

THE DEPARTMENT OF DEFENSE

TASK FORCE ON MENTAL HEALTH CARE

A subcommittee of the Defense Health Board

San Antonio, Texas

Monday, April 16, 2007

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1 P R O C E E D I N G S

2 VADM ARTHUR: Welcome all to this final
3 meeting of the Department of Defense Task Force on
4 Mental Health. Much has been accomplished over
5 the past year.

6 And our purpose here today is first
7 invite the public to witness the task force
8 deliberation on the elements, specifically
9 identified by Congress.

10 And second, later this afternoon, the
11 public has been invited to provide the task force
12 with some testimony.

13 Ms. Embrey the designated federal
14 official for the task force and our parent board
15 the Defense Health Board is here today with us.
16 Ms. Embrey, will you please call the meeting to
17 order.

18 MS. EMBREY: I'd be happy to Admiral
19 Arthur. As the designated federal official for
20 the Defense Health Board, a federal advisory
21 committee to the Secretary of Defense, which
22 serves as a continuing scientific advisory body to

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1 the assistant Secretary of Defense for Health
2 Affairs and the Surgeons General of the military
3 departments, I hereby call this meeting to order,
4 this meeting of the Department of Defense Task
5 Force on Mental Health which is a Defense Health
6 Board subcommittee, to order.

7 VADM ARTHUR: Thank you, Ms. Embrey.
8 Good morning. We are the Department of Defense
9 Task Force on Mental Health and thank you for
10 taking the time out of your schedules to be here.
11 Let us introduce ourselves to you.

12 (INTRODUCTIONS)

13 VADM ARTHUR: This is my first meeting.
14 I took over the co-chair from General Kevin Kiley,
15 the surgeon general of the Army, just two weeks
16 ago. I will be following Dr. MacDermid's lead
17 since she has been on all of the other meetings

18 and knows more about how the meeting should go.
19 But I see very few people in the audience, so just
20 for our familiarization, would you mind
21 introducing yourselves, so we know who you are?

22 (INTRODUCTIONS)

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1 VADM ARTHUR: This Congressionally-
2 mandated task force was asked to look into the
3 current military mental health system. The task
4 force was initially stood up in May 2006 and since
5 then has worked diligently to gather as much data
6 as possible in order to have a comprehensive
7 picture of the military's mental health system and
8 knowledge of what constitutes psychological help
9 for our soldiers and their families.

10 Today we are here to publicly deliberate
11 on our findings as they relate to the initial
12 elements handed to us by Congress. Before we get
13 started, Dr. Thomas Burke is the task force
14 executive secretary. Do you have any
15 administrative remarks for us Tom?

16 DR. BURKE: Yes, Admiral. Yes. Thank
17 you, Admiral Arthur. Good morning everyone and
18 welcome. For all attendees, if you would please
19 be sure to sign in on the appropriate list on the
20 table just outside the front door. Restrooms are
21 located outside the main door, down and to the
22 left. For any telephone messages or any other

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1 administrative needs, please see Ms. Di edre
2 Farrell our staff assistant standing in the back
3 of the room. This morning's session is meant to
4 be deliberative between the members of the task
5 force. Even though it is just for the members of
6 the task force this morning, the session is being
7 transcribed, so would everybody please state their
8 name and speak clearly into the microphones.
9 Later on this afternoon, the task force has set
10 aside time for public testimony and there you will
11 have an opportunity to share your thoughts and
12 comments. And also please be aware that that
13 session will be transcribed as well, so please
14 state your name clearly into the microphone.
15 Thank you very much. Thank you, Admiral Arthur.
16 VADM ARTHUR: You're welcome. Thank
17 you, Tom. Let me turn the meeting over to Dr.
18 MacDermid.
19 DR. MACDERMID: Thank you, and welcome
20 everybody. We have two deliberative sessions
21 today and each has a different focus. This
22 morning we're going to focus on the site visits

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1 made by members of the task force. As you may be
2 aware, task force members visited 38 military
3 installations between approximately September 2006
4 and February 2007.

5 Each task force visit had a similar
6 profile or set of goals. Our goal was to meet
7 with family members, with service members, with
8 service providers, with leadership and also with
9 community mental health providers to try to get a
10 picture of the full mental health landscape at
11 each installation.

12 We had a standardized list of questions
13 that we tried to pursue in each place. We also
14 tried to be flexible to adapt that list as
15 circumstances arose. For example, at some sites
16 we were able to have more time, for example, with
17 chaplains. So we would have more detailed
18 conversations with chaplains.

19 Colonel Dave Orman, his full-time job
20 was task force visits for six months and we're
21 grateful to him and his work for doing that.
22 Deidre Farrell was our support staff member on all

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1 those visits and then task force members were
2 delegates of the task force to visit as schedules
3 and travel itineraries permitted. The visits
4 included locations around the globe, including

5 Europe and Asia.

6 What we'll do this morning is benefit
7 from the work of Colonel Douglas who has conducted
8 an analysis of the after-action report completed
9 after every site visit to identify common themes.
10 So he will be identifying the common themes that
11 he observed in the after-action reports and that
12 will provide an opportunity then for others on the
13 task force to add information that they recall
14 from after-action reports that they wrote or have
15 read. And that will help us to make sure that we
16 are accurately representing the site visits in our
17 discussions.

18 One comment is that -- on thing you need
19 to know is that the task force made a decision,
20 very early on, that our job was to talk about
21 issues at the level of the system. And we made a
22 decision would be nonattributonal and we gave

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1 that assurance at all of our site visits so that
2 people would feel free to talk freely with us. So
3 you will not today hear us saying, "At this
4 installation we saw this and at this installation
5 we saw that." It's a trade-off obviously between
6 allowing those people to feel comfortable talking
7 with us and the specificity of information we can
8 share with you today. So, as I said, Colonel
9 Douglas will be talking about common themes and

10 then task force members will deliberate to make
11 sure that we have that analysis correct.

12 Is there anything anybody wants to add?
13 Did I miss anything? Okay. Well, let me turn it
14 over then.

15 LCOL DOUGLAS: Is everybody -- for your
16 benefit; as we went to each site visit, the areas
17 we tend to look in and questions we asked were,
18 access to care, Tri-service coordination, stigmas
19 and barriers to care, resources and efficiencies,
20 policy, recruitment retention, training and
21 prevention, factors increasing stress and any
22 additional issues that weren't covered under those

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1 major topics.

2 To start off -- looking at access to
3 care, if my computer will cooperate. We'll start
4 with tri-service coordination. What happens most,
5 we've seen at the installation in terms of tri-
6 service coordination -- we're discussing with that
7 is on some installations we have multiple-service
8 entities; Air Force, Navy, Marine Corps sharing
9 information or not sharing information in terms of
10 coordinating the services.

11 What see from -- at most of the site
12 visits are resistance by services who are
13 stationed in the same locale to share services or
14 don't do a very good job coordinating services

15 where some have more than others. That's
16 definitely, in some instances, Asia in particular
17 where there is no other option that we could do
18 better. For instance in the remote bases where
19 you have multiple entities within 20 or 30 miles,
20 even though distance is challenging for some the
21 only other option would be to share resources to
22 coordinate with a sister-service facility or

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1 installations within that 20 miles where you see a
2 shortage. We don't do a good job there.

3 Additionally, in that tri-service
4 coordination, there are some services -- this will
5 be one of the recurring themes is access for
6 children services, where one installation within a
7 geographical area where they could do a better job
8 of tri-service coordination has some level of
9 children services whereas the other may not. Even
10 though it's limited, it's an option. Does anybody
11 recall during their site visits any other major
12 issues in terms of tri-service coordination that
13 they'd like to bring up.

14 DR. MacDERMID: Just a clarification
15 question. For those of you who did site visits
16 overseas, did you feel that there was a pattern
17 with this finding that it was particularly
18 problematic overseas or less so overseas than for
19 remote CONUS locations? Is there any sort of

20 geographic pattern in what you saw?

21 COL PEREIRA: I think that is a pattern
22 overall. But I think that it becomes more

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1 apparent in the overseas locations. It became
2 much more apparent and I think that's because of
3 the reduced number of resources in the overseas
4 locations. The same problem exists in CONUS but
5 because there are so many different resources,
6 especially civilian resources that could make up
7 for the lack of coordination, I think it wasn't as
8 much of a problem as it was, but it became -- it
9 was glaring, glaring overseas, both sides, both
10 European and Asian side, glaring and not so much
11 so in CONUS. But the problem is still there.

12 DR. McCORMICK: Let me just -- I think
13 we need to underscore one of the pieces of this
14 and that is that when you're talking about
15 different entities providing parts of a continuum
16 of care, it's critical that they have similar
17 business practices and that can be anything from
18 what they see as their slice, their wedge of the
19 total pie. It can have to do with the hours of
20 operation of the element they're providing. And
21 those business practices have to mesh. One of the
22 things that we clearly saw was that they didn't

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1 always have similar business practices which meant
2 that the user of the services who had to rely on a
3 tri- service continuum of care could get caught in
4 cracks that were created by the fact that the
5 business practices of the Navy or Air Force or
6 Army component of the continuum of care didn't
7 mesh together well enough.

8 LCOL CAMPISE: It's also startling the
9 lack of coordination and collaboration across the
10 different services in geographic locations where
11 they were similar bases, virtually next door to
12 each other. It was especially highlighted, as
13 Angela mentioned, overseas because you'd go to a
14 site visit where the installation would talk about
15 their feeling about isolation and their feeling
16 that there are very few services outside the gate.
17 And when you mention to them, well, have you
18 coordinated with the base that's five miles down
19 the road from a different service? And they'd
20 say, well, no, we haven't. So I think it
21 highlighted the importance that we really need to
22 be tri- service approach providing services with

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1 everybody communicating and collaborating.

2 COL ORMAN: I think one of the related
3 issues, though, that sort of undergirds (off mike)
4 both Dick's point and Rick's and Angela's point is
5 there's really no identified leadership for
6 behavioral health geographically. So if you look
7 at any particular region, whether it's CONUS or
8 overseas, I was always struck by the fact that not
9 only were people not talking, in some ways it
10 wasn't clear who was responsible for delivering
11 care outside the gates themselves, and hence as a
12 consequence I think you had all these other second
13 and third order affects where people wouldn't
14 talk, where they wouldn't share information, where
15 there was almost a parochialness about we have
16 limited assets and we're only going to use them on
17 our population inside our gates. And those are
18 something that I don't think were intended, they
19 were just sort of the function of the fact there
20 really isn't any leadership structure, if you
21 will, to help local installations to figure out
22 useful ways to share resources and take care of

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1 the total beneficiary population as opposed to
2 their service specific populations.

3 LCOL CAMPISE: If I can just comment on
4 what Colonel Orman mentioned is the fact that some
5 of this was self protective, because if you had
6 very limited resources to be able to meet the

7 needs of your own population, you're certainly not
8 going to advertise in a way that invites
9 additional individuals to come in for services
10 that are already overtaxed. So the underlying
11 assumption is if you want to increase
12 collaboration, you're really going to have to
13 improve the manpower and the resources to be able
14 to meet the needs that exist there and are
15 unknown.

16 DR. McCORMICK: I guess this is a good
17 time to get something on the table so everybody
18 understands, I think, a reality; that is that in
19 the case of most of our recommendations there is
20 the interact. For example, we're talking now tri-
21 service coordination. It really can't be
22 separated from access because one of the fallouts

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1 of what we're saying here is that we really did
2 see instances where, whether, for example a family
3 member could get services on base was a function,
4 not of where they were stationed, but sometimes
5 what uniform they were wearing that a particular
6 service at that particular location may have
7 enough access to treat both active duty members
8 and their families whereas another service, very
9 close, had to send family members to the community
10 for care so that all of our -- as we talk today I
11 think -- hopefully you'll see that there's a

12 dynamic interplay between all the "areas" of
13 concern that we have.

14 LCDR WERBEL: A couple other issues,
15 too, just to add to this. As we've heard from
16 many service members that they want to see a
17 mental health provider in uniform because that
18 person is going to understand them, we've also
19 heard in some of these locations, where it's
20 tri-service that service members from one branch
21 don't want to go see a mental health provider from
22 a different branch, because they don't think

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1 they're going to understand their unique culture.
2 Whether it's Air Force, Army, Navy, Marine. There
3 are probably multiple reasons for that and some
4 that can be addressed.

5 One other thing I wanted to get out
6 there was that the business practices. While some
7 of the business practices might be different, but
8 are behind the scenes and can still be coordinated
9 between branches, between services, those ought to
10 be transparent to the service members. One of the
11 difficulties in a tri-service area where a Marine
12 or a sailor might have to go to an Air Force
13 location or even just call our mental health
14 clinic is something completely different depending
15 on what your service is. So it's one thing if the
16 business practices behind the scenes are

17 transparent to the clients and the beneficiaries,
18 but when the beneficiaries get confused because
19 they wouldn't even know where to go to get
20 services on a different branches installation
21 because it's got a different name, we sort of put
22 stumbling blocks in front of them right off the

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1 bat.

2 LCOL DOUGLAS: Going back to Dick's
3 point and access to care, there's multiple things
4 that we saw through access of care, so I'm just
5 going to take them one at a time. The first one
6 I'm going to list is TRICARE and tell you what we
7 heard on the site visits and almost everywhere and
8 then we'll go from there.

9 So as far as TRICARE, Medicare is
10 reimbursing at a higher rate than TRICARE. Many
11 community providers would rather take Medicare
12 than TRICARE. Credentialing of TRICARE network
13 providers. TRICARE reimbursement rates, again.
14 The information access to TRICARE information,
15 their website isn't efficient. The TRICARE list
16 for available providers in a certain area are not
17 validated as far as when it comes to referrals.
18 TRICARE providers are (off mike) inappropriate
19 referrals for children and they're seeing adult
20 psychiatrists. Another good example is out of 103
21 providers only three were accepting TRICARE and

22 this was supposedly a current list that was made

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1 available to service members. So these are kind
2 of things in TRICARE as far as access to care that
3 really come to light. And who is monitoring the
4 TRICARE network around installations for service
5 members and making sure that information is
6 accurate, there is enough providers or if there's
7 a deficit of providers, who is -- who do we go to
8 or back to the TRICARE entity to say, hey, we're
9 short network providers, what can we do?

10 DR. BLAZER: I would just like to make a
11 comment or two. This is something we actually
12 have not discussed that much on the committee up
13 to now, but I think it's important to get it out
14 on the table. And that is that even though these
15 are somewhat random reports in terms of comparing
16 TRICARE to Medicare; whenever I hear someone
17 saying Medicare pays better in the mental health
18 area, I become very concerned because mental
19 health payments in Medicare are atrociously poor.
20 I have just finished a term as president of the
21 American Association of Geriatric Psychiatry and
22 we are seeing many psychiatrists who cannot

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1 practice in the community because of the level of
2 Medicare reimbursements. So that is very much a
3 red flag, I think, for us to look at. Even though
4 our data may not be systematic the fact that
5 someone is telling us in a particular community
6 that they would rather take Medicare for mental
7 health services is of very much concern.

8 MS. FRYAR: One of the consistent things
9 that we heard was the shortage of child
10 psychiatrist and access to care for children for
11 any mental health services, whether it be mental
12 health or behavioral health services.

13 LCOL DOUGLAS: That was my second point.
14 That seems to be at every installation we've been
15 to on every site visit that the shortages of
16 services for children and that -- adolescent
17 children as well as young children.

18 MS. FRYAR: It isn't just a problem in
19 the military; it's nationwide, so that point needs
20 to be made.

21 DR. McCORMICK: I just want to say that
22 when we went to a site visit, I think clearly we

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1 all decided early that we would try to take the
2 perspective of when we're talking about access,
3 does the system work for the unsophisticated wife

4 of an E-2 who perhaps has a deployed service
5 member and has a problem herself or with her
6 family member. That has to be, as far as we're
7 concerned, I believe the litmus test. And in
8 terms of TRICARE we try very hard to get a full
9 breadth of input, not only from service members
10 but from family members, from providers in the
11 community. That was part of our site visits as
12 well, and as well as the local providers on the
13 base. The way I see it is -- and it got to be
14 complicated, but one of the kind of findings that
15 we found as we went around was that in some cases
16 there was a "perfect storm" in terms of access.
17 I'll use the example of outpatient care or care
18 for a teenager who has a substance abuse problem.
19 There's a very well accepted continuum of care for
20 such a person. When you look at how this "perfect
21 storm" works there what you'll see is that TRICARE
22 does cover inpatient. Now any of us who have

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1 worked in substance abuse know that inpatient is
2 really only used for detox and if the only thing
3 you do is detox somebody you're really just
4 wasting your money. The rest of the continuum of
5 care includes regular outpatient, intensive
6 outpatient, partial hospitalization and
7 residential care. The reality is that when you
8 look at the TRICARE, because of the "perfect

9 storm" of policies and access, the only places
10 that you can -- they have certified places for
11 residential and partial hospitalization, but in
12 terms of substance abuse they only exist in, I
13 think it's 14 states. So there are 17 states --
14 there are 37 states out there, for example, where
15 you can't get partial hospitalization. Now
16 remember partial hospitalization is something
17 you're supposed to go to every morning and then go
18 home every night. But the "perfect storm" comes
19 in that TRICARE regulations then state that you
20 can only get simple outpatient care from somebody
21 who works at one the certified partial
22 hospitalization or residential programs. That

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1 means if you live in New York, if you live in some
2 huge state, the state of Washington, 37 states,
3 you basically have no access to outpatient care
4 because you don't live close enough to one of
5 these facilities to be able to drive every day.
6 So that's the kind of dilemmas that an E-2's wife
7 can face a set of "perfect storms" about lack of
8 access to facilities and then regulations or
9 policies. Intensive outpatient isn't allowed
10 because mental health services, unlike medical and
11 surgical services, can't be updated based on new
12 technology. We heard that from everybody
13 including the TRICARE officials that that's a

14 problem, yet nothing has happened. So that --
15 it's that kind of level of concern that I believe,
16 and certainly in all the site visits I did, that
17 we saw again and again. It's just kind of mind
18 boggling sometimes to an E-2, for example, and his
19 family.

20 DR. MacDERMID: And I know you didn't
21 mean to suggest that all the wives of all the
22 E-2's are unsophisticated, merely that there are

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1 some who are unsophisticated about the mental
2 health system, correct?

3 DR. McCORMICK: Right. Actually, what I
4 often said, and I would say this to forums, I said
5 my wife is a -- God bless her is somebody who does
6 not need any more assertiveness training. You
7 can't judge a system on whether she could tackle
8 it and wrestle with it and make it yield, you have
9 to judge it -- although in some cases even she
10 couldn't beat the system, but you have to judge it
11 for somebody who may feel depressed themselves or
12 overwhelmed themselves and is less sophisticated.
13 There was a time that she was less assertive, I
14 think.

15 LCOL DOUGLAS: That again was one of the
16 issues with access to care is understanding and
17 how the service members are educated on how to
18 negotiate the system. I mean, it's done

19 differently on every installation by every service
20 how that information is put out there and the ways
21 it's presented to them, whether it was websites or
22 what have you, but it's hard just to negotiate if

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1 it's not done well in continuous education. So
2 that was then one of the issues with the access of
3 care is I don't know how to access it because the
4 system is too complicated or I haven't been
5 provided the information or at least a central
6 place to start to start negotiating that system.

7 LCDR WERBEL: Colonel, I'd like to just
8 jump on that because that was one of the things I
9 was going to bring up is while we heard this
10 related specifically to TRICARE, but it was across
11 the board in all of the other areas, too. And
12 it's exactly what you're talking about is that
13 despite many, many good efforts that we've seen to
14 get information out to beneficiaries, we're still
15 somehow missing the boat based on the comments we
16 heard in terms of marketing. We heard in TRICARE
17 specifically -- at least one of the TRICARE
18 representatives that they provided a call-in
19 service to find available clinicians, but from
20 every person that we heard in that region, they
21 didn't have any clue there was a service available
22 to do that for them. That came up in a lot of

1 different areas besides just TRICARE that there's
2 lots of different programs and services out there,
3 but there's still a disconnect despite all of the
4 advertising and marketing of getting it to the
5 beneficiaries and the folks that would need to be
6 able to use it to access care.

7 LCOL DOUGLAS: One of the other points
8 that was brought up as far as access to care is
9 the use of military OneSource. There's a few
10 instances where some service members didn't know
11 what it was, but for the most part we found most
12 providers actually providing the information to
13 patients because they would be able to get into
14 see somebody sooner by utilizing OneSource sooner
15 than waiting to work through the system to get an
16 appointment. We'll discuss military OneSource
17 deeper. It's a good thing, but again, making that
18 known to people that it's available, but again
19 there were some underlying issues after they've
20 seen and utilized their time with OneSource
21 there's been a deficit and how has that
22 information get back to -- or if doesn't need to

1 get back to the installation provider depending on
2 what they were seen for.

3 DR. McCORMICK: I want to say just one
4 other thing that one of the things we tried to do
5 is wrap our arms around these special issue for
6 reserve component, reservist, national guard. And
7 certainly in the area of access there are unique
8 and additional challenges for somebody who is a
9 reserve component where they basically today have
10 civilian health insurance and tomorrow are
11 suddenly part of the military and then some point
12 down the road again make the flip-flop back. And
13 we're talking about conditions like PTSD that have
14 a very long tail on them. And people that come
15 from perhaps a small town in Ohio, where I'm from,
16 not near any military base, they again have to
17 rely on and negotiate a multitude of possible
18 sources of care, both military and sometimes
19 community or civilian. We certainly did see that
20 as we got as much contact as was possible. I'd
21 have to say that on the site visit part it was
22 more difficult obviously to find reservist than it

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1 was other active duty components.

2 MS. FRYAR: With regard to the access
3 standards another common thing we heard was the
4 extensive wait times to get an appointment for
5 mental health services.

6 LCOL DOUGLAS: Another thing that we
7 uncovered as far as access to care was counseling,
8 marital counseling. And marital counseling is not
9 covered by TRICARE. It is offered on many of the
10 service installations, but there aren't a lot of
11 marital counselors but there's been an increased
12 demand for marital counseling. So again another
13 access issue that we uncovered and discussed at
14 every visit is to ask that question: Do you
15 provide marital counseling and how many counselors
16 do you have available. Anyone else access to care
17 issues that they can recall?

18 COL ORMAN: Yeah. I think we sort of
19 need to get the fundamental challenge on the table
20 because all the comments are really an outgrowth
21 of it. It's pretty clear to the task force
22 members that had the opportunity to travel to

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1 perhaps more than a few sites that the themes that
2 Jonathan has articulated are universal. But
3 they're more applicable to the non-urban,
4 geographically isolated installations, which are
5 many among the four services. And this is also
6 applicable to the reserve issue that Dick brought
7 up, because they're spread, obviously, across the
8 50 states. Nationally we have shortages in
9 several of the mental health disciplines. We've
10 already mentioned child psychiatry services, child

11 psychology, child social work. I think all those
12 things are generally defined by where the
13 beneficiary is relative to the behavioral health
14 provider base. So the challenge for all four
15 services is there's lots and lots of installations
16 that are relatively small, frequently 5-, 10,000
17 or less and they're located geographically outside
18 of urban region and hence there's not a lot of
19 attractiveness, if you will, from any of the
20 behavioral health disciplines to locate them
21 themselves. They're in sufficient numbers to not
22 only deliver care to whatever the military

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1 beneficiary load is at that particular
2 installation, but they're not distributed
3 adequately enough in terms of sufficient numbers
4 to take care of the civilian population as well.
5 So one of the challenges I think TRICARE faces
6 that also spills over into the reserve component
7 challenge is: How do you attract providers to
8 places where historically they haven't congregated
9 for a couple of reasons? Payment is just one, but
10 these are not attractive places for lots of
11 people. And so how do you compensate for that; in
12 my mind is the real question. That's when you
13 bump up against what I see as the fundamental
14 challenge for TRICARE, which is how do you design
15 a compensation system that truly is going to get

16 people attracted to areas where you need them to
17 be in order to provide services for beneficiaries.
18 And I think philosophically that's the bridge we
19 haven't crossed yet. Which is can we design a
20 reimbursement system that's better than Medicare
21 that will deliver a mental health benefit to our
22 beneficiaries where they live as opposed to how we

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1 would like it to be? And I think until we're
2 willing to spend the resources and evolve our
3 policies and de-complicate how we serve the
4 benefit to the beneficiaries, we're sort of
5 chasing our tail. And so hopefully as the task
6 force report here gets finalized some of our
7 recommendations can address that.

