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**DoD TASK FORCE ON MENTAL HEALTH  
FULL TASK FORCE MEETING  
FORT HOOD  
DAY ONE**

**The Plaza Hotel  
1721 Central Texas Expressway  
Killeen, Texas**

**Wednesday September 20, 2006**

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**2**

- 1 PRESENT:**  
**2 DoD Members of the Mental Health Task Force:**  
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- 3 LTG KEVIN KILEY, Surgeon General, U. S. Army -  
4 Falls Church, VA
- 5 COL ANGELA PEREIRA, PH. D., Department of  
6 Behavioral Health Dewitt Army Community  
7 Hospital - Fort Belvoir, VA
- 8 COL DAVID ORMAN, Director of Residency Training  
9 in Psychiatry, Tripler Army Medical Center,  
10 Oahu, HI
- 11 CAPT WARREN KLAM, Senior Medical Officer,  
12 Mental Health Director Navy Psychiatry  
13 Specialty Leader, Staff Child/Adolescent  
14 Psychiatrist - Naval Medical Center, San  
15 Diego, CA
- 16 Other Federal Members:
- 17 ANTONETTE ZEISS, PH. D., Deputy Chief  
18 Consultant, Mental Health Services Healthcare  
19 Group of VA Central Office, Washington, D. C.
- 20 Non-Federal Members:
- 21 DR. DAN BLAZER, II, M. D., MPH, PH. D., Professor  
22 of Psychiatry and Behavioral Sciences,  
Professor of Community and Family Medicine -  
Duke University Medical Center
- MS. DEBRA FRYAR, Deputy Director of Government  
Relations Military Family Association
- RICHARD McCORMICK, PH. D., Assistant Clinical  
Professor, Psychiatry Dean Case Western  
Reserve School of Medicine

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- 1 PRESENT: (continued)
- 2 SHELLEY MacDERMID, PH. D., Professor of Child  
3 Development and Family Studies and Director  
4 Military Family Research Institute, Purdue  
5 University
- 6 DR. THOMAS BURKE, Executive Secretary to the  
Task Force

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P R O C E E D I N G S

LTG KILEY: Good morning, I'm Dr. Kevin Kiley the Army Surgeon General and the co-chair for the Mental Health Task Force that's meeting here today.

I've got a little script here I'd like to read. This is our first open session; we're all very excited about it. I'd like to welcome all of you to this congressionally directed task force on mental health, and we have much to accomplish today as we endeavor to gather the information needed to deliver the Task Force's report to the Secretary of Defense, containing assessment of and recommendations for improving

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15 the facilitation of mental health services  
16 provided to the men and women of the armed forces  
17 and their families.

18 Ms. Ellen Embrey, the designated federal  
19 official of the task force's current federal  
20 advisory committee, the Armed Forces Epidemiology  
21 Board, had an unavoidable conflict and will not be  
22 able to attend the meeting. In her absence, she

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1 has appointed Colonel Jeffrey Davies, the Army  
2 Surgeon General's Executive Officer, as the  
3 alternate designated federal official.

4 Colonel Davies, would you please call  
5 the meeting to order?

6 COL DAVIES: Thank you, General Kiley.  
7 As the alternate designated federal official for  
8 the Armed Forces Epidemiological Board, a federal  
9 advisory committee to the Secretary of Defense,  
10 which serves as a continuing scientific advisory  
11 body to the Surgeon's General of the military  
12 departments, I hereby call this meeting of the  
13 congressionally directed Task Force on Mental  
14 Health, an Armed Forces Epidemiological Board  
15 subcommittee to order. General Kiley.

16 LTG KILEY: Thank you Colonel Davies.  
17 I'd also like to note that both Colonel Tucker and  
18 Colonel Sutton have done a tremendous job in

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19 preparing for this task force. And we'd like you  
20 to accept our deepest appreciation for your  
21 willingness to host the meeting and to providing  
22 the outstanding support that you've been providing

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1 to the staff, and the task force throughout their  
2 visit at Fort Hood.

3 At this time, before we get started, I'd  
4 like to introduce the members of the task force,  
5 and provide a brief explanation for why we're here  
6 and what we want to accomplish. First let me  
7 introduce the task force co-chair, Dr. Shelley  
8 MacDermid, and then we'll go down the table. Dr.  
9 MacDermid, the floor is yours.

10 DR. MACDERMID: I think I'll just sit.  
11 Welcome everyone. Thank you very much for being  
12 here. We're looking forward to what you have to  
13 tell us today. Let me introduce the other members  
14 of the task force to you. We have Colonel Dave  
15 Orman, Dr. Dan Blazer, Deborah Fryar, Dr.  
16 Antonette Zeiss, and Angela Pereira, Dick  
17 McCormick, Warren Klam, and our Executive  
18 Secretary Tom Burke.

19 Our job this morning is to learn from  
20 you. We are not here to evaluate Fort Hood. We  
21 are not traveling around the world to evaluate  
22 other installations. Our job is to learn about

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1 the delivery of mental health services to military  
2 members and their families. And we're trying to  
3 do that by going to the places where that's  
4 happening. Between now and the end of February,  
5 there will be members of the task force traveling  
6 almost every week to places all around the globe.  
7 And we will also be reading and studying and  
8 receiving information that we can try to process  
9 to put together. If you visit the website of the  
10 task force and read the bios of the members,  
11 you'll see that there's a tremendous amount of  
12 experience and expertise on the task force. But  
13 we are all, also, very eager learners. So we look  
14 forward to what you have to tell us.

15 Let me just check. Dr. Burke, do you  
16 have administrative matters that you need to  
17 handle?

18 MR. BURKE: Just one or two, very  
19 quickly.

20 DR. MacDERMID: Sure.

21 MR. BURKE: Again, I would like to thank  
22 Colonel Tucker, Major Morris, Colonel Sutton, and

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1 all the 3 Corps and Fort Hood staff who assisted  
2 in making this a very successful trip for the task  
3 force. For the task force members, after the town  
4 hall meeting, there will be working lunch in the  
5 Colorado Room. And for General Kiley, Dr.  
6 MacDermid, Colonel Orman, and myself, there will  
7 be a business meeting during the lunch hour.

8 Restrooms are located down the hall, and  
9 right at the bank of telephones. And if any of  
10 the task force members have any kind of support  
11 communications requirements, please see Ms. Deirdre  
12 Farrell. The next full task force meeting will be  
13 on September 19th and 20th, and will be hosted by  
14 the San Diego Naval Medical Center.

15 DR. MacDERMID: That's October.

16 MR. BURKE: I'm sorry. October 19th and  
17 20th, and hosted by the San Diego Naval Medical  
18 Center. Thank you very much, Dr. MacDermid.

19 LTG KILEY: Well, in my first official  
20 act as the co-chair, I'm going to ask either  
21 Colonel Tucker or my aide to get rid of this  
22 podium, because it's driving me crazy. So can we

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1 get this thing off the table?

2 I too would like to echo Dr. MacDermid's

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3 comments. I'm particularly honored to be part of  
4 this task force. And my role as the Surgeon  
5 General and Commander of the U.S. Army Medical  
6 Command, we have been working extremely diligently  
7 over the last three to four years since our global  
8 war on terrorism began in assuring the mental  
9 health, preservation of mental health and return  
10 of good mental health to our soldiers and to their  
11 families, and/or retirees. And we've done that in  
12 a whole host of ways. So when the opportunity  
13 arose from Congress' intent to take a holistic  
14 look at this issue for soldiers, sailors, airmen,  
15 marines, coast guardsmen, and their family members  
16 and Dr. Winkenwerder asked that I serve as the  
17 co-chair, I was particularly honored. I think  
18 this is a tremendous opportunity to do the right  
19 thing for our military and their families. So I  
20 am particularly excited to hear from those of you  
21 in the audience that would like to tell us  
22 personal stories, observations, systemic issues,

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1 processes, problems, however you see our military  
2 community responding to the issues associated with  
3 military life, deployment, redeployment, global  
4 war on terrorism, et cetera.

5 We really haven't really got formal  
6 ground rules. We'd ask you to come to the

7 microphone, one of the three microphones, identify  
8 yourself, and at least for the start, we kind of  
9 think maybe 10 minutes would be a reasonable limit  
10 of discussion. If the committee would like to  
11 hear more or ask more, certainly, we'll go longer.  
12 But from a presentation perspective, I think --  
13 don't you think, Shelley, 10 is a good start, and  
14 we'll see how that works out.

15 In my experience in open forums in the  
16 past, frankly, in other venues, it's simply a  
17 matter of getting into the line in front of the  
18 microphone, and coming up and talking to us. I  
19 don't believe that we have any, necessarily,  
20 prepared presentations for you. This is, kind of,  
21 we're in receive mode. We're waiting and  
22 listening for your comments and suggestions. And

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1 as best we can in open discussion, if we can  
2 answer questions that we know the answers to,  
3 we'll be happy to try to pass that on to you. But  
4 there's a lot more that we're going to have to do  
5 as a task force, and forward our recommendations  
6 up to the secretary of defense, who will then  
7 forward it over to Congress. And I'm sure at the  
8 appropriate time those deliberations and  
9 recommendations will be made public.

10 So with that -- unless any of the other

11 Board members would you be interested in making  
12 any opening comments? I'd be more than happy to  
13 turn it over to anyone else. No? Okay. The  
14 floor is yours.

15 MR. TIETJE: If I may introduce myself.  
16 I'm Eldon Tietje, Executive Director of Central  
17 Counties Mental Health and Mental Retardation  
18 Center. Our center covers five counties to  
19 include Bell, Coryell, Lampasas, Hamilton and  
20 Milam. Namely, then, we cover the surrounding  
21 area of this military installation. We are  
22 provided state funds, which have been,

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1 unfortunately, shrinking since about 1995. And we  
2 know the population is growing. The state limits  
3 our services to adults, to the very severely  
4 mentally ill. Children who are out of -- in  
5 jeopardy of being placed outside of the home or  
6 otherwise outside of their natural environment,  
7 like being moved from a regular classroom to  
8 special ed or so on and so forth. We have clinics  
9 in Killeen, and Temple. Children and adults in  
10 both locations. And we have one combined clinic  
11 in each of the counties.

12 I would say that, again, we have had a  
13 variety of local efforts to coordinate mental  
14 health, and health services in general. But we

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15 have found that it is a difficult procedure to  
16 become an approved provider with our budgets and  
17 our mission so tight we have not pursued to become  
18 a TRICARE prime or a TRICARE provider. But I  
19 would maybe ask that that be looked at to see if  
20 local community mental health centers might have a  
21 process that is streamlined that is not at great  
22 expense to them as far as person power, to be able

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1 to become a provider.  
2 Also, state rules prohibit us from  
3 spending state funds on people who have other  
4 sources of payment. In other words, we can't  
5 subsidize TRICARE payments by adding state dollars  
6 to them. We're not supposed to be able to do  
7 that, nor can we -- we can't provide mental health  
8 services to a variety of illnesses that are not  
9 necessarily focused on by the state, but then we  
10 cannot use state funds for that. In other words,  
11 if there would be a minor depression or other  
12 kinds of things, we cannot use state funds for  
13 that other than to access the person and to  
14 determine what level problem they have.  
15 We also provide a 24-hour crisis call  
16 line, and we receive a variety of calls from  
17 active duty and from their dependents and so on.  
18 And we have not really found a very, very good way

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19 of conveying concerns at times that are expressed  
20 over these calls as a way of following up. We do  
21 have some, again, relationships with the  
22 psychiatry staff on the base. But I think, again,

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1 some recognition of how can a local system  
2 interact better with the military installation,  
3 and also then I think is unnecessary duplication.  
4 If we have to provide a crisis line, I don't know  
5 that the military installation should also have to  
6 provide one, but rather that we somehow be able to  
7 work together on that. I think that throughout  
8 Texas you would find that most community MHR  
9 centers would be very willing and interested to  
10 work with, more directly, with the military  
11 installations both the active duty and their  
12 dependents. And of course in our area here we  
13 have many retired as well. But we do encounter  
14 these kinds of barriers.

