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THE DEPARTMENT OF DEFENSE

TASK FORCE ON MENTAL HEALTH
A subcommittee of the Defense Health Board

February 26, 2007

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1 PARTICIPANTS:

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2 LTG KEVIN KILEY
3 COL. JEFFREY DAVIES
4 DR. SHELLEY MacDERMID
5 COL. ANGELA PEREIRA
6 DR. DICK McCORMICK
7 COL. DAVID ORMAN
8 DR. ANTONETTE ZEISS
9 LT. COL. JONATHAN DOUGLAS
10 DR. LAYTON McCURDY
11 CPT. WARREN KLAM
12 DEBORAH FRYAR
13 RICK CAMPISE
14 DR. DANIEL BLAZER
15 LCDR AARON WERBEL
16 DR. THOMAS BURKE
17 MAJ. CLEMENS PRESOGNA
18 SUMATHY REDDY
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20 MARY CARSTENSEN
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1 P R O C E E D I N G S
2 LTG KILEY: Good morning to everyone.
3 We seem to have been pretty successful in getting
4 most all of the members of the Task Force here
5 despite some weather challenges. I think our two
6 missing in action should be here; Doctor McCurdy
7 and Doctor MacDermid will be here later this
8 afternoon.

9 I'd like to hit the gavel, ask everyone
10 to be seated. It looks like we're ahead already.
11 And welcome all of you to this open session of the
12 Department of Defense Task Force on Mental Health.
13 This Congressionally mandated task force asked to
14 look into the current military health care system.
15 And the overall intent of our visit here today is
16 to gain insight into that system and ultimately
17 provide Congress with recommendations for areas of
18 improvement, but also to acknowledge areas that
19 are flourishing.

20 we have several important topics on our
21 agenda for today, so let's get started. Ms. Ellen
22 Embrey, the Designated Federal Official for the

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1 Task Force's parent Federal Advisory Committee,
2 the Defense Health Board, had an unavoidable
3 conflict and will not be able to attend this
4 meeting. In her absence, she has appointed
5 Colonel Jeffery Davies, the Army Surgeon General,
6 my Executive Officer, as the alternate Designate
7 Federal Official. Colonel Davies, would you
8 please call the meeting to order?

9 COL. DAVIES: Thank you, General Kiley.
10 As the Acting Designated Federal Office for the
11 Defense Health Board, a Federal Advisory Committee

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12 to the Secretary of Defense, which serves as a
13 continuing scientific advisory body to the
14 Assistant Secretary of Defense for Health Affairs
15 and the Surgeons General in the Military
16 Departments, I hereby call this meeting to order.

17 LTG KILEY: Okay. Thank you, Colonel
18 Davies. Let me start the next phase of this by
19 asking -- we're going to ask to go around the
20 table and do introductions. Jeff, if you'd go
21 ahead and start.

22 COL. DAVIES: Yes; I'm Colonel Jeff

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1 Davies and I'm the Acting Designated Federal
2 official for the meeting.

3 LTG KILEY: I'm Doctor Kevin Kiley, Army
4 Surgeon General, Commander, U.S. Army Medical
5 Command, and one of the co- chairs, along with
6 Doctor Shelley MacDermid who'll be here a little
7 bit later.

8 DR. MCCORMICK: I'm Dick McCormick, a
9 clinical psychologist, one of the civilian
10 members.

11 COL. ORMAN: My name is Dave Orman, I'm
12 a military Army psychiatrist.

13 DR. ZEISS: I'm Doctor Antonette Zeiss,
14 I'm a clinical psychologist, and I represent VA on
15 this Task Force. I'm the Deputy Chief Consultant
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16 in the Office of Mental Health Services here in
17 Washington, D.C. for VA.

18 LT. COL. DOUGLAS: I'm Lieutenant
19 Colonel John Douglas, Headquarters Marine Corps,
20 Manpower Reserve Affairs.

21 CPT. KLAM: I'm Doctor Warren Klam, I'm
22 a Navy psychiatrist.

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1 MS. FRYAR: Deborah Fryar, I'm the
2 family member representative on the Task Force.

3 MR. CAMPISE: Good morning; Rick
4 Campise, a pediatric psychologist.

5 DR. BLAZER: Good morning; I'm Dan
6 Blazer, I'm a psychiatrist epidemiologist from
7 Duke. I am also a civilian member of this Task
8 Force, but also I am the liaison of this Task
9 Force to the oversight board for this Task Force,
10 that's the Defense Health Board, I'm a member of
11 that Board.

12 LCDR WERBEL: Good morning; Lieutenant
13 Commander Aaron Werbel, I'm the Behavioral Health
14 Affairs Officer at Headquarters Marine Corps and
15 the Marine Corps Suicide Prevention Program
16 Manager.

17 LTG KILEY: Okay, thank you. Now I'd
18 like to ask Doctor Burke to come forward and make

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19 some administrative announcements, if you would,
20 please.

21 DR. BURKE: Thank you, General Kiley.
22 Good morning and welcome to everyone. would you

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1 please, if you haven't done so already, please
2 sign the general attendance roster on the table
3 outside. we will be transcribing this open
4 session, so please use the microphones when you're
5 speaking and clearly state your name. The
6 transcripts will be published on the Task Force
7 web site within 90 days of this meeting. we would
8 request you be mindful of the other attendees here
9 and allow those who are speaking courtesy and
10 respect. Restrooms are located in the main
11 hallway, down the hallway to the left. And if
12 there are any administrative requirements, please
13 see Ms. Farrell in charge of audio/visual or Ms.
14 Severine Bennet in the table in the main hallway.
15 Thank you, General Kiley.

16 LTG KILEY: Okay. Thanks, Doctor Burke,
17 I appreciate that. I'd also like to note again
18 that anyone can submit testimony to us online.
19 Now, our first speakers today are Colonel Reddy
20 and Major Presogna, who are here from the U.S.
21 Army Reserve Command to give us a short lay down
22 on their issues, concerns, recommendations to the

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1 Task Force from the perspective of the U.S. Army
2 Reserve Command. Colonel Reddy, or whoever, the
3 floor is yours.
4 MAJ. PRESOGNA: Good morning, General
5 Kiley, members of the Task Force and guests. My
6 name is Major Clem Presogna, I'm with the Army
7 Reserve Command Surgeons Office headquarters in
8 Fort McPherson in Atlanta, Georgia. What I'm
9 going to cover is the phases of deployment for
10 Army Reserve soldiers and the ability that we have
11 to identify mental health issues and the process
12 by which we provide care to them during those
13 phases.
14 During the pre-deployment phase that's
15 before mobilization, soldiers are identified
16 through the pre-deployment health assessment,
17 which is a screening exam that soldiers receive
18 during pre-deployment to identify any medical or
19 mental health issues, also,
20 soldier/buddy/commander reporting that can occur
21 during that time phase. The Annual Medical
22 Certificate, which is an annual medical

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1 declaration that Army Reserve soldiers identify
2 any medical problems that they have during a
3 pre-deployment time period.

4 And also, we talk about the future as
5 the periodic health assessment which is phasing
6 into action now which replaces the every five year
7 physical exam, it'll be an annual exam which will
8 include specific mental health screening
9 questions.

10 Under the provision of care for Army
11 Reserve soldiers during the pre-deployment time
12 period, we have early TRICARE, which is a 90 day
13 pre-MOB TRICARE benefit for soldiers and family
14 members, we have the Line of Duty, which a Line of
15 Duty is a provision of medical care which finds a
16 mental health or medical problem in a reserve
17 soldier occurred in the line of duty, or it was
18 identified with their ability to function in the
19 Army Reserve, and that provides care for the
20 soldier for that specific injury. Also, soldiers
21 have employer/personal insurance or self-pay, and
22 of course, that's an issue area.

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1 During deployment or mobilization of an
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2 Army Reserve soldier, identification of mental
3 health issues occurs during medical screening at
4 the mobilization station under what's called the
5 25 day rule. And as a part of the 25 day rule,
6 the soldiers are examined within the first 25 days
7 of their I guess getting to the MOB station, and
8 if a medical or mental health problem is
9 identified during that time period, then the
10 soldier can be released from that mobilization,
11 returned to the Reserve Forces as a Reserve Forces
12 member, and then becomes the asset again of
13 the Reserve Forces. Also, there's a
14 soldier/buddy/ commander reporting which is going
15 to occur during all times.

16 But under the 25 day rule, the provision
17 of care is a little different. If it's a
18 pre-existing problem, in other words, if the
19 problem is not related to the soldier's military
20 service or his military functions and there's no
21 Line of Duty written for the soldier in relation
22 to that identified mental health issue, then the

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1 soldier has to rely on their employer or personal
2 insurance to cover the care needs or self-pay. If
3 it's a Line of Duty injury or identified through a
4 Line of Duty, then the soldier would receive care

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5 through the Line of Duty provision of care.

6 At demobilization, after the
7 mobilization and upon returning to home, the
8 identification of mental health issues starts with
9 the post-deployment health assessment which occurs
10 in country prior to the soldier returning to the
11 Continental United States; also, again, the
12 soldier/buddy/commander reporting and the de-MOB
13 Station processing, which is another review of the
14 soldier's medical and mental health issues.
15 Provisions of care under the de- MOB Station or
16 return to CONUS issue includes Medical Retention
17 Processing which is a voluntary program. Reserve
18 component soldiers must voluntary to remain on
19 active duty for the provision of care for their
20 medical or mental health issues that were related
21 to their deployment, and it continues to maintain
22 them in an active duty status in Medical Retention

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1 Processing, in a medical hold-over status.

2 There's also the TRICARE benefit which
3 soldiers would receive and continue to use. The
4 Line of Duty type care is also always available,
5 the VA employer or personal insurance, and of
6 course, self-pay.

7 During the post-deployment phase, this
8 is after the soldier returns to the Reserve

9 Forces, is now back into his home unit, drilling
10 on his battle assemblies, and has -- after 90 days
11 of return to country, the soldiers -- all soldiers
12 that have been mobilized complete the
13 post-deployment health reassessment, which is
14 another tool, another screening tool used to
15 identify medical and mental health issues that
16 soldiers may have occurred or suffered from during
17 their deployment phase; also
18 soldier/buddy/commander reporting and family
19 reporting comes and plays an important role at
20 this time.

21 One of the new avenues of identification
22 and some intervention includes Battlemind

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1 training, which Major Thomas will be covering
2 after me. Some other issues with post-deployment
3 mental health care include the Medical Retention
4 Processing 2. MRP 2 is another opportunity for
5 reserve component soldiers to apply to return to
6 active duty status, to receive medical care for
7 their medical and mental health issues that were
8 related to their mobilization. It's a voluntary
9 program and they do have to have a Line of Duty
10 indicating that an injury did occur during the
11 time that they were mobilized.

12 There are also the Line of Duty care
13 through the Military Medical Support Office;
14 there's also the TAMP benefit. TAMP is a
15 Transitional Assistance Management Program which
16 provides TRICARE medical benefits for soldiers and
17 their families for six months after they're
18 released from their mobilization.

19 There's also TRICARE Reserve Select;
20 TRICARE Reserve Select, again, is another
21 voluntary program and it's a fee based program for
22 reserve component soldiers. The soldier must pay

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1 a cost share with the federal government for the
2 TRICARE Reserve Select coverage.

3 There's also VA care for two years after
4 mobilization for soldiers, and VA care for life
5 for combat related injuries or conditions that
6 have been identified. Also, local military
7 treatment facilities; if a reserve component
8 soldier lives within the catchment area, a 50 mile
9 area around a military medical treatment facility,
10 they can also apply their for care and receive
11 care. Military One Source, which is a web based
12 contact or also telephone contact system that can
13 provide some mental health treatment for soldiers
14 and family members. Hooah 4 Health is a CHPPM
15 sponsored web site that can provide some

16 additional information for soldiers related to
17 mental health care. The Army Reserve Family
18 Program, which has been very instrumental in
19 helping us with the IMA, Individual Mobilization
20 Augmentee, and IRR, Individual Ready Reserve
21 soldiers, in contacting them, keeping them
22 informed of their benefits, and continuing to

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1 identify issues that may arise during the
2 post-deployment period.

3 We also have the Military and Family
4 Life Consultants Program which we're getting good
5 feedback on, it provides anonymous confidential
6 support to soldiers and their families, and
7 Operation Ready, which is a trainer type program
8 which provides some resilience training for
9 reserve component soldiers.

10 Also, during the time period when
11 soldiers are simply in the reserve components, on
12 an annual basis, they receive an Annual Suicide
13 Awareness and Prevention training, which is a part
14 of annual training issues that soldiers receive.
15 There's also a referral to chaplain and/or
16 appropriate medical health care professionals if
17 notified at risk during a drill weekend or a
18 battle assembly.

19 And also, unit command structure and
20 family readiness support groups provide ongoing
21 support to soldiers when issues are identified.
22 And I'll be followed by Colonel Reddy.

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1 COL. REDDY: In addition to what Major
2 Presogna said, we also have management enrichment
3 retreats and single soldier retreats for returning
4 soldiers, and these occur within three months
5 after they come back, and it is sponsored by the
6 chaplain's office. We've had a very good feedback
7 on that. It basically concentrates on
8 communication skills. Next slide, please.

9 I basically am going to be talking about
10 the issues facing the soldiers. You can read the
11 three of them. I'm going to first go with the
12 training of soldiers and family for resiliency.
13 Before I start that, I do want to say that General
14 Stanz is very committed to this issue of care to
15 the soldiers and the families, and to all of us,
16 basically soldier readiness and family readiness
17 mean -- are viable to mission readiness.

18 And the two areas I'm going to talk
19 about in this is training and outreach. Training,
20 we have to make sure that all the soldiers who
21 come back, no, actually who deploy, have had
22 suicide awareness and prevention training.

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1 And the second thing is, in the
2 pre-deployment period, we want to make sure that
3 we have Battlemind training when they come back,
4 and that basically helps them reintegrate into the
5 civilian life. We also want to make sure that
6 there's Battlemind training before they deploy so
7 they know what to expect when they go to war and
8 what kind of skills they need to survive in that
9 environment. We also feel like we need to
10 pre-deployment training for the families,
11 basically to let them know what to expect, what to
12 expect in the relationship, what the children
13 might go through, what the spouses might go
14 through, what the husband might be going through.

15 And then coming back to -- in the
16 post-deployment period, also in the pre-deployment
17 -- when the soldier is deployed, we want the
18 family readiness groups to be calling the
19 soldiers' families and identify those spouses who
20 may be having a lot of trouble because of the
21 deployment and offering them appropriate services.

22 And coming back to outreach programs, it

1 applies to both the soldiers and the families.
2 For the soldiers, they don't drill for 90 days
3 after they come back. I do not know if it's a
4 policy or a memorandum, I'm not sure.

5 At the higher level, they're trying to
6 change it, only because soldier is lost once he
7 comes back, and especially if he's being cross
8 leveled, if he's the only one who's gone, then it
9 even becomes more difficult for him to discuss
10 what happened to him with anybody.

11 Nobody wants to hear, his wife doesn't
12 want to hear, his children don't want to hear, his
13 friends do not want to hear, his civilian employer
14 doesn't want to hear, and we want -- until that is
15 changed to 30 days, we would like for the family
16 in these groups to be calling the soldiers, just
17 trying to find out how he's doing, and if he's
18 identified as having problems, we want that to be
19 recorded somewhere. The problem with -- some of
20 the problems we have in the Army is data
21 collection and storage for retrieval in future
22 analysis. So we have a record of how many people

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1 are having trouble in this period kind of thing.
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2 And for families, the same thing throughout, just
3 to identify somebody who may be having trouble.

4 Coming back to Provision of Mental
5 Health care to soldier and families, in the
6 post-deployment period, we do have ASIS training,
7 basically Applied Suicide Intervention Skills
8 training, basically to -- in case somebody is
9 attempting suicide, other than awareness, then
10 this is like a first-aid training to prevent
11 suicide. Next slide, please.

12 To access, we have barriers to care, and
13 they basically are a stigma, and amongst -- and
14 this is a study from Walter Reed from July, 2004,
15 it's an old article, but they said only 38 to 45
16 percent of people who are identified as having
17 mental disorders, they indicated interest in
18 receiving help; and amongst these, even a smaller
19 percentage actually received help.

20 And how do we overcome this, and I think
21 it's easier said than done. We always say train,
22 train, train, train the soldier, train the peers,

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1 train the leadership, train the commanders, but I
2 think the Army soldiers have a very unique
3 problem, because as soon as the company go back to
4 work, and they cannot tell the civilian employer

5 I'm having some kind of a problem, or unless we
6 have some kind of confidential employee assistant
7 program, it is very difficult to help these
8 soldiers. And also, recognizing a mental health
9 illness, it is so subtle, it's not like high blood
10 pressure or diabetes where you can measure
11 something, it's so subtle, and it has so many
12 varied clinical features, it could be just a back
13 pain or a headache that doesn't go away or
14 irritability, I mean it's a lot of symptoms, very
15 varied, and it's very hard to tell. Next slide,
16 please.

17 And the other problem we have with
18 accessing care is the distance. We see this all
19 the time; they say I live 110 miles away from the
20 VA, what do I do. Even though he has a Line of
21 Duty and he can request through the MMSO, which is
22 Military Medical Support Office, they do pay for

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1 local service.

2 There are people, like an American
3 Samoa, where they say we don't have any
4 psychologists, we don't have any psychiatrists,
5 even for minimal outpatient therapy, we had to put
6 them on active duty and send them to Hawaii;
7 that's a very expensive proposition, because we
8 have a lot of soldiers, and we are doing it for a

9 certain portion of soldiers, how about the rest of
10 them which were in the United States, so the VA is
11 supposed to -- should help us in this situation by
12 sending out a team to American Samoa to give -- to
13 help with psychological help for these soldiers.

14 And then, of course, the time span, when
15 the soldiers have to take time off for
16 appointments, they lose. And some people, like if
17 they're working for UPS or something, they say it
18 is almost impossible, so they just don't go. And,
19 of course, employment issues. And the third thing
20 is availability of appointments. There are
21 psychologists, there are social workers, there are
22 psychiatrists in the VA who really do help. I

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1 only know about that in VA where if you go,
2 they're taken to a section when you say you're a
3 VA veteran and they take care of you and you're a
4 priority number one.

5 But still, after a few months, there are
6 so many priorities that this gets shifted to
7 primary care doctors. I used to work at the VA
8 and I know I used to see a lot of patients, and
9 those people are not so well equipped to handle
10 these special situations. Next slide, please.

11 And these are the mental health

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12 disorders which were recognized after combat duty,
13 and that is -- those are major depression, general
14 anxiety, PTSD. What they found out was, these
15 soldiers actually had mental health, some of them
16 base line, they had mental health illnesses. And
17 before deployment to Iraq, according to that new
18 Journal of Medicine article it was 9.3 percent.
19 And next slide, please.

20 And this is just a brief slide on
21 suicides. The Guard suicides, their numbers are
22 not very accurate because they count differently.

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1 And amongst these 20 suicides we had in 2006, half
2 of them had been mobilized or deployed, and the
3 other half of soldiers who were just basic
4 soldiers who had never been deployed or mobilized.
5 And then we had -- I think a few more people -- in
6 addition to the 20 suicide, 12 attempted suicide.
7 Why is recognizing this mental health illness
8 before deployment or in the Army Reserve
9 important? Because when we have mentally ill
10 soldiers, it effects operation readiness and also
11 war fighting capability. Next slide, please.

12 This is just assuming -- this is an
13 assumption. A cost of recruiting a soldier in
14 2004 was more than \$14,000, and this came from
15 Time Magazine. Cost of training a soldier, let's

16 say the soldier has some -- we're losing around
17 30, and at \$5,000 a year, if you're training for
18 ten years, it's about \$50,000; and even at an
19 incidence rate of three percent, normally in the
20 general population it's much higher, I think it's
21 nine to 12 or higher. And we pulled these people
22 from the general population.

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1 Even at the incidence rate of three
2 percent, if you lose the soldiers for war efforts,
3 it's going to cost us approximately many, many
4 millions of dollars. And, of course, when you
5 reduce the number of suicides in the reserves or
6 in all the components, it will increase unit
7 cohesiveness and morale, because suicide is just
8 not loss of one soldier, it effects the whole unit
9 and the families and more than that.

10 And, of course, if we can recognize
11 mental health illnesses and treat them in a timely
12 manner, we will have increased number of trained
13 deployable soldiers. Next slide, please. The sad
14 part of this is, mental health illness, even
15 though it's hard to detect unless you have some
16 screening tools, they can be effectively treated,
17 but they have to be recognized in a timely manner,
18 and that will minimize lots of trained soldiers,

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especially with critical MOS's.

20 And also, we can -- if they cannot be
21 treated, we can at least board them out, and we'll
22 have a timely disposition of unfit soldiers, and

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1 then we won't have to cross-level them, because we
2 have soldiers going to the MOB Station and then we
3 find out all this, and they send back, and now we
4 have to find a soldier to fill their slot. And so
5 it will reduce the amount of cross-leveling due to
6 mental health issues, and it's a cost effective
7 process, and it improves war fighting capability.
8 Next slide, please.

9 So I think we need a study basically to
10 know the prevalence and the incidence rate of
11 mental health conditions in the Army Reserve
12 soldiers, and when we know that, I think we can
13 definitely answer questions about the risk of
14 psychiatric illness problems the soldiers will
15 encounter later on.

16 And this should be maybe easier now
17 because Major Presogna just said that we're going
18 to have PHA, which is the Periodic Health
19 Assessment, annual assessment, if the Task Force
20 would recommend, what kind of screening questions
21 we should add to that, then we can screen them for
22 mental illnesses, and that should give us some

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1 data as to what the prevalency is and what the
2 incidence is. And the other thing we find in Army
3 Reserve soldiers is, when we have a suicide, of
4 course, everybody is upset, the recommending
5 general to everybody, because it's not only lost
6 for life, it effects so many people, and we have
7 press, and we want to find out what could we have
8 done to have prevented it.

9 In the active component, we have a
10 photoprocess, we can use the DODI and command
11 direct them for care or to the hospital. In the
12 reserve soldiers, if a soldier calls his first
13 sergeant saying, listen, I'm having this kind of
14 trouble, we have no process in place to refer
15 these people, they are just TPU (Troop Program Units) soldiers,
they
16 are not under our control, and it becomes a very
17 difficult issue.

18 We can tell them, hey, you need to call
19 911, go to the hospital, that kind of stuff, but
20 we don't know -- and, of course, we have trained
21 people with more suicide awareness and prevention
22 and ESIS (?) and so hopefully somebody is able to

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1 -- many people are able to recognize the symptoms
2 and hopefully try to prevent and get that person
3 out, at least give first aid, like psychiatric
4 CPR, but what do we do after that, it's just for
5 that time, and we have no idea what we should do.

6 I mean I don't know how logistically
7 possible it is, but we were thinking maybe can we
8 -- we had a look at what it costs us to lose these
9 soldiers, and then obviously, we had to compare it
10 against if we establish a local mental health
11 insurance for the reserve soldiers, because -- I
12 mean lots of health insurance is private health
13 insurance, they have limit on how many times they
14 can go to the psychiatrist. That's one of the
15 suggestion. Again, we just have to see if it is
16 feasible, riskfully feasible. And the second
17 thing is, I mean we have to come up with some kind
18 of referral process for the soldiers, and then the
19 PHA, he's going to be -- use a screening tool to
20 detect pre-existing mental health conditions.

21 And the other problem we have in the --
22 not just in -- I don't know if it's in the active

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2 component, at least for the reserves, we have
3 data, but we don't collect and store them
4 somewhere for analysis later, and also to see if
5 the programs implemented have been effective. So
6 it's very, very important that we have a
7 centralized data storage place for retrieval and
8 future analysis for further studies.

9 And we also feel like we need a case --
10 Guard has a case manager at every state, and of
11 course, we are wide spread, we have got so many
12 subordinate commands, units, and we want to
13 establish a case management like structure, maybe
14 include a behavioral and health specialist at the
15 subordinate command along with a chaplain and a
16 family readiness group, so that the soldiers --
17 and they go and visit various units, and the
18 soldiers may be more willing to talk to somebody
19 who is closer to them kind of, those are our
20 suggestions. Next slide, please.