8 DR. McCORMICK: Let me just say this
9 isn't talking about v-codes or marital counseling
10 as an example, a v-code -- is an opportunity to
11 say, first of all we did see places where things
12 really were excellent. We saw bases where an
13 active duty member and their families could
14 immediately go in and get, for example, marital
15 counseling on base from well-trained people.
16 Unfortunately, sometimes not very far away there
17 would be quite the opposite where the base mental
18 health facility was understaffed and they didn't
19 provide care to families at all. And then you got
20 into this kind of "perfect storm" issue that

21 marital counseling is not a covered service under
22 TRICARE, it's one of the v-codes. Grief

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1 counseling is another good example of that so that
2 you really then have these dis-equities of access.
3 By that I mean that Marine Smith one place
4 can get a range of services that someone else
5 can't get. And when a base was able to provide
6 this excellent service, I have to say, quite
7 frankly we saw examples and the centralized data
8 on the codes used in MTFs underscored, 30 to 40
9 percent of the work is with things like marital
10 counseling and grief counseling and things like
11 that. So there's no question that these are
12 needed services. When they are provided at an
13 MTF, military treatment facility, they are often
14 the most common problem presenting, although they
15 are a problem that TRICARE doesn't cover.

16 LCOL DOUGLAS: I'd like to move on to
17 stigma and barriers to care. This is probably one
18 of the hardest things that we've uncovered because
19 it's so far reaching and it's different for
20 everybody else because it's -- being a service
21 member myself it's kind of a mystery because the
22 stigma to seeking care is because we don't

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1 understand the ramifications of what's going to
2 happen should I seek care.

3 So the things we hear is, again, I'll
4 lose my security clearance, I'll be seen weak if I
5 seek care, I want to seek care, but how can I do
6 it without anybody knowing, because if I'm a
7 junior service member, my whereabouts need to be
8 known, so I have to tell somebody where I'm going
9 and then the rumor mill begins. Provider
10 discretion in seeking care. How do we break
11 stigma? Is it through education? Many services
12 -- actually, I won't say many services, but the
13 new trend now for some -- most leaders is to see
14 -- have noted that okay, well, one way to get over
15 stigma it would be through education.

16 And there's also unique challenge into
17 our senior leadership. What do we do for them?
18 They have a significant stigma when they need to
19 seek care. How do they go about it? If they're
20 not seeking care, why would I want to go seek
21 care? So every base we've been to understands the
22 stigma issue and is trying to come up with ways to

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1 resolve it either through senior staff NCO
2 leadership education and making them the first

3 contact point, having a senior staff NCO or
4 Non-commissioned officer, who understands instead
5 of putting up the barrier getting them into the
6 system. But it's a two-way street trying to break
7 the stigma. That will be the hardest thing to try
8 to do that we've seen is -- is it educate -- what
9 is it going to take to break the stigma barrier to
10 care? Everybody has a different opinion, but
11 we've all agreed and uncovered that one of the key
12 things that's going to have to happen is education
13 of everyone from the lowest common denominator to
14 our senior leaders we all have to have a basic
15 understanding of stigma and mental health and our
16 mental fitness to reduce that issue of I just need
17 to go talk to somebody and there's nothing wrong
18 with it. Some services do it better than others.
19 The Army embeds mental health professionals with
20 their soldiers. The Marine Corps is just now
21 getting on board with that program and we're
22 almost there. But we've got an issue here where

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1 the Air Force has noted that embedding mental
2 health will help reduce that stigma.

3 LCDR WERBEL: One of the interesting
4 things about this and we've discussed this on the
5 task force as well and I think in some public
6 forums too is that, yeah, the make-up of this task
7 force is not complete and it couldn't be without

8 100 people on the task force. And one of the ways
9 that we've tried to deal with that is that the
10 site visits, making sure we've got a lot of
11 different focus groups, and we're talking a lot of
12 different populations and one of the things that
13 often gets left out in discussions of stigma is
14 what are those who feel the stigma, what do they
15 think the solution is? We've come up with lots of
16 ideas, a lot of professionals have great ideas
17 about how to overcome stigma, but what we've --
18 interestingly what we've repeatedly heard on site
19 visits, when we asked our enlisted personnel: How
20 do you address stigma? One of the things they've
21 said to us on a number of occasions is line us up
22 and make us all go see a mental health provider.

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1 Normalize it. I'm more likely to go in and sit
2 behind the door for 15 minutes if everybody else
3 in my entire unit also has to go sit behind that
4 door for 15 minutes with a mental health provider.
5 And I think that that sometimes is a shocking idea
6 to senior leadership, officers and medical
7 providers that enlisted personnel would actually
8 say, please, just line us up and mandate that we
9 go see mental health, all of us in the entire unit
10 on a periodic, regular basis. And that was their
11 solution to stigma, so I think we need to take not
12 of that.

their

18 frankly we wouldn't have had to because when we
19 got a group of people together whether they were
20 first sergeants, non-commissioned officers, service members,
21 family members, the issues of stigma just come out
22 and that's understandable because clearly it is a

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1 real issue. It is a difficult issue when you have
2 someone working in an occupation where you need to
3 know if they have some psychological problems, but
4 then there also have to be some balancing of the
5 needs of the force against the needs of the
6 individual. In that regard, then, I would just
7 say that I think that we did try and the site
8 visits were very illuminative as Aaron just said
9 in coming up with creative ways to deal with this.
10 It does again blend with all the other
11 recommendations. When somebody is making a
12 decision to seek mental health care they're doing
13 a decisional balance of the pros versus the cons.

14 And one of the cons is clearly all the
15 concerns about what effect it will have on career,
16 on your security clearance, on how you are
17 respected by your fellow service members and
18 officers.

19 The pro side -- part of the solution to
20 stigma is to make the pro side as strong as we can
21 by normalizing it and having people it's an okay
22 thing to do and to address all the other cons. So

1 if there is a barrier to access you put that with
2 all these concerns about stigma and it just makes
3 the stigma worse. In many ways the issue of
4 stigma, the issue of trying to assure that people
5 seek care when they need it and don't feel that
6 there are barriers is at the core of everything we
7 saw on the site visits, came out all the time.

8 DR. POWER: And I think one of the cross
9 walking major issues for our deliberations has
10 been: How do we make all of that stigma awareness
11 and stigma education a part of our leadership
12 mandate? I mean, how do we inculcate that whole
13 approach to speaking about and talking about and
14 overcoming the stigma that institutionalized
15 within our society, that's institutionalized
16 within our systems and our services, which is no
17 different than the way it is generally in the
18 public? And how much that issue of stigma
19 resonated across the deliberations around where
20 leadership needs to be expressing itself, where
21 leadership needs to be demonstrating an
22 acceptability as mental health as a part of

1 overall health, and how leadership needs to be
2 exemplifying that belief and inculcating that at
3 every level in the military system I think is
4 quite unique to our deliberations and to this task
5 force's recommendations.

6 LCOL DOUGLAS: And there's a second
7 order effect to the stigma beyond the service
8 member; it's their families. I mean, if the
9 service member is doing that same mental debate
10 and the pros and cons, it's transferred to the
11 family members when it's time for them to seek
12 care, too. And we've seen that as a trend, too.
13 Because it's the same -- it's actually the same
14 question. My spouse should go seek mental health
15 it might still damage his career. So the stigma
16 is not just with the service member, it extends to
17 the families.

18 COL ORMAN: At one of the site visits,
19 that will stay unnamed, I had an E-5 come up to me
20 and said, "You know, Doc, for years you made me go
21 to the dentist. I've got bad teeth. Every time I
22 go annually they find something new wrong. I have

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1 to sit in that chair, get the shot that makes me
2 faint, have somebody drill on my teeth and you
3 guys spend much more money on the jaw than you do
4 on my brain. And you mandate that I go to that

5 dentist even though I know when I go I'm going to
6 suffer. So it's not clear to me why we don't do
7 the same thing to take care of my brain and my
8 family's brains." It just sort of struck me as it
9 sort of captured how the dental folks figured this
10 out years ago and we haven't quite made the leap
11 in terms of taking care of the most important
12 organ system in our body to doing this for our
13 mental health as well.

14 MS. FRYAR: Jonathan, you mentioned
15 about families often they're the first ones to
16 notice there's a problem, whether it be immediate
17 family or extended family. And as part of that a
18 lot of what we heard is they want to know how to
19 normalize this so that they can get the service
20 member access to the care they need.

21 DR. MacDERMID: This is a good time for
22 us I think for us to move to a break. We have a

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1 15-minute break scheduled for 10:00 and we're just
2 about there. So the committee will adjourn to
3 their room next door for a few minutes and all of
4 you feel free to catch a breath of fresh air and
5 we'll see you back here in 15 minutes.

6 (Recess)

7 DR. MacDERMID: Let's get started again.
8 We will continue talking about the themes from the
9 site visits and Jonathan, I'll turn it over to

10 you.

11 LCOL DOUGLAS: To continue on with some
12 of our themes from the site visits and discuss
13 resources and efficiencies. One of the big things
14 that's affecting our resources and efficiencies is
15 many of the shortfalls that are being mitigated
16 with GWOT funds which right now most services are
17 only programming -- or at least planning on
18 through '08, which is identified in the shortfall
19 and resourcing many of the programs in terms of
20 mental health that we're trying to maintain right
21 now. Along with that resources and efficiencies
22 recently there's been a contract let for all the

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1 service -- for military life consultants. And
2 this has been seen in good and bad at some of our
3 site visits as we've gone to different places
4 efficiency of that because there wasn't a lot of
5 consulting done when this contract was let for the
6 military life consultants.

7 The other big thing was the hiring
8 practices in terms of efficiencies. There's a
9 huge lag once you know the resource you need to
10 hire a new mental health professional three months
11 or more. Before the individual comes on board,
12 again, knowing that process it's hard to get
13 quality people to fill these positions. Again,
14 those positions are normally being paid with the

15 GWOT fund so it's kind of a trickle-down effect
16 that we've seen in all the installations. They
17 have GWOT funds to hire people but the process is
18 so long and lengthy some of them pull their
19 package along the way because, again --

20 Again, the resources and efficiencies
21 just kind of ties back to the tri-service
22 coordination piece. You know we're seeing some of

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1 these same problems with resources and
2 efficiencies not necessarily in tri-service but
3 within the same hospital or MIF staff of being
4 able to share resources.

5 One of the issues we've seen again is
6 the mandatory training that's put upon the service
7 members even our mental health providers are just
8 -- health providers in all. Uniformed members are
9 required to take so much mandatory training and at
10 this time and date they feel it's -- you know, I'm
11 doing this training, but I'm not seeing patients,
12 is there a way we can mitigate the training so I
13 have more time to patients. That has been
14 mentioned by everybody, because it takes a lot of
15 their work day to meet this mandatory training
16 requirement. This is the same actually for
17 service members. Upon their return trying to
18 mitigate some of the mandatory training and they
19 need to give them adequate time and dwell time.

20 This goes back to a comment here as we love to
21 spend more in units, but again, between now and
22 seeing required capturing of their day job,

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1 mandatory training, the actual time to see
2 patients is quickly decreased.

3 Has anybody else noted anything beyond
4 those large items in terms of the resources and
5 efficiencies?

6 LCOL CAMPISE: I just wanted to comment
7 on the GWOT contracting situation. It was one of
8 those really good ideas that didn't pan out to be
9 as successful as we had hoped. You know the idea
10 of it -- if you have a shortfall on manning then
11 you hire temporary workers and these temporary
12 individuals can apply services and then when
13 they're no longer needed then you can just
14 encourage them to get employment elsewhere. In
15 reality what we found was that by saying we're
16 going to temporarily hire you, the level of people
17 that you can attract to it is diminished. And
18 then number two, if you do attract a very highly
19 qualified individual, we discovered that they were
20 very quick to jump to a GS position that opened in
21 the area. So at some installations the turnover
22 rate for the contract employees was 200 percent.

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1 So when talk about continuity of care it's
2 completely blown out of the water if there's
3 constant turnover in that position.

4 DR. McCORMICK: I guess maybe this is a
5 place to again say something that was very
6 positive in my and I believe all of our experience
7 on the site visits, and that is when we met with
8 mental health providers who were embedded at the
9 unit level, whether that's in the Army at (off
10 mike) combat team level or the Oscar pilot program
11 that the Navy has with the Marines. Universally
12 when we talked to these mental health
13 professionals that basically are assigned to a
14 combat unit and stay with that unit, both when
15 they're deployed and when they're back at base,
16 first of all we were impressed with the dedication
17 of these people. We also got consistent feedback
18 that this was the best way to get over stigma,
19 that they were seen as part of the unit, they were
20 wearing the uniform, they were with them every
21 day. They were able to consult with commanders,
22 consult and be more accessible, if you will; less

1 stigma to soldiers, Marines and that they really

2 felt they were doing an important job albeit often
3 a very difficult job because they were deploying
4 with the units themselves and that put tremendous
5 stress on them and their families.

6 DR. MacDERMID: I have one other thing I
7 guess also related to the topic of efficiencies.
8 I think it's a fair generalization to say that we
9 were impressed with the dedication and
10 resourcefulness of many of the mental health
11 professionals that we met at different
12 installations, where there were lots of examples
13 of people who had come up with very creative
14 strategies for dealing with issues. For example,
15 the people at some installations who had taken
16 upon themselves to monitor the TRICARE network and
17 maintain a list of providers who were accepting
18 patients as a service to their beneficiary
19 populations. Or installations that had done a
20 really good job of creating risk reduction
21 councils that were monitoring data and trying to
22 do something about it. It's been said a number of

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1 times in the task force that we don't -- any time
2 that the task force says something critical the
3 intent is not to indict people who are working in
4 the system. Now we're impressed with the
5 dedication and quality. Everybody's dealing with
6 a really tough situation that would stretch any

7 system And so our comments are simply in an
8 effort to try to help the system improve and deal
9 with the challenge that is before it. I don't
10 know if anybody wants to add anything to that.

11 MS. EMBREY: I have a question. When
12 you come up with your report, I assume then that
13 there will be some best practices that you've
14 identified that would benefit from expansion
15 across the system; is that correct?

16 DR. MacDERMID: There certainly are best
17 practices that I think you will see --

18 MS. EMBREY: In and out of the
19 department.

20 DR. MacDERMID: -- in the report. I
21 think another thing that you're likely to see is
22 recommendations about research, because in a lot

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1 of cases because many of these things are so new,
2 the initial indications are very, very positive
3 but there hasn't been time yet for empirical
4 investigations. And sometimes those things are
5 consistent with the list of the kinds of projects
6 that are now being funded and sometimes they are
7 not. So you are likely to see some
8 recommendations about priorities for future
9 research that would provide the evidence. But,
10 yes, there certainly are things that have come up
11 to the task force as being particularly intriguing

12 ideas to pursue for the future.

13 LCOL DOUGLAS: And looking again at
14 resources and efficiency one of the things that
15 was noted is there's no risk adjusted
16 population-based staffing model being used looking
17 at the growing requirement and demand on mental
18 health providers and a lot of that has to do with
19 current policy.

20 I'll jump over to policy so we can talk
21 about that. Again that risk adjusted population
22 there's been a lot of concern with RVU's and how

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1 mental health providers have to categorize and
2 account for their workload. That is a common --
3 through every provider we've spoken at every
4 installation is that time required and how they
5 have to account for their time to see providers
6 against other health professionals in the MIF is
7 not appropriate for the work that they're actually
8 doing.

9 DR. McCORMICK: Let me just -- I think
10 that's a very important point and let me try to
11 rephrase in a minute. I believe what we saw in
12 the site visits is unexplainable variation in the
13 level of staffing in an MIF for the population of
14 servicemen that it's covering. So that at Base A
15 we would see a very small MIF for a population and
16 then at Base B, which had the same population, we

17 would see a much more robust at the MIF, so that
18 certainly something that we found across our site
19 visits.

20 Again, going back to a point that was
21 made earlier, we also take into account that what
22 mental health people do is not just seeing someone

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1 in their office when they come with a problem, but
2 it ought to be to build resiliency, it ought to be
3 to do preventive work, it ought to be to try to
4 strengthen the force. Those kinds of things
5 aren't easily matrixed in a workload system so
6 that it speaks to the issue of how best to staff
7 an MIF for a population of people and with the
8 idea of being able to provide a broad range of
9 psychological services for that population
10 including preventive services and resilience
11 building so that you can end up with a system
12 where there is more equitable staffing so that
13 your access to service depends on your problem not
14 on where you happen to be on what base at a
15 particular time.

16 LCOL DOUGLAS: Another theme I've put
17 under policy that we've seen as we visit some of
18 the site visits, there have been service members
19 who have been receiving, we've been told, less-
20 than-honorable discharges in response to behaviors
21 that might be a secondary to a diagnosable mental

22 health disorder, because they weren't being

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1 adequately evaluated during the administrative
2 process.

3 COL ORMAN: This goes back to what Dick
4 said earlier that all these things are
5 interconnected so to pick up on his point of the
6 inequitable distribution, if you will, of
7 behavioral health providers between installations,
8 between services, the way it plays out and the
9 point you just made Jonathan is that in some
10 installations there really are a relative dearth
11 of behavioral health providers and yet there's a
12 constant need for the system to be evaluating
13 service members as they ETS or otherwise are
14 administratively separated from their particular
15 service. And the way that plays out in a fashion
16 that's not desirable is oftentimes service members
17 perhaps aren't given adequate evaluations before
18 they undergo some sort of administrative process
19 and where our concern was particularly highlighted
20 is when that administrative process is adverse.
21 So if they're being separated for UCMJ reason or
22 some sort of misconduct or disciplinary reason

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1 that may be characterized as an honorable
2 separation or sometimes dishonorable, we saw
3 evidence that there is cause for concern
4 systemically. That some of those folks are not
5 getting an adequate evaluation of their trauma
6 exposure either traumatic brain injury or PTSD as
7 they're being administratively separated from the
8 service and these obviously have lifelong
9 implications in terms of their access to VA care,
10 et cetera. And so the lack of uniformity and the
11 lack of perhaps some oversight to ensure that
12 these undesirable separations happen appropriately
13 I think is uniformly a cause for significant
14 concern on the part of the task force and is
15 reflected in our report.

16 DR. McCORMICK: Just say one thing on
17 that and that is that on the site visits we tried
18 very hard to see a full range of service members
19 including those who have been recently brought
20 back from deployment. And we all of course come
21 into this with an awareness that some of the
22 normal stress reaction that people have are things

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1 like irritability, a little more trouble handling
2 anger. That's true both in terms of trauma and
3 some of those are also true in terms of mild

4 concussive injuries so that people do come back
5 from deployment changed somewhat in their
6 behavior. And an example of how all these
7 recommendations come together is that the
8 education of commander and non-commissioned
9 officers on the reality that this is going to
10 happen and the ability to then make sure that
11 people understand that this may not be somebody
12 who all of a sudden has become a bad soldier or a
13 bad Marine, but that this is something that has to
14 be death with in a medical rather than an
15 administrative way is something that we tried to
16 staff and look at every place we were. And this
17 whole policy issue, part of the solution is
18 education. And you'll see that again and again
19 that there may be a policy problem but part of the
20 real solution is educate a non-commissioned
21 officer that you've got to expect this kind of
22 behavior and get this guy the help he needs rather

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1 than decide he's a bad Marine and he needs to get
2 out.

3 MS. EMBREY: Can you clarify the policy
4 issue that you just spoke to?

5 DR. McCORMICK: Well, the policy issue
6 is the policy to make sure that everybody abides
7 by the requirement that someone gets a full
8 medical evaluation and a decision made as to

9 whether they need to be medically boarded or --
10 and possibly be taken out of the service. If that
11 is followed, if everybody got that medical
12 evaluation then there would be the opportunity for
13 soldier X perhaps who comes back, has always been
14 a good soldier, comes back and all of a sudden
15 he's getting some DUI's, all of a sudden he's more
16 irritable, he's not as good a soldier; to make
17 sure that all of the medical implications of the
18 trauma he may have gone through are taken into
19 account and when the decision is made what to do
20 with soldier X and that rather than overlook and
21 it being dealt with as an administrative, bad
22 behavior issue. The policy exists right now, it's

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1 just our concern as whether it is being uniformly
2 -- if there's resources partly and whether there
3 is education so that he gets to the right person
4 and gets that part into the equation.

5 COL ORMAN: There's also a dynamic here
6 that's subtle, which is units have every reason to
7 try to identify members that are not performing
8 well particularly if they're on the bubble for
9 another deployment, which is frequently the case.
10 So their incentive is to try to get that
11 dysfunctional service member off their rolls as
12 rapidly as they can in order to get, hopefully, a
13 healthy and functional replacement. That

14 particular incentive works against the very thing
15 that we're concerned about, which is that before
16 people are sort of moved out of the system
17 rapidly, in the interest of the mission, that
18 there exists some sort of forum where their
19 medical issues that Dick was just eluding to can
20 be addressed in a deliberative way without the
21 dynamic being such that the unit leadership feels
22 this urgency to kind of move them on. So it's

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1 partially a resource issue in terms of making sure
2 we have adequate behavioral health providers to do
3 these sorts of evaluations. Some of it has to do
4 with the very structure of how we go about
5 replacing dysfunctional membership inside units,
6 particularly in time of war and I don't think this
7 system's quite grappled with the implications at
8 the soldier, Marine, Sailor, Airmen level of those
9 two dynamics colliding in terms of imperatives.
10 So you juxtapose that with a resource-deficient
11 system and I think we've -- the disability system
12 has got its own issues that contribute to this. I
13 think, again, to use Dick's analogy, we sort of
14 have a "perfect storm" for occasionally phenomenon
15 happening that nobody wants. So it's not a bad
16 people argument it's the fact the system just
17 hasn't made peace with the fact that in time of
18 war there really is this urgency to get

19 replacements rapidly into units, but we need to be
20 paying attention to the individuals to make sure
21 that their needs and what we owe them as service
22 members is not trampled upon.

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1 MS. EMBREY: Can I ask a clarifying
2 question about that? I just want to make sure I
3 understand it because in the end institutionally
4 this is a really important piece of --

5 COL ORMAN: This is a huge issue.

6 MS. EMBREY: Is it the gap between the
7 process for dealing with UCMJ issues and its
8 intersection with the medical community to make
9 the proper assessments about whether or not this
10 behavior is truly underlying because of a mental
11 health issue or otherwise?

12 COL ORMAN: As Dick said, I don't think
13 it's so much policy. I'll use some psychiatric
14 terminology, there's not a holding environment for
15 people where we're not sure what the proper
16 disposition is yet. And even though we have
17 things called Med-hold companies, et cetera,
18 because of the complexity of the disability
19 process, some of the logistical issues associated
20 with Med-hold companies and not wanting the
21 numbers in them to get too large, et cetera, I
22 think inadvertently there's sort of this rush to

1 judgment about individual soldiers, Marines,
2 Airmen, et cetera that oftentimes gets in the way of
3 objectively determining whether or not this should
4 be UCMJ driven versus we need to re-look at these
5 behaviors that resulted in the soldier getting
6 into trouble in the context of what's happened to
7 them in the last year or so. Again, it's always
8 dependent on good people doing what they're
9 supposed to do, but good people when they're too
10 rushed, when they're overburdened with too much
11 work will often just sort slip into whatever is
12 expedient and again we're concerned there are
13 soldiers, Airmen, Sailors and Marines that suffer
14 as a consequence.

