

FEB27MHTFmeetingtranscriptsFINAL.txt

THE DEPARTMENT OF DEFENSE

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

February 27, 2007

Doubletree Hotel Crystal City
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1 PARTICIPANTS:

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2 LTG KEVIN KILEY
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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
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2 GERALD CROSS
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1 P R O C E E D I N G S
2 LTG KILEY: Welcome to this session of
3 the DOD Task Force on Mental Health. For those
4 who were not here yesterday, this is a
5 Congressionally mandated task force asked to look
6 into the current military mental health system.
7 The overall intent of our meeting here today is to
8 gain insight into that system and ultimately
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9 provide Congress with recommendations for areas of
10 improvement, but also to acknowledge areas that
11 are flourishing.

12 Today's open session deliberations will
13 be on a series of topics which we'll work our way
14 through. Later in the afternoon, we will open to
15 the floor to receive testimony from the public
16 regarding the military health care system. For
17 those of you that weren't here yesterday, let's go
18 around the table again and introduce ourselves.
19 would you introduce yourself?

20 COL. DAVIES: Yes, sir, I will. I'm
21 Colonel Jeff Davies. I'm the acting Designated
22 Federal Official for the Task Force.

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1 LTG KILEY: I'm Lieutenant General Kevin
2 Kiley, the Army Surgeon General, and the Commander
3 of MedCom.

4 COL. PEREIRA: I'm Angela Pereira, the
5 social work representative on the Task Force.

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

9 MS. POWER: I'm Kathryn Power, Director
10 of the Center for Mental Health Services and an
11 Officer in the Navy Reserve.

12 COL. ORMAN: I'm Dave Orman, active duty
13 Army psychiatrist, member of the Task Force.

14 LT COL. DOUGLAS: Lieutenant Colonel Jon
15 Douglas, Headquarters Marine Corps, Manpower and
16 Reserve Affairs.

17 DR. MCCURDY: I'm Layton McCurdy, adult
18 psychiatrist, civilian member of the Task Force.

19 MR. CAMPISE: Lieutenant Colonel Rick
20 Campise, pediatric psychologist.

21 LCDR WERBEL: Aaron werbel, I'm the
22 Behavioral Health Affairs Officer at Headquarters

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1 Marine Corps.

2 LTG KILEY: Okay. Thank you. Next,
3 Doctor Burke, do you have some administrative
4 comments?

5 DR. BURKE: Yes. Thank you, General
6 Kiley.

7 LTG KILEY: You're welcome.

8 DR. BURKE: Good afternoon and welcome.
9 would all attendees please sign the general
10 attendance roster on the table outside, if you
11 haven't done so already? we will be transcribing
12 these open sessions, so please use the microphones
13 when speaking and clearly state your name. The
14 transcripts will be published on the Task Force
15 website within 90 days of this meeting. Restrooms

16 are located down the hall on the left, and any
17 administrative requirements please see Ms. Bennet
18 at the sign up desk or Ms. Farrell, who's audio
19 visual. Thank you very much, General Kiley.

20 LTG KILEY: Thank you, Doctor Burke.
21 Okay. Now, Ms. Ellen Embrey, the Designated
22 Federal Official for the Task Force parent Federal

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

9 COL. DAVIES: Sir, yes, I would. As the
10 acting Designated Federal Official for the Defense
11 Health Board, a Federal Advisory Committee to the
12 Secretary of Defense, which serves as a continuing
13 scientific body to the Assistant Secretary of
14 Defense and the Surgeons Generals of the Military
15 Departments, I hereby call this meeting to order.

16 LTG KILEY: Thank you, Colonel Davies.
17 Doctor Shelley MacDermid, who is my co-chair on
18 this Task Force, should return momentarily from

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19 some administrative duties. It's our intent to
20 carry on this deliberative process from now until
21 1500, at which time we will take a break and then
22 resume at 1530 with public comment here in the

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1 conference, ending at approximately 5:30 or
2 earlier if there's no further public comment. And
3 with that, I'd like to turn this over to
4 Lieutenant Colonel Jonathan Douglas to begin the
5 discussions. I think, Jon, you're going to tell
6 us a little bit about what the public has been
7 telling us on our website.

8 LT COL. DOUGLAS: Yes, sir. The
9 testimonies have been submitted so far as to --
10 can be easily subdivided into three discrete
11 groups that have submitted testimony; the first
12 group being veterans, pre OIF OEF, family members,
13 and service members, and then providers.

14 Looking at the material that's been
15 submitted, I've kind of broken it down to various
16 times that we've already discussed, just a partial
17 and discuss, based on what we did yesterday,
18 obligations, wars and families, quality and
19 continuity of care, leadership issues, resources,
20 TRICARE providers, stigma and policy, mental
21 health screening technology, and research and
22 suicide prevention.

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1 So I've kind of gone through all of the
2 testimony and pulled out key points that are in
3 that testimony and kind of bend it that way just
4 for ease of discussion. First off, getting
5 preferences, I wanted to go straight to stigma,
6 just because --
7 LTG KILEY: Sure, go ahead, whatever you
8 prefer.
9 LT COL. DOUGLAS: There was --
10 LTG KILEY: We will support you.
11 LT COL. DOUGLAS: -- there was a very
12 interesting policy submission from a senior
13 officer --
14 LTG KILEY: Okay.
15 LT COL. DOUGLAS: -- who had suffered
16 from depression for the most part of his career,
17 who, over time, finally decided to seek help. His
18 issue was when he did finally convince himself
19 after, to seek help, suffering, and dealing with
20 the possibility of some suicide ideation,
21 did give -- receive command support.
22 LTG KILEY: He did or did not?

1 LT COL. DOUGLAS: He did. His command
2 did support him, gave him the time off to check
3 himself into a mental military treatment facility,
4 was disappointed in how the treatment went,
5 because the focus of his treatment, once he got
6 there, it seemed the goal was to out process him,
7 treat him and return him to duty. So he expounded
8 on that, how he did do a full career, but stigma,
9 again, that addresses the stigma issue from his
10 perception.

11 LTG KILEY: It's interesting though; it
12 also addresses another issue that I'd be
13 interested in Layton's observations from the
14 private sector or Dick's, which has to do with
15 this -- is duality the right term, Dave Orman?

16 DR. BURKE: Dual agency, sir.

17 LTG KILEY: Huh?

18 DR. BURKE: Dual agency.

19 LTG KILEY: Dual agency, yeah. Thank
20 you. Which is that, you know, we -- what's the
21 role of military psychiatric health care as it
22 relates to individuals who were admitted to the

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1 facilities? Is it to heal and make whole and well
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2 again, and/or is it to simply document the
3 process? Dave, what do you think, can I ask?

4 COL. ORMAN: Sure. With regard to that
5 officer, there's actually one additional issue I
6 think we might want to keep in mind, this whole
7 notion of a VIP syndrome. So you have the issue
8 of returning him to duty as quickly as possible,
9 which is sort of the concern for the fighting
10 strength victim.

11 You have this issue of trying to serve
12 his own personal needs and those of his illness to
13 the maximum degree possible over the course of a
14 hospitalization, and then you have a systemic
15 issue which happens when you have an officer in
16 our system who seeks care, whether it's in-patient
17 or out-patient, but particularly in-patient, which
18 is, they tend to get treated differently and often
19 not to their benefit because of their officership,
20 and I think those are all relevant issues for
21 discussion.

22 DR. MCCURDY: I think it's fair to say

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1 in the private sector there is, you know, there is
2 the prevailing objective which is to deal with the
3 patient, and I think in the military there are
4 these two goals. One is to -- mission readiness

5 is really the prevailing responsibility of
6 everyone in uniform, and then you have one that
7 has to measure that in terms of the obligation to
8 the patient, and I think it makes it more
9 challenging for the professionals. There's no
10 question about that because -- and I've heard,
11 over time, initially when I came on the Task Force
12 and started working, people said to me it will be
13 very difficult for civilian providers to adapt and
14 understand the military culture. I didn't really
15 understand that. I didn't believe it, to be
16 candid.

17 I've come to believe it, because I think
18 there are a variety of things and I think one of
19 them is this philosophy that there are two agents
20 and one agent takes precedent over the other, it's
21 kind of complicated.

22 To respond to something that Dave says,

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1 the VIP syndrome works in the civilian world, as
2 well. It's just easier in the military to identify
3 who the VIP is. They don't have to tell you. In
4 the private world, in a psychiatric hospital, or
5 in any other part of the hospital, the important
6 people will tell you that they're important and so
7 -- and they expect certain things from you.

8 LT COL. DOUGLAS: Okay. Sticking within
Page 11

9 the -- kind of looking at stigma, one of the
10 providers had an issue that was very interesting
11 -- we've discussed it for duty, that definition
12 and what it means, in terms of stigma and policy.
13 Fit for duty, as it's been referenced, doesn't
14 always mean fit for duty in a mental health sense,
15 so that's a definition that has come up, been
16 brought, and we've discussed, as it needs to be
17 clarified when somebody is fit for duty.

18 LTG KILEY: I'm interested in the Task
19 Force members observations about this stigma
20 thing, because to me, from where I sit at least,
21 this is -- I see this, and I think we've talked
22 about this and we've heard people comment about

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1 this, that this is one of the most critical
2 issues, and you know, there's about three or four
3 different ways that this stigma works or its
4 characteristics or maybe facets of a, you know,
5 octagon or a disco ball or something, where -- and
6 we saw this a little bit at Fort Carson when
7 we were talking leadership and talking to the
8 junior leadership at Fort Carson.

9 And you talk to young sergeants, or at
10 least it was reported in a couple of the media
11 reports that the young sergeants would turn to

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12 other young soldiers that were having challenges
13 and issues and would say, look, you know, we're
14 all dealing with this stuff, buddy, you just need
15 to suck it up, you need to ruck up and move on
16 instead of running over to the mental health
17 clinic every week, as though somehow, you know,
18 you were weak, or you were somehow inferior, or
19 you weren't capable because of this, you know,
20 requirement to go seek mental health services,
21 that's one piece. The second piece is the issue
22 about security clearances. I mean one of the

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1 questions you get asked on your periodic security
2 clearance survey, you know, for top secret and all
3 the rest of that stuff is, have you seen a
4 behavior health specialist in the last one, two,
5 five, seven years, you know, and you kind of go,
6 well, maybe I have, maybe I haven't, so what? And,
7 you know, that sits there, and you know we've
8 heard about this where soldiers, sailors, airmen,
9 or marines worry about their security status. You
10 know, every officer has a secret clearance, I
11 think, and so that's another thing, having nothing
12 to do with the perception.

13 And then a third area is the reverse of
14 the first piece, in my mind, which is the senior
15 leader, you know, in a position of not only great

16 responsibility, but great authority, who now is
17 perceived as needing mental health services, and
18 does that mean that person is now not capable of
19 doing the things that they need to do?

20 So I think, you know, if -- and to me,
21 you know, I don't have a recommendation sitting
22 here, frankly, because I don't know how the heck

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1 you legislate or how you would do policy, other
2 than what Fort Lewis is, I mean what Fort Carson
3 is doing right now, which is getting right down to
4 every sergeant and lieutenant and talking to them
5 about how important it is that soldiers have the
6 opportunity and willingly and actively seek help
7 when they think they need it. I'd be interested
8 in your thoughts on that before we move onto the
9 next thing, because I really think, and I've been
10 quoted several times that this is one of the big
11 things, I mean because it stops people from
12 seeking health care, it forces them out into the
13 community. You know, we heard the presenter
14 yesterday talking about the population she serves,
15 that it's almost, you know, we're not going to
16 talk to you about those guys, because they don't
17 want to be known to be seeking health care.

18 I think that fragments the health care.

19 I think it impacts on continuity. What do you do
20 if you're out in the community quietly getting
21 health care and you're PCS to a new community and
22 you can't find that health care in the new

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1 community because you've been quietly doing it,
2 instead of working your way through the referral
3 systems, as potentially problematic as they can
4 be; so what do you all think?

5 COL. PEREIRA: I think one of our main
6 objectives is to try to normalize mental health
7 and the need for mental health, and I think that,
8 one, if we heard from more senior leaders, like
9 the first example, that were able to come out with
10 a positive experience and share that, that would
11 do a lot for reducing stigma.

12 We've also talked about the need to have
13 it be part of training at every level for every
14 soldier, airman, marine, sailor, and to make sure
15 that they get it in their development training,
16 and also in all leadership training through the
17 course of their career. We've talked about
18 normalizing it in -- with the need for a routine
19 mental health screening, much like our medical
20 screening, that's periodic at this point. We
21 don't have anything like that for mental health,
22 and if we continue to make our service members

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1 interact with mental health on a regular basis,
2 and make it part of being a service member, I
3 think it will do a lot to help reduce stigma.

4 LT COL. DOUGLAS: I would agree with
5 you, and that's also been observed in some of our
6 other testimonies, is routine mental health
7 screening for all service members, continued
8 training, and not just for the service members,
9 but also for providers that are not uniform
10 providers.

11 DR. MCCURDY: I think it's important,
12 also, to recognize that when we're dealing with
13 stigma, we're dealing with a reality that has
14 existed since the time of the Greeks and the
15 Romans. It's not peculiar to the military, it's
16 been prevailing. Is it better right now than it
17 was 10 or 20 years ago or certainly 100 years ago?
18 Yes, it is, of course it is. And within my
19 professional lifetime, I've seen things change
20 significantly.

21 I mean some of you may or may not know
22 this, but 20 years ago, if you applied to a

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1 medical school, you had to answer a question if
2 I've had any psychiatric treatment. They didn't
3 ask you about any other kind of treatment, but
4 just that. And once earlier in my life, I would be
5 sent a note from the Dean's office saying is this
6 -- please see this person and tell me if they're
7 going to succeed in medical school. And I mean
8 this was the level of it, and let me remind you
9 that Mr. Danforth was going to be a candidate to
10 be Vice President of the United States and was
11 removed because he'd had psychiatric treatment.
12 There are just tons and tons of examples of how
13 this has prevailed.

14 It is improving, and I think, frankly,
15 that the military's campaign may be one of the
16 real marks that's going to improve things, in
17 general, across non-military and the rest of the
18 world. The more that we can talk about this and
19 recognize it and work with it, the better we're
20 going to be.

21 The NIMH, National Institute of Mental
22 Health, has a campaign now, real men get

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1 depressed. well, why do they need to say that?
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2 They don't say real men get flu. I mean we're
3 dealing with something that's a reality, and I
4 think the object is -- the difficulty is, it keeps
5 people from treatment.

6 MS. POWER: Let me add to Layton's
7 comment about the fact that my belief is that the
8 military is both a microcosm of society and the
9 vanguard of society. So however we look at
10 dealing with the issues, like stigma, we should
11 think of the military as a sector that is both a
12 microcosm and a vanguard. And I hope that the
13 military, as a result of our discussions here, as
14 well as elsewhere, is going to take the lead in
15 eradicating stigma, and fear, and discrimination
16 that exists in mental illnesses, and I agree that
17 it's improved enormously. Just to show you how
18 much people are paying attention to this, Congress
19 gave the Substance Abuse and Mental Health
20 Services Administration funds appropriated in '05,
21 continuing in '06 and in '07, to do an anti-stigma
22 campaign, and that is an important message, that

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1 when Congress says you are going to do an anti-
2 stigma campaign, that's a message to society that
3 says we need to, in fact, eradicate and eliminate
4 the stigma.

5 The interesting part about this campaign
6 is that it's focused, and you'll be seeing it just
7 like you saw real men, real depression, you'll be
8 seeing it soon on your televisions and radios.

9 This particular campaign is focused on
10 18 to 25 year olds, a prime target, first of all,
11 in terms of the military population, and the theme
12 is what a difference a friend makes, and it's all
13 based on research that when you first start
14 talking with an individual about an emotional
15 problem, or a difficulty, or a diagnosis that you
16 received, the first person that you talk to,
17 whether it's a family member or a friend, is the
18 key to the trajectory of the illness for the rest
19 of your life, because the reaction of that person,
20 in terms of acceptance of mental illnesses, is
21 going to, in fact, inform your own recovery. And
22 it's a fascinating campaign based on the fact that

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1 in that age group, there's an 18 percent
2 prevalence rate of mental illnesses, highest level
3 of mental illnesses of any other age group, and
4 yet the lowest percentage of help seeking
5 behavior. So that's the kind of progress I think
6 that, Layton, as you've indicated, has improved
7 enormously over time, but I think the military can
8 use those kinds of campaigns to bump up and really

9 be the vanguard for society in terms of stigma.
10 LT COL. DOUGLAS: I just want to point
11 out, along with that, there is a unique group that
12 did submit testimony, our female service members,
13 who by the -- minority, but if they're seeking
14 mental health services, they don't even have their
15 peer group to converse with. So that was one of
16 our other testimonies, and she pointed that out to
17 herself, that she's at a disadvantage, even
18 amongst her peers, in being able to seek help for
19 the obvious reasons.
20 MR. CAMPISE: Another vulnerable group
21 is going to be the reservists. At our recent site
22 visit, I had never considered this before, but the

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1 reservist told me that he was reluctant to seek
2 mental health care, not only because of the impact
3 on his military career, but also his civilian
4 career. He was reluctant for them to find out
5 that as a result of his military service he was
6 having difficulties and they would no longer be
7 supportive of him remaining in the military and
8 serving in a civilian job.
9 LTG KILEY: Well, I think it's, you
10 know, I don't disagree that, you know, we're on
11 the vanguard and we have the, you know, potential

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12 to really do some ground breaking breakthrough
13 stuff.

14 I'm reminded of the adage that I'm going
15 to paraphrase here, you know, if the Army wanted
16 you to have depression, they would have issued it
17 to you, and there's a piece of that that, you
18 know, is at risk, but at the same time that we
19 have, you know, tremendous resources to take care
20 of individuals, we have a tremendous
21 responsibility, we have a terribly hard mission,
22 and it kind of hits right at the nexus of the

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1 resiliency of soldiers, sailors, airmen, and
2 marines to be able to execute that, whether it's
3 landing an aircraft on an aircraft carrier or in
4 the submarine or, you know, flying to 40,000 feet
5 for hours and hours.

6 And those same strengths can also be
7 potential weaknesses in the sense that the
8 standards are very high, you know, we don't
9 tolerate soldiers that have to spend, you know,
10 every day of the week in a mental health clinic,
11 and by tolerate, I mean, you know, from a
12 retention, from a screening retention perspective.

13 So I don't -- that's why I think this
14 whole piece of the stigma, in this culture, is as
15 critical as anything we do. Some of the stuff

16 we've done in the Army with the post-deployment
17 screening and, you know, instead of saying okay,
18 if you answer yes to the mental health question,
19 I'm having problems with mental health, you know,
20 go get in the short line with the psychiatrist,
21 everybody goes to see the psychologist, everybody
22 does. So everybody walks in, closes the door, and

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1 spends 20 or 30 minutes. We've gotten mixed
2 reviews on that, but I still think there's great
3 value to that, and it's -- I think it's going --
4 I'm hoping, hope not being a course of action,
5 it's going to continue to turn our culture to say,
6 look, you know, you've heard me say this before,
7 but when they come back from deployment, we don't
8 ask the soldiers how's their dental health, we sit
9 them in a dental chair and have them open their
10 mouth and we take a look for ourselves.

11 People don't self-refer for mental
12 health screening necessarily, and sometimes ask
13 them how their mental health is as effective as
14 asking how their dental health is; we'll see.

15 LT COL. DOUGLAS: Okay. We talked
16 probably extensively this morning about
17 counseling. There are three distinct concerns
18 with counseling that have been submitted, first

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19 being marriage counseling. I think we've
20 discussed that and the lack thereof in some
21 services, the availability of marriage counseling,
22 that was one. The second was grief counseling for

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1 family members and their children. And then the
2 other, which I found interesting, was for family
3 members whose service member is suffering from
4 polytrauma, a dual diagnosed PTSD TBI, and
5 counseling for the extended family. One case in
6 particular, you've got the spouse, adolescents in
7 the home trying to understand the PTSD and lack of
8 counseling for them.

9 They were fortunate during their moving
10 around until he was out processed that there was a
11 focus group at, I think their third stop, once
12 they finally got to their home of residence. But
13 -- so those three pieces of counseling have been
14 submitted and we've talked at least two of them,
15 but I found them interesting, the family member
16 whose spouse is suffering from polytrauma and how
17 that affects the other families and their concerns
18 of where do we get counseling for the rest of the
19 family while we're trying to understand and deal
20 with --

21 MS. POWER: Was this a lack of
22 counseling available through TRICARE, Jonathan?

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1 LT COL. DOUGLAS: Through the VA.
2 MS. POWER: Through the VA.
3 LT COL. DOUGLAS: This is a --
4 initially, they just -- they were just dealing
5 with the, as best they could, the diagnosis and
6 treatment. Once they were out processed through
7 the MEB and sent to the VA, they were at that loss
8 throughout the system. They moved three times,
9 through three -- from an MTF, then to two other VA
10 centers before their home of record, but along the
11 way, lack of counseling as problems surfaced in
12 the family, how to deal with that.
13 COL. DAVIES: That makes me mindful of
14 our meeting that we had at Fort Hood, when the
15 young lady came forward and talked about how much
16 great support she had received after she'd lost
17 her husband, the grief counseling that went on
18 being in that community. But what about the young
19 wife, maybe with some children, loses her husband
20 and then leaves the military community, so to
21 speak, and goes out, what kind of follow-up do we
22 have in that particular domain?

1 LT COL. DOUGLAS: That was a separate
2 submission too, also. How to we connect these
3 families who have departed the service, just for
4 support, having left the service, whether - either
5 from medical reasons or being a widow, so --

6 DR. MACDERMID: Can somebody educate me
7 about what the current programs and policies about
8 that are? So there's a widow or a widower,
9 obviously they don't have the same kind of
10 connection with the service that they once had.
11 Do they have access to family support centers?
12 Can they go there and receive any kind of
13 treatment? How does it work; can somebody tell
14 me?

