year-and-a-half ago about the
20 program So we'll send you that. Plus we have
21 all the numbers of all of the different places
22 we've been, who we've talked to. And we also have

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1 slide presentations set up based on all the
2 accumulated data for every issue or problem, or
3 for community members; for veterans, for VFWs, for
4 family members, for mid-cycle -- for the whole
5 array of deployment-cycle needs that we will send
6 you all of them, and all the pamphlets.

7 DR. MacDERMID: Great.

8 MAJ RASMUSSEN: We probably have 30
9 different pamphlets. Oh -- and the answer to
10 grief -- Military One Source is not real good
11 about grief counseling. The Vet Centers offer
12 free grief counseling to people who are survivors
13 of soldiers that have been lost.

14

DR. MacDERMID: Thank you very much.

15

And I want to thank you for the work that you're

16

doing, and the creativity you're exhibiting in a

17

difficult time. Does anyone have any questions

18

you wish to ask? (No response)

19

DR. MacDERMID: Can I just do a really

20

quick commercial? The Milwaukee Journal Sentinel

21

did a five- day article on Mark Samples. I don't

22

know if anyone's familiar with him. Mark was a --

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1

it says here, "Mark Samples won the Navy's highest

2

peacetime award. He saved the crippled USS Stark.

3

Now he's in a Wisconsin prison." Awesome article.

4

It absolutely is very easy to read, and tells you

5

everything you wanted to know about the journey

6

from being a normal person to being a PTSD, combat

7

stress victim. Thank you so much for what you

8

guys are doing. I'm so excited.

9

(Applause)

10

DR. MacDERMID: Our next speaker is Joan

11

Samuelson, the parent of a service member --

12

correct? Thank you. Welcome.

13

MS. SAMUELSON: Hi. I'm the mother of a

14

soldier in the Army. My name is Joan. I feel

15

very appreciative to be here and see how hard all

16

of you are working on trying to be there for our

17

soldiers. Our son returned from a year of service

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18 in Iraq. We felt very blessed that he came home
19 alive and unharmed. We soon discovered our joy in
20 his return has led him on a roller-coaster ride of
21 dysfunction. He actually re-upped and took his
22 new assignment to Hawaii, where he was told he

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1 would be part of a striker training unit. That is
2 what he did in Iraq. Before arriving in Hawaii
3 his wife left him. She couldn't handle his mood
4 swings and many other factors entered into it. He
5 went to Hawaii with hopes of immersing himself in
6 work. When he got there, the stories changed
7 daily and his strikers never arrived. And they
8 couldn't tell him when they were going to arrive.
9 He has been diagnosed with PTSD. And as I have
10 sat and listened to what the speakers have shared,
11 it might be anxiety disorder, along with
12 depression. But he has had a hard time getting
13 help; making poor choices under the stress; and
14 ended up in the brig; many doctors appointments
15 not made because he has had no support, no one to
16 advocate for him and others like him. That is why
17 I am here: to be an advocate for the many men and
18 women who are suffering, and the Service wanting
19 to get rid of them and not discharging them with
20 honorable, where they would have the benefits to
21 help themselves. Instead, they want to give them

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1 do what? My son has two daughters and is very
2 concerned what will happen to them if he loses all
3 benefits. I have not spoken to my son since
4 before Thanksgiving, and was informed he got moved
5 to Fort Lewis a week ago. But I have received two
6 letters, and I would like to share one with you.
7 I have softened it up a bit as to not offend
8 anyone. And what you've got to understand is that
9 he was pouring his heart out, probably for the
10 first time since he'd been back from Iraq. So
11 some of it's just kind of silliness, but this is
12 what he wrote: "Merry Christmas. Who would have
13 ever thought that someday I actually got a card
14 out to someone on my own. I did, however, have to
15 tear out a couple of sheets of paper so I didn't
16 stretch it out too long. I will never be able to
17 say I lived a boring life, and writing from jail
18 is something I never expected. "I am such an
19 important criminal, they even have to transfer me
20 to a higher security type prison (actually, I
21 don't know that, but it just sounds more
22 interesting). "Hard letter to write, you know.

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1 These last couple of years have been my toughest
2 yet. I keep telling myself it's just God testing
3 me, and I don't want to take another more test.
4 Look back on the last five holidays hasn't been
5 all that great. In fact, the last five have been
6 horrific, to say the least. The first one, Coco
7 -- " -- which was his wife -- "Stella, one year
8 old, myself had the Glen/Mona fiasco -- " -- it
9 was a family thing -- "Then the following
10 Christmas I stayed at wonderful chemical factory
11 beach resort in Iraq. Coco and I fought the year
12 I came home. Last year I spent Christmas alone at
13 a biker bar, thinking the Vikings were playing,
14 ate nasty turkey, drove aimlessly for hours, and
15 go drunk by myself. "This year I'll be
16 celebrating in prison. This is supposed to be a
17 cheery time of year, but from now on I'm
18 celebrating in July. "I wish I had something fun
19 or funny to say, because most times I can. But I
20 don't -- so, whatever. "I truly don't know how
21 much communication I will have with the world once
22 I get out. Kind of depends on what happens, and

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1 all. I'll write you some scenarios so you can all

2 have an idea, as I can't talk that much on the
3 phone. "To begin: during that time, I will travel
4 to Florida, Colorado and then back to Hawaii,
5 scoping houses and schools. If I get an OTH and I
6 don't get any benefits, I am totally screwed. I
7 am going to build a boat out of straw and sail to
8 Japan. And like the dude in 'Batman Begins' -- "
9 -- which I certainly never saw, but this is just
10 where his mind was going, okay? -- " -- just like
11 the dude in 'Batman Begins,' I will wander barren
12 lands of the Far East and grow my beard until
13 someone asks me to get a blue flower from some
14 bizarre mountain top. "I am so sorry-- I just
15 absolutely hate life right now, and I've got no
16 one to talk to. I try so hard every day to wake
17 up with a positive attitude, but I really don't
18 know how much I can keep going like this. "If my
19 medical board goes through, I will be looking at
20 houses in one of three states: Hawaii, Florida or
21 Colorado." I'm not for sure why he'd want to go
22 back to Hawaii, because it hasn't been a pleasant

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1 experience for him, but he loved the land. He
2 liked the temperatures whatever. But that's one
3 that he keeps putting in there. "I won't be
4 living there except during non- school months, and
5 renting it out to students or military during