15 I might, just for purposes of more  
16 background information; in the state of Texas,  
17 there are -- every county is covered by a mental  
18 health center. In Texas law, there was a  
19 provision put in place to appoint a local group as  
20 the local authority for that area representing the  
21 state's interest for mental health and mental  
22 retardation services. The Texas law sets this up

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1 through a sponsoring agency requesting of the  
2 state to designate their area, and then the law  
3 provides that the sponsoring agencies appoint the  
4 board of trustees and that in essence, then, the  
5 local mental health mental retardation center is a  
6 unit of local government set up under state law,  
7 but is not a part of state government. Just like  
8 a county or a school district, and so on, is that  
9 the law that sets it up in a certain particular  
10 way, and that we have to function in that manner.

11 Because it is a governmental entity we  
12 do all of our business in open meetings, and we  
13 are under the open information act. So we are a  
14 very open organization as far as anyone wanting to  
15 know about us, or how we do business and how we  
16 are stewards of the public fund. In my past  
17 worked in Fayetteville, North Carolina, and was a  
18 part of the child mental health project that was  
19 there at Fort Bragg. And I saw how that special  
20 project was very, very beneficial to the military  
21 community, and there was a deployment while that  
22 pilot project occurred, and obviously it exceeded

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1 all of its budgets because the demand was very  
2 high. But I think that dealing with child mental  
3 health and family mental health issues while  
4 active duty are deployed or in preparation for  
5 that, and for the return is very, very important.  
6 And I think consideration of the local mental  
7 health community having some ability to provide  
8 special programming in that manner. Now, again,  
9 you can say, well, certainly the installation  
10 could do that, and yes, they could. But, again,  
11 it's how much do we duplicate what our  
12 capabilities are, and to what advantage to the  
13 ultimate recipient of the services. That project  
14 in North Carolina was, I think, very cost  
15 effective for what it delivered, and we would have  
16 some interest if something similar would be  
17 possible to develop a similar project on an  
18 ongoing basis or similar services on an ongoing  
19 basis in our area. I'd be open to any questions  
20 that you might have about the public mental health  
21 system, and how it is operative in the state of  
22 Texas.

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1 DR. McCORMICK: Thank you. Part of what  
2 we do, as general information, we did a site visit

3 before this public meeting, and we had the  
4 opportunity today to meet with some local  
5 providers out of Multiplex. One of the things we  
6 are interested in is whether there is a full  
7 continuum of mental health care for dependents,  
8 family members since there is limited capability  
9 at the medical treatment facility at Darnall to  
10 provide mental health services for families. One  
11 of the things we heard yesterday is the perception  
12 that there was a lack of substance abuse treatment  
13 capability for adolescents and young people,  
14 number one. And I would like -- I don't know if  
15 MH and substance abuse are divided in Texas, but  
16 I'd be interested in your perception of that, if  
17 that is in fact your perception, as well.

18 And the second thing is we did discuss  
19 the issue of how difficult it was to get providers  
20 credentialed under TRICARE. Your perception seems  
21 to be different than what we heard yesterday, so  
22 I'd also be interested in that.

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1 MR. TIETJE: To speak to the substance  
2 abuse effort. Again, historically in the state of  
3 Texas is that there was a separate Texas  
4 commission on alcohol and drug abuse that was put  
5 in place by state government. About, probably in  
6 the late '90s there were some real difficulties

7 with their funding mechanisms and their  
8 accountability, and they had overcommitted and  
9 some of the funds had been misused, and so the  
10 funds were withdrawn. We were a substance abuse  
11 provider, public, for both adults and children,  
12 but our funding was reduced from, I think, about  
13 400,000 to 18,000 and we were expected to do the  
14 same level of service. With that money we just  
15 had to give it up. We hated to do it, but we had  
16 to give it up. And we have since then tried to  
17 compete for funds. The state of Texas has not  
18 funded their substance abuse services adequately  
19 at all. There is the ability under state statute  
20 to commit people under a substance abuse  
21 commitment; however, it's not used at all because  
22 the way the law is written is that the provider

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1 has the ability to decline the commitment, and  
2 matter of fact, there aren't any providers. The  
3 closest residential service is in Waco, and it is  
4 greatly smaller than what is needed. This is a  
5 very crying need in the state of Texas for  
6 improved substance abuse services. At that same  
7 time, when the funds were reduced, a lot of the  
8 funding got shifted from the public community  
9 system, into the prison system. And they started  
10 prison substance abuse programs. That money has

11 since then been diverted out of substance abuse  
12 into the general prison budget. And there is very  
13 little that is occurring in the prisons of Texas  
14 as well.

15 Now, on the issue of becoming an  
16 enrolled provider. My understanding of it, and we  
17 have not undertaken it, is that it is a very  
18 detailed process for a public entity to go through  
19 and apply for vendor status, and then that process  
20 goes for three to six months before it is dealt  
21 with. I attended a different conference in  
22 Washington, D. C., in which this was discussed, and

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1 the process was explained to me and it is as I --  
2 in portraying it, this was how it was explained to  
3 me, that yes, it is a complicated process and that  
4 -- this is, again, it may be simple for an  
5 individual provider to become registered and  
6 recognized. I think it's quite different for a  
7 clinic, because -- and we can't really -- it  
8 doesn't make good sense for us to try to have each  
9 of our providers registered as separate providers,  
10 but we would do it as a clinic, because we have  
11 personnel coming and going, and I think that  
12 that's the part that's really complicated.

13 LTG KILEY: Can I ask; do you bill as a  
14 clinic? If you were to bill for TRICARE

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15 beneficiaries who receive your health care, is it  
16 a clinic bill like you were a hospital, provide a  
17 hospital bill, or do you have individual providers  
18 who bill individually?

19 MR. TIETJE: No. We would bill as a  
20 clinic. We do provide some services. And it's  
21 kind of like when those services aren't available  
22 in the community, then payment is authorized to us

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1 and we do provide services. Again, we do serve a  
2 number of very chronically mentally ill family  
3 members of active duty or retired military.

4 LTG KILEY: And is the issue one of just  
5 being a TRICARE registered provider, or is it an  
6 issue you perceive of being in the network as a  
7 provider in the network with, I think, Humana is  
8 the provider in this region.

9 MR. TIETJE: It's truly I think both.  
10 One is to become a provider, but then to be in  
11 that network. And, also, does it pay the costs.  
12 I mean, we can't -- if it pays us \$100 but what we  
13 provide costs 120, we can't do it.

14 LTG KILEY: Is also part of the issue,  
15 in your clinics mind, the reimbursement rates for  
16 what we call CMEC.

17 MR. TIETJE: Yes. Now, I'll say, again,  
18 the public mental health system, we use both

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19 licensed and non- licensed care providers and we  
20 have been forced to do that by the finances of how  
21 we do business. We employ many bachelor' s-level  
22 counseling staff, which, again, TRICARE only

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1 recognizing, I think, the licensed staff. And  
2 this is, again, the difference between a public  
3 mental health system and a private provider group.  
4 And we utilize our bachelor' s-level people as  
5 service coordinators and other roles like that  
6 where they are adequately prepared to carry out  
7 those roles in a high quality manner. I thank you  
8 so much for the opportunity to speak with you.

9 LTG KILEY: Are there any other  
10 questions from the task force members? Sir, thank  
11 you very much. That was very enlightening.

12 DR. BLAZER: Just one quick question.  
13 In a somewhat ideal situation where the funding  
14 issue could be worked out and the registration  
15 issue could be worked out, are there enough  
16 providers in the area, period, to provide the  
17 services that might be required?

18 MR. TIETJE: I think that there is.  
19 And, again, if the volume would be such that it's  
20 much larger than we would estimate, I think that  
21 over time the provider system could put in place,  
22 adequate, person power to do that. The thing of

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1 it is, again, for us to exist as a mental health  
2 center, we have to employ psychiatrist, we have to  
3 employ psychologists, and so on and so forth. I  
4 mean, that is just for us to have our door open,  
5 we have to have those staff available. And I  
6 think that, again, we could recruit or through  
7 contract arrangements increase the capabilities  
8 that we would have.

9 MS. TRIVETT: Good morning. I am B. J.  
10 Trivett, I'm director of internal audit at 3 Corps  
11 in Fort Hood. But I am here this morning as just  
12 an individual. And I come to share a personal  
13 experience with you. I have a personal interest  
14 in this issue.

15 I have a disabled son who is 25. His  
16 first diagnosis was at the age of five, and  
17 because of my job, or jobs, in federal service, I  
18 have mental health receiver experience as a parent  
19 for a child in four states; Nebraska, North  
20 Carolina, Tennessee and Texas. So I've been in  
21 direct contact for a number of years in various  
22 mental health community services. In fact, at one

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1 time my son was eligible for TRICARE benefits, and  
2 under those benefits received a fair amount of  
3 decent treatment that was in fact inpatient, as a  
4 child.

5 I will tell you that our mental health  
6 services, even here in Texas, and I think the  
7 mental health office told me that Texas was rated  
8 48th out of the 50 states, as in, 48, 49, 50, for  
9 services for mental health. That's certainly been  
10 my experience. And at the same time, I would tell  
11 you that our mental health community services  
12 provide the absolute best service they can. But  
13 it is grossly inadequate to the need. And what we  
14 find is that most adults who have significant  
15 mental health illnesses, because their personal  
16 needs are so demanding on families, they end up  
17 homeless or in prison because they're not able to  
18 handle life and there isn't enough support system  
19 in existence to provide that support for them.  
20 And I tell you this -- and I realize your  
21 perspective is services to, primarily services to  
22 active duty and their families. But I tell you

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1 this so you understand that there are almost no  
2 adequate services available on the economy. So if

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3 you don't provide it to active duty and their  
4 families, the availability in other places is so  
5 poor, that essentially you're their only answer,  
6 and you need to hear that. Now, it's not quite  
7 that bad obviously in 47 other states, but it's  
8 not that good even in the good states, and I don't  
9 know where those are. Because I was -- because my  
10 son was eligible for TRICARE as a child, we  
11 secured residential treatment for him in Kansas,  
12 but we lived in Nebraska. So you need to  
13 understand that there were no services available  
14 in Nebraska. I had a seven year old that was a  
15 four-hour drive away. When I lived in Tennessee,  
16 the services were somewhat better coordinated with  
17 the schools because the school system paid better  
18 attention to this. And in North Carolina he had  
19 the availability of some limited group home  
20 residential situations. I will tell you today  
21 he's in an apartment, and he's absolutely not able  
22 to function. I provide what physical support I

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1 can, but what he gets out of mental health  
2 services here is basically minor medication  
3 management for psych meds, an appointment  
4 approximately once every six weeks. What he needs  
5 is daily treatment programs that put him a group  
6 setting that provide some entertainment,

7 attention, a group setting that provides  
8 structure. And those are available in many other  
9 states and the expenditure provides an opportunity  
10 for -- you spend money there so you don't spend  
11 them with emergency squad coming every week  
12 because he's got to get attention somewhere, or  
13 because the police come because he's believing  
14 that people are trying to break into the apartment  
15 when there's nobody there. So the money is going  
16 to be spent one way or the other by somebody.  
17 It's only a question of how you spend it and the  
18 quality of life for people around you and how you  
19 do that. And I just tell you that so you  
20 understand the extraordinarily limited services on  
21 the economy and the need that that creates when  
22 you have special situations with active duty and

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1 the deployments that they encounter and the strain  
2 that places on their families. Thank you.