15 COL. PEREIRA: I think, at least in the
16 Army now, we've heard that they can stay part of
17 their community for, and stay in housing, for one
18 year. Is that across the services?

19 LT COL. DOUGLAS: That's DOD wide.

20 COL. PEREIRA: DOD wide; so they're
21 still able to access for that first year all of
22 the services that would have been available to

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1 them before?

2 DR. MCCORMICK: I think the other issue
3 that's come up, though, is that, in reality, very
4 often it's the closest relative are parents, you
5 know, the average marine is, you know, 17, 18, 19
6 years old, single, and the grieving people are
7 really parents who have never really been
8 connected with the military, and how assertive are
9 we in outreaching to them. And we heard, of
10 course, some very heartfelt testimony from more
11 than one mother as we've taken that.

12 LT COL. DOUGLAS: And that was, again,
13 this came up in testimony submission, too, that
14 exact scenario. Young service member is the one
15 that's injured; how does the parent fit into the
16 scenario who's trying to take care of their only
17 child or maybe only child plus another child
18 through the system and their concerns, again,
19 counseling for them.

20 They don't really break counseling,
21 because they're the parent, but we're able at some
22 places to get some help since they're in the

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1 facilities trying to mind and take care of their
2 -- but along with that came up some of the MEB
3 process and a point of there needs to be more
4 education for the family member, either a parent

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5 and/or a spouse, about the MEB/PEB process. Once
6 their -- somewhere along the line, once their
7 service member is severely injured and it looks
8 like they may not be able to return to active
9 duty, somewhere during their treatment somebody
10 needs to provide them that information in a
11 coherent fashion, as opposed to what seems to be
12 happening, at least through testimony submission
13 is, they're getting it all at the same time.

14 There are so many others trying to
15 receive care at the same time they're being asked
16 about MEB issues, which they're not prepared to
17 respond to, and they just would like, you know,
18 slow the process down or just, you know, break the
19 two apart, get them the information in a coherent
20 fashion, and have them time to digest it.

21 DR. MCCURDY: What is the process? I
22 missed the acronym.

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1 LT COL. DOUGLAS: Oh, Medical Evaluation
2 Board or Physical Evaluation Board. A very
3 interesting submission from a -- I'll say
4 provider, actually it was a chaplain, I gathered
5 that much from the submission. But the question
6 is to who -- most of you -- okay. I have to read
7 this, because it's very - the most acute problem
8 with mental health system in the military is one

9 of proponency, who is in charge, and I know
10 we've discussed this, as far as who is the one
11 body in the military institution who speaks with
12 authority regarding mental health regarding
13 service persons and their families. So there are
14 other individuals out there who comes to the same
15 conclusion that we have in some of our
16 discussions, that there is not a single person at
17 any installation where they could at least co-see
18 and ask to --

19 LTG KILEY: Thoughts on that? Dick,
20 you've been --

21 DR. MCCORMICK: Well, I think where it
22 plays out, and it sort of relates what you said

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1 earlier about marital counseling, sometimes there
2 are so many people that have a piece of the pie
3 that when there's a hole in the pie, nobody's
4 responsible for the hole.

5 So we certainly insight this; I've seen
6 repeated examples where marital counseling isn't
7 evident and available, and it -- different people
8 might provide it, but if everybody doesn't have
9 the resources or the will, no one provides it, and
10 that's where I think, as we've discussed, having
11 one person at the local level who is responsible

12 for kind of -- not only coordinating what happens,
13 but looking at the big picture, and where are the
14 gaps, and having the ability and authority to do
15 something, and, of course, the resources to fill
16 those gaps is critical. And it doesn't surprise
17 me what you said earlier, that one of the most
18 common submissions was about marital counseling,
19 because certainly, we heard that repeatedly,
20 including from chaplains.

21 DR. MACDERMID: It's really a surprise,
22 in a way, that there's so much rhetoric about

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1 family support and there's so much rhetoric in our
2 society about marriage, and yet the marriage
3 support activities in the military are uneven, I
4 guess is the best word.

5 I mean the chaplains are doing a lot
6 around marriage enrichment sorts of things as
7 resources allow, but therapy is unevenly
8 available, and training for couples' issues I
9 think is uneven, so that's a challenge.

10 But the bigger challenge even I think is
11 to acknowledge that when we talk about military
12 members and their families for about, what, half
13 of military members, a third of military members,
14 we're talking about parents, not partners, and our
15 systems, our support systems are not oriented at

16 all to deal with parents.

17 I mean family readiness groups are not
18 really designed for parents, access to certain
19 kinds of services, like grief counseling, that's
20 not oriented all that much toward parents, at
21 least as I understand it. I'm always happy to be
22 corrected, but --

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1 DR. MCCORMICK: well, I think it was
2 also instructive that on really the last site
3 visit we did at the NATO Base, was that
4 Geilenkirchen, where there was a very small mental
5 health group on the Air Force base, but they were
6 adequately staffed to deal with all issues. The
7 number one problem presenting was, in fact,
8 marital counseling.

9 LTG KILEY: I mean is -- I thought I was
10 following the discussion here. Maybe I missed
11 something, but --

12 DR. MACDERMID: We drifted?

13 LTG KILEY: No, no, no. I may have
14 drifted. Listen, you all didn't drift, but I can
15 drift in a heart beat. Marriage counseling as
16 part of mental health, or is it just another -- I
17 mean I agree with showing.

18 we have seen this, you know, with our

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19 wounded soldiers at Walter Reed, where husbands,
20 not husbands, fathers and mothers come in and they
21 are totally clueless about the military. And the
22 FRG's, you know, they've got a lot in their

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1 rucksack for Army as it relates to handling
2 family issues, and the Army has come light years,
3 even from Desert Shield, Desert Storm and
4 recognizing that you can't just train and deploy
5 the soldier, you've got to be helping the family
6 member too, and that spectrum over time has gone
7 from mowing the grass and getting the commissary
8 to, you know, a family that knows how to take care
9 of itself is much better than one that's being
10 taken care of by somebody else.

11 But the marriage counseling piece, what
12 are your thoughts? I'd be interested in that, in
13 terms of -- I mean I grant you, if you're in an
14 unhappy marriage, you have a mental health issue.
15 I mean, you know, I mean I got that, but what do
16 you think?

17 COL. PEREIRA: So that was a real
18 question?

19 LTG KILEY: Yeah, it was.

20 COL. PEREIRA: Is marital counseling
21 part of mental health?

22 LTG KILEY: Yeah.
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1 COL. PERIERA: Okay. Well, that
2 question explains why we don't have marital
3 counseling in all of the different places that we
4 need to.
5 LTG KILEY: Are you speaking to the
6 Surgeon General now, Colonel, or are you --
7 COL. PEREIRA: No, sir.
8 LTG KILEY: That's a joke.
9 COL. PEREIRA: No, sir. But --
10 LTG KILEY: That was a joke.
11 COL. PEREIRA: -- but if that is the
12 belief system of the, especially the medical
13 community, then it kind of -- yes, it would flow
14 down to -- at the local installation level, we
15 don't have marital counseling, because we haven't
16 put emphasis on marital counseling. But, yes,
17 it's an integral and a very basic mental health
18 component.
19 LTG KILEY: It may be a mental wellness
20 component, I mean, you know, it's almost a
21 preventative type of thing.
22 COL. PEREIRA: Well, it can be, but it

1 can also be treatment. If you think about,
2 especially right now, the numbers of warriors that
3 we have returning, a big part of their problem
4 with reintegration is the marital relationship and
5 the distancing that goes on with many warriors,
6 even if they don't have PTSD, that element is
7 still often there.

8 LTG KILEY: Directly reflects on
9 readiness, absolutely.

10 COL. PEREIRA: Correct.

11 LTG KILEY: Completely concur with you.
12 Is marriage counseling so much different or so
13 unique relative to the mental health services
14 associated with anxiety, depression, or PTSD, that
15 it's, you know, it's a whole other category? I
16 mean, I'm not being stupid to be stupid here. I'm
17 just -- I find this discussion very interesting,
18 because I haven't had much discussion about this.
19 We've been talking about PTSD, and depression, and
20 suicides over time, but what are your thoughts on
21 that?

22 DR. MCCURDY: Thank you, General Kiley,

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1 for bringing up this topic, because I think it is
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2 just crucial, and I know that you're playing
3 straight man so that we can get this topic on the
4 table, and recognizing your medical specialty,
5 there are things that are engaged there that we
6 might wonder, is it disease oriented when you do
7 marital, pre-marital counseling, et cetera. So
8 we're talking about a full range of approach, but
9 I think it's more difficult with mental health,
10 quite frankly, seriously. I think the problem is
11 the boundary between illness and either
12 prevention, or resiliency building, or just
13 something that's not going to lead to illness is
14 very complicated, and I think that's one of the
15 things that has made it difficult for the
16 appropriate allocation of resources, because
17 there's so many things that mental health
18 professionals, providers, do that don't generate
19 RVU's, and remember how the RVU system got
20 constructed, it got constructed around a
21 reimbursement system.

22 And I think that one of the things that

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1 I hope is going to come out of our work is going
2 to be the recognition as many insurance companies
3 are beginning to recognize that prevention work,
4 that resilience building work, are all critical

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5 and crucial to the welfare of the troops, the
6 readiness of the troops, and also to the
7 postponement of greater medical costs.

8 LTG KILEY: I think that's a good point
9 worth discussing for a minute. And I want to be
10 real clear, because I've said this in public
11 forums and in the press and everything else, you
12 know, there is no question that, at least for the
13 Army, it's done a lot, not all, but a lot of the
14 deployment preparation and deployment, in terms of
15 resources that the local medical communities have.

16 If a commander sees mental health
17 requirements laid on him or her, at Camp X, Y, or
18 Z, as they prepare to deploy soldiers or marines,
19 and I can only speak for the Army, and they see
20 the need for increasing mental health resources in
21 order to do pre-deployment screening,
22 pre-deployment counseling, pre- deployment

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1 therapy, pre-deployment screening to rule in, rule
2 out PTSD, or to document stability before we go,
3 they get whatever they want, which begs the issue
4 of this RVU issue.

5 And to my way of thinking, I concur that
6 if a mental health -- and I've heard Dave say this
7 before, and Angela also, that, you know, if you're
8 not getting the RVU's down at the camps posts and

9 stations, you don't count. But, you know, the RVU
10 and RWP thing is kind of an artificial construct
11 on our posts. It's a way to document, in my mind,
12 in a more business like and effective manner the
13 work we do do, because we can compare with the
14 civilian sector, we can compare and contrast, are
15 we getting the bang for the buck stuff.

16 I mean we used to work with clinic
17 visits, and appointments filled, and x-rays, and
18 30 years ago, 20 years ago we used to do MCCU's;
19 remember that, MCC, you get ten MCC's for the
20 mission and one MCC a day, and you know, I
21 remember one pediatric department, they'd give an
22 MMR and they'd get three MCCU's, one for the M,

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1 one for the M, and one for the R, and it's just a
2 matter of gamesmanship.

3 I mean with the stroke of a pen, the
4 department could quantify, to some extent, the
5 work being provided for the chaplain's work,
6 marriage counseling, life skills training,
7 resiliency training, and then the more complex
8 mental health issues, and we'd get past it. The
9 issue I get, in my mind, is addressing the fact
10 that marriage counseling, as valuable and critical
11 as I think it is, is just another, you know, chick

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12 in the nest, you know, looking for resources, and
13 so the answer is, you know, what's the
14 prioritization? Is marriage counseling more
15 important than face-to-face pre-deployment
16 screening? Should we do both?

17 well, in the global war and terrorism,
18 where the Congress has resourced us to do whatever
19 we need to to take care of the global war and
20 terrorism, we're okay. Post-hostility, at least
21 of a current urgent issue, which our present
22 circumstances are, you know, we kind of overt back

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1 to no supplementals and we're kind of back into
2 our core budget of trying to maintain and carrying
3 a lead in soldiers, sailors, airmen, and marines,
4 and now all of a sudden, you know, you don't have
5 the global war and terrorism justification for
6 additional resources, you're kind of back to how
7 do you ration it.

8 And that was part of what my question
9 about, you know, marriage counseling was, is how
10 is that piece of it going to have the same throw
11 weight as in-patient psychiatric care for the
12 severely affected, you know, the severely
13 depressed or the suicidal, active suicidal
14 individual?

15 DR. MCCURDY: well, it's --
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16 LTG KILEY: That was a lot, but, you
17 know, I don't think there was a question in that
18 pile there anywhere.

19 DR. MCCURDY: No, I think you made a
20 good point. Interestingly, I think, and I've
21 thought about this with the military over the
22 course of the last several months, I think that,

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1 unfortunately, capitation in the private system
2 went astray for some reasons of -- business
3 related reasons.

4 I think from a health care perspective,
5 the capitation concept, which, in many ways, the
6 military has the opportunity to do that, the
7 capitation concept was very good, and if you look
8 at Kaiser Permanente, it worked very well for
9 them, and still does for a long time, and it
10 permits resources to do things that are not
11 otherwise reimbursed with RVU's, and I think this
12 is where I hope our Task Force is going to go with
13 the military.

14 DR. MCCORMICK: One last thing on the
15 marital counseling, and again, we saw places where
16 there really are robust marital counseling
17 programs, sometimes in mental health, sometimes in
18 marine counseling services. On the other hand, I

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19 think one thing we did see consistently is that
20 any place you go, there's a lot of resources put
21 into FAP, and I've used this analogy before. I
22 mean, in many ways, I think primary care is to the

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1 intensive care unit as marital counseling is to
2 FAP.

3 You have good marital counseling really
4 to keep people from getting to the point that they
5 need FAP, and yet I think that there are a number
6 of instances we saw where really there was a very
7 strong FAP program for the people who had gotten
8 to the point where there really was abuse in the
9 home, and yet no marital counseling, and so it's
10 like focusing on the real sick part rather than
11 the preventive primary care part.

12 LTG KILEY: I would think FAP would
13 throw a wider net than just marriage counseling,
14 too. You look at PTSD and your control
15 nightmares, drug and alcohol use as a result of
16 that, there may be other missions in FAP than just
17 -- I don't disagree, though, that marriage
18 counseling, if it diffuses issues that would then
19 lead to abuse is very --

20 LCDR WERBEL: This is the problem I
21 think that we have to address in there, is that
22 when there is a scarcity of resources, when

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1 there's a limit on resources, I think that we tend
2 to make our decisions, our business decisions, not
3 always in a way that takes into account the most
4 significant needs of the individual, and then the
5 problem with that is that then loops around and
6 maybe those business decisions were not even in
7 the best interest of the organization.

8 And in the mental health clinic, the
9 first thing to go is anything that's a V Code.
10 well, it's not the most severe syndrome or it's
11 not a disease process, so as the resources become
12 more scarce, we're just going to see
13 schizophrenia, severe depression, bi-polar
14 disorder, we're not going to see adjustment
15 problems, we're not going to see marital therapy.
16 But then what happens is, if those don't get seen
17 somewhere else, maybe they're not going to be seen
18 in the mental health clinic, that ends up leading
19 to the problems that show up in the mental health
20 clinic.

21 So in that loop, the things that often
22 get pushed out when there's a limit on resources,

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1 because they're not seen as the most significant
2 issues, end up just increasing the number of
3 significant issues that show up later on.

4 So it doesn't mean that necessarily the
5 MTF, the Military Treatment Facility, has to
6 provide the marital counseling, but that we have
7 to ensure that there is some resource available
8 for that, those V Code, adjustment disorder,
9 marital counseling type problems, or we're really
10 running the risk of just exacerbating the case
11 load in the mental health clinics.

12 DR. MACDERMID: Well, I would take it
13 even a little bit further than that, although,
14 maybe it's completely an artifact of resources,
15 but I would say that despite rhetoric to the
16 contrary and practice, we don't act very much as
17 though we believe in systems theory. So when push
18 comes to shove, we say we'll treat the member, not
19 the family, we'll focus on the member first and
20 sort of leave the family aside. Well, that
21 ignores the fact that members are very worried
22 about their families and that causes issues. I

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1 just had it happen, actually, that we were looking
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2 to do some research on marital processes around
3 PTSD, and you know, if you have PTSD in a marriage
4 and you have marital quality issues, how do those
5 things interact, and again, the rhetoric was,
6 well, resource is in tight, therefore, we need to
7 focus on the member. So this sort of didactic
8 stuff is not all that relevant.

9 well, there's a point at which that
10 stops making sense. The idea that you can treat a
11 member without treating a family or that if you're
12 not -- if you're treating the family, you're not
13 treating the member somehow. So it may be
14 completely an artifact of scarce resources, but I
15 want to push a little bit sometimes and say, hey,
16 quit saying families are so important all the time
17 if we're not going to behave as though it's a
18 system.

19 So, for example, one question I have is,
20 are there any barriers in any of our practices,
21 policies, or procedures that would prevent a
22 clinician from treating a couple as a system? So

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1 if someone goes to an MTF and there's an issue,
2 maybe it's not even a marital counseling issue,
3 it's an individual mental well being issue, but it
4 clearly has bearing on how things are happening in

5 the house, is there anything that would prevent an
6 MTF provider from seeing both people together?

7 DR. MCCURDY: You raise a very
8 interesting point.

9 DR. MACDERMID: Yeah, but can somebody
10 give me an answer?

11 DR. MCCURDY: Yeah.

12 DR. MACDERMID: Oh; you know the MTF
13 answer?

14 DR. MCCURDY: I think so.

15 DR. MACDERMID: Oh, okay, sorry.

16 DR. MCCURDY: I think that what you do
17 is, one person declares themselves a patient and the
18 other person is there conjointly. I believe I've
19 heard about this in the military. It certainly is
20 the way you do it in the private sector. One of
21 the interesting struggles that emerges sometimes,
22 if it's really a marital conflict, is conflict

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1 about who gets to be the patient, and sometimes
2 that takes more negotiations than the work itself.

3 LCDR WERBEL: So what we're set up with
4 then is a how do you find a loop hole to do
5 marital therapy.

6 DR. MACDERMID: And isn't that a little
7 silly?

8 LCDR WERBEL: Yes.
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9 LTG KILEY: I don't know, Dave, you
10 know, or Angela, I mean, you know, in the
11 privileging process, are there specific skill sets
12 that are required of counselors to do marriage
13 counseling? I mean I'm not qualified, I don't
14 think, to do marriage counseling, and you know, if
15 I was sitting at Fort Bliss and I was seeing
16 patients, you know, except in a very narrow lane
17 in my specialty, if I was talking broad
18 counseling, I'd probably be practicing outside of
19 my privileges, wouldn't I?

20 COL. PEREIRA: Yes, sir, that's a good
21 point. There are different skill sets for doing
22 marital counseling, as there are for family

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1 therapy. A clinician who is trained to work with
2 individuals doesn't necessarily have the skills,
3 nor will be credentialed to do couples counseling
4 or family therapy, and the issue of seeing two
5 people instead of one, for those who do have that
6 skill, it reflects negatively on the RVU's,
7 because you can only count one person, so that is
8 going on, and because TRICARE does not see couples
9 either, that same game is being played on the
10 TRICARE side, where one person is the identified
11 patient, the partner comes in with that person,

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12 and then marital counseling, under the guise of
13 individual counseling, takes place.

14 LT COL. DOUGLAS: Okay. I'm going to
15 try to string a thought together here concerning
16 what our providers think is happening out with
17 them, and it seems to mirror exactly what we've
18 seen in our sight visits.

19 stability providers, particularly active
20 duty members that are affected by PCS deployment,
21 that interfere with delivery of care to their
22 patients, which, in turn, affects the provider

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1 burn out.

2 The length of time to see a provider
3 with those that are left behind, and again, they
4 brought up their concern, the additional training
5 they internally had to do subject to uniform
6 leadership, RVU concerns, which ties back into our
7 concern about quality of care, and continuity of
8 care, and lack of resources, and supply of
9 providers. So it's exactly what we've seen, but
10 this is testimony submitted, and that's multiple
11 providers, they'd seen some of the same concerns.
12 And one additional thing is policy, in particular,
13 recent DOD policy guidance concerning deployment
14 limiting psychiatric conditions, that's November
15 2006, from Doctor Chu.

16 COL. PEREIRA: Can you tell us
17 specifically what those comments were?
18 LT COL. DOUGLAS: Policy concerns?
19 COL. PEREIRA: Yes.
20 LT COL. DOUGLAS: Sure. The 7 November,
21 2006 DOD policy guidance on deployment
22 limiting psychiatric conditions will create a

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1 major rift between health care and providers and
2 unit commanders.
3 COL. PEREIRA: That was the entire
4 comment?
5 LT COL. DOUGLAS: I'll pull that one
6 right up; hold on. And the second half of that
7 was the policy guidance for medical deferral
8 depending deployment to theater of operations. At
9 the 9 February, 2006 one, which gave that three
10 month window, where you could be evaluated and
11 delay your deployment while validating whether you
12 could be deployed or not.
13 COL. ORMAN: Before we lose your first
14 thought, let me just sort of pose some concerns I
15 have that speaks to a broad variety of issues the
16 Task Force has been sort of wrestling with. Part
17 of my experience, in terms of at least Army mental
18 health is, there's an assumption often on the part

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19 of MTF commanders who are not behavioral health
20 providers, that much like primary care, perhaps
21 pediatrics and some other generally primary care
22 oriented specialties, that the behavioral health

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1 system has some sort of surge capacity in times of
2 peace, and how this plays out in a way that I
3 think impacts on what our work is about is, when
4 we go to war, such as GWOT, there is no surge
5 capacity.

