

SD transcripts 10.20.06 FINAL.txt

UNITED STATES DEPARTMENT OF DEFENSE

TASK FORCE ON MENTAL HEALTH

San Diego, California

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THOMAS BURKE, Executive Secretary to the Task Force

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P R O C E E D I N G S

DR. MacDERMID: Good afternoon. Thank you very much for joining us. We're going to begin. I am Shelley MacDermid. I am the co-chair of the Department of Defense Mental Health Task Force. I am going to ask Colonel Davies to perform his official duties and open this public meeting.

COL DAVIES: Thank you, Dr. MacDermid. As the acting designated federal official for the

11 Armed Forces Epidemiological Board, a federal
12 advisory committee to the Secretary of Defense,
13 which serves as a continuing scientific advisory
14 body to the Assistant Secretary of Defense for
15 Health Affairs, and the Surgeons General of the
16 military departments, I hereby call this meeting
17 to order.

18 I would like to ask all of those that
19 are here today to please use the microphones since
20 we are recording today's session. And it would
21 help us to be able, if you would, to identify
22 yourself so that as we put the transcripts

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1 together we have that information. Dr. MacDermid.

2 DR. MACDERMID: Thank you very much.
3 And Dr. Burke you have some housekeeping
4 announcements you want to make?

5 DR. BURKE: Thank you very much, Dr.
6 MacDermid. I'm Dr. Thomas Burke. I'm the
7 Executive secretary of the task force. Just a
8 couple of administrative announcements, the first
9 is a simple one. The restrooms are down at the
10 end of the lobby on the left. And also I would
11 like to repeat what Colonel Davies said. The
12 proceedings today are being transcribed and they
13 will be part of public record. You should all be
14 aware of that whenever you make your statements;

15 if you would please use the microphones, because
16 the transcriptionist cannot hear you if you don't
17 use the microphones. Thank you very much. Thank
18 you, Dr. MacDermid.

19 DR. MacDERMID: Thank you. I'm going to
20 begin this afternoon by asking the members of the
21 task force to introduce themselves. Can you all
22 hear me before I go further? Yes? Thank you.

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1 And then I'll explain a little bit about why we're
2 here and the purpose of this meeting and then we
3 will very quickly get to what you have to tell us.

4 (Introductions)

5 DR. MacDERMID: The mental health task
6 force was created by an act of Congress. And our
7 job is to make recommendations to Congress about
8 ways to improve the military mental health system.
9 We are obligated to produce a report that we
10 deliver to the Secretary of Defense by May 15th of
11 next year. He then has an opportunity to add his
12 response to the report and transmit the report to
13 Congress. In an effort to carry out our mission,
14 we are traveling around the world to talk with
15 military members and military service providers,
16 subject matter experts and others to learn about
17 the state of the mental health care system in the
18 military. What's working well, what's needed,

19 what people out there want us to recommend. Our
20 site visits are routinely, including meetings like
21 this one, to ensure that anyone who wishes to
22 speak with us can do so. If this forum turns out

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1 not to be one that feels comfortable for you or
2 there's something that you want us to know that
3 you don't want to say in this forum, there's an
4 e-mail address up there that you can use to get
5 your information to us. We are here to learn from
6 you. We are enthusiastic about mental health. We
7 are eager students and so we are happy to hear
8 what you have to tell us. So who would like to be
9 first?

10 MR. POTTER: This is Mark Potter from
11 the Veterans of Foreign Wars in Washington, D. C. ,
12 and we represent about 1.2 million combat
13 veterans. The one thing I don't see on this board
14 is senior enlisted representatives or second
15 Lieutenants because they're the ones that deal
16 with the troops. If you want to break through
17 that stigma of sending troops to psychiatrists,
18 which I had to deal with, I was a battalion chief;
19 I'm a retired hospital corpsman chief who spent a
20 lot of time with the FMF. God forbid you send a
21 Marine up to psych, I mean, that would basically
22 turn into a fist fight between me and a couple

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1 gunnys, because they'd -- he's okay, he's
2 malingering, blah, blah, blah. If you want to
3 break through that barrier, you're going to have
4 to deal with the Sergeant Majors, the gunnys, the
5 chiefs, the first Sergeants because they handle
6 the troops directly, also the second Lieutenant
7 and the first Lieutenants, you're going to have to
8 get through to those folks. I think what you guys
9 are doing is a great and noble thing, but that's
10 the thing you have to get through.

11 DR. MacDERMID: We're eager to do that.
12 So tell us how.

13 MR. POTTER: I mean you're going to have
14 to get the enlisted community involved. Just not
15 being a retired chief, but the troop handlers,
16 because they know the troops and they have more
17 sway over the troops than officers generally do,
18 because they work with them directly. I mean,
19 they're with them 24/7 a lot of the times, and
20 they know their troops. If you break through that
21 barrier, and they're just as bad that the senior
22 enlisted. If they have a problem they used to

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1 come to me all the time and say we'll send you up
2 to talk to somebody. Oh, no I can't do that
3 because they afraid they'll hit their fit reps,
4 the pro's and cons and will basically mess up
5 their career or their career path or lose a
6 security clearance. They have a fear of that.

7 DR. MacDERMID: How do we engage that
8 audience? Do we set up meetings with them to talk
9 with us as we're going around?

10 MR. POTTER: Yes. I would set up
11 separate meetings with the senior enlisted
12 leadership, because they're the ones who are the
13 troop handlers. I think that would be the best
14 response to get through to the enlisted side of
15 the house, since they're the majority who fight
16 the wars and they're out there on the front lines.
17 Those folks and the second Lieutenants and the
18 first Lieutenants and the captains, those are the
19 ones who are out there. So you're going to have
20 to get through to that community first. I think
21 it would be great to have a couple Sergeant Majors
22 or even a Master Chief on the board.

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1 DR. MacDERMID: Unfortunately, the law
2 determined who would be on the board, not us. We

3 don't have the authority people to the task force.
4 We do, however, have the authority to decide who
5 we talk to and who we issue invitations to and how
6 we organize site visits and where we go. So we're
7 early enough in the process that there are things
8 that we can do to respond to these needs if
9 they're out there. Frankly, we are hoping to
10 continue trying to do a better job to make sure
11 more people know about meetings like this one,
12 because these were created specifically to allow
13 not just enlisted leaders but enlisted members to
14 talk to us. So I certainly hear that part of your
15 message. I'm guessing there are other parts to
16 your message?

17 MR. POTTER: Yes. Also from our rank
18 and file I hear this a lot from Vietnam veterans,
19 they're concerned that they're needs are going to
20 be pushed aside to help the new veterans, and we
21 hear the quite often. They said new veterans are
22 getting more care. What I tell them is each war

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1 we have they get a little bit better at treating
2 people. Eventually, hope to get it down pat, but
3 they're afraid they're going to be ignored and
4 pushed out by the wayside, especially the mental
5 health area.

6 DR. MacDERMID: And what would that look

7 like? Denial of service, is that what they're
8 afraid of?

9 MR. POTTER: That's what they think.
10 It's not happening, but that's what they perceive
11 is going to happen, and we keep telling them it's
12 not. I mean, we'll take care of you like they
13 always have especially if they're in the VA
14 system, so the VA system is taking care of them
15 for the most part, or vet centers around the
16 country, but they just have this perceived notion
17 that they're going to get bumped out of the system
18 because the new veterans coming -- which is, I
19 mean, it's not true, but that's their perception.
20 And we try to tell them that nobody's going to get
21 pushed out of the system because you have new
22 veterans. And one of our concerns is the VA may

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1 get overwhelmed because eventually these troops
2 are going to be discharged especially all the
3 reservists. The VA is a large organization but
4 one of their concerns is maybe they'll be
5 overwhelmed by all the mental health problems, not
6 just to mention all the physical problems they
7 have to deal with. That's just a few of our
8 concerns. Thank you very much. If your
9 organization would care to submit a written
10 statement to the task force with your

11 recommendations for what the ideal vision of a
12 military mental health system would look like, we
13 would be happy to see that. There is a written
14 invitation to that affect that's going up on the
15 website, the AFEB website, soon. The webmaster
16 has it but it's not up yet. But I'm telling you
17 that you and your organization and others are
18 encouraged to submit such statements because they
19 help us make sure that we've turned over every
20 rock and are thinking about every issue. Thank
21 you for your contribution. I believe Commander
22 Werbel has a question.

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1 LCDR WERBEL: Just going to ask a follow
2 up. Since you alluded to the distinction of the
3 new veterans and the old veterans, I would think
4 there's probably enough but I don't know in terms
5 of the trends, the things that you're seeing of
6 issues, areas of concern with what you consider
7 the new veterans, maybe veterans from OIF, OEF in
8 your organization?

9 MR. POTTER: Well the concerns are, I
10 mean, are they going to be treated for the rest of
11 their life, because some of these have to be cared
12 for the rest of their life especially the amputees
13 and people with severe mental problems. And the
14 concerns of our older veterans just to piggy back

15 on the Vietnam vets, they concerned about the new
16 veterans too because from their experience when
17 they came back from Vietnam, a lot of those folks
18 felt like they were just pushed aside, they
19 weren't taken care of. And they don't want that
20 to happen to the new vets who are coming out of
21 the war. You have that one side that says, okay,
22 we're going to lose some of our privileges because

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1 of the new vets, but the majority of them want to
2 take care of the newer vets because they don't
3 want the nightmare that happened to them happen to
4 the new vets and that's one of the main concerns
5 about OIF and OEF is that five, six years from now
6 they're not forgotten about.

7 LCDR WERBEL: Are you seeing differences
8 in their needs compared to what the prior needs
9 were?

10 MR. POTTER: Needs and just the
11 different types of -- this generation is
12 privileged generation and they want everything and
13 they want it now. It's just a matter they don't
14 like to be laying around the hospital, you know,
15 the amputees. It's just a different type of
16 person that fought in Vietnam that's fighting now.
17 If that makes sense.

18 DR. MacDERMID: Thank you. Who else has

19 things to teach us?

20 MS. ANDERSON: My name is Elena

21 Anderson. I'm a civilian; I'm a high school

22 teacher, the wife of a Sergeant who is retired

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1 because he is an amputee in the Marine Corps. He
2 was amputated in 1996. And I'm in sort of very
3 unique position because I myself spent eight days
4 at Balboa San Diego Naval Medical Center in the
5 psych unit. Two days in the locked ward and six
6 days in the unlocked ward. So the reason I jumped
7 up right away was because I got to spend a lot of
8 time with the young men that you were talking
9 about, the current enlisted gentlemen. That's all
10 I had that were there and what their fears were.
11 And I can also talk later about what my own
12 experience was as a dependent. But I met a lot of
13 young men who were afraid to talk and told me,
14 because I'm a high school teacher, and they could
15 have been my students, frankly. They could have
16 been my kids. But they were afraid. They would
17 not -- they told me a lot of things they would not
18 tell to the people who were there who were
19 supposed to be spoken to. But the forums that we
20 were given to speak in were completely unrealistic
21 for a regular depressed person to stand up and
22 talk about how we felt, leave alone for a person

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1 who is in the military to stand up to talk about
2 how he felt. Each morning we would go into the
3 living room space and one of the people who worked
4 there -- part of my side effects are not being
5 able to remember things like words. One of the
6 people who worked there who was young and clearly,
7 obviously untrained in psychiatry and psychology
8 would ask each of us, "So how are you feeling
9 today? What's your name?" Write the word that we
10 said, like, depressed, sad or whatever like that,
11 on the board and then say, "And what is your goal
12 for today?" And some people's goals were as
13 simple as to do their hygiene for the day. One of
14 the boys who was running that meeting actually
15 said, "Oh, well that's a room full of a lot
16 depressed people. What can we do for you?" Now,
17 these are all people who were just about to kill
18 themselves. We came to you, for you to tell us
19 what you can do for us. We didn't know or we
20 wouldn't have been there. I have sat in the
21 pharmacy waiting room for two hours waiting to get
22 meds which is an average experience for anybody in

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1 the military life. I think you all probably know
2 that. Just in sitting there, I was sitting next
3 to a couple of other recent amputees and because
4 my husband has that same experience and because of
5 some of the things they were talking about about
6 their mental health services that they were
7 getting, I just engaged in conversation with them.
8 They were afraid to talk to anybody within the
9 system about what was happening. They were afraid
10 they were going to lose rank, they were afraid
11 they were going to go to the brig, they were
12 afraid they were going to be kicked out entirely,
13 they were afraid they were going to lose their
14 benefits. And that's why I'm speaking, because I
15 feel like I'm speaking on behalf of all those
16 people that are too scared to come and talk to you
17 because they will lose their jobs. During that
18 time, because I was also enrolled in the Sharp
19 Mesa Cognitive Behavioral therapy intensive
20 outpatient program, I learned a lot there in that
21 civilian place. So these boys, who I could tell,
22 and they were talking about it were getting really

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1 anxious because it was a room very crowded. They
2 had just come back from Iraq and it was really

3 loud in the room and we talked about how loud
4 places like that make us really nervous. Well,
5 one of the things you could do is count the chairs
6 here to distract yourself. And they had never
7 heard of doing just distractions like that for all
8 the time they were there. I was in the hospital
9 for eight days and I got, maybe, four hours of
10 good therapy. One of those hours includes when a
11 volunteer brought her two old dogs in so that we
12 could play with them. And another of those hours
13 includes when luckily we were allowed occasionally
14 to walk outside with the recreational therapist
15 but nobody else, even on the unlocked ward, and I
16 noticed the chapel and said, "Oh, there's a
17 church. Sunday is coming, can we go to church,"
18 and one of the other patients of course told me,
19 "Yeah, they can't deny you, especially you a wife
20 of a Marine, your right to your religion." So
21 that was another way for us to get to sneak out
22 basically from the unlocked ward and get an hour

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1 of therapy that wasn't even supposed to be there.
2 Does anyone have any questions for me?