21 And basically, once we collect the data,
22 it can be applied according to different
organizations, the National Guard, the Army, and

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1 then as mental health issues are all inclusive and
2 effect troops of all ages, cultures, MOS's, and
3 ranks. Next slide, please.

4 And I'm sure everybody is aware that
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5 mental health conditions were the second most
6 reason for medical holdovers. It is not so now,
7 but it was so in 2004. And in 2004, it was the
8 third most common for treatment at the VA. And
9 mental health is just as important as physical
10 health for the overall soldiers' well being.

11 And if they're not commonly -- I mean
12 this is a fact, that they're not commonly
13 recognized prior to deployment, therefore,
14 inadequately treated, and it effects the Operation
15 Readiness and war fighting capability of the
16 Force. And improperly diagnosed and treated mood
17 disorders such as depression can lead to suicide.
18 And those are something that are easily treated.

19 And basically, we just need to do a
20 study to answer the questions about the risk of
21 psychiatric problems in Army Reserve soldiers, and
22 this is very critical to our war fighting

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1 capability.

2 That's all.

3 LTG KILEY: Thank you, Doctor Reddy.
4 Any members of the Task Force have questions?

5 DR. BLAZER: Yeah, I have a question,
6 going back to one of the first things, it has to
7 do with pre-existing conditions.

8 what if someone has had in the past a
9 major depressive disorder, they've had a total
10 recovery from that, they're off medications,
11 they're deployed, they have another depressive
12 episode, it's clearly related to the deployment,
13 would they be covered or would that be considered
14 a pre-existing condition that would not be
15 covered?

16 COL. REDDY: They would be covered,
17 because an exacerbation of a pre-existing
18 condition is a Line of Duty condition. Either a
19 new condition or exacerbation, aggravation of a
20 pre-existing condition is a Line of Duty condition
21 and they'll be covered for life.

22 DR. MCCORMICK: I had a question. A

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1 couple of us actually visited a reserve unit
2 weekend before last, and many of the things you
3 have put out here were very much on the table
4 there.

5 There's list long laundry list of
6 possibilities, many of which don't really work, or
7 many of which reservists don't seem to understand.

8 So my question is, number one, has
9 anyone done any follow-up surveys of reservists
10 after they've returned and have been back let's
11 say for a year, year and a half, as to whether

12 they really feel they have access to services and
13 what the barriers are; and number two, how, in
14 your impression, how user friendly is the LOD
15 process?

16 COL. REDDY: No, there hasn't been any
17 study, that's the whole weakness of the whole --
18 that's the weakness of the whole system. We don't
19 have studies period, we don't have data storage,
20 we don't -- so, no, we don't have a systematic
21 analysis or a systematic questionnaire of what
22 happened to these soldiers, were they well before

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1 they went, and what's happened to them since then,
2 how easy was it for them to access the care, and
3 what's been the results, no, we do not have any
4 data on that.

5 MAJ. PRESOGNA: Let me answer the
6 second. I can answer the second one, because I
7 deal with that a lot myself, the Line of Duty
8 issue. The Line of Duty process is dependent upon
9 the soldier receiving the copy of the Line of
10 Duty, it has to be certified by the region, the
11 Army Reserve region has to certify that the Line
12 of Duty was in the line of duty, and that's
13 casualty area command signs off on a small three
14 line paragraph, and that approves the Line of

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Duty.
The Line of Duty then has to be processed by the unit administrator, the soldier's full-time unit administrator at that reserve center, sent to the Military Medical Support Office, the soldier has to make contact with the Military Medical support Office, the soldier has to find the care provider, have the care provider

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talk to the Military Medical Support Office, approve the plan of care that's issued, and then receive the care. So it can be a complicated process, but if the steps are followed, it works well for the steps that are followed. But it is a complicated process for a soldier, and there is probably some limitations in the knowledge of the process at the reserve unit level.

DR. MCCORMICK: Well, I just would comment that if the issue is something like PTSD, it's not just complicated, it means he's having to put his problems on paper to a whole bunch of people.

COL. REDDY: I want to answer it. The LOD process and psychiatric conditions is not the same. Basically, if the person says, I have PTSD, we take that at face value, within a year, we take it as face value, he's covered. For PTSD,

19 depression, after they come back, they really
20 don't have to have Line of Duty, they are going to
21 be covered at the VA and the MTF.

22 DR. ZEISS: I wanted to go back to

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1 something you had mentioned earlier also, which is
2 the changes in the periodic health assessment,
3 that's certainly something we've been interested
4 in terms of what those periodic health assessments
5 should look like; can you give us anymore
6 information about when that's going to begin and
7 what will be the breadth of assessment included in
8 that annual review?

9 COL. REDDY: It's going to be
10 implemented in the next few months, from what I
11 know. And we used to have a physical every five
12 years, and then, you know, so this can go for five
13 years, and they have problems, they have not been
14 identified, and all of a sudden we moving them and
15 finding out they're not available for deployment,
16 so now they've changed to every year, it has a lot
17 of questions, mostly with physical health, some
18 mental health, but they're not -- I have not
19 looked at the mental health questions, but they're
20 not -- I mean I want to use the tool, to be able
21 to pick up mental illnesses which might be subtle

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22 kind of, and that's where I think I want the input

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1 of the mental -- Task Force people, personnel into
2 that and see how best we can use the tool since we
3 are going to be administering the tool the entire
4 Army, National Guard, and reserve component. It's
5 going to be throughout the Air Force, throughout
6 all components.

7 MAJ. PRESOGNA: I'll add a little bit to
8 that. On the periodic health assessment, the Army
9 Reserve implementation plan, we're going to
10 implement the program very similar to how we
11 performed the post-deployment health reassessment
12 program, in that a soldier would go online to a
13 computer or in a face-to-face event with a
14 military contractor, would complete the screening
15 tool of the periodic health assessment in a series
16 of questions and answers that the soldier
17 provides.

18 Based on the answers to those questions,
19 then further evaluation occurs for the soldier at
20 that point, and so that's the process. And
21 currently it uses a very basic screening questions
22 for mental health, have you thought about suicide

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1 recently, have you had problems with family
2 relationships, have you noticed an increase in
3 difficulty coping with stressors, those types of
4 questions. There's currently four questions on a
5 PHA related to mental health issues.

6 COL. DAVIES: Any other questions?
7 Thank you, Colonel Reddy, Major Presogna. Our
8 next speaker today is Colonel Jeff Thomas. Jeff
9 is a research psychologist at the Walter Reed Army
10 Institute of Research. He's going to be talking
11 to us today about the Battlemind Training; Jeff.

12 MAJ. THOMAS: Good morning, Colonel
13 Davies; good morning, everyone. Okay, as I was
14 saying, good morning, everyone.

15 My name is Major Jeff Thomas, and I
16 appreciate the promotion, Colonel Davies, that's
17 great. I am a research psychologist at Walter
18 Reed Army Institute of Research. I'm here on
19 behalf of Colonel Hoge who couldn't be here this
20 morning, but it's a real privilege to be here to
21 talk about Battlemind Training.

22 This is something I've been involved in

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1 as a researcher and a trainer and I'm very proud
2 to talk about it with everybody here. Next slide,
3 please.

4 The purpose is, obviously, to inform the
5 Task Force about what Battlemind Training is. And
6 I want to take about 20 minutes, and I have a lot
7 of ground to cover, we'll see how far I get in 20
8 minutes. Talk about the prevalence rates in the
9 active duty for combat veterans, talk about the
10 state of mental health training prior to
11 Battlemind and what led us to see the need to
12 develop some new training for soldiers, talk about
13 the Battlemind Training concept, in particular,
14 talk about the post-deployment Battlemind
15 Training. We've done some validity studies on it
16 at WRAIR and talk about where we're headed in the
17 future with the Battlemind Training concept. Next
18 slide, please.

19 Familiar to everybody on the Task Force,
20 I'm sure, these are some data looking at some of
21 the psychological consequences of combat, and
22 whether we assess this through population-based

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1 means, i.e., the PDHA, PDHRA, health care
2 utilization data, or what I'm more familiar with,
3 which are the Land Combat Study data and some of
4 the screening studies that we've done at WRAIR;

5 this is a very typical pattern of data that we
6 see.

7 And that we typically see an escalation.
8 This actual graph here is a brigade combat team
9 that we assessed in 2003, pre- OIF. We were able
10 to follow-up with them at three months immediate
11 post-deployment and again at 12 months
12 post-deployment. And this is a very classic
13 escalation in terms of depression or its anxiety,
14 PTSD, or any mental health problem
15 post-deployment. So we see an escalation.

16 This has been consistently demonstrated
17 in the Land Combat Study over and over again. And
18 from what I've seen recently in some of the PDHA,
19 PDHRA data, as well, so this is the general
20 pattern, okay. Next slide, please. To summarize
21 the data, which many of you are familiar with
22 here, we typically see about ten to 15 percent of

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1 soldiers developing PTSD after deployment, and an
2 additional ten percent that have symptoms of
3 depression, anxiety, or PTSD that could benefit
4 from care. And as I just pointed out, the trend
5 is for this to increase over time after
6 reintegration. And we've also looked at combat
7 exposures, i.e., the number of combat experiences

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8 soldiers and marines face when deployed, and we
9 see that that is directly related to PTSD
10 symptoms.

11 And as was mentioned before by Colonel
12 Reddy, we do see that soldiers that screen
13 positive report stigma issues, and this vacillates
14 between 40 and 60 percent depending on the unit we
15 ask.

16 Of course, this is something that we
17 talk to leaders quite a bit about, they can have a
18 big impact over breaking through stigma with
19 soldiers and marines, so that's one thing I'll
20 talk about here in a few minutes.

21 The other way to do that, which is part
22 of the training, is to focus on the behavioral

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1 health training and awareness program, and that's
2 the lead in to the Battlemind Training I want to
3 talk about. Next slide, please.

4 Okay. So one of the things we noticed
5 when OIF kicked off is that we really had a
6 pre-deployment stress training brief that took the
7 place of basically everything, it was the one size
8 fits all approach to doing stress training. And
9 what happens when you have something like that is,
10 it was a little bit too general, it was a little
11 bit too academically oriented, you know, we're

12 talking to soldiers and marines, and if we're
13 doing inverted U curves, their ears flap shut,
14 okay, so we knew there were some problems with the
15 training, we needed to do a better job. The other
16 issue is that we have a very active deployment
17 cycle, sort of unprecedented recently, and so we
18 need to look at issues that soldiers and marines
19 face at different times throughout the deployment
20 cycle.

21 The training needs to be consistent with
22 military culture. If we break into a Psych 101

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1 lecture, it's generally not as well received as if
2 we're talking to soldiers in soldiers language,
3 okay. You need to make sure that the training
4 includes a recognition of stigma barriers to care,
5 and I mentioned how leadership plays a critical
6 role in that.

7 We need to talk about how combat effects
8 everyone and normalize reactions. I'll bring this
9 up again when I talk about the Battlemind design
10 for immediate reintegration right after soldiers
11 come back.

12 And we really need to train and
13 reenforce actions that soldiers, leaders, and
14 buddies can take. So it's a big emphasis on

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15 looking out for your buddy and for small unit
16 leaders to look out for their soldiers.

17 And since I'm at WRAIR, the Walter Reed
18 Army Institute of Research, we have a vested
19 interest, as does MedCom, in seeing if this stuff
20 actually makes a difference, so I want to talk
21 about some efficacy studies we have really
22 briefly, okay. So Battlemind, that's the lead in

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1 there, Battlemind Training is designed to address
2 this need. Next slide, okay.

3 This is the definition of Battlemind.
4 It's not a term that we developed, it was a term
5 actually that General Crosby Saint a USAREUR
6 commander came up with in I think the '80's, early
7 '80's, and we liked it, and we adapted the term,
8 "soldier's inner strength to face fear and
9 adversity in combat with courage", and we define
10 that as resiliency, and it has two components that
11 we hone in on when we train soldiers, self-
12 confidence and mental toughness.

13 By self-confidence, you can look at how
14 we define that as really having a self-efficacy,
15 both the general and specific traits of
16 self-efficacy there, i.e., soldier skills and
17 general skills that have gotten you through your
18 deployment will be helpful as you move forward.

19 Mental toughness, that as a soldier or a
20 marine, you will face set-backs, there's no doubt
21 about that, in a deployment, but these are not
22 insurmountable, these are things that can be

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1 overcome, and the ability to maintain positive
2 thoughts during times of adversity. Next slide,
3 please.

4 These are really the tenants of
5 Battlemind Training, okay. And as I mentioned
6 earlier, we've done a lot of work with these in
7 terms of post-deployment at two different time
8 points which I'll bring up. But this isn't
9 something that we just sat around and came up
10 with. The first bullet there, evidence-based, the
11 training was really designed from feedback from
12 soldiers through surveys, interviews, and focus
13 groups that took part in the Land Combat Study,
14 okay. That's a study we've done at Walter Reed
15 Army Institute of Research. We have over 53,000
16 soldiers that have participated in that study.
17 And we weren't trying to reinvent the wheel, we
18 really turned things around, issues that they
19 brought to our attention, and turned that around
20 to help soldiers that are coming back from
21 deployments now, okay, so it's evidence-based.

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1 sure that you have vignettes and illustrations
2 that soldiers can relate to. Strengths-based, one
3 of the things we set out to do was really talk
4 about soldier skills that they already have or
5 that they developed or honed while they were in
6 combat, okay, and how these skills can be helpful
7 for their transition home.

8 And it is not so much focus on the
9 medical deficit model, these are the problems,
10 stress, stress, stress, it's focused on skill sets
11 that soldiers already have. In that sense, it has
12 elements of sort of a positive psychology message
13 to it, okay.

14 Training, we focus on skill development.
15 The training is interactive, as I mentioned, the
16 vignettes and the illustrations, it's didactic,
17 there's give and take, it's not solely education,
18 although education is a part of that.
19 Explanatory, we do talk about some of the
20 paradoxical reactions soldiers have, like when
21 they get back, extremely happy to be back home,
22 but they're a little bit edgy, they're a little

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1 bit angry, they get back home, they want to relax,
2 but they're not really able to, they have startle
3 reaction. So these are things that we bring up
4 and talk about during the training.

5 And, of course, it's action focused. We
6 behaviorally anchor our recommendations for
7 soldiers. These are things you can do, and we're
8 not just going to talk in terms of a stress or
9 strain model or stress or strain outcome model.
10 Next slide, please.

11 This is a slide that we actually use for
12 soldiers talking about the transition home for
13 post-deployment, from "war zone" to "home zone."
14 And as I mentioned, we really build on the skills
15 they have and they've demonstrated in surviving a
16 deployment in combat. But caution them that these
17 skill sets, while they serve them very well in
18 deployment, these are things they need to be
19 mindful of and perhaps adapt a little bit when
20 they come home, okay.

21 And we talk about with soldiers, how
22 everybody transitions in their own way, okay,

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1 everybody has their own story about reintegration
2 and coming home, okay. And as I noted before, we
3 want to build on soldiers existing strengths.
4 Next slide, please. So what you see here is,
5 aren't we clever that we spelled the Battlemind
6 acronym right here. I mean we're -- I don't know
7 if that factor analyses, but that isn't the point.
8 The point is, it's heuristic, it's to help
9 soldiers, it's to train soldiers. So what you'll
10 notice when you look at this is, on the left side,
11 these are the skills that are in red, on the left
12 side of the verso sign are skills that
13 soldiers already possess or developed and honed
14 when they were in combat, okay. And on the right
15 side are potential problems that can happen when
16 soldiers come home, okay.

17 And what we do is, we go through each of
18 these ten Battlemind skills with soldiers and talk
19 about potential problems when they come back home,
20 things to be mindful for, and specific actions
21 that they can do, okay. Next slide, please.

22 This is a transition slide, in that I

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1 want to show what we're doing with Battlemind in
2 and around the deployment cycle. I mentioned that
3 earlier, where, you know, we didn't really have
4 mental health training that was designed for the

5 deployment cycle, and it's not going to be the
6 same training.

7 I mean soldiers that come home two weeks
8 after deployment have a little bit different
9 issues than soldiers 180 days later, which as
10 Colonel Reddy pointed out, have different issues
11 than perhaps soldiers that have never deployed and
12 they're getting ready to go. So this is the first
13 slide, where I'll talk about things we've done and
14 where we're going. So right now, we're looking at
15 post-deployment Battlemind Training, and it's the
16 training that is done at immediate reintegration
17 within the first two weeks when soldiers come
18 home. Next slide, please.

19 As I said, this is immediate
20 reintegration training. And during this training,
21 we focus specifically on soldier safety, i.e.,
22 risk taking behaviors, they've just gone home, so

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1 we want to emphasize potential problems with risk
2 taking behaviors, and personal relationships, that
3 they need to acclimate, they need to reestablish
4 their relationships, they've been gone an awful
5 long time.

6 More than anything, the most important
7 thing we do in this block of training is normalize

8 reactions, okay. The body is home, the mind has
9 not quite got home, this is very typical, it's
10 very typical, it's normalizing reactions that
11 soldiers have. The startled reactions that
12 soldiers may have the first couple weeks when they
13 get back, these are adaptive, these are things
14 that are normal, and it's putting that message out
15 to soldiers that it's okay.

16 Now, obviously, up until a point, and
17 that's what everybody knows in the room, that at
18 some point these things can become problematic.
19 But we want a normalized reactions, these are
20 things that soldiers typically face right when
21 they get home, okay.

22 So we want to teach soldiers when they

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1 should seek out mental health for themselves and
2 buddies. One of the great mechanisms for making
3 an appeal to soldiers is talking about buddy care
4 and buddy aid, because that's really important
5 during deployments, and it's something that, if
6 they think they're tough and I don't have any
7 problems, they sure as heck like to look out for
8 their buddies and they always will, so that's a
9 direct appeal to them, and they'll start thinking
10 about that a little bit more. Next slide, please.

11 As we make our way around the deployment
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12 cycle wheel I guess, we're now in the
13 reconstitution phase. This is the second
14 post-deployment Battlemind Training that we've
15 developed and the one where we've had incredible
16 support from General Kiley and Army MEDCOM in
17 implementing. And General Kiley, in fact, in May
18 ordered the implementation of this Battlemind
19 Training in conjunction with the PDHRA at 90 to
20 180 days post. It's been extremely successful.

21 I want to talk about that a little bit.
22 we've also produced the DVD, and this is in the

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1 field.

2 I know that when we were doing some of
3 the Land Combat Study work, when that directive
4 came out, sir, I got a call immediately from one
5 of our units and said, hey, what's this about, can
6 you help us out, and it was very nice to see that
7 it just -- in the active side, it really happened
8 that quickly, okay.

9 And it's continuing the transition home.
10 I've been involved in some studies when I was in
11 Germany, looking at screening issues and
12 highlighting the importance of when you should
13 talk to soldiers, when you should go back and have
14 another look, and it seems that the three to six

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15 month time point is very important. Next slide,
16 please. The specifics on this training, as I
17 said, it's done as part of the PDHRA process now,
18 and it's a re- emphasis on the normal reactions
19 and symptoms to combat, okay.

20 And we talked to soldiers about
21 Battlemind checks, okay, that things have --
22 you've settled back in home and family and your

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1 job, you're coming back off block leave, you're
2 back into your unit, and you know, we talked about
3 normalizing reactions that can occur immediately
4 post-deployment, but there are some signs and
5 symptoms and things you should be very watchful
6 for at three to six months if something is
7 lingering. If you notice it in yourself or
8 others, perhaps now is the time to talk to
9 somebody about it. So that three to six month
10 time point is very critical.

11 We also present, in conjunction with
12 this training, five myths of mental health, and
13 it's just about an awareness issue, things that
14 soldiers have misconceptions, that mental health
15 is not any of my business, that, you know, people
16 just could benefit by ignoring their problems,
17 that soldiers that need help will get help, well,
18 we know that doesn't always happen because of

19 stigma issues, okay, and that only weak folks are
20 effected by combat, and that's just simply not
21 true, okay. So these are some of the myths we try
22 to debunk when we go through the training. Next

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1 slide.
2 Now, this is the piece that, you know,
3 where I come in as a researcher, I'm very excited
4 to talk about this. We haven't published any of
5 the data and you don't see any graphs or anything,
6 any modeling or anything up here, but we just had
7 our Steering Committee meeting, and of course, the
8 Battlemind studies are part of our research
9 program. We had Doctor Matt Friedman is on our
10 Steering Committee and he was there and giving us
11 some feedback on some of the stuff we presented to
12 him.

13 And we've done some Battlemind efficacy
14 studies at post- deployment, in fact, we've done
15 it two times, and we did a randomized control
16 trial at the platoon level, where we sent
17 different groups to basically different versions
18 of training, i.e., what would be typical stress
19 training and Battlemind Training, and not
20 surprisingly, the first way to evaluate the
21 benefit of training I guess is just ask soldiers

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what they thought of it, and it was very well

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1 received, it was right on point.
2 The second way is a little bit more on
3 our side of things, where we want to demonstrate
4 that it actually has an impact. And soldiers who
5 had received both the post-deployment, immediate
6 reintegration, and the PDHRA Battlemind reported
7 improved mental health and follow-up health
8 surveys, okay.
9 A clinically significant different score
10 is on the PCL, for instance, the Post-traumatic
11 Checklist. For those people that were in that
12 Battlemind Training group, literally four or five
13 months before, I mean it's incredibly powerful.
14 It's provocative because it's an hour block of
15 instruction, yet we see the magnitude of the
16 effect. So there's something going on there, it's
17 not just 45 minutes, perhaps there's discussions
18 that happen, they talk with their spouse about
19 things, but we're very encouraged by the data.
20 Obviously, we need to continue to process and
21 analyze the data, but we're very encouraged by
22 what we're seeing so far with regard to

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1 post-deployment Battlemind Training. Okay, next
2 slide. I'm sorry, one more slide, okay.

3 I talked somewhat from a center of
4 gravity for myself, which is the work on the
5 post-deployment that I've been involved in as a
6 researcher, but we also, as Colonel Reddy pointed
7 out, she highlighted a need for different types of
8 Battlemind Training to be available in and around
9 the deployment cycle.

10 And so what you see, the bottom bullet,
11 are some different programs that we're rolling out
12 right now in terms of developing, okay, not
13 involved in any validity studies, not under a
14 research protocol right now, but training that
15 we're developing, okay. And we have training
16 we've developed for spouses, which I'll talk about
17 briefly, pre-deployment, a couple varieties of
18 that, we have, based on the Battlemind concept, we
19 have an AAR debriefing technique, and Battlemind
20 first aid. Next slide, please, okay.

21 Around the deployment cycle we go, and
22 we have the next version of Battlemind I want to

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1 talk about are the spouses and couples Battlemind,
2 which you can conduct right when soldiers come
3 back or preparing to go out the door, we have a
4 couple different versions of this for spouses and
5 couples that we're developing. Next slide,
6 please. We define it for spouses very similar --
7 in a very similar manner as we do for soldiers,
8 okay, it's ability to face deployment with
9 resilience and strength, and the two key
10 components here are independence and resiliency.

11 So a deployment is a hardship on a
12 family, there's no denying that, but it's also
13 talking to spouses and families about the
14 potential to grow from it, positive growth in
15 terms of being more resilient and more
16 independent. Next slide, please.

17 This is the heuristic we use to talk to
18 spouses and couples that very cleverly spell out
19 the Battlemind acronym yet again. These are all
20 issues, again, that we've, you know, we've done
21 focus groups, we've talked with experts in the
22 field, and it's not an exhaustive list by any

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1 means, but these are things that we talk to
2 spouses about in terms of the training, and
3 couples, when we can get the soldier and the
4 spouse in there at the same time, we do that.

5 Next slide, please, okay.

6 As was alluded to earlier, we do have
7 some pre- deployment modules that we're
8 developing. And this would be for soldiers, you
9 know, in the mobilization phase of the deployment.
10 And we have three different versions, we have a
11 version for leaders. I mentioned this already
12 twice, I'll mention it again, leadership is
13 critical. The climate and the organizations are
14 really set by junior leaders, okay. And climate
15 and attitude towards mental health is also set
16 there, not surprisingly, okay. So this is a great
17 area for an intervention, it's specific things we
18 talk to leaders about that they -- they may not be
19 aware of their impact on soldiers mental health,
20 and there's a lot of data that we can talk about
21 with regard to that. Next slide, please; we'll go
22 ahead and skip a slide.