6 All of those active duty providers that
7 have heretofore populated the clinics, the
8 in-patient services, et cetera, on a sequential
9 basis are often in parallel or deployed. And when
10 they get deployed, we're talking numbers that most
11 MTF's have three to six to sometimes a few more
12 professionals, when they get deployed they leave
13 huge holes.

14 I mean an entire out-patient service
15 will go down, or the in-patient service provider
16 is the one that's deployed, and because we haven't
17 built surge capacity into our systems, these
18 continuity issues immediately become apparent.

19 There isn't somebody because you're too
20 deep on the in-patient service, you just sort of
21 hand over your patient load. There isn't somebody
22 in the out-patient clinic necessarily, if there's

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1 only one psychiatrist at that MTF, that you turn
2 over the psychotropic prescribing responsibilities
3 to, and so there's sort of this cascade effect
4 that impacts on patients, impacts on providers,
5 impacts, in my opinion, on the mission, or because
6 we haven't built redundancy under our system, and
7 that redundancy could be civilian, it doesn't have
8 to be all active duty, because we haven't built it
9 in upfront, then we have this negative cascade of
10 consequences that impact on the quality of care
11 for patients, the satisfaction and morale of the
12 provider, and, frankly, the mission of the MTF to
13 support the local beneficiary population. So that
14 plays out multiple venues that we've already
15 discussed.

16 This whole business of how do we
17 resource the system, how do we staff the system,
18 how do we ensure there's adequate depth, and I
19 think that's going to be a large part, frankly, of
20 our report, which is, how do we get from where
21 we're at where there is a lack of surge capacity
22 to a position where in the future we have that

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1 available to us?

2 MR. CAMPISE: And on the surface, the
3 hiring of the GWOT contractors seemed to be an
4 acceptable solution of that, but what we found
5 going from installation to installation is,
6 there's a long lag time between the hiring --

7 DR. MCCURDY: Right.

8 MR. CAMPISE: -- that there's some
9 barriers for the contracting process, and that,
10 unfortunately, since it's a one year contract and
11 at most a two year contract, assume as a lucrative
12 GS position opens up somewhere else, in six months
13 you're replacing that contractor.

14 LTG KILEY: I feel an obligation to
15 weigh in here a little bit now, you know, in
16 defense of -- I would agree that if you just walk
17 into a mental health clinic and say you, you, you,
18 and you, you're going next week to the CRC at Fort
19 Bliss and you'll be gone for a year, that's
20 catastrophic.

21 I don't think any of us have the
22 resources at hand to build redundancy into every

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1 camp, post, and station in the mental health
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2 community, notwithstanding that they may already
3 be under resourced and that we should be further
4 resourcing them to begin with, I don't quiver with
5 that.

6 I do think that since the long war
7 started, we have gotten better at predicting, to
8 some extent, who's going, when they're going, and
9 how long they're going for, and it gets back to
10 Jon's earlier comment, which I wanted to comment
11 on, which is there's no question that the
12 personnel turmoil of OPTEMPO over mental
13 health providers at every level is very high and
14 is very disruptive, and, frankly, in many
15 respects, there is at risk for the challenges of
16 deployment and combat as anybody else is, and in
17 some cases, more, that that's all a big challenge.

18 I think that commanders are challenged
19 even if, for example, as Commander of MEDCOM, I
20 can give, you know, the Fort Carson commander all
21 the money he wants, he's got a challenge finding
22 people to come. The Commander at Fort Leonard

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1 wood needs more people, you know, out in the
2 woods, lost in the woods as they call it, or Fort
3 Huachuca, they're looking for mental health. well,
4 you know, it's only a matter of money, okay.

5 If we're willing to pay 450 to \$500,000
6 a year for a psychiatrist, my sense is they'll
7 come and stay a long time at \$500,000 a year,
8 okay. And so the challenge commanders have is
9 balancing that normal tension between I got the
10 demand and don't bother with a lot of the active
11 duty forces left, so what exactly is the make up
12 of the demand, from, you know, luxuriant, and I
13 don't mean that in a pejorative sense, but, you
14 know, \$500,000 a year psychiatrists versus
15 allowing the community to provide that health
16 care.

17 But I do think that even in an ideal
18 world, as at least I've just articulated, even in
19 that ideal world, this personnel turnover, this
20 deployment, and redeployment, and potential threat
21 to redeploy, or you deploy to Iraq for a year and
22 you come back, and in four or five months you've

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1 got a cross level from one installation to another
2 for three months to cover while we try to build a
3 contract or something, that can get very tiring
4 and can wear the force down, I think.

5 And I think the whole force is concerned
6 about that; whether it's -- how severe it is or
7 not, I don't know, and you know, down at the local
8 MTF, Dave Orman, you know, at your local mental

9 health clinic, do they see that strategic view? I
10 don't know, and maybe we aren't doing as good,
11 maybe we're kidding ourselves, but, you know, what
12 do you think?

13 COL. ORMAN: I think it's a function of
14 the 30,000 foot level view versus on the ground
15 view, sir. And let me just sort of give a couple
16 of key words that help me think about it. I think
17 when you're dealing with low density specialties,
18 we're literally on a non-war footing basis and
19 just everyday business you've got three or four
20 providers.

21 when you take even one, and much less
22 two or more, you always stand the potential of

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1 breaking the system, and typically, those places
2 are those rural, non-urban, geographically
3 isolated post-installations, where up front they
4 have the disadvantage of not having a community of
5 support provided through the TRICARE network, nor
6 do they have providers out there in the civilian
7 sector that are willing to sort of step up to the
8 plate and be hired and augment services.

9 So to the degree, all the services
10 function with those geographically isolated,
11 non-urban, low density specialty areas, I think

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12 this phenomenon pertains. And the question is, is
13 there a cost affective way to be prepared for this
14 or do we have to sort of do the \$500,000 shrink
15 thing? If you're going to have the service there,
16 you've got to pay for it, and there's a reason
17 there's low density, and I think we need to sort
18 of think through, have we thought about that at
19 the 30,000 foot level in the way that's meaningful
20 at the local level.

21 LT COL. DOUGLAS: Colonel Pereira, that
22 specific concern about the policy guidance on

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1 deployment limiting psychiatric conditions is the
2 time factor. If you have a professed psychiatric
3 issue, ongoing issue, you have to have a pattern
4 of stability without significant symptoms for at
5 least three months prior to deployment, so that
6 providers concern is that having one of those too
7 long, and to break the system, all you would have
8 to do is profess that you have some kind of
9 psychiatric problem to be now put in that three
10 month period of stability, therego, you don't have
11 to deploy.

12 So there's the friction that's built
13 between the commanders and mental health is, you
14 know, I just have to raise my hand and voluntarily
15 go see mental health and say I have a problem, and

16 I can't deploy for three months now, because I
17 need that three month period, so that's their
18 concern.

19 COL. PEREIRA: I'm surprised to hear
20 that, because since that new policy has been out,
21 we've been specifically asking providers their
22 thoughts on it and they've been largely positive.

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1 I mean disagree with me, you know, Task Force
2 members, if you've seen anything differently, but
3 they thought that, specifically, the areas covered
4 were very appropriate, and we didn't hear too much
5 about the time lines, but overall, they were
6 positive feedback.

7 LT COL. DOUGLAS: Again, we just kind of
8 touched on a reason just a few moments ago about
9 being in rural areas. Two concerns have come up;
10 National Guardsman injured on active duty returned
11 to his local area. Treatment -- he is -- can't
12 drive, polytrauma, PTSD, and TBI. He is more than
13 an hour from a VA treatment center. There's
14 issues with his family getting him treatment.

15 Second issue with the rural area; family
16 member is now a widow, still gets services, there
17 are no child counseling services in her town at a
18 military treatment facility, she has to pay out of

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pocket because TRICARE will not cover grief
20 counseling for her children. So it's kind of a
21 TRICARE issue rural concern, and then the VA issue
22 rural concern reaching treatment.

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1 DR. MACDERMID: Does anybody know why
2 TRICARE doesn't cover grief counseling?
3 COL. ORMAN: That's V Code.
4 DR. MACDERMID: Oh, because it's not
5 clinical, all right. So TRICARE won't cover any
6 --
7 COL. ORMAN: V Code.
8 DR. MACDERMID: -- TRICARE will not
9 cover any V Codes?
10 COL. ORMAN: It's not defined as V
11 Codes, that's correct.
12 DR. MACDERMID: Okay.
13 LT COL. DOUGLAS: And I think it was
14 brought up a few months ago, Feres doctrine. I
15 vaguely -- there was concerns from providers that,
16 or not providers, it was just a service member
17 about that being looked at, again, and I know we
18 mentioned the recommendation that we'd look and
19 have them review at least the Feres doctrine and
20 how it pertains to the military, if I'm not
21 correct.
22 LTG KILEY: I didn't hear that

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1 discussion. Can anybody remind me of that?

2 COL. ORMAN: Yeah; just for kind of the
3 record, the Feres doctrine has to do with the
4 ability of active duty to sue for perceptions or
5 reality of negligence of care, inadequate care, et
6 cetera. To my knowledge, we have yet to discuss
7 that inside the Task Force.

8 DR. MACDERMID: We've been identifying
9 -- we've been building a selection of policies.
10 We've agreed a couple of times that we need to
11 take a look at policies and talk about changes
12 that might be needed and we've identified a list
13 of candidate policies to go over and assemble
14 them. We need to agree, at this meeting still,
15 exactly what policies need to be in that packet so
16 we can get it delivered to everybody, and I expect
17 we'll be discussing them in detail in March.

18 LT COL. DOUGLAS: Nobody's seen on our
19 site visits and this just corroborates it, the
20 shortages or lack of child psychiatric services or
21 services available for children across the board,
22 not just counseling, but pediatric services,

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1 that's been mentioned, in particular, OCONUS, and
2 also domestic violence counselors, victim
3 advocacies, OCONUS, a lack of them being
4 available.

5 LTG KILEY: Are victim advocacy
6 personnel part of the mental health?

7 LT COL. DOUGLAS: It goes back to when
8 we were talking about FAP. We have igmabiged (?)
9 in CONUS, but those noted that are not available
10 OCONUS.

11 MR. CAMPISE: Who's attributing that?

12 COL. PEREIRA: For --

13 LT COL. DOUGLAS: That was German.

14 MR. CAMPISE: They are over there.

15 COL. PEREIRA: They are over there, and
16 for the Army, they fall under ACS for Air Force --

17 MR. CAMPISE: Family advocacy.

18 COL. PEREIRA: Family advocacy, as well.

19 LTG KILEY: So advocates?

20 COL. PEREIRA: But for the Air Force,
21 they're actually part of the clinical team. For
22 the Army, they're part of the community preventive

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1 side --

2 LT COL. DOUGLAS: In the Marine Corp, we
3 have both.

4 COL. PEREIRA: -- versus clinical.

5 LTG KILEY: Are they ombudsmen,
6 spokespersons, or are they therapeutics?

7 MR. CAMPISE: Case managers, and
8 typically just the victim advocate that deals with
9 sexual assault and other issues like that falls
10 under the wing commander. So it's an installation
11 or a wing commander that they directly answer to.

12 LTG KILEY: Is there something unique
13 about the military in terms of their need/demand
14 for child psychiatric services?

15 COL. ORMAN: I'd say, sir, that the
16 answer is a qualified perhaps.

17 LTG KILEY: Thanks for being so clear
18 there, Doctor.

19 COL. ORMAN: Well, you know, I think
20 this whole business of parents moving around is
21 certainly not unique to the military. I do think
22 parents moving around and being in harms way for

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1 unpredictable extended periods of time perhaps is
2 unique to the military, and so I guess the generic
3 question in my mind that speaks to this issue is,
4 do we have a special obligation in the military to

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5 make sure that adequate child support services to
6 include the clinical part of that equation are
7 available. And without knowing what the right
8 level is, I think that is the question that we
9 need to have some sort of response to.

10 MR. CAMPISE: Right; and I think it's
11 exacerbated by the fact that you have a special
12 needs child in a family in which one of the
13 parents deploys, and so the family is short handed
14 in taking care of that child's needs, and the
15 mother or the husband reports and it's a six to
16 nine month wait for a child psychiatry
17 appointment. And the individual deploying knows
18 that two months after they deploy, they still
19 won't have that psychiatry appointment.

20 DR. MACDERMID: I'll add one other
21 thing, which is that, of course, we've all heard
22 over and over again that there's an enormous

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1 shortage of child clinicians or clinicians who
2 treat children in the civilian world. So the
3 shortage in the military is, in part, an artifact
4 of that.

5 The other thing I would say, though, is
6 that we know precious little, frankly, about
7 military kids and what their experiences are. For
8 example, we don't know what the long term

9 implications are of a four year old kid never
10 having seen a parent for half of their life, one
11 of their parents.

12 we don't know what the cumulative affect
13 is of multiple year-long deployments on kids. we
14 don't know how kids are supposed to or how kids
15 would normally adapt to a parent who comes home
16 from war missing limbs. There aren't literatures
17 on some of these things, and the military does not
18 have a very -- I mean if they don't have an active
19 research program about some of the marital and
20 family issues, they certainly don't about
21 children.

22 LTG KILEY: well, one, I have three,

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1 what would you like to know about military
2 children, seriously? Actually, Steve Cozza at
3 Walter Reed has done some interesting stuff with
4 the children of injured soldiers, so -- and you're
5 right. We're trying -- and there have been, I
6 think there have been other publications and
7 surveys, I thought.

8 DR. MacDERMID: There used --

9 LTG KILEY: In fact, I think you've done
10 some, haven't you?

11 DR. MacDERMID: Yes, I have.

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LTG KILEY: There you go.

DR. MacDERMID: And I know that literature a little bit, which --

LTG KILEY: There you go.

DR. MacDERMID: -- is why I said what I just said. Very little of that research is longitudinal, very little of it is a very large scale, and if you look, for example, at military research programs, family issues, and child related issues rarely come up, and military IRB's are fiercely uninterested in allowing access to

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children. And all of that may be for very good reasons, but I'll say we need to be a little cautious sometimes about our conclusions about children, because we have very sketchy knowledge of what's happening with children and what the implications for children are.

LT COL. DOUGLAS: I'll finish up here with this last one. Most of us were in Fort Lewis for our open session and this was presented to us at testimony there. But to read through and have time to digest it, this is a -- I'll start out -- it's got a leadership issue. If -- I'll try to refresh your memories, it was the dual military family. She came to present it to us, her husband, they were both captains. He started in

16 Germany, deployed to Iraq, returned to Germany,
17 went from Germany to Fort Sill, Fort Sill to
18 another duty station. Along that continuum
19 somewhere, he developed his symptoms for PTSD,
20 subsequently committed suicide.

21 The question is, where was leadership's
22 responsibility along that continuum to take

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1 action, because no action, reading through her
2 testimony, apparently taken anywhere along her
3 particular case, at least as she submitted it. And
4 it seems there are multiple opportunities during
5 these three PCS stuff where something or someone
6 either, on the medical side or even so the uniform
7 leadership side should have caught something and
8 done something. So I kind of categorize this as a
9 leadership issue on both sides of our medical and
10 in line.

11 COL. PEREIRA: That goes back to our
12 discussion this morning about a lack of consistent
13 system, although it does exist, that it does exist
14 in the Air Force for tracking service members with
15 identified mental health needs and were very bad
16 about that from PCS to PCS. That's one of the
17 areas that needs some looking into, as well as the
18 post-deployment health risk assessment process and

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19 what happens after we've identified those folks
20 and they move.

21 LT COL. DOUGLAS: And I think --

22 COL. PEREIRA: I agree it's a problem.

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1 LT COL. DOUGLAS: And I think the unique
2 -- into this one -- I'll tell you again to refresh
3 your memories, he was finally referred out in
4 town, because he couldn't been seen on post with a
5 psychiatrist or a psychologist, he was referred
6 out in town, diagnosed out in town, through
7 TRICARE, has having PTSD, and no action was still
8 taken. And that's the highlights from what's been
9 submitted to date.

10 LTG KILEY: That's great. Thanks very
11 much. And that was the first -- who was going to
12 discuss the second? Who was going to introduce
13 some discussion topics of the second?

14 DR. MACDERMID: Well, one of the
15 activities that's happened just very recently that
16 we haven't had much of an opportunity to hear
17 about is that a visit was made to Guard and
18 reserve folks in Ohio, and so we were hoping that
19 the team that did that visit could talk a little
20 bit about what they learned and that would be a
21 spring board toward Guard and reserve issues more
22 generally. Doctor McCormick, does that mean

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1 you're up?

2 DR. MCCORMICK: well, either me or
3 Doctor Orman. It was an opportunity to get Doctor
4 Orman to the sunny shores of Ohio.

5 MR. CAMPISE: Were we going to
6 non-attributional though? Do we want to be
7 identifying specific places that we visited?

8 COL. DAVIES: We do not in this
9 particular thing, more generic type, but I take it
10 it was in the Buckeye state.

11 DR. MCCORMICK: Right. All right. Very
12 good; thank you. In terms of visiting a reserve
13 unit, actually it was a Marine Reserve Unit that
14 experienced casualties, we had an opportunity,
15 and, of course, for the Task Force this has been a
16 challenge for us to get our arms around reserve
17 members since, on our visits to bases, very often
18 we don't have an opportunity actually, to come
19 face-to-face with reserve elements.

20 There were a number of good things that
21 I would say were worth noting, and one was that,
22 at least in this case, despite our concerns that

1 when reservists come back following deployment,
2 this unit had deployed, had come back about a year
3 and a half ago, that they might be isolated and
4 cut off.

5 Really, not as a matter of doctrine, but
6 as a matter of the initiative of the former
7 commander, there was a considerable amount of
8 effort put into bringing the group together on a
9 very regular basis outside of the normal one
10 month, one time a month weekend to do a number of
11 things, but really it served the purposes of
12 getting them together to talk about, to sport
13 themselves, and lots of friendships were clearly
14 established.

15 We met with many of the members of this
16 unit, and those personal buddy kind of contacts
17 continue. So they were able to support each
18 other, even though they lived often very far from
19 each other and weren't returning to a specific
20 base as a unit.

21 The other very positive thing was that,
22 and it showed again the importance of the

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1 initiative and appropriate training of the corpman
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2 as a company level unit, so that, again, the
3 medical asset was really a corpman, the corpman
4 level, who in this particular case, did take a lot
5 of initiative to try to kind of muster, if you
6 will, mental health resources.

7 On the other hand, there was a
8 recognition that the amount of training and stress
9 and the aftermath of, you know, took a lot of
10 casualties, of deployment was lacking; that as a
11 corpman, he didn't feel that -- they didn't feel
12 -- the corpman didn't really feel that they got
13 the training that they needed to identify and be
14 able to deal with things up to the level that they
15 could deal with them.

16 There was also, frankly, quite a bit of
17 dissatisfaction with, and concerns about, access
18 to mental health services through the vehicles
19 that they had available, which would have included
20 the VA and TRICARE, if they signed up and paid the
21 large co-pays, Military One Source, which really
22 there was little awareness of and use of at all.

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1 Dave, anything else?

2 COL. ORMAN: Yeah; let me just sort of
3 augment some of Dick's comments. Again, on the
4 positive side, this unit had, I think superb

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5 ongoing leadership. There was an active duty
6 Marine captain who, and along with a cadre of
7 staff there that were full-time, and literally
8 went out of their way to ensure these folks came
9 together periodically and supported each other, to
10 include their families. In fact, they were having
11 a pig roast, I think, the weekend we were there.

12 The other thing, though, that was very
13 impressive was there was a full-time Navy corpman
14 assigned to this Marine unit, and even though it's
15 a reserve unit and they only do their thing once a
16 month, et cetera, this guy literally put himself
17 in a case manager position and sort of
18 aggressively and relentlessly pursued trying to
19 get care for the residual conditions that many of
20 these Marine riflemen had suffered during their
21 year of deployment to Iraq roughly a year and a
22 half ago.

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1 One of the striking things about his
2 initiative was, and he readily acknowledged this,
3 is, he had no super ordinate support. Even though
4 there's ostensibly a Marine Reserve Surgeon or a
5 Navy Reserve Surgeon someplace that's "his backup
6 and supervision," he was doing all of this on his
7 own initiative. So there was a couple of things
8 that struck me about that that I think may

9 ultimately speak to some recommendations we might
10 want to make, which is, there appears to be a lack
11 of infrastructure in the reserves to support well
12 meaning and highly motivated people who are trying
13 to provide post-MOB support services for medical
14 and mental health care to their populations.

15 And I just think that's a systemic
16 issue, it doesn't speak to anybody's particular
17 failure, it's just something that perhaps,
18 historically, hasn't been recognized, but when you
19 have ongoing conflict, such as GWOT, at least in
20 my opinion, that's something we need to kick
21 around or to address as a Task Force.

22 The other is sort of leadership support

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1 and education, and Dick touched on this, which is,
2 how is it we had this one Marine captain who got
3 it, if you will, in terms of how he provided
4 ongoing support for his reserve membership, and
5 yet when you talk to him, he didn't get any
6 training about this, he just sort of got it, and I
7 think we could perhaps do better in his career
8 development and parallel career development for
9 other officers are along the lines of what does it
10 take to make sure everybody gets it, and they
11 understand how important this is, because

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12 otherwise, I think this unit would have been in
13 really sad shape had those two factors not been
14 operable.

15 LT COL. DOUGLAS: I think that's a
16 benefit, as I've noticed from my career and being
17 on independent duty, you have a lot of latitude
18 and motivating individuals like that corpman and
19 captain, knowing that their lack of resources and
20 their distance will pick up and fill in the gaps,
21 because to do it through normal channels is just
22 too long and arduous.

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1 MS. POWER: I have a question for Dick
2 and Dave. In terms of -- because this was in a
3 state that is well known for its reintegration
4 programs, was there any connection to some of the
5 other state Guard and reserve reintegration
6 programs; was this just a stand alone stellar unit
7 with appropriate leadership and infrastructure
8 support from a Navy and Marine Corps Reserve
9 Center, or did you know that?