3 DR. MacDERMID: What do we do? How do
4 we make the young men and young women less afraid?

5 MS. ANDERSON: Well, even I was a little
6 bit afraid. My room, the women's room, which was

7 my room, was right next to the telephone and there
8 was supposed to be this little border around the
9 telephone so that the gentlemen using the phone
10 couldn't see directly into my room, but my bed was
11 as far away as that chair. My dresser space was
12 right here and they could see all my business.
13 Some of them would say, "Oh, you look like you
14 slept so well last night." I got yelled at by one
15 of the people who worked in that psych ward when I
16 tried to just move things around a little bit, and
17 one of the other people who worked there had
18 allowed me to just turn the blind a little tiny
19 bit so that I'd have the privacy that a woman
20 should have compared to all of these boys. I
21 think the same thing the gentleman said the people
22 who actually work with these young men need to

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1 change their attitude. I have heard way too many
2 jokes about mental illness. I even, as a teacher,
3 didn't want to come forward myself and I'm just
4 done being afraid, but I'm still depressed, I'm
5 still on disability, but I didn't want any of my
6 colleagues to know that it was happening. But I
7 think that the people who are the direct bosses
8 and the people who are going into training, right
9 from boot camp need to know -- because some of the
10 boys who were there were just right from boot

11 camp, need to know that it's not going to affect
12 their career. But I don't believe that that's
13 necessarily true. I don't even believe that being
14 here right now is worth anybody's time, like I
15 have so little faith at this point. And I'll have
16 you know because I was a newspaper advisor; I
17 contacted all my friends in journalism at the
18 Union Tribune, at several major television things,
19 telling them that this was here and forwarding
20 your website information, which I only got --
21 found because I needed to fill a prescription and
22 saw it and thought oh, my gosh, look, they're

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1 going to talk about mental health.
2 COL PEREIRA: You said you would be
3 willing to share some of your own experiences.
4 What has your experience been in accessing care
5 for yourself and your ongoing care since your
6 hospitalization?
7 MS. ANDERSON: Well, my -- I believe
8 that I've always suffered dyphynia low grade of
9 depression, but then I had a miscarriage after
10 several, a lot of infertility treatments including
11 a surgery, and none of my health care providers
12 ever asked me about how I was doing emotionally,
13 with having that physical health care taken care
14 of perfectly well. I know how -- although my

15 husband has surgery every year. So maybe if
16 somebody would have asked me earlier, but nine
17 months after the miscarriage everything sort of
18 started falling apart. A civilian pastor of my
19 church told me, "You know, I think you maybe need
20 to see and get some more help." I went to a
21 civilian social worker and got some help from her,
22 then was enrolled in Cog as Sharp Mesa Vista,

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1 which I cannot recommend enough to anybody, and
2 then I needed to be hospitalized, because after
3 three months of trying to get better, I, as an
4 overachiever was, like, this isn't working, I'm
5 not getting better. I might as well just kill
6 myself. And my doctors knew I would succeed if I
7 were try anything. TRICARE, our insurance
8 company, wouldn't allow me to be hospitalized at
9 Sharp Mesa Vista Hospital, where I firmly believed
10 I would have received more therapy than four
11 hours. I had to be transported to Balboa.
12 Fortunately, they let my husband come and pick me
13 up and drive me there. I had to be stripped down
14 and changed into the clothes that they give you.
15 Of course which, I mean, look at me. They gave me
16 the men's clothes in kind of the medium or large
17 all week long. And then after the eight days I
18 went back to my civilian care. It's expensive to

19 get -- for getting the prescriptions, to get the
20 handwritten prescriptions from the psychiatrist to
21 work at -- work somehow for TRICARE, but not
22 exactly for TRICARE. I don't really even

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1 understand it. It takes extra hours at the
2 pharmacy, you have to wait for your turn and then
3 you get to give them your paper, and then you have
4 to wait again while they put you back into the
5 whole circle. And all of that for a depressed
6 person -- I mean, I am so much better now to be
7 able to stand up here and talk, because this is
8 not what depressed people do, and this is going to
9 take -- I'm going to have to recover tomorrow.
10 This is a lot of energy. I don't know if I
11 answered your question right. It's a bad side
12 effect that I can't remember things.

13 DR. MacDERMID: Thank you very much for
14 sharing with us. Pamper yourself a little
15 tomorrow. We appreciate your sharing.

16 MS. ANDERSON: Thank you. Does anybody
17 else have questions?

18 LCDR WERBEL: I do, actually. You
19 mentioned the fear of coming forward for a number
20 of folks, both on the ward, but also the couple
21 that you were sitting with at the pharmacy when
22 you were waiting for getting your prescriptions

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1 filled. Now it sounded to me like, and I just
2 wanted to clarify that the fear of coming forward
3 then wasn't so much about my symptoms, my
4 concerns, but was maybe coming forward with
5 complaints about the system?

6 MS. ANDERSON: Well, I had complaints,
7 but I also filled out the cards to say you did a
8 good job to show that I wasn't just complaining.
9 Their fears were, I think, driven because they
10 didn't get any mental health care at the beginning
11 of their problem. Just like I didn't, just like
12 when I had a miscarriage after all that
13 infertility treatment, no one said, how do you
14 feel emotionally about that? They ended up doing
15 something they shouldn't have done, and then
16 ending up in the psych ward. So their fears were
17 founded on I left for a night when I shouldn't
18 have, or I got in a fight with somebody because
19 they're so bottled up with their anger. So,
20 unfortunately, their fears were sort of valid
21 because they had physically done things they
22 shouldn't have done. But if somebody had given

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1 them an outlet to talk about how they felt, I
2 strongly believe they would have not perhaps done
3 whatever it is that they did.

4 LCDR WERBEL: Have you, both yourself
5 and also in your conversations with others, have
6 you discussed what some of the -- besides no one
7 asking sometimes, what some of the other barriers
8 have been to seeking out that assistance?

9 MS. ANDERSON: Yes. Actually, I am very
10 well connected, so I also know chaplain from the
11 services and Seals who have come back and Marines
12 who have come back. And I've been told by all
13 three different parties that what happens is that
14 the boys sit in a room in a circle and there's a
15 chaplain there or some other kind of mental health
16 provider there, and they're asked how they feel,
17 and given a little business card that has on the
18 back on it things like, if you're feeling down,
19 get some sun, do some exercise, do something you
20 like to do. Things that are so basic and silly,
21 and then they're asked how they feel in front of
22 all of their peers and that's not a question I

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1 believe most men, leave alone, most service men
2 could answer in front of all these people that

3 they've been out killing people with and then
4 having to clean up -- I mean, the stories the boys
5 told me about what they had to do were gruesome.
6 They're not going to -- it would be totally
7 humiliating and I just don't think that they could
8 talk like that. I think they might talk in a
9 one-on-one situation, but I don't think that the
10 military wants to know. Because can you imagine
11 how much you would have to pay to help all these
12 people. I'm sorry to be so cynical.

13 DR. MacDERMID: You're allowed.

14 DR. McCURDY: Could I ask a question?
15 Your fertility treatment, was that in the naval
16 hospital system too?

17 MS. ANDERSON: Yes.

18 DR. McCURDY: Okay. Thank you.

19 DR. MacDERMID: Other questions? Thank
20 you very much for your contribution. We
21 appreciate it.

22 MS. ANDERSON: No problem. If anybody

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1 has any other questions, I'd be more than happy to
2 answer them.

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

4 MR. DINGER: I'm a retired military
5 officer, United States Navy. I'm a Mustang, 16
6 years enlisted, 13 and a half years commissioned

7 so I know both sides of the story.

8 DR. MacDERMID: Can you tell us your
9 name, sir?

10 MR. DINGER: This young lady is telling
11 a wonderful story. She needed help and she tried
12 very hard and she got that help. I spoke to the
13 Colonel here yesterday about a similar situation
14 here in San Diego. About a little over a month
15 ago, a young wife of a Marine deployed to Iraq,
16 had a young baby, the baby was very colic, she got
17 no sleep. The baby was crying continuously. She
18 wasn't getting any help and she was feeling lower
19 and lower every day. She finally wrote Dear Abby
20 a letter, tried to explain, said she didn't think
21 she would harm her baby, but she needed help.
22 Abby's staff got a hold of the Navy Medical Center

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1 here in San Diego, they got her help, they got her
2 treatment. She wrote back to Dear Abby and said
3 she's taking good care of the baby, he's over his
4 colic and things are going great. A recent
5 newspaper carried a follow up and everything is
6 still going great, her husband is coming back
7 home, his deployment is over. It's unfortunately
8 we have to wait until it gets to the bursting
9 point before people can get help as she explained.
10 She went to a pastor, she went to her military

11 (off mike) and stuff and nobody knew how to really
12 help her. They could give her suggestions, go see
13 your doctor, take an aspirin, or go to bed. That
14 doesn't solve when you have a crying baby at home,
15 and you're young, 18 years old you don't know how
16 to handle it. They hit the nail on the head
17 yesterday very good, very repeatedly, we need
18 training. We need visibility on the mental health
19 problems. Some of the things we can do, as this
20 gentleman here spoke about, is the military clubs
21 who are the first exposures to the returning vets
22 when they come back, they come down to have a beer

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1 or to talk with somebody that's been in the
2 service, has done what they did, know what they
3 did and things like that. You go to the service
4 clubs and you talk about mental health problems
5 and nobody knows what you're talking about, don't
6 even care what you're talking about. Not their
7 problem, but it is. I think I'm one of the first
8 people that talked to the returning vet when he
9 comes back and he has a mental health problem. He
10 comes down to the VFW, he has a beer or two, he
11 finds out I'm the chaplain of the post, he finds
12 out I'm the service officer, so he likes to talk.
13 That's about the first time his family knows
14 anything is wrong, but he'll talk to us guys where

15 (off mike) did what he's done. We've been there.
16 Your staff, task force, needs to get a hold of the
17 coalition back there in Washington, D.C., I think
18 there's about 60-some organizations with the
19 American Legion, VFW, reserves, I can go on and on
20 because I'm a member of most of them. But they
21 don't know anything about mental health. But
22 headquarters needs to go out to those

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1 organizations and get them involved. Most of them
2 have training sessions. They have training for
3 the field service officers. They don't tell you
4 anything about mental health. They tell you where
5 to get a form to send in to get a metal, where to
6 get your service record, things like that. But
7 those people ought to be talking about what mental
8 health is enough like we got yesterday to be able
9 to interpret what the veteran is trying to tell
10 you and heading in the right direction for help.
11 So I know for sure that the American Legion and
12 the VFW are very big in membership for all the
13 veterans. If you did nothing, start with them.
14 The Navy League is a bunch of old fogies like me.
15 I'm the president of the Navy League in Coronado.
16 But those guys I can talk to they're 80 years old,
17 yeah, I got grandkids I need to talk to, they need
18 to be exposed what the mental health problems in

19 our military is because we have the doctors from
20 Balboa come and talk to our membership. We have
21 the commanders and commandants of the Navy and
22 Marine bases come out and talk to our membership.

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1 We're small. We're only about 200 people over
2 there in Coronado, but we can make a little bit of
3 an impact if we know what we're talking about.
4 We're not old and retired like everybody says we
5 are, and that's the same with the VFW and American
6 Legion, a bunch of old fogies sitting around
7 getting drunk. A lot of them are -- they're
8 trying to forget. Maybe they've got mental
9 problems. But we need more training. And I think
10 the task force is a wonderful idea. I think the
11 general's had his hands cut out in trying to get
12 through the barriers that you're faced with with
13 monetary funding and with getting a staff that
14 will stay aboard. And what Commander Russell
15 talked about yesterday, you've got to give them
16 incentives if that's what it takes, give them
17 incentives. We can get another doctor 15,000 if
18 they'll stay on, why can't we give a psychologist
19 15,000? I think he earns his pay, if he does
20 nothing but save that one person right back there
21 that got up and told you about her trials and
22 tribulations. Thank you for your time.