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1 We do have Battlemind Training for
2 soldiers, which I think is what Colonel Reddy
3 talked about. Virginia enlisted soldiers that
4 perhaps this is their first deployment, where we
5 talk about expectations, realistic expectations
6 for the deployment, soldier actions they could
7 take during the deployment to build resilience,

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8 and then finally we have a module for helping
9 professionals or behavior health care providers,
10 okay, challenges that they face, and again, this
11 is informed by data.

12 As part of the mental health assessment
13 teams or advisory teams, we've commonly surveyed
14 providers in-theater, as well, and so this is just
15 a summarization of some of the issues they've
16 faced and talked to us about, okay. Next slide.

17 Complete the deployment cycle wheel. We
18 have two types of training that are very new, so I
19 hope you don't pin me down too much on these, but
20 I will present them, the Battlemind AAR
21 debriefings and Battlemind first aid, okay. And
22 again, this could take place a couple different

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1 times during deployment. Obviously, it could be a
2 bit driven or something that would take place
3 during the deployment, but could also take place
4 immediately after return, upon return, okay. Next
5 slide, please, okay. The Battlemind AAR
6 debriefings, there's been an awful lot of people
7 that have talked about the efficacy and success of
8 debriefing, and everybody on the Task Force, I'm
9 sure, knows a lot more than I do about it.

10 We have done some studies at WRAIR
11 looking at debriefing efficacy. One of the things

12 we thought we'd try to is, because the Battlemind
13 concept is very well received, is use some of
14 those principals and integrate it into our own
15 version of training.

16 You can see some of the things listed in
17 the bullets, under the second bullet, where it's a
18 little bit different, okay. We integrate military
19 culture into the ground rules, discuss positive
20 and negative reactions, do not differentiate
21 between the cognitive and emotional reactions,
22 unlike the CISD technique, we focus on stigma, we

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1 talk about that during the actual debriefing, we
2 talk about Battlemind concepts, and emphasize
3 buddy care, as well, so these are some things
4 we're doing with this version of the training.
5 Next slide, please.

6 I mentioned that we are looking at
7 Battlemind first aid, okay, and what this is is
8 really pushing down to a unit level or somebody
9 that's clinical personnel, organic to a unit
10 perhaps during the deployment, it's making it --
11 first aid care, just Battlemind skill sets that
12 these folks can actually implement, okay.
13 Clinical personnel, it can be used to identify
14 soldiers that are passing through the medical

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15 system. We have over 50 percent of soldiers with
16 mental health problems that don't seek care, we've
17 talked about that already. But the average
18 soldier accesses the medical system four times a
19 year, okay, so that's an opportunity to talk to
20 people, okay.

21 It teaches our own personnel Battlemind
22 Training so that they understand what soldiers

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1 have been through, okay. It teaches a brief
2 screen, and it increases knowledge and confidence
3 so that they're more likely to engage family
4 members and just show concern, okay, so it's a
5 mechanism for making that happen.

6 For the medics or people that are in the
7 unit, they know their people better than anybody,
8 you know, they're not going to come talk to Doc
9 Thomas or Doc so and so, a soldier is most likely
10 to go talk to the medic or their buddies in the
11 unit, okay. So it puts them in a position where
12 they notice slight deviations in behavior,
13 something they can pick up on, it gives them a
14 little bit of a skill set. It's not diagnosis by
15 any means, but it's just an awareness, pushed down
16 to clinical personnel and medical personnel that
17 may be in the unit. Next slide, please, okay.

18 One of the things we did at Walter Reed
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19 Army Institute of Research last summer is, we had
20 a general officer summit, where we had all the
21 medical command officers in the Army, and this was
22 obviously a part of the conversation, and General

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1 Kiley said, you know, this is really important, we
2 need to have Battlemind Training be a part of what
3 all soldiers experience in terms of their Army
4 career from the get go all the way through their
5 professional development, just to check in with
6 them across their career life span, you know.

7 So soldiers that are new to the Army
8 would have a version of Battlemind, where mental
9 health and behavioral health issues awareness is
10 taught, if a senior leader is at a pre-command
11 course, they can talk about understanding mental
12 health and how this can be a strategic tool for
13 being successful, things they need to be vigilant
14 for.

15 And on the medical side, we've already
16 integrated some of the Battlemind Training into
17 the combat and operational stress courses and
18 worked very closely with General Kiley's office
19 and the AMEDD Center and School in San Antonio
20 to integrate some of the Battlemind Training, as
21 well. It's a bit of a busy slide, I apologize

22 FEB26_MHTFmeetingtranscriptsFINAL.txt
about that. Next slide.

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1 So to wrap this up, in a nutshell, I
2 mean I've covered a lot of ground here, but
3 Battlemind Training builds on soldier strengths
4 and spouse strengths, it depends on the version of
5 Battlemind you're talking about, and it's
6 something that soldiers and spouses need to be
7 aware of throughout the deployment cycle, okay.
8 The one size fits all stress training package
9 really, it just isn't appropriate these days,
10 okay. It gives a standardized package for people
11 to talk about mental health issues. One of the
12 things we would notice is, although there was a
13 generic sort of one size fits all stress training
14 package, is that people are smart and have their
15 own background, they would take it and tweak it
16 and play with it a little bit, and it could look
17 different depending on where you went, depending
18 on who the health care provider was, okay. So
19 this at least gives us a very standard package
20 that MedCom has developed that everybody has
21 access to, okay.
22 Used to talk about soldier and leader

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1 resiliency and preparing for deployment, and as I
2 said, it talks about a developmental program for
3 mental health training across the deployment
4 cycle. Next slide.

5 I know I covered a lot of ground here.
6 The one thing I want to plug is, we have a web
7 site, www.battlemind.org, and we are also -- the
8 Battlemind Training, all the training is available
9 on the G1's web site, under their deployment cycle
10 support program link, okay, so two places you can
11 have access to it. That includes the
12 post-deployment, as well as some of the spouse
13 stuff that we're working on right now. So subject
14 to any questions, that concludes my talk.

15 COL. DAVIES: Does the Task Force have
16 any questions for Major Thomas?

17 DR. MCCORMICK: Yeah; I mean the war is
18 now, and my question is whether, number one, do
19 you have any data on what percentage of soldiers
20 coming back actually get the Battlemind Training,
21 both in the active and in the reserve component,
22 and number two, and somewhat related to that, is

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1 this or should it be something that is on the
2 dashboard that is metric for line commanders, not
3 AMEDD commanders in terms of the percentage that
4 actually get this product?

5 MAJ. THOMAS: well, to answer your first
6 question, as I said before, General Kiley put out
7 a directive for active duty units to take part in
8 the Battlemind Training with PDHRA, so that is
9 mandated right now, that's happening.

10 DR. MCCORMICK: Mandated within AMEDD?

11 MAJ. THOMAS: No, mandated -- well, for
12 instance, I mentioned, okay, I had mentioned the
13 Land Combat Study, we are working with a
14 maneuver unit there, and so that directive went
15 out to their medical personnel, so I know the
16 directive has gone out, and just from the number
17 of hits on our web site, and I don't have any hard
18 data on it, but my sense is that it has been
19 rolled out very well in the active duty side.

20 Now, to transition to a discussion of
21 Guard and Reserves, I know that it has certainly
22 been rolled out in the Guard and Reserves, and we

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1 had done some work with a brigade in the National
2 Guard and had worked very closely with the vet
3 centers of the VA who took on the mission to help
4 us do some of the post- deployment health

5 reassessment work, and we did a lot of traveling
6 helping train those guys, so it's been -- it's
7 starting to be structured and integrated, the
8 extent to which that's happening I don't have hard
9 data on it. I can only speak from, you know, the
10 unit I worked with in, you know, before, so --

11 COL. REDDY: Not all reserve soldiers
12 who have gone to war and come back have had
13 post-deployment health risks, but only I think 30
14 percent have completed their PDHRA, along with
15 that, they're getting the Battlemind Training.

16 MAJ. THOMAS: And I'm sorry, sir, you
17 had a second part to your question?

18 DR. MCCORMICK: Would it be useful and
19 important for this to be a metric like on the
20 dashboard for operational commanders, as many
21 things are now, the percentage of soldiers who
22 actually get it?

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1 MAJ. THOMAS: You know, yes, it would.
2 I mean I would love to see that happen, to be a
3 metric that's tracked. And my experience with the
4 Land Combat Study and outbriefing a number of line
5 commanders is, they all see the importance of it,
6 and if there's a way to solidify that importance
7 and make it something that is tracked just like a

8 lot of other numbers are in a brigade or a
9 battalion, I think that should happen, absolutely.
10 COL. SHELTON: Colonel Shelton, retired;
11 I was going to ask a question, has the Battlemind
12 Training been given to the civilian physicians in
13 our mental MTF's, because as you mentioned, less
14 than 50 percent may seek care for mental health,
15 and they come to the hospital four times a year,
16 as you said --
17 MAJ. THOMAS: Yes, sir.
18 COL. SHELTON: -- they may see a
19 civilian, you know, health care provider, and this
20 may be the call on that soldier saying that I have
21 mental health problems and need to be picked up by
22 a civilian physician to be aware of what, you

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1 know, what may be stressing that soldier out.
2 MAJ. THOMAS: Yeah, that's a good
3 question, sir, we've talked about it generically
4 with regard to clinical personnel that work in and
5 around the unit, whether it's an MTF or whether
6 they're an asset. I'm aware of another AMEDD
7 program, respect.mil that really pushes some
8 of these issues to a primary care setting, and
9 perhaps there's overlap between the military and
10 civilian providers there in respect.mil. Yes,
11 ma'am.

12 COL. RITCHIE: Hi, Colonel Ritchie here,
13 a psychiatry consultant. Back to your question
14 about tracking the Battlemind, as I think you
15 know, we do track very closely compliance with
16 PDHRA, and in the vast majority of cases, I can't
17 say in all, Battlemind is given in conjunction
18 with the PDHRA, so it's a pretty good surrogate
19 marker. The last I looked at the numbers, the
20 compliance on the active duty side was 88 percent,
21 on the National Guard side it was about 45
22 percent, and on the reserve side it was about 20

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1 percent. Sounds low, but all of these numbers are
2 coming up, and the reserves and National Guard
3 have worked very hard to try to put the PDHRA in
4 place. As you're very well aware, there's a lot
5 of challenges that they have in terms of
6 instituting it at the drill weekend, but it's very
7 high visibility there. Can we do better, yes, and
8 we're trying very hard to do that.

9 COL. DAVIES: Thank you. I'm going to
10 have to close off comments from the audience right
11 now, because we do have to stay on track here.
12 Usually the Task Force is the one that asks the
13 questions, and I know people had filled in the
14 information there, and we will have an open

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15 session later for the Task Force to take those
16 particular issues on. Major Thomas, thank you so
17 much, Jeff, for sharing.

18 MAJ. THOMAS: Thank you, sir.

19 COL. DAVIES: Our next speaker is the
20 Director of the Army Wounded Warrior Program,
21 Colonel Mary Carstensen. They told me that Mary
22 had just gotten here. Here we go, Mary, you're

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1 on.

2 COL. CARSTENSEN: Good morning,
3 everyone. All right. Can you hear me okay?
4 Greetings, everyone. Thank you very much for this
5 opportunity to present and to spend some time this
6 morning talking to you about the Army wounded
7 warrior Program. We will send the slides on
8 digits. I just send a note to my staff, so they
9 should be getting to you shortly. But I had some
10 handouts that you could refer to to get started.
11 The program that we're talking about, U.S. Army
12 wounded warrior Program is a program that was put
13 together in 2004, in an effort to facilitate the
14 transition of our most severely injured and
15 wounded through this continuum of injury.

16 I think the initial thought was to help
17 them transition out of our Army. And as any new
18 and evolving program, one that you're building at

19 the same time that you're operating it or you're
20 dealing with the real issues, some of those
21 missions and those visions change with time.
22 so the first slide actually talks about

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1 our vision statement. As you know, everything,
2 all of those visions, all of those words have
3 something -- some meaning behind them, and it
4 means we're looking at our soldiers and families
5 being self- sufficient, contributing members of
6 our community, and that community could be back
7 into our Army or it could be into a civilian
8 community of their choice.

9 so we're looking at those choices being
10 informed choices, we're hoping that we can
11 maximize the federal benefit, which is quite
12 robust, making sure that non-profit organizations
13 are duplicating that effort and so on, duplicating
14 the federal benefit and so on.

15 we talk about living and spousing our
16 warrior Ethos, I will put my mission first, I will
17 never quit, I will never accept defeat, I will
18 never leave a fallen comrade, the latter being the
19 guiding principal for this program, but we also
20 feel that the battle through rehabilitation and
21 recovery for this group of soldiers and that Ethos

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is as relevant to this battle as it was to one

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1 in-theater. And then we talked about our mission,
2 and that mission is really three-fold, it's
3 touching soldiers, providing personal assistance,
4 it's working with our commanders and our Army,
5 making sure our business processes are in place,
6 that they're educated, understand that there's a
7 tool for them, as well as their soldiers, and then
8 looking at how we can leverage policy and even
9 legislation, if necessary, to make sure we have a
10 smooth transition.

11 The population, the next slide that
12 we're talking about, are those soldiers that are
13 eligible for medical retirement, so that's a 30
14 percent disability rating in our Army. They are
15 in support of GWOT's, it's really looking 2000
16 forward. The majority of our soldiers are coming
17 out of theater, it's the intent of the program,
18 but if someone has a qualifying injury that was
19 obtained in another fashion, we include them into
20 our program, as well.

21 The injuries that we're talking about
22 are those catastrophic wounds and injuries. They

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1 are those, lives have been changed forever. We do
2 include traumatic brain injury, and we do include
3 PTSD as a diagnosis. And that latter one is the
4 one that we're somewhat more challenged with.

5 When someone is coming out of theater,
6 actually those last two; when someone is coming
7 out of theater, if they've had a serious,
8 traumatic, physical injury, we can tell in our
9 casualty reporting system, we can tell through our
10 tracking system, so we get a sense of the severity
11 of that injury, but we don't necessarily know that
12 on PTSD, and sometimes we don't know that on
13 TBI's, especially on the moderate TBI's. And we
14 do rely on our Army -- our Medical Department. I
15 shouldn't just say Army because we're also working
16 with Bethesda and Balboa (NMC San Diego).

17 We look at those main portals of entry,
18 those providers, to convey that this is a serious
19 illness or injury that you will want to engage in,
20 that will likely be life long, that will likely
21 take time for rehabilitation, for therapy, and so
22 on.

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1 The next slide talks about, it's a slide
2 that we just recently put together, trying to help
3 us convey this continuum of injury, from the time
4 of notification all the way through transition,
5 and the amount of players that are interested and
6 can impact and make a difference on these soldiers
7 and their families lives.

8 We are working on a tracking system that
9 allows us to pull from legacy data bases so that
10 we know as much as we can about soldiers as we
11 can, such as their award history, their assignment
12 history, their education history, as well as -- it
13 becomes a tracking system for us and a call log
14 system, so regardless if I'm in San Antonio or if
15 I'm in South Dakota or in Virginia, I have a sense
16 of what has been our interaction with this soldier
17 and what some of their issues have been, and what
18 linkages we have made with these other agencies
19 for these families. The next slide talks about
20 the number of soldiers that we're currently
21 tracking. There are a little over 1,500 soldiers
22 in our system. The upper right hand corner talks

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1 about COAD/COAR continued on active duty, continue
2 on active reserve, fit for duty, those are our
3 soldiers that have -- our AW2 soldiers that have
4 come back in to our Army.

5 And at this point in time, I do have one
6 with PTSD as a diagnosis that is stated in our
7 Army. And I have a couple with -- not as a 30
8 percent disability, but with a ten percent
9 disability for PTSD.

10 I also wanted to bring up here that the
11 bottom box talks about soldier to SFMS ratio.
12 Soldier Family Management Specialists are case
13 workers of sort, and they are the folks that
14 provide that hands on personal assistance. Right
15 now we're looking for a ratio of about 30 to one,
16 30 soldiers for one Soldier Family Management
17 Specialist; but as I said before, it's still a new
18 program, we're still growing, we're still
19 learning, I'm not quite certain what is right with
20 that number yet.

21 It's probably been just in the last, I
22 guess it's been about seven months now that we've

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1 tripled the size of our program.

2 So our experience is now becoming more
3 proactive versus reactive in nature. The next
4 slide talks about the soldiers that we're
5 following by injury category. And I've asked the
6 staff to try to sort this out so you get a sense
7 of which ones have PTSD. And when you look at

8 this, a couple things I should probably say up
9 front; 70 percent of our population is already
10 medically retired, the rest are in our health care
11 system or they are still in our Army as -- back in
12 our Army as an assignment. Of the total
13 population, 20 percent have a secondary or a
14 primary diagnosis of PTSD, and actually I was
15 surprised by that. I would have thought for this
16 most severely injured group I would have seen a
17 higher percentage of PTSD, especially as we look
18 at some of the other numbers that are being
19 published, and so I am surprised by this.

20 Most of the data that I got here is
21 coming out of our physical disability system, so
22 these are -- already been through the medical

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1 evaluation boards, 70 percent have gone through
2 the physical evaluation boards, and that is what's
3 been documented.

4 To also say on that population, the
5 primary injury category, PTSD, 91 percent of those
6 have been temporarily retired, right about the 30
7 percent range, and almost every month, as I go
8 back and look at my data, soldiers are going from
9 the 30 percent and are being separated. Very
10 seldom do I see a PTSD that goes to a higher
11 percentage, so some things that you may want to

12 consider as you're looking through your processes.

13 The next slide talks about who our
14 Soldier Family Management Specialists are and what
15 the staff consists of. And I basically already
16 discussed that with you, but they're the folks
17 that help navigate this maze of benefits and helps
18 sort out this -- try to take on whatever role we
19 can to keep soldiers and families focused on their
20 injury and on their rehabilitation. The soldiers
21 and families that we're talking about, generally
22 speaking, are in this continuum of care for about

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1 18 to 36 months. The next slide shows where they
2 are located. We have soldiers and families
3 distributed throughout the country. We have just
4 recently partnered with our VA. As you look at
5 the population, 70 percent are retired, so that's
6 where we probably need to be.

7 I also learned that not all of our
8 soldiers are maximizing their VA benefit or even
9 linking to it at all. And so I put our Soldier
10 Family Management Specialist in the VA for two
11 reasons; one, pull our families and soldiers into
12 the VA, and then two, at the same time, I tell
13 this to our VA partners, as well, that way I'm
14 going to push my guys to the front of the line, so

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15 when they do come to the VA, we want to get them
16 at the head of the line, and that's been working
17 very well for us.

18 And like I said, just by dispersing
19 these folks across the country, we've been able to
20 -- we're identifying more soldiers that may have
21 separated without even going through a medical
22 evaluation board process, we've been notifying --

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1 we've actually brought soldiers back into our Army
2 so they could go through an MEB and a PEB
3 process so that they would qualify for a medical
4 retirement, and there's been other issues, I mean
5 lots of issues in terms of looking for
6 efficiencies and changing our business processes.
7 I do have soldiers on some of our primary
8 installations, where we have population centers,
9 but for the most part, our folks are at RBA's.
10 The next slide talks about continued, on active
11 duty, and I just put that in there just to get in
12 so to remind you that our soldiers are educated
13 and counseled about their ability to stay in our
14 Army.

15 I've got about 30 some that are in the
16 queue right now, about 30, just shy of 30 that are
17 in our Army, that already opted to come back into
18 our Army, and so part of that is a learning

19 process, it's a cultural change for our Army.

20 We work very closely with our Human
21 Resources Command, it's our career managers, they
22 work at developing five year career plans for our

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1 soldiers. And so before they even make a
2 decision, as they're discovering what is possible
3 for their futures, we hope that they are doing it
4 with good information.

5 They know what the future may look like
6 in our Army, they understand -- it forces them to
7 articulate what their Army goals are and then
8 let's see how we can ensure that they have
9 productive and fulfilling and personally
10 gratifying careers, that it's the goal of that
11 program, and so far it's been very successful.

12 It also helps to train our Army's
13 leaders on accommodations on considering the
14 health care requirements that the soldier may need
15 to consider. We're almost looking at an EFM,
16 Exceptional Family Member type program for this
17 population, so we are considering their health
18 care requirements as we work the assignment
19 process. Next slide. This slide talks about
20 community support. And I brought this slide into
21 this briefing for a couple of reasons, one, we

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have -- America has been amazing in coming forward

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1 and saying we want to help your wounded soldiers.
2 They are -- their employers, I probably
3 get three or four a week that come on board to say
4 we'd like to hire wounded warriors, we have
5 communities that have put coalitions -- built
6 coalitions within their own community, within
7 their states, to receive wounded soldiers, and you
8 may have heard about some of those.
9 Some have almost a scholarship contract,
10 where they say come into our community for five
11 years, we'll help you with transportation,
12 housing, job development, job skill development,
13 and we will help you then be -- and we'll provide
14 the social network that becomes very important
15 during this transition time.
16 There are other communities that are
17 working also at job -- at mentoring. Some are
18 very selective on the populations that they
19 choose, some are looking for physical injuries.
20 The population I'm probably most concerned about
21 are those invisible wounds. We go back to our
22 population numbers with 18 percent being, I think

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1 it's PTSD, about 14 percent -- 14 percent I think
2 PTSD, 18 percent TBI, those invisible wounds I get
3 very, very concerned about as they transition into
4 our communities. So what does that look like?
5 How do we help those communities respond and
6 accept those families into their neighborhoods?
7 we talk about being a good neighbor, and that's
8 why I bring this slide, the second reason I bring
9 this slide in. The federal benefit, again, is
10 quite robust.

11 But we are not -- what I can't do is, I
12 can't outsource being a good neighbor, and it's
13 that social support system that I think becomes
14 very, very important. And what can I do, what can
15 we do as DOD, as a federal -- and VA, what can we
16 do to prepare those communities for these soldiers
17 and families moving in? It's part holding our
18 folks accountable, and at the same time, it's
19 being tolerant that their life has changed
20 significantly, and I think that's going to be an
21 important role, part of their education and
22 outreach that needs to be conveyed.

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1 The next slide talks about a -- just a
2 couple slides to tell you some of our initiatives.
3 The first one is about a financial calculator.
4 we've noticed that a lot of our soldiers, and I
5 bring this specifically for this population, as
6 well, are concerned about what their future is
7 going to look like, and how am I going to make a
8 transition, and what is my medical retirement
9 going to look like, what's my VA disability going
10 to look like, and it's a calculator to help all
11 soldiers work their way through this disability
12 process and get a sense of what is on the other
13 side.

14 The first phase of it will be more of an
15 online tool that you can go in and use on your
16 own. And as you work through the process, the
17 Soldier Family Management Specialists are trained
18 to ask very specific questions and to work with
19 the developers of the tool so that we can come up
20 with a more precise expectation predictor of what
21 their disability compensation might look like.
22 And that way, then they can start making some

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1 plans about what they need to do once they
2 transition, what work do they need to be looking
3 at, what's their salary requirements going to be.
4 And we often see that this tends to

5 delay their transition, and so I'm hoping that
6 this will be a tool that will facilitate that
7 process. Right now we're doing it manually and
8 have had some very good feedback and good results.
9 Often times it's the unknown that prevents folks
10 from moving forward, so this has been helpful.

11 Then this summer, last summer and last
12 fall we held a couple of symposiums, and I did
13 that because I was -- I had a sense of what some
14 of the challenges our soldiers and families were
15 dealing with, but generally those who were coming
16 from a few and not from the population as a whole.

17 So we brought in soldiers and family
18 members, a care giver, and we asked them to
19 present issues that they were facing, and we held
20 focused working groups, we had subject matter
21 experts at our working groups, we facilitated them
22 formally, we took like two symposiums, we took 240

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1 issues and came out with about 26 issues. At the
2 same time, I asked them a couple of questions; I
3 said, what helped you and your family transition
4 out of our Army, and what were those things that
5 caused you the greatest concern. And as you look
6 at the list, the first three are family,
7 community, and faith, on the summer symposium,

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8 followed with TSGLI and the AW2 program. In the
9 fall, it was family, AW2, TSGLI, peer support, and
10 their therapist. So I tell my folks, whatever we
11 do, don't get in the way, obviously, of family,
12 community, and faith.