10 DR. MCCORMICK: Well, on the good news
11 is that it was clear that there was attention from
12 the VA and people to get there to try to meet with
13 them. So again, it's different than Guard, I
14 think, quite frankly. The initiative in Ohio was
15 with Guard. But secondly, it again underscored

16 how important it was to really do it at the unit
17 level and at the buddy level, if you will, as an
18 important and just integral step to having it all
19 work well.

20 we also did see, I think, and I think
21 the whole Task Force has seen this as we go
22 around, the evidence of the late penetration of

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1 symptoms of PTSD. There were some -- again, in
2 the reserves, these were in my -- compared to my
3 experiences at active marine bases, these were
4 somewhat older Marines and they were quite open
5 about what they were going through and some of
6 them were just now starting to really get some of
7 the severe symptoms, severe aftermath, a year and
8 a half later. So again, something --

9 LTG KILEY: Do you think that's a
10 function of not having properly been screened
11 early on that they're now having symptoms, or do
12 you think that's de novo stuff that would not have
13 been detected early; do you have any sense of
14 that?

15 DR. MCCORMICK: Well, I --

16 LTG KILEY: Because it's very worrisome
17 to me. Excuse me, I didn't mean to interrupt, but
18 it's very worrisome to me that, you know, this is

19 kind of like the tip of the iceberg or the bow
20 wave concept that's coming at us, that, you know,
21 if we don't get real aggressive with screening and
22 diagnosis early on, I mean almost the fact of

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1 you've been in hard combat, you know, you hate to
2 label people that way; what do you think?

3 DR. MCCORMICK: Well, I think two
4 things. Some of the excellent work actually done
5 at Walter Reed by Hoge, you know, when you see his
6 graphs of the number of the percentage reporting
7 problems, it's right after deployment, six months,
8 and 9 months, it just goes up.

9 LTG KILEY: Right.

10 DR. MCCORMICK: So there's a certain
11 underlying phenomenon there. I think the other
12 thing is that, you know, and it's not just
13 Marines, I think it's soldiers, too, people try to
14 suck it up at first, and deal with it, and things
15 just start to snowball.

16 COL. ORMAN: Yeah; I think this whole
17 phenomenon of it's cumulative, sir, is operable,
18 and the other thing is, what's also cumulative is
19 their dysfunctional behaviors, and so it's sort of
20 a vicious negative feedback of where, as they
21 drink more, as their marriages deteriorate, et
22 cetera, their degree of their own perception of

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1 dysfunction escalates, as well.

2 So I'm not as convinced that the
3 expression of the illness is so late arriving, in
4 other words, in many people it takes a year and a
5 half, three years. I think the overt expression
6 of their symptoms, their behaviors, sort of
7 impact, if you will, 18 months, two years, et
8 cetera, in a way that, frankly, we haven't given
9 enough thought to.

10 COL. PEREIRA: On a recent site visit,
11 we met a psychiatrist who was in charge of an
12 in-patient ward that had some interesting thoughts
13 on reservists and National Guard, and that was
14 that the incidents of PTSD and other mental health
15 problems seems to be greater among that
16 population. One of the reasons he thought was
17 because of the less training, you know, less
18 exposure to the kinds of military missions and
19 environment than the active component. And also,
20 he had a firm belief that there were, in general,
21 more people with mental illnesses already within
22 the reservists and National Guard population that,

1 because of the non-concentrated environment for
2 long periods of time, were able to mask some of
3 those illnesses and get by without being detected
4 until a deployment came along and they were
5 immersed in that environment for long periods of
6 time.

7 MS. POWER: I think he had also added,
8 Angela, that it was, in addition, it was this
9 nature of the repetitive kind of trauma that was
10 experienced by some of the people that they were
11 seeing there, so that it was not just the
12 pre-existing condition, but also the kind of
13 trauma that was experienced in this particular
14 conflict that was really very difficult for the
15 older reservists and Guard members to deal with.

16 LT COL. DOUGLAS: I'm asking my fellow
17 Army service members; what's the ability from a
18 Headquarters perspective, if you know, to support
19 reserve units say for counseling services for
20 something that this unit saw, to the impact on
21 their families, where Headquarters Marine Corp
22 deployed additional counselors to that area out of

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1 our resources to support them because it was the
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2 right thing to do? We foot the bill and sent them
3 there just because, I mean we had that kind of
4 flexibility just because we're organized.

5 COL. PEREIRA: You're saying you're more
6 organized than the Army?

7 LT COL. DOUGLAS: I'm saying we're
8 smaller and --

9 LTG KILEY: I mean if --

10 LT COL. DOUGLAS: -- we're smaller, and
11 we owned, as you've seen at those site visits, we
12 own most of those -- the civilian counselors, we
13 own all of those and pay the bill on them, so we
14 can technically move them at will.

15 LTG KILEY: If you're asking what the
16 Army does and what resources they bring to bear
17 for whole units demobilizing, who've been in hard
18 combat, the fact of the matter is, the policies
19 are that we don't keep those reservists at their
20 camps for more than four or five days and then
21 they're gone for 90 days. So we, you know, we
22 worry about that. I don't know; do you have any

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1 more thoughts? I mean, I think that's -- it's an
2 issue, I mean they kind of melt back into the
3 community, back to their homes, and at 90 days
4 they come back for, you know, a weekend drill.

5 COL. DAVIES: I know specifically, sir,
6 as it relates, though, to perhaps units that have
7 been extended in theater where there could
8 potentially be issues with families and those
9 types of situations, you worked very hard to get
10 the right resources, the team work, whether it's
11 dental, whether it's mental health, whether to
12 assess what that unit's going to need and be able
13 to respond to that.

14 LTG KILEY: Yeah, but if, you know, 30
15 percent of the soldiers said I really need to see
16 some counseling at Fort McCoy, on their way back
17 in, you know, we haven't put the counselors there,
18 because it, I mean it takes them five days to
19 de-MOB with everything else they've got to do.
20 They don't have another three or four weeks of
21 authorization, unless they're ill enough that we
22 put them in the (off mike) and we stop their

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1 de-MOB process.

2 LT COL. DOUGLAS: This unit, the way it
3 worked, we had sent counselors forward to the home
4 town for the families once the notification was
5 made of the casualty rate. The casualties that
6 assist with that is kind of what I was -- I know
7 the issue. We had the same issue with our
8 reservists; once they de-MOB, it's hit or miss.

9 LTG KILEY: The other problem is, many
10 of these units are cobbled together from across
11 the country. The last big brigade out of
12 Minnesota actually had soldiers from eight or ten
13 different states that were pulled together, to
14 include medical units.

15 LT COL. DOUGLAS: Complicated.

16 COL. PEREIRA: Still, that issue of 90
17 days not coming together as an organized group has
18 some implications. We had a discussion today
19 during our working group meeting that, on
20 continuity of care, that perhaps that time is way
21 too long, because there's nobody to eyeball that
22 reservist, National Guard person after coming back

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1 from a deployment and going back to a community
2 where perhaps there are no peers there. I'm not
3 sure that's the best thing to do, because it seems
4 that if you did drill in between, on a normal
5 basis, a 30 day basis, at least somebody would
6 have some visibility and that person would be
7 surrounded by their peers again, who could maybe
8 identify some issues.

9 DR. MacDERMID: This question is
10 inspired by that question, but it's a bigger issue
11 than that. I just pulled up a chart that I had

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12 about the size of the overall force and the
13 allocation of the force between the reserve and
14 active components, and I'm not sure I have exactly
15 the right numbers, because I know there are
16 different kinds of things.

17 But if I'm understanding it right, when
18 we made the transition to an all volunteer force,
19 we were about 40-ish percent reservists, and now
20 we're over 60 percent in the reserve component.
21 Has funding and support structures shifted in the
22 same way? In other words, are the Guard and

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1 reserve -- is the reserve component getting its
2 fair share of the resources, in terms of supports
3 for mental health?

4 DR. MCCORMICK: Well, that's an
5 excellent point. That's another thing we
6 discussed when we met. We need to have more
7 information. What we've heard is from some model
8 programs, and first of all, let me pick up a
9 little about on Angela's point. From one of the
10 model state National Guard programs, we've
11 identified four of them, modeled in terms of
12 reentry programs, they actually did specifically
13 address this 90 day issue and the adjutant
14 general, without attribution, kind of wiggled
15 around it and got them together. The issue,

16 though, that -- the other thing that we've noted,
17 and I think we could discussed as a Task Force is
18 that some of the National Guard, 52 National Guard
19 elements, the 50 states plus the territories, have
20 a dedicated mental health person at the adjutant
21 general level who is basically there to help
22 coordinate mental health services for the Guard in

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1 that state.
2 what we're not sure of is who pays for
3 those people. I confess my own ignorance as to
4 knowing how many of the assets at a particular
5 level of the Guard, at the state level, are active
6 duty, I know some of them are active duty, and if
7 there was a mental health person for a given
8 state, whether that would be paid for by the Guard
9 Bureau or by the state.
10 But at any rate, and we need to get that
11 information, because I think it speaks to the
12 issue of whether we should recommend that every
13 one of the 52 elements have a dedicated mental
14 health person whose responsibility would be to be
15 sure that there was a state of the art, modeled
16 after some of these clearly model programs in the
17 states, for every Guard element or every Guard
18 entity to do that.

19 So I don't know if anybody knows or we
20 certainly need to get somebody from the Guard
21 Bureau to tell as to how -- if there were to be a
22 mental health person for each Guard entity, who

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1 would fund that? would that be funded by the
2 Guard Bureau or would that be required to be
3 funded by the state?

4 MS. POWER: And I would raise the same
5 question then, contextually for the reserve
6 component, because obviously, that's -- your
7 question is germane relative to the percentage of
8 Guard and reserve that had participated, and if we
9 can have the Guard Bureau describe what Dick has
10 raised, but across the reserves, across the
11 services, it's going to be a very different
12 answer.

13 DR. MacDERMID: Right; and this actually
14 gets to something that Kate and I were talking
15 about, which was, Kate and I both had notes that
16 we wanted to hear more from Guard and Reserve
17 Surgeons, right, is this ringing a bell, and we
18 couldn't remember exactly what the questions were
19 that we wanted to ask, right?

20 SPEAKER: Yes, the last time.

21 DR. MacDERMID: So, why don't we spend a
22 couple of minutes now getting straight on that?

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1 we may not be able to have them come to a meeting,
2 but we might be able to do a tele-com or
3 something. So what are the questions that we
4 would like to ask Guard and Reserve Surgeons?
5 MS. POWER: What is your first one?
6 DR. MacDERMID: My first one?
7 MS. POWER: About the percentage of
8 participation in the global war and the resources
9 --
10 COL. DAVIES: Kathryn, I'm sorry, can
11 you speak into the microphone?
12 MS. POWER: Your question, Shelley,
13 about the resources shifting appropriately were
14 reflecting the percentage of participation in the
15 global war and terror.
16 DR. MacDERMID: Okay. Kate, are you
17 getting -- do you hear that?
18 SPEAKER: Yes.
19 DR. MacDERMID: Okay. Thanks; good.
20 COL. ORMAN: The other is what we heard
21 out of Ohio, which is, where is the reserve
22 medical infrastructure for following up on

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1 residual issues after these guys come back? I
2 was, frankly, appalled that this corpman was
3 having to shoulder all of the burden without any
4 backup and, again, I don't think it's a bad people
5 argument, but there's just not structure and
6 system in place in the reserves for people that
7 are trying to do the right thing by their fellow
8 reserve unit members to have the kind of
9 horsepower and support they need, to get the right
10 thing done, whether it's through the ospencies (?)
11 in the VA or through continued DOD medical
12 processing, et cetera.

13 DR. MCCORMICK: Well, then there's the
14 specific question that is -- guard level, and
15 secondly, would it be feasible for us, would it be
16 advantageous for us to recommend, if we do feel
17 that there should be a mental health person in
18 each state or each Guard entity, would it be
19 reasonable for us to recommend that that be a
20 Guard Bureau funded position to assure that it got
21 uniformly allocated rather than having to rely on
22 funding at 52 state and territory levels?

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1 MS. POWER: What is the mechanism used
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2 by the individual services at the individual
3 reserve unit level to distribute information,
4 disseminate information about services that are
5 available particularly in behavioral health,
6 connection with the VA, connection with DOD,
7 connection with TRICARE, what's the process used?

8 MR. CAMPISE: And way down into the
9 weeds is, how are they tracking people who come up
10 positive on the PDHA and the PDHRA? Some of the
11 reserve units I've seen have done a very good job,
12 and I was somewhat alarmed when one reserve unit
13 said that they thought that what we needed was
14 three or four months post- deployment, they needed
15 some kind of survey to find out how they're doing.

16 DR. MCCORMICK: That raised another
17 point that did come up in our visit, and that was
18 that there was a perception, and again, this is
19 just a perception on the part of the marines, that
20 they had less follow-up than they had been
21 promised when they made positive responses on the
22 PDHRA regarding mental and medical conditions.

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1 They had expected a more assertive response than
2 they got. And, in fact, the corpsmen got very
3 little -- apparently -- I think it's done by a
4 contractor, correct me if I'm wrong, the corpsmen

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5 got very little actual soldier level feedback on
6 what they even responded so that even he claimed
7 he had to reask the questions just to --

8 MS. POWER: Colonel sited the site visit
9 where the in-patient unit and Community Services
10 folks had some extensive experience with the Guard
11 and reserve, and I'm trying to remember, Angela,
12 whether they talked about the fact that there was
13 a lack of resources for them to treat the Guard
14 and reserve, but they did it anyway, and this
15 whole loop around whether or not they actually had
16 identified resources, so my question would be, if
17 there are active duty sites that are delivering
18 services to the Guard and reserve, what kind of
19 resources are identified, and what is available,
20 and what is known?

21 COL. PEREIRA: We had said that there
22 were no additional resources, that the numbers,

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1 and there were large numbers of National Guard and
2 reserve that they were seeing, was coming out of
3 hide, they had to just make due with what they
4 had. In addition to that, on the community side,
5 ACS was providing a lot of services to these
6 folks, and they also did not get funded for that
7 or resource for that additional help that they
8 were giving National Guard and reservists, again,

9 a very large number.

10 DR. MACDERMID: I know that there are
11 lots of places where Guard and reserve issues come
12 up in other topics. Are there any other things
13 that people want to get on the table here and now,
14 because otherwise, we've got 20 minutes, we could
15 move on to talk about screening a little bit?

16 COL. ORMAN: A topic that we haven't
17 talked about this afternoon, but we talked about
18 this morning is, this whole business of
19 behavioral, health, leadership, advocacy at a high
20 level. We made reference to it, perhaps making a
21 potential recommendation at the State Guard level,
22 but I think to the degree we're going to recommend

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1 things for the active side, there needs to be a
2 parallel system on the reserve side, and I don't
3 think we've had that discussion or gone there
4 quite yet.

5 DR. MACDERMID: It would be hard to do
6 that until we hear a little more from leadership,
7 so Kate and I will have to strategize about how
8 best to get that to happen. Okay. Let's talk a
9 little bit about screening then. This is
10 something that we've talked about a number of
11 times. We struggle because, for example, there is

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12 a fairly elaborate now series of screenings that
13 are associated with deployment, and there are some
14 problems with that that we've been talking about.
15 There are issues about reservists, and there are
16 issues about procedures, how the PDHRA and the
17 PDHA are administered. So we've talked about it
18 on the phone in small groups, but I'm interested
19 in getting a sense of where, you know, do we have
20 a consensus, where are we at on feelings about
21 what screenings should look like, how it should
22 happen, when it should happen, what the evidence

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1 base for it is and so on.
2 DR. MCCURDY: Would you, to get us
3 started, would you sort of review what we decided
4 in that small group? I mean we came a conclusion
5 and I think it might be a good place to start.
6 DR. MACDERMID: It's probably premature
7 to say it was a conclusion, but it was maybe food
8 for thought for the rest of the Task Force to
9 consider. I think that one thing that we thought
10 would make a lot of sense would be to recommend --
11 I mean one of the problems is that there's not
12 necessarily always agreement about what screening
13 instruments should be used, and there's lots of
14 variability across places and times and what
15 happens, so it seemed like it would make sense to

16 suggest that the DAD VA clinical practice
17 guidelines be used for guidance regarding what
18 screening instruments should be used.

19 we've also had long discussions about
20 the degree to which we should try to time
21 screenings around deployment or whether we should
22 simply have an annual, whether we should suggest

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1 that there be simply an annual mental health
2 screening and not try to deal with all this timing
3 sort of issue, or some combination thereof, so
4 that's something that we can talk about as a
5 group.

6 COL. PEREIRA: I think that there are
7 two issues that we need to look at and consider
8 before we really go into this discussion in depth,
9 and those are, first, why does the recent
10 guidelines, Jon, the ones that you were talking
11 about that we've, you know, been made aware of
12 that were put into policy in November, I believe,
13 of 2006, what, if any, are there specific
14 guidelines about when and how that's to be
15 administered, because if that is to be done prior
16 to deployment, it seems like it's pretty thorough,
17 why would we additionally put questions in the
18 pre-deployment process that were either

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overlapping or related to those questions.

20 The second one is that early on, help me
21 with this, I think it might have been Fort Hood,
22 that, maybe not, that we were made aware,

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1 somewhere, that there was a draft of a
2 recommendation for possibly having annual mental
3 health screenings, or was that medical screening
4 with mental health questions? It was annual
5 mental health screening; do we know the outcome of
6 that recommendation, where in the process of being
7 accepted as policy or not? It is? Because those
8 were two things we were talking about.

9 LCDR WERBEL: Was that a specific
10 service document or something like that?

11 COL. PEREIRA: Yeah, I'm sorry, I think
12 that was just Army.

13 LCDR WERBEL: Okay. We've heard, and I
14 think this is a really interesting phenomena,
15 especially in light of the fact that it ties right
16 into what we were talking about with stigma
17 earlier this afternoon, that, you know, one of the
18 ways to normalize this is to make, as General
19 Kiley said, a mental health check-up like a dental
20 check-up, you know, on an annual basis, you open
21 your mouth, and your status, you know, I can't
22 remember what all the numbers are and what have

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1 you.

2 But the PDHA, the PDHRA was not
3 developed as a -- now, I didn't help develop it,
4 so I might be, you know, not perfectly accurate on
5 this, but I don't think it was really developed as
6 a mental health screen, it was developed as a
7 health deployment screen to cover the whole basis.

8 I don't think we would be being
9 redundant if, in addition to a screen that is
10 timed to deployment, the deployment cycle, there
11 was also an annual mental health screen that was
12 specific to mental health in the same way that an
13 annual dental check is specific to dental.

14 And one of the interesting things that
15 we've seen as we've gone around on these site
16 visits, I just had a chance to speak recently at a
17 forum for officers, for leaders, and it was
18 mentioned by a corpsman actually, this idea of
19 annual, and I saw a lot of faces out there like,
20 oh yeah, we'll get our troops to do that, sure.
21 But one of the phenomenal things that we've been
22 hearing as we've been going on these site visits,

1 at almost every single one when we've had a focus
2 group of senior enlisted leaders is, they have
3 suggested to us, well, you know one way to do this
4 and get us all more -- over the stigma is to line
5 us all up and send us in to the shrink, have every
6 single one of us, starting with our leaders, go
7 through a mental health screen, and then they were
8 talking about redeployment and what have you, but
9 I think that would answer a lot of questions. And
10 it doesn't have to be either/or with PDHRA, which
11 is something tied to deployment and then something
12 tied as an annual check-up.

13 DR. MACDERMID: How do we deal with the
14 issue -- I guess there are two things, and I hold
15 up three fingers. One is that we have heard lots
16 of examples of it being very logistically
17 challenging, expensive, and of questionable value
18 to try to time some kinds of screening right
19 before deployment, because peoples answers are
20 distorted for all kinds of reasons.

21 There has been some discussion about how
22 useful is the information that we get immediately

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1 after deployment, certainly for mental health, and
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2 I don't know about medical issues. And then
3 there's the logistical difficulty of trying to get
4 all these things timed really well. So we hear
5 all kinds of examples of, you know, the PDHA gets
6 done late, the PDHRA gets done early or late or
7 not at all, and it's three assessments. So I
8 would be not very optimistic that adding to that
9 an annual would be very feasible, and I'm not sure
10 what the value added of it would be; can somebody
11 debate with me?

12 MR. CAMPISE: What's interesting is,
13 regardless of what we decide, at least the nine
14 Air Force bases that I went to, they had already
15 started doing that independently, where the --

16 LTG KILEY: Doing what?

17 MR. CAMPISE: -- the PHA that you get on
18 an annual basis, that they had already started
19 adding their own mental health questions to it.
20 So whether or not we come up with a policy and a
21 template for them, they're going to do it. It
22 would be nice if we could actually guide them

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1 rather than let them do it independently.

2 DR. MacDERMID: Wait, you said PHA and
3 annual?

4 MR. CAMPISE: The PHA is an annual --

5 LTG KILEY: The periodic health
6 assessment is now an annual.
7 DR. MacDERMID: But isn't there a
8 pre-deployment -- oh wait.
9 LTG KILEY: That's a different one,
10 PDHA.
11 MR. CAMPISE: That's different. This is
12 something that everybody regardless of deployment
13 status gets on an annual basis.
14 DR. MacDERMID: But there's a
15 pre-deployment assessment, there's an immediate
16 post-deployment assessment, there's a 90 day
17 post-deployment assessment --
18 LTG KILEY: Correct.
19 DR. MacDERMID: -- and clearly they have
20 acronyms that are far too similar for me to
21 absorb.
22 MR. CAMPISE: Yes.