3 LTG KILEY: Thank you. Are there any --  
4 we don't have any questions? Thank you very much.

5 MR. LOVE: Good morning ladies and  
6 gentlemen. I take it Skyline Plaza; most of you  
7 are from at least up in the D. C. area? My name is  
8 Kirt Love, K-i-r-t, L-o-v-e, with a small service  
9 group called the Desert Storm Battle Registry. I  
10 am a disabled combat veteran from the first gulf

11 war, and I have a vested interest in this from the  
12 standpoint of my own handling of the system,  
13 actually in central Texas. My treatment here at  
14 the Temple Teaque Medical Center and the  
15 subsequent problems over a 10-year period in this  
16 region.

17 DR. MacDERMID: Mr. Love, I'm sorry to  
18 interrupt you. But could you move the microphone  
19 up a little bit. I'm having -- a little hard to  
20 hear you. Thank you.

21 MR. LOVE: I'm sorry. I'm trying not to  
22 get an echo there. But from my own experiences

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1 from the Gulf war and personal experiences during  
2 the key battles at that time and the problems that  
3 followed afterwards, it was so difficult to get  
4 any type of care or to get anything done in  
5 central Texas. And it took me the better part of  
6 10 years to get even my claim taken care of. It  
7 eventually ended up leading to an advocacy  
8 campaign that led to the doorstep of Washington,  
9 D. C., of which I spent the last six years there.

10 I moved back here to Crawford just a few  
11 months ago actually having tired myself of the  
12 Washington, D. C. arena and how difficult it is to  
13 get anything done there. But I'm also very  
14 familiar with the public laws and the materials

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15 that led to this appointment and these committees  
16 including the original public law 105-A5, which is  
17 the pre- and post-deployment health screening  
18 system. And actually I've been participating with  
19 the office of Special Assistance in Gulf War  
20 Illness, which became the deployment health  
21 support director, which all it's different  
22 entities, now, to where it's Force Health

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1 Protection. And so I know these particular  
2 individuals and I know others like Mike Kilpatrick  
3 that came up through the ranks who had started  
4 from gulf war illness. Most of what is in place  
5 now started originally with gulf war illness and  
6 has changed to what they call deployment health  
7 versus individual or specific deployments. Now, I  
8 monitor very closely what happens here at Fort  
9 Hood and this particular area, what is also vested  
10 for the troops coming back from Iraqi freedom. In  
11 fact, I actually spoke with deployment health very  
12 zealously in 2002 before the troops deployed  
13 because I was very concerned what they were going  
14 to facing in Iraq. And I had certainly vocalized  
15 in the media that this was going to be hand-to-  
16 hand combat, or fighting from house to house, and  
17 the Iraqis certainly didn't want us there, because  
18 they didn't want us there 15 years ago.

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19                   So I've watched the news and the media.  
20 I've watched this unfold, and I've asked around  
21 what the community here, what they're  
22 experiencing. Some of the pros and cons of their

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1 handling of their medical situations here at Fort  
2 Hood. Now, Darnall Army Hospital has had some  
3 problems in their screening process as far as  
4 accessibility, and some of their staff have  
5 certainly complained to me, nurses and others,  
6 which I wish were here today so they could  
7 vocalize on their behalf. In fact, I want to  
8 backtrack one element here; I don't want to  
9 deliver anecdotal address here, because this is  
10 certainly not what the committee is looking for.  
11 And I tried very hard for the last few days to get  
12 people here and participate. So I don't really  
13 wish to speak on their behalf, I would prefer they  
14 speak on their own behalf, but unfortunately  
15 because of the circumstances many of them were not  
16 notified in time. So hopefully they'll be here by  
17 about 11:00 and I pushed very zealously to get  
18 them here.

19                   Now, myself, again with Darnall and  
20 other facilities, I'm finding the problem is that  
21 they may do the survey, they may fill out the  
22 survey paperwork on the post-deployment forms, but

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1 they're not necessarily getting the full medical  
2 exam or follow-up medical exam. In fact,  
3 follow-up medical exams are almost nonexistent at  
4 this time. So we've got a problem with people  
5 falling through the cracks.

6 Now, also, strangely enough, soldiers  
7 that are having problems are diverted to the  
8 Temple Teaque facility. And as they go to the  
9 Temple Teaque facility, one of the problems that  
10 they're finding there is that their records, for  
11 instance, their DD2-14 does not reflect their  
12 service in Iraq. So the Temple Teaque facility  
13 actually has to turn them away until their records  
14 reflect that information. So I'm finding a  
15 variety of soldiers that are in complicated  
16 circumstances wherever they go. There's either a  
17 system that's very loosely in place or there's no  
18 follow-up. What they do run into around here is a  
19 certain degree of stigmata that they're dealing  
20 with, with the illness itself or the problems they  
21 come back.

22 Now, I watched very closely a variety of

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1 individuals here. They come back, they're very  
2 quickly re-integrated into the population here,  
3 and they don't have quite enough time to  
4 decompress from certain areas that they were in,  
5 especially in Baghdad. And so many of them come  
6 back, and I've observed it myself, where they  
7 drive on the streets here as if they were in  
8 Baghdad. They feel like they're still trying to  
9 avoid the IEDs. They don't say it, they don't  
10 really acknowledge it, but they're certainly  
11 getting more of their share of traffic tickets and  
12 other ailments, which shows that there's a  
13 precursor to a problem. And I think we're going  
14 to have increasing problems with this lack of  
15 decompression where a lot of these individuals  
16 that come back that really they want to play the  
17 jock mentality we had back 15 years ago. You  
18 don't complain, you don't go down to, you know, do  
19 anything with the medical departments. You don't  
20 walk in and volunteer. They're going to be; you  
21 know, display the military and be a good soldier.  
22 Well, the problem with being the good soldier is

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1 it takes 10 to 15 years afterwards to get taken  
2 care of especially if they're going to be doing an

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3 exit exam and they're not going to volunteer  
4 certain facts. And certainly one thing that's a  
5 big stigmata in the military is admitting that you  
6 have some type of problems upstairs in coping or  
7 adjusting with what you saw. Now, if somebody got  
8 their head blown off, a friend was blown up with  
9 an IED, or just being in a country where every day  
10 you're surrounded by people who hate you, that  
11 would kill you in a moment, and you've got 10, 12,  
12 15 months of exposure to that continual hatred day  
13 and night. I only myself had just a few months of  
14 it in Iraq, 15 years ago, but it was -- it's still  
15 something that has a lasting impression that  
16 totally, completely changed my life after I served  
17 then. And I'm sure that these people returning  
18 now will have that lasting impression of just --  
19 if nothing else, the pressure of all that hatred  
20 and anger for such an extended period of time and  
21 how do they cope with it. I would like to see  
22 something a little more proactive at the Fort Hood

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1 region then what I've been watching down here to  
2 try to solicit these people and bring them, but  
3 not associate it with the term "mental health." I  
4 mean, that's part of what's meant to be done here  
5 is how to bring them in and how to get them to  
6 participate. But PTSD is a very real condition

7 and there's much more than 34,000 troops that have  
8 returned with PTSD, the numbers are much higher.  
9 That's just what VA and DoD are acknowledging at  
10 the time that have actually come through the books  
11 and have exhibited symptoms. The numbers are  
12 probably closer to about 100,000 at this time.  
13 But PTSD has such a stigmata with it from the  
14 Vietnam War that maybe there's something we can do  
15 in terminology or some way we can de-emphasize it  
16 so that they'll participate, but still seek the  
17 care that they're going to need to adjust. And  
18 there are going to be levels of conditions that  
19 we're going to be dealing with here, and acute is  
20 something that falls through the cracks. Until a  
21 condition becomes chronic, usually the system  
22 tends to ignore it, and I think that's kind of

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1 after the fact when we're dealing with the  
2 soldiers.  
3 Now, I was a little disappointed with  
4 the media presentation of this one. I talked with  
5 Colonel Gibson and the others up at Skyline Plaza,  
6 the last two weeks, and I take part responsibility  
7 in not soliciting the federal register myself more  
8 actively down here on this particular meeting in  
9 order to bring people in, but I hope that the  
10 committee in the future as you address other bases

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11 and other installations, you'll be a little bit  
12 more involved with veteran's service  
13 organizations, with the media, the local  
14 committees in mental health -- I mean, mental  
15 health facilities in those regions and give them a  
16 little more heads up to participate at these  
17 different installations. I'm sure that by 10:00  
18 or 11:00, this room will be a lot more full, and I  
19 told people try to get in at least by 11:00, so  
20 I'm hoping for greater attendance. But I do ask  
21 that the committee try in the future to be a  
22 little bit more involved with those communities

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1 that you're walking into and not walk into it  
2 cold, as you've done here today. And I'm not  
3 faulting you for this. This is the way a lot of  
4 this has been is hurry up and catch up throughout  
5 the years. Where do we go with this one from  
6 here. But I'm hoping that, again, there will be a  
7 serious look at Fort Hood, maybe, just maybe  
8 before this committee finishes, you'll come back  
9 one more time and hopefully there will be more  
10 people to participate and talk to you. Also, I  
11 hope that you'll make some recommendations to  
12 implement something more active here at Fort Hood.  
13 Something that's a little bit more exposed, a  
14 little bit more advertised, something that's a

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15 little more accessible with a friendly face on it.

16 I appreciate your time and patience at  
17 this time. I'm curious, did anybody have any  
18 questions?

19 COL PEREIRA: Thank you for sharing that  
20 information with us, I think it's very helpful.  
21 Are you willing to talk a little bit about your  
22 personal experiences, particularly, did you

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1 yourself go to the local VA for a lot of your  
2 care? And if so, how was that for you personally?

3 MR. LOVE: Ironically, one of the things  
4 that the service officers do when they're dealing  
5 with a claim, especially of my own, rather than  
6 put you through for the health conditions that you  
7 have at the time, they actually recommend PTSD.  
8 Technically speaking, it's the easiest claim to  
9 grant. But unfortunately there are a lot of  
10 problems related with a veteran PTSD claim that  
11 actually keep you from certain types of medical  
12 care, especially when it starts to drift into  
13 Somatoform or other types of conditions. And  
14 that's one of the things I would really like to  
15 avoid in the future when dealing with veterans is  
16 the use of terms like Somatoform or neurotic  
17 depression, or some of these older retired terms  
18 that need to be passed on. We're dealing with

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19 neurology here, and I did not get a good  
20 neurological workup for the first five years that  
21 I was dealing with them. Neurology has never  
22 entered into the equation even though I had

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1 begged for it once I understood what I was looking  
2 into, that there were neurological mechanisms. So  
3 my problem is the DAV representatives and others  
4 mean well, they'll write you up quickly, but it's  
5 a basis of substantive information. And without  
6 six months of materials to support your claim,  
7 it's very loosely done and you get a zero to  
8 thirty percent claim.