13 Then you look at what the concerns are,
14 and in both of those we have challenges with
15 employment, with finances, challenges with
16 benefits, medical rehabilitation, and on the fall,
17 conference stress and PTSD came up. And in terms
18 of -- as we looked closer at the issues, stress
19 and PTSD became more noticeable. And actually, it
20 tends to come more from the family member's
21 concern than it was coming from the soldier's. So
22 let me share a couple of those with you in the

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1 next two pages.

2 And I'm asking the slide preparers to
3 send -- forward the entire packet of issues, by
4 the way, to be part of the official record, so
5 that you have all 26 issues. But here -- this is
6 the summer, they brought out that the initiation,
7 the medical -- the MEB/PEB was a challenge.
8 They felt that they were being asked to leave our
9 Army sooner than what they were ready to. And
10 when I look at the population that was making
11 these recommendations, it was coming from our

12 soldiers with PTSD, it was coming with our
13 soldiers with TBI. GWOT family mental health
14 care, clinics specifically to help family members
15 was recognized as a need. When you start looking
16 at that more closely, they are talking about lots
17 of folks who want to provide counseling, but they
18 need -- they want more, they really are looking at
19 more of the clinical intervention and having that
20 linked to their soldier's care.

21 And so it's the time of that
22 intervention and making it appropriate to what

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1 their soldier -- and where their soldier is in the
2 continuum of injury. And that's, again, going
3 back to that third slide or so. What are the
4 challenges, the counseling challenges along that
5 continuum, and have we as a system, because I
6 haven't figured this out for AW2, but I'm looking
7 at our partners, as a system inserted some sort of
8 support throughout that entire continuum of
9 injury.

10 And then the third one, it was TBI, and
11 I guess they just put that in here because they
12 are looking at all rehabilitation, they're looking
13 for simultaneous rehabilitation, not only at the
14 predominant injury, but tending to all the

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15 injuries at the same time rather than segmenting
16 them.

17 And this comes from our TBI families,
18 obviously, but it also is a predominant
19 discussion, especially from our mothers of our
20 soldiers that are talking about their concern if
21 they have not dealt with their PTSD throughout our
22 acute injury phase. And maybe it is and they

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1 don't recognize it, or maybe it's not and they
2 have not been included in it and they're not
3 certain how to deal with it. Especially again,
4 we're looking at soldiers that are in our
5 hospitals, 18 to 24, 36 months, and they are
6 concerned that we have not dealt properly with the
7 -- all the injury rather than just looking at one
8 of the predominant ones.

9 Again, TBI came up quite a bit as an
10 issue of interest in the long term rehab, and
11 again, it goes back to that simultaneous
12 rehabilitation. Then we look for multiple trauma
13 patients. Then we look at the standardization
14 support groups or family members.

15 And as we look at this a little more
16 closely, again, they are not looking so much for a
17 support group of someone who is living with a
18 soldier, of an amputee, of a burn victim, or of a

19 -- other catastrophic injury, they're interested
20 more about a support group as they are in that
21 continuum of injury.

22 So I've just been notified, how am I

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1 going to deal with this event, how am I going to
2 deal -- how do I learn -- what do I learn from
3 being at Ft. Sam Houston, I've never traveled
4 outside of South Dakota, what am I doing in
5 Washington, D.C.

6 The next phase is looking at my soldiers
7 in intensive care, he's going to be there for
8 quite some time, how do I work through that
9 process, and then they work through their
10 continuum of injury. And so that's the kind of
11 support groups that came out of these symposiums
12 that they were looking for. Much discussion on
13 who should have had those support groups.
14 Obviously, you've got some subject matter experts
15 as these mothers and these spouses and family
16 members transition with their soldier through our
17 continuum of injury. The concern is, though, that
18 they need some kind of an authoritative source,
19 because the barrack's lawyer, the Malone House
20 lawyers, whatever, start taking over and folks
21 don't know what is true versus what is fact. And

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22 at the same time, we as uniform members need to

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1 make sure that we are current in all the issues,
2 because often times, those folks are going to know
3 things that we haven't yet been exposed to.

4 The next one was on our VA and their
5 receipt of folks and the transition into our VA
6 from our DOD facilities. Lots of work is being
7 done already on these issues. A counsel and
8 colonel was put together within the Army that
9 included VA. The Department of Defense has been
10 working family transition issues. Our Surgeon
11 General has put together the TBI Task Force. And
12 I know I talk TBI, and I know we're talking mental
13 health here, but there's so much of this that
14 tends to overlap, and so I just -- I'm bringing
15 that forward to you.

16 There are issues within the department
17 looking at how do we deal with all wounded
18 warriors and making sure that our chain of
19 command, our existing case worker management
20 system all are informed on these issues and can be
21 an outreach and a detector of when we have
22 something that needs to be pushed forward to

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1 another level. The next slide talks about some of
2 the things that we have done. I already talked
3 about the grassroots organizations to you and the
4 importance of helping these communities receive
5 our soldiers, helping to manage their
6 expectations, that nearly 30 percent of our
7 soldiers have this invisible type of wound, how do
8 you receive and how do you incorporate them into
9 the community when they're going to be challenged
10 with employment, retaining employment, isolating
11 or determining what their life goals are going to
12 look like, when those are going to change as they
13 work through their own rehabilitation.

14 we talk about training becoming probably
15 the most -- it's part of my mission, I mean it
16 always is, I guess, when we're in our Army. But
17 for this group of folks, to develop people who
18 have an understanding of this entire continuum of
19 injury, not to replicate our chain of command, not
20 to replicate our VA, our Army Medical Department,
21 how do I -- I need to educate them continuously on
22 where are those sources -- are those pockets of

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1 benefits that can facilitate and help soldiers
2 through this process.

3 And what I learned a year ago, we've put
4 processes in place, we've done better, we're
5 putting fixes in place, we've changed regulations,
6 but something new is popping up today, and really,
7 we're still pretty early on in our understanding
8 of this. If you look at 2003 invasion -- when we
9 went into Iraq, five years later, we're now, I
10 guess we're at four years later, some of these
11 guys have just now gotten out of their -- those
12 first guys are just now getting out of our health
13 care system. And now we're learning what is
14 happening once they have made these transitions
15 back home.

16 That is a big unknown. As many
17 employers that come forward that want to hire our
18 soldiers, I don't have a soldier to match all that
19 goodwill.

20 A lot of our soldiers need to take a
21 break. A lot of our soldiers are going back to
22 school, a lot of them came into our Army for

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1 education benefit. Many of them don't know where
2 to go back home to. They may have come into the
3 Army because they didn't want to be at home, so
4 they're searching for what comes next, and that is

5 a concern for me.

6 They're young, we know our own children
7 and our own lives, that, you know, folks change
8 careers, what, seven times, is that the average,
9 why would it be any different with this
10 population? But they're going to be challenged
11 with accommodation requirements and challenged
12 with some other long term issues revolving around
13 this injury category, this injury.

14 we talk about the Soldier Family
15 Management Specialist expansion, I told you that
16 we've grown in the last year, that I think is
17 going to be revealing, help me to better
18 understand what is going on in this transition and
19 how I can bring soldiers and families to the
20 table, to bring them into our VA, to maximize the
21 benefit, to help develop their life plans. The
22 next one is the symposium issue, we talked about

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1 that. I have another one coming up in June of
2 this year. I really expect that to be probably
3 even bigger than what we have done the last couple
4 of years, because the interest in our subject
5 matter experts who are going to take on these
6 issues and work them for this -- for our Army and
7 for the department.

8 I also have aligned with an organization
9 called the National Organization on Disabilities,
10 it's a non-profit organization. What they have
11 helped me understand is that the percent of people
12 employed with disabilities has not changed since
13 world war II, and so with our population, we know
14 that's unacceptable, and so what can we do to
15 improve this transition, to improve the
16 opportunity for employment, and not just jobs, but
17 for careers.

18 And again, it goes back to educating our
19 employers as much as it is to ensure our soldiers
20 and families understand what their opportunities
21 and their options are. A huge benefit, Department
22 of Labor has accommodation in hiring benefit.

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1 The VA has the vocational rehabilitation
2 and interest benefits. They also have the
3 education benefits, both from VA -- via VA and
4 through their time in our Army. So how do we
5 bring all of this together? And how do we
6 maximize private interest, as well? And so we
7 have asked the NOD to -- they're doing actually a
8 pilot program with us where we're going to put a
9 career counselor along side our Soldier Family
10 Management Specialist and we're going to do that
11 in three different locations and see if we can

12 make a difference in terms of maximizing the
13 benefits as far as bringing our soldiers in,
14 looking at long term career successes. And let's
15 see, we've got a web site coming up that we're
16 using to link soldiers with work.

17 we've got a web site that is looking at
18 a private area, you know, for log in only for this
19 population, looking at chat support rooms, where
20 we're going to try and address some of this
21 continuum of injury, some kind of private space
22 that soldiers and families can stay linked to

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1 other soldiers and families, and I'm hoping that
2 that helps out, and they will all be monitored by
3 some sort of a subject matter expert so we can
4 make sure that we keep the authoritative, or what
5 does the regulations say, at the same time, keep
6 tabs on if we need to make some changes in our own
7 business processes to better facilitate the needs
8 of this group of folks.

9 It has been an incredible opportunity
10 working with this population, as many of you know
11 sitting in this room that is interested in their
12 well being and in their futures. And they are
13 dedicated to making a difference to the lives of
14 those that follow.

19 But we applied that -- are you familiar
20 with Vassar decode, sir? It's the disability
21 rating system of the VA and the medical -- that
22 DOD uses, and there's like 5,000 codes out there,

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1 and in order to help us determine a disability
2 rating, and we took those and assigned them to the
3 severe injuries categories.

4 Now, I did take -- and as I look at
5 mental health, I did take PTSD as a diagnosis.
6 Those that I probably -- and probably consumed my
7 greatest challenge right now is the other mental
8 health diagnosis, and so we're taking a look at
9 those, did they come out of theater, should they
10 be in this group, should they not, and we have not
11 gotten that far.

12 DR. BLAZER: Excuse me, maybe I'm not
13 being clear.

14 COL. CARSTENSEN: Oh, I'm sorry.

15 DR. BLAZER: I think that, from what I
16 understand, since the inception of the program,
17 about 1,500 individuals have been enrolled in the
18 program; is that right?

19 COL. CARSTENSEN: Well, I don't ever say
20 enrolled, you just either are an Army wounded
21 warrior or you're not.

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DR. BLAZER: Oh, okay. So of all the

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1 individuals, this 1,500 figure, is all of those
2 who you would have identified as a potential, over
3 this two year span, is the potential who would
4 have, from the data that you have, would have been
5 eligible for this program?

6 COL. CARSTENSEN: That is correct.

7 DR. BLAZER: Got it, okay, thank you.

8 COL. CARSTENSEN: I'm sorry.

9 DR. MCCORMICK: Maybe a somewhat related
10 question; PTSD is a little different than, well,
11 maybe TBI is, too, than some of these disorders in
12 that it may have a later penetrance, you know, the
13 severity of it may not be evident when they
14 immediately leave the theater. If someone were to
15 develop severe PTSD 18 months later, would there
16 be a portal of entry for them into this program?

17 COL. CARSTENSEN: If they had already
18 been medically retired, we would get them through
19 our VA partners; if they have not yet been
20 medically retired, yes, we will pick them up as
21 they either go through the PDS system, our
22 physical evaluation system, or we would pick them

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1 up through our relationships with the clinicians
2 at our primary installation sites. But this
3 clearly is the population, this and moderate TBI's
4 is the population, and I really have to rely on
5 our medical departments or referrals from our
6 providers.

7 COL. DAVIES: Is there another question?

8 MS. FRYAR: I have a question in regard
9 to the follow- up, after they're medically
10 retired.

11 COL. CARSTENSEN: Yes.

12 MS. FRYAR: How are they tracked or
13 followed in this system, and are they followed for
14 like 18 months afterwards with the Soldier
15 Management Family Specialist or how is that done?

16 COL. CARSTENSEN: Right now, we -- when
17 I first came into the program, they were saying it
18 was five years that they would be followed; right
19 now I'm saying it's as long as it takes, because
20 again, when you look at this -- the injury, the
21 acute piece of the injury is already at 18, like I
22 said, about 36 months, so the follow on a couple

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1 years is not going to be enough, so I just say as
2 long as it takes. So the goal here is that
3 they're adequately linked with their VA, they're
4 working with their Department of Labor counselors,
5 they're aware of all the benefits, their state and
6 local benefits, but we continue to follow. The
7 mechanism that we're following now is 30 days,
8 once every 30 days, unless there's an issue, and
9 we continue to work that until it's resolved.

10 And they all know their -- my goal is to
11 make sure they know who their counselors are,
12 there's a good relationship built, and so they
13 call back in when they've got something that they
14 need to have handled versus waiting for us to
15 learn about it some other way.

16 COL. DAVIES: Thank you, Colonel
17 Carstensen. We'll go ahead and take a ten minute
18 break, we'll cut that down, ten minute break, so
19 we'll gather here again at 10:05. Thank you so
20 much.

21 (Recess)

22 LTG KILEY: Doctor MacDermid, I'd like

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1 for you to introduce yourself to everybody since
2 you weren't here. She just was able to get in
3 after her flight was delayed last night.

4 DR. MACDERMID: Good morning, everyone.
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5 I apologize for my tardiness. I am Shelley
6 MacDermid, I am Co-Chair of the Task Force. In my
7 regular life, I am an Associate Dean in the
8 College of Consumer and Family Sciences at Purdue
9 University and a Professor of Child Development
10 and Family Studies. I also co- directed the
11 Military Family Research Institute located at
12 Purdue.

13 I'm very glad to be here.

14 COL. DAVIES: well, our next speaker
15 today is Mr. John Casciotti, he's the Deputy
16 General Counsel for the Office of the Assistant
17 Secretary of Defense for Health Affairs; Mr.
18 Casciotti.

19 MR. CASCIOTTI: Thank you. I'm the
20 health lawyer in the DOD Office of General
21 Counsel. And next slide, please. This is what I
22 want to talk about. This is a little outline. A

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1 couple of things -- okay. Just a little overview.

2 An overarching theme that we'll see
3 recur as we run through a few things dealing with
4 confidentiality is this notion of balancing
5 interest that favor confidentiality versus
6 interest that favor disclosure, and that's really
7 what the law tries to do in a lot of these areas.

8 There's several specific provisions of
9 the HIPAA regs which we'll run through that
10 address the balancing these interests, and
11 particularly in contexts that relate to
12 occupational activities and job related risks and
13 situations, how the law deals with those
14 particular things.

15 There's a special rule where they note
16 concerning psychotherapy notes in HIPAA, the
17 couple of related rules outside of HIPAA, but
18 nonetheless, dealing with confidentiality have to
19 do with a courtroom privilege and substance abuse
20 counseling statute.

21 And then just to provide a context to
22 compare how the law deals with some of the matters

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1 concerning health records and mental health
2 records, I'll say a little bit about
3 confidentiality in some other contexts. Next
4 slide. Okay. First to set the stage, when legal
5 matters in writ large, the law as it deals with
6 matters military, there's an overarching theme
7 that recurs over and over again and it provides a
8 frame of reference for this discussion, as well as
9 many others.

10 This is a quote from a Supreme Court
11 case that describes the military as a specialized

12 community, and says that, "The very essence of
13 military service is the subordination of the
14 interests of the individual to the needs of the
15 service." So as you look at matters where you're
16 trying to balance these things, that is an
17 overarching proposition concerning -- that
18 influences military law in a very big way. And so
19 in that context, this balancing of group versus
20 individual tends to tilt in favor of the group
21 interests. Next slide, please.

22 Okay. The next six slides, I'm going to

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1 quickly go over some basic rules of HIPAA. HIPAA
2 now establishes the basic law and the basic legal
3 standards applicable to the privacy of health
4 information. When I'm talking about the HIPAA
5 regulation, what I'm talking about for the most
6 part here are the regulations issued by the
7 Department of Health and Human Services. These
8 are the HIPAA regulations that apply to the whole
9 country. DOD has an implementing version of those
10 regs, and there's a couple of things that are
11 special DOD twists on that, but for the most part,
12 we're talking about the government-wide regs.

13 As a general proposition under HIPAA,
14 uses and disclosures of protected health

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15 information are safeguarded, but there are a whole
16 list of permissible uses and disclosures for a
17 whole variety of reasons, and there's a slide on
18 each one of the things listed here and I'll talk a
19 little bit about.

20 Also, kind of a general cross-cutting
21 notion under HIPAA is what's called the Minimum
22 Necessary Rule, and it's important to keep that in

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1 mind because the point of that is that even when
2 one of the specific reasons for a disclosure is
3 present authorizing a use and disclosure of
4 protected health information, the Minimum
5 Necessary Rule says only such information is
6 really necessary to accomplish that, so it's not a
7 blank check to turn over everything. Okay, next
8 slide.

9 All right. Now, starting to run through
10 these, one thing, HIPAA allows disclosures of
11 protected health information when the patient
12 provides an authorization, that's very straight
13 forward, but the implementation of that is
14 interesting because it gets into, and here's the
15 first time, it recurs frequently, notion of
16 occupational context being special, where there's
17 a permissible disclosure based on some particular
18 job related activity. This is one example of

19 that. I had to renew my security clearance last
20 month, and I noticed this form -- a whole stack of
21 forms you have to fill out for that purpose, I
22 noticed this is one of the forms I had to fill

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1 out, it says, "I hereby authorize", this is an OPM
2 form, yeah, Office of Personnel Management form,
3 "I hereby authorize the investigator special agent
4 duly accredited representative of the authorized
5 federal agency conducting my background
6 investigation to obtain the following information
7 relating to my mental health conditions", I'm
8 sorry, "my mental health consultations"; and it
9 goes on to list some things, anything that would
10 impair my judgement or reliability; setting aside
11 that I'm a lawyer, that doesn't count for this
12 particular purpose, but there's an example.

13 I had to sign this in order basically to
14 keep my job, because I have to have a security
15 clearance for my job. So the law recognizes that
16 when there's a particular job related activity,
17 that's a justification for disclosing otherwise
18 protected health information. And that occurs in
19 a lot of context of applications to be a police
20 officer or a pilot or some things like that,
21 again, occupational context carry a lot of weight.

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22 Next slide, please.

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1 Another category of permissible
2 disclosures under HIPAA are those which are
3 required by law. And the regulation, this is a
4 very broad definition of what is required by law,
5 it's basically anything that would be enforceable
6 in court, so it's much broader than just things in
7 statutes, it could be things in agency
8 regulations, administrative proceedings, and that
9 sort of thing. A DOD specific example of such a
10 requirement is set forth in the DOD instruction
11 that governs the Disability Evaluation System, and
12 it requires, it says medical personnel shall --
13 DOD medical personnel shall report to the
14 Disability Evaluation System any diagnosis that
15 they make of a military member that would -- that
16 based on the retention standards, would indicate
17 that that military member is not fit for duty so
18 that the process can go try to adjust that. Next
19 slide, please.

20 Another example, HIPAA allows
21 disclosures of protected health information for
22 public health activities. And the fine print

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1 under what that means includes a number of things,
2 sort of the traditional communicable diseases,
3 obviously, but in addition to that, a number of
4 things come up again that have special
5 occupational focuses and occupational injuries,
6 illnesses, fitness assessments and the like.

7 In the DOD context, of course, public
8 health activities includes a lot of health
9 surveillance activities, and I know you've been
10 looking at the post-deployment health assessment,
11 that's certainly a part of that undertaking.
12 Next, please.

13 Another category of HIPAA allowed
14 disclosures of protected health information,
15 relates to disclosures regarding a serious threat
16 to public health or safety. Now, here because of
17 the unique function of the military, that very
18 specialized community the Supreme Court talked
19 about, there may be a threat to the health or
20 safety of other people or the public that ties
21 itself up with the issue of carrying out a
22 military mission, threats to other people who are

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1 engaged in that mission or threats to people who
2 look to that mission to be successful as a part of
3 what protects them.

4 And this is something that's in the DOD
5 reg which specifically connects that, the threat
6 to health or safety with a threat to a military
7 mission. Next, please. So, again, we very
8 quickly ran through a number of considerations
9 that the HIPAA regulation recognizes are proper
10 for uses and disclosures of protected health
11 information, and particularly with this
12 occupational context and this impact on health and
13 safety of others kind of a context.

14 And HIPAA then goes a step further,
15 recognizing again the unique nature of the
16 military in our society, the HIPAA reg, the HHS
17 reg actually includes a special exception just for
18 the military, and it says that a health care
19 provider may disclose information regarding
20 individuals who are members of the Armed Forces
21 for any activities deemed necessary by appropriate
22 military command authorities to ensure the proper

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1 execution of military mission, broadly worded.
2 It's the commander who decides what's really
3 necessary here to protect the military mission,
4 and again, broadly worded. Note that this applies

5 to all health care providers, not just DOD health
6 care providers. This is in the HHS reg that
7 applies to the whole country.

8 So just to give an example, if a
9 military reservist called up to active duty,
10 deployed to Iraq, let's say, serves, comes back
11 home, and now is a veteran, and is also back in
12 the reserves, so it has two statuses, as a
13 veteran, goes to the VA, gets health care from the
14 VA, the VA doc, let's say, says, oh, geez, here's
15 an issue that may render you non-deployable, at
16 least for a temporary period while we try to work
17 it out, you know, the command is certainly going
18 to need to know that, so they know, hey, one of
19 the guys in the reserves, in case we have to go
20 again, got to know that we have somebody who's
21 potentially non-deployable so we can resolve that
22 issue. We don't want to be deploying somebody

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1 who's got some kind of a medical reason not to be
2 deployed. Next, please, okay.

3 Those are the basic rules of HIPAA.
4 There's one more HIPAA thing worthy of note, and
5 that is that HIPAA has a special rule concerning
6 psychotherapy notes. Psychotherapy notes are
7 notes maintained as a result of a counseling

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8 session by the mental health provider and kept
9 separate from the main medical record. Now, you
10 can't keep everything separate, of course; what
11 goes into the main medical record are the basics,
12 the prognosis, and the diagnosis, and the
13 treatment plan, and the progress and so forth, but
14 other things, other information, other thoughts
15 that the psychotherapist may have as trying to
16 evaluate a particular situation, those things can
17 be kept separate in psychotherapy notes. The
18 significance of that is that the rules for
19 disclosures are much more protective of
20 psychotherapy notes, few are grounds for
21 permissible uses and disclosures of that
22 particular information. Next, please.

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1 Now, there's a couple of things that are
2 outside the context of HIPAA, but are,
3 nonetheless, note worthy. One is -- this is a
4 courtroom rule, this is a courtroom privilege.
5 Some of you may know that about ten years ago, the
6 Supreme Court decided a case called Jaffe, in
7 which, for the first time, the court recognized
8 that there is such a thing as a psychotherapy
9 patient privilege in the Federal Rules of Evidence
10 that apply to federal civilian court. This is the
11 military counterpart to that. The military

12 adopted this rule to establish a counterpart to
13 that.

14 what this says is that in matters of
15 military justice under the Uniform Code of
16 Military Justice, in a court martial proceeding,
17 for example, the patient has the right to prevent
18 disclosure of any confidential communication with
19 a psychotherapist that is part of the treatment
20 process.

21 But again, as often is the case, there
22 are some exceptions to this rule, and one of the

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1 exceptions is that if there's some information
2 that's come forward there that is necessary to
3 disclose to protect the safety and security of
4 military personnel, classified information, or the
5 military mission, that would be a permissible
6 exception. Now, I should say this has much less
7 impact than HIPAA rules. HIPAA governs the
8 clinic. This is a courtroom rule and that just
9 doesn't come up that much. But nonetheless, it
10 does show that where the law has focused on an
11 issue and tried to address that balance of
12 interest, this is what has been provided. Next
13 slide, please.

14 This is another non-HIPAA rule, but it's

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15 worthy of note. Congress has passed a couple of
16 laws dealing with substance abuse. There's one
17 for drug abuse and one for alcohol abuse treatment
18 activity that are about the same, and that rule
19 provides for confidentiality of such records.