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1 DR. MacDERMID: And you're saying now
2 the Air Force is adding -- no --
3 MR. CAMPISE: No.
4 DR. MacDERMID: -- Air Force already has
5 --
6 MR. CAMPISE: Every service already has
7 that.
8 LTG KILEY: Every service.

9 DR. MacDERMID: Those three things, but
10 --
11 MR. CAMPISE: Every service already has
12 their PHA.
13 DR. MacDERMID: -- the periodic health
14 assessment.
15 MR. CAMPISE: Right.
16 LTG KILEY: Health assessment; there's
17 four, there's the PHA, periodic health assessment,
18 there's a 2795 and a 2796, how about that.
19 DR. MacDERMID: Oh, well, thank you very
20 much.
21 LTG KILEY: That clears it right up,
22 doesn't it? Pre and post-deployment health

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1 assessments.
2 DR. MacDERMID: But that periodic for
3 the Army is, what, every five years as it is right
4 now?
5 LTG KILEY: No, the rules changed.
6 MR. CAMPISE: It's annual, it's now
7 annual.
8 DR. MacDERMID: It just changed.
9 LTG KILEY: It's now every -- based on
10 Congressional legislation, it's now every year.
11 Now, it's as assessment, it's not a physical exam

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12 necessarily, and it's a self-assessment.
13 COL. PEREIRA: Does it have mental
14 health questions?
15 LTG KILEY: I think it does, but I don't
16 know.
17 MR. CAMPISE: We had a sampling of
18 mental health questions, but it's been greatly
19 expanded. But every time you ask for a copy of
20 it, it varies from base to base. So it would be
21 nice if we could have some standardization.
22 LCDR WERBEL: Also, Shelley, for what

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1 you're saying, I mean the face validity is clearly
2 there, because we're being -- as we have gone
3 around to these site visits as a Task Force and
4 what we're seeing is, we're being asked to do
5 that. We're not suggesting even necessarily, hey,
6 we've got this great idea, what do you think of
7 it, they've been bringing up to us, on more than
8 one occasion, many I would say, line us up and
9 send us all in to see mental health, you will
10 normalize the experience for us, and you'll give
11 us an opportunity to tell what we're experiencing
12 without having to out ourselves as the one guy or
13 the one gal who's going to see mental health.

14 DR. MACDERMID: Right, I understand
15 that. But I'm trying to be cognizant of the fact

16 that people also say to us, you know, we get
17 surveyed to death, we get assessed to death, we
18 spend too much time away from our duties --

19 LTG KILEY: Right.

20 DR. MACDERMID: -- because we're doing
21 these other things. It's too expensive and it's
22 too hard for providers to try to get all of these

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1 assessments administered at exactly the right
2 moment, and if you can't administer a
3 post-deployment health assessment at the right
4 time, and the 90 day and the immediate, you know,
5 get all screwed up, then what are you getting for
6 it?

7 LTG KILEY: Well, you know, I think one
8 of the critical issues here is deciding, you know,
9 what it is we would be achieving or attempting to
10 achieve with an annual mental health assessment,
11 okay. Now, if its real purpose is to further
12 destigmatize the process by having everyone go in
13 and "normalize it", that is a fairly expensive way
14 to do that.

15 If it is to glean information and to
16 identify soldiers, sailors, airmen, and marines
17 that are struggling and could use health care
18 benefits, there may be some value to that if

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19 somebody shows me the data, because, you know,
20 sitting here, I'm going to say a rough swag, you
21 know, 75 to 85 percent of the force is relatively
22 mentally healthy.

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1 They may have nightmares once in a
2 while, you know, occasionally they have road rage,
3 not necessarily any of that is okay, but in terms
4 of the kinds of symptoms and issues that would
5 make someone go to seek mental health, even
6 without stigma, I worry that we're going to treat
7 100 percent of the people for 10 to 15 percent of
8 the people who really need it. And you can say,
9 well, this assessment is just short, but I mean
10 when you start to do the logistics of it, oh, by
11 the way, just sitting in a dental chair for a
12 quick dental check is a logistic nightmare, it's a
13 lot of work, it's getting people scheduled,
14 getting them away from training, getting them into
15 the building, having the right marrying up of
16 dental resources to do that.

17 And so then it gets back to a little bit
18 of what Shelley said, which is the timing issue,
19 you know. If you've got a unit, you've got a
20 brigade deploying in March of '07, and their
21 anniversary for a PHA is June of '07, why not use
22 the pre- deployment screen as their PHA?

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1 DR. MacDERMID: Or vice versa.
2 LTG KILEY: Or vice versa, exactly. So
3 I think, you know, we might want to look at some
4 kind of annual assessment, whether it's a mental
5 health focused assessment or just a wellness
6 assessment, whether it's online and/or
7 face-to-face. I think we want to be careful in
8 terms of, you know, what kinds of things we start
9 distilling down as recommendations, because we've
10 already been told that there's a PHA, we already
11 do the PHA 2795, PDHA 2796, and then the PDHRA,
12 which I think is a 2900, isn't it?
13 DR. MacDERMID: Yes, I know that, it is.
14 LTG KILEY: I think that's a 2900, there
15 you go. So, you know, then do we want to do an
16 additional screen for mental health just to lower
17 stigma some more? Because what happens is --
18 COL. ORMAN: I think we need to turn the
19 question on its head. Somewhere along the line
20 the system made a decision, presumably with cost
21 at some level being in mind, cost benefit in mind,
22 that it was appropriate and necessary for every

1 service member to open his mouth annually and have
2 a professional take a look inside the oral cavity
3 to assess for caries and other problems, and
4 I would argue that at any given time, probably not
5 more than 30 percent of the force need some active
6 dental work.

7 And the money was spent to wreck the
8 infrastructure, to fund that, and to continue to
9 resource it year after year after year. And
10 dental work, I would argue, is probably
11 stigmatized, as well. I don't know a lot of
12 people that enjoy going to see a dentist to have
13 them look in their mouth, whether you're going to
14 get drilled on or not. So the question --

15 LTG KILEY: Yeah, I do, but I need to
16 talk to somebody about that.

17 COL. ORMAN: You do, if that's true,
18 sir. So perhaps the question is, if we're willing
19 to do that to take care of the jaw, recognizing
20 that that impacts on the mission, if pain erupts
21 there and that sort of thing, what are the
22 arguments why we shouldn't be spending money on

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1 trying to do this for the brain? And for all the
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2 implications that dysfunction of the brain,
3 whether it's TBI, behaviors, legal issues, all the
4 things that manifest themselves as behavioral
5 dysfunction, why aren't we thinking that way in
6 terms of asking the fundamental questions of, we
7 do it in this domain, but we don't do it in this
8 other domain. And I think that's where we ought
9 to sort of start and debate, what's appropriate
10 and what do we need to do in the future that
11 speaks to issues that I think are far beyond
12 dysfunctions of the jaw, and yet we've erected
13 huge infrastructure there.

14 LTG KILEY: well, you know what -- in my
15 view, if we've got the proper tools, very similar
16 to a dental x-ray and to a mirror and a pick to do
17 the diagnosis, then I'm all for it, you know. The
18 other end of the spectrum, you know, is a routine
19 chest x-ray with a physical exam, where the data
20 would say you don't produce anything, routine
21 pre-op chest x-ray to rule out pathology, we don't
22 do that anymore, why, because the data says you

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1 don't find anything.

2 So you've got to have the right tool.

3 And I think the mental health specialists have got
4 to tell us whether a 15 minute visit, having

5 answered a questionnaire is, you know, I mean, you
6 know, an x-ray of a carry doesn't lie. I mean you
7 can go in and say I don't have any dental pain,
8 you can look at the x-rays and say, well, you
9 know, you've got a crack here and you've got a
10 filling here that needs to be replaced.

11 My concern is that the entire mental
12 health arena is much, much more complex than that.
13 And it's not that it wouldn't be a good thing to
14 have and an ideal circumstance, but gosh, that may
15 require four or five in-depth interviews and
16 visits to get to a point where you can say, well,
17 you know, Colonel Orman, you appear to be okay
18 this year, why don't you come back and see us in a
19 year again for another series of things.

20 LCDR WERBEL: Sir, I don't think it
21 would require that much, and I think that we do
22 have the science at a point where we could do a

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1 short face-to-face screen and at least make the
2 determination of does someone need a little bit
3 further screen. But you're absolutely right in
4 that, you know, where's the data that shows this
5 would be helpful.

6 The problem is, if we don't do it, we'll
7 never get that data, at least on, you know, some
8 smaller term model. The reason that you don't do

9 chest x-rays anymore is that they were being done
10 and then we know they weren't value added.

11 we have a lot of anecdotal evidence from
12 site visits from other information that suggests
13 that this would be a good thing to do, both to get
14 more information, to find out where the mental
15 health problems are, and which of our soldiers,
16 airmen, sailors, or marines are suffering from
17 them, to help them, and to destigmatize, but I
18 don't think destigmatizing is the main reason, but
19 if we don't do it, we won't get the data.

20 LTG KILEY: Are you talking about
21 additional mental health questions in the PDHA or
22 are you talking about a focused mental health

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1 interview for every single sailor in the Navy
2 every year?

3 LCDR WERBEL: I shoot for the moon, sir;
4 I'm talking about a face-to-face mental health
5 screen on an annual basis for every soldier,
6 sailor, airman, and marine.

7 LTG KILEY: I think if we get to the
8 point where we're going to recommend that, we
9 better do an order of magnitude estimate of cost
10 to do that, okay.

11 COL. PEREIRA: I don't think we need to

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12 go that far. I think we add questions, well,
13 you're telling me that we already have questions
14 on the periodic health assessment.

15 LCDR WERBEL: But what our senior
16 enlisted leaders and our enlisted men and women
17 who have spoken to us have said is that, I've
18 heard them say, I'm tired of filling out survey
19 after survey after survey after questionnaire,
20 I've not heard them say, I'm tired of having a
21 chance to talk one-on-one with someone and tell
22 them about what I'm experiencing, and I've heard

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1 them ask for that.

2 COL. PEREIRA: Well, what format does
3 the PHA take?

4 LCDR WERBEL: It's a questionnaire.

5 COL. PEREIRA: Self-administered
6 questionnaire, not a face-to-face?

7 LCDR WERBEL: Some of those result in a
8 face-to-face and they're supposed to.

9 LTG KILEY: It's a focused mental health
10 interface.

11 LCDR WERBEL: But it's not about mental
12 health specifically.

13 DR. MACDERMID: I think there has been a
14 fair amount of enthusiasm in our discussions about
15 the value of the PDHRA, given the data that we've

16 seen about the emergence of mental health issues
17 following deployment, and there has also been
18 enthusiasm, I think, for face-to-face contact with
19 a mental health provider during the PDHRA process.
20 That's not speaking to the issue of any sort of
21 annual screening. But I just wanted to check; am
22 I recalling correctly or no?

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1 DR. MCCORMICK: Yeah, I think that's a
2 good clarification, that based on our site visits,
3 a face-to-face encounter during the PDHRA, again,
4 which is with post-deployment, 90 days roughly,
5 that the norm isn't -- certainly is not
6 consistently the norm that there is a face-to-face
7 encounter, a universal face-to-face encounter. So
8 even going from where we are to that level would
9 be a step, an incremental step, and involve cost.
10 But I think we've had some consensus that at least
11 that first step was needed.

12 LTG KILEY: Okay. Does anybody have any
13 other pressing comments that you want to make
14 before we close this deliberative session? If
15 not, we will take a 30 minute break and come back
16 at 3:30 for comments from the public. Thank you.

17 (Recess)

18 COL. DAVIES: -- federal official for

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19 this meeting. I'm Colonel Jeff Davies, and we're
20 going to go ahead and begin our open public
21 testimony today. Doctor Burke, do you have any
22 administrative announcements before we begin?

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1 DR. BURKE: Yes; thank you, Colonel
2 Davies. Good afternoon, everyone, and welcome.
3 For all attendees, would you please sign the
4 general attendance roster on the table outside if
5 you haven't done so already. Please be aware that
6 we will be transcribing these open sessions, so
7 please use the microphones when speaking and
8 clearly state your name. The transcripts will be
9 published on the Task Force web site within 90
10 days of this meeting.

11 We would also ask you to be courteous
12 and respectful of your fellow speakers. Restrooms
13 are located outside, down the hall on the left.
14 And for any administrative requirements, please
15 see Ms. Bennet or Ms. Farrell. Thank you, Colonel
16 Davies.

17 COL. DAVIES: Thank you, Doctor Burke.
18 As we begin this session, we do have several folks
19 that have come to give their testimony today, we
20 thank you for your time, that you've taken time
21 out of your busy day to come here and to share
22 with the Task Force those issues that are in your

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1 heart today.
2 we'd like to limit the time to ten
3 minutes so we can assure that we get everybody in.
4 we're not going to be done until 1730, that's how
5 long we have the open Task Force meeting this
6 afternoon. And I'm going to turn it now to Doctor
7 MacDermid. Doctor MacDermid.
8 DR. MACDERMID: Thank you very much,
9 Colonel Davies. Welcome, everyone, and thank you
10 for taking time out of your busy lives to educate
11 us. You'll find that we are eager students, and
12 perhaps we should go around and tell you who we
13 are, because I know some of you were not here in
14 the earlier session. Would you like to start,
15 Warren?
16 CPT. KLAM: Yes; I'm Doctor Warren Klam,
17 I am a Navy psychiatrist, I'm a Navy psychiatry
18 specialty leader.
19 LCDR WERBEL: I'm Aaron Werbel, I'm the
20 Behavioral Health Affairs Officer at Headquarters
21 Marine Corps.
22 MR. CAMPISE: Good afternoon. I'm

1 Lieutenant Colonel Rick Campise, I'm a pediatric
2 psychologist.

3 LT COL DOUGLAS: Lieutenant Colonel Jon
4 Douglas, Headquarters Marine Corps, Manpower
5 Reserve Affairs.

6 COL. DAVIES: Colonel Jeff Davies,
7 Office of the Surgeon General.

8 COL. ORMAN: My name is Dave Orman, I'm
9 an adult psychiatrist.

10 MS. POWER: Kathryn Power, the Director
11 of the Center for Mental Health Services at the
12 Department of Health and Human Services and also
13 an officer in the Navy Reserve.

14 DR. MCCORMICK: I'm Dick McCormick,
15 clinical psychologist, one of the civilian members
16 of the Task Force.

17 COL. PEREIRA: I'm Angela Pereira,
18 social worker representative to the Task Force.

19 DR. MACDERMID: And I am Shelley
20 MacDermid, Co-Chair of the Task Force and
21 Associate Dean in the College of Consumer and
22 Family Sciences at Purdue University, where I also

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1 directed the Military Family Research Institute.
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2 So as Colonel Davies said, we'd like to try to
3 hold folks to ten minutes. Experience tells us
4 that when we do that, we routinely use up all of
5 the time that we have. So let me open the floor
6 to whoever wishes to begin. Proximity wins,
7 welcome.

8 MR. DORAN: Doctor MacDermid, ladies and
9 gentleman, before I start, I would like to
10 introduce myself. I'm Jim Doran, I'm a retired
11 Navy CW4, I'm the National Service Director for
12 AMVETS. You all received this report yesterday,
13 Voices in Action.

14 I was the issue or am the Issues
15 Committee Chairman for this symposium.

16 I would like to commend the Secretary of
17 the Navy for sending a young Naval officer to
18 Commandant Marine Corps Headquarters to teach them
19 about behavioral sciences, because the Marines
20 need all the teaching of behavior that they can
21 get. Sorry, Colonel, I had to take that shot.
22 Ladies and gentlemen, before I start, I do want to

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1 comment real quickly on things I've heard you
2 discuss over the last two days. Yesterday,
3 Colonel Carstensen from AW2 --

4 COL. DAVIES: Carstensen.

5 MR. DORAN: -- mentioned a PTSD time
6 frame for guys who have been separated, getting
7 back into AW2. In my own particular case, and I'm
8 30 percent disability rated for PTSD, my PTSD is
9 aviation related, been crashed in, crashed down,
10 and crashed at just too darn many times, and I had
11 it all compartmentalized, and I had it in control,
12 and ten years after I retired, I was staring out
13 my office window at Miami International Airport
14 and watched an airliner go in, and I haven't been
15 right when it comes to airplanes ever since.

16 So the time frame, in my layman's
17 opinion, is pretty much irrelevant. When it's
18 going to break out of the box, it's going to break
19 out of the box, and we have, as individuals, have
20 no real control over that.

21 Many of the men and women you'll be
22 working with in the field or have already worked

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1 with are accepting their separations from the
2 military. You folks in your current capacity are
3 spending a lot of time dealing with the Veterans
4 Health Administration, those are good people, but
5 when you're dealing with the Veterans Benefits
6 Administration, please let your troops understand
7 that the VA is not our friend, they are not filing
8 claims for disability with the VA, they are filing

9 claims for damages against the United States of
10 America, and they need to go into that with that
11 outlook and with a professional service officer,
12 whether it's from an organization like mine or the
13 county or the State Department of Veterans
14 Affairs, somebody who knows the veterans laws to
15 work with them at no charge on that basis. VIP
16 syndrome, I'm a victim of the VIP syndrome,
17 minding my own business at my 7:30 in the morning
18 audiology exam at Bethesda last summer, when I was
19 unceremoniously ordered out of the booth because
20 the Under Secretary of the Navy wanted my time for
21 his audiology exam.

22 For me personally as a retiree, I didn't

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1 mind it, I had nothing else to do that day but
2 hang around Bethesda, but when I was outside
3 waiting, I heard all the ways he had treated and
4 brow beat the corpsmen and the junior medical
5 officers that were in the audiology department.

6 Yeah, there's a VIP syndrome, and yeah,
7 it's important that a flag officer or a regimental
8 commander or a squadron commander get back to his
9 job, but there's no reason for anybody, and this
10 particular Under Secretary is also a Captain in
11 the Navy Reserve, there's no reason for anybody to

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12 treat enlisted personnel like anything less than
13 they are, professionals in their chosen field of
14 work.

15 Stigma, stigma is not such a big thing
16 in the VA arena as far as mental health goes. It
17 can be in the military arena, and I agree with a
18 lot of what I heard. A lot of active duty
19 personnel are afraid to go and see a mental health
20 professional because that can come back and plague
21 them in promotions and assignments down the road,
22 and these folks, a small percentage of them, but

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1 enough that it is something that we should pay
2 attention to, do go out and see private health
3 care physicians and psychiatrists. It's a shame,
4 but that's the way it is. And it's not a military
5 thing. You'll find, and I've spent 15 years in
6 corporate America before I went in the Veterans
7 Advocacy, and you'll find that in corporate
8 America, a lot of executives who are seeing mental
9 health professionals don't want it known
10 throughout their corporation, as well.

11 The other side of the coin, hey, if it's
12 good enough for our Hollywood superstars, it's
13 darn sure good enough for our squad leaders, and
14 the Hollywood superstars have no compunction about
15 publicizing they're seeing therapist and going

16 into rehab and things of that nature.

17 Somebody on the left side of the room
18 earlier this afternoon talked about female
19 National Guard, combat vets, and PTSD all in the
20 same breath, I don't remember who it was or what
21 the exact subject was, but that particular
22 individual is a friend of mine, she has just been

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1 interviewed in Newsweek, and it will probably be
2 on the stands this Sunday. She's a female combat
3 Army National Guard PTSD victim.

4 which brings me into my report. This is
5 a very large report, it's 181 different issues,
6 220 some recommendations, it was not put together
7 by us, I simply formatted it, my publications
8 department had it printed. It was put together by
9 a group of 437 veterans in Illinois last October.
10 They represented all branches of the service, all
11 geographic areas in the nation, and many, many
12 veteran service organizations, and even some not
13 affiliated with veteran service organizations. A
14 lot of the information in there is pertinent to
15 veterans benefits and homelessness and things of
16 that nature.

17 But in the cover memo that most of you
18 should have gotten, there are a number of issues

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19 that I think would be very important for your
20 people, you and your staff, to take a look at
21 regarding mental health.

22 Two of the biggest, hot issues that

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1 we're pushing, and we're pushing them on the
2 floors of Congress, and when we testify in this
3 report at the House VA Committee next month is
4 post- traumatic stress disorder, everybody is
5 aware of PTSD amongst combat veterans. Not too
6 many people outside of this room are aware of PTSD
7 related to sexual trauma with female service
8 members in the field, from their comrades in their
9 own companies, squadrons, platoons, et cetera, and
10 of course, the combat issues that the ladies have.

11 The treatment for a woman suffering from
12 post-traumatic stress disorder outside of DAD, a
13 combat veteran going to VA, is virtually
14 non-existent. VA says they have it, they have it
15 on paper, but the truth of the matter is, they go
16 into group therapy sessions, most of their
17 patients are men, and I'm sorry, folks, these
18 ladies are mostly suffering from sexual trauma
19 areas, they are not going into group therapy with
20 men, it's not going to happen, and VA is not at
21 that point where they're offering them group
22 therapy sessions with women only. That's

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1 something that we're very hot on, something that
2 needs to be very strongly looked at.

3 Lastly, General Kiley threw a bunch of
4 numbers out, and I've got them in the book, 2595,
5 27, 2900, PHAR, PHD, APG, no, that's a different
6 set of initials. Basically, this screening report
7 that we do in the Department of Defense is a very
8 excellent tool, except once it gets up to, is it
9 DSMS or DMMS, once it gets to whatever the
10 computer geniuses are in the DAD, it never leaves
11 that computer system again.

12 Ladies and gentlemen, these reports
13 cleaned up to make them anonymous statistical type
14 things should be farmed out to the Veterans Health
15 Administration and Health and Human Services,
16 because once these folks get discharged from the
17 military, it's VA and HHS that is looking at their
18 mental health needs, and the stats, the figures,
19 DAD has them, DAD sits on them, it's something
20 that's going to require Congressional legislation
21 to change, and we are working on that. I am free
22 for any questions that you folks may have for me

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1 concerning this report on the needs of young
2 veterans.