6 school season. I want to go to a tech school for
7 interior and exterior car work; everything from
8 collision reports, painting, re- upholstery, car
9 audio, etcetera, etcetera. Eventually I want my
10 own business, and then continue on so I can learn
11 how the car works, also. Never been a grease
12 monkey, so to say, but I have an appreciation for
13 nice cars. " This is the first time, I think,
14 since he was in the service that he ever gave me
15 any idea as to where his thoughts and his plans
16 were at. Because since he's been home from Iraq
17 he has had no plans. "It's a reasonable business.
18 I like art. My hours would be mine; no one in
19 charge of me; always changing -- plus it will give
20 me the opportunity to spend time with my girls. "
21 He does have two daughters, five and
22 three-and-a-half. "If my board does go through

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1 and I get a general discharge, I will do
2 everything the exact same way, only I will have to
3 wait 12 to 18 months. " I'm not for sure why that
4 12 to 18 months, but that's what he shared with
5 me. "I'm not a sissy. Sometimes I can and could
6 have been melodramatic over some things, but I've
7 never been a sissy. Mom, Dad, JJ -- I grew up
8 around you all, so it may just seem easier for you
9 all to have a better understanding of what I am

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10 going through than some sissy behind his desk
11 punching numbers and signing papers all day. "And
12 no one has a clue why it affects some people
13 greater than others. A little amusing, I guess --
14 I was sitting here thinking how to describe this
15 part of my issue. And the only way to compare it
16 is to compare it with prairie dogs. When you go
17 prairie dog hunting and you shoot the dog, his
18 family picks him up and drags him into the hole.
19 People who -- no offense -- go to war on TV claim
20 to understand. They put the yellow stickers on
21 their cars and trucks and pat themselves on the
22 back because they are patriotic. When people

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1 complain about the struggles they are facing
2 returning home, people are quick to boast: 'I
3 understand.' "People have no clue what it is like
4 to literally dodge bullets, to kill another human
5 being, to be on edge 24 hours a day, seven days a
6 week, 52 weeks a year; watching another human
7 being die, screaming in agony, holding his
8 intestines in his stomach -- and you know there's
9 absolutely no way this guy is going to make it
10 another 20 minutes, and you have to tell him,
11 'It's going to be okay,' over and over, so he
12 doesn't freak out. "Less than one-tenth of one
13 percent are in the armed forces. One percent of

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14 that will see, or have seen combat. "I sit inside
15 a jail cell, along with several other combat vets,
16 facing other-than- honorable to a punitive
17 discharge, because I didn't get the help I needed
18 when I got home from Iraq and I wound up using
19 drugs. Someone tell me why I have to lose so
20 much. "Every day hurts. Yet I go to some office
21 personnel telling my attorney 'Ain't no way in
22 hell he served honorably.' Who appointed some

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1 insensitive person in charge, anyway? "I am
2 scared to death of getting out of jail. What to
3 do? Where to go? What about Stella and Bella? I
4 am not a functioning adult and, Lord knows, Coco
5 isn't either. "People who boast about those
6 yellow ribbons should be required to write
7 Congress, and Senate and their governors one
8 letter for each ribbon, asking why there are still
9 soldiers like myself who are not receiving the
10 honorable respect they deserve." He put on the
11 bottom of his letter "KIA" -- which I had no idea
12 what that meant until today. "Specialist
13 Samuelson." Thank you for listening.

14 DR. MacDERMID: Thank you very much,
15 ma'am.

16 (Applause)

17 LTG KILEY: May I ask you a question?

18 First of all, thank you very much.
19 MS. SAMUELSON: (off mi ke)
20 LTG KILEY: I'm sorry?
21 DR. MacDERMID: Here, let me get you a
22 glass of water.

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1 LTG KILEY: Thank you for coming and
2 talking to us. And I am sorry that your son has
3 struggled this way. My question to you is: do you
4 have any insight, in terms of the details of why
5 he either didn't avail himself of mental health,
6 or he wasn't offer mental services or counseling
7 when he first returned. Or is this something that
8 snuck up on him? Do you have a sense of that at
9 all?
10 MS. SAMUELSON: All I can share with you
11 is what he has told me. I know when he came back
12 from Iraq we were asked, as family, to stay away
13 at least a month -- you know, because we lived in
14 different states. He got back to Fort Lewis --
15 because they wanted to give family -- him, his
16 wife -- a chance to get together, whatever type of
17 thing. About a week-and-a-half after he returned
18 home, he did share with me an episode at a gas
19 station. He was pumping gas in his jeep, and he
20 heard a motor, and he hit the ground. And when he
21 came to his sense, or whatever, you know he got in

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22 his jeep and had a meltdown. He called me. He

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1 told me about it. I know that they were focusing
2 a lot on -- he had counseling immediately, but it
3 was counseling for marriage. It was all about he
4 and his wife, and how he was supposed to, you
5 know, make his way back into the family unit.
6 They went to counselors. I know that they did.
7 He was not allowed to discipline those girls at
8 all -- I mean, for at least the first two months.
9 He was told he could not say anything. So I know
10 a lot of it was issues within his family unit. I
11 think the rest was just -- I don't know what
12 happened. I really don't. And then -- he had
13 signed up for five years, and when he came back
14 from Iraq they were going to get out of the Army.
15 And then he got to looking at all of it, and he
16 thought: "Well, if I get out of the Army, other
17 than benefits, what do I have to provide for my
18 family. Because all I've done is artillery." You
19 know -- he did the striker thing. So then when
20 somebody approached him about this whole striker
21 thing, and him being part of training, that really
22 interested him, and so then he decided to re-up.

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1 LTG KILEY: How long after he was back
2 did he re-up, do you know?
3 MS. SAMUELSON: Mmm -- it was probably
4 -- he got back in November, and I would guess that
5 he probably re-upped like in May. He had a
6 certain amount of time that he had -- you know,
7 there was like two times; you know, one time
8 within a certain amount, and then there was like
9 this other. And I think it was probably five, six
10 months, is what I'm thinking. And so then they go
11 on this family -- you know, he gets his break of
12 time before he's going over to Hawaii, and then
13 his wife informs him, "I'm not going with you, and
14 neither are the girls." So he decided to go
15 anyway. And I think it really came into play once
16 he got over there to Hawaii. He had several
17 change of commands over there -- I think three, at
18 least. The first one was awesome. He was so
19 happy, so pumped when he first got there. He
20 said, "These people understand me." He was -- he
21 was pumped. And then he got a change of command,
22 and his strikers didn't arrive, so his whole thing

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1 -- what job did he have to do? There wasn't

2 anything for him to do, except for -- look, as he
3 wanted to see doctors, and go and make
4 appointments. They just pooh-poohed him: "You
5 were just at the doctor last week." And this is
6 what he shares with me. Who knows whether all of
7 it's real.