20 But again, when Congress addressed this
21 issue, Congress recognized, wait a minute, there's
22 a special case in the military, special

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1 circumstance in the military, so both of those
2 statutes include a specific exception, any
3 interchange of records within the Armed Forces is
4 exempt from the confidentiality rule of that
5 particular statute. Next, please, okay.

6 Those are the basic rules. I know I'm
7 going through this real fast, we want to have time
8 for questions and so forth. Those are the basic
9 rules applying to health care and mental health
10 records. To put this in some context, to help,
11 you know, understand it, it's not all one sided,
12 it's a complicated area, here's a couple of places
13 where the law addresses confidentiality in some
14 other contexts; one is communications to clergy,
15 and the rule here is a little bit different, the
16 rule here is, those are confidential, butt out, no
17 exceptions. And so communications, as long as
18 it's part of a religious activity doesn't apply to

19 something that is maybe off line in some other
20 context, but as long as it's part of some practice
21 of religion activity, the rule is, it's
22 confidential, the law is not going to get in the

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1 middle of that, not going to interfere.

2 I think that's, you know, obviously a
3 function largely of the value our society puts on
4 freedom of religion as protected by the First
5 Amendment, where the rule is basically the
6 government, you stay out of it, you have nothing
7 to do with that. Next, please.

8 Another example, communications with
9 lawyers. Again, the law is very protective of the
10 ability of a client and a lawyer to discuss things
11 and for the lawyer then to maintain the
12 confidentiality of discussions that are with the
13 client. There is an exception here, though, and
14 that is pertaining to any future crime or fraud.

15 So keep in mind, you're not allowed to
16 go talk to your lawyer about how you can get away
17 with some future crime, that would be outside of
18 what's protected and under the confidentiality
19 rules. And again, there's a constitutional basis
20 for this, because under the Constitution, anybody
21 charged with a crime, of course, has a right to

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22 counsel, and so here again, the law is pretty much

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1 hands off of whatever is going on and somebody
2 discussing with their lawyer. Next, please.
3 A third comparison I think is worthy of
4 note, and this is very interesting because this is
5 a DOD creation, I mean DOD is not the only one,
6 but this particular exercise of it is a DOD
7 creation. This appears in a DOD directive
8 concerning the reporting of sexual assault cases
9 and allows military, it has to be a military
10 member to be covered by this, military sexual
11 assault victims to make a restricted report
12 regarding the sexual assault, and the idea of this
13 is to encourage the victim to come forward and
14 seek health care and seek other counseling and
15 other services, and if the victim doesn't want to
16 get the cops involved, doesn't want to get -- let
17 the commander know about it, there is a set of
18 rules that provide opportunities for restricted
19 reporting, and of course, has some analogies to
20 situations where you want to make sure the patient
21 is not reluctant to come forward and seek help,
22 and so this rule was established by DOD for that

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1 very purpose.

2 But again, as most of these rules,
3 there's always a balancing, and there's some
4 exceptions here, and an exception in this context
5 is that if the doc providing services to the
6 sexual assault victim comes to the conclusion that
7 there is a diagnosis, a condition, a situation
8 that really has a significant adverse duty effect,
9 that some, you know, the commander is going to
10 have to find out something about that, why isn't,
11 you know, why isn't this soldier at work or, you
12 know, what's going on here. Now, that can be, you
13 know, that can be contained and you don't have to
14 get into anymore information that's absolutely
15 necessary, but that does give rise to some
16 potential disclosure. Okay, next slide.

17 So, you know, taking a step back and
18 looking at this comparison of things, you can see
19 that as the law wrestles with these issues and
20 tries to balance the interest favoring
21 confidentiality versus the interest favoring
22 disclosures in a particular context, you do get a

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1 variety of results.

2 I know you're wrestling with an issue
3 that we've all, of course, in the department
4 talked about over the years of how to get that
5 proper balance in the context of mental health.

6 You can see some things here in the
7 middle show that there are several contexts in
8 which that balance gets somewhat refined to really
9 look at the specifics of what's going on a
10 particular case, and there are some examples of
11 big, bright lines on the sides, but also some in
12 the middle here, some attempt to do careful
13 balancing, psychotherapy notes, this in, this out,
14 you know, Minimum Necessary Rule, okay, this much,
15 but not anymore, that sort of thing, and those
16 might provide some useful frames of reference as
17 you consider this thing. Next, please.

18 Okay, conclusions; writ large, HIPAA
19 does do this balancing in trying to look at what
20 favors disclosure, what favors confidentiality, in
21 a number of contexts, in the big picture,
22 recognizing that there are job related

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1 circumstances, occupational circumstances, things
2 that have to do with the health and safety of
3 other people, things that have to do with
4 requirements of law, where the balance tilts in
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5 favor of disclosure, to let those activities that
6 society holds important go on and take place, and
7 in other cases, it tilts in favor of protecting
8 confidentiality.

9 The military is a unique category, a
10 unique function in our society, and it's really --
11 some of these considerations that are recognized,
12 the military is probably the best example of those
13 things being true, and some of those
14 considerations are really super sized in the
15 context of applying it to the military.

16 But still, some balancing has to take
17 place to try to reconcile what is necessary to
18 protect the mission and what is best to give the
19 patient some greater autonomy and control over
20 that information. So that is the state of the
21 current law as I understand it, and open for
22 questions.

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1 COL. DAVIES: Any questions from the
2 Task Force?

3 DR. ZEISS: I have one backing up to the
4 HIPAA information you were providing, and I'm
5 coming from VA context, and I want to just check
6 out an implication I think is there in what you
7 were presenting, but I want to make sure that I

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8 get it clarified. When you were presenting the
9 revealing mental health information by a DOD
10 provider, the language you used, based on the
11 HIPAA regulations, is shall, that that shall be
12 communicated, and in talking about other providers
13 outside the military, the language on the slide is
14 those providers may communicate that information.
15 And we have construed that, or at least I have, to
16 be a very meaningful distinction in terms of what
17 a VA or other private sector provider might be
18 expected to do, that they could provide
19 information without breaking HIPAA regulations,
20 but they are not required to provide that in a way
21 that a DOD provider would be; can you comment on
22 that?

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1 MR. CASCIOTTI: Yes, a good question. I
2 had to go fast and I went too fast on this. HIPAA
3 doesn't require any disclosure, okay, HIPAA
4 permits disclosure. In the context to HIPAA,
5 HIPAA says this is confidential, start out with
6 the premise, medical information is going to be
7 confidential, and then says, but here's exceptions
8 to that rule where medical information may be
9 disclosed; in other words, you do not violate
10 HIPAA if you disclose information in these
11 circumstances.

12 So then you turn to, okay, well, how did
13 you get from the may to the shall, not in HIPAA,
14 that comes outside of HIPAA, in the DOD context,
15 that comes, and I gave you an example of the DOD
16 instruction, where it says that within DOD, DOD
17 providers shall report so that the Disability
18 Evaluation System can be activated. Within the VA
19 context, the determination of whether it's a
20 shall, or it's a shall sometimes, or if it's a we
21 don't know, or it's up to the provider, or if
22 it's, you know, call your lawyer or whatever,

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1 that's a matter for the Secretary of Veterans
2 Affairs to decide. As I understand the VA
3 interpretation of the rules, it is the same as
4 mine, in other words, that VA recognizes it
5 certainly would not be a HIPAA violation to
6 disclose in that case. Exactly what the VA does
7 or under the VA circumstances, I don't want to,
8 you know, speak for the VA.

9 DR. MCCORMICK: Somewhat related, what
10 about TRICARE and Military One Source, where the
11 military is paying for the service, but the
12 service provider is not in the command structure,
13 is that a may or a shall?

14 MR. CASCIOTTI: You have to talk about

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15 those two things separately is my understanding,
16 Military One Source versus TRICARE.

17 For TRICARE, if it's for a member of the
18 military and DOD is paying the bill, DOD can as a
19 condition of paying for a health care claim,
20 TRICARE can always say, well, we want to check the
21 medical records because we want, for any
22 beneficiary, make sure that the care was really

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1 provided as claimed, make sure that it complies
2 with the quality assurance standards and that kind
3 of stuff, so there's a whole range of reasons.

4 For a military member, one of those
5 reasons would certainly be, oh, we need to know
6 what's going on with military members because
7 they're a valuable asset. So as a condition of
8 paying for it, so doc, if you are providing health
9 care, you've got to be willing to follow the rules
10 of the payer, and that is certainly a permissible
11 disclosure by the doc, and that would be a basis
12 for DOD to say we need to know what's going on
13 there. Now, DOD, for a lot of routine stuff, who
14 cares, it's not worth a lot of trouble, but
15 certainly if there's something that's significant
16 going on, the rules would permit that kind of
17 disclosure.

18 Now, Military One Source is different.

19 As I understand Military One Source, it is not
20 really health care, it is counseling, counseling
21 for all sorts of things, financial matters, and
22 family issues, and so on and so forth. But as I

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1 understand Military One Source, if those
2 counselors identify something that really looks
3 like this is a health care issue, this is an issue
4 for somebody needing a health care professional,
5 that's referred.

6 So there you're not really dealing with
7 HIPAA rules that govern that process, and to my
8 knowledge, I don't -- I guess I better stop
9 because I don't think I have enough knowledge
10 about anymore on Military One Source if it's under
11 what circumstance anybody in DOD might ask for
12 information. I never heard of that, but I got to
13 tell you, I'm not that sure about that. Yes, sir.

14 COL. ORMAN: One of the things that the
15 Task Force is wrestling with is this whole
16 business of what really undergirds stigma is the
17 perception of service members about where the cut
18 points, if you will, where the thresholds are with
19 regard to the privacy of information that they
20 share in the context of some sort of mental health
21 setting. The threshold question is real

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22 important. Certainly, there's a perception piece

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1 of that that's dependent on how well educated the
2 service member is, how well educated the
3 leadership is, frankly, how well educated the
4 clinicians are, but there's a reality to that, as
5 well, which is, if I touch mental health, then
6 much like that OPM form you read with regard to
7 your own security clearance, it's going to raise
8 questions that potentially might jeopardize my
9 career, and then that tends to get exaggerated and
10 distorted by the service members that lends itself
11 to stigma.

12 So to get to kind of the bottom line on
13 my question, it appears to me that the cut points,
14 the thresholds, if you will, have sort of been
15 made on the basis of what leadership historically
16 or regulation writers historically have decided
17 based upon their own sense or common sense should
18 be the threshold for reporting.

19 So, for instance, security clearance,
20 you read the question, if you touch mental health,
21 then the investigator that's relooking your
22 security clearance has a right to look at your

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1 records. And I guess my question to you, where's
2 the evidence basis that that ought to be the
3 appropriate threshold as opposed to an
4 alternative, which is, they could only look in
5 your mental health records if you've been
6 hospitalized, which would be a threshold cut
7 point. Do you have any thoughts or comments about
8 that?

9 MR. CASCIOTTI: I can't answer that, I
10 don't know. But what's behind all those
11 judgements, these are what the regs say, this is
12 what's been established. My impression is that a
13 lot of people who are thought to be experts in the
14 field have certainly had a play in the development
15 of those regulations, I think I can say I've seen
16 that happen, but to get behind that and -- I
17 simply don't know what's gone into their life
18 experiences or their studies or, you know,
19 research done, I simply don't know.

20 You're probably in a much better
21 position than I to really evaluate whether you
22 think the merits of that case are there, and you

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1 know, weighing all the probably conflicting
2 evidence, you know, and uncertain evidence about
3 that.

4 I think that's certainly an issue that's
5 open for, you know, for review and consideration.
6 None of this stuff is written in any kind of stone
7 tablets. These reflect judgements that people
8 made, you know, over periods of time.

9 DR. MACDERMID: If I'm understanding
10 what you're saying correctly, the requirement for
11 command notification regarding treatment for
12 substance abuse then is something that is required
13 by DOD regulation as opposed to statute; is that
14 correct?

15 MR. CASCIOTTI: Right; statute permits
16 it, DOD regulation requires it.

17 DR. MACDERMID: Okay, thank you.

18 COL. DAVIES: Any other question? Mr.
19 Casciotti, thank you so much.

20 MR. CASCIOTTI: Thank you.

21 COL. DAVIES: Our next speaker is Doctor
22 Gerald Cross, he's the Acting Principal Deputy

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1 Under Secretary of Health for the Veterans Health
2 Administration; Doctor Cross.

3 DR. CROSS: I'm joined today by two
4 members of my staff, I'd like to introduce them,
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5 Tony Gorgiono (?) from the Business Office, and if
6 any questions come up relating to eligibility,
7 Business Office type things, Project Hero, he'll
8 be happy to talk to you during the meeting or off
9 line. And we also have Doctor Ira Katz. Ira is
10 the head of Mental Health Services for VA
11 nation-wide, and remarkable responsibilities, and
12 he'll be presenting immediately following me. But
13 I may call on him to assist me as we go through
14 this.

15 Now, I had envisioned this presentation
16 as being sort of a seminar in a graduate school
17 type environment, where we would be sitting around
18 a table and we could engage in talk and get to
19 what the issues are that you want to talk about,
20 I'm quite willing to do that, I prefer to do that.

21 what we've actually come loaded for
22 today is the Chamber of Commerce presentation on

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1 VA. And I'd like to go beyond that. I'd like to
2 deal with substantive issues, answer the questions
3 that are relevant to you. I can go through the
4 slides, I can skip the slides, but there are a
5 number of issues I'd like to talk about. And I'm
6 afraid the previous speaker may have taken my
7 notes that were laying up on the podium, which is

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8 okay because I know it all by heart. VA medical
9 system is a remarkable system nation-wide and
10 overseas. People sometimes don't realize that
11 we're in foreign countries, Germany, Korea, Guam,
12 other locations.

13 And in that environment for the VA with
14 so many locations, we see a lot of folks, about 50
15 million plus encounters per year. An encounter
16 can be a lot of things. If we focus directly on
17 appointments, that would come out to be about 39
18 million actual normal every day appointments that
19 you would understand.

20 -- 155 hospitals, 841 clinics, 209 vet
21 centers, and I want to say that vet centers, I'll
22 talk more about them in a moment, will be

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1 increasing in numbers, probably going up a couple
2 of dozen over the next several years, maybe even
3 sooner, 135 plus nursing homes, 800 plus clinics,
4 over 1,000 places, I want to say 1,000 points of
5 light, I don't know, over 1,000 places where one
6 can receive medical care and engage with the VA.

7 Now, the course of this, I'm going to
8 tell you some things that we're very proud of, and
9 I think that you should be proud of your VA, it's
10 a remarkable organization, we're very dedicated
11 people, many of whom have devoted their lives to

12 helping veterans, please don't forget that. I
13 have 195,000 employees, and I think the vast
14 majority of them have dedicated themselves to
15 doing what is best for veterans and to doing
16 everything that they can for veterans.

17 I'm also willing today to talk to you
18 about challenges that we face. The success that
19 the VA has had in recent years has brought about
20 in many ways a revolution in care for us and that
21 has achieved so much renowned is based on three
22 factors, it's a triad, and that triad is very

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1 basic, and I want you to understand that primary
2 care for our veterans through a system of
3 enrollment, performance measures, when we set
4 certain priorities, we expect them to be carried
5 out and we measure those to make sure that they're
6 carried out, and then an electronic health record
7 that has been an amazing success for us, very
8 popular with our users.

9 When you put those three things
10 together, you have suddenly -- if you're missing
11 any one of those, you wouldn't be able to do this,
12 but with those three things together, you're able
13 to produce dramatic change in a very large
14 organization that makes a difference in the

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15 outcome and the lives of the patients that we see.
16 I'll give you an example.

17 We decided that for our population,
18 diabetes was an area of great concern, and we saw
19 increasing levels of diabetes throughout our
20 population, and so we said we've got to do
21 something about this, and so we actually set an
22 outcome measure, hemoglobin A1C, which relates to

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1 morbidity and mortality, and said that for your
2 population, we want you to get the entire
3 population below a certain level on their
4 hemoglobin A1C, a measure of diabetic control.
5 Medicare does this, as well, by the way. In fact,
6 we can compare ourselves to Medicare and civilian
7 care on many different measures.

8 Would it be boasting for me to say that
9 we beat them every time? We produce better
10 results on the measures that are comparable
11 between our system and their system across the
12 board, hemoglobin A1C being an example that I just
13 wanted to highlight for you.

14 Now, I want to be precise in how I just
15 made that boastful statement, because actually, in
16 civilian care, they tie us on one measure, we're
17 working on that, but on the others, we're well
18 ahead.

19 And because of that and because we
20 achieved that success, we've had some recognition
21 in the media, and so Business Week a few months
22 ago, USA Today, Newsweek, ABC News, and so forth,

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1 highlighting the success that the VA has had in
2 turning the corner to becoming more adept to
3 producing those outcomes that are so important to
4 our patients.

5 And before we get to anything else,
6 there are a couple of things I wanted to highlight
7 related to this. New initiatives are under way
8 that I think that you should know about that
9 relate to the veterans that we care for, and in
10 many cases also, we're seeing some active duty in
11 these categories. Tele-medicine, folks coming
12 back from deployments, reservists, National Guard
13 don't necessarily live next to one of our big
14 medical centers, and so particular for these
15 individuals, and particularly for mental health,
16 we're finding ways to connect to them and smaller
17 communities at home, right in their own kitchen or
18 living room, putting devices in place in their
19 homes, 21,000 as of this moment, where the
20 individual connects back to the medical center,
21 back to the C block, community based out-patient

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22 clinic, and talks to their therapist, their social

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1 worker, their psychologist, their psychiatrist, or
2 their primary care person to monitor them.

3 Let me give you an example of how this
4 works. To move away from the mental health issue
5 for a moment, let's say that you have an
6 individual who is in critical balance and they're
7 going to be bouncing back and forth to an
8 emergency room frequently, they have congestive
9 heart failure, and if they get out of balance, the
10 fluid backs up from their heart into their lungs,
11 they have trouble breathing.

12 what we found is that by putting
13 technology into their homes, it can monitor
14 certain physical aspects that relate to how that
15 balance is being maintained, and when we see
16 certain characteristics changing, we're
17 communicating with them directly by phone and
18 through this device to say, hey, you're moving in
19 the wrong direction, we need to intervene, we need
20 to adjust your medicine, we need to make other
21 changes, and by doing so, we have documented that
22 we keep them out of the emergency room, they don't

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1 have to come to the emergency room, they don't
2 have to come and sit and wait in an emergency room
3 for some period of time which can be an unpleasant
4 experience for any of us, that never happens.

5 And by doing that, by preventing one
6 instance of that, we pay for the machine, because
7 that visit would have been very expensive, it
8 would have been unpleasant for the individual,
9 everybody came out a winner.

10 we're doing a similar phenomena with
11 mental health, tele-mental health. And I had
12 wondered if a person with certain mental health
13 problems would be willing to engage effectively
14 through a television. And my mental health
15 professionals, Tony and Ira and others, are
16 telling me that actually they seem to like this,
17 and yes, they do engage through that modality very
18 well.

19 And so we put out 21,000 of these so far
20 and we're expanding continually. Why should the
21 individual have to come to see us? I think
22 periodically that's important to do. But more and

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1 more of the VA is reaching out to the person where
2 they live, engaging with them at home or in their
3 community.

4 Another example of this, pharmacy, we
5 don't want the individual to come see us to get
6 their pharmacy prescription. Go to your CVS or
7 whatever pharmacy down the street here, you go in,
8 you turn in your prescription, you stand around
9 for a while, you come back, whatever, a tad bit
10 inconvenient, even if it goes well.

11 what we want to do is deliver the
12 medicine to their home. We have a chronic disease
13 model. Many of our patients typically are on the
14 same medication for long periods of time. Most of
15 what we do is not acute care, so why not provide
16 that medication directly to them?

17 we've gotten so efficient with this in
18 our CMOPS sending out this that we have reached
19 the phenomenal level, almost mythical level called
20 Six Sigma in terms of equality of some of these
21 actions that we take. It's so accurate, so
22 precise, and it's so convenient for the patient.

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1 By the way, it's also more cost effective for us.

2 Retinal scans, we're going through a
3 process right now through our telemetry of getting
4 a retinal scan on all of our veterans who meet

5 certain criteria. This relates to diabetes. We
6 want to have that record in our computerized
7 system and monitor a condition that can lead to
8 blindness, and we want to prevent that, but we're
9 using it for something else, we're using it for
10 patient education, because when we do the retinal
11 scan, it goes into our system, it's read centrally
12 by an ophthalmologist.

13 The reading and the picture goes back to
14 the primary care doc who's sitting at his desk
15 with the patient right here next, can pull up the
16 image on the screen, show them their retina, read
17 the changes, and highlight for them what this
18 means in terms of diabetic control, what this
19 means in terms of smoking, what this means in
20 terms of diet, and maintain -- and taking their
21 medicine.

22 Our polytrauma system of care is a new

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1 innovation that VA has brought forward in the last
2 two -- two and a half years. We wanted to look at
3 individuals comprehensively, in a
4 multi-disciplinary fashion. And those are fancy
5 words and I want to tell you what that really
6 means.

7 we have blind programs, we have TBI

8 programs, we have PTSD programs, we have physical
9 therapy and occupational rehab, but the nature of
10 injuries that we're seeing returning from overseas
11 at this time said that we had to change our
12 stovepipe system.

13 we had to bring all of these elements
14 together in a way that met the needs of the
15 individual, as opposed to saying, okay, we're
16 going to work on your TBI at this program, and
17 then we're going to take you down the street and
18 make some different set of appointments and work
19 on your PTSD, and then on another occasion we're
20 going to work on your occupational therapy over
21 here.

22 And so a group of leaders at the VA,

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1 some of whom are here, put together four sites
2 where we could provide in an intensive degree
3 in-patient sitting, all of these services, in a
4 comprehensive manner for the individual all
5 working as a team. Those sites were Richmond,
6 Minneapolis, Tampa, and Palo Alto. Then we said
7 that's not good enough, they're not going to stay
8 at those sites, they're going to move out back
9 home to where they came from, we need to get these
10 services closer to their home, we need a step-
11 down, shall we say, approach. And so we've just

12 opened 17 new level two centers to get them closer
13 to home. We now have one -- level ones that we
14 already did; we now have one level two site in
15 every one of our regions.

16 And then from there we have even other
17 services getting them back closer and closer to
18 home in a progressive manner, bringing all these
19 services together in one location, treating the
20 individual as a package rather than in segments.

21 DOD and VA, I've been around DOD for a
22 long time. I worked with one of your

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1 distinguished panel members, Dave Orman, was a
2 member of my staff at Fort Hood. In all of my
3 experience over those years, I have never seen the
4 communication and cooperation and collaboration
5 between VA and DOD that we have now.

6 In fact, we have so many meetings, this
7 being an example, that it seems almost second
8 nature at this point. What this means, intangible
9 results for our veterans is this, when you go to a
10 polytrauma center and walk down the hallway,
11 you'll see someone standing there in a uniform
12 that looks very much like this uniform.

13 And so if that person has a pay problem
14 related to the United States Army or the Marine

15 Corps, here's a person that they can talk to on
16 the spot who understands those kind of issues and
17 can help them work their way through our two large
18 systems. If you go to Walter Reed, you'll see a
19 person in this kind of uniform, probably a social
20 worker or a nurse, and we have placed VA staff at
21 eight, or is it nine now of the large military
22 treatment facilities. That's what we mean by that

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1 often and over used and over blown term, seamless
2 transition.

3 we're not going to do away with the two
4 -- we're not going to do away with the DOD and
5 we're not going to do away with the Department of
6 Veterans Affairs, but we want to make them work
7 together for that veteran, that service member as
8 well as we can, and by doing that, the tangible
9 thing that we have done is to put our people
10 there, and DOD has put their people with us to
11 manage that process.

12 Plus, we're communicating in so many
13 other ways. We're exchanging information, we've
14 worked out all kinds of ways to start exchanging
15 laboratory results and all kinds of other
16 information electronically, even while still
17 observing HIPAA guidelines.

18 Our service connected individuals, those

19 that means those individuals coming out of --
20 something happened to them in the military that
21 has caused a physical or mental problem, pay no
22 co-pays and no enrollment fees.