3 DR. MCCORMICK: Do you have any feedback
4 to us through your service officers as their
5 counseling and dealing with OIF and OEF veterans
6 regarding their perception of access to mental
7 health services, whether it's through the VA or
8 through TRICARE for Life or whatever?

9 MR. DORAN: Doctor, you hit on a pretty
10 good subject for us, because AMVETS has a
11 Memorandum of Understanding with the National
12 Guard Bureau, and my people do the traveling
13 around the state and working with the Guard on the
14 pre-MOB and post-MOB briefings.

15 And the bottom line is, what DAD has got
16 available and what VA has got available, from our
17 viewpoint, is some pretty good programs. They all
18 need tweaking, everything needs tweaking, it's
19 technology and life goes on, but the National
20 Guard is in a whole different ballpark, because
21 once that guy gets out of the service and he goes
22 back to Mooselake, Wisconsin, he's got a 300 mile

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1 drive to the nearest VA medical center, he's got
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2 no military post in his vicinity, other than the
3 ten or 15 people in his squad from the National
4 Guard that live there to help him as a support
5 group that have any idea what he's talking about.

6 And that's one of the problems we as
7 veterans all face, is that we found that if you
8 haven't been there, you don't have a clue what
9 we're talking about. So the National Guard is
10 pretty much out of the loop in a lot of areas.
11 when they're deployed, their dependents are pretty
12 much way out of the loop. The National Guard has
13 a program in place, it's a very good program,
14 FGRPS, FGPRS, Family Group Readiness Program
15 Services, but again, it's the same situation, the
16 program is run at the general level, they do a lot
17 of field work, but not all the dependents get the
18 word and get to attend these particular meetings.

19 Mental health for service members, one
20 of the things that we think should be, could be
21 done is more in the line of prevention than
22 treatment. The treatment we go through, or at

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1 least it's been my experience with the treatment
2 I've been going through, has been pretty good.

3 I see my psychiatrist four or five times
4 a year to get my prescriptions upgraded, I see my

5 psychologist at the vet center every Friday from
6 9:00 to 10:00, and you know, we get a lot of stuff
7 taken care of. But it's just our feeling that
8 something should be done earlier on.

9 when you're in basic training or platoon
10 leader school or the Naval Academy, whatever your
11 source before you hit a line unit or a fleet unit
12 is, somebody should be there to let you know what
13 you may or may not run into. I mean we all know
14 the definition of PTSD as laid out in DSM4, and
15 that's some pretty nice verbiage, but as I'm sure
16 you can find out from a lot of these service
17 members that have been here, the DSM4 description
18 reads like the job description of a combat
19 infantryman, because they see things that the
20 average individual will never expect to see in a
21 lifetime and will never understand unless they
22 have seen it. These troops need to be pre-briefed

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1 on some of that stuff, and you can't do it all,
2 you can't hold their hands, but we've got to do
3 what we can to help them out. Thank you.

4 DR. MacDERMID: Thank you very much.
5 wait, don't go away. I have a request for you,
6 which is that we -- I've taken a quick look at
7 your report with great interest, and as a group,
8 we agree that we want to take a look at reports

9 that other groups have done and cite them. I
10 would like to request a favor from you, please.

11 MR. DORAN: Certainly.

12 DR. MacDERMID: Would you be willing to
13 email either to me or the Task Force has an email
14 address, just to the Task Force email address, a
15 brief description of the methods that were used to
16 arrive at the recommendations that you're making?
17 Because you described to us, you know, the group
18 that you have, but I don't see anything in the
19 report about --

20 MR. DORAN: It was 26 separate work
21 groups, and I have the email address in my pocket,
22 and I will take care of that by the end of the

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1 week.

2 DR. MacDERMID: Thank you very much,
3 sir, I appreciate your contribution.

4 MR. DORAN: You're welcome.

5 DR. MacDERMID: Thank you. Who's next?

6 MS. BURNS: Good afternoon. I am
7 Constance Burns, Constance A. Burns, Foundering
8 President and Exec Director for the National
9 Association of American Veterans; we're in the
10 Greater Washington Capital region, and we also
11 service our regions around the nation.

12 And the reason why our organization as a
13 non-profit was established back in 2005 was to
14 provide assistance, financial, for our service
15 members and their dependents and the severely
16 wounded service members returning from the war in
17 Afghanistan and Iraq.

18 Right now we're doing career counseling,
19 we're doing some work with family counseling, for
20 the marriages, and we know that the suicide rate
21 is up high, and we're trying to provide counselors
22 around the nation to work with that.

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1 we do directly work with walter reed,
2 with Guided Imagery. If you notice the slides
3 that I have, I don't think I'll have enough time
4 to go through all of them today because I only
5 have ten minutes, and I have five minutes of which
6 I'm sharing with Lieutenant Colonel Mary A. Jones,
7 she's our Director of Regional Support Services
8 for the National Association of American Veterans.

9 Mary, just raise your hand, I just want
10 to let them know that you're here.

11 we would like to thank you for this
12 opportunity to support the RH 1815, 213, Section
13 723 and 731, and to share some of our services
14 that we provide for our veterans that are severely
15 wounded returning from the war and their

16 dependents. We'd like to say, first of all, that
17 NAA believes that post-traumatic stress disorder
18 is a disease. We believe that the disease is very
19 pronounced among military personnel today due to
20 the frequent world-wide deployments, mission, and
21 most currently the war on Terror.

22 we find that they are placed in a very

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1 stressful situation, and they find themselves in
2 something that is beyond their control, and they
3 need all the help that they can get. We'd like to
4 see early detection, some way where you can have
5 the doctors go through a series of question, and I
6 question what type of questions that will be
7 adequate enough to determine whether they're the
8 best ones to find out whether they're suffering
9 from this illness.

10 But we find that most of the service
11 members have to deal with this in their own way,
12 and we feel that they do need coping skills. We
13 have a very capable staff, right now they're
14 volunteer staff, but they are experienced mental
15 health trained personnel available to assist our
16 veterans and our service members and family
17 members.

18 we also have experienced substance abuse

19 counselors with eight years training in the field.
20 we also have guidance and counseling educators
21 with a masters level, faith-based trained
22 personnel, we have military chaplains, community

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1 ministers and pastors, advisory counselors, all
2 working with the VA, because we're under the
3 Office of the Secretary of VA to assist our
4 service members and our young disabled Americans
5 returning from the war. We have one proven stress
6 management technique that we're using and it's
7 called Guided Imagery. It has been successful in
8 helping patients to reduce stress and manage their
9 life. Now, we sponsor a seminar type program with
10 the Walter Reed Army Medical Center and the Armed
11 Forces Retirement Home in Washington, D.C., we've
12 done so last year, in March, and we're going to do
13 so again in April of this year.

14 we have like three documented cases of
15 post-traumatic stress disorder; one was an active
16 duty major, single parent, she lost her home in
17 Mississippi during Hurricane Katrina, her daughter
18 was killed during Katrina, Hurricane Katrina, and
19 currently she's responsible for a three month old
20 baby girl, which is the daughter of her -- the
21 grandchild of her deceased daughter, and then she
22 has a second daughter that was employed to Iraq

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1 and now needs support with the two children, her
2 two children.

3 So now the major is suffering from
4 post-traumatic stress disorder, she's trying to
5 find out how she's going to deal with raising the
6 three children by herself, she's seeking help, and
7 she wants to remain in the Army, but the Army unit
8 says she's got to retire, so she's crying out for
9 help. A second case is an active duty sergeant,
10 he was severely wounded July, 2005. He reported
11 after leaving the hospital that, two weeks and a
12 half later, that he was unable to sleep,
13 difficulties communicating to wife and children,
14 constantly angry, and there was some verbal abuse
15 with the children and his wife. She finally
16 separated in that particular incident.

17 Another example is a U.S. Army reserve
18 staff sergeant, single parent, she witnessed the
19 death of another soldier, she had years of
20 instability, she became homeless, jailed, and now
21 unemployed. We say that PTSD overall, I've just
22 mentioned three cases out of the 5.2 million

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1 Americans with PTSD, and we feel that our service
2 men and women are among Americans not wanting to
3 seek help and appear to be mentally weak and not
4 fit for duty. Many are silent, and the stigma of
5 not coping is too great.

6 we feel that the soldiers do not make
7 the link with common symptoms like headaches,
8 nightmares, or elevated high blood pressure as
9 being linked to post-traumatic stress disorder.
10 And we feel that there is also a lack of proper
11 diagnosis that impact directly upon the level and
12 type of support that the soldiers receive.

13 And there also is a negative perception
14 of mental health counseling and duty performance
15 that keeps the soldiers from reporting PTSD
16 symptoms. we feel that getting help can come from
17 a lot of sources, I mentioned chaplains and
18 counselors and doctors and other professionals.
19 we feel that they need to be ready to readily
20 assess for service members to get the help that
21 they need to return to normalcy. Guided Imagery
22 is a relaxation technique and it's aimed at

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1 helping the service members ease distress and
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2 promote a sense of peace and tranquility in that
3 person's stressful life.

4 Also, this process is used by
5 incorporating the power of the mind to assist the
6 body in the healing process by using sound,
7 visual, touch, and smell. Relaxation is essential
8 for this process to work and it would be most
9 successful if the mind is relaxed.

10 So we have a tape that we provided for
11 the Task members, it's from Diane Tusek, she's the
12 President and Founder of Guided Imagery,
13 Incorporated, and it grew out of Cleveland Clinic
14 in Ohio.

15 And she has carried over a million
16 people through this process, and it has about 69
17 percent rate, approval rate in the research
18 material. So now I'd like to let Mary, Lieutenant
19 Colonel Mary Jones talk about NAAV -- and what
20 we're doing.

21 COL. JONES: Thank you. I would like to
22 say I'm very happy to be here, I was here earlier

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1 and heard some of the statements from the Task
2 Force, and I agree with totally all that's been
3 stated, also by the gentleman with the American
4 Veterans Organization. There's a couple, and I

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5 will be brief, quick points that I would like to
6 bring out. First, I would like to give my own
7 personal testimony, because I'm kind of dual
8 headed when it comes to the mental health area.
9 As mentioned, I'm a retired lieutenant colonel,
10 and I have -- I'm a parent also of twin boys that
11 have been diagnosed under the -- on the autistic
12 spectrum, as well my husband is also a retired
13 soldier who's a veteran of the Gulf War.

14 And what I'm seeing, and I'll give my
15 personal testimony first, starting with my
16 husband, he's just starting now, he was deployed
17 during Desert Storm, and served, you know, great
18 -- following his return from that particular war,
19 and did great and wonderful things afterwards, but
20 recently, I've only recently started to notice
21 some change in his behavior, and it started off as
22 minor changes, just from just frustration of maybe

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1 going through the transitional retirement process
2 and just dealing with, you know, normal things of
3 just taking care and being functional with work
4 and taking care of the family.

5 But as I started to become more involved
6 with the organization that I'm involved with, the
7 National Association of American Veterans and
8 dealing with veterans, in particular as with the

9 PTSD, getting more data on that, I'm starting to,
10 and of course, I started to provide that
11 information to my husband.

12 And so there was one particular episode
13 in particular where he's really frustrated about
14 different things that are going on with the boys,
15 with work, and we have two older children,
16 teenagers, as we all know, as stressful as it is,
17 trying to raise them, and I just -- I made a
18 statement, I said, Ken, I think you need to go and
19 be evaluated for PTSD, and he almost just stopped
20 in his boots and what are you talking about, and I
21 said because some of your irrational behavior and
22 your -- and just your mood swings, along with

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1 elevated blood pressure and some other things, the
2 high cholesterol and, you know, just how you're
3 starting now to react to different situations at
4 different times truly tells me that he's under
5 spectrum, is the term that as I was sitting and
6 thinking about what can be done to help diagnose
7 the veterans, well, it brings me back to what
8 we're doing now for the autistic children.

9 If there is a way that the mental health
10 community can put together some type of range of
11 -- and put a name that says that if you're on this

12 far to the left, then based on these symptoms or
13 whatever, then you can have this name associated
14 to kind of describe where you are on the PTSD
15 spectrum, because I think that will help.

16 If we can -- say if you're experiencing
17 this, reacting this kind of way, it may not be all
18 the way to the left where you're, you know, really
19 have a split in your personality or you're really
20 just, you know, throwing bottles at work, but
21 there are some mood swings or some outbursts here
22 and there, that if someone had knowledge that you

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1 were -- served in the war zone or a very stressful
2 situation, that they can help you work through the
3 process to understand what is happening, because
4 what I noticed with him is, when I mentioned that
5 maybe you have some degree of PTSD here, it never
6 really occurred to him that what he was
7 experiencing could be related back to his
8 experience. Because now if you were to have
9 approached him and ask him about, you know, what
10 are some of your experiences in the military, and
11 if he starts talking about when he was deployed,
12 because he was a tanker, and being out in a fox
13 hole, and one night when they were overrun with
14 bullets and he's down in the fox hole with a
15 marine warrant, and the marine warrant was, of

16 course, very afraid, and so him being the officer,
17 you know, he looks over to his master gunner and
18 say, hey chief, he said, you know, do you want to
19 go to Heaven or Hell, and so -- because my
20 husband, you know, we're faith based, and so, you
21 know, at that moment, he was able to witness to
22 the warrant officer, and he was able to give

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1 encouragement to that warrant officer.

2 And he will tell you that, you know, he
3 went into the war zone knowing that he was going
4 to come out of the war zone okay because he had
5 that confidence in the person, in the higher being
6 that was protecting him, and that was what got him
7 through.

8 Now, a lot of soldiers don't have that,
9 but by my husband being at the right place at the
10 right time, being able to witness, that helped.
11 And so not only with the warrant officer, but with
12 several other soldiers we've gone around, he's
13 witnessed to or helped individuals who were
14 suicidal. The suicidal programs, back when we
15 were talking about leaders having the right tools
16 to mentor and to teach and train the soldiers to
17 get them through different situations or whatever,
18 and he will tell you about when the battalion was

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19 supposed to have been given suicidal prevention
20 programs before going into a stressful event, and
21 the commanders that chose not to give those
22 suicidal prevention programs, we had a soldier

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1 that was killed or went out and committed suicide
2 because he didn't get the information.
3 so information is very critical. But
4 also, having some tag that we can place upon when
5 a soldier is displaying a particular emotion or
6 whatever, that's something that's non- threatening
7 to that particular soldier, that he can say, oh,
8 well, I have this condition, and that people
9 around him can come to the aid, because I will
10 tell you that without having a diagnosis, without
11 having something that says I'm doing this or I'm
12 reacting this way because of this, it is very
13 difficult for other people to come in and to
14 understand and say, okay, I understand what you're
15 talking about, I understand what that means,
16 because it links back to a particular time where
17 that person experienced a particular stress in
18 their life, and as a result of that, he can summon
19 all the support that he needs.
20 I can share with you that I just read
21 where Constance was talking and asking a person
22 who's a psychiatrist, and she was saying that we

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1 have a particular soldier or veteran that we're
2 dealing with, can they come, or what help can you
3 provide to this particular person, and the
4 statement that came back said that I am a
5 psychiatric or I'm involved with psychiatric
6 rehabilitation, I'm not sure if I can provide
7 support or help to your veterans, because when
8 they come to me, they have to have a diagnosis,
9 and so here again, without giving the soldier some
10 type of diagnosis, here's an organization that's
11 dealing with rehabilitation, but the soldier can't
12 get or the veteran can't get their foot in the
13 door to receive the support and the help that's
14 needed, because with the diagnosis from a
15 psychiatrist, it can't be a diagnosis from just a
16 primary care physician, but without the diagnosis
17 from a psychiatrist, they can't even get their
18 foot in the door to receive the treatment.

19 I'm over the time as far as personal
20 testimony. So I'll stop here subject to
21 questions, and if there's time permit, then I can
22 come back and give another personal testimony that

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1 leans on from the child perspective, parents
2 trying to find support to help deal with a child
3 that's been diagnosed.

4 And fortunate for me, my children were
5 diagnosed on the mild scale of it as far as
6 autism, but I've seen families and I've been in
7 rooms and I've seen the tears of families, and I'm
8 talking about active duty service members who have
9 children who are diagnosed with a range of autism
10 that they're dealing with. And when they go to
11 the military facilities, even though the records
12 are indicated that they're exceptional family
13 member people, and they have services that are
14 available to them, I can tell you that they do not
15 know, the people who are supposed to be available
16 to provide information, to say, here, sit down,
17 let's talk about your options, they do not know
18 the options. I had to go to the community in
19 order to find out. And even when I went to the
20 community, there was limited resources that are
21 available to help guide and to give me options as
22 to what can I do.

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1 The only way that I found out what my
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2 options was was through the small parent support
3 groups that are available throughout the whole
4 community, and that's unfortunate, because some
5 people shy away from the parent support group, and
6 the parent support groups is only as strong as the
7 people who have experience that are attending
8 those parent support groups.

9 So we need more information with the
10 exceptional family member, counselors, as to what
11 is available not only through the military
12 channel, but also in the local community. What
13 programs do the state mental health program have,
14 you know? Do I qualify for the Medicaid/Medicare,
15 how do I get -- how do I reach out and tap into
16 those resources? They're not getting it.

17 I won't call the particular post that I
18 went to, but they're not getting that information.
19 And so it is people like me and parents like me
20 who know, you know, it's like every time I find
21 out about people who have children. I have a
22 person at my office, he's a single parent, a

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1 person taking care of two boys that are severely,
2 in his particular case, they're severely mentally
3 retarded. Now, if you can imagine, this is one
4 man taking care of two children, and they're

5 teenagers, and they're mentally retarded, one of
6 them to the degree that just about every week, the
7 boy is bleeding so much or having seizures that he
8 has to stay -- or he has to leave his job in order
9 to go and take care of his son. These are cases,
10 these are -- I mean I can go on, but I yield to
11 questions.

12 DR. MACDERMID: Thank you very much,
13 ma'am. Any questions? Thank you very much for
14 your testimony, we appreciate it very much, and
15 best wishes.

16 MS. RHEEM: General Kiley, can you hear
17 me? Yes. Doctor MacDermid and other members of
18 the Task Force, I'm Kathryn Rheem, and I'm a
19 marriage and family therapist here representing
20 the American Association of Marriage and Family
21 Therapists, 24,000 members. Thank you very much
22 for soliciting AMFT's recommendations regarding

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1 this crucial Task Force.

2 We share your desire to provide best
3 possible mental health services to military
4 service members, recently discharged veterans and
5 their families. I currently work in partnership
6 with the Strong Bonds Program of the U.S. Army
7 Chief of Chaplains Ministry Initiatives
8 Directorate, and I formerly worked at the Fort

9 Belvoir Family Life Center. I have treated many
10 service members and their spouses and children.
11 As you know, they often struggle with deployment
12 issues, relocation challenges, and marital
13 distress due to high stress work environments, job
14 related separations including multi-deployments,
15 and the impact of physical and emotional trauma in
16 service members and/or his or her family members.

17 My colleagues and I have developed a
18 weekend program for service members returning from
19 Iraq and Afghanistan and their spouses. This
20 program uses empirically validated techniques
21 focused on the emotional reconnection between
22 service members and their family.

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1 Nationally, there are 50,000 state
2 license MFT's who hold a minimum of a masters
3 degree and who have completed a 2,000 hour
4 clinical internship supervised by professionals.
5 Approximately 30 percent of MFT's hold doctoral
6 degrees.

7 In addition to focusing on familiar and
8 other interpersonal relationships, MFT's are
9 trained in the spectrum of psychotherapeutic
10 diagnosis and treatment. This experience is
11 particular important for service members whose

12 work often performed far away from families for
13 extended period may require close coordination
14 with others to avoid death or serious injury.

15 Because of the stresses of deployment
16 and combat, unless a service member or veteran has
17 adequate family and peer support, this environment
18 may create mental health problems requiring
19 professional treatment. The absence of or
20 untimely delay in such treatment may result in the
21 service member or veteran harming self or others,
22 or in any case, reducing their quality of life.

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1 As you know, recent research has found significant
2 mental health consequences of the conflicts in
3 Afghanistan and Iraq. For example, one study
4 found the estimated risk for returning service
5 members for PTSD was 18 percent from service in
6 Iraq and 11 percent from service in Afghanistan.
7 Another study found about one-third of middle
8 eastern veterans sought help for some type of
9 mental health problem.

10 I have included citations to these and
11 other sited studies in my written statement that
12 you have received. Marriage and family therapist
13 treatment techniques have been found effective
14 across a broad spectrum of mental health
15 conditions ranging from PTSD to schizophrenia.

16 As the Task Force 16 elements indicate,
17 there are many aspects of mental health that may
18 effect service members, recently discharged
19 veterans and their families. For instance, since
20 1966, many MFT's have provided mental health
21 services under DAD's Champus/TRICARE program, and
22 this generally appears to be working well in

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1 regard to the needs of military family members.
2 Likewise, it is appropriate that a
3 number of MTF's serve as military chaplains and
4 family advocacy program staff. I will thus focus
5 on three Task Force elements that we believe are
6 most deserving of recommendations for change;
7 those are elements B, I, and K. First I will
8 address Task Force element B, service members
9 access to mental health services. AAMFT urges
10 that DAD petition the Federal Office of Personnel
11 Management of a general schedule, GS job
12 classification, specific to MFT's as presently
13 exists for psychologists with the GS180 series and
14 social workers with the GS185 series.
15 We further urge that DAD consider
16 obtaining by hire under contract at least one MFT
17 per military treatment facility or similar clinic
18 installation so that the specialized service would

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19 be available to all service members who need it.