8 LTG KILEY: Is he getting any counseling
9 now?

10 MS. SAMUELSON: I don't know. I know he
11 told me, when we were able to communicate with one
12 another, how he was asking for them to put -- you
13 know, he says, "Put me in some kind of a chemical
14 dependency program." You know, "Do something with
15 me. Help me." And they kept saying, "Well, we
16 don't have any resources for that. We don't do
17 that." You know. And he kept hearing many
18 different answers. And now that he's been shipped
19 from Hawaii back to Fort Lewis, I still -- my
20 husband hear from him two nights ago, didn't have
21 a whole lot of information; had to call collect --
22 I don't know why. Because he's got a calling

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1 card. But they must not let him use it. So I
2 don't know what's going on there.

3 LTG KILEY: How long is he going to be
4 in -- is he in jail?

5 MS. SAMUELSON: Yes, he is -- as far as

6 I know. I have no information. I really don't.
7 It's very frustrating to have gone that long and
8 not been able -- but I got the letter. I got a
9 second letter, too, but that one was almost -- it
10 was really la-la. It really was. Basically what
11 he said in there, though, was that he wished that
12 he would have died over there instead of coming
13 home to this.

14 LTG KILEY: Well, I'm sorry. Thank you
15 for answering that question. Any other questions?
16 (No response)

17 DR. MacDERMID: Our next speaker is
18 Brian Altman from the American Counseling
19 Association. Welcome.

20 MR. ALTMAN: Chairman Kiley, Chairwoman
21 MacDermid, and the entire Department of Defense
22 Task Force on Mental Health, my name is Brian

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1 Altman, and I'm speaking on behalf of the
2 American Counseling Association. The American
3 Counseling Association, known as ACA, is the
4 world's largest association exclusively
5 representing professional counselors in various
6 practice settings. The American Counseling
7 Association represents licensed mental health
8 counselors who work within the Department of
9 Defense, and service providers within the TriCare

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10 program Licensed mental health counselors are
11 the only nationally-recognized master's level
12 mental health providers within the DoD and Tricare
13 that do not have independent practice authority.
14 Our nation's military personnel and their families
15 deserve to have the best mental health care
16 available. The Department of Defense conducted a
17 demonstration project which allowed licensed
18 mental health counselors to practice independently
19 in two catchment areas. A Rand report evaluating
20 the demonstration project found that being in the
21 demonstration area was associated with greater
22 odds of favorably rating counseling and treatment;

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1 a greater chance of reporting an ability to
2 usually or always get urgent treatment as soon as
3 needed; greater odds of being able to usually or
4 always get an appointment as soon as desired; and
5 a greater chance of reporting the ability to get
6 help by telephone; as well as a lower risk of
7 never having to wait more than 15 minutes to see a
8 clinician. The Rand study also found that in the
9 demonstration area, the percentage of
10 beneficiaries seeing a psychiatrist, receiving
11 both therapy and medication, increased
12 significantly; and the beneficiaries seeing
13 licensed mental health counselors were more likely

14 to receive medications than were beneficiaries
15 seeing other types of mental health providers.
16 Based, in part on the Rand study, the House of
17 Representatives has included a provision allowing
18 licensed mental health counselors to practice
19 independently in the last two Department of
20 Defense authorization bills. Unfortunately, the
21 provision was not included in the final bill
22 either year. As Ms. Powell and Ms. Raezer

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1 indicated, updated DoD policy regarding LPCs is
2 supported by consumers. The National Military
3 Family Association supports allowing licensed
4 mental health counselors to practice independently
5 so that its members can have the best access to
6 mental health care possible. Also as Ms. Powell
7 and Ms. Raezer indicated, just before adjourning
8 the 109th Congress, the House and Senate passed
9 legislation -- passed 3421 -- that would allow
10 licensed mental health counselors to practice
11 independently in the VA, and hold positions
12 supervising other mental health professionals,
13 such as clinical social workers and psychologists.
14 This will increase the pool of high quality mental
15 health professionals available to serve our
16 nation's veterans, and lead to better quality
17 care. DoD mental health consumers should be given

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18 the same access to providers that also specialize
19 in PTSD and other mental illnesses associated with
20 individuals who return from combat. ACA urges the
21 DoD Task Force on Mental Health to recommend that
22 our nation's military personnel and their families

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1 have the best possible access to mental health
2 care by allowing licensed mental health counselors
3 to practice independently in DoD programs. That's
4 my prepared -- I also wanted to respond to the
5 question regarding levels of licensure, etcetera.
6 There is a very specific CFR within the Tricare
7 program that sets out exactly what qualifications
8 a licensed mental health counselor has to have in
9 order to become a Tricare provider. So following
10 the Federal preemption of state laws, not only do
11 licensed mental health counselors practicing in
12 Tricare have to be licensed by their state at the
13 independent level, but the Tricare CFR requires
14 that there be 3,000 of post-master's supervised
15 experience, and that you have a master's degree in
16 mental health counseling. So if there is any
17 variation between a level of licensure or
18 different states, it's all preempted by the CFR
19 regarding LPCs in Tricare.

20 DR. MacDERMID: Can I ask a question?
21 Because I don't know a lot about counselors of

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22 this variety. Can you talk a little bit about how

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1 the issues that you aim to treat, or the
2 approaches to treatment, might differ in any
3 systematic way from what we might see, for
4 example, among marriage and family therapists, or
5 master's level social workers?

6 MR. ALTMAN: There is not a tremendous
7 amount of variation. In other programs, as Ms.
8 Powell indicated, 90 percent of managed care --
9 FEHBP, etcetera -- the three groups are treated
10 essentially the same.