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1 DR. MacDERMID: Thank you, sir. I have
2 a couple of questions. Sir, could you please
3 state your name?

4 MR. DINGER: My name is Harlan Dinger.
5 D-i-n-g-e-r. I'm a retired Lieutenant Commander
6 30 years in the Navy on the aviation side. And
7 I've done a lot of praying going off those
8 carriers at night, but I always got back.

9 DR. MacDERMID: And we're glad of it.
10 Thank you for your contribution. I do have a
11 follow-up question and some other people might
12 also. When you talk about the engagement that can
13 happen with the VFW and other veteran's
14 organizations, and that training is needed. I
15 want to be sure I understand what your idea is.
16 So is your thought is that if members of the VFW
17 and other similar organizations had access to
18 information and training about things like combat
19 stress and other things, that they would be able
20 to be part of the outreach mechanism to support
21 other returning vets? Is that what you're
22 thinking?

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1 MR. DINGER: Yes. Most of the people
2 nowadays; even when your 80 years old can diddle
3 with the computer. There's a lot of information
4 on the website. NHBI has a tremendous amount,
5 NAIL has lots of information. So if you want to
6 use a little initiative and go on you can get a
7 lot of information, but I think our leaders back
8 in Washington need a packet from your task force
9 saying give this to your councils, your posts and
10 your ships. Now, when I say "ship," a lot of the
11 VFWs are not posts they're ships. The one I
12 belong to in La Mesa is a ship. They have the
13 prerogative they could either a post or they can
14 be a ship. But our leaders in Washington, if they
15 had that could pass it down to our districts, our
16 state people, and in turn it'll come down to the
17 local post, ships or councils. But we need from
18 your task force what the official goal is what you
19 want us to do to help you. We're not trying to be
20 doctors, we just want to be able to tell a young
21 soldier that's having a crying fit over a beer
22 that he's got problems at home and if he don't go

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1 to work his wife's going to kick him out. So he
2 needs two counselors, one to get him a job and one

3 to fix his marriage. But that's what they come in
4 there for. We may be old guys but we've been down
5 the road for a long time and they will listen to
6 us. They won't listen to their dad or their
7 mother; they'll come and listen to us. So give us
8 some facts, probably something similar to the
9 package that was presented yesterday. If that was
10 in writing and then distributed out so that it
11 would get to all the posts and ships, it would
12 give us something to go on then all we need is
13 initiative in the posts and hopefully guys like
14 him will boot us along and make us to it. Thank
15 you very much. Any more questions?

16 DR. MacDERMID: Nope. Don't believe so.
17 Thank you.

18 MS. ANDERSON: Sorry, I'm back. It's
19 Elena Anderson again. But I wanted to add on to
20 what he said because I had asked at the -- where I
21 was, the psych ward, because I noticed my family
22 and my husband is wonderful and he came despite

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1 being in medical school and having finals coming
2 up, he came to visit me every day. I noticed most
3 of these boys don't have visitors; can I come and
4 visit them? And they said of course not until six
5 months after they like you to be separated and
6 better, and I'm still not better and I think it's

7 been six months. That kind of thing that this
8 gentleman was talking about might be useful
9 because to not have a visitor when you're there in
10 the psych ward and all they did was they'd go in
11 and watch MTV together, by themselves. And I'd
12 sit out and talk with my family or friends who
13 visited. But the domestic violence issue also
14 needs to be addressed. Living in Mira Mesa, we
15 lived next door to a military family who we called
16 the "angry family," unfortunately our bedroom was
17 next to their kids bedrooms. Every morning, every
18 single morning -- the dad was deployed, became
19 deployed partway through our living there, the mom
20 would come in and start with her yelling at her
21 son and the son would start yelling at the mom,
22 every now and then it sounded like maybe somebody

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1 was getting hit and then the dad came back and it
2 really didn't get better. But I have to tell you
3 that even the doctors at Balboa Navy Medical
4 Center, just one of them and he was just a recent
5 graduate, so perhaps we can excuse him, said to me
6 when I was sitting in there recently, because I
7 also this summer got to have a lumpectomy, I don't
8 have cancer -- but I was concerned because I had
9 been losing a lot of weight and I was bruising
10 easily and he, as if they were out surfing or

11 sitting in a bar, slaps my husbands knee and goes,
12 "You've got to stop hitting her around like that."
13 I was just -- my husband and I were both taken
14 aback. I said, "Well, that's definitely not it,"
15 because he's the gentlest man in the world. I
16 filled out a complaint form about that because
17 that cannot go on. If he had said something like
18 that to my next door neighbor there would have
19 been more bruises that night or somebody might
20 have been killed. So it's not even just --
21 everybody needs to become more sensitive to mental
22 health. And it's not just within the service,

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1 it's within the whole entire world, and it took me
2 months before I was able to say "I have
3 depression," even to myself, leave alone to other
4 people. But people need to be trained not to do
5 things like that.

6 DR. MacDERMID: Thank you. Who's next?
7 MS. WHEELER: My name is Barbara
8 Wheeler. I'm a citizen. I'm a member of the
9 public, I'm not affiliated with the military, and
10 I'm getting up to say what I have to say in spite
11 of the fact that I'm going to cry during it,
12 because the issue I think is so tragic what we're
13 doing to the families and the young men and women
14 who are coming back. It's not surprising that

15 there aren't very many people here as a public
16 input, because there isn't enough information that
17 comes out when an event like this is happening. I
18 happened on the information in the North County
19 Times this morning, just a little tiny article and
20 did happen to say where it was. I noticed later
21 that the Union Tribune article didn't even say
22 that there would be an opportunity for public

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1 input today or even where the hearing was being
2 held. There needs to be more information out
3 about this issue and its affect on all of us. As
4 these other people have noticed, it's not just the
5 individual that has the emotional problem, it
6 affects their whole family, it affects the
7 community, it affects people they may run into
8 with road rage, anybody. I have a statement:

9 Before retiring, I worked specifically
10 with families of children with special needs,
11 disabilities or special medical conditions. These
12 families typically experience lots of stress and
13 stress relates to the military issue. We moved
14 six years ago to be near our son's family, thus we
15 are in northern San Diego County along with many
16 military families. As I became more familiar with
17 how military experiences affected family, I became
18 more concerned about the levels of support

19 especially for those returning from the conflicts
20 in the Middle East. Yet we continue to see
21 incidents of domestic violence as we've already
22 heard about. Some of what I have read indicates

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1 that there is now greater understanding and
2 recognition of the need for support for the one in
3 the military as well as their families, given the
4 impact not just on them, but on the society as a
5 whole. I had been encouraged to think that
6 program funding would follow that understanding.
7 A few weeks ago I read that mental health programs
8 were being under funded by the Veterans
9 Administration to the tune of tens of millions of
10 dollars. Yet in the recently passed budget for
11 the Department of Defense, I read that Congressman
12 Duncan Hunter insisted on including an item for
13 continuing hunting on Santa Rosa Island off the
14 coast of Santa Barbara with the explanation that
15 it helped the mental health of paralyzed veterans.
16 This was despite disclaimers from veterans groups
17 about the need for such a program. Congressman
18 Hunter has not responded to my request for
19 information regarding how many veterans have used
20 this program or the cost of same, I have also
21 inquired whether he or any other congressman have
22 hunted there. Since I am in the 50th

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1 Congressional district I also requested this
2 information from Congressman Bill Bray. He has
3 not responded either. I believe that better
4 support for effective mental health programs for
5 veterans is absolutely critical. Anything less is
6 unthinkable.

7 I guess my question for you is: What
8 can people in the community who understand some of
9 this but have no clue about how to go about having
10 some influence on helping with getting more
11 funding, emphasizing the need for that? What can
12 we do when our congress people don't even respond
13 to questions about it?

14 DR. MacDERMID: Well, certainly
15 continuing to make noise to them is a very good
16 first effort strategy. But let me open the
17 microphones to my colleagues and thank you for
18 your heartfelt support. You are in more ways than
19 perhaps you know preaching to a very enthusiastic
20 choir and our struggle is to figure out how do we
21 accomplish the very thing that you want to see a
22 system that doesn't leave people behind or leave

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1 people out. Any guidance you have to offer us
2 about that would be very much appreciated, but
3 suggestions from colleagues?

4 DR. McCORMICK: Actually, I retired from
5 the VA. I was drug through a mental health in the
6 VA health care system of Ohio. I think what
7 you're -- and in all honesty, we wouldn't have the
8 amount of mental health resources we have in the
9 VA today were it not for the advocacy of not only
10 people, but obvious -- the way to be most
11 effective is often to be part of an organization.
12 So whether it's a better service organization or
13 some other community organization, those voices
14 are heard more loudly by the people who can
15 influence including members of Congress, then
16 individuals. I know I'm just speaking for myself
17 not as a member of the commission. One of the
18 things that worries me that that advocacies voice
19 is getting less loud because perhaps people aren't
20 joining those organizations in the numbers that
21 they once did.

22 DR. MacDERMID: Other comments,

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1 suggestions? We hope you'll continue trying to
2 fight the good fight. We will too. Others?

3 MR. HEVEZI: My name is Matthew Hevezi,
4 and I am a former Marine, enlisted. I am a
5 multi-tour veteran of Navy mental health care and
6 VA mental health care. I had an appointment at
7 8:00 a.m. in Loma Linda at the VA Medical Center
8 today, and I drove here in order to testify. I'm
9 here 10 percent for myself and 90 percent for
10 three individuals who are unable to be here and
11 speak on their behalf. I'm not going to give
12 their names because they haven't given me
13 permission to give their names. But I'm confident
14 that what I have to share with you about their
15 experiences will be very valuable. The three
16 general areas that these individuals -- let me
17 back up; I encountered two of these individuals,
18 one an active duty infantryman, and the second an
19 active duty Navy corpsman and a third I never met,
20 but his mother shared his experience with me. I
21 have no way to verify whether or not what they
22 told me is true or not because I wasn't there, but

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1 I am convinced 100 percent of the accuracy of
2 their experiences that they shared with me. The
3 three general topics that these individual's
4 experiences will cover are self medication and
5 barriers to mental health care. Two, PTSD and the
6 effects of PTSD, and last is suicide.

7 The first Marine that I want to talk
8 about was an NCO who was an infantryman in Iraq,
9 and he was on top of a typical Iraq home, three
10 stories high and he was hit with a rocket -- he
11 wasn't hit directly with a rocket-propelled
12 grenade, he was knocked off the building by the
13 explosion of a rocket-propelled grenade that went
14 off next to him. He was wearing a full combat
15 load which included a pack. And this pack more
16 than likely saved his life, but he did sustain
17 back injuries and concussion injuries that
18 required that he be med evac'd to the nearest
19 field hospital, then to Kuwait and then to Germany
20 and then to -- I can't recall the hospital on the
21 east coast, but he was at the east coast. He was
22 in care at the east coast and then eventually made

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1 it back to Camp Pendleton where he was going
2 through rehab, physical rehab for his physical
3 injuries. During that time he was assigned to the
4 rear echelon which in an infantry unit that has a
5 few members that stay behind to handle the
6 administrative duties of the unit while the unit
7 is deployed where ever they're deployed at.

8 And as he was going to his -- and he
9 went through multiple surgeries to fix his
10 injuries which were mainly to the back, I don't

11 know if I said that. During his time at the
12 unit's company office he was ostracized and teased
13 a little bit. It's not clear really why that
14 happened, but he lashed out at the people who he
15 referred to as "REMPs," that's a rear echelon
16 person, but the acronym contains a foul word that
17 I'll spare you from. But he resented their
18 teasing him and he had an outburst that caused him
19 to be hospitalized in the psychiatric ward at the
20 Navy Hospital here in San Diego. That's what got
21 him to the hospital. When he came back to
22 Pendleton and saw his doctor at the battalion aid

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1 station at Camp Pendleton for his unit, he
2 confided in the doctor that he thought that he was
3 having some mental difficulties that he didn't
4 know how to deal with and that he wanted to get a
5 referral to the mental health unit at the hospital
6 at Camp Pendleton, which is viewed by many people
7 who are out in the outer units aboard the base, as
8 kind of golden ticket, but that's where you'll get
9 really good care. However, the doctor at the
10 battalion aid station told him that he was fine
11 and gave him some basic suggestions on how to deal
12 with his emotional turmoil. And what I believe,
13 from his description was PTSD, bad. He also felt
14 guilty about being separated from his unit and he

15 turned to alcohol and marijuana to self medicate.
16 And he ended up testing positive for marijuana,
17 and the last time I spoke to him -- I don't know
18 where he is now, I lost contact with, but the last
19 time I spoke to him, he was going up for a summary
20 court martial and bad conduct discharge for drug
21 use.