9 Now, I first granted -- my first claim  
10 was granted in '97 and it actually was with  
11 presidential help, and Clinton stepped in and I  
12 got 10 percent, which was abysmal. And it was  
13 done on a technicality, so it took me several  
14 years in D.C., until I met with Principii's staff  
15 across from the White House. And after I met with  
16 them, two weeks later they gave me a ratings  
17 decision for 60 percent, which is not the way the  
18 system should work. But what I has seen and  
19 experienced in the Gulf war is a little different  
20 from what we experienced this time around.  
21 Because when we went through the Gulf war 15 years  
22 ago, most everything that happened around us was

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1 extremely large scale. You know, 10,000 of this,  
2 100,000 of that. Stuff that the movie industry  
3 will never replicate, a really bizarre fire show,  
4 but it all happened at 1,000-feet plus. So you  
5 weren't hand to hand, it wasn't the same thing.  
6 So it took on an almost alien characteristic to  
7 it, much of the battles, because you saw things at  
8 a distance, it's easier to deal with it, and yet  
9 there are still -- I still have the flashbacks  
10 from a lot of the key battles, because they were  
11 just so helpless. When all this is exploding  
12 around you and people are dying and all you can do  
13 is just sit and watch, because you do not have  
14 anything to implement other than what happens  
15 immediately around you on a small scale.

16 These kids that are in Iraq right now  
17 are going through what I was afraid of 15 years  
18 ago. What I thought was going to happen then,  
19 which was an occupation, when we went to fight the  
20 gulf war we figured we're going into Baghdad.  
21 Instead they turned us around at the northern  
22 border of Kuwait and said, no, we're finished,

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1 we're going to Kuwait and occupy. And I figured  
2 we would be there for 12 to 18 months, the Iraqis  
3 would hate us and they would be picking us off one  
4 at a time, and it didn't happen. So we were very  
5 fortunate. We were brought back May, June of that  
6 year and it was over. And then I didn't come back  
7 to the hero's welcome. A lot of us, like myself,  
8 came back and were, like, "Why did you come back?"  
9 Everybody waved the flag at the time, all that  
10 bravado, "Oh, you're in Iraq." Then afterwards it  
11 became more like jingoism, "Ehh". So a lot of us  
12 were forgotten, and especially forgot now. In  
13 fact, Gulf war is frowned on by the Department of  
14 Defense at this time. And we're shunned and  
15 spurned and kept away. And deployment health  
16 director now won't even answer my questions even  
17 though I'm one of the top advocates at this. So  
18 now we've got these kids out here that have lived  
19 in this occupation, that they face the pure hatred  
20 and the fear every single day, 12, 15, 18 months  
21 and they come back. They don't think there's a  
22 problem because they got used to living that way,

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1 but it's not that way here anymore, and they're  
2 going to have that difficulty where they're going

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3 to feel that edge. They want to fight, they want  
4 to do something, they're really tense, they're  
5 very aggravated, very excitable, and they're kind  
6 of a ticking time bomb. Some of them have been  
7 programmed for war, and they're coming back to an  
8 area that's not at war. So they're going through  
9 now what I thought I would be going through 15  
10 years ago. So I really feel for these people,  
11 because in America, Americans won't understand.  
12 They just cannot understand what this environment  
13 is like. There's just nothing like it here. The  
14 level of the things that are happening and the  
15 total fear that you feel, even if you won't say  
16 it. You're out there; it's exploding, it's  
17 happening around you, somebody very close to you  
18 just died. Most of these people that are deployed  
19 come back and know at least somebody in the unit  
20 that died, and died really grotesquely. And  
21 that's something that really sticks in their mind,  
22 especially the head injuries, the leg injuries,

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1 the very traumatic injuries that stay with them.  
2 So I know that these kids that are coming back are  
3 not facing what we faced 15 years ago, they're  
4 facing something worse, and Americans have been  
5 desensitized to it. So I hope that, again -- I  
6 hope that the committee will understand that

7 Americans are a little insensitive, and it will be  
8 up to the committee to take the additional step  
9 that the American community itself won't be able  
10 to. Does that answer most of your questions?

11 LTG KILEY: Any other questions? I'd  
12 like to ask you -- I very much appreciate your  
13 comments. Very candid. And I think that you're  
14 in the unique position speaking to the task force  
15 to do -- if I could compare and contrast. And,  
16 so, you know, you touched on some issues that we  
17 in the Army in particular, but all the services  
18 have been working on, specifically the pre- and  
19 post- deployment screens. And you've identified  
20 some issues that we have concerns about, which is  
21 denying symptoms, and then the hypervigilance that  
22 soldiers in particular experience when they get

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1 back on the roads; reacting to sharp sounds,  
2 invasive driving. It translates into home life;  
3 it translates into work, et cetera. And you sound  
4 like you have been engaged in this, which is  
5 fortuitous for us.

6 So, I would be interested if you could  
7 speak for a second to your assessment of how the  
8 Department of Defense and the Army handled, dealt  
9 with, assisted you, particularly as you came back  
10 from the gulf war, where I also was, although I

11 didn't cross into Iraq, although I visited once;  
12 what your experiences were, what the mental health  
13 and the larger medical, and then even the larger  
14 command community, how they looked upon you, how  
15 they helped you or didn't. As compared with how  
16 you perceive the -- just for the sake of the ease  
17 of discussion, how the Army and the Army medical  
18 department and the VA are helping and recognizing  
19 and destigmatizing some of these issues. Do you  
20 see any improvement from 15 years ago in terms of  
21 how the Department of Defense's programs and  
22 policies and the health care we're delivering, or

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1 attempting to deliver, is that making any  
2 difference? Because you're comments about the  
3 stigma of mental health, we see that all the time.  
4 I'm very interested in your comments about the  
5 stigma of PTSD. So I'd be happy to hear your  
6 thoughts on that.

7 MR. LOVE: Well, one aspect of this  
8 since I had left the military in '92, there really  
9 wasn't any DoD involvement until basically 1997  
10 when the office of special assistance Gulf war  
11 illness started their campaign in town hall  
12 meetings to solicit veterans. Of course, almost  
13 upon their immediate start, I was in contact with  
14 them, constant contact, these last nine years and

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15 have worked with them ever since. And there was a  
16 certain degree of trepidation to the way that they  
17 conducted themselves, because it was not only very  
18 standoffish in the beginning, but a lot of felt  
19 that we were just being pumped for information and  
20 then brushed aside, and it actually did happen on  
21 that scale. I was actually a very bashful person  
22 in the sense that I didn't want to speak or

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1 participate. I figured there would be someone  
2 else to do this, there's always someone else to do  
3 this, and as time passed I realized there isn't  
4 someone else to do this. It's a very small group  
5 of individuals that will extend themselves to do  
6 this type of work because it's very difficult. So  
7 it's half and half, because it's a two-edged  
8 sword. You've got people in the Department of  
9 Defense that do care, prior military service that  
10 are in the system. They'll collect the  
11 information, they'll talk to you and they'll share  
12 details within the guidelines of their job  
13 description, and what they're allowed to say. I  
14 find that from the first gulf war to the second,  
15 you know, this region gulf war era, the biggest  
16 problem we have is documents to support burden of  
17 proof, and DoD is extremely closed lipped when it  
18 comes to burden of proof to any incident that

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19 happens in Iraq. So when a soldier returns,  
20 unless you photograph, document, do everything  
21 yourself to record the event that you saw in the  
22 region, you come back and you have no substantive

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1 evidence then the burden of proof does not support  
2 benefit. And so you find yourself on your own,  
3 what I call the Army of one syndrome, where you  
4 basically get out there and you have to fight for  
5 yourself and the unit's not there to back you when  
6 something happens. Generally, because there's  
7 that peer pressure that that individual is coming  
8 forward with health problems, generally they're  
9 castigated by their fellow compatriots. So  
10 there's a problem out there where the peer  
11 pressure keeps people from responding. Now, VA on  
12 the other hand, I went to them and solicited them  
13 in '94 when I was at the height of my health  
14 problems. They were willing to follow protocol to  
15 a point. They were willing to do what they were  
16 told by Congress, they were told by others to do,  
17 but they weren't willing to step beyond that  
18 point. And so I was promised an awful lot from  
19 '94 to '97 and never saw anything. So I spent the  
20 first seven years home from the war with nothing,  
21 fighting for myself, alone, ostracized from  
22 community, very isolated and people, like I said,

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1 they'd look at you and they'd go, "You're  
2 obviously just starting trouble, because you want  
3 attention." And so you kind of find that your  
4 constantly under attack from a variety of  
5 individuals that question your motivation. They  
6 don't understand your home life. They don't know  
7 what you're living with, but it's very easy for  
8 them to judge. And the feeling is they've been so  
9 desensitized by the few individuals, the  
10 opportunists, that come along, they're taking  
11 advantage, that's it's just the few bad apples  
12 that spoil it for everyone else. And anybody  
13 that's dealing with mental health a lot of times,  
14 after two years, you become desensitized because  
15 you're just here so much. Both ways. And it's  
16 very easy to be judgmental, but by '98 and '99, I  
17 found increasingly that VA started switching to  
18 Somatoform or personality disorders. Their intent  
19 was to say, you have a personality disorder, well,  
20 unfortunately personality disorders you can't get  
21 compensation for. So I've been seeing  
22 increasingly, recently a lot of research is

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1 pointing towards personality disorder versus  
2 neurological research. So, as I've watched this  
3 change and the different agencies, each one step  
4 in, I've also noticed from '97 to 2002, government  
5 oversight went from the height of coverage to  
6 where it dropped off to where there is none. And  
7 then after 2002, when there was no oversight in  
8 place anymore, the arena changed and grass roots  
9 groups were no longer welcome in D.C., and those  
10 were usually the mouthpieces of the veterans were  
11 the grass roots groups. So what you're relying on  
12 now is you're relying on the veteran's service  
13 organizations, American Legion, DAV, VFW, and the  
14 others to pass on information of what they see in  
15 the field. But what you're getting from them,  
16 unfortunately, is you're getting it from the  
17 people in D.C., who are in D.C., and they're not  
18 seeing us out here on the lower echelon. And so  
19 when you're out here and you're getting  
20 representation it's very different from what  
21 you'll see in D.C. that's represented to the House  
22 and the Senate. And I participated in all this at

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1 all levels. So we're -- as far as where we're at  
2 right now, I see similar problems, not on the same

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3 scale, there's a lot in place, and I also want to  
4 recognize Secretary Anthony Principii who had  
5 stepped in aggressively in 2003 to make sure that  
6 records and other materials would be tracked,  
7 because I was told by deployment health support  
8 director in 2002, we will not track medical  
9 records. We're not going to follow you in Iraq,  
10 you're on your own, and this was Mike Kilpatrick  
11 and others that had told me this in confidence in  
12 these meetings. And then in 2003, Principii said,  
13 "No. We're going to track them. We're going to  
14 work with them." So VA stepped up and made  
15 changes in 2003 to set something in place. But  
16 I've also watched over time, this has been  
17 de-emphasized. And so this is one of the reasons  
18 I -- I dislike the term deployment health which is  
19 what they're going to be facing right now with  
20 Iraqi freedom, because deployment health is a term  
21 to kind of throw everybody in one pot, but it also  
22 de-emphasizes any issue. From Vietnam, Korean

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1 War, any of those stop being a war, then you  
2 suddenly become deployment health. And so I hope  
3 that OIF will be taken more seriously. And I do  
4 know the seamless transition team is doing their  
5 job. I do know the point of contact information  
6 is distributed at most VA medical centers. And at

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7 Temple Teague over here, Elaine Conckel's name is  
8 up on every wall down there in the clinics. So at  
9 least seamless transition is picking up some of  
10 the slack. I've even worked with a variety of  
11 these websites trying to explain to them some of  
12 the loopholes, how they go back to the beginning,  
13 and you just start over again. And with a lot of  
14 these soldiers being so irritable and grumpy,  
15 they're not going to do it. In fact, I've also  
16 been in articles the last years. And the last  
17 article here recently was called PTSD and  
18 Politics, where I explained how when you go into  
19 VA medical center, there's a process sort of set  
20 up where if you are a violent individual, very  
21 excitable, you're kind of provoked. And once  
22 you're provoked, they deem you violent, once

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1 you're violent they don't have to deal with you  
2 anymore, and they'll use security and others to  
3 keep you at bay. And so I would like to implement  
4 something on a different scale, actually practiced  
5 in Australia with their soldiers, and they have a  
6 PTSD program there that's more involved, more  
7 one-on-one, more family oriented than the American  
8 programs that are going on at this time. And  
9 they're having a greater success, I think, than we  
10 are here. And so I hope that at least the

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11 committee will look outside the United States at  
12 how PTSD is handled or traumatic events around the  
13 world, not just here exclusively to our own  
14 military. Does that answer your questions?