15 DR. McCORMICK: It's another example of
16 intersecting things. Frankly, and we saw examples
17 of this. If there is a unit that has an Oscar or
18 Army embedded mental health person, the likelihood
19 that this kind of thing will slip through the
20 cracks is less because you have somebody at the
21 unit level who can work with command, Sergeant,
22 unit command and raise the issues. I think the

1 greater danger is when you don't have that
2 embedded person. And some people just make a
3 reasonable, perhaps from their level of education;
4 a reasonable mistake about missing something that
5 shouldn't be missed that of course can have
6 lifelong implications because ironically, in the
7 worse case scenario, somebody who gets a very bad
8 discharge but also not be eligible for VA care.

9 LCOL DOUGLAS: Many things were in this
10 policy when we asked this policy question on the
11 site visits. Normally it was -- we would say the
12 issues with current policy and the way they've
13 been implemented, but many times it's a lack of
14 policy or new policy that we think should be made
15 in the light of what's going on now. For instance
16 there's no ulterior policy for local mental health
17 care leadership in terms of being responsible for
18 all those resources at that installation that are
19 part of the base infrastructure in terms of the
20 base counselors, the -- whatever else is on base
21 that's under this larger umbrella of mental
22 health. Again, it all goes back to recurrent

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1 themes of tri-service coordination where now the
2 coordination issue is with the counselors. There
3 is no policy in effect now that kind of directs
4 the overall arching look at mental health at every
5 installation and all those pieces that go with it.

6 And back to Colonel Orman's issue about drugs
7 because that's a piece of it, too, but tied to
8 policy and how it's reported and how it's taken.

9 DR. MacDERMID: Let me ask something
10 about that. One of the things that we struggle
11 with throughout our work is that the term mental
12 health -- if you use the term mental health
13 professional in the military it pertains to a very
14 specific group of people, a very specific group of
15 providers. And yet if you talk in terms of the
16 mental health landscape or the landscape of
17 providers in the military who are concerned with
18 psychological health, to use a broader term, it's
19 much larger. And it exists as is true in the
20 civilian world within lots of different funding
21 streams and authority structures and offices with
22 different names. And from the perspective of the

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1 military member and his or her family any of these
2 places or providers might be the place that they
3 would choose to go when they perceive the need for
4 help. For example, chaplains are very often the
5 first stop. We've tried very hard to be attentive
6 to the full landscape because we've tried to take
7 this perspective of -- the service member's
8 perspective. And a service member in distress
9 doesn't really care which stovepipe something
10 lives in. They care about can they get the help

11 that they need someplace. So we struggle
12 sometimes with the use of terms. And when you can
13 use the term mental health and when you can't. So
14 one of the challenges you run into then when we've
15 done site visits is that it varies from place to
16 place to degrees which each of the different part
17 of that landscape of providers who touch
18 psychological health know about what's going on
19 each of the other parts of the landscape. And the
20 reality is that sometimes, not always, but
21 sometimes I felt like we were some of the first
22 people to sort of come along to ask the overall

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1 question. I'm sure that's not true, but it was
2 striking sometimes how poorly in tune these
3 different components were with each other. And it
4 was also striking sometimes how well in tune they
5 were with each other. In any complicated system
6 getting the pieces that -- be well aware of what's
7 going on is a challenge. And so what Jon is
8 talking about now is part of the challenge at the
9 local installation level, whose responsibility is
10 it to make sure that they know what the needs are
11 that members and their families have for support
12 for psychological health, which we use in a
13 broader way than just talking about mental health
14 professionals? And to what degree is the system
15 able to meet those needs? Where are the gaps?

16 And who has the authority to take action to
17 address them?

18 LCOL DOUGLAS: It all goes back to
19 resources and efficiencies. If you give that
20 leader the ability to coordinate with those other
21 entities on his local area, they can better manage
22 and resource their efficiencies and maybe

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1 streamline the system where any urgent case where
2 I needed to see a no kidding mental health
3 provider in the MTF, well, if I knew what was
4 going on, maybe he just needs to see a counselor.
5 They have more counselors than psychologists on
6 the installation, we've determined. We can push
7 more service members that way when delaying them
8 for an appointment. But that's the policy not
9 clearly out there right now.

10 LCDR WERBEL: I'd like to be a little
11 repetitive here because I think it just bears
12 repeating. We've talked in many of the areas
13 we've been looking at so far about the stovepiping
14 between the different services and this is such an
15 example of the stovepiping that we see within each
16 of the services in particular the -- just using as
17 an example, the Navy and the Marine Corps have, in
18 addition to their mental health providers at the
19 MTFs in almost every installation, if not every
20 installation a Fleet and Family Support Center or

21 a Marine and Family Services Counseling Center
22 where they provide services for (off mike) V-codes,

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1 marital counseling, what have you. But we have
2 been in installations where the interaction
3 between those is fantastic and they're talking on
4 a regular formal basis about the services they're
5 providing and needing. And we've been in
6 installations where they have locally put up
7 incredible barriers, not just they're not
8 communicating, but there are specific barriers to
9 that communication where -- and at least
10 installation we visited the psychologist and
11 social workers at the counseling center were not
12 allowed to make referrals directly to the mental
13 health department, they had to go through primary
14 care. So we've seen kind of both extreme ends of
15 the spectrum, but the norm is really in the middle
16 which is just stovepiping and there isn't any
17 formal structure.

18 I think it's worth noting that there's
19 at least one example out there in the Air Force of
20 a systematic attempt of overcoming that with a
21 formalized program of bringing people together at
22 the local installation level and a headquarters

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1 level. I don't think that's cracked the nut
2 either yet in terms of solving the problem, but at
3 least there's one example of a formal service-wide
4 attempt at working at. And then there's just a
5 lot of local initiatives, but that stovepiping at
6 the service level and the local installation level
7 is very significant.

8 DR. McCORMICK: Just one other thing
9 that we did observe and that is, again, it goes to
10 the differences in the services, the various armed
11 services. What Aaron was talking raised a good
12 example. In the Marine Corps, the Marine Corps
13 family services do, I guess invariably, every
14 place I was, they did have counselors there that
15 did marital counseling. On the Air Force, on the
16 other hand, they have a family service center and
17 by policy they do no counseling at all. So you
18 have these differences just between the services
19 in what the function of the various parts of the
20 stovepipe may or may not do. Then it, of course,
21 is incumbent upon someone to try to make sure that
22 base-wide somebody is doing it.

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1 LCOL DOUGLAS: Or is at least aware of
2 the shortfall so you can try to mitigate it or at

3 least know what your shortfall is, the question is
4 asked.

5 I'll move on to recruitment and
6 retention. As you can imagine, we have espoused
7 that there's a definite shortage of mental health
8 providers at our installations in particular child
9 services. So one of the big issues we keep
10 hearing about retention is there's still a
11 requirement for these providers to go forth with
12 our service members and deploy. Well because
13 there's a shortage, many are going just as
14 frequently if not more than some of the people
15 they're caring for which creates a huge gap in
16 continuity of care back at their local
17 installation where they have to stop treatment for
18 people they're seeing because they have to deploy
19 forward. And again -- recruitment and retention
20 -- so that's affecting recruitment and retention.

21 Competitive pay upon departure as we see
22 and bring more civilian providers on board to fill

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1 the gaps at some of these installations. And
2 there's an issue of who is taking care of those
3 mental health providers who are going forward to
4 care for our service members. There's a
5 recruitment and retention issue there. It's not
6 just the -- the mental health (off mike) for our
7 chaplain. We've asked that of the chaplains,

8 well, who's taking care of the chaplains. Who are
9 kind of filling some of these gaps and taking care
10 of their needs?

11 COL ORMAN: Jonathan, can we kind of
12 pause there? I'm sort of a root cause guy and
13 oftentimes retention and recruitment gets sort of
14 praised in the immediate and the obvious which is
15 it is somehow a reflection of inadequate pay and
16 inadequate bonuses. But I've been doing this for
17 30 years and retention on the active duty side is
18 really a function of a couple of factors that
19 rarely touch upon pay or bonuses although that
20 will be the first thing that pops into people's minds
21 if you ask them what are they thinking about.
22 What retention really is about is working in an

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1 environment you feel good about and pay and
2 bonuses certainly comprise some of the landscape
3 of that. But I'll tell you what comprises more of
4 it, which is you're working with other people who
5 are reasonably satisfied with what they're doing
6 and you're working in an environment where things
7 are moving in a positive direction, even though
8 they may be under a fair amount of distress.

9 So let me sort of back up in history. I
10 think war sort of brings out what wasn't planned
11 for and I think there was decisions made by people
12 that were not even currently and in leadership

13 positions years and years ago when I first started
14 my career to more and more sort of take people off
15 active duty, convert those jobs into civilian jobs
16 with the idea we're going to gain efficiencies, et
17 cetera, et cetera. And I think those are very
18 well meaning people and they all have good hearts
19 and they were trying to do the right thing. I
20 think what the war has sort of highlighted for all
21 of is you better not downsize your active duty
22 contingent, whether we're talking behavioral

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1 health or any other mission force. You better not
2 downsize them past the point where you can sustain
3 a surge or fight the kind of war perhaps you
4 weren't anticipating. So recruitment and
5 retention now is really a function, not so much of
6 pay, but rather people are no longer happy and
7 they're particularly unhappy about the fact things
8 are, from their perspective as a behavioral health
9 provider, moving in the wrong direction. And so
10 whether it's the fact they're going to be
11 deploying every year and a half, every two years
12 or perhaps in some cases more frequently, whether
13 or not their work environment has a critical mass
14 of active duty colleagues that can commiserate
15 with the stresses they're feeling. All those
16 things are moving in directions that are perceived
17 as being less than positive for most of our

18 behavioral health providers in uniform. I think
19 it's really a reflection of a decision made many
20 years ago that we were going to civilianize a lot
21 of the services and I think we better rethink our
22 fundamental assumption if we intend to have a

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1 force in the future, which is: We need more
2 uniforms and how we're going to get there I think
3 is a huge challenge, but if we don't start moving
4 in that direction and sort of get off of this
5 notion that we can just turn everything into a
6 contract or civilianize it, the work environment
7 for the active duty who are absolutely -- you have
8 to have a critical mass of those people to sustain
9 a war fight. I think we may be either on the
10 verge or below that critical mass and we need to
11 pay attention to that. Hopefully this report will
12 sort of wake up the existing leadership that I
13 don't think participated in these decisions of
14 many years ago to the fact that we've got to be
15 doing things to make the work environment, and I
16 use that in the very broadest sense of the word,
17 make the work environment more attractive for
18 people to continue to consider careers and we
19 better pay attention to our HPSP programs and our
20 GME programs and all the things that feeds the
21 pipeline for these active duty people to be in
22 uniform. And we need to be more ecumenical. We

1 need to develop social work programs and pay
2 attention to our psychology programs as well our
3 physician GME programs. So all those things, I
4 think, are part and parcel of ensuring that we
5 have a continuous pipeline of people that want to
6 say in and as they move through the system feel
7 like there's a career development path that's
8 going to work for them, work for their families
9 and that they're not going to be deployed every
10 time they're turning around because spouses make
11 decisions about people staying in the service and
12 we need to remember that.

13 DR. McCORMICK: Let me just give a
14 little grounding here, too. One of the strengths
15 of the site visits, because that's what we're
16 talking about right now, is the tremendous number
17 of mental health providers, military mental health
18 providers we had an opportunity to talk to. I
19 would estimate it was over 500, which is a
20 substantial number of all those who are doing this
21 work. Let me, first of all give some credit to
22 General Kiley who is no longer here, our former

1 co-chair, it was actually he who strongly
2 recommended that we should get out there, boots on
3 the ground, and see as many people and that was
4 the reason we did so many site visits.

5 It was at those site visits, visiting
6 and seeing so many mental health providers that we
7 really are able to inform ourselves and inform
8 this report about the critical issue of how do you
9 get people, mental health professionals, in the
10 uniform and keep them in the uniform, because as
11 we've said earlier this morning, having somebody
12 in uniform is a critical issue in many ways,
13 including stigma. People are going to talk to
14 somebody with the mental health person with
15 uniform before they talk to a mental health person
16 with this uniform. And it allowed us to put a
17 face on some of the other statistics we're seeing.
18 I'll just use one example, and that is the
19 psychology internship programs, which in the
20 military have always been a huge strength. When I
21 was running programs in the VA, we often lost our
22 best applicants to the military psychology

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1 internship programs. For the first time, perhaps
2 ever now, they did not fill their slots this year
3 and there were significant shortfalls. We saw
4 that kind of lurking out there as we went around

5 in our site visits. And the strength of the site
6 visit is we got to see, as Dave just said, some of
7 the personal reasons why that's happening. These
8 are professions that often have women. So you
9 have a young woman who intended to and would
10 probably have kept a career as a mental health
11 professional in the military, but she missed her
12 kid when they were between one and two and now
13 she's going miss the kid growing up between three
14 and a half and four and a half. That just, again,
15 on the decisional balance thing it just makes it
16 very difficult. The war and the frequent
17 deployments really are an issue in terms of
18 retaining good mental health workers in the
19 uniform just when we need them most and that's a
20 dilemma.

21 LCOL CAMPISE: And if I can just add
22 onto this, I don't think that we can, in any way

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1 overstate the problem that we're having with
2 retention and recruitment. Just to go back to the
3 psychology internship programs. The Air Force has
4 always been able to fulfill its quota. In fact we
5 typically bring in 24 to 26 per year. For the
6 first time ever this year we only filled 13 of
7 those slots. So that's only 50 percent of the
8 people that we needed were we able to recruit for
9 the Air Force. It's not just a problem for this

10 year, but those people would have been in the
11 service for four years. So that's a gap that's
12 going to continue to exist for the next four
13 years. And the Army was in a similar position
14 where they were only able to fulfill half of their
15 slots. So I think it's a tail that's going to
16 last for quite a while. It's not just, like,
17 well, next year we'll just recruit more. That's
18 what the Army tried to do, they tried to double
19 their quota and they weren't able to meet that
20 quota at all.

21 And just to follow on Colonel Orman's
22 comments, you know, there's no magic solution

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1 because every different group that exists within
2 the military there's really a different problem,
3 but the underlying problem is the quality of life
4 that's been created. For our brand new accessions
5 what we're finding is money is a big issue, but
6 those middle and senior, for them we've
7 civilianized a lot of the leadership positions so
8 there's no advancement opportunities for them.
9 They can be clinicians or they can be clinicians.
10 So they can no longer be a program director or
11 they can run a research facility. All those are
12 now GS or contract positions. So if you're
13 looking for advancement within the military it's
14 been limited for you. So it was not unusual to

15 find a mid-level individual with 10 to 13 years
16 that say they were getting out. And that's going
17 to leave us with an incredible vacuum of corporate
18 knowledge about our military system. So it's not
19 as though you can just continue to replace
20 everybody getting out with brand new captains who
21 have no knowledge of the system.

22 LCOL DOUGLAS: Continuing on to let at

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1 -- you'll see here that all these things seem to
2 merge or cascade together because we asked the
3 question of structural organization as we went on
4 our site visits and as Commander Werbel mentioned
5 there is when it comes to mental health and I've
6 eluded to before, there is no central leadership
7 at the installation to corral all these things.
8 It's best as best best can is best during normal
9 -- how we normally structure things in the
10 military. The Air Force, as Commander Werbel
11 eluded to does have something in place at their
12 installations to vet issues that span beyond the
13 MIF to other programs. No other service currently
14 has a group that meets on a quarterly basis to do
15 that the Air Force does have.

16 DR. MacDERMID: Although some
17 installations do it.

18 LCOL DOUGLAS: Some installations saw to
19 do that on their own because they saw the need

20 that they should meet on a regular basis to
21 discuss those issues.

22 As Ms. Embrey asked about the report we

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1 look at best practices. When it comes to
2 structural organization we have seen some out
3 there that seem to work and the Air Force's BEHA
4 program is -- Colonel Campise that's been around
5 for how long now the BEHA?

6 LCOL CAMPISE: It's been around for 10
7 years.

8 LCOL DOUGLAS: Ten years. So that's one
9 thing that we've looked at as possibly being the
10 best practice if implemented correctly.

11 LCOL CAMPISE: And BEHA is putting
12 mental health people in primary care clinics.

13 LCOL DOUGLAS: That's just another
14 avenue to get more people in to see a mental
15 health professional.

16 Move ahead to one of the more prevailing
17 issues, as we've eluded to is training and
18 prevention.

19 MS. EMBREY: Excuse me. Can I ask a
20 question? Again, I want to make sure I understand
21 what you just said. This is an observation that
22 institutionally the Department would benefit from

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1 having at the installation level a corporate
2 capability to integrate the continuum of care
3 across both the medical, behavioral health
4 department and the family support and chaplaincy
5 and other support services that are available at
6 that installations to provide a continuum of care
7 in an integrative fashion to the people who are
8 there; is that correct?

9 LCOL DOUGLAS: Yes.

10 DR. McCORMICK: Let me just say that
11 there's another piece to that and that is that
12 even within the mental health piece, one thing we
13 were looking at is there -- because it is very
14 often it is the base and TRICARE and other direct
15 contracts that provide it; is there someone who
16 takes it at their responsibility and is empowered
17 to, in fact, see that there is a full accessible
18 continuum of care with all the elements. Some of
19 them with -- and again there are challenges. We
20 did find on site visits to bases where mental
21 health MTF person didn't feel they had any
22 responsibility for the mental health part of

1 TRICARE, even though most of the recipients were

2 getting their care there. And then as you say
3 there's the additional layer if some of those
4 services are offered on base so that we are, in
5 fact, saying -- we did, again we're on the site
6 visits, we did see a lack of clear corporate
7 management superstructure that would assure that
8 someone is responsible for a full psychological
9 continuum of care.

10 COL ORMAN: And it goes beyond that
11 even. The leadership was lacking at the
12 installation level. Part of -- if you talk to the
13 people on the installation who felt some
14 responsibility, whether it was the medical side or
15 the family support side or TRICARE part of their
16 problem is there's no integration above them, so
17 there's nobody to appeal to in the corporate
18 structure to assist them in trying to go about
19 integrating services and trying to address
20 shortfalls and resources whether it's providers or
21 monies or whatever and because there's no
22 superstructure above them there's a sense of

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1 helplessness that it really is sort of futile on
2 their part to try to organize things locally
3 because all they'll do is identify deficiencies
4 which will make them feel bad and yet there's not
5 route to try to get those things addressed in a
6 coherent, integrated way. And so I think most of

7 the task force members share the notion that there
8 has to be structure above them that is empowered
9 to be advocates for resources and to have a seat
10 at the table to ensure that efforts to integrate
11 at an installation level are supported above them.
12 Again it's not a bad people argument, I think it's
13 just the issues have been highlighted now that the
14 system is under stress that historically that kind
15 of superstructure doesn't exist.

16 DR. McCORMICK: I wanted to say we saw
17 best practices where it does exist. The dilemma
18 is that those best practices were very much
19 dependent on the will and personalities of the
20 people currently on duty. That's a shifting base
21 to build it on.

22 MS. EMBREY: What are the

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1 characteristics of an installation where those
2 best practices occur, because if you want to
3 really make a difference and when you do have a
4 department that is structurally organized in
5 functional stovepipes; you have the installation
6 manager, you have the installation commander, you
7 have multiple components on a base with different
8 chains of command, so how do you bring that all
9 together in a constructive program of integration
10 that would work based on how the department
11 currently does its business? I don't think we're

12 going to be able to do a complete change of the
13 way we do business, but we do need to leverage
14 some strong characteristics of how it is being
15 done well.

16 DR. McCORMICK: We can't name names.
17 I'll give you a composite of two places where I
18 felt it was working. The first thing was that
19 there was an MTF, medical treatment facility that
20 had an adequately staffed mental health
21 department. So there was a core and they were
22 treating both active duty and their families. So

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1 there was a core place that served as a base of
2 operations. And then the leadership of that was
3 somebody who had a vision and actually took a kind
4 of consumer- oriented approach and said if I was
5 an E-2's wife, what would I do? And then went
6 beyond that and reached out to -- and frankly I
7 think this is the easiest part, was able to reach
8 out to and get the cooperation from the chaplains
9 and the support groups, the family support groups
10 and also had enough resources to delegate somebody
11 to kind of oversee the TRICARE part of it. Call
12 the list of 100 names and see how many will take a
13 new TRICARE person.

14 And then without mentioning names,
15 sometimes perhaps even shade regulations. Rather
16 than to say to somebody you're supposed to --

17 here's the list of 100 providers try your best,
18 say, well, here's the list of 100 providers, but
19 just between you and I you probably want to start
20 with this one and this one and this one because
21 they're most likely to give you something. So it
22 starts with that base of a well enough staffed

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1 mental health core and then works from there.
2 DR. MacDERMID: I'll add one other thing
3 that I say that I thought was helpful and the rest
4 of you can disagree if you think it's not
5 representative, but I was very impressed at least
6 one of the places where we went where they had
7 developed a standard list of outcomes that they
8 felt really operationalized kind of the quality of
9 life or the psychological well being of their
10 beneficiary population and they met as a large
11 group regularly to review those and that went out
12 to command. So everybody in every stovepipe sort
13 of had the same picture of what was going on and
14 that was fairly rare, at least in the places that
15 I saw and then it went all the way up the command
16 and in the current system that's the person who
17 has the ability to do some work on behalf of the
18 full continuum. But I defer to the rest of you to
19 comment about that.

20 LCDR WERBEL: I would say that the piece
21 that I think is missing from that that we did see

22 at least one location is that when that structure,

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1 even just as it's been described, really had the
2 direct line and was being held not under the
3 auspices of the MIF's commander, but under the
4 auspices of the installation commander, because
5 then the other piece that's missing when you've
6 got a group together to deal with the stovepiping
7 is the beneficiaries. And we saw, at least in one
8 location if not a few, where those meetings were
9 being held, but also the senior enlisted
10 leadership for the base and a spouse
11 representative from the base and someone who had a
12 direct line back to the installation commander was
13 part of those meetings so that not only the
14 leaders who owned the service organizations, but
15 the leaders of the beneficiaries and the
16 commanders for that installation were all a part
17 of that together and were able to share
18 information back and forth.

19 LCOL CAMPISE: We actually saw two
20 different models of successful collaboration. One
21 was top down and one was bottom up. In the bottom
22 up episode it was the helping professional on the

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1 base that had just gotten sick of their inability
2 to meet the needs of the base individuals. So
3 they just independently decided to get together
4 and identify and respond to the needs that they
5 saw. So it was a very motivated, very animated
6 group that was working to deal with the issue at
7 the lowest possible level.

8 On others we saw the formerly most
9 powerful person on the base say this is important
10 to me and they pushed that attitude down through
11 the mid and the lowest levels. So I think that it
12 doesn't matter whether you come from top up or
13 bottom up, but at some point leadership at the
14 very top has to buy in and the quandary that we
15 saw was that even when you had a motivated base,
16 they could identify an issue that was bigger than
17 the installation and say this needs to be work.
18 So they would raise it to the next level of
19 leadership who would say, you know that's DoD
20 policy; we don't want any feedback on that. It
21 became very demotivating for those folks trying to
22 buy feedback on a policy that needed to be

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1 changed.