22 The second individual that I'd like to

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1 share about was a Navy corpsman who I also
2 encountered and became friends with in the Navy
3 medical mental health care system. This man was a
4 super corpsman, and for those of you who aren't
5 familiar with corpsman, they're just like Marines,
6 but they are actually members of the Navy and they
7 are trained to treat the wounded Marines in the
8 field, and also at the hospital too. They do do
9 some admin duties at the hospital. But this man
10 was built like a running back, fearless, very,
11 very, competent corpsman, junior enlisted and he
12 was well regarded and well liked by his Marines.
13 He did two tours in Iraq and he completed more
14 than 500 combat casualty evacuations, individual
15 Marines or Iraqi's that were injured and required
16 to be transported back for further medical
17 treatment. This was during two tours in Iraq.
18 When he returned to Camp Pendleton, after a period

19 of several months he began to -- the PTSD began to
20 set in. As many of you know it takes some time
21 before PTSD begins. He was sent to the hospital
22 at San Diego mental health unit as an inpatient

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1 and was evaluated. The second time I saw him
2 after he spent time in the hospital, he confided
3 in me and asked for my advice, he wanted to know
4 what he should do, because he was told that he was
5 going to be discharged for a personality disorder,
6 for narcissistic personality disorder, which, for
7 those of you that don't know, is not compensatable
8 through the current regulations that govern what
9 conditions are disabilities and which ones are
10 not. So basically his fear was that he was going
11 to be discharged from the Navy with no aftercare.
12 I did not know what to tell him. I didn't speak
13 to this man for about -- I don't know how long,
14 several months, and I sent him an e-mail, and I
15 called and left messages on his phone and I never
16 heard back from him. So I contacted the last unit
17 that he worked with and asked his co-workers and
18 his leading petty officer where he was and they
19 said they didn't know. I raised the BS flag and
20 demanded, as a friend of his, to tell me where he
21 was, and eventually they told me that he was in a
22 civilian hospital and had just been in a serious

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1 car accident. I went to see him the next day at
2 the hospital and he was hooked up to all manners
3 of machines. He was asked by a family member to
4 transport a distant cousin on a weekend. He had
5 just bought a brand new car and he had been
6 drinking. Also he was using alcohol to self
7 medicate, and although he wasn't fall down drunk,
8 he was over the legal limit when the accident
9 occurred. The car was t-boned, his passenger was
10 killed instantly, and he was seriously injured.
11 This man crawled out of the car before medics
12 arrived, EMTs, ambulance and crawled to the
13 passenger side of the vehicle and began to try to
14 administer first aid to his cousin. She did not
15 have a pulse, and he passed out. When the medics
16 arrived they managed to bring him back to
17 consciousness and this man, from his experience in
18 Iraq knew exactly what was going on with him. He
19 knew his lung was punctured and he knew his lungs
20 were filling up with blood, because he had treated
21 this condition many times in Iraq. And he told
22 the EMT that if they didn't put a tube in him that

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1 he would die. He was sure of that. The EMT did
2 not know how to do this, he wasn't trained to do
3 this procedure and this Navy corpsman told the EMT
4 that he needed to call to the hospital and have
5 the doctor walk him through it on the phone, which
6 he did and he was saved and he went to the
7 hospital. He was hospitalized for, I think, at
8 least three weeks maybe more. Then he was
9 transported to the Navy hospital at Camp Pendleton
10 where he contracted pneumonia because his
11 injuries, which the lungs, and he -- from what he
12 told me, I didn't see any charts or talk to his
13 doctors but he almost died of pneumonia when he
14 was in the hospital, he became very sick. This
15 Navy corpsman is no longer on active duty, he is
16 100 percent disabled, but now he's in jail, and I
17 don't know what his future is going to be. I only
18 saw him once.

19 The third individual that I want to tell
20 you about, the experience was shared with me by
21 his mother. She was a single mom and he was
22 enrolled in a private school in New England,

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1 college, university. I'm not sure which one it
2 was, it was either -- maybe they're the same. But

3 after 9/11 he decided to join the local Marine
4 reserve unit against his mother's wishes, but she
5 knew that since he was an adult it was his right
6 to make that choice and she ended up supporting
7 his choice. His unit was activated and
8 transferred to Camp Pendleton. While at Camp
9 Pendleton during pre-deployment training he was
10 put on mesoquin therapy, for those of you who
11 don't know what mesoquin is, mesoquin is a
12 anti-malarial prophylactic that's given to service
13 members who deploy to areas around the world where
14 there's a threat of malaria. He began to exhibit
15 extreme psychiatric symptoms and side effects from
16 what later his mother was sure was caused by
17 mesoquin. As an example of his behavior, he stood
18 in formation and attempted to remove his uniform
19 in formation. He was hospitalized at Camp
20 Pendleton for suicidal ideations, and the unit --
21 this was days before the unit was to deploy, and
22 he was released to his unit, and the next day

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1 boarded an airplane with his unit and was on his
2 way to Iraq. His unit stopped in Delaware to
3 refuel before leaving for Kuwait, and at this time
4 -- and it was the first time that he called his mom
5 and told his mom that he was extremely afraid and
6 worried about what was happening to him, and he

7 was afraid about going to Iraq. It wasn't just
8 the type of phone call -- you know, there's a lot
9 of people that deploy or go to dangerous places
10 have fear, but his mother described this phone
11 call as pretty extreme and she was very, very
12 worried. She did not know about any of the
13 previous events that happened because she's not
14 entitled to know that due to the privacy act. She
15 felt that her son was very likely ashamed of what
16 was happening with him from a mental health
17 standpoint. The unit arrives in Kuwait and the
18 first night there this Marine was discovered by a
19 platoon mate with the barrel of an M-16 in his
20 mouth with the magazine inserted. His friend
21 walked up and intervened and took the magazine out
22 of the weapon. However, there was a round

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1 remaining in the chamber and the Marine shot
2 himself and died. The mother is still recovering
3 from her own mental illness following the death of
4 her son.

5 Those were the three experiences that I
6 wanted to share with you today. And I also wanted
7 to note three last points before I surrender the
8 mike and I apologize for being long.

9 First of all, as the woman previous to
10 me noted that this event was not well publicized.

11 One of the gentlemen on the task force, who is the
12 secretary, mentioned that notification was sent
13 out seven to ten days prior to this event;
14 however, I did some checking yesterday and at
15 least for the San Diego newspaper, that
16 notification arrived on Tuesday this week.

17 Second admin point that I wanted to make
18 is that in my own experience and I would be happy
19 to share my own experiences with any of you
20 privately, I'm not comfortable speaking about them
21 today for a number of reasons, but I wanted for
22 you to know from one individual's experience, is

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1 that there's a trend right now in the Department
2 of Defense medical, especially mental health care
3 system and in the VA to under diagnose mental
4 health conditions.

5 The last point, and probably -- I'm
6 confident is the most important point, is that
7 there needs to be a DoD-level mandate that
8 commanders, from generals all the way down to the
9 platoon level, need appropriate mental health
10 education and training. Right now there's a link
11 on the Marine Corps website, it's called something
12 for Marine -- Guidebook for leaders for Marines in
13 distress. Whether or not somebody goes to that
14 link and reads through the material on that

15 website, which is very good, I don't think it's
16 mandatory. Maybe, but I don't know that it is or
17 isn't. But there needs to be mandatory mental
18 health training in this day and age and what we're
19 doing in the military. Again, I apologize for
20 being long, but I felt very compelled to share
21 these things with you today. Thanks.

22 DR. MacDERMID: Thank you very much for

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1 preparing so carefully and sharing that
2 information with us. Are there questions that
3 members of the task force would like to ask?

4 COL PEREIRA: I know that you said that
5 you're reluctant to share your own situation with
6 us. But would you be willing to share with us
7 where you're getting your care now?

8 MR. HEVEZI: VA Loma Linda.

9 COL PEREIRA: Okay. And how was your
10 transition process from DoD to VA? Was that --
11 how was that?

12 MR. HEVEZI: I had good and bad, but
13 mostly bad.

14 COL PEREIRA: Could you talk a little
15 bit about that?

16 MR. HEVEZI: I'm not comfortable.

17 COL PEREIRA: Okay. Thank you anyway.

18 Thank you.

19 LT COL CAMPISE: I have a question for
20 you if you don't mind. Can you tell me exactly
21 what type of training you'd like for us to
22 emphasize for leadership in regards to mental

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1 health?

2 MR. HEVEZI: I thought about that and
3 I've heard the panel ask many times what should we
4 do? I don't have the insight to know what to
5 recommend to do. My suggestion is only general.
6 I don't know how earnest the support is to fix the
7 problems to fix the problems in mental health in
8 the military and the VA today from the top levels
9 on down. And I don't know what resources they
10 would make available to do that, money, staff,
11 time. So I don't know how to answer your
12 question, sir.

13 LT COL CAMPISE: Okay. Thank you.

14 DR. MacDERMID: I have one question. In
15 each of the stories that you told us, each of the
16 people you told us about, the common thread seemed
17 to be that there are places where the system could
18 have done a better job of preventing what
19 ultimately was a bad outcome. Do you have
20 suggestions for us as you think about those
21 stories about the things that should have been in
22 place that weren't, or the things that should be

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1 put in place now to reduce the likelihood that
2 such things would happen in the future?

3 MR. HEVEZI: From my experience, the
4 level of care and competence of care varies
5 widely. I've had really; really great doctors and
6 I've had unbelievably bad doctors. So get more
7 good doctors would be my suggestion.

8 DR. MacDERMID: That sounds like a very
9 good idea. And I think the chuckles reflect the
10 fact that we agree with you and we've been
11 spending actually quite a bit of time trying to
12 figure out how we do that. So I don't know what
13 the ultimate recommendation is going to be, but it
14 certainly is a topic that's getting some
15 discussion.

16 MR. HEVEZI: For the record, I am here
17 as a private citizen, but my intention and my goal
18 is to become a veteran's advocate for this current
19 generation of veterans.

20 DR. MacDERMID: Thank you for your
21 service in the past and in the future. I'm
22 thinking somebody has a question.

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1 MR. HEVEZI: Thank you for that
2 opportunity to testify.

3 LCDR WERBEL: I would just like to give
4 you a little bit of information actually, not a
5 question. Since you brought up the -- the website
6 is called the leaders guide for managing Marines
7 in distress. It is briefed to every staff
8 sergeant course, NCO, academy, commander's course,
9 first sergeant course in the Marine Corps. And
10 over the course of the last year, although it
11 fluctuates from week to week, has largely been the
12 number one visited website on the Marine Corps
13 community services portal.

14 DR. MacDERMID: There was someone else
15 who was queued up to speak. Is that you, sir?

16 MR. GRAVES: Good afternoon. I'm
17 surrounded by a lot of courageous people. I'm not
18 very courageous in front of the mike, so bare with
19 me.

20 DR. MacDERMID: Could you state your
21 name, sir. I'm sorry to interrupt.

22 MR. GRAVES: My name is Wally Graves.

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1 I'm a family support manager for naval special
2 warfare. I recently retired after 20 years. I

3 was a corpsman and Special Forces medic and a seal
4 for 20 years. What got me in the job now is I
5 help create a combat stress program for naval
6 special warfare. Now, I'm trying to do it for our
7 families. So I can speak on two sides for what
8 we're doing for the members now active duty and
9 some of the issues with the families. AS the
10 first gentleman said, we've got to get the
11 leadership, and I think on the members side what
12 the leadership we need is the mid-level leaders,
13 the guys that are out there in the trauma, in the
14 combat with the soldiers. One of the ways, I was
15 thinking in our community to do that is to get to
16 some of the guys that have come back, they're
17 heroes and they need to go around and maybe do
18 some speeches or some briefs. People that have
19 been in combat, I think are more aware of the good
20 stuff that comes out of counseling and to actually
21 get help for people. Some of the senior enlisted
22 at the command, master chief or the Sergeant major

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1 level, we have to get buy in from them too, but a
2 lot of them are removed from the task unit, so
3 they're patrolling Fallujah or the streets of
4 Baghdad. We need to tap into the E-7s, the O-3s,
5 the guys that are out there in the combat
6 operations. I get nervous in front of the mike.

7 Some of the -- I too, the advertisement for this
8 meeting, a friend of mine e-mailed the flyer to
9 me, so that's how I got this on Monday. So I sent
10 it out to our ombudsman and asked for some of
11 their input on the questions you asked for you
12 access. A couple things I got back, and I really
13 haven't had time to call on them to reach down,
14 but these are just a couple of the bullets that I
15 got. Quality of care at the fleet and family
16 service center. A lot of our spouses are
17 complaining about that. I've been working with
18 the San Diego fleet and family service center for
19 the last two months and I think they have awesome
20 clinical services. And every organization I've
21 spoken with has been doing really very supportive
22 work, but I think in the past maybe there's --

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1 once again, as the gentleman says, there's good
2 counselor's and there's bad counselors. I think
3 part of the perspective on the Navy side is for us
4 in spec war we're more like the Marines. So if
5 you go and talk to a counselor there, they're used
6 to the deployment cycle. A ship leaves on Sunday
7 at 7:00 a.m. and comes back six months later on
8 Sunday at 8:00 a.m. compared to the Seals and the
9 Marines that they're deployment and the combat
10 stress. I think Navy's going to get smart next

11 year when they go to their 10,000 IAs deploying
12 with these troops. So I think we'll get better.
13 But the support is there, all the free
14 infrastructure, fleet and family service center;
15 the counselors are a great resource. It's just a
16 matter of them getting caught up to the times that
17 we're in and what our young men and women are
18 doing.