15 LTG KILEY: Yes, it does. Thank you  
16 very much.

17 MR. LOVE: Thank you for your time,  
18 ladies and gentlemen.

19 LTG KILEY: Thank you for your service,  
20 and thanks for your comments. Very much  
21 appreciated. Thank you.

22 MAJOR DUDA: Good morning General Kiley.

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1 Good morning panel. I'm Major Duda. I'm the 4th  
2 Infantry Division Psychiatrist and I just recently  
3 returned from Iraq, so I have a lot of things that  
4 I could, both share with you as well as answer  
5 many questions on what treatments were given to  
6 soldiers out there on the front lines.

7 Just to give you a very brief  
8 background. I was stationed at Camp Taji. I had  
9 a social worker, Ph.D. -- level social worker with  
10 me, Ph.D. psychologist, as well as a '91 x-ray and  
11 a senior mental health officer, a senior mental  
12 health NCO.

13 Additionally at Camp Taji we had combat  
14 stress control assets that had another

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15 psychiatrist there as well, another psychologist,  
16 and they had multiple -- they had an occupational  
17 therapist and some other mental health providers  
18 NCOs. A couple of things for the soldiers were  
19 that we left the area feeling that the soldiers  
20 did receive very good mental health care while  
21 they were out at Camp Taji. One of my biggest  
22 concerns that I read from on of the articles a

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1 couple years ago that was probably in the New York  
2 Times and recently with the year that I was  
3 deployed was saying that the doctor gave me a hand  
4 full of pills and never talked to me again. To  
5 counteract that, we made sure that that was never  
6 the case.

7 One, we made sure that prescribing  
8 practice is the patient came back. We also had  
9 open groups. Just to give you an example, on  
10 Mondays and Wednesdays we had an open group where  
11 if you had problems to deal with, the big problems  
12 were depression, family issues, work environment.  
13 So the patient always knew, the soldier always  
14 knew that they could come in and see somebody and  
15 talk to on Monday and Wednesday. Friday's we  
16 opened up a partner relation problem group and  
17 that became standing room only. Unfortunately for  
18 a lot of soldiers, you get support there as well.

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19 Additionally, we are basically open 24/7 for the  
20 soldiers. What did that mean? Is that we had our  
21 normal clinic hours and somebody would be on call  
22 and the on-call person would go see the soldier,

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1 deal with the issues, whatever that may be.  
2 Additionally, the chaplains that I knew on Camp  
3 Taji actually lived in the chapels. So the  
4 soldiers also had access to the chaplains 24/7.  
5 We tried and support the commands, and whenever  
6 they ask us for any help, be it critical stress  
7 debriefings, be it this soldier is having a  
8 problem, and I felt that after the course of the  
9 year that we were there is that we felt that the  
10 mental health care was even -- we felt being  
11 better than being back in the states and I may be  
12 comparing that to Washington D. C., which is  
13 considered the psychiatric capital, Philadelphia,  
14 other places. There's no place in the world where  
15 you can walk in and see a psychiatrist in 15  
16 minutes, except at Camp Taji and a few other  
17 places in Iraq. The longest I think patients ever  
18 waited to see somebody in mental health was two  
19 hours, and that includes getting into the law and  
20 getting in-process and everything. So it turned  
21 around and it was very quick for them. And we  
22 made sure that we helped them out in as many ways

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1 as we could. The one way that we had difficulty  
2 in helping them out was when they wanted to go  
3 home. So that was a big issue that the soldiers  
4 had, which we had to balance between the  
5 military's needs, the soldier's need, and the  
6 mission's need. Throughout the course a lot of  
7 patients were started on medications. A lot of  
8 them to help them sleep, a lot to help with  
9 depression, a lot had anxiety as well. And you  
10 also have to address with -- the comments the  
11 previous gentleman made, unfortunately, I'm sorry,  
12 I forgot your name. Soldiers did deal a lot with  
13 horrific images. There were many times I sat  
14 there the soldier told me about how he had to pull  
15 his dead buddy out of the vehicle and half his  
16 body was still there. So the soldiers had some  
17 horrific issues, they know they can come and get  
18 help.

19 Part of curing mental and horrific  
20 issues, I don't know if people have been following  
21 the latest buzz word of compassion fatigue. There  
22 was a study recently from 9/11 doing compassion

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1 fatigue, which is basically secondary post  
2 traumatic stress disorder symptoms for providers.  
3 Basically you don't even need to go ahead and see  
4 the horrible events. You sit there over the  
5 course of a year and you hear enough horrible  
6 events, they eventually start to affect the  
7 providers. A big concern that the study had was  
8 the fact that providers would have nightmares,  
9 re-experience the events that were painted to  
10 them. I spoke with a variety of providers across  
11 the different spectrums. I spoke with physicians,  
12 I spoke with PA's, I spoke with mental health  
13 officers, I spoke with chaplains, got a cross  
14 section of about 15 to 20. Roughly half  
15 acknowledged some symptoms in the spectrum of  
16 compassion fatigue burnout from the length of  
17 their deployments. All the providers that I spoke  
18 to were on the year-long deployment. So the  
19 positives about our soldiers having 24/7 mental  
20 health care access as well as medical care access  
21 is that it also takes a toll on the providers as  
22 well. So there's a lot of balancing issues as

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1 well as whether or not we're burning the candle at  
2 both ends for the providers that are sent out for

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3 over six months. The majority of people that  
4 spoke about it said that about six months was a  
5 time where they could keep going full force, give  
6 emotional support, give sympathy, be there a 100  
7 percent for the soldiers. They said six to twelve  
8 months, the difficulty was faced by the providers  
9 trying to be able to go ahead and still provide  
10 the sympathy and support for the soldiers because  
11 one of the things that mental health -- you try to  
12 do is try to maintain your own mental health, and  
13 one of the key ways that -- I'm sure that the rest  
14 of the people also agree with, is being able to  
15 leave your job, being able to see your family,  
16 being able to do things that you enjoy in your off  
17 time to decompress. Well, unfortunately none of  
18 those things are available for mental health  
19 providers are very few. The couple ways you can  
20 decompress is basically go work out, and watch a  
21 movie, but there's no other support that you get.  
22 And when I speak with the providers, they were

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1 actually they were happy that I actually asked  
2 them how they were feeling, because unfortunately  
3 they haven't seen -- that kind of got pushed under  
4 the blanket, pushed under the rug because there  
5 are more important issues as well, because people  
6 are dying and everything else.

7           But one of the things that we did feel  
8     like, I want to reiterate, is that the mental  
9     health care was to the gold standard to platinum  
10    standard. Better than what the majority of the  
11    United States probably gets and we say that very  
12    confidently. Another thing is that not only do  
13    soldiers experiencing PTSD but a concern about the  
14    providers and that may be something that we'll be  
15    facing. And then another thing about the  
16    reintegration is that at the topic of pre- and  
17    post-health assessment will also be something kind  
18    of difficult as well, is because the good portion  
19    of the soldiers that I saw were soldiers that were  
20    stop-lossed. They came in and they said, "I have  
21    nine months to go. I was supposed to be out last  
22    year and I got stop-loss for one more year." And

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1     the majority of those soldiers, I'd say even  
2     almost 100 percent said that as soon as they're  
3     able to leave, when they come back over the 90-day  
4     stabilization, they're going to go to the four  
5     corners. And what's going to happen with those  
6     soldiers, I don't know. Unfortunately those,  
7     hopefully, will not fall through the cracks, but  
8     they'll be leaving the military health care system  
9     and going out into the public sector. Are there  
10    any questions or anything that the panel would

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11 like to know from my experience?

12 DR. McCORMICK: You touched on it a  
13 little bit already, Colonel, but one of the things  
14 we are concerned with --

15 MAJOR DUDA: I appreciate the promotion.  
16 It's Major, but thank you.

17 DR. McCORMICK: I'm an old man who can  
18 barely see. It looked black to me, but I guess it  
19 is gold. Well, Major, first of all, thank you for  
20 your service.

21 One of the things we are concerned with  
22 is the issue of keeping adequate numbers of mental

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1 health professionals, getting them in a green suit  
2 and keeping them in a green suit in these very  
3 trying times. You addressed it a bit, I believe,  
4 with the fatigue due to deployments. Are there  
5 any other insights you can give us on this  
6 difficult issue of how to get professionals to  
7 take a military career and then stay in?

8 MAJOR DUDA: Well, one of the things  
9 that I know is that health profession scholarship  
10 program which funnels doctors in, so I can speak  
11 first about the M.D.s. I know that from what I've  
12 read that's been decreased; we haven't hit the  
13 numbers that we need to hit. And I think part of  
14 that is because the long war we're in now. I

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15 mean, we've gone from the job that we're doing is  
16 one that -- you can tell an American soldier we  
17 need to go ahead and accomplish this task, and it  
18 will get accomplished. The problem is the task  
19 we're trying to accomplish isn't based on what the  
20 American soldier does; it's based on what the  
21 Iraqi's do. So it's like trying to get your  
22 little brother to do something when you're the big

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1 brother, and the big brother gets very upset about  
2 it. So retentions -- one of the biggest things is  
3 that the long deployments -- I've spoken to my  
4 colleagues that will be getting out very soon. I  
5 will be in for approximately eight more years, but  
6 my colleagues that will be getting out; the  
7 biggest thing is the deployment. You know the one  
8 year deployments especially for professionals;  
9 they just don't want to do it. One of my nurse  
10 friends joked with me and said, "You know I was  
11 trying to be positive. I'm going to go away for a  
12 year and I'm going to be sitting making a lot of  
13 money tax free." And I said, "Well, if you would  
14 be away from your family and friends for a year  
15 and worked 24/7, you'd make a lot of money, too,  
16 here." So I think part of it may be more pay a  
17 little bit shorter deployments. I think six  
18 months everybody can handle and give 100 percent.

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19 Past the six months, I think it would be more  
20 difficult. And there's also just a mental health  
21 care shortage across the country as well, too.

22 I don't know how much we've looked into

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1 about whether or not we can just privatize and  
2 hire contractors to go out as well. I know that  
3 KBR is providing a lot of services overseas and we  
4 may be able to track more mental health  
5 professionals in that they're only going to be  
6 contracted for six months or 90 days. I think the  
7 huge fear is one, the stop-loss, and that may be  
8 carried over to recruiting is that some people may  
9 let you give a few years to the country, but not a  
10 career of service. And being kept longer than  
11 what you anticipate, I know definitely hurts  
12 morale. I had the privilege and luxury of working  
13 with the Struggit (phonetic) brigade as well. And  
14 there were guys that were there for one year, and  
15 then once they were moved over to Camp Taji, they  
16 said they couldn't keep it together anymore. And  
17 it was just because of being stretched out. For  
18 an example, the 4th ID is being told that two of  
19 the brigades will be going back shortly from their  
20 return from Iraq, probably within less than a  
21 year. So I don't think that's common knowledge.  
22 And then the other half will be going back in

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1 about 18 to 24 months. It makes it very difficult  
2 for the soldiers and the families and especially  
3 when a lot of orders are changed due to the combat  
4 mission. I don't think that contributes at all to  
5 trying to keep professionals in or to entice  
6 people to come in.