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1 we have a two year eligibility window,
2 that basically for a combat veteran coming back,
3 someone has been deployed overseas, OIF OEF, when
4 they return, they're automatically into our system
5 by just showing up and saying hello and filling
6 out a few papers. They don't have to go through
7 the disability process to be eligible for health
8 care in the VA for that two year period. That two
9 year period then gives them the ability to start
10 that compensation and pension program, that
11 disability process, and establish their
12 eligibility for life, and to establish their
13 benefits for life.

14 And finally, I want to talk about a
15 couple of other things. I heard the term this
16 morning, "stigma" and mental health, and I think
17 it was actually Dave who mentioned it, we're
18 working on that. We're actually taking initiative
19 for that that we think will impact the entire
20 nation.

21 what we're doing is this, we're doing

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22 something very practical. We know that our folks

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1 are quite comfortable in coming to our primary
2 care clinics, they're familiar with that, they
3 come in and get their blood pressure checked or
4 whatever, they know the people there, they know
5 where that clinic is.

6 There's a bit of a challenge at times,
7 though, when we detect a mental health issue and
8 say, we'd like to refer you over to our mental
9 health clinic. Sometimes they don't show up,
10 sometimes they don't want to get referred, and I
11 think that's the issue that you've alluded to,
12 stigma.

13 So with our support, Tony's support,
14 we're moving forward on an initiative for primary
15 care mental health integration, across our nation,
16 in our facilities nation-wide, to say when a
17 person comes into our primary care clinic, we want
18 to make sure that there are people there who are
19 well prepared to diagnose if they have TBI, to
20 diagnose if they have depression, to diagnose if
21 they have PTSD, and actually to start the
22 treatment process in the primary care clinic, so

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1 they don't have to take a referral necessary, at
2 least early on, and go sit in a waiting room next
3 to a sign that says psychiatry clinic or mental
4 health clinic, in a place where they've not been
5 before, in a place with staff that they're not
6 familiar with.

7 we'll do it in a place where they're
8 very comfortable, start that process there. If
9 they need those other services, we'll still do
10 that, but we've got to get that first step done.
11 If you don't get that first step done, you don't
12 take the second step either. And I think this is
13 one of the most creative things that we're doing
14 right now, polytrauma, mental health primary care
15 integration.

16 A tremendous amount of work, by the way,
17 that we do on training and research. We have
18 affiliations with 117 medical schools, we do more
19 training, more medical training in the United
20 States than does any other organization, period.
21 If you talk to a doctor -- doctors in a hospital
22 anywhere in the United States, any civilian

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1 hospital, you'll find that many of them were
2 trained at the VA.
3 Research, we're doing a tremendous
4 amount of research with increasing focus on TBI
5 and PTSD and amputation care. I'm going to ask
6 for that video in about one minute, My Healthy
7 Vet. Again, we want to engage with the person at
8 home so they don't have to come to the clinic. We
9 have created on the web an access point to the
10 medical record for that individual. I want you to
11 understand what this means. This is phenomenal.
12 They can enroll in our system, and sitting at
13 their computer at home, go on their computer and
14 get their medicines refilled and have it delivered
15 to their house, and all they have to do is walk to
16 the front door and pick it up.
17 We have created a system through My
18 Health Vet that going through the web, they can
19 download some portions of their health record, and
20 if they're getting care say in TRICARE or through
21 some other insurance, through their health care in
22 the civilian environment, they can download

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1 portions of their chart and carry it with them
2 when they go see their civilian doctor and hand it
3 to them so that they have some coordination
4 between the VA and the civilian community.

5 These are some of the things; if I
6 didn't get to any of the other things, I wanted to
7 mention these. I've given you this -- can we pass
8 this out to the committee members? There are more
9 sitting out there in the chairs if some other
10 folks want them. It's a very brief overview of
11 the programs, both benefits and health care that
12 we provide. You know, nothing is like a picture
13 in terms of communicating what we're doing. I
14 picked out two video segments, one relates to
15 amputee care, one relates to mental health.
16 They're each five minutes long. I'm going to ask
17 if we can show track six and show -- I had this
18 filmed just recently to show something that we're
19 doing which I think is very innovative on amputee
20 care. Can we roll that?

21 (video plays.)

22 DR. CROSS: You know, we are from the

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1 VA, and I should point out that all of the data
2 and the thumb drive that I brought over was
3 encrypted. If it's going to start from the
4 beginning, we'll have to back up on that. The
5 entire video is over an hour.

6 DR. MacDERMID: I wonder if we might
7 squeeze in a couple of questions while that's

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8 getting cued up?

9 DR. CROSS: Sure.

10 DR. MacDERMID: I'll start, but I'm sure
11 there are other people who have questions.

12 DR. CROSS: who's speaking?

13 DR. MacDERMID: I'm sorry, Shelley, the
14 co-chair.

15 DR. CROSS: Okay.

16 DR. MacDERMID: Could you say a little
17 bit about the degree to which VA is prepared for
18 the numbers of folks that are going to be coming
19 your way given Operation Iraqi Freedom?

20 DR. CROSS: The question comes up all
21 the time. The VA is being overwhelmed, and you
22 guys can't handle it and you won't admit it, true?

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1 DR. MacDERMID: That's why I'm asking.

2 DR. CROSS: That's why you're asking.

3 It's not true. The number of OIF and OEF that we
4 see, out of those 50 million encounters, it comes
5 out to about four percent I think of our work load
6 at this time. With the budget increases that
7 we've gotten, we're actually quite comfortable, to
8 the point that we're opening new facilities,
9 opening new programs, and enrolling new patients
10 who want to be enrolled.

11 Let me give you some examples. The
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12 occupancy rate for our polytrauma rehab facilities
13 is about 70 percent. The occupancy rate for our
14 in-patient mental health programs is probably less
15 than 70 percent. What we're doing continually is
16 reassessing, looking for those issues where, on a
17 geographical level, we do expect some challenge
18 and we're dealing with it. But the work load that
19 we're seeing out of this so far is within our
20 mission and within our capability.

21 DR. MCCORMICK: To kind of follow-up on
22 that, let me give a little context. I applaud the

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1 idea of having a feedback loop to improve the
2 system, that definitely is true. A couple of us
3 -- and one of the biggest issues we're having
4 trouble getting our hands around are reservists
5 and National Guard. A couple of us visited a
6 Marine reserve unit that took heavy casualties a
7 couple weekends ago, and out of a company they
8 lost 24 men, and we saw about 30 of them there,
9 and the issue came up, they were quite open about
10 it, about their ability to access VA services, and
11 there were more complaints than I would have
12 expected. So my question is this, we know what we
13 know, is there any feedback loop? And the good
14 news is, this group had gotten a lot of attention

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15 from VA, including the vet centers, a lot of
16 visits early on, they were back about a year; is
17 there any feedback loop that --

18 DR. CROSS: These were active duty?

19 DR. MCCORMICK: These were reservists.

20 DR. CROSS: Okay.

21 DR. MCCORMICK: They had been back about
22 a year. Is there any feedback loop on getting

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1 some input from reservists and National Guard
2 about their experience of trying to access VA
3 services?

4 DR. CROSS: I'm so glad that you asked,
5 because we've done that. We did a satisfaction
6 survey, and on our satisfaction surveys, we
7 compare ourselves to the civilian environment to
8 HMO's.

9 We have the data in my slides if you
10 want to see it. We beat the HMO's nation-wide by
11 a substantial margin. But we said that's not good
12 enough, let's go look at OIF and OEF.

13 We did a special survey of them
14 nation-wide, looking at their results, it's very
15 comparable in terms of satisfaction level to
16 overall. Now, that's not good enough either.
17 Statistics don't mean anything if you've got a
18 good story. The PDHRA, this is an area where DOD

19 and VA have linked up quite well, because when you
20 have a unit coming back to do the PDHRA, we put
21 our vet center people on-site as part of our
22 outreach effort, to be in the room when they're

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1 taking the PDHRA and then to answer questions and
2 get them back engaged in our program.

3 If they have an adjustment issue or even
4 a PTSD related issue, the waiting time for our vet
5 centers is zero. And we have 209 of them and
6 we're opening about close to two dozen more in the
7 near future. Having said all of that, that's not
8 enough either, because if I have one person who is
9 unhappy with something and who got a less than
10 warm reception, we have to deal with that.

11 What we're doing then, we've created OIF
12 and OEF coordinators in each of our medical
13 centers, and so when a person walks in and says,
14 I'm returning from the war, we have -- lights are
15 supposed to go off, whistles blow, we get that
16 person in, get them seen as quickly as possible,
17 preferably right then.

18 Systematically, from a systematic point
19 of view, our statistics, and I believe our
20 management, suggests that we're doing well on
21 this. The fact that you can come up with a story

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on occasion suggests that we still have more work

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1 to do, and I'm very willing to do that.
2 SPEAKER: Am I allowed --
3 COL. DAVIES: I'm sorry, we can't take
4 any from --
5 DR. CROSS: Do we have the video? This
6 is going to start off a bit dull and then it gets
7 really exciting. Is this track six? Okay.
8 (Video playing.)
9 DR. CROSS: Cultural change, and that's
10 an example of it, we no longer believe that
11 getting an amputee back to a point where they can
12 be self-sufficient at home and go to the bathroom
13 and make a sandwich in the kitchen is sufficient.
14 We have to evaluate their life dream.
15 What is it that they want to do in their
16 life and how can we help them to do it; if that
17 means special training, then this is the kind of
18 place that we provide it, if that means that
19 having an additional prosthesis so that they can
20 go swimming or running, we provide it, it means
21 that the old paradigms that we had about getting
22 the person up to a point where they're reasonable

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1 self-sufficient is no longer the philosophy that
2 we will tolerate in our system.

3 If I had time to show you the second
4 video, it would relate to PTSD and TBI,
5 fascinating and so subtle video, completely
6 different from this, engaging with a person who
7 has suffered TBI in terms of training them with a
8 brain prosthetic, and training them to regain
9 certain functions in their life. And one of the
10 people in that video, I have actually been with
11 and talked to. You know, the kind of recovery
12 that can be achieved is just, in my mind,
13 phenomenal. I think Ira is up next and we
14 probably want to have some questions.

15 DR. MACDERMID: Anybody on the Task
16 Force have any quick questions that we can ask?
17 I'll just ask one while you're making the
18 transition. Feel free to come on up. We've been
19 talking a lot about access to care for OIF OEF
20 veterans and the kinds of injuries that they're
21 likely to have, and so my question is specifically
22 about the two year eligibility rule that sort of

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1 opens up access.

2 But one concern we have is how long it
3 can take some injuries to emerge. Do you think
4 there's a good fit, is that regulation right, or
5 is that one of the challenges, that there's some
6 things that need to be fixed there?

7 DR. CROSS: Let's suppose that the
8 injury doesn't show up during that two year
9 period. If some other injury had shown up during
10 that period, they would have already gone through
11 that system and been eligible for care for the
12 rest of their life.

13 In the event that they showed up later,
14 we have other options to get them in promptly and
15 quickly, even if they haven't gone through the
16 complete compensation and pension program.

17 I'll give you two examples, make it
18 three; number one, prima facie evidence, a person
19 coming in, they've gotten out recently, they were
20 not OIF OEF, but they have some problem, they need
21 health care, and they don't have time to wait to
22 go through the C&P (Compensation and Pension) process, we can put

them

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1 through our system, into our health care program,
2 into a hospital, into a bed by making the
3 assumption that they will be eligible. And Tony

4 can explain this more to you off line if you would
5 like. It's called prima facie introduction, I
6 guess. Number two, let's say they show up 20
7 years later, and let's say they have a sudden
8 break -- let's create the worst possible case.

9 Twenty years later, PTSD, and they show
10 up on the doorstep of the VA, and they've never
11 had any contact with the VA up until that point,
12 and so they have no eligibility. To go through
13 the C&P process might take quite a few months, the
14 same as the disability process for the military
15 might take quite a few months.

16 But given that situation, we have
17 provision to put them in as a humanitarian case
18 and admit them right then. The caveat is, if it
19 turned out that we do this and they were not
20 eligible, they would have to reimburse us down the
21 road. That rarely, in my personal experience, has
22 never happened. But we do put people in on a

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1 humanitarian base to short circuit that process,
2 because they have the need right now.

3 Number three, if they have a certain --
4 if they have a condition like that and it's for
5 adjustment reaction or PTSD or whatever, that same
6 individual 20 years later can walk into a vet
7 center and be seen that same day, eligibility or

8 not. Other questions? All right. I'm going to
9 turn things over to Ira then, and he's got lots of
10 good information on our mental health programs.

11 COL. DAVIES: Okay; thank you, Doctor
12 Cross.

13 DR. KATZ: Well, I just want to begin by
14 mentioning one of the things, the President's New
15 Freedom Commission, about mental health being an
16 important part of overall health. And in the VA,
17 the way Doctor Cross and Doctor Kussman
18 conceptualize the overall health system, that very
19 much enhances mental health, as well as other
20 components of health. How am I for time? What
21 should I --

22 COL. DAVIES: Our time is way off right

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1 now, but you've got a half hour, and the Task
2 Force is very interested in hearing what you say,
3 and we've got administrative time this afternoon,
4 so --

5 DR. KATZ: Thank you. I'll try to do
6 briefly an overview of our mental health care
7 systems. It's the best of times, it's the worst
8 of times. What do I mean by that? I think as a
9 mental health care system, we're among the most,
10 if not the most advanced in America, but we're

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11 profoundly effected by every case and every
12 example where things don't go as they should. So
13 we're both aware of our progress and of the
14 hopefully rare, but every case is significant
15 lapses. Next slide.

16 we're a system, and we're a provider,
17 payer, and policy environment, and one of the few
18 places in America where all of these dimensions
19 are convergent, so we have a shot at developing
20 something that can, we believe, set the lead for
21 the rest of the country. We're also a member of
22 the community, both community with you and the

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1 broader civilian community to which our veterans
2 return. Next slide, please.

3 what are we? Twenty-one veterans
4 integrated service networks or visions. I'm
5 embarrassed that my numbers are somewhat wrong;
6 156 medical centers, 841 clinics, as well as other
7 care facilities. I had at one point gone through
8 a list and counted 1,300, including multiple
9 campuses for medical centers and almost 200,000
10 employees. Next slide, please.

11 who are the veterans? There are about
12 25 million total veterans in America, 7.2 million
13 enrolled in Veterans Health Administration, about
14 5.3 million served by VHA in every year, and 1.2

15 million or so of them have a mental health
16 diagnosis, 0.9 million each year are seen in
17 mental health specialty care, the difference being
18 those that are seen in primary care for mental
19 health services, and that's a number, as Doctor
20 Cross mentioned, that we expect will increase.
21 Next slide, please.

22 well, historically, these are data from

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1 1990 up to 2003. The VA population was aging,
2 that's something of interest to some people who
3 grew up as gerontologists. It's an interesting
4 story, but a different one. Next slide.
5 Actually, the age of those seen in mental health
6 care is somewhat younger. That's an intriguing
7 story and one we could come up to -- come back to.
8 But the idea that veterans are primarily an aging
9 population was true until 2003, and then something
10 happened. Next slide. Since then, over 630,000
11 eligible veterans have returned from OIF OEF, and
12 about 205,000 have gotten care within the Veterans
13 Health Administration.

14 It's about a third, and the proportion
15 is about the same in former active duty troops and
16 reserve and National Guard members. Next slide.

17 what do they come for? well, the most

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18 common conditions are musculoskeletal
19 conditions. These numbers add up to way over 100
20 percent because most people come back with more
21 than one condition. The area that's the second
22 most common is mental health conditions

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1 corresponding to somewhat more than a third of
2 returning veterans. Next slide.
3 Of these conditions, PTSD heads the list
4 with somewhat less than half of those with any
5 mental health condition. The other conditions are
6 in descending order. I want to mention that these
7 are ICD codes, that if one adds up the depressive
8 disorders, the affective psychosis, and a
9 component of the neurotic disorders that might
10 correspond in a broad view to depressive
11 conditions, they probably outnumber PTSD. But
12 this isn't a horse race. The point of this is
13 that PTSD is a prominent condition among returning
14 veterans, but by no means the only condition.
15 Next slide.
16 what do we see; how big burden or flood,
17 as you asked, are returning veterans? well,
18 Doctor Cross mentioned the four percent figure.
19 The total of the number of veterans who have
20 returned from OIF OEF and received care in the VA
21 is about four percent of the number of veterans

22 who receive VHA care in any one year -- represent

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1 six to eight percent of those, depending on
2 whether you're talking about mental health. So
3 overall mental health specialty care for PTSD,
4 which is in the tabulation I mentioned, the
5 leading condition, it represents about ten percent
6 of those with PTSD seeing in VA mental health in
7 any one year. Is this a big deal? Yes, each case
8 is profoundly important. Is it drowning our
9 system? No; these are substantial numbers, but
10 we're a large system and well able to absorb them.
11 Next slide, please.

12 Okay. What services do we provide? We,
13 in fact, have two mental health care systems in
14 VA. I speak and Tony speaks for the Office of
15 Mental Health Services, which is charged with
16 organizing mental health care in our medical
17 centers and clinics. This is condition focused
18 care on disorders and related conditions that
19 follows a medical model. Mental health care is an
20 important part of overall health care.

21 But there's also a separate mental
22 health system in the readjustment counseling

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1 centers that has very different models. It's not
2 so much condition or disorder focused as problem
3 focused.

4 It deals not with symptoms, but with
5 readjustment difficulties and very much an
6 alternative model. We're part of the medical
7 record; they have their own non-electronic
8 records. They're, as I see it, a safety valve.
9 Those who don't want to come to us for whatever
10 reason, primarily stigma, have another door within
11 VA that they can go to. And the theme and the
12 message behind the readjustment centers is that
13 there's no wrong door, help is available, and
14 counseling and treatment work whether or not in
15 the vet centers or the medical centers and
16 clinics. Next slide, please.

17 What do the vet centers do? I'm sorry,
18 previous slide. There's a menu of services. One
19 of the things they, by law, are able to do that we
20 in medical centers and clinics cannot is to focus
21 more on couples issues and care. Readjustment
22 issues in the family are very much something

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1 they're authorized to provide. They can also
2 provide counseling to families of deployed active
3 duty personnel without the veteran on premises.
4 They provide bereavement counseling, and
5 since the start of OIF OEF, have provided this to
6 a substantial number of people. And there are a
7 menu of other services that they provide, some in
8 health care, some in other areas. They're also
9 coordinated with mental health services and mental
10 health. In medical centers and clinics, if the
11 problem focused care doesn't work, people are
12 referred to condition focused care. Next slide.
13 Since their beginning, the vet centers have been
14 concerned with outreach in the community and in
15 the transition from DOD. They've recently hired
16 100 OIF OEF veterans to provide outreach and
17 really peer to peer conversation. They're
18 involved with PDHRA events, as well as other
19 post-deployment events depending on state and
20 region. All in all, they've seen over 160,000
21 people in outreach or counseling since the
22 beginning of the conflict and have provided

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1 counseling services to over 40,000 veterans and
2 their families. Next slide, please.
3 we compliment what they do in medical

4 centers and clinics by having our own outreach
5 education and care teams that really focus on
6 engaging new veterans in care, dealing with, yes,
7 condition identification, screening, and
8 diagnosis, but really helping returning veterans
9 feel at home and cared for in our facilities.

10 There are about 84 of these programs now
11 that conduct activities like post-deployment
12 clinics that are meant to be user friendly for
13 returning veterans who are, as a rule, younger
14 than our population. Next slide.

15 what do we do about the PTSD which is
16 arguably a signature problem of returning
17 veterans? well, Michael Kussman has been gracious
18 enough to quote me as saying that PTSD is both a
19 specific illness and a very important one, but
20 also a metaphor for all stress related conditions
21 that occur related to deployment, and that's
22 really the model that we use in thinking about

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1 returning veterans. We avoid over pathologizing,
2 we teach coping skills, we're not in a rush to
3 diagnose any condition. We've learned from
4 Jennifer Vasterling's work in the Fort Hood study
5 that there are measurable and expectable effects
6 of deployment even after one controls for mental
7 health conditions and histories of head exposure.

8 We want to teach people how to cope and to wait
9 and overcome these conditions.

10 When there are mental health conditions
11 that represent the source of suffering or
12 impairment, we're not in a rush to diagnose PTSD
13 specifically. In a way, PTSD is the most
14 destigmatized of mental health conditions. One of
15 our challenges may be how to use that as a
16 vanguard in helping to destigmatize all mental
17 health conditions.

18 But veterans may well come to us and
19 say, I'm afraid I have PTSD and it's making it
20 difficult for me to get back into the family, to
21 work, education, or to the community, and one of
22 the first things we do is to see if they have

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1 PTSD. They may have a disorder, but they may have
2 something else, depression, alcohol related
3 problems, other mental health problems.

4 So that we're quite prepared to
5 recognize that PTSD, in some cases, may be a
6 metaphor. We involve the family when it's the
7 veteran's preference. When we develop -- when we
8 make diagnosis, we treat using evidence-based
9 psychotherapy and pharmacotherapy. There's a
10 rumor that there will be a paper coming out in

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11 JAMA this week dealing with a VA study of
12 evidence-based psychotherapy in female veterans.
13 I believe it's true, but it's just a rumor. We're
14 working, even before the paper comes out, to
15 provide training and disseminate the
16 evidence-based therapy throughout our system.
17 Following recovery and rehabilitation models,
18 we're focused, of course, on reduction of
19 symptoms, but even more important, helping
20 veterans return to their functional roles and
21 relationships work in the community, even when we
22 can't bring symptoms into remission. Next slide,

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1 please.
2 The structure of services, there's now a
3 PTSD clinical team or PTSD specialists in every
4 medical center, as well as a series of other
5 programs. One of the initiatives for this year,
6 as Gerald says, is developing mechanisms using
7 tele-mental health to bring specialty PTSD care
8 into smaller community based clinics, including
9 those in rural markets. Next slide, please.
10 Programs under development include that,
11 My Healthy Vet, as Gerald mentioned, and I had
12 mentioned before, the rule out of evidence-based
13 psychotherapy. Next slide.
14 Treatment for PTSD is a specialty area.

15 Our emphasis and the larger part of what we do is
16 on core mental health programs, out-patient,
17 in-patient, and other residential care and
18 rehabilitation settings. Within the VA, substance
19 abuse is a part of mental health, right, that's a
20 different use of the word than SAMHSA, for
21 example. And though we focus on sub-specialty
22 substance abuse programs, we're more and more

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1 focusing on dual diagnosis activities. Well, this
2 is where things were. Next slide. In 2003 or so,
3 it's the other thing that happened at this time,
4 the Secretary and Under Secretary for Health
5 developed a mental health strategic plan for VA
6 based on the principals of the New Freedom
7 Commission. It has 265 elements, and I'm not
8 going to go over them.

9 It can be reduced, though, into four
10 primary factors, treating mental health with equal
11 urgency as the rest of health, improving capacity
12 access, and eliminating disparities, promoting
13 rehabilitation and recovery as models for our
14 specialty care settings, integration of mental
15 health and primary care, and implementation of
16 evidence-based practices. Other key elements are
17 a focus on returning veterans and suicide

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18 prevention. Next slide.

19 There is also, as an aid to implement
20 the strategic plan, funds set aside by the Under
21 Secretary for what's called a mental health
22 initiative, funding that this year represents

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1 about \$306 million to foster the implementation of
2 the strategic plan, increasing capacity, and
3 transforming the culture of care.

4 I just want to go over the numbers in
5 broad categories. Numbers are important, dollars
6 are important in Washington, they're, again, a
7 metaphor for something really important. The
8 mental health care budget in the VA represents
9 about ten percent of the total budget. That's
10 compared to about three percent in Medicare, so
11 we're very serious about mental health. And the
12 mental health initiative represents about ten
13 percent of the mental health budget or one percent
14 of the total VHA budget, which is a way for mental
15 health services in Central Office to use that one
16 percent for steering the system as a whole. Next
17 slide.

18 Okay. I was going to present, but in
19 interest of time will not, the individual programs
20 that might go with each of the factors of the
21 strategic plan. I can provide that if you want on

22 questions. Next slide, please; and next; and

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1 next; and next.