19 Another one was services available for
20 children they're not adequate. I can put that
21 into -- I know fleet and family service center
22 offered couples and for the adults. I don't

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1 believe they see children, but if you go to Balboa
2 -- if a wife comes in pretty upset about the
3 deployment and the combat stress, whether through
4 her husband. You know that children are affected;
5 it's all part of the same pie. So if Balboa had a
6 one-stop shop that someone came in, ease of access
7 when you come into the mental health system. Like
8 the D0 perspective of old age, you know they're
9 standing; they're looking at the whole body, well,
10 look at the whole family. Those are probably
11 going to all be important factors; if the husband
12 or the wives are having difficulties with the
13 combat stress and with mental health, more than
14 likely the children are probably need some help.

15 A lot of the attitudes are the physicians are
16 busy, they have you for 45 minutes and they're
17 worried about their next case that's going to come
18 up. Maybe there's another layer of care after
19 they've seen the primary -- the M.D. or the
20 psychologist that there's another source that they
21 can go spend another 30 minutes with to make sure
22 the whole issue, the whole problem is being

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1 addressed. Maybe they wanted to say some more
2 stuff about their children, but they just -- time
3 constraint at the hospital, and I know everybody's
4 busy and there are shortages of physicians
5 available and everybody's working off of their
6 clock. I don't know. That's just another idea,
7 and then goes back to the stigma that hurts their
8 husband or the spouse's career if they seek mental
9 health. That's my biggest challenge right now is
10 to get Seals to actually raise their hand. I like
11 the Fram commercial, pay me now or pay me later.
12 I'm really hitting the spouses up because I know
13 that they -- the spouses get this. They're a lot
14 smarter than us in a lot of areas; one is they
15 seek help, and getting the warrior to come in when
16 it's just a 10-pound gorilla versus a 400-pound
17 gorilla, that's our challenge. It's mid-level
18 leaders that have one the bronze stars and the

19 silver stars get them out on a stage tell them
20 these are important for the young guy, the E-5 to
21 come in before he hits his wife, before he has the
22 alcohol and the incident. I'm really hitting hard

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1 with the spouses. I'm going to do a campaign, a
2 marketing campaign of the Fram commercial, pay me
3 now or pay me later, because I know a lot of the
4 warriors change their oil every 3,000 miles, why
5 don't they put some effort into their
6 relationships. It takes commitment and it takes
7 culture of the warrior seeking help is related to
8 weakness. And I think part of your plan should be
9 this huge marketing. Somehow we have to reach
10 these guys and we don't want learn our lessons
11 learned from Vietnam and redo that.

12 The training as the Marine Corps,
13 already mentioned, the PC0, PX0 course, the senior
14 enlisted academies that should be huge getting
15 these guys that will be in the leadership role.
16 Another avenue for you guys and your board is the
17 ombudsman assemblies or the key volunteer network.
18 When you have a room full of these ladies or these
19 spouses, these people are in the trenches.
20 They're dealing with these issues every day, and
21 that would be a great avenue for you guys to get
22 some suggestions from. You should tap into that.

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1 The other problem is when we were
2 developing our combat stress program we did it
3 ourselves with a couple GMDs and Navy corpsmen,
4 and peer-to-peer support is great, but the Navy
5 medicine should have a package on all the
6 readjustment issues. We should be able to go to
7 mental health and here's your strategy; here's
8 your pre-deployment strategy, forewarning is
9 forearming, here's your deployment strategy, the
10 enter piece for the spouses and here's the
11 post-deployment strategy. But if you go you have
12 to go to family team building, you go to fleet and
13 family -- everybody's hit and miss, everybody's
14 duplicating efforts. When the professionals, they
15 psychologist and the psychiatrist, you know the
16 best. Families want education on child
17 psychology, how child behavior is. I'm getting a
18 little shaky. Thank you, sir.

19 DR. MacDERMID: Thank you very much.

20 MR. GRAVES: Good practice for me in my
21 public speaking. It's real important
22 reintegration, the warrior transition. The

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1 Marines are doing an excellent job at the family
2 team building. But once again it's all
3 volunteers. I know they have the piece with the
4 chaplain, they have a piece with the hospital, but
5 you should deliver a package to these commander so
6 that when they raise their hand we're have a (off
7 mi ke) and drug use incidents or whatnot, you
8 should immediately respond with your tiger team
9 Educate this command, get a program established,
10 evaluate their program that they're trying to do
11 on their own, and it could be hit and miss.
12 Again, it's personality driven, personality driven
13 by commanding officers spouses. If she's involved
14 you're going to have a great family support. If
15 she's not, half of them might fly to their home
16 when that team goes on deployment. So it's hit
17 and miss everywhere you go, and also it's like the
18 weight is on us who aren't really the
19 professionals to come up with our own programs.
20 Sure, the admiral, the CNO will say you're going
21 to have a program, but then you look around and
22 it's us developing it when Navy medical center San

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1 Diego should be a huge resource and respond to the
2 need of the people in the areas, one of the

3 suggestions. Obviously the Navy doesn't speak to
4 the VA. I just retired, I just had to redo
5 everything, x-rays, MRIs, because they can't draw
6 up the ones I just had done three months prior. I
7 mean, we should all get on that. I know maybe
8 that's not as much your -- the board right here,
9 but it would help that transition from guys
10 getting separated due to issues that are mental
11 health. Bam, he's rolling in, you see the SOAP
12 notes -- I know working on CHCS II or that ones at
13 AHLTA -- and I've even heard the VA program is one
14 of the best in DoD, so why doesn't every service
15 use the same one, we all talk.

16 DR. MacDERMID: Sometimes.

17 MR. GRAVES: Sometimes. And that's the
18 other thing too is two years ago when it started
19 we've had several cases of PTSD in our community
20 and several guys are out because of this. And we
21 never knew until they went to the VA and it's just
22 because of relationship building that we did. We

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1 did a collaboration and got some numbers of what
2 they're seeing without doing HIPPA Act, but they
3 were saying, hey, you guys have a problem and we
4 weren't even seeing it. So there is that
5 stigmatization. In the Marine Corps the psychs
6 are called wizards. And they're called wizards

7 because guys go to psych, they think they "poof"
8 they'll disappeared they'll never see them again.
9 So, marketing, get that mid-level group of leaders
10 that have been there, they've fought the good
11 fight in front of the other guys, tell them it's
12 okay. It's part of the Fram oil commercial, you
13 know, pay me now or pay me later. That's about
14 it.

15 DR. MacDERMID: Thank you very much.
16 I'm sure there are questions.

17 COL PEREIRA: You mentioned marketing a
18 couple times. I think that's a wonderful idea
19 especially you mentioned it a relationship or
20 shortly after you mentioned Seals who are a very
21 hard-core group that they're probably among one of
22 the groups whose minds are going to be the hardest

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1 to change about coming forward when they need
2 mental health services. Do you have any
3 particularly ideas in mind about what that
4 marketing would like to reach a group like that?

5 MR. GRAVES: Yeah. That's just what I
6 said. I need to get the guys returning right now
7 that have had Marines die in their arms, that have
8 had sailors die in their arms that understand that
9 peer support. Staying with your unit is very
10 important. We send our wounded out to the TPU or

11 something like that and he's just lost his support
12 group, he's just lost the people he balled with
13 and he's not doing anything. So you have to
14 empower them to feel good, stay with their units,
15 and get those leaders that understand that to get
16 them in an auditorium, get them out and about to
17 talk to these people, the importance of it.
18 That's your -- the people you want to put on
19 display are the guys that have done that, that
20 have earned these silver stars and the bronze
21 stars and the COMs and all that. You need to tap
22 into that, because they understand. Unfortunately

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1 it takes that experience right now to break into
2 that culture. That's one way. I'm working on the
3 spouses because half the time the spouses are
4 going and hopefully they can last through the guy
5 and bring them in. We have stories of whatever --
6 I don't want to say our community or what, but
7 there's women, spouses out there that are scared
8 to leave their husbands alone with their children.
9 Because coming back during that warrior
10 transition. What's their mechanism? They're
11 afraid to call the master chief because the
12 husband is going to really get upset that she's
13 calling and having check upon him. So I'm using
14 the spouses. I really tapped into that resource.

15 And I'm building fires and I'm putting up the Fram
16 oil commercial. A lot of warriors change their
17 oil every 3,000 miles. Why won't you take that
18 step to work on yourself or your relationship?
19 Education, marketing.

20 DR. MacDERMID: Thank you. Are there
21 other questions?

22 LCDR WERBEL: I have one. I was

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1 actually going to follow up on the spouse question
2 but you just addressed that. You clearly have a
3 great insight into what's going on up there with
4 the warriors and the families and the spouses. I
5 was wondering if you figured out any way since
6 with the married service members, we've got those
7 spouses to try and work with, although they are
8 stuck sometimes between a rock and a hard place
9 since their spouses are always telling them don't
10 go to my command and talk to them. What about the
11 single service members? Have you figured out any
12 way to tap into them using someone else? Parents
13 aren't always accessible or buddies. They don't
14 have those spouses.

15 MR. GRAVES: I've only been in it for
16 two months now and my emphasis is the families.
17 But I'm very intimately attached to the active
18 duty members from my previous job. Single guys, I

19 haven't even thought of that, but it will come
20 when you market the E-7 at the platoon chief, the
21 platoon sergeant, you get them up in front of
22 these guys at an auditorium and tell their

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1 experience then it's okay. You have to do theater
2 based -- they're not going to go into a Kumbaya
3 and closed sessions yet, we're not there yet. But
4 in a theater-based presentation some mock
5 scenarios, some mock role playing, those are the
6 ideas I'm working on to get them, interject some
7 humor, and slowly, if we can tear down some of
8 that misconception.

9 DR. MacDERMID: Thank you very much. We
10 appreciate your contribution. Who's next?

11 MR. HEVEZI: I have to go pick up my son
12 from school, but I have "saved rounds," is what
13 they call it in the Marines when you forgot
14 something that you wanted to say, but you didn't
15 say it.

16 DR. MacDERMID: Given the last story
17 that you told, I'm not sure that's the best term,
18 but go ahead.

19 MR. HEVEZI: I think that this panel
20 will encounter a lot of filters along the way. I
21 don't know how long you're going to be doing what
22 you're doing, but there's going to be various

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1 levels of filters. This is kind of like a raw
2 thing where people can speak without filters, so
3 I'm happy to see that, but I'm sad that it took an
4 act of Congress to put you together and put you on
5 the road. Lastly, I'm going to give you three
6 books that I think would be very valuable to your
7 efforts. Those books are, and some of you may
8 have already read these: Generation Kill, by Evan
9 Wright. Another one that I just picked up: Blood
10 Stripes written by a Marine about Marines, written
11 by a Marine infantry rifle company commander. And
12 the third one is not out yet, but will be out
13 November 2nd is: What was asked of us, by Trish
14 Wood. Thank you. Bye.

15 DR. MacDERMID: Thank you. Drive safe.
16 Who's next?

17 MS. ANDERSON: Well, I'm a high school
18 English teacher on disability and I came up with
19 three different lesson plans for you while you
20 were asking for questions. It's Elena Anderson
21 again. One of the things that I think that you
22 need to do is start at the very, very, very

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1 beginning when you're recruiting and enlisting
2 people you need to right then start teaching them
3 that mental health is something that should and
4 can be talked about. For the single guys, they
5 can be matched with volunteer veterans or people
6 who are higher up in their platoon. I might not
7 use all the right military language. It should be
8 mandatory for the enlisted people and their
9 spouses to get some sort of training in what is
10 going to -- you're going to be facing all this
11 stuff and you are going to have feelings about it,
12 and feeling shouldn't be a bad word. Their
13 leaders need to be taught and the culture needs to
14 be changed. That can be done. I mean, I teach
15 high school. Kids say all the time, "Oh, that's
16 so gay." And they mean it to be stupid, and I
17 know is the wrong environment to use this in, but
18 I don't allow that word to be used in my classroom
19 in a derogatory way. So if every time somebody
20 made fun of somebody who had a mental health
21 problem or made a mental health joke, somebody
22 higher up said, you don't do that here. You have

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1 no idea who you're offending. You have no idea
2 who in this room has a mental health problem, or

3 whose family member does, or whose best friend
4 does. You have no idea how much you might be
5 hurting somebody. You can change the culture just
6 by trying. Also there can be support groups, but
7 I think that the people need to be put in to them
8 the way they were, the way I got my group at Sharp
9 Mesa Vista where there was a personal intake
10 meeting conversation for about half an hour with a
11 professional psychiatrist or psychologist, and
12 then they grouped us into groups that made sense.
13 They didn't put me with all the people who were
14 pregnant or had babies, that wouldn't have made
15 any sense. It wouldn't be hard to find the people
16 who need help. You could just go to the
17 commissary and look at how their kids behave and
18 how their kids get, and who's getting yelled at
19 and who's not. Who's being treated with respect
20 and who's not? But I also -- and this is a Navy
21 seals suggestion, one of my friends, said that the
22 mental health care that is available when

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1 everybody returns should be mandatory, because for
2 him at that time there was something he was
3 talking about, and it was a very brief
4 conversation, but that it was -- you could go to
5 these meetings and see some role-playing stuff and
6 do this or practice role playing, which I don't

7 object to and know it's important and it helped me
8 in my Sharp Mesa Vista work. But it wasn't
9 mandatory, and when these guys get back they want
10 to go the bar, they want to see their friends,
11 they're not going to voluntarily spend their time
12 with the military because that's who they've been
13 struck with for all this time. So it needs to be
14 mandatory before and after their tours that they
15 get some training and knowledge that their hearts
16 are part of what they're physically doing.