20 Many MFT's are located near military
21 installations as shown on the Virginia map
22 attached to my written statement. But under

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1 Section 717 of the Fiscal 2005 National Defense
2 Authorization Act, Public Law 108375, MFT's are
3 explicitly recognized at 10 USC 1091 and 1094 as
4 eligible to provide mental health services in
5 military treatment facilities and other DAD
6 programs on both an employment and a personal
7 service contract basis.

8 The reason for the statutory change was
9 that under prior law, while MFT's were eligible to
10 provide such services under generic "other
11 professionals" authority, MFT's were not
12 explicitly listed in this statute. This was true
13 even though psychiatrist, social workers, and
14 psychologists were all listed specifically. As a
15 result, military job announcements for positions
16 such as psychotherapists and family counselors
17 generally borrowed MFT's from considerations
18 because qualifications were specified as requiring
19 academic degrees in psychology or social work.
20 This inappropriately narrowed the pool of job
21 applicants, even though in recent years, there's
22 been an increase in incidents of service members

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1 mental health problems, as well as local reports
2 of applicant shortages for these positions.

3 Unfortunately, DAD has taken the
4 position that no rule making is required to
5 implement section 717. As a result, DAD has not
6 issued any regulations or other policy
7 promulgations to implement the statutory
8 provision.

9 Thus, although the Navy and Marine Corps
10 include MFT's as eligible for a number of relevant
11 mental health positions, the Army and the Air
12 Force do not, at least in general. Further,
13 during the last two years, the Army and Air Force
14 have changed relevant job titles so that previous
15 reference to generic titles such as
16 psychotherapist and family counselor have now been
17 replaced by the titles of psychologists and social
18 workers, although these duties remain the same.

19 Therefore, we urge that the Task Force
20 recommend to DAD that it issue regulations and
21 other policy documents specifying that MFT's
22 should be eligible for all mental health employee

1 and personal service contract positions except
2 those positions requiring the legal ability to
3 prescribe medications. We further urge that DAD
4 consider obtaining by hire or under contract at
5 least one MFT per military treatment facility or
6 similar clinical installation so that the
7 specialized service will be available to all
8 service members who need it.

9 Next I will address element K,
10 collaboration within DAD. AAMFT recommends that
11 DAD make a written request to the Federal Office
12 of Personnel Management for a new job
13 classification for the MFT profession. MFT's are
14 currently hired under generic job classifications
15 that don't recognize their unique expertise and
16 often restrict them from participation in clinical
17 positions.

18 Social workers and psychologists have
19 separate job classifications. Although like
20 these, other mental health professions, MFT's have
21 independent licenses and require independent
22 classifications.

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1 As I previously noted, the service
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2 branch is varying the extent to which they permit
3 MFT's to apply for mental health positions with
4 the Navy and the Marine Corps, generally
5 permitting this, and the Army and the Air Force
6 generally prohibiting it. We urge DAD to adopt a
7 policy of permitting MFT's to be considered for
8 all relevant mental health positions because this
9 would have a key benefit.

10 Our proposed change would allow the Army
11 and Air Force to draw staff from a wider pool of
12 applicants, thus avoiding local personnel
13 shortages and making available the services of
14 professionals who experience emphasizes familiar
15 and other interpersonal relationships as they
16 effect mental health conditions. The cited
17 barriers of the Army and Air Force which comprise
18 about 60 percent of all active duty military have
19 drastically reduced the opportunities available to
20 MFT's within the DAD.

21 In addition, we urge that mental health
22 service programs at each military treatment

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1 facility and clinic be better integrated with the
2 corresponding local FAP programs and with the
3 services of the chaplain corps, so that these
4 latter programs may be better conduits for early

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5 referrals, mental health services in appropriate
6 situations.

7 Finally, I will address element I,
8 transitioned from DAD to VA. Military health care
9 analysis acknowledge that ideally there should be
10 a seamless transition from DAD to VA for discharge
11 service members who continue to have mental health
12 issues. According to the Congressional Government
13 Accountability Office, one impediment to this goal
14 is that some VA medical centers have reported
15 difficulty in filling mental health staff
16 positions.

17 Under our 2006 statutory change, section
18 201 of Public Law 109461, MFT's are now explicitly
19 recognized as professionals qualified to provide
20 mental health services within the Department of
21 Veterans Affairs. As explained earlier, MFT
22 availability in the VA will help recently

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1 discharged veterans make readjustments to family
2 and civilian life. As with DAD, a central aspect
3 of this law's implementation must be the creation
4 by the Federal Office of Personnel Management of a
5 general schedule job classification specific to
6 MFT, as presently exists for psychologists and
7 social workers.

8 Currently, MFT's may be hired by the VA
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9 only under the social science series, GS101, which
10 requires only a non-graduate degree and pays
11 substantially less than the GS180 and GS185
12 series.

13 Under this lower GS101 class, the VA has
14 hired MFT clinical interns to treat veterans under
15 professional supervision, but once these persons
16 finish their internship and become licensed
17 professionals, they cannot be hired by the VA as
18 professionals. This has deprived the VA of these
19 MFT's prior to experience in treating veterans, as
20 well as a pool of potential employees.

21 Therefore, we ask that the VA, as well
22 as DAD petition the Office of Personnel Management

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1 to develop a GS series specific to MFT's along the
2 lines of those for psychologists and social
3 workers. In addition, I urge that the VA hire at
4 least one MFT in each veteran center as
5 recommended by the 2004 Department of Veterans
6 Affairs Special Committee on Post-Traumatic Stress
7 Disorder, and by the 2002/2003 report of
8 Department of Veterans Affairs Advisory Committee
9 on the readjustment of veterans.

10 In summary, AAMFT urges the following;
11 DAD should promulgate regulations and directives

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12 that add MFT into all existing mental health
13 programs. DAD and VA should petition the Federal
14 Office of Personnel Management to develop a
15 general schedule job classification system similar
16 to those for psychologists and social workers.
17 DAD and VA should include one MFT in each veteran
18 center and military treatment facility.

19 Thank you again for this opportunity to
20 address DAD and VA mental health issues. I
21 believe greater use of marriage and family
22 therapists can make a major contribution to the

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1 mental health of our service members and veterans
2 and their families. I would be pleased to respond
3 to any questions at this point.

4 DR. MACDERMID: Thank you very much, and
5 you get the prize for rapid reading. How does
6 your work or how do you envision the work of MFT's
7 and chaplains complimenting or conflicting with
8 one another in the future given that right now the
9 chaplains seem to be doing most of the marriage
10 work?

11 MS. RHEEM: Yes; right now chaplains are
12 doing most of the marriage work, although there is
13 a severe shortage of chaplains. I believe I've
14 been told I'm the only MFT working in direct
15 partnership with the Corps of Chaplains, and we

16 share the load, we share expertise, work along
17 side each other, so in the position I'm in, I'm
18 providing the clinical therapeutic experience and
19 the chaplain is providing some of the clinical
20 therapeutic experience along with the Army culture
21 and military experience for the benefit of the
22 service member. And so I think we -- there's lots

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1 of possibility and potential to work together. We
2 need to work together for the benefit of the
3 service members. Some service members don't want
4 to go through the chaplains. For religious, they
5 -- an association with the -- some religious
6 affiliation or the family life center, so as
7 others have said today, having an outsider has
8 seemed to be supportive in providing
9 confidentiality and an additional level of safety.

10 DR. MacDERMID: And why would you
11 recommend -- why is your recommendation that MFT's
12 be placed in an MTF as opposed to a family support
13 center?

14 MS. RHEEM: I think -- well, do you want
15 to answer that, Brian? I would say either -- go
16 ahead.

17 DR. RASMUSSEN: Sure; Task Force
18 members, I'm Doctor Brian Rasmussen with the

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19 AAMFT, and I think the point is that although we
20 are involved in a number of the programs, Chaplain
21 Corps, Family Advocacy, Family Life Center, that
22 is not the core element in terms of clinical

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1 intervention with service members who may have
2 very significant mental health issues, and so we
3 feel that our training and experience is
4 equivalent to what a clinical social worker, for
5 example, is able to do, and of course, in many
6 instances, those sorts of personnel are placed in
7 the MTF's.

8 DR. MACDERMID: Thank you. Other
9 questions, Dick.

10 DR. MCCORMICK: Just one clarification.
11 One of the requirements for separate professions
12 in VA always was that -- that there was a national
13 accrediting body of programs to be able to do --
14 assure that programs met a certain standard in
15 terms of education and training, and then only
16 graduates of those programs were currently
17 hireable in VA, for example; is there such a body
18 for --

19 DR. RASMUSSEN: Yes, there is, it's the
20 Commission on the Accreditation of Marriage and
21 Family Therapy Programs, and it is recognized by
22 the Federal Department of Education in a crediting

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1 fashion or for credential purposes.

2 DR. MACDERMID: And a similar question
3 for licensure requirements; how consistent are
4 they from state to state, and what is the
5 examining body and things like that? How can we
6 be assured that there is standardization across
7 the states?

8 DR. RASMUSSEN: Marriage and Family
9 Therapist are licensed in 48 states and the
10 District of Columbia, the two others being Montana
11 and West Virginia, where legislation is currently
12 pending and has been favorably recommended by the
13 state legislative committees this year. There is
14 a model law for licensure, the states, you know,
15 50 states, 48, sometimes have variations, and that
16 is true here, as well as in other areas, but they
17 have largely adopted that, and there is a
18 reciprocity that largely occurs as well when
19 Marriage and Family Therapist moves -- have a
20 license in one state, being recognized if they may
21 move to another and so forth.

22 DR. MACDERMID: Any other questions?

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1 LTG KILEY: Yes, I have a question.

2 DR. MACDERMID: Sure.

3 LTG KILEY: Thank you very much for this
4 presentation, I find it very interesting. In my
5 mind -- we had a discussion early in the open
6 session, and I'm not sure if you all had arrived
7 yet when we had this discussion early on, and I
8 kind of begged the issue in terms of some
9 questions about marriage counseling, but as I
10 listen to your presentation, there's two levels of
11 discussion, one is the mechanics or the
12 bureaucracy, if we can use that term, of
13 recognizing MTF counselors administratively in the
14 GS ratings and recognizing them.

15 Is it your sense or your position that
16 psychologists, social workers, and your marriage
17 and family therapists are essentially covering the
18 same group of mental health issues and counseling
19 issues, or are there niches for each one that an
20 MFT commander, now I'm talking about a medical
21 treatment facility commander, would want to have,
22 you know, marriage and family counselors and

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1 social workers and psychologists, and can you
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2 discriminate for me or distinguish between the
3 three groups about -- and specifically I'm
4 thinking about the process of privileging, you
5 know, what would MFT's do vice social workers vice
6 psychologists in this broad arena of mental health
7 and mental health challenges?

8 DR. RASMUSSEN: Yes, General Kiley, I
9 think that there are a lot of similarities. There
10 is a misconception among some folks that marriage
11 and family therapists are solely marriage
12 counselors, if you have a marital problem, you see
13 them, if you have PTSD, you see someone else; that
14 is really not accurate certainly in the modern
15 era.

16 Sixty-five years ago, the professional
17 did arise as a combination of marriage counseling,
18 and pastoral counseling, some of the folks who
19 practice keep those sorts of perspectives, but
20 they are equally to others, I would argue, at a
21 masters level, credentialed in the generic
22 psychotherapeutic techniques; they, of course, do

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1 not prescribe medications, but beyond that, I
2 would say, in diagnose and treatment, and in fact,
3 in state laws, they are similarly recognized to
4 say clinical social workers.

5 There are a number of credentialing
6 documents that the Navy has used and they're very
7 much parallel to those of say the clinical social
8 workers.

9 LTG KILEY: You said that the Navy is on
10 board more or less, I don't want to put words in
11 your mouth, but the Air Force and the Army have
12 been resistant to recognizing the counselors as
13 equals in that regard; do you have an
14 understanding of why that is?

15 DR. RASMUSSEN: I don't really, so --

16 DR. MACDERMID: And I might be wrong
17 here, so please correct me if I am; would I be
18 correct in concluding that MFT's, while arguing
19 that they can provide treatment for more than
20 simply marital issues, they would also argue that
21 traditionally trained clinical psychologists would
22 not normally be prepared to treat marriage and

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1 family issues?

2 DR. RASMUSSEN: I would say that the
3 three groups you mentioned, psychologists, social
4 workers, and MFT's share a common body of
5 knowledge and clinical experience in regard to
6 psychotherapeutic techniques. We do believe, and
7 there's substantial academic and clinical
8 preparation prior to licensure and in practice,

9 that marriage and family therapists have a further
10 perspective beyond this generic in looking at
11 relational interpersonal issues, that is to say,
12 if Joe has a drinking problem, is Joe's wife does,
13 as well, that is a relevant factor in treating
14 Joe. Joe may be treated as an individual, but
15 that should be considered, and perhaps Mary needs
16 assistance in regard to not reenforcing that type
17 of inappropriate or problematic behavior on Joe's
18 part.

19 DR. MACDERMID: I'm guessing that's not
20 the first time you've heard that question?

21 DR. RASMUSSEN: Yes.

22 DR. MACDERMID: Just a guess. Kathryn.

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1 MS. POWER: One of the things that you
2 know we're looking at at the Department of Health
3 and Human Services is the future of the behavioral
4 health care work force --

5 DR. RASMUSSEN: Yes.

6 MS. POWER: -- and I know that you've
7 participated in some of those discussions. And
8 the fact is that from the DHHS perspective,
9 marriage and family therapists have been
10 recognized as one of the five core disciplines
11 within Health and Human Services, so from a broad

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12 mental health perspective, psychiatrists,
13 psychologists, social workers, nurses, and
14 marriage and family therapists are collectively
15 seen.

16 And to get to General Kiley's comment,
17 the reality is that marriage and family therapists
18 are actually used according to the needs of the
19 system in which they are in, is my understanding,
20 so that --

21 DR. RASMUSSEN: That's correct.

22 MS. POWER: -- you have a variety of

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1 AAMFT members who are dispersed across state
2 systems in both community health centers and
3 community mental health centers, and like the head
4 of that center, just like a commander would make a
5 determination, in terms of set of skills,
6 predilection for particular kinds of activities,
7 expertise, et cetera, that you are perceived that
8 way; is that a fair assumption?

9 DR. RASMUSSEN: That is.

10 MS. POWER: Okay.

11 DR. RASMUSSEN: And I think, you know,
12 the other I think important point is that our
13 members feel they have a unique contribution,
14 that's not to say that you want a mental health
15 clinical program using only one marriage and

16 family therapist, but that they, in some
17 instances, can add value in terms of clinical
18 interventions with many service members and their
19 families, and I think often the problems that
20 present are related, whether it be deployment or
21 whatever, there are a lot of family elements from
22 both the service member and the spouse or

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1 childrens' perspective, so we would take that
2 position.

3 DR. MACDERMID: I have one more question
4 and then I'll defer to Aaron. Can you tell us
5 what activities AMFT has engaged in with regard to
6 helping its members to prepare to treat people
7 with PTSD?

8 DR. RASMUSSEN: We have, you know, been
9 involved in research in regard to the treatment of
10 PTSD, and there are a number of our members who
11 hold themselves out as specialists in that area.

12 That's not to say that every one of our
13 members or any clinician would say they're equally
14 specialized as somewhat of a self- selection.

15 we do not have a sub-specialty
16 designation, so -- however, there is a
17 self-selection, and I think the folks who are
18 particularly interested in working with the

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19 military understand that that is a major skill
20 that they need, and certainly in evaluating any
21 applicants for positions, that would be something,
22 as an employer, that I would want to see, some

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1 kind of skill in that area.
2 LCDR WERBEL: I think it would just be
3 helpful to clarify for the Task Force, and I might
4 not be right on this, so I would value any
5 correction from the Task Force or from you, sir,
6 would be that, from my understanding, the MFT's
7 that are employed by the Navy and the Marine Corps
8 at this point are working in not the military
9 treatment facilities, but in the fleet and family
10 service centers and the MCCS counseling centers.
11 DR. RASMUSSEN: I think numerically that
12 is correct in terms of the majority. But I do
13 understand that there are some in military
14 treatment facilities, and I believe it's correct
15 to say that in some particular installations,
16 there is a greater degree of integration between
17 the family programs and the MTF's than at others,
18 and so there's an idiosyncrasy to some degree
19 here, as well.
20 LTG KILEY: Do they have clinical
21 oversight and high level of supervision, whatever
22 that means?

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1 DR. RASMUSSEN: I'm not aware that they
2 would necessarily be the chiefs of service in this
3 area, but -- so obviously there's a direct
4 supervisor who would be the chief of service or
5 perhaps some intermediary folks there, as well, so
6 -- but I think that may reflect the fact that this
7 profession is somewhat of a newer and smaller one
8 than say psychology or social work, and therefore,
9 is not as well known and established.

10 DR. MACDERMID: How many hours of
11 clinical training are required for licensure and
12 completion of any accredited PhD?

13 DR. RASMUSSEN: There is not any
14 additional amount required. As with psychology,
15 for example, at least historically, some people
16 would get a masters degree and then they would get
17 their clinical internship, the 2,000 hours.
18 Beyond that, I'm not aware, because it doesn't
19 relate to state licensure other than, you know,
20 whatever the individual academic program would
21 require in terms of the -- providing the PhD
22 degree, so I don't know that there's a consistency

1 there.

2 DR. MACDERMID: Anybody else have
3 anything? Thank you very much for your testimony,
4 we appreciate it very much.

5 DR. RASMUSSEN: Thank you.

6 LTG KILEY: Thank you to both of you,
7 thank you.

8 MR. CRAIG: Good afternoon at this late
9 hour. I'd like to thank the Task Force for the
10 opportunity to make a few remarks.

11 My name is Tom Craig; currently I'm the
12 recently nominated and named Director of Quality
13 Improvement and Patient Services for the American
14 Psychiatric Association, and I'd like to speak on
15 behalf of the American Psychiatric Association and
16 its 37,000 psychiatry physician members.

17 But just very recently, and Doctor
18 McCormick knows this better, I just told him this,
19 I was 15 years with the VA, the last seven of
20 which I was the Senior Medical Officer in the
21 Office of Quality and Performance in Headquarters,
22 so I have a little bit of experience from that

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1 perspective, as well. what I'd like to do is, in
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2 deference to the hour, to go through some specific
3 issues that the APA would like to bring to the
4 Task Force's attention, areas in which we would
5 like to just identify what we consider to be
6 problematic or potentially problematic, as well as
7 good things.

8 First of all, we'd like to thank you,
9 members of the Task Force, for, you know, the
10 dedication that you have and the commitment to the
11 quality of care for the military and veterans.
12 Your task is daunting, I must admit to you, the
13 list of things that you're supposed to be doing is
14 just incredible, but I think it's a wonderful
15 thing and it's very important to do, obviously.

16 we would also like to commend the
17 efforts of DAD and the VA, the Department of
18 Veterans Affairs, in developing a joint electronic
19 health record system for hospitalized veterans and
20 active duty personnel. We're very much promoting
21 the HR and feel that a secure and confidential HR
22 system that respects the privacy of the patient's

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1 records can help improve the quality of care and
2 smooth the transition for separating and retiring
3 service members.

4 But we do also -- would like to

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5 underscore that we believe a full medical record
6 is necessary for the VA to provide accurate
7 diagnosis in mental health care, so we'd
8 appreciate resolving that issue so that a full
9 medical record would be available. We're also
10 concerned, however, about the increase in need,
11 both in the numbers of service members returning
12 from combat and the severity of the mental illness
13 that they're experiencing. Colonel Hoge reported
14 in 2006 a JAMA article that approximately 15 to 17
15 percent of OEF OIF veterans have such conditions
16 as PTSD, major depression and other mental health
17 problems, and we may be seeing unprecedented
18 numbers of such veterans needing accurate
19 diagnosis and access to high quality care. So
20 we'd like to identify just a few areas that we
21 think we'd like to underscore.

22 First of all, in terms of new research,

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1 I think we have unique challenges for new
2 research. The consequences of the Iraq and
3 Afghanistan war I think represent a national
4 public health issue, not just limited to the
5 military or the VA, and includes, in part, the
6 changing face of the military, the needs of active
7 military, as well as reservists and National
8 Guardsmen, and civilian roles, as well as the

9 changes in gender demographics in the military.

10 There have been unique challenges
11 imposed by the theaters of war and the stressors
12 inherent in multiple deployments, as well. I
13 think the armed services have contributed a
14 significant body of literature and research in the
15 understanding of war related trauma, especially in
16 defining what's expectable in the face of war
17 trauma, as well as what may be preventable in
18 terms of long term complications that could lead
19 to chronic conditions and disability.

20 Just as a parenthesis, I'd like to say
21 that I opened a PTSD unit at Northboard (?) VA a
22 number of years ago and treated patients with that

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1 condition, so I do have some personal experience
2 there. But we do still need a better knowledge
3 about the evidence-based treatments for combat
4 PTSD. One of my roles at the VA and now at the
5 APA is to develop clinical practice guidelines
6 related to evidence-based treatments.

7 So I think this is important research
8 that needs to be supported. The secondary area
9 that we'd like to emphasize is the work force.
10 The good news, I think, and witnesses before your
11 own Task Force have testified to the high degree

12 of accessibility that in country personnel have to
13 psychiatric care, as well as care provided by
14 other mental health professionals in the combat
15 theater of operations.

16 Our concern or what seems to be an
17 issue, however, is the potential for deteriorating
18 stateside services depending on the geographic
19 location of the returnees. Based on some
20 projections that we've seen, in terms of adequacy,
21 once the current class of psychiatric residents
22 completes their training, the services will have

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1 approximately 92 percent of projected psychiatric
2 force needs, but some of the other non-physician
3 mental health professional groups such as
4 psychologists will probably not be close to that,
5 so I think we're concerned about the adequacy of
6 the work force.