2 DR. McCORMICK: Let me just speak to
3 bottom up one more time. In both of the instances

4 that I thought were the best practices, there was
5 both an available resource and somebody who
6 recognized that if you were an E-2 you have a
7 challenge. And they dedicated one -- they came up
8 with, in one case, one number that you called and
9 one person who you could call and then they would
10 triage you and help you understand the alphabet
11 soup.

12 DR. POWER: But the other leadership
13 dimension that we observed on one site visit was
14 that one of the individuals, and I think it gets
15 to Dick's point about how this depends mightily on
16 an individual experience and individual
17 leadership, was that he basically said he did not
18 want to experience as a reserve member what he
19 experienced coming back from Vietnam; and
20 therefore his installation would do very
21 aggressive outreach to the Reserve and Guard
22 community. And I thought it was notable the

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1 amount of time and energy and effort that was put
2 into that extensiveness of the community that I'm
3 responsible for includes everyone in the Guard and
4 the Reserve within a reasonable concentric circle
5 around the MIF that I'm responsible for. That's a
6 practice that is imbued, I think in terms of risk
7 taking and being courageous and saying the
8 community is much larger than simply the active

9 duty that I'm responsible for. It was very unique
10 and a wonderful practice.

11 DR. McCORMICK: On Guard, I think one
12 thing should be said on this topic and again it
13 goes to best practice but the challenge ahead.
14 The Guards of course have a different structure,
15 there's 52 entities, the states and the
16 territories. We saw best practices where there
17 were Guard elements, you know, the adjacent
18 Generals who had a full-time mental health person
19 on their staff who was basically responsible for
20 looking at, as I said earlier, some of the very
21 complex mental health issues for Guard. But the
22 reality is that the reality is that's only true in

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1 three or four out of the 52 as far as we could
2 tell. So again it's a structural issue as to
3 whether -- and it's a funding issue because you
4 get between the states -- with the Guard, but it
5 also goes to Reserve components. And that goes to
6 the issue of whether there is an organizational
7 structure to look after and support the mental
8 health needs of Reserve component members, and if
9 not, can we learn from the best practices and
10 somehow resource in policy that this should exist.

11 MS. EMBREY: This, as the designated
12 federal official, it is important that I think
13 that some of these systemic or gaps that you

14 provide us in your report some guiding principles
15 on what kind of a program needs to exist at the
16 installation level. What does it look like? What
17 are its important characteristics? And who are
18 the stakeholders that have to participate in
19 making that a successful program? Because your
20 report is going to Congress and your report is
21 going to Health Affairs, which is a medical
22 entity, but you're talking about a much larger

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1 multi- discipline, leadership, family support,
2 installation management kind of set of players who
3 aren't necessarily in the health chain of focus so
4 it will become quite important, I think, to the
5 Department in evaluating how to proceed with your
6 recommendations to understand that this is bigger
7 than health, although it's at its core, health.
8 We have to be able to understand what you observed
9 both within the department as well as some best
10 practices outside the department and what we need
11 to be able to be focusing on, because we're
12 dealing with the whole person, not just their
13 encounters in the health system.

14 LCOL DOUGLAS: You're exactly right,
15 because as we discuss training and prevention,
16 that as we've seen at every site visit when we ask
17 that question it strictly pertains to the training
18 of service members and leadership. Not with

19 mental health, but education on what it is and how
20 do we better accommodate each other. So, yes, it
21 goes beyond mental health because every service --
22 every site visit, Air Force, Navy, we need to

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1 better educate us from the junior guy to the most
2 senior guy and have a common understanding on what
3 is mental health and how do we take care of each
4 other and understand the nuances in our own mental
5 health system. So that definitely goes beyond --
6 this report will touch the service (off mike) in
7 terms of we're asking you to do something and
8 implement this into our professional military
9 education so we can better take care of each
10 other.

11 MS. EMBREY: You've talked about
12 recruiting and retention. You've talked about
13 efficiency and resource availability. You've
14 talked about access and stigma. One of the
15 discussions that I haven't heard that I would be
16 interested in hearing about is the role of the
17 primary care provider in this system, in this
18 continuum of care and how we need to make them
19 better partners. So if you could address your
20 thoughts about that, I would very much appreciate
21 that.

22 COL ORMAN: Let's start perhaps with

1 challenging the assumption that -- there's an
2 assumption in the question which is the primary
3 care model is optimal for mental health. I think
4 I speak for most of the membership of the task
5 force, one of the things I think we believe that
6 we saw in our site visits, as well as from our own
7 experience that we bring to this effort, is that
8 mental health is primary care. And this notion
9 that your average primary care physician, nurse
10 clinician, whatever the nature of the provider,
11 PA, et cetera, has both the wherewithal in terms
12 of their training and clinical experience, and the
13 time, that's probably the more critical issue, to
14 address mental health issues in 10, 15, 20-minute
15 appointments, I would argue is a fundamental flaw
16 in the model that we're trying to use to deliver
17 behavioral health services.

18 So the first thing I would sort of speak
19 to as much as Rick already eluded to with the Air
20 Force BEHA model, we certainly need behavioral
21 health embedded in primary care and I'm a firm
22 believer in that. But the notion that primary

1 care is a delivery system for mental health care
2 of any complexity at all, in my opinion, and
3 again, I think the task force, if fundamentally
4 flawed. Again, it goes back to this core premise
5 we have that everything is interwoven. Because
6 behavioral health isn't adequately resourced in
7 terms of professional personnel, many things get
8 pushed into primary care that I think we would
9 argue are not appropriate, and that I think we
10 heard from enough primary care providers on our
11 site visit, they would argue as not appropriate
12 because they don't have the training or the time
13 to deal adequately with the complexity of the
14 issues. So there certainly is lots to be said
15 about our interaction with primary care. We could
16 do a much better job than historically we have. I
17 think the Air Force does have best practices going
18 there. But I want to get on the table up front
19 that our fixing that does not really address the
20 core issue, which is behavioral health is where
21 people go, whether it's through the Fleet and
22 Family Support Services route or the chaplains or

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1 whatever, there's a common pathway where
2 ultimately mental health issues end up. And if we
3 don't resource that system better, we can put
4 people under primary care, we can generate more
5 referrals, but fundamentally all we've done is

6 short of shift where the problem is and we haven't
7 addressed in a way that I think was graphically
8 illustrated in our site visits.

9 VADM ARTHUR: Colonel, let me just offer
10 a small opinion. I think primary care is one of
11 the right places to enter the system. And our
12 primary care providers need to have enough
13 education to be able to recognized signals of
14 difficulty, as we say, and to refer the
15 appropriately and quickly to the right place. I
16 think you've hit on one of the major issues and
17 that is: What are the entry points and what are
18 the educational components that we should have for
19 those entry points? They could be the primary
20 care manager. It could be the nurse in emergency
21 department. It could be the school counselor for
22 the children. I think it's important for us to

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1 recognize the entry points, the educational
2 components that will allow the entry points to
3 properly see the risks and the resources to get
4 them referred to the right place.

5 DR. McCORMICK: Let me just kind of go
6 directly to the question, too. We did see best
7 practices where there were mental health providers
8 embedded in primary care. It has a number of very
9 positive things. First of all there are people
10 the first person they will go see is their

16 general. I think that's something that we all
17 agree with. I think Dave's point, which is one
18 that I think we don't want to forget as well, it's
19 just like having primary care physicians
20 understanding something about the heart, does not
21 replace the cardiologist. I mean there are --
22 there are a lot of problems that are going to have

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1 to go to the cardiologist. On the other hand,
2 they don't get to the cardiologist many times
3 until the primary care doctor sees and recognizes
4 that this is something the he or she is not
5 capable of dealing with. I think in some ways
6 what we need to realize that there certainly is a
7 spectrum of mental health morbidity in the
8 military, but given the extreme stress that many
9 of our soldiers are facing, given the fact that
10 they're in a war, we're going to see more complex
11 issues many times with these persons and we
12 definitely need to have the specialty mental
13 health care available for those individuals. But
14 on the other hand, they will never -- in some ways
15 they will never get to the specialty people if we
16 do not have that bridge built to primary care and
17 if the primary care physicians aren't understood.
18 And I think the point that Dick made is absolutely
19 right on target. It's been shown over and over
20 and over again. A lot of depression, for example,

21 fairly simple depression many times gets treated
22 and actually can treat fairly effectively in

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1 primary care. But on the other hand you need an
2 educated group in primary care to know when to
3 refer out.

4 VADM ARTHUR: I think it also speaks to
5 the fact that people seldom will come in saying, I
6 think I need some mental health counseling. I'm
7 not mentally well. They'll come in saying, I feel
8 bad. I feel blue or they come in with the
9 consequences of acting out that we as
10 professionals should recognize as having a mental
11 health basis.

12 DR. BLAZER: This is actually a very
13 good reason for embedding. You don't just embed
14 for the patients who are walking into a clinic;
15 you embed for the doctors in that clinic. If a
16 doctor in that clinic becomes more comfortable
17 with mental health, mental health providers and
18 what the spectrum of services that a mental health
19 provider can provide, then that primary care
20 physician or otherwise is going to be much more
21 knowledgeable and willing to take that individual
22 who doesn't come in with the major complaint and

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1 really work that referral. It's not just a
2 question of saying you need to go see so-and-so,
3 but it's actually encouraging phrasing that
4 referral in a way to the soldier and sailor in
5 such a way that that individual ends up going to
6 see the person.

7 DR. McCORMICK: In the military I think
8 we have to also realize that this is unique.
9 Corporal Smuckatelly in the Marines, he talks
10 about "Doc" he's often talking about a Navy
11 corpsman. So that's the additional challenge that
12 when we talk about primary care in the military,
13 especially with deployed people and this is also
14 true in Reservists, it's really a matter of having
15 mental health consultation and education for "Doc"
16 who might be a medic or a Navy corpsmen who needs
17 to understand what to do and where to send it
18 next.

19 COL ORMAN: One other important issue
20 that I think we need to keep in mind in this whole
21 embedding and primary care brings up; several of
22 us here went through the first Gulf War and the

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1 aftermath. The aftermath was, in my opinion, from
2 a medical perspective more traumatic than the war

3 itself. Soldiers, Sailors, Marines, Airmen
4 frequently exhibit their distress in somatic ways
5 and that's not to say that they don't have real
6 headaches, real back pain, real fatigue and all
7 the myriad of ways people present to primary care.
8 It is to say though if we're more sophisticated
9 about what those symptom constellations often
10 represent, there's nearly always a distress
11 component in there, whether it's a function of
12 their deployment, perhaps they lost their
13 marriage. If they're Reservists perhaps they lost
14 their employment or their business. The more we
15 can get an educated primary care force to work,
16 hopefully with embedded behavioral health
17 providers, to get things routed into the primary
18 etiology of the complaint, I think the less -- the
19 more efficiency we're going to have and the less
20 long-term dysfunction those soldiers, Sailors or
21 Marines are going to experience. So I want us to
22 be sophisticated about the fact there's a huge

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1 amount of co-morbidity that travels with mental
2 health problems that are in the somatic domain and
3 I saw tons of tons of money spent on million
4 dollar work-ups that I could have spent an hour
5 with somebody had I seen them on the front end and
6 probably precluded because it turns out the
7 headaches were really a stress-related phenomenon.

8 I want to make sure we get that in the discussion
9 in that the leadership understands the importance
10 of the crossover and the co-morbidity and how
11 behavioral health really is an asset that's
12 underutilized to help with what, in many cases be
13 classified as sort of exotic syndromes.

14 MS. EMBREY: If I could, again, as one
15 of the important, not necessarily the most
16 important, but as an important recipient of your
17 work, it becomes very important to me that you
18 present in your recommendations models that help
19 us understand how to institutionalize these
20 principles. It is clear to me that stigma
21 prevents a lot of people from walking into or
22 asking for care in the mental health or behavioral

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1 health clinics directly. Clearly there is a role
2 for going to the doc because I don't feel good for
3 whatever reason and having that referral to the
4 behavioral health clinic or the specialist inside
5 the system is one closeted way, if you will, to
6 achieve that objective. But if there are training
7 imperatives, if there are issues associated with
8 asking our primary care provider to do too much,
9 if there are good models that you've seen or that
10 work in private practice, these are very important
11 to us because if we're going to seek to improve
12 our overall capacity to deal with the whole person

13 and their families, then we need to organize for
14 that success and we don't want to waste time
15 guessing on the right model to use. If you spent
16 the last year looking into this it would be
17 extraordinarily helpful for us to understand what
18 the various roles are. And I think Admiral
19 Arthur's point about points of entry into the
20 system is very important. We do have the
21 multi-discipline -- you have chaplains receiving
22 people, you have family support counselors

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1 receiving people. How do they interact with each
2 other? What do they need to know? How often
3 should they be talking? Is a case management
4 model appropriate? How do we address these
5 issues? They are multiple things that drive
6 behaviors and responses to situations. How, as a
7 community, do we achieve that customer-focused,
8 service member and family member focused approach
9 to helping this individual cope with their
10 situation? I can see the passion that you all
11 have, I see that you know what the problem is, my
12 challenge to you would be to give us a solution we
13 can work with or a model for a solution we can
14 work with as an institution. Because if you don't
15 organize for success you cannot achieve it.

16 DR. McCORMICK: Let me just say -- those
17 are excellent points. One of the other things we

18 did do on the site visits is whenever possible try
19 to talk to talk to primary care doctors. I will
20 make this observation; again, almost invariably
21 both the service member and his family can get
22 their primary care on the base. The primary care

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1 clinics are basically staffed to handle the whole
2 population of service members and family members
3 living nearby. The best examples, as we just
4 said, were when there was a mental health person
5 in primary care. The next best is when there was
6 an adequately staffed mental health clinic so that
7 at least the pediatrician or primary care doc
8 could send it internally. Somebody he knows,
9 somebody he or she has a relationship with to take
10 care of it if it was more than they could handle.
11 The worst cases and we heard this from primary
12 care docs was when the local MTF mental health
13 wasn't staffed to take care of families, which was
14 very common. They, the primary care doc then had
15 to worry about somehow getting a child
16 psychiatrist off the TRICARE network and who is
17 going to do that? And in their 15 minutes they
18 just don't have the time to do it. So that's one
19 of the structural issues: Is there a mental
20 health system that is accessible that supports the
21 primary care doc including the pediatrician? Is
22 that best done in-house and if not, can you build

1 a TRICARE network that is user friendly enough to
2 have that hand-off handled?

3 VADM ARTHUR: I think excellent points.
4 I think we've really gotten to the heart of one of
5 these matters here. I think this a good time for
6 us to break as well. It's 11:30. Let me ask that
7 -- Ms. Embrey, do you have any other closing
8 remarks before lunch?

9 MS. EMBREY: No, I don't, sir.

10 VADM ARTHUR: Then let's meet back here
11 at 1300, that's 1:00.

12 MS. EMBREY: We're adjourned until the
13 afternoon.

14 (Whereupon, a luncheon recess was
15 taken.)

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1 A F T E R N O O N S E S S I O N

2 MS. EMBREY: As the designated official
3 I am reopening the afternoon. I need to say the
4 proper words, so I will.

5 I'm the designated federal official for
6 the Defense Health Board, which is a federal
7 advisory committee to the Secretary of Defense,
8 which serves as a continuing scientific advisory
9 body to the assistant Secretary of Defense for
10 Health Affairs and to the Surgeons General of each
11 of the military departments, I hereby call this
12 afternoon session of the Department of Defense
13 Task Force on Mental Health, a subcommittee of the
14 Defense Health Board, to order. Admiral Arthur.

15 VADM ARTHUR: Thank you very much, Ms.
16 Embrey. And I'm going to turn it back over to Dr.
17 MacDermid.

18 DR. MACDERMID: We'll take a small
19 detour along the way for Dr. Burke. I think he
20 has some administrative announcements.

21 DR. BURKE: Yes. Thank you, Dr.
22 MacDermid. Welcome to the afternoon session. All

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1 attendees, would you please be sure that you sign
2 in at the table out front.

3 VADM ARTHUR: Tom, while you're doing
4 that we actually went and we introduced everybody

5 in the audience, I think, except for you. You
6 came in a little bit late, so you didn't get to
7 hear who everybody here is and we don't know who
8 you are.

9 (INTRODUCTION)

10 VADM ARTHUR: Great. Thank you very
11 much. Welcome.

12 DR. BURKE: The restrooms are located
13 outside this door. Turn left and they are down
14 the passageway on the left. If there are any
15 administrative requirements, please see Ms.
16 Farrell, the lady in the red coat. This
17 afternoon's session is being transcribed so please
18 state your name clearly. Later this afternoon the
19 task force has set aside time for public testimony
20 and there you will have an opportunity to share
21 your comments. Please be aware that your comments
22 will be part of the transcription, so please state

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1 your name clearly and speak into the microphones.
2 We will have microphones available.

3 DR. MacDERMID: Thanks. Welcome back
4 everybody. This afternoon our primary task is to
5 deliberate in open session on the elements that
6 were part of the legislation that created this
7 task force. There were originally 16 elements.
8 Two additional ones were added late last year. I
9 also want to make it clear or just remind everyone

10 that these are deliberations, not conclusions. So
11 our goal here is to try to make sure that we've
12 got all the information on the table that we can
13 think of so that when we do finalize our
14 recommendation, we have all the pertinent matters
15 top of mind. That's especially true this
16 afternoon because although the task force
17 deliberations started out being very heavily
18 driven by the way that the elements that organized
19 us, that created us were structured, as we did
20 more site visits and as we gathered more data I
21 think the deliberations took on a somewhat
22 different shape. So the elements are very much in

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1 our minds but they don't really define the
2 dimensions of the issues in the way that they
3 ultimately ended up seeming to us. We don't have
4 a lot of time so I think what might make good
5 sense is for us to group the elements in the ways
6 that we did when we first started.

7 The task force, early in its existence,
8 organized itself into four working groups based on
9 categories into which the elements fell.

10 The first set of elements dealt with
11 active duty and we had an active duty working
12 group. We started out with four elements in that
13 group and then it expanded a little bit. So maybe
14 what we can do it just spend a few small minutes

15 on each element and make sure that we've got the
16 relevant information in hand.

17 VADM ARTHUR: And we are going to just
18 spend until 3:00 because we want to be sure that
19 we hear all of the people that are hear to give
20 some testimony. So we will cut off our discussion
21 before the break, before 3:00.

22 DR. MacDERMID: So the first element --

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1 here's the wording: "The awareness of the
2 potential for mental health conditions among
3 members of the armed forces." My impression of
4 what's out there is that -- I'm not aware -- I
5 don't think we heard of any large scale data
6 collection efforts that assess awareness of
7 potential mental health conditions in exactly the
8 way that the element seems to imply. The closest
9 approximation, I think, is in a survey of health
10 related behaviors whether the question about
11 people who thought that they might have a need for
12 mental health counseling. And that number is 17.8
13 percent of DoD respondents who indicated that they
14 had either received treatment or sought treatment
15 felt that they had a need for mental health
16 counseling. I don't have the number yet for just
17 the sample as a whole. But are there are other
18 pieces of information that we should include?

19 DR. McCORMICK: Yeah, actually I think

20 there are. Part of what the task force did was to
21 try to look at everything that's currently
22 available and published or internal and also do

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1 data calls. Actually I think we have a number of
2 other things. For example we have the 2007 data
3 from the PDRHA which shows, for example, and I'm
4 an old person and this is coming off the top of my
5 head, but it showed that in terms of the
6 percentage that check on of the psycho-social
7 concerns, it's I believe, like, 32 percent for
8 active duty Army, 20- some percent for active duty
9 Marines and 49 percent for National Guard. So we
10 have the PDRHA data which is very much up-to-date
11 data. We also of course are very much informed by
12 -- the military has done an excellent job of doing
13 surveys, anonymous surveys, including in theater.
14 So there are at the moment three published mental
15 health assessments that were done over in Iraq,
16 MHAT data and we have that, which also again gives
17 some good figures on percentage acknowledging
18 problems those who are -- data on barriers. I
19 think that again informs this as well. And then
20 there are some other surveys that have been done,
21 for example, an anonymous survey of the main
22 National Guard that's just been published that

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1 we've looked at that again shows high double
2 digits, you know, the 30 to 40 percent range of
3 problems such as relationship problems after
4 deployment, anger problems after deployment. So I
5 think we do have a very good balance of surveys,
6 both anonymous and non-anonymous as well as the
7 health survey that you talked about earlier,
8 Shelley to make the case very compellingly that
9 these are very common concerns and issues and
10 therefore go to the core of not just a minority or
11 small segment of our warriors but are at the core
12 of many if not in some cases most of the warriors.

13 COL ORMAN: But we also have historical
14 data that's taken from various databases in terms
15 of what are the discharge diagnoses and how do
16 they fall out on a relative scale. And we know
17 this data is pre-war, we know that just a baseline
18 when the services are at peace that mental health
19 issues are the number two reason people exit the
20 service. So I think there's a very extensive data
21 set that we have available to us in the literature
22 and through the surveys Dick just mentioned that

1 document the pervasiveness of mental health

2 concerns among all four services.

3 DR. MacDERMID: I think it's the wording
4 of the element that hangs me up a little bit
5 because "the awareness of the potential for mental
6 health conditions," is a little (off mike).

7 COL ORMAN: But that gets at another
8 element which is whether or not the leadership,
9 whether or not the average marine, soldier, sailor
10 understands these data sets or has been informed
11 about them or trained up on them, is one of the
12 challenges to be addressed. But I think we need
13 to be clear the data exists and it's not soft
14 data.

15 LCDR WERBEL: There's another -- and
16 Shelley I think this addresses what you're talking
17 about, another way of reading this question is not
18 so much what do the mental health providers, what
19 do we know about the existence of this problem,
20 but is there an awareness for this potential and
21 the date you're looking for then is also what are
22 the leadership statements and published messages

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1 and memos about the importance of mental health
2 and mental illness amongst their service members.
3 And the data points for that are what are those
4 statements? We can see in the, for example, in
5 the Commandants Guidance in the Marine Corps
6 there's specific statements about mental health

7 and how it should be treated on a equal footing
8 with physical health. And other service leaders
9 have statements like that. I think we ought to
10 comment on the existence and maybe some of the
11 gaps in those statements and where they should
12 occur for this particular element.

13 DR. MacDERMID: All right. Let's move
14 on. Next element is the access to and efficacy of
15 existing programs in primary care and mental
16 health to prevent, identify and treat mental
17 health conditions among members of the armed
18 forces including programs for and with respect to
19 forward deployed troops.

20 We've talked about this a number of
21 times and our sense is that our best data comes
22 from the MHAT data collection effort; is that

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1 right or are there other things that people know
2 of?

3 DR. McCORMICK: Well, again, I think we
4 have -- of course the MHAT data is only about
5 while deployed. That's a subset of the issue. I
6 guess my only read is that in terms of access,
7 first of all in visiting the 37 bases we chose all
8 the largest bases as well and tried to do an
9 on-the- ground assessment of access and I think
10 that -- and then there are some of the parts of
11 the surveys, including MHAT, but also some of the

12 other surveys that have been done that do address
13 this question. It is though an under-researched
14 question in my opinion. I think that's what we
15 found especially among the Guard and Reserves. No
16 one really has responsibility for asking them so
17 they haven't other than the main study asked them
18 what is your access to care.

19 On efficacy, again, I think we've taken
20 the approach that we tried to look and see what
21 measures there are of efficacy. Now efficacy is a
22 very difficult thing to measure. We saw examples

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1 of structural measurements of it. You have a
2 certain program. We saw some process measures.
3 We saw very little outcome data in terms of really
4 measuring whether people get better over time.