2 Focus on OIF OEF is something that I do
3 want to focus on. There's outreach, as we talked
4 about, as well as extensive inreach, identifying
5 mental health problems among those who come to VA
6 for primary care or specific medical services.
7 There are PTSD programs, a new center to monitor
8 the care and identification of people with
9 military sexual trauma throughout the system, and
10 dual diagnosis programs.

11 There are also three centers of
12 excellence for PTSD and mental health being set up
13 throughout the country at the advice of Congress
14 that will be technical assistance centers for the
15 rest of the country in dealing with these things.
16 Next slide.

17 Suicide is a big deal, and we formed two
18 centers to provide technical assistance, and a
19 number of programs, some of which modeled after
20 DOD programs, some modeled after community based
21 programs, to approach suicide prevention in two
22 ways, from a public health model and from a

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1 clinical model. The basic assumption is that
2 suicide prevention requires adequate capacity and
3 ready access to a high quality mental health care
4 system, as well as initiatives that focus
5 specifically on suicide prevention.

6 we're doing that, and to support this at
7 a local level, as of April 1st, suicide prevention
8 coordinators will be funded in each of the 156
9 medical centers to foster the identification of
10 people at high risk, to enhance their monitoring
11 and care, and to provide aspects of the public
12 health model, including training for all within
13 the VA, as well as those in the community that
14 come in contact with veterans. Next slide,
15 please.

16 The vision for the program after the
17 strategic plan is to move from specialty mental
18 health services as the sole component of the
19 system to a transformed specialty care system that
20 focuses on recovery and rehabilitation that will
21 exist side by side with integrated mental health
22 systems in primary care focusing on improved

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1 access and quality of care for the common mental
2 health conditions. Evidence-based psychotherapy
3 and clinical neuro science-based treatments will
4 be delivered across the spectrum of therapy. I
5 think that's the end. Next, yes. Thank you.

6 DR. MACDERMID: Dan.

7 DR. BLAZER: This is one quick, and you
8 did not mention this, but I think Doctor Cross did
9 say something about this. From what I understand,
10 there are going to be some increased residency
11 training positions that will be funded by the VA
12 given the burden of mental illness that I
13 anticipate you will continue to see. Will a
14 sufficient, almost like a statement I guess, will
15 a sufficient number of those be delegated for
16 training psychiatrists?

17 DR. KATZ: I don't know the exact number
18 of new positions that are going to be mental
19 health focused. On the other hand, you know, as
20 you've always taught, mental health is too
21 important to be left to the mental health
22 professionals, and through these integrated care

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1 systems, training and recognition management and
2 treatment of mental health will be part of all
3 training for physicians and other professionals in

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4 the VA system.

5 we're also beginning to toy with the
6 notion of whether there should be, I hate to say
7 this because it's such a charged issue, but is
8 there room for and a need for yet another
9 psychiatric sub-specialty, this one dealing with
10 stress resilience and PTSD, it's something an
11 active dialogue.

12 DR. BLAZER: I guess the reason I'm
13 thinking about this is just that point, and that
14 is, you're in a unique position to undertake the
15 training, and as we've talked many times in
16 another area, yes, it will be very important to
17 train the primary care physicians and other
18 individuals, but at the same time, you have to
19 have the trainers, as well, and so you have to
20 have the people who have the specialty knowledge,
21 and I would hope that there would be enough
22 emphasis on the people at the top, as well as

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1 people on the front line, as well.

2 DR. KATZ: Yeah, you know, other
3 coordinating positions and leadership roles are
4 recovery coordinators in each facility, really to
5 help with the transformation of the specialty care
6 system. This is training of our parent staff
7 rather than the next generation, which we also

8 have to be concerned with.

9 DR. MacDERMID: I have a question. Do
10 you have any idea how far away, for example, if
11 you were to think about reserve and Guard
12 populations who come back and are geographically,
13 widely distributed, do you monitor at all how far
14 away people are geographically from the nearest
15 care? For example, do you have any idea how many
16 Guard and reserve members might be 200 miles or
17 more away from the nearest facility?

18 DR. KATZ: I don't have the data in that
19 form. Something I'm proud of is, if you compare
20 our population now with that which we saw ten
21 years ago, we're seeing twice as many people with
22 mental health conditions who, on average, have to

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1 travel half as far to get to VA care. The number
2 a decade ago was, on average, 26 miles, the number
3 now, I believe, is 13 miles, on average.

4 DR. MacDERMID: I'm having flashbacks
5 about the SAT's at this moment. It's one of those
6 scary word problems, but I think I get the point.
7 Thank you. A couple of other questions; it sounds
8 like VA, frankly, has been a little more
9 successful than DOD in growing its mental health
10 infrastructure. Do you have any advice about, or

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11 recommendations, or suggestions for DOD in terms
12 of the things that it should be doing better or
13 differently?

14 DR. KATZ: Doctor Cross?

15 DR. CROSS: I would never be so
16 presumptuous as to give advice --

17 DR. MacDERMID: Oh, please.

18 DR. CROSS: All right. Let me tell you
19 what's been going on. If you look at a graph of
20 our mental health providers in terms of numbers,
21 and social workers, psychologists, and
22 psychiatrists, we just plotted that out, and

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1 they're all going like this, it's a nice little
2 curve upward.

3 One of the reasons that we're able to
4 attract more folks than we might have in the past
5 is our physician pay bill and other recruitment
6 efforts that we're doing. We were a bit behind in
7 that area. And some of our leadership about two
8 years ago, two and a half years ago, started
9 working with Congress to get that adjusted, and
10 we're now very competitive, much, much more so
11 than in the past.

12 And so we can go into a community and
13 offer to attract top notch physicians right out of
14 the community and into our system now that we were
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15 not able to do necessarily in the past.

16 DR. MacDERMID: You teased us earlier by
17 saying to us --

18 DR. CROSS: I teased?

19 DR. MacDERMID: You did; you said that
20 you would be willing to talk to us a little bit
21 about the challenges that you're facing; could you
22 say a little bit about that?

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1 DR. CROSS: Yeah, I will, and I'm off
2 the record, right, nobody is going to take any
3 note of this?

4 DR. MacDERMID: Right.

5 DR. CROSS: We have -- let me start by
6 saying, you know, you asked about do we know where
7 are patients are, you know, in terms of in rural
8 environments and so forth. We do have a model
9 that projects that currently and into the future,
10 and we spent a great deal of effort on that. That
11 is, in fact, by itself a challenge to get that
12 right.

13 when we look at the numbers, we get
14 better and better at this, and we've engaged with,
15 you know, civilian folks, universities, and
16 contractors to try and help us with this. I think
17 we're doing better than -- we're within a one

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18 percent margin or less in terms of accuracy on
19 that right now, and that helps us in working with
20 Congress and projecting our budget and those kinds
21 of things.
22 what I'm going to say now is, enough for

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1 attribution, as they would say in the war college,
2 and understanding that it will be immediately
3 attributed. I've talked to Ira and Tony about
4 this, as well. I'm a family physician and that's
5 how I see patients. I see them as a whole. I may
6 have talked -- during the course of a visit, I may
7 see that person about their blood pressure and
8 about their depression. And so when you talk
9 about mental health, it's not just, as even I have
10 emphasized, just social workers, psychologists,
11 and psychiatrists. Primary care in our system and
12 in the United States as a whole has a significant
13 role in that. And one of the challenges that we
14 have and that I have as a family physician,
15 primary care person, is to make sure that we do
16 that better.

17 Quite frankly, I don't think we've done
18 that all that well in the past. And I think that
19 we're providing in the civilian environment about
20 50 percent of the treatment for depression. So
21 one of the things that we're doing is using our

22 technology to try and make us better. We have

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1 pulled down reminders that when a patient comes in
2 that says, have you talked to this patient about
3 depression. And then it gives you the questions
4 to ask the patient. It makes it almost, you know,
5 as full proof as we can make it.

6 Then we're working with Ira's folks to
7 have the kind of resources right in the clinic so
8 that if I have a question about a complex patient
9 that I was not really comfortable in handling
10 previously and would have referred, I can get that
11 answer right there on that location.

12 Some groups that we deal with in the VA
13 and that you deal with in DOD and elsewhere and
14 that everyone deals with come forward and talk to
15 me frequently as if the patient was not a unitary
16 entity. They come and lobby us for disease
17 specific entities. And so this group that may be
18 talking to me today may see bi-polar disorders as
19 the most important thing, and they're not the
20 least bit interested in cancer. I, as a leader in
21 the VA, have to balance these, and this is one of
22 the challenges I have in dealing with people who

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1 come forward with their own areas of interest.

2 I have to think of it in terms of the
3 patient, the patient, the family, what's best for
4 them, and balance these issues out as best I can,
5 and not see it as a stovepipe issue or something
6 that is an area of interest for this group only.

7 when I meet with these groups, that is a
8 challenge for me, because they don't want to talk
9 about anything else, that's the thing that's most
10 of interest to them, and if I don't give them the
11 right answers perhaps, they will certainly be
12 talking to someone else and saying, you know, we
13 need to set aside dollars, we need to restrict, we
14 need to force, whereas I want to be proactive, I
15 want to be balanced, I want to be comprehensive, I
16 want to be interdisciplinary. That's one of the
17 challenges I face right now.

18 DR. MACDERMID: Thank you very much,
19 sir. Anyone have any additional questions?

20 MR. CAMPISE: I have a question for you.
21 It's not unusual for me to encounter veterans who
22 seem to be woefully uneducated about their VA

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1 benefits and there are reasons for that, you know,
2 information overload when they receive it; are
3 there any specific policies or regulations that
4 need to be changed so that you have better access
5 to recruit the people you can provide services to?

6 DR. CROSS: I think we have to look at
7 our policies and regulations. I'm not sure that
8 they're completely the way that we want them. I'm
9 looking at one right now on dental care, and I'm
10 concerned that an individual coming back, there
11 are certain policies that have time elements, and
12 so you have to apply within a certain amount of
13 time. I don't like that personally. I want to
14 work with Tony over here and others to see what we
15 can do to expand that, to make that a more
16 forgiving and easier approach.

17 Let's say the time element for dental,
18 is it 60 or 90 days? It's 90 days; let's say that
19 that reservist has come back and they spent a
20 couple of days at Fort Dix, they didn't hear
21 anything about dental there because they were,
22 zoom, out the door and focused elsewhere.

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1 And then they go home, they go on leave
2 or block leave, they have an extended period of
3 time, we may not see them back very much for 90

4 days, and by that point in time, it may be getting
5 really close to the deadline or maybe even too
6 late. I don't like those kind of approaches. I
7 want to try and expand those, make those more
8 liberal, make those more forgiving. I'm working
9 on that.

10 DR. MACDERMID: Any other questions?
11 Thank you very much.

12 DR. CROSS: I see the boss has arrived.

13 DR. MACDERMID: Thank you very much,
14 Doctor Cross.

15 COL. DAVIES: We've got a little change
16 in the schedule here. Next up is Doctor Tania
17 Glenn, she's going to talk to us about the
18 Resiliency Program in the Marine Corps.

19 DR. GLENN: Good morning. Thank you for
20 adding me to your agenda. I was told I have ten
21 minutes and five minutes for questions. So I'm a
22 Texan, however, I found after 911 that I'm a New

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1 Yorker at heart, so I'm going to talk fast and get
2 you guys to lunch hopefully right on time.

3 A little bit about my background, I have
4 a clinical practice in Austin, Texas and
5 Alexandria, Virginia. I've somehow figured out
6 how to live in two cities and I fly back and
7 forth, usually 90 miles an hour with my hair on

8 fire. I've been dealing with trauma for the past
9 15 years, basically since my career started. My
10 focus has been trauma PTSD in all of my work. I
11 specialize in law enforcement, fire, EMS,
12 military, and aviation folks.

13 For the record, I have a lot of what I
14 call phantom clients, and these are folks who pay
15 cash and keep it off the record, because that's
16 the only way they're going to come in. That's
17 what I do both here and in Austin. I also am a
18 managing partner of a company called Readiness
19 Group International. If we can go to the next
20 slide. Readiness Group is an internationally
21 based consulting company and we do a lot of work,
22 we work with the FAA accident investigators, we

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1 work with the Marine Corps now, the reserves, we
2 do a lot of work with federal agents, the
3 marshals, FBI, we work with American Airlines,
4 Southwest Airlines, et cetera, in dealing with
5 trauma, preparing their programs for worst case
6 scenario and then what to do in the aftermath, so
7 that's a little bit about what I do.

8 This program is about four years old.
9 In the perfect world according to Tania, when I
10 was done at Ground Zero with NYPD, we would have

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11 started working with the Marines to get them
12 ready. It's taken a few years, a lot of
13 persistence and stubbornness on our part, some of
14 this has -- a lot of this has been done for free
15 up until the past year, when we were finally
16 placed on contract for our services.

17 How this started is, we visited with a
18 colonel who had just gotten back from Iraq at Mac
19 41 (?) in Fort Worth, Texas. He said, show me
20 what you got, we did a presentation for his group
21 there, and the feedback from the sergeant majors,
22 all the way up to the colonels, all the way down

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1 to the, you know, the lance corporals was, where
2 has this been, we've needed this all along, why
3 didn't we get this information, this would have
4 been helpful. A sergeant major's wife said, you
5 know, if I had known this 20 years ago, my
6 marriage would have been a lot easier. The
7 colonel who brought us into this program said that
8 he had an experience in Iraq where his roommate
9 was a flight surgeon, and their rule was, where
10 they lived, where they roomed together, their rule
11 was, we don't talk about work, we come -- we're
12 done with the day, we don't talk about it, we just
13 push it out the door and we have our down time.

14 what happened is, this flight surgeon
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15 ended up in a catatonic position and had to be air
16 lifted out of Iraq because he never had a chance
17 to process his trauma, and he said, boy, I sure
18 could have used this. Can we go to the next
19 slide?

20 Okay. So what is this Fourth Marine
21 Aircraft Wing Combat and Operational Stress
22 Control Program? What we're doing with the Fourth

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1 Marine aviation component is, we are doing a
2 program that is designed to build resilience. The
3 key in this first bullet is, this is a resilience
4 program, this is a readiness and retention
5 program, it is designed to keep marines in the
6 fight, it is designed to prepare them to go, it is
7 designed to provide them with the mental armor
8 that they need to understand what to expect and
9 what to do about it, that's very, very important
10 is that second half of what to do about it.

11 We use this combat and operational
12 stress as a science. We explain it to marines,
13 and of course, in terms that they can identify
14 with, as to what happens to the mind and the body
15 when it's impacted by significant stress, and how
16 to take care of yourselves, and then how to manage
17 it when you get back, okay. In this program, what

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18 we do, we do pre-exposure briefings, we call them
19 pre-exposure briefings or pre-deployment
20 briefings. The pre- exposure briefings are like
21 an inoculation of resilience. They tell marines,
22 this is what happens, worst case scenario, here's

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1 what to expect, and here's how to look out for it,
2 here's what to do about it, here's how to look at
3 it in your buddies and notice things in your
4 buddies, and here's what you do about it, here's
5 how you manage your stress, here's how you take
6 care of it.

7 we demystify post-traumatic stress
8 disorder, we explain exactly what it is, why it
9 happens, how it occurs, and what to do about it,
10 and how to nip it in the bud as much as possible.
11 we talk to them about fighter fight; of course,
12 with marines we call it fighter fight because
13 marines don't run.

14 And we tell them, in fighter fight,
15 chronic states of fighter fight, what happens to
16 your body over time, how the human body is not
17 really designed for this, but the marines are
18 showing us that they have the capacity to sustain
19 this fighter fight for days and weeks on end, what
20 happens, why you numb out, what to look for when
21 you're numbing out, why you do that, and then how

22 to make sure it doesn't effect your return home.

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1 we talk about all of the things that
2 they need to get them ready to go, and it is
3 amazing, because the marines have given us the
4 feedback, yeah, this is exactly what you told us
5 was going to happen and I knew I wasn't going
6 crazy because you told me what to expect and what
7 to do about it, which is so important. We do
8 post-exposure briefings. This is when they come
9 back, we put them into small groups, and folks
10 from Readiness Group team up with marines.

11 Usually we've got, you know, a really
12 respected sergeant major or someone along those
13 lines, you know, what they call an awesome devil
14 dog, and we do these presentations with these
15 marines, we go over quickly what we covered in the
16 pre-exposure briefing, and then in the
17 post-exposure briefing, what we're addressing,
18 very, very important, are what we call the Big
19 Six, the Big Six issues upon return and what to do
20 about it and what to expect, how to, you know,
21 reintegrate. And then we have small group
22 discussions where the guys get to talk about their

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1 deployments, okay. Obviously, this is led by a
2 marine.
3 we have separate and additional
4 briefings for women. What we have noticed is, the
5 female marines, we address them like they're a
6 bunch of guys, okay. Women process trauma
7 differently, they come home with different issues,
8 they have different family issues, they have
9 attachment issues with their kids, and we don't
10 have the time when we're doing big groups of men
11 and women together to address those specific
12 issues, so we've added an additional female
13 marines brief, which gives them a chance to
14 address their own issues. Another thing that we
15 noticed and a reason for these female specific
16 briefings is that, in 1998, I went through the
17 Austin Police Academy because I worked so much
18 with law enforcement, so I took six and a half
19 months off and learned how to beat people up, it
20 was a good time. Somebody told me, you know,
21 Tania, going into this academy, you have to be,
22 because you are one of four women, and there's 52

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1 men, you have to be better, faster, stronger, and
2 you have to shoot better, you have to be better at
3 everything, otherwise they're going to be like,
4 oh, that's because she's a woman.

5 what we noticed when we were giving the
6 big briefings with men and women combined is that
7 the guys would come up and talk to us and joke
8 with us afterwards and talk about their spouses
9 and issues with families and what's going on with
10 them, but the women would avoid us, because that
11 would be a sign of weakness for the females to
12 come and address us, especially with their male
13 peers watching. Again, it would be like, oh, you
14 know, there goes the women's club, so we
15 absolutely have implemented this in a different
16 way.

17 And then we address the families. with
18 the families, we do pre and post-exposure
19 briefings. My business partner and I, we're both
20 military wives, and we've had the don't move the
21 toaster from one side of the microwave oven to the
22 other briefings, realizing that those aren't

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1 effective, so we address with the families similar
2 to what we do with the marines, similar
3 information, sort of calmed down a lot for the

4 family members so we don't scare them. The big
5 thing is that these marines are getting consistent
6 presentations. A lot of times when we address the
7 leadership, we call it chance or choice, you
8 either risk it and you risk the care of your
9 marines to someone who may download this
10 presentation and read it off the slides and have
11 no idea what they're talking about, or you make a
12 choice.

13 This is a marine to marine advocacy and
14 education program. The most important thing is
15 that this is a marine program. We are teaching
16 marines, as COSC warrior advocates, they're called
17 COSC warrior advocates, how to identify and help
18 other marines, very, very important, because you
19 know who marines want to talk to, it's not people
20 like me, it's other marines. There is such a
21 power in that peer process, in that mentoring
22 program, that that's what we're doing.

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1 We also are training every group of
2 marines how to look out for each other when
3 they're overseas so they know what to do and what
4 to look for and what to say to each other when
5 times get tough.

6 This is a supplement, this is a culture
7 shift in the Marine Corps, and I liken it to if

8 the Marine Corps culture, this is my sort of
9 analogy, if the Marine Corps culture is an MRE,
10 MRE's are functional, they're designed to give you
11 the proper nutrients and calories to make you go,
12 to keep you in the battle, they're efficient, they
13 contain some things that, you know, do some things
14 to your digestive system, okay, but whatever, it
15 works, and it's usable, and it's user friendly,
16 and it serves a purpose, okay. What we're doing
17 is, through this program, we're tossing a multi-
18 vitamin into that MRE, okay, because if we change
19 the culture, number one, we wouldn't want to
20 change the Marine Corps culture because it's
21 great, number two, if we change the culture, we
22 might end up with a Stouffers Lean Cuisine, okay,

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1 and that's completely ineffective.
2 So what we're doing is, we're dropping a
3 multi-vitamin into these MRE's, and that's what
4 this program represents to the Marine Corps
5 culture, it's a shift, it's not a massive change.
6 We're also addressing warrior mindset
7 conditioning. This is done by a marine who's
8 using a lot of Lieutenant Colonel Dave Grossman's
9 information on killing and the effects of killing,
10 okay, very, very important. We actually have a

11 lieutenant colonel who's assigned full-time to
12 this program and that's how much the marines have
13 endorsed this program. Okay, next slide.

14 Okay. So the warrior advocate, this is
15 very important, those marines trained as warrior
16 advocates, they go through three days of intensive
17 training. Their job is command and unit
18 education, okay, and this is an ongoing thing. Of
19 course, we're feeding them that information, we're
20 training them, we're doing their recurrent
21 training, because our job is to stay on the cusp
22 of what we're finding in the research and what's

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1 working and what's not, so we transmit that to the
2 marines who are the COSC warrior advocates. They
3 are doing peer mentoring for normalizing stress
4 responses. They know what to look for, they know
5 where to go, they know what resources to provide,
6 they know how to refer, they know how to talk to
7 marines, and this is great stuff.

8 This program has been likened to the
9 MCMAP Program, the Marine Corps Martial Arts
10 Program, which is highly regarded as a peer
11 process mentoring program that is really,
12 throughout the Marine Corps, is very well
13 respected.

14 They give knowledge and resources when
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15 appropriate. If a marine says, you know what, I
16 think you ought to go talk to this person and he's
17 okay to talk to or she's pretty cool to talk to, I
18 know she's, you know, a talk doc shrink thing, you
19 know, but it's really okay, coming from another
20 marine versus coming from someone like me saying,
21 you know, I think you really should go for help,
22 it makes a big difference.

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1 This also gives them interfacing time
2 with mental health people like me, and they
3 realize that we don't all sing Coombaya and light
4 candles and sit in circles. Very important that
5 they are trained to recognize the signs and
6 symptoms of Operational Burnout, and then one of
7 the biggest, most powerful ways we have these COSC
8 warrior advocates out there doing things is
9 through those individual augmentees. Those IA's
10 come back out of their units, they slip through
11 the cracks, they go home, before you know it, we
12 call it Combat to K-mart, before you know it,
13 they're back at their jobs, they've had no sense
14 of reintegration, and this is a huge challenge.
15 We have IA's spread across the country, and
16 catching them is a very important thing that our
17 warrior advocates are doing. Next slide.

18 Okay. So what does it involve? Ethics
19 training, we've actually tied in a little bit of
20 the ethics training. With the tragedies of
21 Haditha, the Commandant of the Marine Corps
22 indicated, you will do ethics training, so we're

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1 killing two birds with one stone. As we go out
2 and do these trainings, we're also getting a
3 marine to do ethics training, that is now
4 mandatory, which is a nice way to kind of tie it
5 all, not only do you get this, but you also get
6 ethics training.

7 Continuous education and marine to
8 marine mentoring, okay, like I said, that
9 mentoring process is very important. Pre and
10 post-exposure or deployment briefings, currently
11 we are doing these and we are beginning to use our
12 COSC warrior advocates as our partners in these
13 presentations. Eventually more and more we want
14 to hand this over to them and for them to do it
15 and for us just to provide the education and the
16 updates.

17 Senior leadership training, I will tell
18 you that when we do these briefings, everyone from
19 colonels to your NCO's are emailing us and calling
20 us from overseas saying, okay, this is what
21 happened, this is what I did, what do you think,

22 and it's become a really great avenue and a

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1 resource for them, they love that, because they
2 know that we will be there for them and provide
3 them with any feedback that we might have while
4 they're there. And then, of course, the COSC
5 warrior advocate training which we're doing
6 quarterly. Okay, next slide.

7 The goal for COSC, this is General
8 Papak's program, General Papak of the Fourth
9 Marine Air Craft wing. He wants each marine to be
10 given the tools to transition successfully between
11 these three mindsets. Now, this is the warrior
12 mindset, but we're talking about the stateside
13 sort of drilling Marine, we're talking about the
14 battlefield mentality, and then transitioning back
15 and becoming a citizen and going back to work.
16 That is much easier said than done. And I think
17 all of you know we expect this to happen way too
18 fast.