11 DR. MacDERMID: And is that 90 percent
12 of managed care programs? Or 9?

13 MR. ALTMAN: No -- 9-0 -- ninety.

14 DR. MacDERMID: Thank you.

15 MR. ALTMAN: So the only general
16 variations could be that, traditionally, clinical
17 social workers, or social workers in general,
18 maybe have an additional class, etcetera, focusing
19 on case management, as opposed to the clinical
20 psychotherapeutic course work. But all mental
21 health counselors, especially ones that would
22 treat within Tricare under the CFR, have the

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1 ability to do out-patient psychotherapy, focusing
2 on the same types of DSM-4 disorders as marriage
3 and family therapists and clinical social workers.

4 DR. MacDERMID: And would that include
5 PTSD?

6 MR. ALTMAN: Yes. Whenever we go to the
7 Hill, or meet with people at TMA, we always bring
8 our best practices in PTSD, journal articles. At
9 our conventions we consistently have continuing
10 education seminars or lessons for mental health
11 counselors who are working with veterans or active
12 duty military personnel and their families, to get
13 that continuing education on PTSD and treating
14 military families, etcetera.

15 DR. MacDERMID: And what, if any,
16 procedures does your association have in place to
17 discipline members who are found misbehaving; to
18 monitor competence of people who are licensed --
19 anything like that?

20 MR. ALTMAN: Well, ACA only has the
21 ability to do that for its own members. The state
22 licensure boards independently do the -- will

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1 discipline or revoke licensure in the states. If

2 they are members of ACA, then our code of ethics
3 was recently revived, in 2005. We have an ethics
4 offer on staff. There's an ethics committee that
5 reviews individual counselors who are members and
6 decides whether to revoke their membership. And
7 in the 22 states who have licensure boards that
8 have adopted the ACA code of ethics as their own,
9 there's interconnection in terms of communication
10 where, if an LPC board in a particular state has
11 revoked licensure, they will inform ACA that our
12 member has had their license revoked. And I
13 believe there is a reciprocal agreement that if
14 ACA has a revoked membership based on the ethics
15 committee recommendation, and the state has
16 accepted the ACA code of ethics, then we in turn
17 will contact the state and let them know that.

18 DR. MacDERMID: Thank you. Angela?

19 COL PEREIRA: Have you, as the
20 professional association, been able to gather
21 information from each of the states about their
22 licensing requirements and their licensing levels?

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1 Do you have that information?

2 MR. ALTMAN: Yes, we publish a document
3 -- the 2006 document was published in, I believe,
4 March; and our 2007 "Licensure Requirements for
5 Professional Counselors" will be released in late

7 COL PEREIRA: Is that specific for every
8 state?

9 MR. ALTMAN: Yes, it's a state-by-state
10 analysis of all the requirements to become a
11 licensed professional counselor.

12 COL PEREIRA: Could you make that
13 available to us?

14 MR. ALTMAN: Certainly. (Pause) Thank
15 you very much.

16 LTG KILEY: Thank you.

17 (Applause)

18 DR. MacDERMID: We have about 15 minutes
19 before we take a break. Is there anyone else who
20 was hoping to speak? (No response) In that case,
21 we'll take a break now. And we will reconvene at
22 3:00 p. m.

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1 (Recess)

2 DR. MacDERMID: Back on the record. I'd
3 like to welcome Mr. Richard Snider, with the
4 Noncommissioned Officers Association.

5 MR. SNIDER: I arrived late, and I
6 apologize for that, because this is a very
7 important meeting. In fact, it is a monumentally
8 important meeting to hear the words from my
9 colleagues and those that I will present to you

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10 from the Non Commissioned Officers Association
11 regarding mental health issues that we see. And
12 we're not doctors, we're not clinicians. We are
13 former NCOs, who have been there, who have done
14 the game, who have played the game. We were in
15 our own wars, and we know the experience, and we
16 know what we are looking for in our colleagues who
17 deploy and who come back. And I think that one of
18 the most important things that I have seen -- and
19 I speak now on behalf of our National Commander,
20 Gene Overstreet, a former sergeant major in the
21 Marine Corps, and on behalf of the service
22 officers that work with me with the Non

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1 Commissioned Officers Association. What we have
2 seen, there's been a tremendous impact on mental
3 health issues on all people -- active duty, Guard
4 and Reserve -- who have deployed to Iraq and
5 Afghanistan; a tremendous impact. And, you know,
6 I'm not telling you anything new. Because all of
7 this has been published. It's been published in
8 the New England Journal, it's been published in
9 the Post, The Times, in New York and Washington,
10 that they're seeing more and more people with
11 mental health issues coming back from this war
12 than any other. And I'm going to tell you
13 something: you in the armed services, the Guard

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14 and Reserves, the members of this committee, you
15 need to start making sure that your people are
16 taken care of, not only within your individual
17 service communities, but by the VA. What do I
18 mean by that -- "by the VA"? And why am I telling
19 you, the military, Guard and Reserve
20 representatives that. I guess I'm telling you
21 that for this reason: there have been more Guard
22 and Reserve deployed to the Gulf, or to Iraq and

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1 Afghanistan, than there have active duty people.
2 Yet, when you go over to VA, and you look at the
3 number of claims submitted that are based on
4 mental health issues, you find a
5 disproportionately smaller number of claims
6 supporting Guard and Reserve members who have been
7 overseas, who have had mental health issues, and
8 who have been demobilized, went back to their
9 units, and went back to their homes, went back to
10 their families. And they managed to screw up
11 their families. They managed to screw up their
12 employment. And they sought help from VA through
13 the two-year window of opportunity to go in. But
14 the number of claims supporting the number of
15 people are just not a match to what they should be
16 on an average with active duty military people.
17 They are not a match. They ought to be about the

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18 same percentage. In fact, if you deploy more
19 Guard and Reserve, it stands to reason that their
20 experience with terrorism -- their experience --
21 would mean higher numbers of Guard and Reserve.
22 You ought to be asking yourselves, as the DoD

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1 Mental Health Task Force: what the hell is going
2 on? What the hell is going on, that the numbers
3 don't match up? What is going on when you start
4 seeing statistics on homelessness. And I'll tell
5 you, we partnerships with Swords to Plowshares in
6 San Francisco, and we just got the first report of
7 putting a worker out in the San Francisco area to
8 talk with veterans returning from the war on
9 terrorism. I didn't expect they'd be busy.
10 Young, vibrant, active duty people separating. I
11 didn't think they'd be showing up on the streets
12 as fast as they have, or in the numbers that they
13 have. But we're seeing a population return that
14 is ending up on the streets, and ending up
15 homeless. There's something wrong with that
16 picture. We're seeing Guard and Reserve members
17 who were fully employed when they went to the war
18 on terrorism -- fully employed. And we're seeing
19 them come back saying, "Gee, I just don't want to
20 be in law enforcement anymore," "I just don't want
21 to do the job," "I want to do something