17 DR. MacDERMID: Thank you. We have
18 about 20 minutes left. I want to make sure that
19 people who have been waiting to speak get a chance
20 to do so. Did you have something just quick that
21 want --

22 MR. GRAVES: I think it's real important

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1 the mandatory training. If you -- it's all about
2 inoculation and living in denial. Before you go
3 into the combat zone the pre-deployment training
4 you need to talk about it and you need to open
5 that we're in a risk business. To be forewarned
6 is to be forearmed. During the deployment is real
7 important for the families. They're worried for
8 the safety of their loved ones. The children are
9 acting out and they have the issues. So it's a
10 three-part phase. Then just prior to the men

11 coming home, or the spouse coming home, they get
12 their readjustment training, how to reunite the
13 love, how to communicate with the children when
14 you come back, but again none of that is
15 mandatory. It's all hit or miss per -- do you
16 have a great chaplain? Do you have a great doc in
17 your unit? Or do you have -- or they're doing it
18 themselves. Where, again, if it was mandated, the
19 DoD program, we have a chance now to take the best
20 practices from everywhere and build the best
21 program for our ladies and men that are out there
22 doing this stuff. We've learned from Vietnam,

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1 Congress is full of people that were feeling
2 guilty for what happened during the Vietnam years.
3 At the same time the Marines have the warrior
4 transition. The Marines do a lot of things right,
5 and for the first 96 hours when they come back
6 they get a couple classes again. The chaplain
7 even speak at how to -- a game plan for love
8 making with your spouse, you know, get your game
9 plan on. Think about that. The communication
10 with your children, the readjustment, because that
11 is the most critical period of the decompression
12 is 14 days when they return. So they all have
13 this mandatory period that they attend maybe four
14 one-hour classes over a ten-day period before

15 they're all allowed to go on the post-deployment
16 vacations that it's mandatory, because those are
17 the times you're going catch some of these things
18 or educate our folks on what's good and help them
19 through that time.

20 DR. MacDERMID: Thank you. Are there
21 others here who have information to share with us?
22 Yes, sir. Can you use the microphone, please?

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1 And clearly state your name.

2 DR. RYAN: Yes. I'm Dr. Ed Ryan from
3 Riverside. I'm a psychologist and I'm here for the
4 second half of the program, but after listening to
5 things that people are saying here; I had a
6 canned, coined kind of presentation, but I would
7 like to speak during this part of it, too, if I
8 could? If there's time to do that?

9 DR. MacDERMID: Sure. Yes. Actually,
10 just hang on one sec. Is there someone else here
11 who's only here for this segment that was still
12 hoping to speak? Then can we ask you to speak
13 first so that we're sure that you get the time
14 that you came for. Thank you very much doctor,
15 sorry to defer.

16 MS. GRAY: My name is Rosanna Gray. I'm
17 a retired naval officer. I was enlisted in the
18 Army. I've been receiving care from DoD or the VA

19 since, I guess, 1978, and I was medically retired
20 for this type of thing, what we're talking about
21 here, mental health. I could go on and on and on,
22 but I wanted to hit on two things while I have the

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1 opportunity and I'll just write the rest to you.
2 One is the role of the chaplain in all of this. I
3 recently had an experience over the last two years
4 with a chaplain who, I guess in a nutshell I would
5 say, although he spends a large percentage of his
6 time doing what he calls "counseling," I felt he
7 was unqualified to do what he was saying that he
8 was qualified to do and that in my relationship
9 with him there was a role reversal and I was the
10 one counseling him. I developed a very strong
11 attachment to him immediately upon meeting him.
12 So our relationship continued. Throughout his
13 deployment I stayed in touch with him. He
14 transferred to the Naval academy now and I'm still
15 in touch with him, but in the process of trying to
16 come to terms with -- know what was going on, I
17 talked to his colleagues, I talked to -- I wrote
18 to his department head, never received a response.
19 I went to his commanding officer. I did all kinds
20 of things in order to address it and nothing
21 happened. So I'm not sure what I'm saying the
22 problem is. It just seems like when it comes to

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1 the chaplains, who I think play such a critical
2 role in things like suicides, sexual assaults,
3 hidden addiction, family problems, et cetera, et
4 cetera, et cetera; some of them, just like we've
5 alluded to are qualified to do what they're doing
6 behind closed doors and some of them may not be,
7 but there's no accountability and there doesn't
8 seem to be -- at least in my experience here, a
9 process for the recipient of care to address that.

10 The other thing that I wanted to say is
11 about availability of care just in a logistic
12 sense because it hasn't been brought up, but
13 you've probably heard about this from other places
14 that you've been. For example, here at the VA you
15 can only get appointments between 7:30 and 4:00,
16 and if you're a substitute teacher like me, you're
17 working during those hours, and you virtually have
18 to take a whole day off to go to the VA for an
19 appointment. If you are on active duty, with my
20 experience, although I've been retired for about
21 13 years this is just something that I think is a
22 recommendation. I know that when I was stationed

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1 twice and went to Pearl for my mental health care,
2 and both times that I was there the clinic hours
3 were arranged so that the staff got Wednesday
4 afternoon off, but then there was one evening a
5 week that they were supposed to work in order to
6 compensate for that afternoon off. But on that
7 evening, they didn't see patients. It would have
8 been so much easier on my life to not have to
9 explain to my chain of command why I was having to
10 go the clinic for my appointments with my
11 psychiatrist or my psychologist and to be able to
12 go those evening appointments when I was working
13 days. Those types of things I think are so
14 helpful. In that particular case they were
15 already -- those hours were already being spent at
16 the clinic, but they weren't given to patients.
17 So I think those types of logistical types of
18 things are also things that can be done to make it
19 easier to get care and to reduce the logistical
20 difficulties sometimes that you go through to try
21 to get to medical, especially for mental health.
22 Thank you.

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1 DR. MacDERMID: Thank you. Does anyone
2 have any questions? Okay. Thank you. Is there

3 anyone else who was hoping to speak in this
4 session? We have about 10 minutes left, doctor.
5 Would you like to go ahead?

6 DR. RYAN: I'd like to take just a few
7 minutes of your time and I wanted to speak to this
8 audience because of things I'm hearing here,
9 because I'm here actually to talk to -- I'm with
10 the Vietnam veterans of America. I'm Dr. Ed Ryan.
11 I'm a psychologist from Riverside. I'm a combat
12 veteran from veteran from Vietnam with the 9th
13 Infantry Division. I have done stress seminars
14 throughout the country, stress in general and
15 PTSD, and traumatic brain injury seminars. And I
16 want to say to these people, that one of the
17 things that I see wherever I go and that includes
18 the medical community and especially includes the
19 medical community, is that they do not know jack
20 about stress. I taught the UC Irvine medical
21 school for six years, and there is not a course on
22 stress at UC Irvine medical school. These people

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1 don't know what stress is and education, patient
2 education is so vital, that you have to know what
3 you're talking about. And part of post traumatic
4 stress disorder is the word stress, and stress is
5 very simple. But they don't teach it and most
6 people don't know it. I did a seminar in Santa

7 Barbara last week and people looked at me like I
8 was being weird. People say I want all the stress
9 out of my life, and I said that is a death wish,
10 because the absence of stress is death, stress is
11 something that happens to make you react, period.
12 It's the other part of the PTSD that people need
13 to understand, study, and educate people about. I
14 got e-mails back out of Santa Barbara of the
15 people that -- Vietnam veterans who are about the
16 same age I am, that had no idea what PTSD was all
17 about. So in this part of the program I wanted to
18 bring that out to people. To get into the
19 literature, get into the knowledge about what PTSD
20 is and it came out of Vietnam veterans of America
21 primarily pushing the issue and that's when it
22 came with DSM-4, and that lays it out precisely

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1 what PTSD is, and it has nothing to do with
2 charging Hill 881 in the middle of the night in
3 your underwear. It has to do with a lot of things
4 that have to do with the military. That various
5 things that happen in the military -- there's been
6 a big controversy over the years about you had to
7 be in country in Vietnam before you could have
8 PTSD, baloney. There's TBI, traumatic brain
9 injury, which is concussions. There's what
10 they're calling now MST, military sexual trauma is

11 what they're calling it now. In the old days, we
12 just called it rape. But there's a lot of places
13 that PTSD comes from and there's a lot of stigma
14 about PTSD that needs to be overcome. And so what
15 I want to say -- I'm going to say more during the
16 second part of the program, but what I wanted to
17 say here before people that may not stay for the
18 second part leave, there's vet centers here in San
19 Diego. I'm out at Riverside. I was part of the
20 first vet center that ever operated out of
21 Riverside. I talked to the people at the vet
22 center in Orange County last week, and they are

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1 very, very, very, very in tuned to treating
2 veterans and families of Iraq and Afghanistan
3 veterans. Let's face the fact, we're a dying a
4 breed, Vietnam veterans, they aren't making any
5 more of us, but they are making more of Iraq and
6 Afghanistan veterans. The best centers are (off
7 mike) over and I know there's a vet center here.
8 I know the people in the vet center here. If
9 you've got problems with people, call the vet
10 center and get involved with education. And with
11 that I'm going to drop it from here. Thank you,
12 ma'am. I appreciate the time to talk to you.

13 DR. MacDERMID: Thank you very much.
14 Anyone else have anything they wish to add at this

15 time? If not, I will turn the microphone over to
16 Colonel Davies --

17 COL DAVIES: One more.

18 MS. ANDERSON: I was hoping for another
19 person. But two suggestions from the Sharp Mesa
20 Vista hospital program were teaching grief,
21 because everybody at some point in their life
22 experiences a loved one or in war situations tons

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1 of people around you whether they're on our side
2 or their side. Teaching how to deal with grief
3 would be a really good idea in that pre-going to
4 war time. Also teaching how to deal with guilt,
5 because I think a lot of the people are coming
6 back feeling guilty for a variety of things that
7 they've had to do that they probably don't need to
8 feel guilty about. So those would be things to
9 add to your lesson plans for the enlisted people.
10 Thank you.

11 DR. MacDERMID: Thank you. Colonel
12 Davies.

13 COL DAVIES: Yes, Dr. MacDermid. We're
14 going to take a 30-minute break and we'll be back
15 here at 3:00, 15:00 and start back again. Thank
16 you.

17 DR. MacDERMID: Thank you all.

18 (Brief recess taken)

19 COL DAVIES: Good afternoon. We're
20 going to go ahead and open the session back again.
21 Dr. MacDermid, turn the program back to you.
22 DR. MacDERMID: Thank you very much,

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1 Colonel Davies. I think there are some of you who
2 were not here at the beginning of the earlier
3 session today. So let me tell you that I am
4 Shelley MacDermid. I am co-chair of the
5 Department of Defense mental health task force.
6 The task force was created by Congress and given
7 the assignment of making recommendations to
8 improve the quality of mental health service
9 deliveries to military members and their families
10 including retirees and veterans. We are obligated
11 to produce a report to be delivered to the
12 Secretary of Defense by May 15th and he then has
13 an opportunity to add his comments before
14 forwarding the report to Congress. We have been
15 traveling around the world trying to talk with
16 military service providers, military members,
17 family members, veterans, anyone who has an
18 interest in this topic who wants to tell us what
19 they think we need to know so that we can make
20 recommendations that meet the needs of the people
21 that we all care very much about and want to
22 serve. This session this afternoon was intended

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1 to provide an opportunity for military service
2 organizations and veteran service organizations to
3 tell us what they would like us to know and what
4 the concerns of their members are. We are happy
5 to learn from you. So unless there -- is there
6 anything that anyone wishes to add, I will open
7 the microphones. I know some of you have had an
8 opportunity to speak already, but if there are --
9 sir, I know you had planned to speak this
10 afternoon already. So if you'd like to lead us
11 off, feel free or not.