5 We did see a best practice, I think a
6 potential for this in a behavioral, computerized
7 behavioral health record because that gives you a
8 platform for really doing some true outcome data
9 and in that particular setting there was some true
10 outcome data. So I think we are in a position to
11 make recommendations about how to structure,
12 including a behavioral health record the feedback
13 loop that you need to be able to improve services
14 by actually looking at outcome over time. The
15 only other thing I would say is that we did -- one
16 of the other advantages of visiting so many mental

17 health facilities we did try to look at whether
18 evidence-based best practices are being used. The
19 advantage of an evidence-based best practice is
20 that you do at least have a clearly researched
21 approach, let's say cognitive behavioral therapy
22 for PTSD so the research is done to show that this

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1 works. Then it's a matter of seeing on a process
2 basis how much is it really being translated into
3 practice in the system. So we did look very
4 carefully at how well and how well informed and
5 whether people are using the DoD best practices.
6 And in mental health, again to their credit, DoD
7 has some very well established practice
8 guidelines. In that regard we did find that they
9 were seldom really measured -- they was seldom
10 measurement as to whether they were in practice
11 and use. And the translation of those practice
12 guidelines in the practice, we did not find a lot
13 of evidence of that, so that is certainly
14 something we can comment on and make
15 recommendations about.

16 DR. MacDERMID: I just find one other
17 source of information -- this is about during
18 deployment and again comes from the Army. But you
19 might recall that late last fall there was the
20 report issued from an Army behavioral health
21 summit. There was a paragraph in there that dealt

22 specifically with care during deployment. Here's

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1 what it said, "Evidence-based medicine is actively
2 practiced on the battlefield. Mental health
3 professionals are well trained and provide a
4 variety of services including medication,
5 individual counseling, group counseling, forward
6 deployed care and command consultation. A full
7 range of psychopharmacologic treatments are
8 available and policies have been developed for
9 their appropriate use in theater. Mental health
10 professionals in theater are highly motivated to
11 provide state-of-the-art care to deployed
12 soldiers. The vast majority of soldiers who
13 receive care in theater for acute stress reactions
14 or PTSD are returned to duty." So I'll just sort
15 of throw that out there if anybody wants to say
16 anything about it or add anything else.

17 MS. EMBREY: I have a question about --
18 this is clearly a requirement for you to assess
19 and make recommendations to improve access to and
20 efficacy of existing programs in primary care and
21 mental health care. And the real issue here is
22 the inventory of such programs. A

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1 characterization of where they exist and the
2 extent to which we have access data, utilization
3 data and whether or not we are seeing a rate of
4 efficacy. Again, I don't know that we have good
5 measures for that at this point, but I think that
6 the idea here is to catalog the existing programs.
7 And the previous question is really about how well
8 known these programs are to the active duty forces
9 and the service population in terms of the fact
10 that these potential problems will exist
11 particularly at this point in time in our
12 operational environment that this is a very
13 important area of care, of continuing care and
14 prevention. And I think they were interested in
15 finding out whether or not the population as a
16 whole recognizes this is a natural demand in our
17 system that we have to have capacity to support.

18 I understand that you were looking at
19 particular things, but have you done the inventory
20 of existing programs in such a way that that would
21 be addressed as part of your report?

22 DR. MacDERMID: I believe that we have.

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1 One of the things -- I should explain that our
2 recommendations are not organized according to the
3 elements of the report. At least that's sort of

4 how it's looking like it's going to turn out.

5 MS. EMBREY: Okay.

6 DR. MacDERMID: So I think what's going
7 to happen is that the elements are actually going
8 to be listed toward the end of the report and will
9 indicate a summary of here are all the different
10 sections that deal with this issue. For example,
11 for this particular element, I think things that
12 come into play are the continuum of care and what
13 are the big pieces of the continuum of care in the
14 military and who gets access? Where are the gaps
15 and for whom in the continuum of care? I think
16 it's been challenging all the way along to be sure
17 that we have all the information that we need
18 about forward deployed folks because not all the
19 information exists. It's pretty difficult on the
20 battlefield to run out and do outcomes assessments
21 about mental health treatment. So even though the
22 MHAT reports are Army only and even though they're

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1 self-report only, they seem to be the best data
2 source that we have.

3 DR. McCORMICK: Let me just address that
4 one other time. It's a very well taken point and
5 there's kind of the two extremes. For example, we
6 did seek and did get from Maximus the certifier of
7 all residential and partial hospitalization
8 programs in TRICARE a complete listing of where

9 their facilities are. So that with regards to
10 partial hospitalization we can say, for example,
11 they only exist in 17 states. So that's a clear
12 example of a huge gap for a partial
13 hospitalization program. We can list the 33
14 states that don't have them. It's actually in
15 their report.

16 At the other extreme there is -- we were
17 unable to find a really clinical inventory of all
18 the cognitive behavioral programs for PTSD
19 existing in MIFs, it does not exist. I think
20 there we will be able to make recommendations
21 about structure. The answer to your question is
22 that there's a whole continuum of how much

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1 specificity we are able to collect from available
2 data.

3 MS. EMBREY: So to make sure I
4 understand then, in the context of the elements as
5 they were prescribed to you the task force will be
6 addressing your knowledge of existing programs in
7 both primary and mental health capacity and then
8 addressing that in the context of whatever
9 approach you're going to be providing in your
10 report? That you'll be addressing capacity to
11 deal with these issues and cross-referencing it to
12 this particular element, rather than dealing with
13 the element specifically?

14 DR. McCORMICK: Yes.

15 VADM ARTHUR: I think there's so much
16 overlap with all of the elements in the report,
17 which each of the elements that were specified
18 that it's impractical to do it element by element.

19 DR. MacDERMID: Right.

20 VADM ARTHUR: And I think you'll find
21 that each element is covered quite well by the
22 composite report.

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1 DR. MacDERMID: Let's move on then and
2 keep in mind this is also an active duty section,
3 so these elements deal specifically with active
4 duty.

5 This one is: The reduction or
6 elimination of barriers to care including the
7 stigma associated with seeking help for mental
8 health related conditions and the enhancements of
9 confidentiality for members of the armed forces
10 seeking care for such conditions.

11 There are a number, a plethora I would
12 say, of data sources about stigma and empirical
13 validation of the fact that stigma is real. The
14 survey of health related behaviors has items about
15 it. Some of the articles by Hogue list it and
16 notable there are the fact that concerns about
17 stigma in his 2004 article were more prevalent
18 amongst those who had positive indications for

19 mental health problems than folks who did not.
20 That's particularly of concern. Actually if I
21 went back through our early briefing, I found a
22 very good one that was made by Lieutenant Colonel

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1 Rick Campise sitting down the table about career
2 impact of stigma, perceptions of stigma and then
3 actual career impacts of seeking help, which not
4 surprisingly given what most providers will tell
5 you only in a very small minority of cases was
6 there -- did there appear to be a perceptible
7 career impact and those were usually small. And
8 it was particularly rare for there to be a
9 confidentiality violation when someone self
10 referred. But there are policy ramifications here
11 about the ability to self refer.

12 LCOL CAMPISE: And that's in the
13 November '06 Military Medicine. You referenced
14 the article.

15 DR. MacDERMID: In terms of reducing or
16 eliminating stigma, this is one of those issues
17 that really cuts across almost every section of
18 the report or every type of issue that we talked
19 about because stigma -- dealing with stigma seems
20 to require that you deal with training, I think it
21 requires that you deal with staffing, it requires
22 that you deal with where you place providers. It

1 has to do with the policy that you have about when
2 people -- when commanders need to be notified and
3 so on and so on. Are there any other issues that
4 people want to get on the table with regard to
5 this element?

6 I'll point out one other thing, in MHAT
7 data from the first MHAT to the most recent, the
8 reports of concerns about stigma had fallen quite
9 a bit, so that's a piece of good news about
10 stigma.

11 COL ORMAN: And we need to make sure
12 that we include Commander Sammons' article a Navy
13 psychologist did a good job.

14 DR. MacDERMID: Yes. I had the pleasure
15 of reading that within the last three days or re-
16 reading that within the last three days. Anything
17 else anybody want to add?

18 It was telling I think what was in that
19 article. It was very consistent with many of the
20 discussions that we've had about the ways that you
21 prevent stigma or reduce stigma or making sure
22 that treatment is effective and it's accessible

1 and people know about it and all the sorts of
2 things that we've heard testimony about and that
3 we have talked about. Anything else about that?

4 The early identification of treatment
5 and treatment of mental health and substance abuse
6 --

7 MS. EMBREY: Excuse me. You did not
8 address and I was wondering -- and it's a real
9 issue particularly in the military and that's
10 about confidentiality. I mean, did you have --
11 that is certainly -- it's been a big issue for
12 individuals in other endeavors that I've had. The
13 command and control structure doesn't allow a
14 whole lot of individual rights for confidentiality
15 especially when you have a combination of
16 behavioral health issues and behavioral outcomes
17 that put you in a position of being subject to the
18 UCMJ and command and control structures. So this
19 idea of confidentiality becomes quite important.
20 Have you drawn any conclusions or identified any
21 specific issues that we could benefit from at this
22 point?

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1 DR. MacDERMID: We have. And I think
2 one useful way to think about it is to use the
3 model of thinking about physical health where we
4 accept that it's normal and expect that everyone
5 who has a physical health problem will seek and

6 receive treatment for that problem and in most
7 cases will be able to resume their normal
8 activities with no future consequence from having
9 had that experience. That is not always the
10 truth. Mental health issues are not always
11 treated the same way in policy. Where current
12 policy sometimes seem to assume that the simple
13 fact of having sought treatment has some sort of
14 tail that is presumed to be a concern.

15 MS. EMBREY: Is that a policy or
16 practice?

17 DR. MacDERMID: Policy. For example,
18 when you are asked at different occasions to fill
19 out paperwork and asked whether you have ever
20 received any mental health treatment that is a
21 policy because it's on that form, but the reality
22 is if the question had been have you ever been to

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1 a doctor, you would say yes and expect that it
2 would have no consequence, but mental health is
3 treated a little bit differently. So our
4 discussions, I think have focused a lot on what's
5 the realistic parallel here. If you've gone to a
6 psychotherapist for smoking cessation, is that
7 something that you should fill out on paperwork
8 that your commander needs to know about. What
9 should be the parameters of what commanders need
10 to know about? It came up especially I think when

11 it came to alcohol treatment and when are the
12 appropriate -- which is worse? Someone who won't
13 go for treatment and is therefore walking around
14 with some big weapon and they have an alcohol
15 problem because they were concerned about command
16 notification and the commander doesn't know about
17 it? How do you resolve that? These are the
18 things that we debated.

19 VADM ARTHUR: Well the debate can center
20 around whether you're good at inventory control on
21 the third shift at K-Mart or whether you're
22 capable of guarding nuclear weapons. I think what

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1 we want to do is make sure that we don't miss
2 something that could have a very serious
3 consequence. So what the military may do in
4 certain circumstances is go a little overboard and
5 say, well, have you ever been to a mental health
6 provider and then to drill it down. And if you've
7 been there for smoking cessation; okay, no big
8 deal. Check, not a consequence. If you've been
9 there been because the voice is telling you to do
10 things, then we need to pursue. So I don't know
11 how to perfectly provider fidelity for the
12 guarding -- safeguarding of nuclear weapons while
13 only asking the appropriate questions every time.
14 I know there's got to be some leeway there and we
15 just have to find the right mix.

16 LCDR WERBEL: I think we are addressing
17 this and will in our report, but one of the issues
18 there for confidentiality really is still related
19 to education and stigma in that the way we treat,
20 in practice at least, not necessarily in policy,
21 regular medical appointments is that there is
22 typically no stigma associated with I'm going to

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1 see the doctor for a medical appointment, but you
2 don't necessarily have to say exactly what that
3 doctor's appointment was for. If we can get to
4 the point where we're effectively addressing the
5 stigma of seeing a mental health provider we would
6 then in practice be able to reach the same level
7 of confidentiality in that, which is it's okay to
8 say I'm going to see a mental health provider, but
9 you still don't necessarily have to say exactly
10 what you're talking about and what you're going
11 for. But it's inextricably linked to education
12 and the stigma attached to it.

13 VADM ARTHUR: You still have to balance
14 the government's need to protect -- you know,
15 we're giving these people weapons. So there is a
16 balance. And if you say you're going to your
17 podiatrist, there's not much in the care of one's
18 foot that affects your ability to own an automatic
19 weapon. But if you're going to see a mental
20 health provider, there are circumstances that we

21 would want to have an interest. And I think how
22 we vet those and how we sort that out is

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1 important. Stigma is a very, very difficult thing
2 especially for a force that depends on almost an
3 impression of invincibility in order to do what it
4 does to go in the face of overwhelming lethal
5 danger every day and to know that you're not going
6 to be the one that gets hit and you will prevail,
7 you will be effective in your military mission.
8 So it's a very delicate balance that the civilian
9 sector really doesn't have.

10 LCDR WERBEL: And part of the education
11 is not just the service members who are going for
12 appointment. Most of our commanders are pretty
13 comfortable that a podiatrist or an orthopedic
14 surgeon is going to tell them if the service
15 member who saw them for their foot is not fit for
16 duty because of a foot injury. I don't think we
17 have the same level of confidence amongst our
18 commanders that a mental health provider is going
19 to tell them exactly what level -- and maybe
20 because it's more of a slippery slope, it's not so
21 clear cut as the foot injury of when that
22 individual should be a concern for the commanding

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1 officer. So we need a lot of education for mental
2 health providers and for commanding officers.

3 VADM ARTHUR: I hope we can define that.
4 I mean psychosis, homicidal, suicidal intent, yes.
5 Depression? Probably not. Work-related anxiety,
6 anxiety from a relationship or remorse over some
7 incident. You know those are all life adjustment
8 issues and I think we should be able to separate
9 those out.

10 LCDR WERBEL: I agree. And if we can
11 educate both sides on that better than everyone, I
12 think, in the end will be more comfortable with
13 Ensign or Corporal So-and-So went to mental
14 health, okay. And if that doc isn't telling me
15 something then I don't need to know anything more
16 about what that issue was.

17 VADM ARTHUR: We may just want to
18 re-label it. Because for so long "mental health"
19 "go see the shrink," you know, has been a negative
20 imprimatur and perhaps what we want to do is
21 re-label the counseling or the services that are
22 provided such that it normalizes the referral

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1 rather than making it "go see the shrink" that has
2 the negative connotation. I don't know that we

3 might want to just remarket, repackage, remarket
4 some of this as we normalize.

5 DR. McCORMICK: I mean, there is a
6 threshold issue and I think one thing we did learn
7 -- and I agree with the Admiral. I think clearly
8 I think we believe the best person to make these
9 determinations is some mental health person who
10 thoroughly understands the military culture and
11 the military responsibilities of the force. I
12 believe what we're going to be trying to do in the
13 report is make some specific recommendations about
14 how to have that happen better because right now
15 there is a concern that -- there is a belief out
16 there that if you go to military mental health
17 you're going to ruin your career regardless.
18 Whereas you do have options. You could go to
19 military OneSource or if you're overseas, the
20 Family Life Consultants where there is absolutely
21 no release of information by anyone and it may be
22 by being seen by a provider who is less aware of

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1 the realities of weaponry and everything in the
2 military. So that -- right now you could in some
3 ways argue that maybe you have the worst of both
4 worlds if you have a system that keeps you both
5 from going to the professionals who may be best
6 able to make the judgment and yet give them an
7 out, give them another opportunity on DoD's dollar

8 to go get complete confidential care that will get
9 back to command not at all.

10 MS. EMBREY: I think the issue about the
11 paperwork is a valid one and I think maybe if we
12 got to the basis for what that paperwork
13 represents and what we're trying to protect the
14 system and the individual against. I mean, I
15 don't know exactly where those questions occur and
16 for what reasons, but I think it's appropriate to
17 ask those questions. If there's a chronic
18 decision-making dysfunction, but if you have
19 alcohol issues or whatever, that may be a
20 temporary situation which may not warrant checking
21 that box if it was identified and resolved. So I
22 guess -- what's the root cause about these

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1 concerns and the need for confidentiality and when
2 are we just asking the question and just
3 continuing to reinforce this stigma without basis.

4 DR. MacDERMID: It does have a lot to do
5 though too with severity. If you've been
6 hospitalized for a mental health issue that's a
7 much different matter than you received five
8 sessions of therapy. And I think right now the
9 documentation of contact with mental health is not
10 very refined and there could be some refinement
11 done there so that it doesn't need to have this
12 tail.

13 VADM ARTHUR: We still need to keep in
14 mind that we're giving these people automatic
15 weapons and we're stressing them even more by
16 putting them in situations where they're lives are
17 at danger and lives of other Marines and soldiers
18 are depending on them. So there must be the
19 balance.

20 LCOL CAMPISE: A perfect example of how
21 we breed the stigma in a situation has to do with
22 security clearances. At a number of bases that we

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1 visited we actually had people stand up in the
2 audience and say "All I did was go for marital
3 therapy, so I had to check the box, and of course
4 that generated a paper review and so my security
5 clearance is delayed for a length of time or it
6 would have been really unnecessary if I could have
7 just ignored that box and said no for something as
8 simple as going in for marital therapy or having
9 gone through a divorce and sought some counseling
10 for the end of that relationship."

11 MS. FRYAR: Rick, I think also what has
12 lended itself to the stigma is that that marital
13 therapy -- the record may be tagged and perhaps
14 five or ten years down the road when their records
15 are pulled for their security clearance perhaps
16 that might come up as a red flag. So you're
17 absolutely right.

18 LCOL CAMPISE: The rest of their career.
19 Oh, you went for therapy 15 years ago.

20 MS. FRYAR: But it was marital therapy
21 or relationship counseling.

22 VADM ARTHUR: Well, I would just again

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1 say that there's an interest. I'm one who hasn't
2 checked that box for that very reason. Going to
3 therapy having to do with a marital issue. My
4 present wife is a Navy nurse, I heartily recommend
5 Navy nurse over a lawyer. So I check the box and
6 it's well explained, but I understand also that I
7 may have checked the box because I was manic-
8 depressive, I'm not, and had to be hospitalized
9 and we have to know that before we put people in
10 positions of access to serious weaponry or to
11 national secrets. Whenever national secrets are
12 given up people are always going back, let's look
13 at the background. Did we miss anything? Our
14 standard is perfection and I know it should not be
15 but we in government service are held to a very
16 high standard by the newspaper, by the courts, by
17 the American people, by the legislature to not
18 make mistakes with secrets and serious weapons.

19 LCOL CAMPISE: One of the things that we
20 as a task force struggled with was the whole issue
21 of regardless of whether we know about it or not
22 we have people in the military who are using

1 drugs, whether it's illegal drugs or whether it's
2 legal drugs or it's alcohol. And we have people
3 who have mental illness whether we know about it
4 or not. So how to bring that untreated group that
5 exists whether we acknowledge it or not into the
6 light and have them receive treatment at the same
7 time ensuring that they don't have their finger on
8 a nuclear weapon.

9 VADM ARTHUR: That's true. In my case
10 the counseling was 27 years ago, but I still check
11 that box. And I go for urinalysis tests about
12 once a month. I mean, here you've got a 3-star
13 Admiral going to have a urinalysis for drugs. But
14 I do it because I understand that everybody does
15 it and everybody else in the military understands
16 that we want a drug-free workplace and we want a
17 workplace free of threats to our security. It's
18 just a very delicate balance and when you don't
19 err on the side of secrecy or the weapons security
20 we can have some serious consequences. When we
21 err on the side of the individual then we're not
22 having as much stigma but we're taking a lot more

1 risk and I guess the question is where do you want
2 the line that says risk?

3 DR. MacDERMID: Okay. This next element
4 is probably the one that's been the most
5 challenging to try to figure out. It reads: The
6 early identification and treatment of mental
7 health and substance abuse problems through the
8 use of internal mass media communications
9 including radio and television and other education
10 tools to change attitudes within the armed forces
11 regarding mental health and substance abuse
12 treatment.

13 One of the things that we did was to
14 find out about how armed forces radio and
15 television uses its resources to address mental
16 health issues. So we have a bunch of detail
17 about, in particular, the public service
18 announcements, the PSA strategy, because that's
19 really the main way that things happen. That's
20 primarily a public affairs operation as opposed to
21 a mental health or a clinical operation so there's
22 a rotation of PSA's that get used, many of which

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1 touch mental health and particularly recently
2 there's been work on suicide prevention. This is
3 just my opinion out of my head but there may be
4 opportunities perhaps to work more strategically

5 in coordination with the people who oversee health
6 work even more strategically with the people who
7 oversee PSA's to have sort of coordinated
8 messages.

9 There are also a ton of websites and we
10 didn't do an inventory of websites and there's
11 actually a specific question later about a
12 specific website. But we've talked a few times
13 about how the problem doesn't really appear to be
14 that there's a shortage of information. It's
15 almost the opposite where there's sort of an
16 avalanche of information and the challenge is how
17 do you get the right piece of information into the
18 hands of the person who needs it at the moment
19 that they need it. That's the struggle. Does
20 anybody have anything they want to add to this
21 particular element?

22 DR. McCORMICK: Just to point out that

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1 the last part of that phrase really does cover --
2 we are going to be covering that in a lot of ways
3 and that's the education to change attitudes. We
4 again did find best practices. This goes to a
5 point that was made earlier, I think maybe by the
6 Admiral, that part of the real thrust is to try to
7 normalize stress reactions so that things like
8 Army's Battle Mind or Family Battle Mind are good
9 examples of "education tools" to change attitudes.

10 I think the attitude we recognized and will be
11 making specific recommendations about who to
12 educate and how to educate them to in fact try to
13 normalize attitudes about stress reaction.

14 DR. MacDERMID: One source is probably
15 also a good example in this category where there's
16 education offered but also support and resource
17 and referral sorts of things.

18 MS. EMBREY: Can I ask a question about
19 the role of our external media. Have you explored
20 as part of this particular issue the -- I mean,
21 you guys are experts in stress reaction and stress
22 adjustments that are considered to be "normal"

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1 given various circumstances. In order to address
2 the issue of people having difficult times on that
3 continuum of depression, if you will, from mild to
4 extreme, all the evidence of all the research that
5 I've ever seen is that the earlier one
6 acknowledges that they have an issue and they seek
7 appropriate health. The less chronic it is and
8 the more effective that individual is at coping
9 with future encounters in the world of depression
10 and stress adjustment reaction. So how can we
11 work with external media to educate the population
12 at large because my perception -- I'm a civilian.
13 I don't see that happening for the population. In
14 the post 9/11 environment, the nation as a whole

15 was dealing with a whole series of challenges to
16 what they considered normal and there's a lot of
17 stress about we're under threat, we potentially
18 could be attacked. There's a lot of feeling of
19 insecurity and a lot of people reacted negatively
20 in a lot of variety of ways. I think the overall
21 population could benefit from what is a normal
22 reaction to these high stressors and how we as a

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1 nation of individuals should not approach having
2 these feelings as a negative and that there are a
3 wealth of resources and approaches for coping with
4 this that is important to seek early. I don't
5 believe the onus of this kind of a problem needs
6 to be put on the backs of the military even though
7 I believe the military certainly has the largest
8 challenge because we're in the fight. But the
9 family members who are here -- our whole
10 infrastructure in our communities feel the stress
11 of our neighbors going to war and the families and
12 the support systems that are in place. Have you
13 explored how we might use -- not use, but leverage
14 the Discovery channel or the Health channels,
15 cable networks or anything like that to bring out
16 the state of mental health and behavioral health
17 programs and their effectiveness as part of an
18 education to society not just the military?

19 DR. MacDERMID: The element dealt

20 specifically with the use of internal mass media
21 so we did not spend a lot of time on external mass
22 media. But if you look to your right, one of our

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1 nation's experts on the issue is sitting beside
2 you so we'll let her speak.