19 So what we're trying to do is arm these
20 marines with enough knowledge and enough
21 information of what to expect and how to manage
22 this transition so that they can understand what

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1 happens and why it happens and why things happen
2 the way they do, and again, what to do about it,
3 that is very important.
4 He has had many, many Vietnam vets,
5 General Papak has had many Vietnam vets who have
6 said, please don't do to them what happened to us,
7 please, very, very important. Next slide. Okay.
8 I know I'm preaching to the choir, we owe it to
9 them. This slide looks a little bit dark from my
10 viewpoint, but that marine right there, I promise
11 you that after our briefings, every Marine that we
12 talk to will know exactly what to say to that guy.
13 They know that look, that thousand yard stare, and
14 they know exactly what to say to that guy. They
15 used to say, must suck to be you, now we have them
16 saying appropriate things like, okay, where's your
17 mind, how are you doing, what do you need, so
18 we're teaching marines how to take care of other
19 marines so when the thousand yard stare hits, they
20 know exactly what to do. Next slide. Okay,
21 questions.
22 DR. MacDERMID: We should be glad we

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1 have a New Yorker, we'll get lunch earlier.

2 DR. GLENN: New Yorker at heart.

3 DR. MacDERMID: Questions?

4 MS. FRYAR: Yeah, I have a question.

5 Congratulations on getting through your briefing
6 so quickly.

7 DR. GLENN: Thank you.

8 MS. FRYAR: It sounds like a great
9 program. Do you have any outcome data on the
10 success of your program and how many marines have
11 actually been through the program and families?

12 DR. GLENN: We actually have. So far we
13 have done -- our evaluations have been
14 self-reports, and marines, believe it or not, have
15 given it rave reviews. What we're doing now is,
16 we are working with a company that is beginning a
17 study, and they're going to be addressing reserves
18 and National Guard, et cetera. We're going to
19 piggyback onto their study and look for outcome
20 results in that way. We haven't had a chance to
21 study it, we've been really busy getting it up and
22 going and fighting for it, but that is the next

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1 step.

2 DR. MacDERMID: Could you talk a little
3 bit about how you -- because this is a reserve

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4 operation, right?

5 DR. GLENN: Correct, uh-huh.

6 DR. MacDERMID: So how does this work
7 with the logistics of reserve deployment? So, for
8 example, people come back and then they disperse,
9 how do you deliver this material to them and to
10 their families? How do you chase down these IA's?

11 DR. GLENN: Okay. What we're doing is,
12 before they leave, their pre-exposure briefing is
13 occurring in that training up time, and we go to
14 where they are, and then when they come back, as
15 they come back, as we're getting return dates,
16 which is tricky in scheduling, and believe me,
17 it's really tricky, because I have two practices
18 and live in two cities, but as soon as we have a
19 date, we either catch them as they're doing their
20 outbriefs; for example, we have a group, MACAS 23
21 out of Denver, their pre-exposure briefing was
22 done in Denver when they were training up, as they

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1 come back through Quantico, we're hopefully going
2 to catch them in Quantico, if they have enough
3 time for us, if not, we'll catch them on their
4 first drill weekend, where everybody will be
5 present in Denver as soon as we can. And we're
6 also looking at time frame and the most effective
7 time frame, and we're starting to generate that

8 feedback, is when is the best time to do this, is
9 it at Quantico as they just got back, or is it,
10 you know, during their first drill weekend. The
11 IA's, we're sending the COSC warrior advocates out
12 there to address them. As the command tells us,
13 hey, I've got this person, I've got this person,
14 we're actually teaming them up with a COSC warrior
15 advocate to go out and do the briefs for them and
16 their families.

17 DR. MACDERMID: And how do you get
18 family members; you said you do the
19 post-deployment briefing at the first drill
20 weekend, but family members aren't usually at
21 that, so what do you do then?

22 DR. GLENN: We bribe them with food and

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1 child care and fun things, make it a family day.
2 Families are the hardest, but you know what, what
3 happens is, word of mouth is that this is a really
4 cool program and I really enjoyed this, you should
5 make sure you go next time, that's what we rely on
6 the most, is for spouses to kind of push each
7 other to go. But we do everything we can to get
8 as many people as we can.

9 DR. MACDERMID: And what kind of
10 participation do you get, what percent?

11 DR. GLENN: Sometimes we'll have 75 and
12 sometimes we'll have seven, so yeah.

13 DR. MacDERMID: Okay, thank you.
14 Anybody else?

15 DR. ZEISS: I just want to say one thing
16 while Tania Glenn is here. I came before the last
17 Task Force, I don't know if you remember, I'm a
18 Colonel in the Marine Corps, and I just retired, I
19 had been a CO, and I had been hoping for the
20 Marine Corps to do something for the years that I
21 -- before I retired. I came up with this program,
22 I mean I found this program out there. I know

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1 Battlemind is out there and they're doing a great
2 job and we're all trying, you've got all of these
3 stovepipes, you know, working in their own areas.

4 But I just wanted her to come here
5 because I thought this program was outstanding,
6 and it's a step forward for the Marine Corps, even
7 though it is only in the reserves right now, it's
8 a step forward, and as you're looking at best
9 practices as a Task Force, I think it's important
10 to look at all of the opportunities and options
11 that are out there.

12 DR. MacDERMID: Thank you very much,
13 ma'am. Anyone else? Thank you very much for your
14 presentation.

15 COL. DAVIES: Our final speaker this
16 morning is Colonel Christine Scott, she's going to
17 talk to us about accessions mental health.

18 COL. SCOTT: Good morning. Well, this
19 morning I was, well, actually late last night I
20 got a call from Colonel David Niebuhr, who has a
21 special interest in the -- Colonel Niebuhr is the
22 Chief of Epidemiology at Walter Reed Army

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1 Institute of Research. He was the Chief of AMSARA
2 for the last five years; I took over about a year
3 ago. He has a special interest in mental health,
4 and unfortunately, he got stuck in Miami, in a
5 conference last week, and because of the bad
6 weather, he wasn't able to get out last night, so
7 I'm here to present.

8 This is actually his presentation. I'm
9 going to do my best to walk you through the
10 slides. He is a New Yorker and he can talk a
11 phenomenal rate and he can do 35 slides in 30
12 minutes, but I don't talk that fast, and so I'll
13 probably be skipping a few slides just so that I
14 can get you guys to lunch hopefully within the
15 next 30 minutes. AMSARA is Accession Medical
16 Standards Analysis and Research Activity. Next
17 slide. This is the agenda. I know this looks

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18 large, but I'm going to plow through this,
19 basically go through the mission, past research,
20 some of the National Academies of Science, if
21 everyone is familiar with the book that they
22 recently published, in April of 2006, and some of

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1 our current research. Next slide.
2 So what is AMSARA? It's basically a
3 relatively new organization, ten years old,
4 developed in 1996. It was developed because the
5 -- at the Military Entrance Processing Station,
6 I'm not sure if the military -- I know the
7 military are familiar with that, but the civilian
8 individuals, MEP stations are where our new
9 recruits get their evaluation prior to coming into
10 the military. And so we're going to back up the
11 talk. We're looking at the beginning of the life
12 cycle. These are kids first coming into the
13 military. What we found was that, or what the
14 group found back in the mid '90's is that a
15 tremendous number of physicals were being done in
16 the MEP station, attrition was still high, where
17 it was very, very costly, and so they wanted to
18 look at the standards that these new recruits had
19 to undergo, medical standards, to see whether
20 they're medically capable of coming in, and to
21 actually look at those using evidence.

22

And so the AMSARA was stood up to

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1 support the group that actually looks at the
2 standards. The working group is the AMSWG,
3 Accession Medical Standards Working Group, and
4 that supports the Medical Personnel Committee,
5 which is a three star level committee between
6 medical and personnel. General Kiley actually
7 sits on that committee.

8 So the instruction for the -- DOD
9 instruction, 6130.4, are all the medical standards
10 that we look at, that we go by when we're looking
11 at new recruits coming into the military, they
12 have to meet these particular medical standards.
13 Next slide.

14 So what do we do, how do we look at
15 these as evidence-based? So first, we pick out
16 the conditions that are high burdened, high burden
17 disease, whether we're able to screen and
18 diagnose, and the morbidity attrition. So
19 essentially, what you're going to find is, through
20 the next slides, is that muscular skeletal mental
21 health conditions are high up on the list. Those
22 are ones that we have historically looked at.

1 what kind of research tools do we use to look at
2 these? survival analysis, K series et cetera.

3 After we've looked at this, we will make
4 our recommendations to the AMSWG; ultimately, we
5 get medical consultants involved and make our
6 ultimate recommendations to the MEDPERS Committee.
7 The MEDPERS Committee is the one who actually
8 makes the decision whether to actually change the
9 standard.

10 Now, just to give you an idea how long
11 it can take to do that research, for example, the
12 asthma standard was just changed in 2004, took
13 about three years research, to go through that
14 with not only AMSARA, but the medical consultants,
15 and the standard was changed from not allowing
16 anyone in the military with a history of asthma to
17 allowing individuals who had asthma after the 13th
18 birthday would be disqualified, so those prior to
19 the 13th birthday would not be disqualified. And
20 then also the ADH standard was changed.

21 Previously, the ADH standard was that
22 you would be disqualified if you used any kind of

1 medication for ADD or ADHD after the 13th
2 birthday, you were disqualified, and that was
3 subsequently changed in 2004, that if you had good
4 performance, off medication for at least one year
5 prior to enlistment, you could come in even with a
6 history of ADHD. Next slide. So some of the
7 potential problems, let me just look at my notes
8 here since this is Dave's slide, basically the way
9 the MEP's works is that you really want to screen
10 out potential failures, and so one of the issues
11 that we have noticed is that, in the MEP's, it's
12 the typical clinical type of exam, where you
13 expect them to give a relatively good history,
14 okay, it's a self-report.

15 But you've got to realize, in the MEP's,
16 you've got a lot of kids who are coming into the
17 military who have different agendas, they really
18 want to get into the military, they're highly
19 motivated for a variety of reasons, whether it's
20 patriotism or finance or whatever, they want to
21 get in, and so sometimes you'll find that they
22 will conceal their condition, and especially for

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1 conditions surrounding mental health. Unless we
2 actually have their medical records, it's very
3 easy to conceal if they've had prior problems.

4 But what we have found is that when kids
5 are honest in the MEP's and they do self-report
6 and then they get a waiver, civilians among the
7 Task Force, if you get disqualified based on these
8 standards, you can go forward and ask for a
9 waiver.

10 And what we found is that individuals
11 who actually get a waiver for that condition
12 actually do quite well in the military, whereas
13 the ones -- there's another piece of the puzzle,
14 when we see kids who get prematurely discharged in
15 the first six months, and we call that an EPTS,
16 Existed Prior To Service discharge, most of those
17 EPTS's do not reveal their condition. Next slide.
18 So essentially, basically what I said is that they
19 have an incentive to report a negative history,
20 okay. Let's go to the next slide. I'm just going
21 to quickly go through the past research. Next
22 slide.

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1 Essentially what I want to show here is
2 that the medical failures, psychiatry are high up
3 as far as in all the different slides I'm going to
4 be showing you. Medical failure is about four
5 percent, it's within the top ten conditions that
6 get medically disqualified. Next slide, okay. So
7 if they get a waiver, ADHD is within the top ten

8 of individuals who ask for a waiver granted. Next
9 slide.

10 These are some of the survival analysis
11 that we've done. In 2000, we did a survival
12 analysis on ADD and depression related disorders.
13 Next slide. What we found was that in ADHD and
14 asthma, we basically found that the survival is
15 just as good, if not better, on active duty if
16 you've been given a waiver for asthma or ADHD, and
17 that was the reason why those two standards got
18 changed; whereas for depression related disorders,
19 actually their survival is not as good when they
20 received a waiver. Next slide.

21 And basically all I'm going to talk
22 about with this is that when you're doing waiver

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1 survival analysis, you have to look at the
2 granularity you have to look at the detail of the
3 clinical history, and we can do this through
4 BUMED. Next slide. Hospital admissions, the
5 number one hospital admissions is psychiatric.
6 Next slide. Go ahead, skip that slide. EPTS's,
7 like I mentioned, existed prior to service
8 discharge; number one on the list is asthma. So
9 these are discharges that occur within the first
10 180 days of being on active duty. And number two

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is neurotic, basically depression, and other
12 psychiatric diagnosis. Next slide.

13 We have done some EPTS case series, and
14 you'll see that in 2002, in reports, we've done
15 one, attention deficit, and also in 2003,
16 depression. There is a web site, AMSARA web site,
17 you can just google AMSARA and you can pull up
18 these reports if you'd like to get more
19 information on those. Next slide.

20 Disability discharges, these are
21 discharges that occur after the first 180 days, so
22 this is actually like a medical board, PEB, and

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1 you can see that musculoskeletal is, by far, the
2 number one, but then after that, psychiatric.
3 Okay, next slide.

4 So what I'd like to spend a little bit
5 more time on is the mental health research that
6 AMSARA has been doing, primarily by Dave Niebuhr,
7 since this is his area of interest. Next slide.
8 More current information, medical failures, which
9 is disqualifications, 13 1/2 percent of all
10 medical failures from 2002 to 2005, and
11 approximately 210,000 applicants, and for medical
12 waivers, this is about 5.9 percent of all active
13 duty waivers. Now, this is active duty only, this
14 does not include reserve or National Guard. And

15 this accounts about 1,400 per year from 2000 to
16 2005 and about 150,000 accessions. So that's the
17 number of people who have actual accessed. EPTS
18 discharges, 41 1/2 percent of all EPTS discharges
19 are due to psychiatric disorders. And you can see
20 the top five in each of those areas. Next slide.

21 This is a survival curve for ADHD, and
22 this is -- you can see that the black dots are

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1 those individuals who had a waiver for ADD, and
2 the purple are fully qualified, and you can see
3 the there's survival between both of these two
4 groups is essentially the same, and that was what
5 precipitated changing the standard, whereas the
6 next slide, you'll see that the survival curve for
7 those with depression, which is the dark blue
8 line, is quite a bit lower, right here, than those
9 who are fully qualified. You have to realize that
10 this is .5 to one, okay. So those who have a
11 waiver for depression do not survive as well in
12 the military. Next slide.

13 Now, what I wanted to talk to you a
14 little bit about was the National Academy of
15 Science Committee on Youth Population and Military
16 Recruitment, okay, the recommendations. This was
17 quite an endeavor by the National Research Council

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18 looking at the physical, medical, and mental
19 health standards. Next slide.

20 You can actually download some of the
21 chapters at that web site. There are
22 recommendations, they basically said that they

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1 needed more research, and I want to point you to
2 number four, comparing the attrition rates of
3 enlistees with and without mental health
4 conditions existing prior to service. Next slide.
5 And they did actually make some recommendations on
6 some of the standards. Because we had made a --
7 it wasn't necessarily arbitrary cut-off of 13 for
8 asthma, there was evidence why we chose that age,
9 but they had recommended that some of the
10 disqualifications for mood and anxiety disorders
11 could potentially be changed to after the
12 applicant's 13th birthday.

13 And it's clearly delineated on how they
14 came to that conclusion in this book. I'm not
15 going to go into a lot of detail on that, but it's
16 very interesting reading, if you want to go back
17 and look at that. Next slide.

18 So as far as screening, they recognize
19 that it's difficult to screen for mental health
20 disorders in the MEP's because of the individual's
21 motivation to get into the military and the ease

22 of not disclosing all the information.

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1 And so they recommended that certain --
2 let me back up. In the MEP's, there's only two
3 questions essentially that get asked, once at the
4 recruit station, so the recruiter asks, have you
5 ever been treated for any kind of mental health
6 condition, been hospitalized, counseling, et
7 cetera, if they say yes, then that recruit only
8 goes forward to the MEP's if they get all the
9 medical records. So it's pretty easy, though, at
10 this point, because word gets around for the
11 recruit -- the applicant to basically tell the
12 recruiter, no, nothing has happened. And then the
13 second question is when they're actually at the
14 MEP's, by the CMO, the Chief Medical Officer, they
15 ask another question, have you ever been treated
16 for any kind of psychological disease, whether
17 hospitalization or medication, so very, very
18 non-specific questions.

19 And what the NAS is recommending is that
20 they make that a little bit more specific
21 questioning, ask specifically about depression,
22 bi-polar, anxiety, et cetera. Next slide.

1 And then they also recommended that a
2 brief questionnaire be instituted. What they
3 actually specifically recommended was prime MD,
4 the PHQ, the patient health questionnaire, which
5 we think may be problematic. It's used in
6 clinics, where people are incentivized to
7 basically tell the truth about what kind of
8 problems they're having. The MEP's is just a
9 whole different animal on how you approach getting
10 this information. Okay, next slide.

11 So briefly I just want to talk about
12 some of the current research initiatives that
13 Colonel Niebuhr is actually involved in.

14 One is looking at psychiatric screening
15 of military recruits, and then another one is
16 doing a collaboration between ARI, Army Research
17 Institute, using the AIM. Next slide.

18 Basically, he wanted to develop -- why
19 don't you go to the next slide, SBIR, Small
20 Business Initiative Research would be a method of
21 having a little bit more specific screening for
22 mental health disorders, but in a way that the

1 applicant wouldn't know, I mean it would be hard
2 for them to determine what you're asking. Rather
3 than asking straight forward questions like, well,
4 are you depressed or have you been depressed, this
5 is a little bit more sophisticated.

6 And these two SBIR's came out, OSD
7 awarded them, and one is being done by a
8 psychiatrist, another one by a psychologist, and
9 essentially it's based by -- it's PDA based, and
10 has questions basically focusing on depression,
11 anxiety, psychiatric medication, et cetera, what
12 you see there in that last bullet.

13 The first phase was basically just
14 developing the questionnaires, okay. Next slide.
15 The second phase was to actually test this in the
16 MEP's, and this has been problematic. This is an
17 IRB approved study, they do get informed consent
18 at the MEP's, they do have a cash incentive, I
19 think it's \$25, but they've had problems, I mean
20 they're just beginning to get up and going with
21 this.

22 The two questionnaires, one is 187

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1 questions and one is 317, so this is very
2 preliminary, they know that they can't use this
3 many questions, they want to see by this phase

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4 which questions they think they can eliminate.
5 And originally what they had wanted to do was
6 follow these individuals on to active duty for at
7 least six months, they haven't even begun to get
8 to that point, and so we don't have any outcome
9 data on this at all. Next slide. The
10 questionnaires are essentially to detect
11 malingering and faking good by the way they ask
12 the questions. They were to be followed for six
13 months, looking for outcomes such as psychiatric
14 disorders, and the objective to that is to develop
15 a predictive model. Next slide.

16 Let me go on to the next collaboration
17 that Colonel Niebuhr, his credence with ARI
18 looking at the AIM. AIM is a questionnaire that's
19 27 item, self-report, there's forced- choice, so
20 basically like our scale, and it has six
21 constructs, adjustment, work orientation,
22 agreeableness, leadership, physical conditions,

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1 and dependability. The questionnaires also
2 include faking good and malingering.

3 what's -- you may be aware that this was
4 initiative -- AIM was originally started in 2000,
5 but was added to the T test, which is Tier Two
6 Attrition Screen, and essentially, Tier Two are
7 individuals who are non-high school diploma

8 graduates, high school graduates, so essentially
9 GED type of individuals.
10 we know that high school diploma
11 individuals do relatively well, but if they get a
12 GED, their attrition is relatively higher. So
13 what they wanted to do was see if they can find a
14 subset of individuals with this Tier Two,
15 basically non- diploma high school graduates, if
16 there's a subset, very highly motivated ones that
17 will do well, and the AIM was incorporated along
18 with a couple of the ASVAB scores, the math and
19 verbal and physical conditioning, I use BMI as a
20 surrogate for physical conditioning, and that has
21 been very, very successful in bringing in
22 additional individuals without high school

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1 diplomas into the military and has shown very
2 appropriate attrition levels that are similar to
3 high school graduates with a diploma. Next slide.
4 So what Colonel Niebuhr had suggested is
5 that we also look at AIM using our waiver data
6 that we have. People have been waived for
7 psychiatric conditions compared to those who have
8 not been waived and seeing -- using AIM in the
9 model to see if this is going to be a predictor,
10 as well as possibly case control, study design.

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11 Okay, next slide.

12 what he would like to do with the SBIR
13 is to take it one step further. If we can get any
14 information whatsoever right now from SBIR, it's a
15 little bit disappointing. But ultimately, if it
16 looks like those questionnaires may be useful, to
17 go ahead and test those in a few MEP's and all
18 comers rather than having a cash incentive where
19 you have a selection bias -- have all comers take
20 the questionnaire and then follow those on active
21 duty for different outcomes, attrition and
22 morbidity, and then potentially down the road is

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1 actually screen in applicants based on what the
2 NAS had recommended. Next slide.

3 So in conclusion, mental health
4 disorders, a relative frequent cause of DQ's,
5 waivers, and EPT's or premature discharge.

6 AMSARA's research in the past has
7 contributed to making the standard for ADHD
8 accession less restrictive. The NAS committee has
9 also recommended making some of the anxiety and
10 mood disorders less restrictive, those standards
11 less restrictive. And the current research that
12 Colonel Niebuhr is doing is focusing in on mental
13 health screening, and the MEP's, as well as
14 challenging some of the standards. And that's the

15 end. And if anyone has any questions, I'll be
16 happy to try to answer them.

17 DR. MacDERMID: Angela.

18 COL. PEREIRA: It looks like about 266
19 soldiers are being discharged per year for EPTS
20 site conditions. Do you have any knowledge of the
21 numbers that we are catching at the MEP's or at
22 the recruitment stage compared to those that are

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1 getting through with waivers, how many we're
2 stopping?

3 COL. SCOTT: In the reception battalion?

4 COL. PEREIRA: Yes.

5 COL. SCOTT: That's a really good
6 question. We particularly don't have that at
7 AMSARA. Actually, I believe Colonel Ritchie might
8 have that information more at hand than me. But
9 all we have in our data bases is EPTS.

10 COL. PEREIRA: Okay. One of the reasons
11 I asked that question is because during our site
12 visits, we hear again and again, the recruiter
13 told me not -- to say no to those questions, so
14 unless we address that issue, I don't see that
15 even a new survey will make a difference, unless
16 -- and is it your plan to have the survey
17 administered by somebody other than a recruiter?

18 COL. SCOTT: Other than a recruiter;
19 that's something we could definitely look at,
20 that's a good point. It's logistically difficult
21 because the recruiter is the very first contact
22 that they usually have, and that's where they do

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1 the initial pre-screen.
2 COL. PEREIRA: Well, the recruiter --
3 COL. SCOTT: Rather than have the
4 recruiter ask, we could just have the recruiter
5 give them the survey.
6 COL. PEREIRA: -- well, if the recruiter
7 tells them even on the survey to answer no --
8 COL. SCOTT: I know.
9 COL. PEREIRA: -- because the recruiter,
10 you know, we're putting them in a very difficult
11 position. Their goal is to get recruit numbers
12 high, recruitment numbers high.
13 COL. SCOTT: Exactly.
14 COL. PEREIRA: And not to screen out
15 people.
16 COL. SCOTT: Right.
17 COL. PEREIRA: So we're asking them to
18 do something that's contradictory to their
19 mission, so I don't see how that could ever work
20 to really fully screen out people that have EPTS
21 conditions.

22

COL. SCOTT: I don't think we'll ever

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1 fully screen out, you're correct, we'll never

2 fully -- I mean it will never be 100 percent.

3 COL. PEREIRA: As long as we're asking
4 the recruiter to do it, no.

5 LCDR WERBEL: I have a quick question
6 for you. Has AMSARA looked at all at the cost
7 benefit analysis of having mental health providers
8 at the MEB stations doing those screenings?

9 COL. SCOTT: No, we have not.

10 DR. MACDERMID: Any other questions from
11 members of the Task Force? Thank you very much
12 for pinch hitting, we appreciate it very much.

13 COL. SCOTT: Okay, sure.

14 DR. MACDERMID: Thanks for your time.

15 COL. SCOTT: Thank you.

16 COL. DAVIES: That concludes the open
17 session this morning, and we will be going into
18 administrative time this afternoon. Back
19 tomorrow.

20 (Whereupon, at 12:37 p.m., the
21 PROCEEDINGS were adjourned.)

22

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