12 DR. RYAN: Good afternoon. I used to be
13 shy, but I'm not anymore, so I'll talk first.
14 Thank you very much, first of all for all the
15 people in this room who have served and are
16 serving. I'm Dr. Ed Ryan. I'm a clinical
17 psychologist, practice in Riverside, California.
18 I served with the 9th Infantry Division in
19 Vietnam, 1967, '68. I'm combat wounded, so I know
20 a little bit about where I'm coming from. I've
21 worked with PTSD for many, many years. I
22 currently sit on the national board of the PTSD

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1 committee of the Vietnam veterans of America. I
2 chaired that committee at the state level for a
3 number of years here in California and have done
4 seminars as late as last week on PTSD to veteran
5 communities and to other communities. I was asked
6 by the national board to come down and talk with
7 you people for a few minutes and they said just
8 make it a few minutes. So we'll make sure that I
9 give -- I gave the whole piece that I'm talking
10 about to the secretaries here because there's no
11 way -- I can't stand up and read this things.
12 There's issues that I want to talk about and
13 address to this committee. PTSD in and of itself
14 is something that's been around for ages. It came
15 into the psychiatric community as a result of
16 Vietnam and the efforts of people after Vietnam to
17 have it recognized as a quote, unquote, mental
18 illness. What happens when you do that, when you
19 classify it a mental illness it adds a stigma to
20 it that people don't want to admit they have it.
21 I don't have it. This is a stumbling block for
22 people today and I believe you're going to see a

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1 lot more PTSD out of Iraq and Afghanistan than you
2 did out of Vietnam, Korea, World War II, for

3 various reasons, because each war, even though
4 they have some things in common, they are very
5 different. The numbers we're seeing coming out of
6 Iraq are much higher, or relatively, so to speak,
7 higher than they were coming out of Vietnam. And
8 after Vietnam, quite a number of years after
9 Vietnam, they started the vet centers, which has
10 been a real boon to veterans, because we're macho-
11 comacho people. We're told to not admit anything
12 is wrong. We're kind of like junkyard dogs.
13 We're put out at night to run around and patrol
14 the perimeter and scare the hell out of anything
15 or kill anything that comes in our area, and then
16 we're brought in the morning and fed a little bit,
17 and if we do what you're told they smack you over
18 the head with a newspaper. So people don't like
19 to come up and admit -- and this is a macho-
20 comacho thing, it has to do with men and women,
21 that we don't like to admit that there's something
22 that we can't handle. This is a big -- this was a

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1 big issue with Vietnam vets, is that you could not
2 admit to somebody that you are having whatever
3 unless you had some camaraderie. This is the old
4 band of brother's thing. This is part of the
5 thing that has to come out of, I believe, through
6 DoD and VA is that -- I heard it hear this

7 afternoon in a number of places that the people,
8 the psychiatrists, psychologists, social workers,
9 various staff members just looked at them like
10 they were crazy and didn't have any kind of
11 understanding. This is one of the things that I
12 believe that the task force and this thing has to
13 do is to put in people in the VA and DoD that has
14 some concept of what PTSD is, and also TBI, which
15 I'll get to in a minute. But people have to
16 understand that. I used to work for the VA here
17 in San Diego and there was a man in adjudication
18 who was very severely burned, very disfigured and
19 he told me to my face that PTSD does not exist.
20 If that's not denial I don't know what is. It has
21 to brought to the attention of people that an
22 education of what PTSD is as opposed to what

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1 everybody might think it might be is important.
2 And that gets down and study it, and that gets
3 down to patient education. The first line of
4 DSM-4 with PTSD is that the reaction to -- and I'm
5 paraphrasing, I'm not reading exactly, but it's
6 the normal reaction to an abnormal stress. It
7 doesn't mean the person that's feeling the
8 reaction is abnormal and that's the stigma that we
9 deal with. So starting with the education process
10 of it and getting the word out to people. We're

11 developing, through the VA; we're developing a
12 series of DVDs that we can put all over the
13 country that covers the various aspects of PTSD.
14 Education is one of the first points.

15 Moving on to TBI --

16 DR. MacDERMID: Sir, I'm sorry. I'm
17 sorry, but can I interrupt you just for a sec
18 while you're right on that topic? I guess I have
19 two questions. One is: When you talk about
20 education and you want people to have more
21 education, could you give us a little more
22 specific idea about that? For example, are you

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1 talking about medical school training? Are you
2 talking about training for new inductees, military
3 leaders, all of the above? What is your thought
4 about that?

5 DR. RYAN: Yes, ma'am. What I've found
6 professionally is that people don't understand,
7 number one, what stress is. And there's only --
8 the three phases of stress is really very simple
9 and that can be put out -- and that's what we're
10 doing with VVA now, we're putting a seminar out on
11 DVD that can be taken or put on the internet, it
12 will be on our website and people can go in there
13 and they can click on and see 10 minutes of an
14 explanation of what stress is. Then click on

15 another site and look and see what an explanation
16 of PTSD is. I found as late as last week I was up
17 in Santa Barbara talking to a group of people and
18 they have not a clue. These were people who were
19 combat veterans. They had not a clue, because
20 nobody's ever taught -- and I got comments after
21 that, nobody's ever talked to me about that.
22 Nobody's ever explained that to me. We put it out

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1 in various fliers, but that doesn't seem to go
2 very far, as far as they fly, but word of mouth,
3 going through the internet now we can move that
4 stuff. We can start advising people, we can put
5 fliers in the offices of the VFW, DAV, VI, DoD,
6 Marine Corps, everywhere so that there's more
7 access to this information so the people know what
8 they're talking about, and people can access that
9 in the privacy of their own home so they don't
10 have to admit. You know, what are you looking at?
11 You're looking at PTSD? So it makes -- the idea
12 is to make it more accessible to more people,
13 easier.

14 DR. MacDERMID: Thank you. And I
15 interrupted you just as --

16 DR. RYAN: I hope that answered your
17 question.

18 DR. MacDERMID: You did. You were just

19 going on to talk about TBI.

20 DR. RYAN: TBI. For some reason that
21 seems to be a new term to people traumatic brain
22 injury. All of a sudden it's clicking up over the

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1 appropriations committee when they cut the budget
2 on the TBI institutes, the seven centers that are
3 studying TBI, all of a sudden there's a big clamor
4 about it. But TBI has been a factor, and there's
5 a saying it's the classic injury in Iraq.
6 Basically what we're talking about is concussion.
7 We use concussion grenades, you know, anybody
8 that's been in the military has been around
9 concussion, been around a lot of fire. Anybody
10 that's been in the military any length of time has
11 got some hearing loss, that's TBI. But it's
12 subtle kinds of stuff that changes very subtly the
13 way a person thinks and the way they perceive
14 things. Again, this is a hidden thing because
15 people don't want to admit that they don't quite
16 hear as well as they used to, they don't quite
17 process information quite as fast as they used to,
18 they're making mistakes, they're forgetting
19 things. This is brain injury, and it ties
20 together with PTSD. It's not PTSD, but it ties
21 together with PTSD because it starts working on a
22 persons self image and self confidence that

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1 they're not as sharp as they used to be. You know
2 my doctor told me it was just because I was
3 getting old. But it could be, it could be not.
4 But I think this is an area too where, number one,
5 we need to continue to put funding into brain
6 injury research. And brain injury research is
7 really only in the last five years started to take
8 hold, and research into brain injury is still in
9 it's infancy in spite of the fact that we've been
10 studying strokes and heart attacks and things like
11 that for years. We haven't really studied the
12 affects of trauma, the affects of concussions and
13 those kinds of things that we're seeing a lot of
14 coming out of Iraq. So I wanted to bring that
15 point up as to emphasize that we need to study
16 this, we need to learn it, we need to put more
17 money into, into neurology. I've studied just
18 enough neurology to be dangerous with it. I don't
19 know because it's a very complicated field and
20 very little is really known about it, but there
21 are things coming up in this world that give us
22 tools to track this and also relate that to PTSD

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1 and other mental situations because basically a
2 person who's got some brain injury doesn't want to
3 admit that they're not as sharp as they used to
4 be, so they shut up, they don't say anything about
5 it. So it's being missed in a lot of the
6 physicals that are coming up. This is the same
7 thing with PTSD. I don't know how true it is, but
8 I've heard that four or five years ago there was a
9 manual, a procedure set up that was designed to be
10 used by the VA for their psychiatrist to screen
11 for PTSD and the VA has never used it. This is a
12 step-by-step process of the questions that need to
13 be asked, the concerns that need to be addressed,
14 and I'm told across the country from VA people
15 that they don't know what I'm talking about. And
16 I give an example of this, it was about six months
17 ago I was approached by a CMH recipient, he
18 fought, he wore three CABs, World War II, Korea
19 and Vietnam. He wore four silver stars, he wore
20 five purple hearts. He applied for PTSD, got a
21 10-minute interview and was turned down. Why?
22 Because the person who did that evaluation did not

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1 ask him anything and did not listen to him. So
2 that is a concern that the VA use the information

3 they have and the tools that they have to
4 determine whether or not a person has PTSD and to
5 what extent. I would say just about everybody's
6 been in combat or been in every traumatic
7 situation has PTSD, but that doesn't mean they're
8 disabled. They're two different issues. You can
9 have diabetes and not be disabled; you can have
10 PTSD and not be disabled. They're two different
11 issues. How disabled are they? What I'm seeing
12 and hearing from veterans is that that process
13 needs to be fine tuned and paid attention to. The
14 other issue that I wanted to bring up was a factor
15 that PTSD does not have to be a result of combat.
16 The majority of PTSD that I've seen in my practice
17 has to do with child abuse, has to do with
18 domestic violence, had to do with the kind of
19 idiot I was when I came back from Vietnam. PTSD
20 goes in various other places and we need to
21 address those issues in wives and children and
22 family members. And we also have to address the

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1 issue, I believe that PTSD does not only come from
2 combat there are many occupations within the
3 military that deal with trauma. The most recent
4 one that I saw was in the L. A. Times recently
5 where the people from Dover, Maryland. These are
6 clerks in a warehouse and what they do is they

7 catalog the remains, the physical remains of
8 people killed in action, but they get to see --
9 they get the wallet, they get the pictures, they
10 get the dirty clothes, they get everything,
11 because packed up -- your foot locker is packed up
12 and sent home when somebody is killed. So I'm
13 hearing things out of those people that the
14 emotional trauma of day after day after day seeing
15 the last pieces and deciding which pieces go back
16 to the family and sorting that stuff out. So
17 there's a -- I think there needs to be a
18 realization that PTSD is not just John Wayne going
19 up a hill, that it's -- comes from a lot of other
20 places and we need to address all of those issues,
21 we need to address that stuff in wives and
22 children, sons and daughters in touch is another

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1 example of an organization that's doing a lot in
2 this process. Sons and Daughters in touch are an
3 organization of people whose fathers were killed
4 in Vietnam. They're doing a lot of things, and
5 they need to be supported also in the process of
6 that. So what I'm trying to say is that there are
7 a wide variety of things out here or resources out
8 here for people. If we get the word out, start
9 out with education within the DoD and VA and
10 within the military services and just keep

11 reaching out and reaching out to our brothers.
12 Thank you.

13 DR. MacDERMID: Thank you, sir. Does
14 anyone have questions?

15 COL PEREIRA: This is a pretty specific
16 question, so if you're not able to answer it fully
17 now, then I'd be interested and maybe you could
18 send us some information. I'd like to know if you
19 can tell us what you think are the -- actually,
20 not what you think, but what are the top three
21 issues related to mental health that you're
22 hearing from your members.

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1 DR. RYAN: The top three issues. Not
2 necessarily in the order of importance. One is
3 the issue of stigma, especially now with the
4 veterans of today, because the veterans of today
5 are the people who signed up, they were not
6 draftees. They signed up to be macho-comacho or
7 to get some college money. So there's a different
8 mind set there, and they don't want to come back
9 and be seen as being weak. This is a whole
10 concept with mental illness as people see you --
11 if you have some kind of mental illness you're
12 seen as being weak in some way. What I've seen in
13 my lifetime is there are a lot of people who look
14 like they're strong, but they've never been

15 tested. You push somebody to the limits, they'll
16 break, but people don't want to admit that. That
17 was one of my fears when I went into the military,
18 that if I went off to war that if I didn't come
19 out, whatever, then that was some sign of
20 weakness. So the first piece is internal that
21 they don't want to see themselves as being weak.

22 Another process that I'm hearing is the

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1 challenging by people of PTSD. There was a big
2 furor within the last year about the VA going back
3 and reviewing old claims to see if they really
4 were PTSD. The big furor about somebody sitting
5 back in some office somewhere would know -- and
6 these were combat veterans, no combat experience,
7 somebody sitting on a panel and saying -- looking
8 at the paper and say well this guy is really not
9 disabled. This guy didn't produce enough
10 information to say he's disabled. Big furor over
11 that. That basically boils down to being judged
12 by somebody who has never walked in your shoes.
13 And in my experience, that's a big deal. I
14 noticed along the wall here, people have a wide
15 variety of military experience, but I don't see a
16 CAB up there, and that doesn't mean anything
17 except there's not CAB up there. And when it
18 comes down to certain things, when I see a CAB I

19 look at a brother and I know that he knows
20 something about what I went through. That doesn't
21 mean that other people who don't wear it don't,
22 it's just a camaraderie thing and this is just

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1 part of the human factor. That people look at
2 that, that somebody's judging me that doesn't know
3 where I've been.