7 DR. MacDERMID: I have different  
8 questions which relate to the very high quality of  
9 care that you felt you were able to provide during  
10 the deployment. What difference do you think that  
11 quality of care made? In other words, what would  
12 be the indicators of success of that high quality  
13 of care?

14 MAJOR DUDA: Well, the indicators of  
15 success; one, we had a group therapy program which  
16 was roughly about eight sessions, two hours a day,  
17 two times a week, so it was about a month. It was  
18 ran by a lieutenant colonel social worker, Ph.D.,  
19 and to that we had roughly 50 people out of 500.  
20 So about 10 percent of our soldiers that we saw  
21 over the year that we saw for more than one  
22 session we considered high risk. And what is high

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1 risk? High risk is they came in verbalizing  
2 suicidal and homicidal ideations. And being over  
3 in Iraq one of the things that is different over  
4 there is that I feel naked right now, because I'm  
5 not carrying my weapon. Weapons are everywhere,  
6 ammunition is everywhere, so being able to  
7 maintain somebody's safety and try to keep them  
8 from killing themselves when you go to the gym you  
9 can grab somebody's weapon to kill yourself is a  
10 little bit more difficult. But with the intense  
11 treatment we did with those 50 or so soldiers that  
12 we had within about three or four sessions all of  
13 them weren't suicidal anymore. So, unfortunately  
14 when we were at Camp Taji we had some suicides.  
15 Those people were not entered into the mental  
16 health care system. But the people that were in  
17 the mental health care system, we had success with  
18 that program of the soldiers staying there not  
19 being suicidal, not being homicidal. They also  
20 weren't air evac'd out of theater so trying to  
21 minimize a stigma of having suicidal thoughts,  
22 homicidal thoughts and go tell the psychiatrist,

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1 go tell the shrink that you're suicidal they're  
2 going to send you home, some soldiers wanted that

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3 and others didn't. And with the support of the  
4 commands as well as having an ambitious threshold,  
5 so to speak, working close with the commands,  
6 those soldiers that were in the group, just to  
7 give you very brief breakdown we spent probably 30  
8 to 40 hours outside of the clinic of time dealing  
9 with them. One reason I'm with command making  
10 sure they had a buddy watch, making sure the  
11 command knew that they were suicidal, so their  
12 weapon or their bolt would be taken away making  
13 sure their room didn't have anything that could  
14 hurt themselves, making sure that they were making  
15 the groups every day, making sure -- it's  
16 basically a buddy watch, no weapon, and making  
17 sure that they have support from the command to  
18 make it into the sessions. And also medications  
19 did play a role. Out of all 50, 100 percent were  
20 on medications at least at one time. However, I  
21 would say that medication does not necessarily  
22 mean a bad thing. Medications were to help sleep,

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1 some were just for occasional anxiety episodes.  
2 And when I prescribed medications out there, I  
3 made sure to prescribe medications that wouldn't  
4 reduce the combat effectiveness of the soldier  
5 because I knew in the back of my mind that that  
6 same soldier is going to be up in the tower in a

7 couple days guarding me, so I wanted to make sure  
8 that they were functional. And the soldiers that  
9 weren't functioning to do their combat jobs, but  
10 we're still treating, we made sure that the  
11 commands knew full well that we're going to take  
12 the soldier out of combat effectiveness for a  
13 while, but it was still easier to take a soldier  
14 out of combat effectiveness for 10 days on a buddy  
15 watch on most occasions then it was to send them  
16 back because it's much more difficult to get that  
17 soldier back once they're out of theater than if  
18 we can treat them in theater.

19 DR. ZEISS: Thanks for the information  
20 you're providing. Very helpful. I would like to  
21 ask you about women soldiers and if they use these  
22 services and whether their adaptations of the

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1 things that you're describing particularly for the  
2 needs of women soldiers.

3 MAJOR DUDA: Once again I don't have the  
4 specific numbers off the top of my head. I'm  
5 actually working on that as we're speaking. I was  
6 caught a little off guard by this panel being  
7 today because I just got back a few days ago. But  
8 roughly female soldiers took up about 20 percent  
9 of our resources versus about, I believe, 10 to 12  
10 percent of our population of Camp Taji. What did

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11 we do different for the female soldiers? Well,  
12 for the 4th ID we had all male providers, but we  
13 did have one male provider who was experienced in  
14 running women's groups working in the prison  
15 system before. So he ran a specific women's  
16 group. Once the other mental health resources in  
17 Camp Taji had females, they also set up a women's  
18 group as well, too. So sometimes the women were  
19 -- the female soldiers were offered the women's  
20 group if we felt that their issues specifically  
21 dealt with being female, and a couple of those  
22 were motherhood issues, being away from their

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1 children, even though fathers also suffer from  
2 that as well, it was just in my experience that  
3 women had more difficulty in dealing with that.  
4 The next thing was if they had specific, any  
5 domestic violence issues as well as the women were  
6 put into that group. If they had any sexual abuse  
7 issues, either alleged during Camp Taji or in  
8 previous experience, they were also put in that  
9 group as well. Over the course of our time at  
10 Camp Taji we had a few soldiers that we had  
11 contacted family advocacy about; concerns about  
12 whether or not their children weren't being taken  
13 care of by the partner that was back in the States  
14 as well as some abuse issues that were finally

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15 brought up and they decided to pursue. Thankfully  
16 those numbers weren't very high, I believe those  
17 numbers were five or less.

18 DR. BLAZER: Again, I want to say it's  
19 impressive to see the work that you're doing. Let  
20 me ask you specifically about one aspect of this  
21 month-long eight-session group therapy; not so  
22 much about the therapy itself. Would there

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1 soldiers who were less likely to have that  
2 available to them if they had the need based on  
3 perhaps where they were located in the country,  
4 the type of activity to which they were assigned  
5 to other factors? I guess what I'm looking for,  
6 you've described a very high level of psychiatric  
7 care to some people, I'm just wondering were there  
8 barriers to others to getting that kind of care?

9 MAJOR DUDA: Well, the soldiers that  
10 were in that high level of psychiatric care, we  
11 worked with commands very closely to provide them  
12 that help. So those soldiers were ones that were  
13 having difficulties and the commands knew it and  
14 we were kind of like the last attempt, so to  
15 speak, before we were going to send them back to  
16 the states. So those soldiers were  
17 decompensating. So they were already taken out of  
18 their patrols, they were already taken out of the

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19 jobs they were doing because they were suicidal or  
20 homicidal or had this vague homicidal or suicidal  
21 ideation towards anybody. So those soldiers had  
22 full support of the command (indiscernible) of

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1 care. For Camp Taji we had a 24/7 walk-in policy  
2 which we had on-call as well as the individual  
3 providers sometimes got called by their individual  
4 brigades if they worked one. So for people that  
5 were acutely having difficulties I saw very little  
6 barriers of care. Sometimes, though, the mission  
7 tempo for those soldiers just meant that the ones  
8 that were not seriously ill, but ones that were  
9 just experiencing what I would just say the stress  
10 of being in Iraq, the depression, the loneliness,  
11 the homesickness, when mission dictated they were  
12 able to come and when they weren't able to come  
13 they weren't or if they'd be on night shift and  
14 their patrols would be at night, the majority of  
15 the groups were all held during the day, they  
16 wouldn't be able to attend the groups; however,  
17 somebody was always available, so if they actually  
18 got to the point where they thought that they  
19 couldn't deal with issues, there was always  
20 somebody at night as well as we also made sure  
21 that people for medications, for instance. We  
22 kept a pretty close watch on them and we never let

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1       them have a huge amount.

2                   LTG KILEY: Can I re-ask a question. It  
3       sounds like you've done an absolutely stunning job  
4       at Taji, did the troops of the forward operating  
5       bases at Fallujah, Tikrit, Mosul, Balad, Baghdad,  
6       green zone, Basrah and the rest of those places;  
7       do you have any sense of whether the rest of the  
8       forces in theater had some or the same or even  
9       more of the level of mental health services that  
10      you all provided?

11                   MAJOR DUDA: I can speak with some  
12      knowledge about Camp Falcon, which was one of the  
13      forward operating bases for the 4 ID and a little  
14      bit about Balad where another Fort Hood  
15      psychiatrist is currently deployed.

16                   At Camp Falcon they had a psychologist,  
17      a Ph.D. Psychologist and 2 91 x-rays, E-4, E-5,  
18      and they were available pretty much non-stop  
19      around the clock so I was keeping in touch with  
20      the psychologist, making sure that he wasn't  
21      getting overwhelmed even though he was and the  
22      other psychologist as well. One of the things was

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1 that they weren't able to see a psychiatrist;  
2 however, they were able to see their M.D.s on  
3 those bases to get them prescriptions. They were  
4 in e-mail contact for medication prescribing. And  
5 just very briefly, for mental health there were  
6 two ways we were able to choose medications, one is  
7 what we had, and then what we liked. So I asked  
8 the providers what they had and if they said they  
9 had a whole lot of "x" as long as it was  
10 reasonable, that was the first line. And if the  
11 first line didn't work and after increasing the  
12 medications then they were always able to consult  
13 me. So groups were available at Camp Falcon. The  
14 psychologist was available. They were doing an --  
15 those at Camp Falcon did a lot of CISDs and that  
16 psychologist over there mentioned the fact that he  
17 was experiencing some the symptoms of compassion  
18 fatigue or secondary PTSD, I don't necessarily  
19 think military providers suffer from compassion  
20 fatigue or burnout, because burnout occurs later  
21 in a providers career, and compassion fatigue --  
22 one, I don't like the way it sounds. And two, I

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1 don't think we suffer necessarily from PTSD but I  
2 think a combination of both. Having some of the

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3 experiences affect you and having a decreased  
4 energy to just a battlefield provider fatigue.

5 At Balad, they had a psychiatrist  
6 available and they had the CSC. So some the  
7 access were set up differently but the  
8 psychiatrist was always available as well for walk  
9 in and in Balad they have a much bigger TNC so the  
10 medics were able to screen and schedule follow ups  
11 for them.

12 DR. MacDERMID: Can I ask a follow-up  
13 question about medication. At these forward  
14 installations where there wasn't psychiatrist  
15 quite as available, what was your sense about how  
16 medication was supervised and for example, were  
17 they as likely to be required to come for a  
18 revisit to be monitored as they use medication?

19 MAJOR DUDA: Well, one, whether or not  
20 they were being seen by a psychiatrist. I think  
21 that one of the things that DoD should look into  
22 is allocation of psychiatrists. It was very nice

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1 and it was a luxury to have two psychiatrists at  
2 Camp Taji and it was a luxury to have two  
3 psychiatrists at Balad. Whether or not we even  
4 need that many psychiatrists in theater could be  
5 something that could be thought about. If a  
6 soldier's mental health issues are so serious that

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7 he actually needs a psychiatrist to manage his  
8 medications, the question is should be whether or  
9 not he should be in theater. I think it's more  
10 than reasonable for a primary care provider to  
11 provide the medications, especially the initial  
12 management because it takes anywhere from the  
13 early end of two weeks, up to two months before he  
14 can see an affect. For instance out at the 4th ID  
15 mental health providers one of the basic things  
16 that we made sure they knew is the side effects to  
17 watch out for as well as to monitor for  
18 suicidality in those started on medications as  
19 well as to be able to tell whether or not if  
20 they're having though disorders, which is  
21 basically broken down to in very simple terms  
22 which is if you don't feel comfortable with them

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1 call and we can discuss it, and either send him  
2 for a look or vice versa and somebody will look  
3 out there and just put him in as safe of an  
4 environment as you can. So the medication  
5 management, I think the very basic ones were  
6 handled well on the primary -- can be handled very  
7 well on the primary level.