3 DR. POWER: Thanks, Shelley. I think
4 that your question actually is one that is
5 encouraging that you're exhorting really all of
6 the federal partners and all of the agencies that
7 have been involved in this to take a look at that
8 issue. And there have been some attempts as we've
9 even had conversations amongst our players to
10 really think about and take that a step further.
11 I'm not sure that will be a substantive part of
12 the report but I think that discussion really has
13 already started. SAMHSA as the mental health and
14 substance abuse agency has its own set of public
15 communications vehicles. Congress gives us money
16 through the Ad Council through a variety of other
17 resources to develop anti-stigma messages, to
18 develop a variety of awareness building
19 educational tools and vehicles for mental health
20 in general because our job is to make sure that
21 Americans understand that mental health is
22 essential to overall health. So that as a result

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1 of the President's new freedom commission was the
2 direction. We also of course have NIMH who have a
3 substantive communication vehicles for letting the
4 public know -- their Real Men, Real Depression
5 campaign, we've talked about those kinds of
6 vehicles are very important. HRSA has been given
7 a variety of resources from the Congress to expand
8 its mental health expertise and capacity at the
9 community health center level. They're looking at
10 some strategic campaigns about how to do that.
11 We're having some collective conversations and
12 Shelley mentioned suicide prevention. We've
13 talked across the DoD interagency efforts in
14 suicide prevention along with NIMH and SAMSA doing
15 some suicide prevention approaches about one of
16 the ways to combat suicide is to have people feel
17 that they can talk about suicide and educating the
18 world at that. This task force and its membership
19 has had an opportunity to start to expose each
20 other to some of those ideas. And I think that we
21 eventually -- particularly with the VA I might
22 add, and the VA has some internal educational

1 materials that I think would apply to the general

2 public and vice versa. We have some things that
3 would apply both to DoD and to the VA. So I
4 consider this to be sort of the beginning of that
5 opportunity and though there -- I think that
6 depends a lot on the targeted audience and for
7 example we're starting the next phase of a public
8 awareness campaign on how important it is to share
9 information about the revelation of mental health
10 and that the healing process just of revealing
11 that you have a mental health problem is in itself
12 putting you on the road to recovery. We're going
13 to highlight an individual who is a veteran in
14 that campaign. So we think that's the way we can
15 start to do some interconnectivity about some of
16 the public general messaging that I think is
17 really important. So your question I think helps
18 encourage us to continue to do that.

19 LCOL CAMPISE: One of lessons that we
20 learned just from our internal customers is that
21 we need to stop creating PowerPoint's to address
22 the need. I think reality -- the customers that

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1 have received those walk away retaining almost
2 nothing. So we need to be much more effective on
3 how we convey information so that it actually
4 sticks with folks.

5 MS. FRYAR: There are also several
6 success stories that are internal that I think

7 that you'll see come out in the report as best
8 practices. You already mentioned military
9 OneSource, you know there's the mental health self
10 assessment program that individuals can online and
11 take. There's the deployment health library,
12 that's another example. There's the deployment
13 health -- oh, I mentioned the library, and the
14 military Home front. Also the Sesame Street
15 Initiative was an excellent example of a success.

16 LCOL DOUGLAS: The Marine Corps -- one
17 of the bases took on their initiative to put one
18 together. It's senior leaders and others who have
19 suffered from PTSD. They've put together a video
20 that we actually were trying to improve on and
21 disperse Marine Corps wide, but -- so there's not
22 a global effort as you're talking about, but

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1 people have found pockets that that is a way -- a
2 better way to proceed.

3 DR. MacDERMID: Thanks everybody.

4 LCOL CAMPISE: Just one other thing
5 about the education tools that we discovered too
6 is marketing is essential. You can have the best
7 product in the world, but if you don't find an
8 effective way to market it doesn't do any good to
9 have it.

10 DR. MacDERMID: Thanks. All right.
11 Let's move on to the second group. This group is

12 evaluation. I think an overarching comment about
13 this group of elements is that it's fairly safe to
14 say that evaluation efforts are not as plentiful
15 as we would hope to see when resources in a system
16 are tight that's hardly the time that people want
17 to start devoting substantial resources to
18 evaluation. And good evaluation takes significant
19 resources to do.

20 With that as a sort of an overarching
21 comment the next element is the scope and efficacy
22 of curricula and training on mental health matters

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1 for commanders in the armed forces. There are a
2 number of people on the task force who are
3 responsible for preparing the material that
4 commanders receive in their training on mental
5 health and perhaps you'll comment on that. I also
6 know that each of the services has a leaders guide
7 for managing personnel in distress which has
8 fairly detailed coverage of mental health issues.
9 But does anybody want to add things that they know
10 about specific training?

11 LCOL CAMPISE: Primarily that it was
12 disappointing that -- the level that wasn't
13 occurring in the sense that throughout the course
14 of an officer and enlisted members career they get
15 professional military education and every time
16 there's going to be a jump in status and

17 supervisory experience. And what we discovered is
18 almost little to nothing is devoted during that
19 period of training to how to recognize and respond
20 to people that are in distress and be responsible
21 for them.

22 MS. EMBREY: Having listened to you all

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1 this morning, it seems to me that the education
2 and training and the ability to recognize and
3 sense a situation that requires attention and
4 follow up in terms of treatment and counseling, it
5 seems to me to be an individual requirement.
6 People need to recognize their friends and it
7 sounds to me like this is a stepwise type of an
8 approach where individuals need to be aware that
9 mental health is a component of an overall
10 person's health and that you should be acutely
11 aware of what those situations are so that you can
12 help your friends and your friends can help you
13 and then as you mature into a leadership role,
14 what is the next level of knowledge and experience
15 that you need to have and how does that get
16 inculcated into the professional military
17 education process and then how that then leads to
18 a whole series of other very high senior leader
19 concerns and issues that get to the kind of crux
20 of the topics we were talking about before,
21 balancing the interest of government versus the

22 rights of an individual.

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1 DR. MacDERMID: In fact, I think that's
2 very consistent with our discussion. This element
3 is specifically about commanders, but I think the
4 content of the discussion, for example, the phrase
5 psychological first aid was mentioned, that we
6 teach very junior people how to recognize physical
7 and deal with minor physical issues. We teach
8 people about medical conditions at a very early
9 stage in their careers, but we don't necessarily
10 do the same thing about mental health that we do
11 with physical health. So very much a sort of
12 public health approach with good awareness with
13 some sophistication even early on about
14 recognizing issues and training all the way along
15 the career. In fact one of the Admiral's first
16 observations was that we don't do -- we probably
17 don't do as much as we should at the service
18 academies.

19 MS. EMBREY: We have gyms at all the
20 installations but we don't have a mental health
21 gym.

22 DR. MacDERMID: Right.

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1 VADM ARTHUR: We will after this report
2 comes out.

3 LCOL CAMPISE: If I could just comment,
4 too. We expanded this beyond just commander into
5 saying it's not a commander responsibility but
6 it's a peer's responsibility that some of the
7 recommendations that we have outlined it as you
8 have what is a peers responsibility, what's a
9 supervisor's, what's the medical system's
10 responsibility, et cetera.

11 DR. MacDERMID: Let's talk about
12 screening. The efficiency of pre- and post-
13 deployment mental health screening including
14 mental health screenings who have experienced
15 multiple deployments. I want to just bring to
16 everyone's attention a couple of things that we
17 heard during our deliberations that we might have
18 lost track of. One is that the Defense Health
19 Board actually considered this issue in 2005 and
20 we were provided a copy of their memo and they had
21 some concerns about the validity of the
22 pre-deployment health assessment and the

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1 post-deployment health assessment. Keep in mind
2 that PDHRA the 90-days post return assessment came
3 along after 2005. Also the behavioral health

4 summit that was held in the Army there were some
5 comments about screening and some of the
6 difficulties that were being run into with this
7 sort of number and sequence of screening, trying
8 to get them all administered in the correct time
9 frame. So I'll just throw that on the table.
10 Does anybody want to add any other observations
11 there?

12 DR. McCORMICK: Well, I think that one
13 thing we carefully deliberated about was the --
14 what is the most appropriate investment in
15 screening. When do you screen? How do you
16 screen? And there are some substantive issues and
17 dilemmas there. On the one hand you ideally want
18 to screen to be kind of a blunt instrument that
19 gives you your first indication and then you go on
20 from there. On the other hand given the reality
21 of stigma in mental health we have carefully
22 considered and saw some best practices where some

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1 of those screens -- some places were doing them
2 with a personal face to face kind of interview and
3 our reporting and had some data to show us that
4 they got better results in terms of people really
5 being willing to sign up or to try to get help,
6 make an appointment to get help so that we will be
7 addressing that issue on the realities of perhaps
8 having to invest more in initial screening when

9 you have a high stigma environment in order to
10 maintain, to catch problems early and to prevent
11 greater problems later. Invest early in screening
12 as kind of a prevention thing, if you will, to
13 prevent later --

14 LCOL CAMPISE: Universally we found that
15 the customers themselves said that they'd much
16 more likely answer the questions honestly if it
17 was administered after they returned from leave
18 for a variety of reasons. Having them do it
19 either in theater or within the first day after
20 returning from theater they were afraid that it
21 would interfere with their ability to take leave
22 so they were likely to de-emphasize any

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1 difficulties they were having. Whereas they said
2 if you let us go on leave for two weeks and then
3 come back we're much more likely to answer it in
4 an honest fashion.

5 VADM ARTHUR: I think that's why we have
6 the post-deployment reassessments in six months.
7 And I think why the Guard and the Reserve are
8 looking at their policy of not getting back
9 together for 90 days after deployment they're
10 looking at doing that earlier so that they can
11 have some time to have the break and then come
12 back and be reassessed. You also bring up the
13 point the we need early assessment. I think if we

14 can identify people who are at risk even as they
15 come into the service we can provide the
16 counseling that will add resilience to their
17 psychological capability. I don't think we fully
18 understand the debt that some of our service
19 members come into the service with already having
20 experienced a great deal of stress in their lives.
21 So early assessment and as the Commander down
22 there said, Aaron you said this morning, early

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1 assessment and counseling for everyone so it's not
2 just some people who -- some of the weak ones who
3 are stigmatized but everybody gets it as a matter
4 of due course.

5 MS. EMBREY: My office happens to be the
6 policy office for the pre- and post-deployment
7 assessments, as well as the periodic health
8 assessment, as well as the separation physical, as
9 well as the accession physical. So I think what
10 I'm most interested in from your perspective is
11 because we are attempting now as a department to
12 address capturing longitudinally the evolution of
13 a person as they evolve in their career in terms
14 of their physical and mental health. I think this
15 question was dealing with the repetitive nature
16 and the effectiveness of so many assessments. In
17 any given year with all the assessments that have
18 been required we will be assessing people as much

19 as five times in a year if they've deployed and
20 returned within that year. I certainly think that
21 may or may not be overkill. At least two of those
22 assessments are required in law, pre and post. We

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1 instituted an annual health assessment in order to
2 make sure that we were addressing more fully the
3 whole person, both physically and mentally. And
4 the real issue here is from your perspective are
5 those instruments sufficient in terms of not
6 diagnosing but screening. Are we asking the right
7 questions at least annually?

8 COL ORMAN: I think before we can
9 address the content question, we do need to
10 address the process and you alluded to it. If you
11 listen to both providers as well as the soldiers
12 that are deploying, redeploying, et cetera, sort
13 of the consistent feedback we got is it's
14 overkill. And sort of their assessment fatigue, I
15 think an undesirable consequence that many of them
16 endorsed is we just pencil whipped the damn thing
17 to get it over with. I think we, at higher levels
18 people tend to forget how busy people are who are
19 doing this sort of deployment, redeployment,
20 reintegration, et cetera, et cetera and the more
21 stuff that you give them to complete that you make
22 a requirement that they have to stop training or

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1 come back early from leaves, or however it's
2 perceived by individual service members, the more
3 it's perceived as not being value added from their
4 personal perspective, the more worthless the
5 content is even if the questions are excellent.
6 And so the issue is is there a balance that meets
7 at some level the political needs of the
8 department to say we've done things to protect the
9 health of our warriors with the reality on the
10 ground of we've got too much to do already and
11 this is just one more thing that I know -- because
12 people don't follow up even when I do endorse
13 positive items, that I know is sort of a waste of
14 my time. Again, I think the feedback we got
15 generically around that whole issue is why don't
16 you just give us a face to face at least once a
17 year and we'll articulate what the issues are in
18 our family and we'll articulate what kind of
19 issues we may have brought into the service with
20 us. And then if you'll make an honest effort to
21 follow through with that then we want that kind of
22 help. But throwing surveys and forms at us five

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1 times a year just makes us devalue that whole
2 thing and we see that at as the leadership sort of
3 trying to protect themselves rather than being
4 honestly concerned about us.

5 VADM ARTHUR: Dave, I certainly agree
6 that four or five times a year is probably not the
7 right answer. I think it's our challenge to shape
8 the assessment tools in such a way that they are
9 meaningful and don't become viewed as nonvalue
10 added. If you drive your Humvee a certain number
11 of miles, you're going to change the oil. We know
12 that's in the maintenance schedule. I think that
13 many of the things that we do ought to just be in
14 the maintenance schedule for the human weapon
15 system as well and become just part of doing
16 business. If it's seen as something outside of
17 the military way of doing business; in other
18 words, here we're going to go train to be a
19 military soldier or marine and then we're going to
20 do this health thing, because it's something other
21 than training to be a good soldier then it will be
22 viewed as nonvalue added. I think an assessment

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1 tool and what we do with it would show great value
2 to building the soldier as much as physical
3 fitness, cleaning the weapons, changing the oil on
4 Hummers.

5 MS. EMBREY: I also think you need to

6 segregate what we do annually to assess the entire
7 forces mental and physical health. And what we do
8 as a means to acutely assess the readiness of an
9 individual to deploy into a combat environment and
10 then upon their return to assess the impact of
11 that deployment on their ability to return to home
12 and to reintegrate. It is unfortunate that we
13 have high demand because we have a large number of
14 people who are going and coming back and
15 reintegrating so we have a series of demands that
16 ask for an annual assessment which is more
17 comprehensive than the screening before and after
18 deployment. But I think what we need from your
19 perspective is when we are obligated to look at
20 how we address individual capacity to deal with
21 their health, whether it's mental or physical,
22 throughout -- from year to year as they're in a

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1 career are we -- are the tools we are using
2 effective at getting us to the conclusion we need
3 and if we are just rotely checking the box that's
4 certainly something we don't want to do. So the
5 tools themselves become very important and the way
6 in which we execute those tools becomes important.

7 I think I'm very, very open to improving
8 the process and reducing redundancy and becoming
9 more effective at doing this, but I also think we
10 would not do our service members a service to

11 eliminate any one of the assessments that have
12 been put in place to ensure that we capture -- we
13 provide safety nets to capture, identify, treat
14 and provide the support that's necessary, both
15 before and after deployment, because an annual
16 review is more about health maintenance than it is
17 prevention. Well it's about prevention too, but
18 it's about health maintenance where the pre and
19 post are about experiential diagnosis.

20 VADM ARTHUR: We prepare people for
21 combat now. We train them in weapons, we train
22 them to be physically fit, we train in combat

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1 tactics, but we have not gotten an assessment tool
2 yet which will tell us how vulnerable they are to
3 the stresses of combat or how well they'll
4 perform. It's only combat that weeds that out. I
5 recall vividly, I was in SERE training early
6 in my career and many of us were there and we all
7 knew that no matter how hard the training was they
8 couldn't kill us. I mean, you can't kill people
9 in the training scenario, so there was really
10 almost no danger. And that security goes away the
11 minute you step into combat and put live ammo in
12 your M-16. You can get killed and it is -- I've
13 been in combat, it is a life-changing event to go
14 under that kind of stress and I don't -- I think
15 it would do us well if we could identify, find

16 some assessment method that would allow us to
17 understand the needs of the most vulnerable and
18 maybe that there are people that shouldn't go into
19 combat.

20 DR. McCORMICK: I think we need to
21 underline method and let me go to your point
22 because screening is something in a broader sense

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1 that I do some work in. If you're doing universal
2 screening you're usually looking for a highly
3 sensitive, not very specific instrument with the
4 understanding that you'll get a certain number of
5 hits and then you'll be able to follow up on them.
6 It's an efficiency issue. When you have such an
7 instrument and it gets to the point that 30, 40,
8 50 percent of your people are being screened in,
9 it needs to make you question whether you're
10 really doing the right thing and whether you
11 really need the dental model where you just give a
12 somewhat more thorough method, maybe face to face
13 to the whole population. That's kind of where I'm
14 coming from. When on the PDRHA you start seeing
15 that high number of hits, then it really does beg
16 the question as to whether the method is --
17 whether screening is really the method as much as
18 it is kind of a resiliency interview for
19 everybody. If it's that common then it does just
20 like with dental, it begs the question as to

21 whether -- and it of course goes into other things
22 we've been talking about that a face-to-face

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1 interview -- and if we could get people to really
2 accept it as a resiliency interview and maybe
3 rather than spending all the money to do five
4 paper and pencil screening with high sensitivity,
5 low specificity issues, you'll get better results
6 with a different method.

7 VADM ARTHUR: You're not suggesting that
8 the dentist do it once a year are you?

9 DR. McCORMICK: Well, my dentist does.
10 My dentist wants me to come every six months but I
11 have an ongoing thing with them.

12 DR. MacDERMID: We should probably move
13 on. The next one is also one that we've struggled
14 with to some extent which is the effectiveness of
15 mental health programs provided in languages other
16 than English. I think it's fair to say that we've
17 struggled to find mental health programs provided
18 in languages other than English, let alone
19 effectiveness data.

20 DR. McCORMICK: Unless you consider
21 acronyms to be a language.

22 DR. MacDERMID: We could have that

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1 discussion. Military OneSource does provide
2 document translation at no cost; it will provide
3 services in 150 languages which we were very
4 pleased to hear. And installations do maintain
5 lists of personnel who speak other languages, but
6 we did not find any evaluation data of mental
7 health programs provided in languages other than
8 English, unless you want to count the evaluation
9 of the Sesame Street Initiative which was provided
10 in both English and Spanish.

11 The next group of elements deals with
12 family issues.

13 VADM ARTHUR: That prior element
14 probably was mostly family issues also?

15 DR. MacDERMID: Yes, that's true. I
16 think what I'll do is group these together just
17 for interest of time. I'll read them all and then
18 we can put on the table whatever people want to
19 add. Access to and programs for family members of
20 members of the armed forces, including family
21 members overseas.

22 The awareness of mental health services

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1 available to dependents of members of the armed
2 forces whose sponsors have been activated or

3 deployed to a combat theater.

4 The adequacy of outreach education and
5 support programs on mental health matters for
6 families of members of the armed forces.

7 MS. EMBREY: Did you conduct any surveys
8 as part of this?

9 DR. MacDERMID: We did not.

10 COL ORMAN: One of the things we heard
11 universally, Shelley, is the families that needed
12 services that most were generically realizing
13 there's many exceptions were generically the least
14 likely to be participating in the support
15 programs. And so on the one hand we've already
16 had our discussions about access and distribution
17 problems geographically with TRICARE providers, et
18 cetera. But perhaps a more fundamental question
19 is when you're no longer talking about active duty
20 where you can sort of compel certain behaviors,
21 what do you with families that commanders are
22 aware have needs. That NCO's that are part of the

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1 chain are aware of have needs or for a variety of
2 good and bad reasons either choose or are not able
3 to avail themselves of whatever care is available.
4 Those were the profound issues I found that I'm
5 not sure there's good solutions for.

6 LCOL DOUGLAS: Another thing as far as
7 families and access to programs. There's still a

8 problem with service members who aren't
9 registering their families with exceptional family
10 member program and then do deploy overseas and now
11 there is no appropriate service for that family
12 member or child who does have needs. What also is
13 happening is people are taking and accepting
14 orders to go overseas and then bringing their
15 families along and they're draining the system on
16 what services are available because their family
17 is known and does have an exceptional -- or a need
18 for services so they're taking away from other
19 services. And that's something that I know armed
20 services has been trying and constantly pushing
21 their service members to register their family
22 succession, family members so we don't assign them

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1 in the wrong place knowing that the services are
2 not available.

3 VADM ARTHUR: Again there's a bit of a
4 stigma there, too. I mean, if you can't go to
5 Okinawa, it's tough to be a Marine because that's
6 where the major training site is overseas. So if
7 you're telling a Marine, well, gosh, you've got to
8 put your family in here and if you can't deploy to
9 Okinawa then we need to know. And if you can't
10 deploy to Okinawa you can't go over with your unit
11 and it affects careers. So part of our working
12 with the service members is making them have a

13 viable career after they put their name on that
14 list.

15 LCOL DOUGLAS: And it was pretty hard
16 for us, from a leadership perspective from the
17 Marine Corps, it pushed a point when General Jones
18 had an exceptional family member and didn't
19 register her.

20 VADM ARTHUR: I know. I took care of
21 her.

22 DR. McCORMICK: I think the question

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1 about whether we did surveys is a very good one.
2 I think we all agree that the ideal survey would
3 be a broad range of family members, both who
4 sought mental health services and who didn't
5 successfully engage in mental health services as
6 to their accessibility. We could find really
7 nothing that approached that. The TRICARE people
8 did provide some data on patient satisfaction in a
9 broad sense, but the literature is very clear that
10 outside of the military that satisfaction results
11 on mental health services are not well tracked by
12 a general patient satisfaction survey. Also of
13 course that's a select sample of people who got to
14 TRICARE so you miss the access issue. So there
15 clearly is a need for more systematic assessment
16 of the family's perception of the accessibility of
17 mental health services and it doesn't exist at the

18 moment.

19 DR. MacDERMID: Well there is sort of a
20 proxy or an approximation with the Status of
21 Forces surveys of spouses and perhaps the survey
22 of Army families which is a survey of spouses. So

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1 we're assembling that information. I think it's
2 fair to say based on discussions that we've had in
3 the task force that families who are located
4 OCONUS sometimes find it more challenging to
5 access services than families who are located in
6 the continental U.S. No? People are shaking
7 their heads.

8 COL ORMAN: I think it's very dependent
9 on where you are in the continental U.S. I would
10 argue there are families that -- because we've
11 heard this, that go out of their way to be
12 assigned overseas, because there's greater access.
13 Whereas if you're assigned to Fort Wachuka or
14 Minot, South Dakota or any number of other places
15 we could name, there is no provider community
16 around you and the provider community that's
17 inside the MIF is fairly minimal.

18 DR. MacDERMID: So that's the
19 difference? Overseas the MIF's are more
20 thoroughly staffed because they know there's not
21 going to be any kind of community provider.
22 There's no assumption made about community

1 providers being available.

2 LCOL CAMPISE: Though there were no
3 formal surveys of family members, a way of
4 inferring the access, which we were able to come
5 up with is we asked the providers for the mental
6 health clinic there about the accessibility of
7 child psychiatry off base. And the answer was not
8 unusual, six to nine months for the initial
9 appointment. And I'll never forget a spouse that
10 was sitting in the audience with her husband who
11 was going to be deploying in two months for Iraq
12 and the husband, knowing that it was going to be
13 six months before that date, so he'd be in country
14 for four months before their down syndrome child
15 would have their first psychiatry appointment. So
16 he knew that he would be leaving his wife with a
17 very difficult situation and there was going to be
18 no immediate assistance on the horizon.

19 MS. EMBREY: You talked earlier this
20 morning about the differences from location to
21 location and between military department and
22 military department about the programs that are

1 available and that even within the same service
2 there are pockets of excellence and pockets of
3 gaps in terms of resourcing at various locations.
4 And this sort of addresses and that in the
5 interdisciplinary nature of this thing between the
6 family support services at installations and
7 what's available at the MTF and the lack of
8 integration there. So it seems to me that you're
9 addressing that issue in the context of not so
10 much the awareness of it, but if you're in a place
11 where it's available, you're aware of it. If
12 you're in a place where it's not available you're
13 not aware of it and I -- that's sort of my
14 impression of your perspective on this.