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1 front-line, intervention-type process that I'm
2 in," -- whether it's health care, whether it's
3 ambulances, whether it's police, sheriff, fire
4 departments or what have you. "I just don't want
5 to be there. I don't want to see any more of
6 that. I just don't want to be involved with it."
7 And they're contributing now to a growing number
8 of people who are leaving the employment that they
9 had, that they were guaranteed upon return, to
10 become job seekers. And you know the statistics.
11 Here again, you can ask (off mike) There's a void
12 for that group of service people, that age group,
13 getting back into the job market. And we're
14 seeing those people show up along with the other
15 people becoming homeless. You're seeing families
16 disintegrate because of war experiences. (off
17 mike) -- for you to do today (off mike) Why for
18 the Guard and Reserve? Why for the active duty?
19 (off mike) You know, as an association, NCOA, for
20 three years now has yelled at the VA, the
21 Department of Veterans Affairs, and said: you
22 people don't have the mental health care resources

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1 that you need to take care of the population. You
2 just are not equipped to handle the problem. And,
3 in fact, we spoke to VA and we said: you know, if
4 you look at mainstream America, and the medical
5 side of the house, you'll see that the medical
6 side of the house has integrated mental health
7 workers with the doctors in the primary care
8 clinics. And with no disrespect to doctors in
9 this room, the biggest stumbling block in VA has
10 been doctors to fully integrate the mental health
11 resources into the primary care clinics of VA.
12 And, in fact, we got a great report. You know,
13 after one of our hearings they came back to us and
14 they said: "Gee, we're covering x-number of
15 clinics, and we think that's great." "We're
16 covering them now like you wouldn't believe."
17 And, you know, the comedy of that was: it was
18 true. It was true. They had more mental health
19 workers in the clinics, around the country, than
20 they ever had. But you know the bad news for VA
21 was that -- I was a member, and still am, of the
22 Homeless Advisory Committee -- and we went out

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1 through Ohio, Cleveland, and some of the others.

2 We went to the hospitals. We met the directors of
3 the VA hospitals. And we met with mental health
4 practitioners. And when we left the hospital,
5 they left the hospital. And when we got to a
6 primary care clinic, they arrived at the primary
7 care clinic. And they worked there four hours a
8 week on a particular day. And when we left there
9 and went to a homeless shelter that had a VA
10 mental health practitioner -- by God, the guy was
11 parking right behind us, where he had followed us,
12 and we had followed him. And we all got out of
13 our cars. And I said, "How many damn clinics, and
14 how many damn homeless shelters are you actually
15 working mental health issues for?" And it was
16 like five. Well, you know, increasing the numbers
17 by five, at four hours a week, is BS. They don't
18 have time to spend with the troops. They don't
19 have time to spend with the troops -- whether it's
20 in the VA clinic, or whether it's in a homeless
21 facility supported with the intervention forces
22 that VA provides to them. They just don't have

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1 time to work with the troops. And our Guard and
2 Reserve -- worse ever. A military guy has the
3 advantage to come back to your hospitals or to
4 your clinic. But that member of the Guard and
5 Reserves, who comes out of rural America, and

6 comes back along with his patriots in arms from
7 the war; fills out a "questionnaire": answer "no,"
8 you're on your way; answer "yes" and you're
9 probably going to have to stay a little bit longer
10 in the process of demobilization then go on home.
11 And guys say, gee -- and gals say, gee -- it's
12 kind of stupid to put a yes down, and say "I just
13 don't feel right," "I don't sleep right," "I'm
14 having problems at night," "The times I've
15 communicated with my wife I didn't know what to
16 say to her. When I wrote back to the kids I
17 really didn't know what to say, other than 'Hello,
18 it's your Dad. I hope everything's fine. See you
19 soon.'" And when they got back home they couldn't
20 relate to their families. They could not relate to
21 their families. They weren't prepared to return
22 to their families. Here's something you all could

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1 do better, in my personal judgment. We talk about
2 Guard and Reserves and how great they are. And
3 they are great. But we're not taking care of
4 them, in my judgment, and in the view of our
5 association, well enough when they come back. And
6 whether they have a transition program, 30 days or
7 a month after they come back, we're not doing
8 enough to talk to the individual soldiers, the men
9 and women; to talk and find out about how it is

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10 really going. You know the crazy thing right now?
11 -- and I'm sure it was brought up today, either at
12 this table or in your earlier part of the
13 meeting -- Senator Dodd from Connecticut making
14 the statement of one of his troops coming back to
15 Connecticut. And in the process of the past year
16 or so, being rated 70 percent for mental health
17 issues, post traumatic stress, and being recalled
18 by the unit for another deployment. And Senator
19 Dodd's letter to the Secretary of Defense --
20 Gates, now -- just this week, raising the
21 question: can't we do a better job of screening
22 the people we're bringing back for second and

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1 third tours of duty? And, by God, I'll tell you
2 what: he's absolutely right. Can't we do a better
3 job? And, you know, DoD just impressed the hell
4 out of me. The Assistant Secretary of Defense
5 sent a letter out to all the service departments
6 just this past week, on psychiatric conditions,
7 and medications that ought to stop a person from
8 deploying on another assignment to Iraq,
9 Afghanistan or the war on terrorism. And I know
10 you've all seen that: what drugs they are not
11 allowed to have or be prescribed for them, and to
12 be re-deployable. You know, it's great that
13 you've done that. But I'm going to tell you the

14 other side of the coin -- and there is another
15 side of the coin. And that side of the coin is:
16 those active duty troops, whose medical records
17 are military medical records are going to see the
18 restrictions on future deployments. And they're
19 going to weigh in their mind's eye the weight of
20 that restriction and non-deployable status on
21 their career, and future career within the
22 military; and they're already going to question