8 COL PEREIRA: I also recently returned  
9 from Iraq where I was Abu Ghraib providing mental  
10 health and combat stress control services for a

11 year. I really appreciate your openness and your  
12 candidness with us. I think that compassion  
13 fatigue is a very real issue, and I struggle with  
14 looking at the value of rotating out our providers  
15 as you discussed earlier and weighing that with  
16 the credibility that we lose being part of the  
17 unit that has been there for the entire process  
18 and the entire year. We have gone toward rotating  
19 a lot of our providers recently including  
20 psychiatrist, although, the rest of the mental  
21 health staff at this point is not being rotated.  
22 What are your thoughts on the affects of doing

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1 that for the entire behavioral health assets that  
2 we have in order to maybe reduce some of the  
3 compassion fatigue?

4 MAJOR DUDA: Well, one of the things  
5 that I like to refer to as kind of more  
6 battlefield provider fatigue, because I think the  
7 compassion fatigue just has a negative  
8 connotation. I don't think we became any less  
9 compassionate, we were just tired. You know it  
10 was very difficult. I think back before the Army  
11 has gone to that modularity system I think that  
12 what you're saying ma'am is correct, is that you  
13 need to have the credibility with the unit that  
14 you're assigned to. I think with the modularity

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15 system and the plug and play, I think that the  
16 Army is looking at the fact that you can take  
17 soldiers from anywhere, put them together and they  
18 can do the job. I see no reason why you can't  
19 plug and play mental health because the jobs are  
20 relatively similar from place to place. And the  
21 unit that you train -- for instance the 4th ID,  
22 and I'm still coming to an understanding of how

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1 the modularity system completely works, but  
2 basically as of right now, I am assigned to the  
3 Systemic Brigade and just by coincidence I think  
4 because of the way we're transitioning over the  
5 modularity, the units that we supported were both  
6 4 ID units. However, another division, I believe  
7 it was 101st was supporting 10th and a few other  
8 units. So you're just going in. So you're now  
9 supporting units that you never trained with. So  
10 credibility I think is a good concept and idea,  
11 but the reality is I have never had a soldier look  
12 at me and say, you know I don't want to talk to  
13 you because you haven't been here the whole time.  
14 The only place where credibility may become an  
15 issue is when the providers decide that this  
16 person needs to be removed from theater and  
17 getting the commands to agree with that.

18 So on command liaison there may be some

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19 difficulty with credibility, but in actual patient  
20 care, I think that if anything, rotating providers  
21 in and out on a three-month or six-month basis  
22 would even increase it. I know that I spoke with

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1 other providers and asked them if you were the  
2 only provider here but you were here for six  
3 months, do you think you'd be able to handle it?  
4 They said, absolutely. You know the fact that  
5 you're there for a year takes its toll. But for  
6 six months I think a lot of providers would be  
7 able to do that and would be more than happy to do  
8 that.

9 DR. McCORMICK: Major, one of the issues  
10 we struggle with is how alcohol misuse and abuse  
11 is handled. And I'd be interested in your  
12 perspective in terms of how it's handled during  
13 deployment. Clearly, the dilemma is the need of  
14 command to know when a soldier isn't able to  
15 function versus the disincentive that notifying  
16 command potentially has on somebody  
17 self-identifying for a problem which means you may  
18 end up with a soldier who has a problem and isn't  
19 getting treatment for it which would seem to be  
20 even a greater threat to force. Can you talk a  
21 little bit about your experience was over there  
22 with alcohol misuse and abuse, and how this issue,

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1 this dilemma played out?  
2 MAJOR DUDA: Well, for the problems with  
3 drugs and alcohol, one of the nice things you can  
4 say about it taking a while to deploy is that  
5 you're basically forced -- the people that have  
6 alcohol problems and have serious physical  
7 addictions to it will come to light before they're  
8 in theater because they're going to start  
9 withdrawing. And that will happen someplace along  
10 the long from here just waiting at the airport to  
11 your next transition stop in Germany or in Kuwait.  
12 So we actually didn't have to deal with anybody  
13 having problems with alcohol addiction or drug  
14 use. We did have some alcohol misuse and from the  
15 soldiers that we had in my experience were all the  
16 younger soldiers and they were able to get alcohol  
17 from either home, mailed to them, or they were  
18 able to get it off the economy very simply part of  
19 the ways we're trying to win the hearts and minds  
20 is buying things off the economy and alcohol, for  
21 good or bad, is becoming one of the things that  
22 Iraqi's are supplying. And the soldiers are

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1 smart; they're able to hide it. I don't think  
2 they're able to -- I think the ones that have  
3 alcohol problems they report. But the same token,  
4 it's much easier to stay away from alcohol, stay  
5 away from the triggers when you're deployed  
6 because you don't see the favorite bar, you don't  
7 see the alcohol, it's even very difficult to see  
8 the commercials over there. So I don't think that  
9 people that have alcohol and drug problems aren't  
10 getting treated. I think that they're put into a  
11 forced sobriety that takes a lot more effort to  
12 break. They have to be very proactive whereas  
13 here you can fall into the temptations or fall  
14 into the triggers much easier.

15 LTG KILEY: General order number one for  
16 his alcohol consumption. So they're not supposed  
17 to be buying some (indiscernible).

18 DR. McCORMICK: I understand. We did  
19 have some input yesterday about soldiers getting  
20 (indiscernible).

21 LTG KILEY: Oh, yeah. I'm sure they  
22 are. I just wasn't sure that you --

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1 DR. McCORMICK: We had once incident of  
2 three soldiers who got alcohol and Ambien mixed

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3 together which has a multiplying affect and they  
4 basically got Article 15s, extra duty, their  
5 hooches are being inspected on a daily basis,  
6 random inspections. Drug and alcohol problems I'm  
7 sure are out there. We didn't see very much of  
8 it, and the drug use, I'm sure that there is some.  
9 We had actually more problems with steroids than  
10 we did with other illicit drugs. People have time  
11 to work out in the gym and go from there.

12 LTG KILEY: You've been up here a long  
13 time, young man, doing some phenomenal  
14 presentation to us. And, again, first, I'd like  
15 to thank you for your service over there.

16 MAJOR DUDA: Thank you very much, sir.

17 LTG KILEY: That's very hard duty. Very  
18 hard duty. And I very much appreciate that and I  
19 know everybody on the panel does, as well as your  
20 division staff. And I had a couple three  
21 questions. Some which you've already touched on,  
22 which is superb.

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1 Have you had any personal experience on  
2 even in general heard of division mental health  
3 personnel, and particularly psychiatrists in the  
4 pre-deployment phase, being forced to or being  
5 pressured to, or feeling pressured to clear  
6 soldiers of mental health issues for deployment?

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7 Now, you referenced the tension that goes on  
8 between the soldier who's got issues, got  
9 concerns, maybe sleep disturbance, mild  
10 depression, hypervigilance issues, et cetera, and  
11 then you work with the soldier and the command to  
12 make those decisions about whether that soldier  
13 should be redeployed or whether -- I was going to  
14 ask you this too, three hots in a cot, far forward  
15 therapy makes a big difference. But how about in  
16 the pre-deployment phase as you're going through  
17 the SRP screenings and stuff, have you heard of  
18 stories of soldiers or your fellow physicians in  
19 particular related stories where they've been  
20 pressured to clear people to go because the  
21 command wants them to go?

22 MAJOR DUDA: I'm not necessarily sure

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1 whether or not soldiers -- whether or not  
2 physicians were pressured to clear people. One of  
3 the things that I did when we left was to make  
4 sure that the rest of the mental health staff kind  
5 of had our vision of what we thought would happen,  
6 which was -- I think it's normal to be anxious, I  
7 think it's normal to be depressed without being  
8 deployed, I think that comes well within -- I  
9 think it's normal to have sleep problems. So I  
10 think the soldiers that were complaining about

11 those issues two months before deployment, I think  
12 that's just part of the normal -- that's part of  
13 the deployment cycle, to be depressed, to be  
14 anxious, to be irritable. Soldiers that had more  
15 severe mental illness, bipolar, or we had  
16 questionable bipolar or thought disorder, were  
17 definitely left behind. Soldiers that were just  
18 having mild symptoms of depression, we also have  
19 another term for it called an adjustment disorder.  
20 I've found that -- which is if you're given a  
21 stressor and you're sad about the stressor, you  
22 remove the stressor, you're not going to be sad,

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1 it's an adjustment disorder. Say, "Well if you  
2 wouldn't go into deployment how do you feel," and  
3 they brighten up, I don't think that's mental  
4 illness, I just think that's reality. So to kind  
5 of keep the floodgates from going we said this is  
6 -- there's psychiatrists and psychologists in  
7 theater. If the mental illness didn't surface  
8 within -- didn't surface -- that the mental  
9 illness -- it's not even mental illness. If the  
10 symptoms didn't surface for greater than two  
11 months before we're deploying, one, we can take  
12 care of you over there, and I think that you'll  
13 muscle through the symptoms, you know, if it's  
14 sleep or anxiety, nervousness or depression, which

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15 are normal. And for very blatant things of course  
16 they're not going to be sending out if they have a  
17 psychotic break, if they have suicide attempts  
18 they're not going to be sent.

19 LTG KILEY: There's been other comments  
20 about sending soldiers into the theater of  
21 operations as part of the deployment process who  
22 carry diagnosis of PTSD. There are another subset

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1 that may be on medications already and are  
2 deployed. The presumption is that they go through  
3 a screening process that clears them to deploy. I  
4 mean, was that your experience in preparation to  
5 deploy? And are you aware of soldiers that were  
6 deployed carrying a diagnosis of PTD?

7 MAJOR DUDA: Well, the first part is I  
8 left Walter Reed roughly about 14 months ago. So  
9 I left Walter Reed PCS'd here and then hit the  
10 ground running. So I wasn't part of any of the  
11 screening processes or anything like that.

12 LTG KILEY: Okay.

13 MAJOR DUDA: Second part is, yes. We  
14 did have soldiers that have the diagnosis of PTSD  
15 in theater, and the question is what do you do  
16 about that? If they're -- they have PTSD and it's  
17 managed, balancing is PTSD a diagnosis which  
18 excludes you from deploying, or is it something

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19 that you can have and still deploy with, and I  
20 think it's now reviewed on a case-by-case basis.  
21 I think the soldiers that have PTSD that are in  
22 treatment before their second deployment are

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1 reviewed very closely. I think the ones that the  
2 symptoms arise coincidentally close to  
3 redeployment; I think reality is that we can't  
4 leave them behind. We need to take them with us;  
5 otherwise you could have units having a lot of  
6 soldiers claiming those symptoms whereas they can  
7 be treated in theater. We actually did have a  
8 PTSD group as well for soldiers to go to and  
9 discuss their symptoms.

10 For soldiers that were in theater, and I  
11 had a little discussion with other providers.  
12 Some providers would actually diagnose PTSD  
13 following the time criteria. My philosophy was if  
14 the soldiers were in theater I felt it was a  
15 little -- it was such a unique environment that I  
16 don't think you can necessarily give somebody PTSD  
17 diagnosis in theater because you haven't taken  
18 them out of the environment. So that would give  
19 them acute stress or that would give them combat  
20 stress with these symptoms. One is that -- one of  
21 the biggest worries a soldier has had coming and  
22 says, "Doc, do I have PTSD?" And I said, "Well,

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1 what's your concern?" He said, "I just don't want  
2 that. If you tell me that this is normal, I can  
3 muscle through it." Now, basically the soldiers  
4 that have come in and had some depression or  
5 nightmares did not want to be diagnosed with that  
6 when they were in theater.