15 DR. MacDERMID: No. I think the data
16 that are available suggests that there are gaps in
17 awareness and that is what you find also in the
18 civilian community that most workers, for example,
19 are fairly imperfectly aware of what benefits they
20 have available. I think that's true also in the
21 military. There are lots of attributions about
22 why families who want or need help don't get it.

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1 One hypothesis is (off mike) people out there who
2 just won't just sort of take action. I don't
3 think that's the whole story. When I went to the
4 Sesame Street event where they were talking about

5 their video tapes, I was astonished to hear that
6 they had 100,000 requests for their materials in
7 the first week of their availability. Somebody
8 was taking action to get that information. And so
9 I think it may have to do with the methods of
10 dissemination and how creative people are,
11 providers are in getting the information out
12 there. I think it does have to do with the
13 avalanche of information that is there and being
14 able to sift out the one piece that you need which
15 does speak to the possible appeal of something
16 like a OneSource where if you can just remember
17 that one thing you might have a better chance of
18 at least getting to something that you need.

19 COL ORMAN: There's almost
20 anti-marketing that goes on. And just to envision
21 a scenario that's very common, if you're a
22 provider, whether it's behavioral health, primary

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1 care, some other specialty in a geographic area on
2 an installation that has a relative dearth of
3 providers, you're very reluctant to market
4 services to a population where you know you can't
5 deliver. And so some of this has to do with what
6 we talked about earlier, which is if there's not a
7 critical mass of what's needed in any given
8 location for any size beneficiary population you
9 certainly can't count on your providers to be

10 marketing services that they know doesn't exist.
11 It's both unethical and it's unfair, but it speaks
12 to why are there pockets where people seem like
13 they're not able to either advocate for themselves
14 or solicit services and the reality is nobody's
15 going to be promising them anything because it
16 just doesn't make any sense and that's the
17 distribution dilemma I think we face.

18 DR. MacDERMID: This would especially
19 relevant for relationship issues. For example
20 during deployment if there are parenting issues.
21 That's another one of those v-code matters. So
22 not covered by TRICARE, possibly not able to be

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1 dealt with at the MIF because half the providers
2 at the MIF aren't deployed and unclear who else on
3 the installation is well prepared to do this. So
4 there can be a gap although very often the family
5 support centers have staff to deal with it and
6 perhaps the child development center is in very
7 good shape also to deal with it. Less often I
8 would say the case at school, off the installation
9 in particular, are prepared.

10 LCOL DOUGLAS: Well, this brings up
11 something else we noticed during -- this is grief
12 counseling and the lack of grief counselors
13 available throughout the system. We found on
14 pocket of excellence during the whole time this

15 task force stood up. I know this is very
16 important because we're allowing spouses to stay
17 on the installation longer now once they become
18 widowed. So grief counseling is very important,
19 but yet it's not available in the majority of our
20 installations.

21 DR. MacDERMID: Let's move on.
22 Continuity of care. This is a group of elements

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1 that dealt with transition from DoD to the
2 Department of Veteran's Affairs. Follow up for
3 Reservists and for discharged, separated or
4 retired members of the armed forces,
5 collaborations among organizations in the
6 Department of Defense and coordination between the
7 Department of Defense and civilian communities.

8 I can make a couple of overarching
9 comments. I guess, especially given recent
10 events, there seem to be some issues with
11 transition that are structural. It's a very
12 complicated process to get from DoD to VA that has
13 many steps and that -- structurally that just
14 takes time and there are now a large number of
15 other groups that are considering those matters.
16 The other overarching comment I'll make is that I
17 think we pretty consistently felt that it is
18 extremely challenging to ensure good transitions
19 and especially good follow up for members of the

20 National Guard and Reserve. That is a very thorny
21 problem. And as of the middle of last year only
22 about 6.1 percent of the PDHRA, the 90-day

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1 follow-up assessment had been completed in the
2 National Guard and 1.4 completed in the Army
3 Reserve, a big backlog, but the problem is even if
4 they complete that assessment who is it that's
5 going to follow up and make sure that they get
6 hooked up with a provider to provide the services
7 that they need. It's a very thorny problem, but a
8 real continuity of care issue that I'm frankly not
9 sure we have a lot of solutions for but it's
10 certainly something that we've discussed.

11 Other continuity issues that people want
12 to raise?

13 DR. McCORMICK: One of these things that
14 we did staff and did talk about was Congress
15 passed a law allowing entry into VA care for two
16 years regardless of level of eligibility. There's
17 a substantial body, and overwhelming body of
18 literature that shows that PTSD, military trauma
19 often first surfaces well after that. Ten years
20 after Vietnam we were still getting many, many new
21 cases. Huge numbers of -- still people coming
22 forward. So we question the logic of a two-year

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1 cutoff for a condition which we know has very
2 delayed (off mike) and the concern that someone
3 two and a half years later could get caught up in
4 the eligibility morass or a condition that
5 ironically the best place to get care ought to be
6 in the VA because you don't necessarily expect
7 civilian providers to be as expert in combat-
8 related PTSD.

9 DR. MacDERMID: Anything else that
10 anyone would want to add here?

11 DR. POWER: I think that I'll just add
12 that we noticed in five or six programs that were
13 interviewed relative to Guard and Reserve
14 follow-up activities that though there were some
15 excellent programs that had really spent the time
16 to develop state level and at a local level strong
17 collaborative working relationships with the local
18 providers, both their mental health agencies and
19 the substance abuse agencies that they were unique
20 and this was an area that we really wanted to pay
21 some attention to in terms of taking those half
22 dozen programs and showing the leadership and the

1 extension of collaborative work that was necessary

2 in order to dig dip into local community and make
3 those resources available for Reserve and Guard
4 and family members. And a tremendous amount of
5 work in order to make that happen. It didn't
6 happen naturally and that the amount of
7 information in terms of getting accurate
8 information to their Guard and Reserve units was
9 really homegrown. There was really no mechanism
10 from a national level from a leadership level
11 where they could get good information about that
12 and they were all developing their own level of
13 presentations and their level of activities. So
14 we like what we saw at some of those state
15 programs, but there's a long way to go.

16 VADM ARTHUR: I think we also need to
17 keep in mind that although we are pretty focused
18 on Iraq, Afghanistan and the current military
19 conflict, these issues of mental health go way
20 beyond wartime service. They are present in
21 normal service life. So I just caution not to
22 build a system around combat that needs to handle

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1 all of the rest of the unique aspects of military
2 service.

3 DR. MacDERMID: Right. And it sort of,
4 I think this war has really highlighted the
5 transition that's happened in the force, it's a
6 much larger role being placed by the Guard and

7 Reserve, not just in terms of percentage
8 representation -- of course the levels for which
9 they've been deployed and DoD, I think has been
10 working to kind of catch up to that proportion
11 shift in terms of the way services are delivered.
12 One of the reasons why -- Dave Orman, help me if
13 I'm wrong, I think that's one of the reasons that
14 OneSource came into being was to try to deal with
15 the geographic bias that historically has happened
16 because services have been organized around
17 installations and that has become less true as a
18 larger and larger percentage of the service
19 members are not near installations.

20 MS. FRYAR: Shelley, I'd like to say
21 something building on what Katharine had said in
22 regard to the National Governor's Association

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1 there are some very productive collaborative
2 efforts happening with the National Governor's
3 Association with regard to mental health that we
4 heard about.

5 MS. EMBREY: I think the issue of
6 continuity of care is being addressed at the
7 cacophony of task forces and commissions that have
8 been established within the last two months and
9 certainly your conclusions on this particular
10 issue would be informative to those communities as
11 well. I think continuity of care assumes certain

12 things about the military health system and the
13 community based healthcare systems that don't
14 exist within the U.S. and that is we don't have
15 compatible electronic health systems in order to
16 move records easily from military into civilian
17 healthcare record keeping environment. There
18 isn't a two-way exchange between the civilian
19 health record of a Reservist and the military
20 health system. So we are dealing with a half of
21 piece of bread in terms of -- you know it's hard
22 to do maintenance on anybody, health maintenance

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1 on anybody if you don't have an understanding of
2 the whole experience. And that is the challenge
3 with the Guard and Reserve is that we only have
4 the records we keep for the care that we provide
5 in our system and the annual certification by the
6 individual that their health has not changed since
7 the last time they came in. So with that there's
8 challenges in terms of providing continuity as
9 they move in and out of the military system. And
10 I think that's one of things that I hope we can
11 learn from in not only your perspective but in
12 some of these other groups that are looking at
13 this is how do we organize and posture ourselves
14 to address this issue so that we do have good
15 continuity of care for our force that must
16 maintain physical and mental fitness. And what is

17 the role of the individual to maintain the fitness
18 when they are not on active duty? And how do we
19 assure that? That's a real challenge for us.

20 DR. MacDERMID: And there are
21 philosophical differences between DoD and VA that
22 are yet to be resolved that we've become very

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1 aware of.

2 The last two things I'll mention --
3 well, maybe more than two, but these are elements
4 that were added after our original charter. One
5 deals with special issues for folks who have been
6 deployed multiple times. In other words, what are
7 the differences between multiple deployers and
8 single deployers? There are data in some of the
9 Hogue studies about multiple deployers versus
10 others, but I wanted just to open it up to others
11 of you that want to cite other evidence.

12 MS. EMBREY: Did you identify that the
13 department was doing any research on these
14 individuals in terms of health outcomes? Is there
15 any ongoing studies other than the Hogue studies?

16 DR. MacDERMID: Well, the Millennium
17 Cohort study would pick up people who are deployed
18 multiple times. I'm not aware of any studies
19 specifically about multiple deployers. I think
20 there are a number of studies that will pick up
21 multiple deployers within their population and

22 then they have the options of looking for

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1 differences.

2 LCOL CAMPISE: There was another one. I
3 don't remember it was specifically Army or if it
4 was one the DoD released recently that came
5 through Joyce's office, through your office.

6 MS. EMBREY: But I don't know that we
7 have -- institutionally, you know, it's a
8 challenge while you're prosecuting a war to draw
9 conclusions about it in the middle of it. I think
10 -- are you making any recommendations about
11 research associated with the effects of multiple
12 deployments on health and maintaining health in
13 the structure or anything like that?

14 DR. MacDERMID: We have talked a great
15 deal about research and have a number of draft
16 recommendations that deal with that. I'll also
17 point out that in that same 2005 Defense Health
18 Board memo there was a list of research topics
19 that made a lot of sense to us and so we would
20 endorse those as well as some of the things that
21 have come up in our discussion.

22 Another element that was added was an

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1 evaluation of availability to members of
2 assessment under the mental health self assessment
3 program of the Department of Defense to ensure the
4 long-term availability of the diagnostic mechanism
5 that the assessment to detect mental health
6 conditions that may emerge in such members over
7 time. As you all probably know the mental health
8 self assessment program offers anonymous web-based
9 self administered assessment that you can also do
10 by telephone or in person and what's covered now
11 are depression, bipolar disorder, alcohol use,
12 PTSD and generalized anxiety disorder. 50,000
13 assessments have been completed so far, but I am
14 not aware of any evaluation data for that yet. It
15 hasn't even been available, I don't think for a
16 full year yet. So I'm not aware of any evaluation
17 data, but it's certainly available. Is there
18 something I'm missing about that?

19 MS. EMBREY: That's being run out of my
20 office and I do know we have a planned evaluation,
21 but it is not completed.

22 DR. MacDERMID: Now also another element

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1 that -- there was also an element that asked about
2 the same program and the availability of
3 assessments for children. And I see nothing

4 available yet there that specifically targets
5 children. Of course adolescents in many cases can
6 complete alcohol use and depression/anxiety
7 measures that were developed for adults. There's
8 nothing there yet that specifically targets
9 children.

10 MS. EMBREY: Do you believe that that's
11 something that should be developed?

12 DR. MacDERMID: You know there are child
13 psychiatrist in the room and I think I would defer
14 to them. Warren is a child psychiatrist and
15 perhaps you can speak a little bit to that issue
16 whether we would want the web-based self
17 assessment program to provide opportunities for
18 parents to perhaps work with their children or
19 children to work on their own.

20 CAPT KLAM: I think children are sort of
21 a silent minority/majority and I think that we
22 don't -- they become symptomatic after they've

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1 been suffering for quite a long time. I think
2 that any tool that we have that can help identify
3 the mentally ill would be appropriate.

4 MS. EMBREY: Are there any such tools
5 out there that could be adapted to that?

6 DR. MacDERMID: Oh, yeah. There are
7 measures of children's anxiety and depression.

8 MS. EMBREY: Perhaps you could address

9 that then in your findings and recommendations.

10 DR. MacDERMID: Okay. The last thing is
11 wanting recommendations on mechanisms for
12 improving the mental health services available to
13 people deployed in OIF and OEF including us who
14 have undergone multiple deployments. We due to
15 take a break so I'll just say basically everything
16 that we've talked about at every other meeting and
17 on every page of the report speaks to those issues
18 so I don't know that we need to do more of that
19 here. Anything else anybody needs to air? I
20 don't know what the -- we will take a break now
21 and we will reconvene at 1500. Thank you.

22 (Recess)

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1 VADM ARTHUR: Welcome back. I see we
2 have some newer people here than we had this
3 morning and earlier this afternoon. This is the
4 open public statement session of our meeting
5 today. Can I just get a show of hands of who
6 would like to speak this afternoon? One, two,
7 three, four, five. Can we just take it in that
8 order, then? One, two, three, four, five? Would
9 that be all right?

10 I'd like to, since we have five people,
11 I think between five and ten minutes each if we
12 could limit it to that that would be good. If you
13 have to go over it, we'll certainly make

14 accommodations. We want to hear what you have to
15 say. If you'd like to ask us questions that would
16 be fine as well. Sir. Could you identify
17 yourself? I should identify myself, first since
18 you're new to the -- I'm Admiral Don Arthur; I'm
19 the Surgeon General of the Navy. I'm the co-chair
20 of the Mental Health Task Force. Dr. Shelley
21 MacDermid is the other civilian co-chair and we're
22 glad that you're here. You have a bronze star?

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1 MR. SALAZAR: Yes, sir.

2 VADM ARTHUR: From?

3 MR. SALAZAR: Vietnam.

4 VADM ARTHUR: Vietnam. Where did you
5 receive your bronze star? What kind of action?

6 MR. SALAZAR: I was at Benewah Air Base
7 in 1965.

8 VADM ARTHUR: Air Force, then?

9 MR. SALAZAR: Yes, sir. That was my
10 primary. From there we went in different
11 directions.

12 VADM ARTHUR: Thank you for coming.
13 What's your name?

14 MR. SALAZAR: My name is Placido
15 Salazar, and presently I'm the state Veteran's
16 Affairs officer for the American GI forum. In
17 that position I'm in contact with quite a few
18 disabled veterans from the Korean War -- well,

19 actually from the WWII, Korea, Vietnam on up
20 through the present war in Iraq and Afghanistan.

21 I'm not really sure about the context of
22 what has been going on or really the -- I just

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1 read briefly in the newspaper this afternoon, so I
2 decided to rush on over here. I live about 35
3 miles from here.

4 But my main purpose for being here as a
5 veteran and representing other veterans is that we
6 see another study, apparently. We've had it up to
7 here with studies. And, you know, the suffering
8 goes on and on and on. Approximately 3- to
9 4,000,000 of us served in Vietnam. The government
10 has spent over \$2 million studying on the effects
11 of Agent Orange and other chemicals. And although
12 the Institute of Medicine declared in 2000 and
13 2001 report that there was no way possible to
14 determine one way or the other whether or not we
15 were exposed or what the effects of Agent Orange
16 would be on us, VA is still using that
17 non-information to keep to denying us benefits and
18 to the families of those who succumbed as early as
19 a year or less after we got back from Vietnam. I
20 feel that we have been through enough already for
21 anymore studies to be conducted. It doesn't take
22 a genius to read the label on, for example, on

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1 Roundup, which is available in most stores right
2 now. Basically that's one of the 75 different
3 chemicals that were included in Agent Orange. And
4 that one there tells you that it's dangerous
5 stuff.

6 If you multiply that times 25, and
7 that's according to the study that even Admiral
8 Zumwalt did back in the 70s where he told the VA
9 exactly what they did not want to hear, so
10 therefore the report was classified. I have a
11 copy of it. The report was classified and it was
12 buried never to see the light of day. Well, it
13 has resurfaced. But in the meantime, I read in
14 that report where our government knew beforehand
15 what the effects of Dioxin would be and there was
16 a doctor in there that -- his name escapes me
17 right now, but he told Senator Tom Dashell, we
18 knew what the effects would be, but we were sure
19 that our government would take care of our troops.
20 They sure have taken care of us by ignoring our
21 illnesses, all our comrades that have died how it
22 has affected their families. They've come out

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1 with unexplained tumors all over their face. The
2 wife of one of my buddies, a tumor next to her
3 face that was actually bigger than her face and he
4 mercifully died about five years ago. Not even a
5 shadow of the man that he was when we became
6 friends before we went to Vietnam. That's a
7 horrible way to go. That's a little bit too much
8 for our country to ask of us and then just cast
9 aside like yesterday's dirty underwear. That is
10 totally unfair and it's about time -- about time
11 that we finally did justice to the Vietnam
12 veterans. Studies and more studies.

13 Now they're starting studies on depleted
14 Uranium and the other chemicals which our new
15 generation of warriors have been exposed to from
16 the 90s until now. How many studies does it take
17 to determine that depleted Uranium is a deadly
18 material? Saran is a deadly material as we heard
19 from the release of Saran in the Japanese tunnel.
20 How many people died instantly? Why do we need
21 more studies? Years, years, years and more years
22 of studies. Like I mentioned before, our

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1 government has spent over \$200 million to study
2 Agent Orange. There was only about 3 or 4 million
3 of us serving there, if they had given us
4 \$100,000, which is better than what we've been
5 getting up until now. If they had given us

6 \$100,000 each that are suffering from the effects
7 of Agent Orange, our government would still be way
8 ahead of the game.

9 I was reading another study on PTSD,
10 which our government did also, on the effects of
11 PTSD on teenagers. It mentions that teenagers are
12 affected with PTSD due to a traumatic experience.
13 What could be more traumatic than for a child to
14 go, for example, to BAMC or any other military
15 hospital where our troops are returning from
16 overseas and to see mommy or daddy missing arms or
17 legs or with their ears melted off their face, the
18 skin melted off their face? What could be more
19 traumatic? And yet our government is totally
20 ignoring the effects of PTSD on our children, on
21 our wives, on our parents. It's about time that
22 we wake up and start facing reality and understand

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1 that when we send our troops -- it's mighty nice
2 to say "We support our troops," well what about
3 supporting our veterans when they return totally
4 maimed if they don't return in a pine box with an
5 American flag draped over it. Thank you very
6 much.

7 VADM ARTHUR: Thank you very much.
8 Thank you for your service and your energy to
9 stand up for veterans.

10 MR. SALAZAR: You haven't seen anything,

11 sir.

12 VADM ARTHUR: I can imagine. I would
13 just tell you the reason this task force was stood
14 up is because we don't want to repeat some of the
15 mistakes we made after Vietnam. This is the
16 mental health task force so we're dealing with
17 PTSD, traumatic brain injury and many of those
18 other issues you talked about. We do not want to
19 repeat what we did to the Vietnam veterans which
20 is to ignore a lot of their post traumatic stress
21 disorder so that they got worse and were never
22 treated.

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1 One of the things that we have talked
2 about at great length is how do we treat the
3 entire family because we realize the service
4 member never serves alone. He or she serves with
5 the entire family, which now is mothers and
6 fathers, spouses and their children. We're very,
7 very concerned about the children. In fact, I'll
8 tell you I testified in front of the House Arm
9 Services Committee a couple of weeks ago. And
10 Representative Jones from North Carolina where
11 Camp Lajeune is said he was at Camp Lajeune he
12 asked a child where his father was -- his father
13 deployed. And the little boy said "My daddy's in
14 Iraq. He's not dead yet." And to have a child
15 think in those kinds of terms about his father

16 just speaks to the effect of military service
17 especially in wartime on our children. So I think
18 we clearly have your message and I think you're
19 spot on in trying to make sure that our veterans
20 and their families are well cared for for the
21 sacrifices they make.

22 MR. SALAZAR: Let me ask you this. Our

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1 government was very derelict before we returned
2 from Vietnam, before we left the country, was very
3 derelict, probably intentionally in not
4 forewarning us that anything that any souvenirs,
5 any jackets that we brought over for our children
6 were drenched in Agent Orange. Consequently even
7 the children that were already born have been
8 affected by Agent Orange. I watched one of my
9 sons just curl up when he was about the age of 6
10 or 7 and up until that time he had gone to the
11 extreme that he had to drag himself across the
12 floor. He and his twin brother were normal up to
13 that point, but for some reason it affected him a
14 heck of a lot more than the other twin. And so
15 far he has not been able to catch up to his --
16 their 45 years old now and he hasn't been able to
17 catch up to his twin brother.

18 VADM ARTHUR: We don't know much about
19 Agent Orange, since we're the mental health task
20 force, but we'll pass this on.

21 MR. SALAZAR: Well, sir -- but the thing
22 is that the effect that has on the entire family,

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1 it's a very stressful situation where you have to
2 see your son dragging himself across the floor
3 that just adds to the rest of the PTSD which I
4 brought back as an unwanted souvenir from Vietnam.

5 VADM ARTHUR: Yes. I understand.

6 MR. SALAZAR: What about the other
7 illnesses that are related to PTSD which our
8 government chooses to keep denying us compensation
9 for -- or even to acknowledge, forget the
10 compensation. Forget the compensation. But it's
11 a shame that our government keeps laughing in our
12 faces in denying the fact that PTSD -- I'm sure
13 you're familiar with the report that was made by
14 Dr. Bascareno?

15 VADM ARTHUR: No, I'm not.

16 MR. SALAZAR: Well, look it up, sir.

17 VADM ARTHUR: Okay.

18 MR. SALAZAR: Because the VA did the
19 same study and they came up with basically the
20 same thing but only if you look for it will you be
21 able to find it as to the various illnesses that
22 are related to PTSD such as heart disease,

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1 vascular disease, rheumatic disease, lung disease,
2 so many, you know, if the brain is affected every
3 other part of the -- if your immune system is
4 affected every other cell of tissue in your body
5 has to be affected and the VA --

6 VADM ARTHUR: That's why we're here. We
7 are here --

8 MR. SALAZAR: Right. But the thing is
9 the VA has known about this for years, why haven't
10 they done anything yet?

11 VADM ARTHUR: Well, I'll let the VA
12 speak to that. But that is why we are here
13 because we recognize PTSD as being a very severe
14 syndrome that we must meet head on before it gets
15 to the point where it affects the families
16 forever. So we are dedicated to that and that is
17 our sole mission.

18 MR. SALAZAR: We appreciate it.

19 VADM ARTHUR: Well, thank you for being
20 here. Thank you very much. Colonel, welcome.

21 LCOL TOLBERG: Admiral Arthur, it's nice
22 to see you again, sir. I'm Lieutenant Colonel

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1 Grant Tolberg and I'm the Marine liaison in charge
2 of the patient administration tracking team at

3 Brook Army Medical Center. I've had the pleasure
4 of meeting the Admiral before on one of his visits
5 to BAMC during my tenure there.