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1 whether or not they're going to be meeting the
2 disability severance board, disability separation
3 -- 14 years of service, 12 years, eight years,
4 "I'm going to have a career. I'm going to serve
5 America. I'm going to do the right thing." And
6 now they're faced with an issue that if they go to
7 mental health they may end up losing the career
8 that they have fought to earn, to keep and to
9 proceed in, and to be a member of the armed forces
10 world. And so I caution you, just in the words of
11 one old guy who's been there and watched it
12 happen -- I watched it in Gulf War I, I watched it
13 with the term "undiagnosed illnesses." An
14 "undiagnosed illness" for any man or woman going to
15 clinics put them into a mental health strain, put
16 them into a process where they were starting to be
17 looked at for separation. And I think we need to

18 be very, very careful. We recommend that you look
19 at this area also; that you look at this area.
20 Because the fact is, our (off mike) So, on behalf
21 of the Association, if I were to say something to
22 you right now: we want you to continue providing

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1 the health care for our military people. We
2 strongly support your emergency services
3 throughout the war. But we want you to look a
4 little bit closer at people who are going back to
5 war, to people coming home from the war; and we
6 want you to follow-up better on the Guard and
7 Reserves who have been there, are now separate for
8 where active installations are -- rural America --
9 and don't have access to all the things that are
10 happening. And then I'd like you also to look at
11 the issue of homelessness for our young American
12 veterans; the people who made the decision, "I'm
13 not staying. I'm getting out. I'm going to go to
14 school -- I'm going to do this, I'm going to get a
15 job, I'm going to do a thousand and one things.
16 But look at the conditions of those young
17 veterans, the jobs that they're not going back to
18 from the Guard and Reserve; the job that a veteran
19 cannot achieve in the marketplace because he has
20 some hangups -- perceive hangups (off mike) And so
21 we'd like you to look at those things. We'd like

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22 you to talk about them. We'd like you to argue

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1 over them. I'd like the two co-chairmen to say,
2 "Dick Snider, you're full of crap. And take this
3 thing out of here." Well, I'm sorry, I'm not
4 going to give you that opportunity. I'm going to
5 lay it on the table, and you can document your
6 answer back to me, and we'll provide an answer
7 back to you all. But, you know, I've got to tell
8 you -- I've got to tell you: when I meet young
9 people that are screwed up, it bothers me. When I
10 look at suicides taking place among veterans of
11 the war on terrorism, it bothers me. When I look
12 at homelessness, it bothers me. And when I have
13 young mothers calling my office as a service
14 officer for NCOA -- I have young mothers calling
15 me saying, "Can't you do something to help us? My
16 husband has a claim in. It's not being processed.
17 It's been a year -- it's been two years -- and we
18 haven't heard anything." It seems to me they may
19 have separated from the military -- they may have
20 separated from the military -- but it seems to me
21 you have an obligation to level your bayonets at
22 VA and say, "Let's move those claims. Let's get

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1 these families of people taken care of. Let's get
2 them the benefits that they are entitled to." And
3 I think we just cannot afford to wait. We cannot
4 afford to wait. We need to step out. You have
5 stepped out well (off mike) You have stepped out
6 well in trying to save lives. And, by God, I
7 commend the Army, the Marine Corps, the Navy; I
8 commend you in your emergency rooms throughout the
9 theaters that bring the troops back here so
10 quickly. But, you know, a troop who comes back to
11 Walter Reed, or Bethesda, or one of our other
12 premier locations right now, don't number in the
13 multi-thousands, multi-multi-thousands. They
14 number at a level that is workable by the system
15 -- and that's cute. But I'll tell you something:
16 for the hundreds of thousands that are coming back
17 with mental health, and post traumatic stress, and
18 other -- quote -- "exotic" injuries from the war,
19 they need to be looked at better, and they need to
20 be worked better by the VA. And I think it's time
21 that DoD and VA begin a more active collaboration,
22 and begin the process of talking about (off mike)

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1 And I'll tell you something: if you come back to

2 me and tell me, "Dick, you know, we've got a
3 seamless transition." I'm going to tell you: it's
4 so seamless, nobody knows it's out there. We've
5 got to fix that. Let's get that bloody thing
6 fixed. Let's get it working. Let's take care of
7 the troops. And I'll tell you something: the
8 story that -- "Well, they're no longer with us.
9 They separated. They got their discharge
10 certificate." That shouldn't mean anything to the
11 leadership of the Department, the military
12 departments. What should matter are the lives of
13 those soldiers and sailors and airmen and Marines
14 and their families, because of the impact of war,
15 and the fact that a grateful nation kind of let's
16 them do their own thing and flounder out there
17 while they're being taken care of by other (off
18 mike) That's what I'd like to tell you today. And
19 I know you probably don't appreciate it. You're
20 probably saying your facts are wrong. Well,
21 that's great. Say it all you want. But, by God,
22 I said it, you heard it, and let's see what

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1 happens next. Thank you.
2 DR. MacDERMID: Thank you Mr. -- oh,
3 don't run away. Thank you very much. I have one
4 question, and then other members may have
5 additional. We, too, are very concerned about the

7 unevenness of the supply of mental health
8 providers around the country -- for both Guard and
9 Reserve, and also active duty families. There's a
10 lot of variability in what's available,
11 particularly in remote areas. Do you have any
12 suggestions for us -- or ideas for us -- about
13 recommendations that we could make that would help
14 to counteract that problem?

15 MR. SNIDER: I do.

16 DR. MacDERMID: Would you be willing to
17 tell us what they are?

18 MR. SNIDER: I'd be happy to do that.

19 DR. MacDERMID: Well, thank you so much.
20 Please do.

21 MR. SNIDER: Thank you for asking. I'll
22 tell you, one of the other VA advisory committees

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1 that I was assigned to for the Secretary of
2 Veterans Affairs -- and I was on the committee for
3 about nine years it was Readjustment Counseling
4 Service. These were the Vietnam Era Vet Centers,
5 the storefronts across America; rural, cities
6 located a distance from VA medical facilities,
7 because my generation didn't trust VA. My
8 generation didn't trust the institutions. My
9 generation didn't think much of government and its

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10 actions. Vet Centers were established with people
11 who were not all professional mental health
12 counselors. But the requirement at that point in
13 time was that they had to be veterans; they had to
14 be combat veterans; they had to walk the walk and
15 do the talk. And these people were assigned to
16 Vet Centers across the country, and they
17 marvelously transition lives coming and needing
18 counseling, needing resources; getting them from
19 beyond the intimate individual group counseling
20 process to the resources that were needed at the
21 Department of Veterans Affairs, or other community
22 resources that were available to them where they