7 A potentially significant interest is
8 the degree to which the multiple extended
9 deployments might impact retention and ultimately
10 recruitment of psychiatrists, other physicians,
11 and non- physician health professionals. So we
12 recommend careful monitoring so that corrective
13 action can be taken to prevent any kind of work
14 force crisis down the road. Another issue that
15 we'd like to just briefly focus on is access.

16 Based on informal observations and
17 discussions with my colleagues in the services,
18 and I work closely with the DAD and our guidelines
19 and credentialing and a number of other areas, it
20 seems that a major access problem is really
21 two-fold.

22 First, as illustrated by the recent

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1 series of articles in the Washington Post,
2 additional support may be required to provide wrap
3 around services to service personnel in the
4 post-acute stage of care, particularly when
5 they're waiting for disability determinations.
6 Secondly, we need to ensure that the mental health
7 needs of the family, the spouses, the dependents
8 and other family members are not forgotten.

9 Types of mental health and substance
10 abuse problems that emerge have significant impact
11 on families, as we all know, but unless the
12 veteran's injury or illness is determined to be at
13 least 30 percent disabling, allowing them
14 continued access to military medical services or
15 TRICARE enrollment, the military family
16 beneficiaries may have very limited access to
17 treatment as they're not eligible for services
18 within the VA system. All that possibly could be

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19 changed, too. I think a while back we did have
20 access briefly. For those service members and
21 their families who remain eligible for military
22 medical treatment, military medical service and

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1 TRICARE service capacity varies depending on
2 location. One option to consider is expedited
3 TRICARE certification of qualified mental health
4 professionals willing to serve the TRICARE
5 population.

6 However, the current processing window
7 of 90 to 150 days for certification, coupled with
8 the fact that practitioner reimbursement is lower
9 than Medicare, create barriers to stateside work
10 force expansion in that area, so that's an area we
11 recommend focusing on.

12 The next issue is stigma which has been
13 mentioned several times. In the civilian sector,
14 individuals needing psychiatric care must deal
15 with public stigma, as well as a limited access to
16 treatment for which they typically pay more than
17 for non- psychiatric medical care.

18 The APA and the entire mental health
19 care field is working to end such stigma such as
20 through the Federal Parity Law to ensure that
21 patients seeking psychiatric treatment don't pay
22 more for or have more restricted access to such

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1 treatment, and the armed services are no
2 different.
3 Active duty personnel must overcome not
4 just the same stigma as civilian sector, but also
5 there are concerns, and sometimes there's some
6 truth to it, that seeking treatment may limit or
7 end their career. We commend the Task Force for
8 performing a great public service by calling to
9 attention the great needs of active duty
10 personnel, and in so doing, helping to reduce the
11 stigma. Other efforts to reduce stigma and
12 discrimination are welcome, as well, such as the
13 efforts the VA is undergoing to improve access to
14 mental health services by locating them in primary
15 care facilities and encourage the expansion of
16 these co- locations.
17 But problems still remain. For example,
18 while the veterans readjustment counseling centers
19 are key pathways to care, returning military
20 personnel have repeatedly indicated they don't
21 want their commanding officers or unit members to
22 see them walking into such a center for fear

1 they'll be perceived as weak or to have an adverse
2 effect on their career.

3 So the APA is hopeful that with
4 continued education on the biological brain
5 changes that occur with combat stress, that the
6 stigma against mental illness, particularly this
7 kind of mental illness, will be eradicated.

8 Another topic, and this is my laundry
9 list, substance abuse. Well related psychiatric
10 sequelae are not limited to PTSD or a specific
11 time frame and can take the form of other
12 emotional and behavioral manifestations, and even
13 increased health risk behavior such as cigarette
14 smoking, alcohol misuse, or reckless driving.
15 Other behavioral problems may not be manifested
16 until some years after the actual combat exposure,
17 as well, and I certainly saw that in my practice.
18 Returning soldiers have always had an increased
19 risk to developing alcohol and substance abuse
20 problems, in due large part to the stress and
21 trauma encountered in their service, and the
22 tendency to self-medicate where treatment is not

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1 available or not sought. This abuse may continue
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2 after separation from military activity and
3 compromise the person's ability to function.

4 Despite this knowledge, discrimination
5 still exists in which there are deductions from
6 disability benefits for these problems. And the
7 APA, again, urges both the VA and DAD to examine
8 these potentially discriminatory practices.

9 Another issue is the National Guard and
10 reserve forces, which pose some special problems.
11 Tens of thousands of soldiers that are deployed to
12 combat zones are from the National Guard and
13 reserve units. These troops most often receive
14 their health care from private, employer sponsored
15 health plans when they return home to civilian
16 life.

17 Given the fact that most insurance plans
18 do not provide adequate mental health coverage,
19 the APA is deeply concerned that people who need
20 care will have difficulty accessing it and the
21 severity of their symptoms and the disruption to
22 their lives will be exacerbated because of these

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1 delays in care. So we recommend that data
2 continue to be collected on the DAD's TRICARE
3 program accessibility to Guard and reserve troops,
4 to monitor the need for expansion and increase

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5 funding for this program. In addition, the APA
6 urges for adoption of insurance parity laws for
7 private employer health insurance, to improve
8 access to care, and would welcome support from the
9 services in our campaign to end discriminatory
10 insurance coverage for mental health care.

11 And finally, military families; the
12 needs of returning soldiers and their families are
13 substantial. While increasing information is
14 emerging on the impact of combat exposure on
15 military service members, much less is known
16 regarding the impact of these experiences on
17 deployed women and family members, particularly
18 children.

19 It's essential that efforts be made to
20 expand our knowledge and that medical and mental
21 health practitioners, business community, and
22 policy makers be aware of these issues. The APA

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1 remains deeply concerned about the ancillary
2 mental health care available from TRICARE to
3 family members of the soldier who is deployed.
4 The same holds true for the families of veterans
5 who have returned and are experiencing
6 readjustment problems.

7 The TRICARE services available are
8 largely dictated by the family's accessibility
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9 geographically to a military base, and whether
10 using TRICARE practitioners or non-TRICARE
11 practitioners, we urge that DAD and VA provide
12 timely access for family members with psychiatric
13 disorders or combat related stress responses to
14 their spouse. Families of returning soldiers who
15 have full access to counseling to help family
16 members deal with temporary or permanent losses or
17 combat should have full access to counseling to
18 help them deal with these losses or combat related
19 changes of the soldiers returning.

20 The needs of military children are
21 particularly unique. Research on combat related
22 sequelae on parenting, as well as an understanding

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1 of the broad range of developmental responses in
2 children is critical to effective service
3 delivery. Where these changes or losses
4 contribute to a psychiatric illness, treatment
5 should be fully and timely accessible in the
6 military or in the VA.

7 So, again, we encourage, the APA
8 encourages VA and DAD to continue to work together
9 for a seamless transition for the soldier family,
10 from soldier to veteran, and that family
11 resilience be an important factor in the

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12 comprehensive care of veterans.

13 In summary, mental health consequences
14 of the Iraq and Afghanistan wars represent a new
15 challenge to the DAD and the VA, partly due to the
16 changing face of the military, the needs of active
17 military reservists, National Guardsmen, and
18 civilian roles, as well as changes in the gender
19 demographics.

20 There have been additional challenges
21 imposed by the theaters of this war and the
22 stresses inherent in multiple deployments. More

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1 training, research, and better accessibility to
2 high quality mental health care are essential to
3 providing quality of care worthy of the men and
4 women and their families who sacrifice so much for
5 their country. The APA would welcome the
6 opportunity to work collaboratively with the DAD
7 and VA and the Task Force to find solutions to
8 some of the obstacles to quality health care for
9 our military retirees and our military.

10 we thank you all for your efforts and
11 better understanding of these unique challenges
12 that this war presents and providing this forum to
13 discuss ways to solve some of the problems it
14 faces. These remarks will be provided in writing
15 to you all, and I thank you very much and really

16 appreciate what you're doing.

17 Any questions, I'll be happy to respond
18 to.

19 LTG KILEY: Thank you.

20 DR. MCCORMICK: Let me, first of all,
21 acknowledge Doctor Craig as one of the very best
22 people in VA in terms of clinical service and

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1 quality in all the years I was there. We also
2 have been concerned about impediments or barriers
3 to getting enough providers, quality providers in
4 TRICARE. And we have heard certainly reports of
5 TRICARE being -- reimbursement rates being an
6 issue, as well as credentialing burdens. Does APA
7 have any -- have they done any studies or do you
8 have any data that would help us ground and
9 establish that as a reality?

10 MR. CRAIG: I'm not sure. I don't have
11 that -- I've been with APA for three weeks, so my
12 files of information is relatively limited at this
13 point, so I'm not sure I could really respond
14 intelligently, but you know, we'll take it down
15 and we'll get the answer for you and we'll get
16 back to you.

17 DR. MCCORMICK: Thank you. It'll help
18 -- any recommendation we make, the more data we

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19 can have to ground it, obviously the more
20 meaningful it will be.

21 DR. MacDERMID: You may be in a unique
22 position to advise us in another issue, and that

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1 is, we've been struggling a lot with how you
2 design a system to provide adequate amounts of
3 care in both peace time and war time, and so we've
4 been discussing a lot, how do you make the
5 decisions about balancing uniform versus civilian
6 providers, how do you create mechanisms to move
7 people back and forth as you need to, who has --
8 how do you make sure that you have the right
9 expertise at the time and place that you need it;
10 does APA have any guidance for us on those issues?

11 MR. CRAIG: Well, again, I can't speak
12 for the APA position. I think my own -- this may
13 not be politically correct, but my own view is
14 federal health care service would be one way to do
15 it, where you would have VA, as well as the
16 military in some sort of collaborative arrangement
17 where the needs could be met according to the, you
18 know, where the work force could be tailored to
19 the needs that could be met.

20 That's not APA's position, so please
21 don't take that as anything other than my own
22 personal feeling. Now, I know from the VA, you

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1 know, there's been a lot of discussions and who
2 knows whether that would ever happen, but that's
3 certainly one way of doing it, or at least
4 providing a way for the total military -- the
5 total federal work force to be shared. We worked,
6 for example, when I was at the VA, we worked on
7 the collaborative credentialing for San Antonio
8 and some of the other areas to try and facilitate
9 the movement of physicians from both services,
10 from DAD and the VA, back and forth as the need
11 because we have the collaborative centers, so I
12 think something like that would, to me, be the way
13 to go, but that's just my personal opinion.

14 DR. MACDERMID: Thank you. Other
15 questions? Thank you very much, sir, we'll look
16 forward to seeing your testimony.

17 LTG KILEY: Thank you, that was very
18 good, thank you.

19 MR. CRAIG: Thank you.

20 SGT. GRAHAM: Good afternoon, Lieutenant
21 General Kiley and panel. My name is Sergeant
22 Donjuan Graham, I'm with the 450 Civil Affairs

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1 Reserve in Riverdale, (?) Maryland. I'm going to
2 give you a brief bio about myself to lead up to
3 what I'm going to say.

4 I spent three years of active duty with
5 the 82nd. After that, I spent four years in
6 college. After college, I was recruited by the
7 federal government and came to Washington, D.C. to
8 work on the Agent Orange and a PTSD study program
9 back in the mid '80's, and at that time, I
10 reenlist in the reserves, 11th Special Forces at
11 Fort Meade. I spent about 11 years with them
12 before they deactivated in '94. At that time, I
13 was in the RRR. After 9/11, I came back in for the
14 unit I'm with now, 450 Civil Affairs. In August
15 of '04, I was deployed to Afghanistan. There
16 wasn't any pre-PTSD program to find out if a
17 soldier was suffering from any sort.

18 My one experience in Afghanistan was one
19 day late January, early February. We were on a
20 mission, an HA mission up in the mountains and it
21 was snow, heavy snow. I was in charge of the
22 humanitarian assistance which we call HA and it

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1 was my responsibility to distribute the food,
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2 clothing, shoes, school supplies and all of that.

3 This one incident, a young girl, could
4 have been no more than about four or five, she had
5 no shoes on her feet and she was shivering. We
6 had practically given out all our HA, so I went
7 back to my truck, and what food that I had carried
8 out of that mission, I gave it to her. Now, I
9 didn't know how much that was going to effect me
10 until I got back to Baghram and I was a PRT in
11 Baghram.

12 At that time, I was overwhelmed with a
13 sensation that just literally brought tears to my
14 eyes that, being a soldier, I didn't want to
15 exhibit that. I pretty much couldn't eat that
16 night because I thought about that incident. The
17 next day, back out on another mission, and well,
18 okay, I'm passed that. Just before we redeployed
19 in July of '05, we were then given that assessment
20 of, well, the questionnaire of what did you see or
21 witness over -- during your tour. I wish I had --
22 but nothing really dramatic that I felt that

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1 caused me to suffer. Upon my return at Fort Bragg
2 at de-MOB, we were again given a series of
3 questions about PTSD and all this other concerns,
4 did you suffer of any sort. And again, I was -- I

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5 felt completely -- felt good about myself that I
6 performed well.

7 I think with me, and I've heard this
8 about people saying the combat stress, I know I
9 changed when I went there and came back, but I
10 think my biggest suffering occurred to me when I
11 came back to try to recover my job in the federal
12 government and was denied after five days. Since
13 that time, the anxiety, the stress, I mean it's
14 just overwhelming, and that's -- we're talking
15 September of '05.

16 Now, I've been able to maintain myself,
17 for the most part because I enjoy wearing this
18 uniform and I enjoy the unit that I'm with, and of
19 course, I enjoy jumping. Nothing has struck me
20 so, and I think from time to time about that
21 incident in the mountains in Afghanistan, about
22 that little girl, but nothing has really touched

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1 or stress me out to the point that I think about
2 trying to go through this process of trying to
3 recover my job, the bureaucracy that I've got to
4 go through or the different channels or the
5 different agencies to get someone to look into my
6 situation, not so much that I'm in denial, but I
7 know I am suffering from something, you know, I
8 hear the PTSD, I want to equate that to me coming

9 back and having to deal with my job situation,
10 because there's been so much anxiety. Needless to
11 say, my finances are -- well, but anyway, what
12 I've endured cannot compare to what I've been
13 subjected to back in the states.

14 I went overseas to perform a mission, to
15 provide something for others, when I came back
16 here, it's like -- it's a nightmare. I had to
17 work post-traumatic, it's a continuous traumatic
18 for me at this juncture.

19 we're about to be redeployed again, and
20 I look forward to being redeployed to continue my
21 mission. what I've suffered since being back here
22 is no comparison, as someone mentioned earlier. A

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1 civilian cannot imagine what goes on in a combat
2 area, but to come back here and have to deal with
3 people that I dealt with and when statements are
4 made, well, I think he's going postal in the five
5 days I'm back, cause people to say, well, look,
6 we're going to take these steps to remove you
7 three or four months down the road, it's
8 incomprehensible what I've been going through.

9 So in summary, I'd just like to say that
10 I understand the post-traumatic of what you
11 experience in a war, but again, my experience, my

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12 suffering, my stress, my anxiety, my sleepless
13 nights does not come from over there, my suffering
14 continues now from me having to deal with the
15 federal government and agency that I thought would
16 welcome me back and try to give me some assistance
17 in that sense, on that matter, and to this day,
18 it's still a continuous saga in my life, but
19 again, I don't allow that to interfere with what
20 mission that I look forward to perform. So in
21 conclusion, I'd just like to say that I will
22 continue to be and proud to wear this uniform as

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1 an American soldier. Thank you.
2 DR. MACDERMID: Thank you very much for
3 your service. I have a question for you, if
4 that's all right.
5 SGT. GRAHAM: Yes, ma'am.
6 DR. MACDERMID: And I think other people
7 may, as well. We bear the burden of trying to
8 make recommendations about a system that has to
9 serve millions of people, at the same time that we
10 know that each of those people, each of those
11 persons is an individual and unique, and so the
12 challenge is, how do you design a system that can
13 deal with both levels of that issue.
14 So my question to you is, how should the
15 system be different; what should be in place that
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16 isn't there now that would have made it easier for
17 you to find the answers to your questions and the
18 help that you need?

19 SGT. GRAHAM: I think before one deploys
20 overseas, they should be given a psychological or
21 some type of -- I don't know, I don't have the
22 answers, I just know that what I went through, I

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1 wish no -- I hope no other person goes through
2 that, what I've gone through. And I know soldiers
3 come back from wounds, missing limbs, I know I'm
4 not unique in my case here. But to try to answer
5 your question, what could you do, I don't have an
6 answer for that. I think most people that go
7 overseas, they go overseas with a good intention,
8 it's when they come back and have to deal with,
9 well, you're inundated with surveys after surveys,
10 questionnaires after questionnaires, it becomes
11 redundant, after a while, you almost become
12 mechanic and you just answer that question, you
13 answer this question, so you're not really -- I
14 don't know if it's a favorable response, but
15 you're not getting the kind of answers that a
16 panel may ask of someone, of individuals, so I
17 couldn't -- I don't know the answer to that.

18 DR. MACDERMID: Do you know if you

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19 completed a PDHRA days after you returned from
20 your last deployment?

21 SGT. GRAHAM: I know at Fort Bragg, we
22 filled out some forms, and when you're de-MOB'ing,

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1 it's pretty much of a rush thing to get a lot of
2 soldiers back. I'm one that wasn't -- yes, I want
3 to get back home to see people, that that wasn't
4 -- I wanted to make sure everything was done
5 properly so that down the road there wouldn't be
6 any question, did you receive this type of
7 treatment or care.

8 So I'm sure there were -- there were
9 instances of people getting some help in that
10 manner, but when you're hit with a phase of
11 paperwork, particularly when you're coming out of
12 a war, combat zone, your mind is at the place that
13 you just want to get back home, I'm willing to
14 fill out forms, documents, papers signed, this,
15 that, and other, and you don't think about it
16 until you've completely wind down. How long it
17 takes to wind down, I don't know, but in those
18 first three to four weeks that you come back,
19 you're just happy to be back home.

20 DR. MACDERMID: Sure.

21 SGT. GRAHAM: So you're signing
22 documents, you're looking at paperwork, you hear

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1 the lectures and all that, you know there are
2 places that they're out there, but once you wind
3 down, once you get back into the rhythm of things,
4 then you begin to understand what you did or what
5 you have to do to get back to that state of mind.

6 But I don't know, it's just one of those
7 things that with me, in working with PTSD and
8 Agent Orange study group back in the '80's, I
9 never thought I'd be up here at a microphone
10 talking about such things.

11 But again, I just emphasize the fact
12 that my stress and anxiety does not come from me,
13 I don't think I'm in that much of a denial, come
14 from me coming back and have to battle a battle
15 here versus the battle that I fought over there.

16 DR. MACDERMID: well, we appreciate your
17 service in both locations and your service here
18 today. Does anyone have any other questions?
19 Thank you very much.

20 SGT. GRAHAM: Thank you.

21 LTG KILEY: Thank you very much.

22 DR. MACDERMID: who's next?

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1 MS. RHEEM: I wanted to make one
2 comment, not representing AMFT, but as a marriage
3 and family therapist and my experience in treating
4 soldiers and their spouses post-deployment.

5 In treating soldiers with increasing
6 rates of PTSD and a higher divorce rate, we all
7 know that proximity to a loved one tranquilizes
8 the nervous system.

9 MFT's have unique training and systemic
10 training to help families have healthier dynamics
11 and healthier relational patterns.

12 Part of what I do as an MFT that may be
13 different than social workers or psychologists is
14 that I'm trained to look at those dynamics and
15 patterns and learn how to work with the dynamics
16 and patterns that create healthier relationships,
17 to mitigate and ameliorate the impacts of PTSD, so
18 that marriages survive and families build healthy
19 patterns or remain healthy.

20 Somehow it was important for me to
21 highlight that systemic nature of our training as
22 we look at family systems over years of training

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1 for couples and family dynamics and how effective
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2 that type of intervention is for post-traumatic
3 stress and other things that can lead to divorce.
4 Thank you.

5 LTG KILEY: Thank you.

6 MS. JONES: I have one other quick
7 statement that I would like the panel to consider,
8 that as we establish the process for soldiers to
9 go to seek the mental health professions while
10 they're in service, I would like the panel to
11 consider the impact that that may have once that
12 soldier retires or leaves the service as it
13 relates to commercial life insurance, because that
14 could impact upon their qualification or their
15 eligibility if they're seeking commercial life
16 insurance and they have gone through a treatment
17 program while they were in service as far as
18 mental health or been diagnosed with a mental
19 health condition, that if there's -- if at all the
20 possibility to collaborate with or to share
21 information so that when they leave the service,
22 that it doesn't impact negatively upon their

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1 eligibility for commercial life insurance.

2 LTG KILEY: Thank you. That's a good
3 point. We could all sit here until 5:30 and we
4 could probably wrap this thing up.

5 MS. JONES: One last --
6 LTG KILEY: Go ahead, quickly, go ahead.
7 MS. JONES: Also, if the panel could
8 also consider cultural differences as we establish
9 processes and procedures, because I know that
10 within my own culture, a lot of persons favor more
11 the faith based organizations to seek support and
12 help from because it is much more neutral and it
13 is disconnected from their profession.
14 LTG KILEY: Thank you. Any other
15 comments or questions from the panel? well, with
16 my co-chair's permission, I'd like to thank
17 everyone who's attended today. I think the input
18 to the committee has been very valuable, and we
19 thank all of you for spending time here today with
20 us, not only in this phase, but earlier today
21 during our open deliberations. There is a web
22 site, if you're interested, if you could see

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1 Doctor Burke or the rest of the support staff,
2 they can give you that web site. And then I think
3 other than that, pending any other suggestions or
4 observations, the open session is closed. Is that
5 for you to say or me to say, Colonel?

6 COL. DAVIES: Sir, you said it, it's
7 closed.

8 (Whereupon, at 5:11 p.m., the
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PROCEEDINGS were adjourned.)

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