6 Let me start by saying that I'm going to
7 keep this very, very short. I am not endorsed by
8 BAMC or even headquarters Marine Corps. I've
9 written a paper for one of my courses because I'm
10 very concerned about what I feel is maybe not the
11 most appropriate educational course that we have
12 to educate our wounded warriors on combat stress
13 and symptoms recognizing the (off mike) post
14 traumatic stress syndrome. I'm really encouraged
15 by what you've said so far Admiral that you all
16 are taking such a serious look at this. The two
17 programs that are in place, Battle Minds for the
18 Army (off mike) transition for the Marine Corps,
19 really don't pertain to the new realities faced by
20 some of our really traumatically wounded. I think
21 Battle Minds kind of impresses me that it's an
22 impressive video production and if it's matched up

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1 with good narration I think it can be very
2 effective for our soldiers that don't have
3 traumatic physical wounds. I think that a lot of
4 the soldiers or marines, if they were to see this
5 that I know, look at this and they're going to
6 look at some of the problems that these soldiers
7 depicted have, and go, you know what? That's not

8 my world anymore. I wish I could have problems
9 like that. So I think that we just need to spend
10 a little bit of money and rewrite these two
11 programs to have a wounded warrior version. And I
12 think that would speak to the audience much more
13 effectively.

14 I think even more importantly than that
15 though, more importantly than the lesson plans
16 that we're going to have is having the right
17 instructor. I think that the doctors and the
18 chaplains that are teaching these courses right
19 now have to stay part of the program, but the lead
20 has got to be, I believe, the combat leaders that
21 took these guys and these ladies to combat. And
22 there's not a battalion commander I know out there

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1 right now that has the time in between his
2 recovering from his last deployment and getting
3 his (off mike) to go back, not one out there has
4 the time to learn about this stuff, coming down
5 and teaching it. You know those guys got to learn
6 about this stuff and come down and teach it. They
7 can come down and they can teach a 45-minute class
8 and get back that night to Camp Lajeune or Fort
9 Orr or wherever they're coming from. And if it
10 can't be the battalion commander, maybe it can be
11 the Sergeant Major or maybe it can be a really
12 dynamic staff Sergeant, but it's got to be a

13 recognized infantryman or recognized combat proven
14 leader that can speak to these guys because they
15 are not -- the last thing that I want to do is
16 insult a medical officer or a chaplain or anybody
17 who's in this, but that's not who they need to
18 hear it from. The psychiatrists that I've met,
19 and it's my pleasure to know at Brooke, I don't
20 think they're that convincing when they're trying
21 to convey to one of my Marines, you know, it's
22 okay to talk to me. These guys see themselves as

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1 John Wayne and it's hard for them to admit to
2 somebody who they may not see as John Wayne that
3 they're not living up to being John Wayne. So I'd
4 really like to get from those.

5 Now, I have -- that's all the time that
6 I really want to take, Admiral. I left a few hard
7 copies of my paper and I left it on electronic
8 copy with Lieutenant Colonel Douglas and I know
9 that he can route it to the people who would be
10 interested in this and maybe like an alternate
11 opinion on it.

12 VADM ARTHUR: Am I wrong, but didn't
13 John Wayne die in the Sands of Iwo Jima?

14 LCOL TOLBERG: But he came back to life.

15 VADM ARTHUR: He did come back to life.
16 Well the point is we may be John Wayne, but we're
17 all human.

18 LCOL TOLBERG: Yes, sir.

19 VADM ARTHUR: And I think even better to
20 teach that course would be a recovered combat
21 wounded marine or soldier who could come back and
22 -- I'll tell you one of the most effective

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1 corpsmen I had when I was commander at Bethesda
2 was HM-2 Alanese and he would walk in and talk
3 with folks about their amputations and they would
4 say, well how do you know? And he would lift one
5 trouser leg while he was working on the ward and
6 say, I do know. He was one of the first
7 casualties who went out to save another Marine who
8 had lost a leg in a land mine incident. To have
9 people who have recovered from these very
10 traumatic injuries go back and stay in the Marine
11 corps as Corporal Wright with no hands stayed in
12 the Marine Corps to be a combat arms instructor at
13 Quantico; it is they who provide evermore
14 motivation to those who are wounded that yes, you
15 can do it. You can get up and be better. But I
16 think you're right, we are just in the beginning
17 of a hiatus. We have been 30 years without a
18 significant conflict. I was in Desert Storm and
19 it was nothing compared to Vietnam or today. So
20 in 30 years we have not collected the expertise in
21 combat experience or in combat wounds. So now we
22 have that expertise and many of them are getting

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1 better. Going back to the Marine Corps, we've got
2 a Seal in the Navy who has lost a leg. He is back
3 in Afghanistan with his unit. So we have people
4 who have recovered and they send no more powerful
5 message about recovery.

6 LCOL TOLBERG: We've got three Marines,
7 Admiral that have been approved to go back with
8 prosthetic hands or feet. And I do believe that
9 the peer visitor program is very important that
10 they are going to get a great deal out of it
11 especially if he's still in uniform. But I also
12 strongly encourage you to really consider the fact
13 of these guys who appear healthy, these combat
14 leaders coming back, because I think that one of
15 the problems that they have, that these patients
16 have is -- especially the ones who this was their
17 first tour, they didn't get all that reeducation.
18 They got the pre post-deployment lecture that
19 everybody else did the day or so before they got
20 on the airplane and I've got a Lance Corporal that
21 says I'm not going to go to that talking group
22 because they're going to think I'm stupid. He

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1 hasn't been educated enough that it's not
2 stupidity.

3 VADM ARTHUR: Yeah, good point.

4 LCOL TOLBERG: And I think that these
5 combat leaders need to come back and say, you know
6 what? Guys who didn't come back to the hospital
7 are suffering from this too. We are all -- the
8 guys were going back and forth and back and forth,
9 we are all suffering from this. You're no
10 different from us in that respect. I think that's
11 the point that needs -- and really only become by
12 those guys who are still slugging it out and still
13 going back like the amputees that you mentioned
14 right here.

15 VADM ARTHUR: Colonel, thank you for
16 what you're doing there at BAMC. That program was
17 highlighted by the Secretary of the Navy as being
18 one of the very best where Marines take care of
19 fellow marines and soldiers because you know what
20 they and their families need. So thank you very
21 much for doing that.

22 LCOL TOLBERG: Thank you, sir. I did

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1 see a clip of your testimony when you mentioned
2 Marine for Life and that was an effective program
3 and it was greatly appreciated -- it was nice to
4 see that -- we are very proud of what we've done

5 so far.

6 VADM ARTHUR: Yes, sir. Hoo-rah.

7 LCOL TOLBERG: But there's always room
8 for more. Thank you very much Admiral.

9 VADM ARTHUR: You're welcome, sir. Yes,
10 ma'am. Good afternoon. You don't have to stand
11 up, you can sit. I know Marine's like to stand.

12 MS. HALL: I'm a teacher. I like to
13 stand, too.

14 VADM ARTHUR: All right.

15 MS. HALL: Thank you. Good afternoon.

16 VADM ARTHUR: Hello.

17 MS. HALL: As I mentioned this morning,
18 my name is Lynn Hall and I'm a professor of
19 counseling at Western New Mexico University where
20 I train masters-level counselors who go on to
21 become professional licensed counselors and school
22 counselors. I apologize for my notes, but I don't

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1 want to ramble. I want to get through these as
2 quickly as I can.

3 VADM ARTHUR: That's fine.

4 MS. HALL: I'm also a licensed
5 professional counselor and a national certified
6 counselor as well as a nationally certified school
7 counselor. But I'm also the mom of a NCO Air
8 Force and who is married with three small
9 children. I have almost ten years of experience

10 working for the Department of Defense as a school
11 counselor in Germany at both the middle and the
12 high school level. That well meant that many
13 times I worked directly with families. Because of
14 my background prior to becoming a school counselor
15 in marriage and family counseling and in grief
16 counseling the families also often consulted me
17 for the issues that they were going through at the
18 time because they were unwilling to go to the
19 psychiatrist or psychologist on board.

20 There were two reasons for that. One
21 because of the stigma involved but also because
22 they felt their needs and their issues were

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1 transitional developmental issues and did not
2 really require the severity of care that might go
3 with seeing a psychiatrist. At the moment I'm
4 also under contract to complete a book called
5 Counseling Military Families to be completed by
6 June and published by the end of the year in which
7 I am attempting to help civilian professional
8 counselors understand the military culture and
9 help them in working efficiently with military
10 families that they might see in their practice
11 whether that be active duty or Guard and Reserve
12 component members and their families. All of that
13 aside however I am here today to represent the
14 National Board for Certified Counselors which is a

15 certification and training organization of over
16 40,000 professional licensed counselors in the
17 United States.

18 I want to applaud the work that the
19 Department of the Defense as well as the
20 individual services have done in the last decade
21 or so to support and understand the mental health
22 issues of service members and their families as

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1 they are faced with obviously ever increasing
2 needs and challenges. (off mike) programs as the
3 family support centers which did not exist when I
4 was working in Germany, the military OneSource
5 counseling services and the recent congressional
6 action in recognizing masters-level licensed
7 counselors by the VA administration.

8 The National Board for Certified
9 Counselors wants to take this opportunity to
10 support the National Military Family Association
11 in their call for additional mental health
12 services particularly in the area of child and
13 adolescent services, marriage counseling, services
14 for families of single soldiers and bereavement
15 counseling. NBCC the national board as well as
16 the American Counseling Association and the
17 American Mental Health Counseling Association are
18 all united and committed to offering technical
19 assistance with your challenge to define and

20 address the mental health needs of our service
21 members and families. Since the early 1970s
22 numerous universities have offered Masters-level

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1 counseling program in both the European and the
2 Pacific theaters. These counselors received their
3 degrees through training and internship within the
4 military communities. In addition there are
5 thousands of highly trained professionally
6 licensed mental health counselors across the
7 country and I would hazard to guess even in all
8 those small world communities who are available to
9 work with the active duty service members and
10 families as well as the Guard and Reserve members
11 and their families who may not have the ready
12 access to military mental health services. And as
13 we're seeing more and more, even long-term retired
14 military who are now re-experiencing stress
15 issues. These professional mental health
16 counselors at both the Master's and Doctoral level
17 could meet some of the needs of the military
18 service member and families that were outlined
19 today.

20 Just to point out a few, this morning
21 you mentioned access to care. The number of
22 licensed professional counselors across the

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1 country coming from programs such as ours at
2 Western New Mexico is on the rise. If these
3 licensed counselors were covered by TRICARE the
4 body of available mental health workers outside
5 the military community could be significantly
6 expanded. By counselors trained in some of the
7 areas that you mentioned as most needed including
8 marriage and family counseling, child and
9 adolescent care including toy therapy and grief
10 and bereavement counseling. You also mentioned
11 the issue of stigma. In my work with families
12 seeking assistance and support and therapy from a
13 licensed professional counselor who practiced from
14 a developmental strength based and transitional
15 perspective seemed less of a stigma then having as
16 the only choice a more medical model or a severe
17 level of care received by psychiatry or
18 psychology. I think that goes to the issue this
19 morning addressed to the normalization or re-
20 labeling of the service. Regarding sources,
21 because of the large number of professionally
22 licensed mental health counselor's access could be

1 more timely and in most cases less expensive. We

2 also believe that these licensed mental health
3 counselors could assist in providing the services
4 needed while the military services are dealing
5 with the internal issue of retention and
6 recruitment.

7 Vice Admiral Arthur mentioned this
8 morning the entry of care. It is often or may be
9 the norm that the spouse is often the first to
10 access mental health care and often because of the
11 difficulty mentioned again this morning of finding
12 appropriate care and sometimes not understanding
13 the military jargon on base, these young spouses
14 will often seek care off base and often beginning
15 with the school counselor. This choice of seeing
16 a civilian professional counselor at an entry
17 point makes a lot of sense.

18 First, it possibly will provide early
19 identification and assessment as well as early
20 intervention of concerns that may go unnoticed for
21 months or years until they reach more permanent or
22 long-term problems such as family violence,

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1 marital dissolution or full-blown PTSD.

2 Secondly, these mental health counselors
3 could act as a support and referral system for the
4 family in finding additional assistance both on
5 base, through the schools or through the
6 community.

7 Third, these services are available
8 everywhere in the country even in the rural
9 country where the additional military services
10 might not be available. I do understand that
11 there might be some issues around these
12 professional counselors understanding and having a
13 sense of working with the military community, but
14 I'd like to add that the National Board for
15 Certified Counseling is ready to work with the
16 military in providing the training necessary for
17 these professional counselors.

18 Therefore, in conclusion I'm urging the
19 task force, as one of your recommendations that
20 professional mental health counselors across the
21 country be allowed to assist in meeting the needs
22 of the service members and their families by

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1 adding their services to those covered under
2 TRICARE. Thank you.

3 VADM ARTHUR: Thank you very much and I
4 think you've hit on two very, very important
5 concepts. First access and access doesn't mean
6 coming into a military hospital, it means getting
7 care wherever you can. School counselors,
8 chaplains, chaplains aides, whatever it is and I
9 think the NBCC is I think right on target with
10 asking for better education modules that will
11 help. The other thing that you point to is

12 stigma. And I think you're exactly right and we
13 addressed that a bit today in getting care at a
14 point where you don't have to say I went to a
15 mental health provider but you got the counseling
16 at the level with the expertise you need. And
17 certainly family counseling is something that we
18 need more of and one of the issues we're dealing
19 with is TRICARE and how that is paid for and I can
20 assure you that we will address that.

21 MS. HALL: Thank you very much. I do
22 have one question. Will the transcription of this

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1 meeting be available at some point either with?
2 Us --

3 MS. EMBREY: It will be published on the
4 internet under the Defense Health Board. You can
5 find it by finding Health Affairs and looking for
6 Defense Health Board, you click on that and you'll
7 have the transcript of this and all other
8 subcommittees and the Defense Health Board
9 deliberations.

10 MS. HALL: Thank you very much.

11 VADM ARTHUR: Thank you very much.

12 MR. WAITINGTON: My name is Michael
13 Waitington. I'm from (off mike), Alabama and I'm
14 a concerned parent. My son served in Korea for 14
15 months in the 2nd ID and then he was transferred
16 straight over to Iraq and served in Habbaniya for

17 a year. He was discharged last August and like I
18 say my only concern is soldiers coming back now.
19 I mean, his time is gone and he was discharged for
20 misconduct. I have entered a transcript with
21 Colonel Orman and I also entered a hard copy and I
22 would like to encourage all of you all to read

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1 that and would be very appreciative. If you do
2 read that and tell us what -- after a year in
3 Korea he was -- we had e-mails and stuff that he
4 was considered the best soldier in the platoon and
5 then bam, bam, you know after six months in Iraq
6 he started being a loner and then he come back to
7 Fort Carson and we couldn't get no help at all and
8 it was through me and my wife's trips out there
9 that we finally did get some. And I would
10 appreciate you-all's attention to that.

11 VADM ARTHUR: Thank you very much, Mr.
12 Whittington?

13 MR. WAITINGTON: Waitington.

14 VADM ARTHUR: Waitington. I know you
15 and I talked earlier this morning about that and
16 we recognize now as we have never recognized
17 before that coming back with post traumatic stress
18 issues, with traumatic brain injury and some
19 people with some real serious injuries causes just
20 the kinds of behavior that you talked about. It
21 causes one to get involved with alcohol and to

22 have some misconduct that may be a sign of the

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1 post traumatic stress rather than a sign of the
2 basic integrity of the individual. You and I
3 talked about more details than you eluded to here
4 and I fully understand your concerns and it's one
5 of the things that I know that we have talked
6 about and have discussed in other forums the
7 aspect of if you don't take care of the post
8 traumatic stress when you get back what are the
9 actions that are likely to be seen. Thank you
10 very much for the time that you took to come here
11 and the courage to get up and say the things you
12 have in favor of your son. And please thank your
13 son for his service.

14 MS. VALDICERI: Hi, my name is Page
15 Valdiceri, I think I said earlier. Right now I'm
16 currently a director of behavioral health for (off
17 mike) of health services but I also do treatment
18 on the side. I'm a licensed professional
19 counselor, I'm also a part of what Lynn Hall was
20 talking about the National Board of Certified
21 Counselors, I'm nationally certified. I'm a board
22 certified expert in traumatic stress and I'm with

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1 the American Academy of Traumatic Stress experts
2 out of New York. I have a couple different things
3 that I just jotted down so forgive me for going
4 over, but I have to tell you and I was telling
5 Shelley this that coming from someone who is
6 clinical, everything that you have spoken about
7 today I was jumping inside of myself because we as
8 clinicians have seen this for the longest time.
9 And to finally have a task force put together to
10 finally bring this to light for our service
11 members is just -- I can't even put to words the
12 passion that I have behind this. A lot of my
13 experience is with first responder communities and
14 that is police, fire, medic and military and
15 they're pretty much cut a lot from the same mold.
16 When Lynn was talking about the licensed
17 professional counselors I know that you were
18 discussing a lot the access on the installation.
19 These service members get more access on the
20 installations but that's just a small piece of it.
21 There's the Reserves, there's the National Guard
22 who are at small places like I think you said in

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1 Ohio where they don't get access. I think that
2 there needs to be -- I know that there needs to be
3 an expansion of providers that you use.

4 Everything that I have seen is that a lot of the
5 military really keep just within the social work
6 community and you're stopping yourself from
7 getting access to providers who can do more for
8 your service members which means TRICARE doesn't
9 get backed up, VA doesn't get backed up. You have
10 providers out there who are trained in combat
11 stress, in trauma, in marital counseling, in child
12 psychiatry, in children. And so I urge you to
13 really take a look at that and take a look at that
14 it's not just one provider that's out there.
15 There's a whole plethora of providers that are
16 waiting but it's hard to step into the military.
17 I equate that to I've done a lot of work with the
18 military and police departments and you have to
19 build a trusting relationship or no one is going
20 to come to see you and I think you had addressed
21 the pre- and post-deployment assessments and I
22 encourage that yes I think it is hard to do face

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1 to face, but I'm all about the face to face. When
2 I have a person sitting in front of me and they
3 can talk and they can know my background, they're
4 better to open up if you walk their walk, that's
5 with anybody. So I'm totally for the face to face
6 for the assessments.

7 Stigma, same thing. If you live in
8 their world, they'll live in your world and that's

9 kind of what we do is -- at least I do as a
10 clinical provider. You go out, you learn about
11 it, you be a part of it and then they're more apt
12 to open up to be a part of your world. It's all
13 about building relationships, it's all about trust
14 and the doors have to be opened so we can culminate
15 and build it together or this is going to stay the
16 way that it is.

17 I think that's about all that I wanted
18 to say although I could go on for a while, but I'm
19 just thrilled that we're getting the chance to do
20 this and you're bringing this to the forefront,
21 but these service members and their families and
22 their kids need to have access to these providers

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1 who are trained in these areas and we are out
2 there and we are waiting and we are training other
3 people to provide different networks that you can
4 utilize. So thank you for giving me this
5 opportunity.

6 VADM ARTHUR: Thank you very much for
7 sharing. I can feel your passion on this.

8 MS. VALDICERI: I tried to keep myself
9 down a little bit.

10 VADM ARTHUR: I would ask who else would
11 we want as a counseling professional except
12 somebody who is passionate about it. And I think
13 the reason you have the people on this panel is

14 because we are for the most part clinicians and we
15 understand. And many of us have been in combat
16 and understand these issues from a patient's
17 perspective as well as a provider's perspective.
18 I can tell you as a physician my main tool is the
19 trust and confidence that my patients have in me.
20 Without it treatment is for naught and you've
21 heard us say I think already today, wherever we
22 can get an entry point for the service member or

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1 his or her family is where we should start because
2 that may be our only chance. So thank you very
3 much and Lynn for bringing this to us. We'll look
4 forward to reading more about that.

5 MS. VALDICERI: If there's anything I
6 can ever do to help, I will volunteer my time and
7 do what needs to be done this cause needs to be
8 looked at, please let me know.

9 VADM ARTHUR: Let me give you my card.
10 We have two facilities, we have Walter Reed Army
11 Medical Center, we have Bethesda, which I
12 commanded for a while. Each of those facilities
13 takes care of the very finest of our Americans.
14 Americans who have given something of themselves
15 and their future for their country and they
16 deserve nothing but the finest treatment from us.
17 Thank you very much.

18 I know those were the five people who

19 had volunteered to speak, but is there anyone else
20 -- Sergeant would you like --
21 MR. SALAZAR: Can I please just have
22 about ten seconds?

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1 VADM ARTHUR: Another nickel? Yes, sir.
2 MR. SALAZAR: My recommendation would be
3 that --
4 VADM ARTHUR: Let me get you the
5 microphone here so that we can have it recorded
6 for transcript. We'll bring it to you.
7 MR. SALAZAR: This is Placido Salazar,
8 I'm a retired Air Force Sergeant and as I
9 mentioned before as the state veteran's affairs
10 officer for the American VA forum I make it a
11 point to hang out with veterans as much as
12 possible. And there's this place in San Antonio
13 where a lot of the troops hang out that are
14 between assignments. Out of those conversations
15 what I would recommend is that the very first time
16 that these troops come back from Iraq or from
17 Afghanistan that they should be thoroughly checked
18 for PTSD symptoms. And I think that in so doing
19 we might be able to maybe prevent incidents like
20 Abu Ghraib and that 14-year-old girl and her
21 family that she was raped and that whole family
22 was murdered in Iraq, because you know can -- I

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1 wish that you had the time there's this place
2 right outside of Fort Sam Houston that's called
3 the Drop Zone and that's where most of these guys
4 hang out and you could get an earful there and a
5 good education firsthand from the guys that are
6 coming back and then having to rotate. In one
7 instance there were three generations in the same
8 war. This guy had tumors all over his body and
9 everything from way back in Korea and then Vietnam
10 and then serving in Iraq. Another very quick
11 thing that I would like to recommend is to maybe
12 encourage or make it easier for veterans that come
13 back with PTSD to maybe be encouraged into the
14 psychology in the field of psychology where they
15 would be able to firsthand have a one-on-one
16 conversation with other PTSD victims. I mention
17 that because I'm lucky that one of the
18 psychologists that I was able to get to help me
19 through the VA is a veteran himself and a PTSD
20 victim

21 VADM ARTHUR: That's a very good
22 suggestion, Sergeant.

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1 MR. SALAZAR: That's what I would
2 strongly recommend.

3 VADM ARTHUR: We try our best to
4 identify PTSD and that's a lot of why this panel
5 exists is to make sure that we don't miss anyone
6 with PTSD and having served in Desert Storm in
7 combat I understand how difficult it is to tell
8 what is PTSD and what is just the normal reaction
9 to combat because everybody who experiences combat
10 is significantly affected. So Sergeant Salazar
11 thank you very much for being here.

12 MR. SALAZAR: It's an honor, sir. Thank
13 you.

14 VADM ARTHUR: Thank you very much. Is
15 there anyone else who would like to address the
16 task force? Thank you all very much. Dr.
17 MacDermid, do you have any comments that you'd
18 like to make?

19 DR. MACDERMID: I do not.

20 VADM ARTHUR: Ms. Embrey?

21 MS. EMBREY: No, sir. Thank you very
22 much for the opportunity to be here and thank you

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1 all who came to talk to us today for your insights
2 and input and your willingness to contribute to
3 the solution. I think we have the same end state
4 in mind and that is to do the very best we can for
5 those who sacrifice much for our country. And I

6 take very seriously the work of this panel and I
7 intend to do everything I can to do right by
8 everyone concerned. Thank you.

9 VADM ARTHUR: Comments from any members
10 of the task force? All right. Let's adjourn this
11 session and again thank you very much for coming
12 all of you, especially those who spoke. Sergeant
13 thank you very much.

14 MS. EMBREY: This meeting is officially
15 adjourned.

16 (Whereupon, the PROCEEDINGS were
17 adjourned.)

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