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1 lived. And I would say that we ought to beef up
2 Vet Centers, on the VA side, and you all ought to
3 look at that model, and you ought to talk with the
4 folks at RCS over at VA, and just get a briefing
5 from them on what is happening. Because I'm going
6 to tell you: whether you like it or not, your vets
7 are showing up today in the Vet Centers. And
8 they're going in for counseling. They're going in
9 for coffee, and they're going in for talk. And
10 you know there is nothing more healthy than coffee
11 and talk with somebody who cares. And I would
12 share with you that the Vet Center program, in my
13 judgment, was wonderful -- was wonderful. And I

14 have visited Vet Centers across the country,
15 Alaska. And I can tell you what: they have solved
16 the problems for a lot of lives. One thing the
17 Vet Centers could do that VA could not do, and
18 that was to bring families into the process. And
19 that was dramatic. Now, you can say: well, you
20 know, we've got our family support centers, and
21 they do a great job. But it's not dealing with
22 the same type of issues, at the same level of

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1 concern for that individual veteran. And I think
2 that the Vet Center has proved that it's workable.
3 And until you get more people qualified in mental
4 health, I would augment the hell out of these
5 locations and get people into them that could
6 provide that service.

7 DR. MacDERMID: Thank you. Any
8 additional questions? (No response)

9 DR. MacDERMID: Thank you very much for
10 your contribution.

11 (Applause)

12 DR. MacDERMID: I believe it's the case
13 that there are not additional people who wish to
14 address the Task Force. And if that's the case,
15 we'll ask Colonel Davies to adjourn the open
16 session; the Task Force members will go to
17 Executive Session. And if others arrive who wish

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to speak, then we'll return to open session.
19 COL ORMAN: (off mike)
20 DR. MacDERMID: I'm sorry?
21 COL ORMAN: (Off mike) Is there a time
22 limit?

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1 DR. MacDERMID: Well, the posted
2 schedule says 'til 5:00. But a bird just
3 whispered in my ear and said "4:15." A big bird.
4 (Laughter)
5 DR. MacDERMID: Yes, sir?
6 MR. POGANY: Thank you. I have an
7 answer for your question -- or I think I might
8 have an answer. A question that you asked earlier
9 was: how can we fix the problem, or start to
10 address to fix the problem that the advocacy group
11 brought up. I think you can start fixing it by
12 bringing in people, veterans, professional trauma
13 experts, into the installations, and making a
14 position or some sort of a job of an ombudsman;
15 somebody that the family member and the service
16 member can have direct contact with to address the
17 issue; somebody that can address the command;
18 somebody that does not necessarily to that command
19 but has direct contact with top-level leadership
20 and can provide services, can provide resources,
21 get them connected, and walk them through the

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process. Because that's what I encountered that

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1 they need. They need someone to help them with
2 individually tailored reintegration. So, just
3 like the Vet Center has positions of G&O outreach
4 coordinator, the OD should have reintegration
5 coordinators -- somebody that they can come to,
6 somebody they can trust. Because trust is a big
7 issue. Somebody that can broaden the services.
8 Thanks.

9 DR. MacDERMID: Thank you. Colonel
10 Davies?

11 COL DAVIES: Are there any other
12 presenters?

13 MR. SULLIVAN: I'm Paul Sullivan, from
14 Veterans for America. I wanted to finish up the
15 question that General Kiley asked when we were
16 running out of time, regarding VA and what they
17 were doing behind the scenes. Part of what's
18 going on -- the biggest problem -- is that VA has
19 not publicized or announced that they have any
20 comprehensive plan for the returning veterans.
21 Okay? I sat in on briefings for the Joint
22 Executive Council, and for the Benefits Executive

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1 Council. I sat in on those. And what I found was
2 there were a lot of people who were talking about
3 problems -- myself included -- and presenting
4 ideas for action, but none were being implemented.
5 I can give you three of the things that we brought
6 up; that were brought up and have not been
7 implemented. The first is very simple: there's no
8 definition for the war. Right now -- you're
9 looking at me and shaking your head -- as somebody
10 who went to the war, do you only count the people
11 in Iraq and Afghanistan? Or do you also include
12 Kuwait and Qatar, Oman and other countries? So
13 until VA knows who was in the war and who wasn't,
14 for the collection of data and preparation of
15 reports, how do you know if your mental health
16 case is from somebody in Kuwait, or somebody who
17 was doing IED convoys in Iraq? So that's the
18 first thing -- very easily fixed by coming up with
19 a definition for the war. Because if you want to
20 know who it is you're talking about, you need a
21 definition. And then once you have that
22 definition, you can collect the information: who

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1 are these people going to the war? Are they

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2 average age 20, or are they average age 25? Is
3 the Reserve different than the National Guard
4 different than active duty? Are there more women?
5 Is it changing over time? We did a snapshot
6 profile. We found that the number women deployed
7 is going down. We did a snapshot and found the
8 number of Blacks deployed is going down, but the
9 number of Hispanics is rising. So those kind of
10 changes in information, you need the definition,
11 you need the data collection. That's simply not
12 happening. VA will tell you: oh, we get a little
13 bit of data from DoD. But they don't have enough
14 data to find out what's going on. The second is:
15 we were also preparing an entire suite of reports.
16 What are these veterans doing when they hit VA?
17 How many are seeking counseling? How many are
18 using the hospitals? How many are filing claims?
19 We had actually put something together as a
20 comprehensive plan -- get this -- starting in
21 October 2001, to start monitoring this. And every
22 time we came up with the idea when there was a

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1 change in leadership, in executives or political
2 appointees, they'd look at it and say, "It's a
3 great idea," and then put it on the shelf. That's
4 why VA has no idea of really what's going on. The
5 third idea for a plan that VA didn't do anything

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6 with was a casualty tracker. And I was the
7 project manager for that, as well. All these
8 three items I was the project manager for. And
9 this project basically did this: when a service
10 member was wounded in action, for any reason --
11 mental health or physical -- and brought to Walter
12 Reed or Bethesda, or any of the other military
13 treatment facilities in the country, VA would be
14 notified. So that if they needed a health care
15 person from VHA, a social worker, or if they
16 needed a benefits counselor to help them start the
17 VA transition process, they were right there at
18 the applicable time with the family. Not right
19 away -- okay. You need the guy to recover for a
20 little bit. But when the discharge process
21 starts, make sure that they're involved. Instead
22 of filling out 20 or 30 different forms for all