4 COL PEREIRA: Sir, this is a combat
5 action badge? That's two combat tours.

6 DR. RYAN: Yeah. Combat -- okay. CAB,
7 thank you, ma'am. I appreciate it. I salute you.
8 But I'm just responding to your question. Not
9 from my point of view, from what I'm hearing from
10 other people. They don't want somebody judging
11 them that haven't been there. And I recognize the
12 uniforms up there, there's a lot of service on
13 that board and I salute that. I'm not disparaging
14 any of that. I respect it. But I'm just saying
15 other people don't.

16 The third thing. The third thing is an
17 attitude that people are malingering with PTSD to
18 gain money. Now, if you look at the VA records,
19 the money for 100 percent VA is somewhere around
20 \$2,000 a month. I don't know the exact figure,
21 but it's somewhere around \$2,000 a month. That's
22 welfare level in California. It makes people

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1 angry to say you're malingering to be on welfare.
2 Now, if you're making no money, \$2,000 a month is
3 a lot of money. But these -- we're not talking
4 about entitlement. When I worked with the VA I
5 heard all these things about entitlement,
6 entitlement, entitlement, entitlement. This stuff
7 is something that these people have earned, just
8 like you earn that CAB, you weren't given that,
9 you earned it with your blood, sweat and tears,
10 and nobody can take it away from you. These
11 people -- there's an attitude within the
12 government, VA, DoD that these people are trying
13 to get something for nothing. They're not getting
14 something for nothing. Every one of these people
15 served just like everybody around me has served.
16 You've earned, it's not entitlement, it's not
17 something for nothing. So that would be the third
18 thing that I'm seeing out there. You be proud of
19 wearing that ma'am. I'm sure you are.

20 COL PEREIRA: Thank you so much.

21 DR. MacDERMID: It's a hard one. I
22 know. I actually have a -- if no one else has a

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1 question they'd like to ask you about your
2 organization. I actually have a question to ask
3 you as someone in private practice. Would that be
4 okay?

5 DR. RYAN: I make my living in private
6 practice.

7 DR. MacDERMID: Yes. So my question is:
8 Are you a TRICARE provider?

9 DR. RYAN: A contract provider? No.
10 I'm forensic. The last ten years I've been
11 forensic. I'm not a contract provider, but I have
12 -- over the years in the past years I have worked
13 in various capacities, provided services, but I've
14 never been a contract provider to VA.

15 DR. MacDERMID: Thank you.

16 DR. RYAN: Any other questions or
17 comments?

18 DR. MacDERMID: Thank you, sir.

19 MR. POTTER: Mark Potter of VFW. One of
20 the main things we're hearing is the accessibility
21 to care for the veteran, because when you get
22 discharged from the military -- I don't know if

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1 anybody's been through a CMP exam. A lot of folks
2 they poke and prod you, they go through a manual

3 see if your knee hurts. They bend you. But the
4 PTSD section, I know folks have been through it,
5 it's like 10 minutes. The social worker or the
6 psychiatrist this person is PTSD, but it's up to
7 the person reviewing the claim, and usually that
8 person really has the medical background. If
9 you've ever been to a regional office of the VA
10 they're backlogged nationwide about half a million
11 records in claims. About 250,000, 300,000 are
12 medical claims. So if they're going through them
13 and by their own admission 11 percent of the time
14 they're wrong especially for PTSD, because you
15 have just have a 10-minute session, and, bam,
16 either you're okay or you're not. I mean, that's
17 one of the problems, and seamless transition,
18 people think they can go to the VA anytime they
19 want and they put in there for two years it's
20 priority group 6 if you know anything about the
21 VA, and it's basically two sessions, the beginning
22 and the end. And you're not seen every week or

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1 every other week or when you want to be seen,
2 dealing a lot with the reservists who are
3 demobilized and bam we're in the VA system; it's
4 not that seamless. I know they're working on it,
5 but they're only seen about twice. This
6 gentleman's talking about decelerating from combat

7 and Colonel you know you've been to Iraq, I've
8 been to Iraq, it's basically like you're in an
9 Indy race and all of sudden they put in a Hyundai
10 when you get back. You're used to the speed, it's
11 an analogy I use, and when you come back here it's
12 kind of anticlimactic. I mean, when I left 1st
13 Marine Division I transferred and even my
14 battalion surgeon goes that's pretty anticlimactic
15 come back (off mike) hop in your car and drive
16 across country to another duty station. But one
17 of the things is accessibility to care post DoD
18 when they're out of the service. A lot of the
19 things we run across DoD say, hey, (off mike) will
20 take care of you the rest of your life, but people
21 don't realize VA and DoD are two separate entities
22 and we heard that from the Vietnam vets, they

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1 promise to take care of us. Well, they lied (off
2 mike) change legislation, because what DoD says
3 and what VA says are two different things and
4 people think they're one in the same and we tell
5 them they're not to determine compensation.

6 DR. MacDERMID: Thank you.
7 DR. RYAN: Are there any questions or
8 comments. I could talk for four days, but I'm not
9 going to. I'm not here to do that.

10 DR. MacDERMID: Any other questions?

11 Thank you very much, sir. We appreciate you
12 talking the time and trouble to share information
13 with us.

14 DR. RYAN: Thank you very much. I
15 appreciate the opportunity and glad to meet all
16 you folks. Again, thank you for your service
17 across the board.

18 DR. MacDERMID: We're grateful. Is
19 there anyone else that wishes to add any
20 information at this time? If not, I think what we
21 will do, if Colonel Davies says this is okay, the
22 task force members will adjourn to an executive

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1 session in a room across the hall, but we'll ask
2 the staff to remain here and if someone comes in
3 the next hour and a half or so who wishes to speak
4 with us, we will reconvene. Is that acceptable?

5 COL DAVIES: Dr. MacDermid, I think
6 that's acceptable. Let me ask one more time
7 before we close this formal session, is there
8 anybody else at this particular time that would
9 like to speak to the task force?

10 MS. GRAY: I just wanted to ask how
11 you're going to publicize the results of your work
12 and how things are going to go on after May 15th.

13 DR. MacDERMID: Sure. I'm not exactly
14 sure of the answer, but I know some pieces. First

15 of all, I believe that this will be a public
16 document. This is a public committee, we've had
17 public meetings, it's a report that needs to be
18 delivered to the Secretary of Defense and then to
19 Congress. So my assumption is, but I haven't
20 fully tested it, my assumption is that it will be
21 available on the web and that you'll be able to
22 read everything that the Secretary of Defense gets

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1 and probably his comments on the way to Congress.
2 We met yesterday morning with Senator Boxer. She
3 expressed her intention to make sure that when the
4 report comes it's widely disseminated and widely
5 publicized. I suspect that promise was slightly
6 contingent on how she feels about what the task
7 force recommends, but I can't speak for her. I
8 would also assume that there may be notification
9 on the AFEB website, the Armed Forces
10 Epidemiological Board website that the report has
11 been delivered or is somewhere in the pipeline
12 between AFEB and Secretary Rumsfeld and Congress,
13 because we operate as a sub-committee of the Armed
14 Forces Epidemiological Board. So those are my
15 guesses about what's going to happen. I don't
16 know if anybody -- does anybody know something
17 that I don't. Did I miss something?

18 COL DAVIES: I think that's a fair

19 characterization.

20 MS. NORRIS: Hi. I'm Ann Norris. I'm
21 with Senator Boxers' staff. The way that these
22 have worked in the past and when we wrote the

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1 legislation we intended for it to work the same
2 way with task forces. The report will definitely
3 be public. Senator Boxer will absolutely want it
4 to be widely disseminated regardless of what it
5 ends up saying.

6 DR. MacDERMID: That's wonderful to
7 hear. I don't mean to cast dispersion.

8 MS. NORRIS: I mean, I think she -- and
9 that's why we did this in this very public manner.
10 So it will seemingly -- when they're presented to
11 the Congress and in the past hard copies -- I'm
12 referring to the task force on sexual assault
13 which is something we modeled this after. Hard
14 copies were available, online copies were
15 available, and so we'll do everything that we can.
16 I imagine we'll put it up on our website, the
17 Senator's official federal website at some point,
18 and they've been available on DoD's website in the
19 past. I'm Ann Norris by the way with Senator
20 Boxer's staff and I'm her contact for all of this
21 so if you have any questions, I'll talk to you
22 afterwards.

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1 DR. MacDERMID: Thank you very much for
2 speaking up. I should add that I've had several
3 people comment to me that it was very inspiring is
4 the right word to hear Senators Boxer's
5 encouragement yesterday to us, not to let
6 ourselves be drawn into the predicting the
7 politics of what our recommendations might mean.
8 She really pushed us to think big, to not allow
9 ourselves to be limited too much by what we
10 thought might be doable or not doable, but our job
11 really was to tell her and tell the American
12 people what we think, the best possible mental
13 health care system in the military will be. And
14 her passion was palpable. It was an inspiring
15 message and it's inspiring to think that people
16 care so much about the work that we've been asked
17 to do and I know that we all care about it very
18 much as well. Definitely get her e-mail and nag
19 her. It doesn't sound like you're going to have
20 to nag very hard, but you've got a pipeline to the
21 information you need.

22 MS. GRAY: I was thinking I want to see

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1 you all on CSPAN too.

2 DR. MacDERMID: Maybe ABC would be
3 better. That's a joke.

4 MS. GRAY: It's on record now.

5 DR. MacDERMID: We hear you, and we'll
6 do the media negotiations later.

7 COL DAVIES: One more time before we
8 close this official open session of the DoD mental
9 health task force, I ask if there's anybody -- and
10 it looks like somebody would. Please step
11 forward.

12 LCDR COUGHLIN: Good afternoon. I'm
13 Lieutenant Commander Kelly Coughlin, U.S. Coast
14 Guard. Coast Guard gets a lot of their services
15 from the DoD. I was just in the area as a
16 student, a grad student at the Army Baylor
17 program, my second year interning for health care
18 administration. Last year, as we went through our
19 academics, we didn't touch about how as
20 administrators to provide mental health on a
21 higher level. We were bean counting, and learning
22 the finances and stuff like that. We did have a

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1 mental health symposium on Katrina, which was more
2 community based, but we never really touched on

3 mental health in the medical. Right now I'm
4 interning at TRICARE South in San Antonio, and
5 once again I know there's a problem with getting
6 network providers or getting it out there for that
7 and I think it is very important as this gentleman
8 over here said that it's -- through my research
9 for some of my papers I have to do right now, it's
10 to associate that provider that has the experience
11 with that. So somehow as MIFs are optimizing
12 where that mental health is and the optimization,
13 I haven't heard that mentioned anywhere to date,
14 yet, to bringing those services into the MIFs and
15 making them available during the off hours which
16 would be great and releasing that stigma. And
17 also as an operational person, I have been to
18 Persian gulf also in prior Army experience. So I
19 have some idea that's been difficult to even in
20 the field getting people to seek the help, getting
21 the command to support even when a doctor has said
22 that person needs inpatient treatment and they

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1 would deny that person and get them underway on a
2 cutter to follow that up eight days with an
3 emergency med evac in the middle of the Pacific
4 ocean to Wake Island where this person could have
5 dealt with some of their issues on their own time,
6 now 180 people of the ships crew knew about it,

7 and then to come back a couple months later and
8 for that person to try to commit suicide. So
9 there's a whole bunch of levels of getting the
10 information out to the command levels to not
11 stigmatize to actual understand when there's a
12 diagnosis, to get the treatment out there with
13 qualified providers and to get the health care
14 administrators to be thinking about how that fits
15 in the whole scheme things. Because holistically
16 if we help with the mental health then it should
17 all improve from there. So it actually does help
18 bean counting, but to get that message across.
19 Thank you.

20 DR. MacDERMID: Thank you.

21 COL DAVIES: We'll go ahead and say it
22 one more time, because we had a gentleman that

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1 just walked in. We are going to go ahead and
2 close this session unless somebody has something
3 that they would like to share with the task force
4 at this particular time. We will leave it open
5 for the possibility should someone desire to share
6 with the task force until 17:00. The task force
7 will reconvene in the room right across the hall,
8 I'll remain here until 17:00 and at that time we
9 will be closed and I will come and get the task
10 force if there is anybody else that shows up. So

11 without any further ado, this session is closed.
12 Have a great Army day, navy Day, VA Day, Civilian
13 day.

14 (Whereupon, the PROCEEDINGS were
15 adjourned.)

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