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1 the different kinds of VA benefits -- health care,
2 a ramp to your house, disability benefits, Vet
3 Centers, you name it -- it would all be done on
4 one form. This was the first time all of those
5 stovepipes were eliminated and there was one data
6 collection instrument. There were even reports
7 that told you who was using this, what was VA
8 doing, what were the results. All of that was put
9 on the shelf. More than a million dollars was

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10 spent to make sure that we had a project and knew
11 who all the casualties were. And what happened
12 was the political appointees came in put it on the
13 shelf. In fact, what it tells the people like me,
14 who are the career employees when I worked at VA,
15 is that VA really wanted to close their eyes to
16 the problem. So -- there are some great people
17 providing care to the veterans when they get in.
18 And the doctors are great. I've been to lots of
19 Vet Centers, I've been to lots of hospitals; I've
20 been to the regional offices where they process
21 the claims. All those folks are doing a
22 tremendous job. What you have are blinders at the

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1 top. They really didn't want to see this. So --
2 again, what VA really needs is a comprehensive
3 plan. They have a lot of these tools sitting on
4 the shelf that could make the cooperation between
5 VA and DoD much stronger. They're choosing not to
6 do that. Someone needs to bring these things back
7 up on the table and say: "why aren't you
8 implementing these? If they're not good enough,
9 make them better. But otherwise, start doing some
10 of the things that they need to be doing."
11 Because if they don't know how many patients are
12 going to come in, they're not going to have the
13 right people on staff, and then the veterans are

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14 going to fall through the cracks. So -- thanks

15 very much. It's a longer answer.

16 LTG KILEY: No, that's good. Thank you.

17 MR. SULLIVAN: The bottom line is the VA
18 just simply doesn't have a plan.

19 LTG KILEY: Okay. Thank you.

20 DR. MacDERMID: Thank you.

21 MR. POGANY: This is Andrew Pogany,
22 Veterans for America. I wanted to address two

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1 more programs. And this is all just coming out of
2 interacting with soldiers, talking to them, and
3 finding out: where do you get your services? What
4 programs do you know about? The Army Wounded
5 Warrior Program -- the Army Wounded Warrior
6 Program is an awesome concept, an awesome idea.
7 It is helping soldiers. But it is not reaching
8 the ones that need the help. When I got educated
9 by the sergeant major who runs that program and
10 Colonel Carstonson, their eligibility criteria
11 limits soldiers very, very much. They have
12 explained to us that the two signature injuries
13 that they treat and see people for are traumatic
14 brain injury and PTSD. However, in order to be
15 eligible for the Army Wounded Warrior Program, you
16 have to receive a 30 percent disability rating
17 from the PEB. And that 30 percent disability

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18 rating has to be for a single injury. So if you
19 are injured, or rated 10 percent for your knee, 10
20 percent for your eyeball, and 10 percent for PTSD,
21 you're not eligible for Army Wounded Warrior
22 Program. So if that can possibly be addressed and

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1 changed -- because it seems almost like the
2 Wounded Warrior Program misses the people that
3 need the care the most, and they only, with their
4 eligibility criteria, are able to pick up the ones
5 that actually get a lot of the care already. And
6 then also for the Military One Source program,
7 when it comes to the issue of stigma, soldiers are
8 very reluctant to access Military One Source for
9 mental health services because of the six-visit
10 limitation. To address the issue of stigma --
11 I've asked around over and over and over -- and
12 the answer has come up: hey, if we could go to
13 Army One Source, or Military One Source and seek
14 mental health services through them, and have
15 unlimited access, we'd go immediately. But, now I
16 can go six times. Then I've got to go back to my
17 MTF, then I've got to go back to my unit. And
18 the issue of stigma is still there. That's what
19 soldiers are reporting. Now, then, there's the
20 issue that they can access Military One Source for
21 six times for each issue, which is great on paper.

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1 combat stress, he doesn't know how to
2 differentiate between his depression, his anger,
3 his marital problems. They just go in and say, "I
4 have problems." And the lack of education for
5 them to be able to access it, knowing that it's
6 for each issue is a problem also. I've also
7 called One Source several times, and I've been
8 informed that Military One Source mental health,
9 worldwide, has 82 providers in their network that
10 provide care on the ground. We've attempted to
11 get providers that are in our network -- we still
12 have a provider network of mental health care
13 providers in the community that provide services
14 for free. Some of those have attempted to become
15 Military One Source providers, and they cannot.
16 And apparently the reason they are not able to do
17 that is because one of the requirements of the
18 company that owns the contract -- which is a
19 Canadian company that deals with employee
20 assistance programs -- because the requirement is
21 that they have to have three years of employee
22 assistance program experience, and a lot of

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1 providers don't have that. So, again, it's an
2 eligibility criteria that limits providers from
3 getting into that program. If this panel and this
4 Task Force can address those issues, it would be
5 greatly appreciated. Thank you.

6 COL CAMPISE: Now, who was it that told
7 you those requirements?

8 MR. POGANY: The people that answer the
9 phone for Military One Source; the call center,
10 the master's level providers.

11 COL CAMPISE: I've never heard that
12 requirement. In every installation we've gone to,
13 people have praised the fact that they have
14 immediate access to Military One Source whenever
15 they called, within 48 hours, they have an
16 appointment. So it's hard to believe that they
17 would have a network with only 82 people.

18 DR. McCURDY: But the contract does not
19 say "mental health care." It, in fact,
20 specifically exempts mental health care and it
21 deals with other kind of life-management issues.

22 LTG KILEY: You can't go to Military One

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1 Source (off mike).

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DR. McCURDY: You can't get treatment

there. It's non-Tricare reimbursable diagnosis.

MR. POGANY: And what you said,

Lieutenant General Kiley, is exactly what they're looking for. So if the mental health care piece can maybe be extracted and a program can be stood up that is called "combat stress," and then you augment that with "combat stress" or something outreach coordinators, directly in view of the full units that come back, I think we could accomplish a lot. Thank you for your time.

LTG KILEY: Thank you.

(Applause)

COL DAVIES: Before we close, is there anybody else that wants to present? General Kiley, Dr. MacDermid, Task Force -- this open session is officially closed.

(Whereupon, at 4:00 p.m., the

PROCEEDINGS were adjourned.)

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