7 LTG KILEY: Appreciate the answers.  
8 Just want to get just a couple more. This is  
9 tremendous insight. Thank you. You made the  
10 comment that during your month-long twice weekly  
11 group therapy sessions, and you said at any one  
12 time you had about 50 in there --

13 MAJOR DUDA: I'm sorry, sir. We had 50  
14 that went through that whole program that were  
15 high risk. We had more than were high risk when  
16 Dr. MacDermid asks me what we thought our success  
17 was, that was the number that came.

18 LTG KILEY: And I guess what I was  
19 hearing you -- and I don't want to project to what  
20 you were saying. But in a 12-month period  
21 managing the high-risk soldiers, is it correct to  
22 presume that as you brought them into this group

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1 therapy it was through-put process, that as they  
2 went through the twice a week therapies, they got  
3 counseling, they better understood their  
4 circumstances and how they were reacting to it,  
5 was there light at the end of the tunnel for these  
6 soldiers or did you just over a whole 12-month  
7 period of time accumulate a group of soldiers that  
8 you had to take the weapons away from them, buddy  
9 them up, and you kept them in theater for 12  
10 months, or was there kind of a ramped up intense  
11 therapy and observation, and then over time  
12 because of the therapy and the group therapy you  
13 were able to return them to the unit with their  
14 weapons back on combat patrols.

15 MAJOR DUDA: The majority of them  
16 returned back to the units with weapons in combat  
17 controls. A few of the soldiers that we didn't  
18 return weapons to was speaking with the commands  
19 and discussing what jobs these soldiers are doing  
20 and whether or not they need to carry a weapon at  
21 all times or not. So we didn't -- at the end of  
22 the deployment we didn't necessarily have the same

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1 group that was in the beginning. What we did  
2 happen, though, was that we also implemented

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3 trying to liaison with the commands, both the  
4 different brigade commanders, the company  
5 commanders, the chaplains as well as the medical  
6 providers. We also had either weekly or monthly  
7 meeting updating the providers on the status of  
8 their soldiers. And for the most part we're able  
9 to return weapons to the combat arms soldiers,  
10 we'll say that we probably returned almost 100  
11 percent of their weapons and they were able to go  
12 back on combat patrols. The combat support  
13 soldiers, one, there wasn't as much of an urgency  
14 to make sure that they can give their weapons  
15 back. So one of the things as a provider is even  
16 though there's many weapons is that I felt  
17 uncomfortable giving them back a weapon even being  
18 vaguely suicidal. Commanders can do that because  
19 the commanders have responsibility over them, but  
20 I felt as a mental health professional giving a  
21 weapon back until they were not suicidal was  
22 something that I wasn't going to do.

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1 LTG KILEY: A couple of last quick  
2 questions. Did you see much di novo significant  
3 mental illness? Vis-à-vis aberrant thinking,  
4 psychotic breaks, did you see much of that in the  
5 troop population?

6 MAJOR DUDA: We had a few psychotic

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7 breaks. I think over the course of the time that  
8 I was there we probably had about four or five.  
9 Both psychotic breaks as well as substance-induced  
10 thought disorders. So for instance one person got  
11 off the helicopter and they were brought to us  
12 because the people in the flight line thought he  
13 was acting really funny, and he was. When people  
14 have the thought disorders, I usually don't worry  
15 about teasing out specifically what they have.  
16 This person isn't thinking right; he doesn't need  
17 to be here, let's go ahead and get his thinking  
18 right. So we had some substance abuse. Somebody  
19 took a little too much Concerta and they were  
20 enjoying themselves. Another person -- we had a  
21 couple of soldiers mix and match steroids which  
22 induced mania to them. And then we had a couple

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1 of soldiers that just broke because, very simply,  
2 the three things that can cause a psychotic break  
3 is a proper age, most of the soldiers in the  
4 proper age, in the early to mid-twenties. Second  
5 one is stress, and I think anybody can argue that  
6 being deployed isn't stressful. And the third one  
7 is toxic insults. So much of the soldiers, at  
8 least didn't have the toxic insults of drugs and  
9 alcohol, but they did have the stress and possibly  
10 the bad-brain hereditary symptoms and just a few

11 of those.

12 LTG KILEY: Again, I apologize. But  
13 this is very revealing to me. You talked about  
14 either compassion fatigue or battlefield health  
15 care provider fatigue. Is it fair to say that  
16 battlefield infantry combat arms fatigue also  
17 happen? Did it happen at the same rate, less or  
18 more, because they're all there for a year?

19 MAJOR DUDA: Well, I think one of the  
20 things is the jobs are different is: One, the  
21 infantry people also have their down times much  
22 more. So if the infantry people were down minus

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1 -- because when there were IEDs we had a quick  
2 reaction force. So the quick reaction force  
3 people they're the ones that are on call to react,  
4 and then you've got the other infantry people that  
5 know when their patrols are. So they're  
6 patrolling, they're up. When they're down,  
7 they're down. With the providers, it's always a  
8 24/7 --

9 LTG KILEY: Right.

10 MAJOR DUDA: And of course infantry  
11 people are also 24/7, but it's very --

12 LTG KILEY: It's different. Last  
13 question. And thank you for tolerating. I'm very  
14 interested in your comment that's been echoed by

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15 other presenters about the concern about or maybe  
16 the stigma associated with PTSD. And I say that  
17 because I guess my impression was in the last 15  
18 years we've struggled hard to identify an ideology  
19 for gulf war illness. We begin to understand that  
20 maybe what we were missing was something that  
21 subsequent to the gulf war was identified as PTSD  
22 and now we're kind of saying that how we got it,

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1 we've got a legitimate condition with  
2 neurobiological -- reflected neurobiologically as  
3 well as psychologically and emotionally, and from  
4 the person, the sleuth who is looking for the  
5 diagnosis that sounds like good news. What I'm  
6 hearing is troops don't want that diagnosis as  
7 though there's a stigma associated. Could you  
8 elaborate on that just a little bit more for me?

9 MAJOR DUDA: Sir, I would have to say  
10 that this is coming from being in theater, being  
11 in Camp Taji, being there -- the troops just want  
12 to hear that they're normal. They don't want to  
13 hear --

14 LTG KILEY: They don't want to hear that  
15 they're normal? Is that what you said?

16 MAJOR DUDA: Hear that they're normal.  
17 One of the things I felt in good conscience I  
18 could reassure them is that they were reacting

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19 normally to a very abnormal situation. And of  
20 course the ones that had -- an issue that anybody  
21 had -- I didn't see any soldiers that were so  
22 incapacitated from their symptoms that they

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1 weren't able to perform their job. The question  
2 is is it the soldiers that were there -- which I  
3 thought was also part of treatment too is to  
4 reassure them that what you're going through is  
5 normal. It's okay that you're having these  
6 nightmares. It's okay that you have less, energy,  
7 concentration. A lot of people go through that.  
8 It's going to get better. I thought it would be  
9 much worse for me to say, you do have PTSD and  
10 this is what you're going to be relegated to.  
11 There's much more treatment, and every single  
12 soldier that we saw, we also telling them to come,  
13 see mental health if there's ever any problems  
14 when you are back stateside.

15           And then just very briefly for that is  
16 that so you know that the previous gentleman's  
17 concern was getting any documentation about what's  
18 happening for their symptoms. So I can't speak  
19 anything about the documentation when they come  
20 back, but I know the documentation they have in  
21 theater varies in one of two major ways. One, we  
22 have something called MC4, which is supposed to

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1 shadow CHCS II. There's still some, probably,  
2 what I would say some glaring technical problems  
3 in MC4; one is that it doesn't speak to any  
4 computers back stateside. So we weren't able to  
5 get an answer of what happens to the notes that we  
6 put into these servers here where is that  
7 information going? So we weren't able to be told  
8 about that, but now from the provider point of  
9 view they're either putting it into the MC4, which  
10 goes into their medical record or for us we had  
11 handwritten documentation. We were deciding  
12 whether or we would go with computerized  
13 documentation, the reality was there weren't  
14 enough computers for us, so it was handwritten.  
15 And now those records are basically -- those  
16 records are now -- should be going back to the  
17 mental health clinic and to be added to the  
18 soldiers records. Some of the difficulties we may  
19 see for records is the modularity concept which is  
20 -- I saw soldiers from all around the country and  
21 whether or not their commands are going to  
22 proactive of getting their medical records is

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1 something that -- issue that we brought up, issue  
2 that we talked about at our liaison meetings.  
3 When we left, the idea was that there are brigade  
4 surgeons or their brigade NCO sergeants would be  
5 hand signing out all their records to make sure  
6 that it got back to their redeployment sites.

7 LTG KILEY: Okay. Any other questions  
8 for the doctor? Doctor, thank you very much for  
9 your service to the nation and Army and then  
10 thanks for standing up here for a good long time  
11 answering our questions. We appreciate that very  
12 much. Good work. We're 15 minutes late to take a  
13 15-minute break. So we're going to take that  
14 break now. We'll reconvene in about 15 minutes.

15 (Recess taken)

16 LTG KILEY: We're ready to go. Whoever  
17 else would be interested in addressing some things  
18 to us, or concerns or issues? Our plan is to go  
19 until 12:30. We have a hard stop at 12:30.

20 WARE: Good morning task force service  
21 members. My name is (indiscernible) 1st Class  
22 Ware, the forefront infantry division HSC Company

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1 44AFB. I have some mainly personal issues and  
2 concerns I need to make some comments on. And for

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3 the most part they're dealing with treatments and  
4 certain facilities as far as services are  
5 concerned. My first comment will be on the issue  
6 of treatments. I too am a soldier diagnosed with  
7 post traumatic stress disorder for about a year  
8 and a half now. During 2003, I was at the first  
9 rotation with 4th Infantry division down in Iraq.  
10 I was at Camp Caldwell and Camp Speicher. I  
11 didn't stay there too long. I was infected with  
12 cutaneous leishmaniasis if any of you guys are  
13 aware of that disease. My concerns were I was med  
14 evac'd from Iraq to Landstuhl to Walter Reed  
15 Medical Center, where they, at that time, gave the  
16 treatment for leishmaniasis. There were other  
17 treatments that were available. I took the  
18 Pentastam, if any of you guys are aware of the  
19 Pentastam treatment for cutaneous leishmaniasis.

20 DR. ZEISS: Excuse me for interrupting.  
21 But it's a little hard to hear you. Would you  
22 mind bringing your microphone down just a bit?

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1 Thank you.

2 WARE: Sure. My issue is I received the  
3 treatment. It's a 20-day treatment, IV injection.  
4 After you receive the 20-day treatment you get  
5 back to your forwarding unit. They redeploy. In  
6 my case I didn't get the opportunity to redeploy

7 due to certain conditions that I encountered with  
8 the treatment. And my concerns are, I don't know  
9 if anyone is as concerned as I am about the  
10 treatment that I received concerning some of the  
11 conditions that I have now. I guess can speak for  
12 most soldiers that are getting certain services  
13 and treatments for the most part, I hear a lot of  
14 arguments. I hear them every day because I'm back  
15 here in the rear about the services that they're  
16 receiving. Most of them are being denied of  
17 certain treatments or services that they need.  
18 For me personally I was infected in 2003, I  
19 received the treatment in 2003 and I've undergone  
20 surgery. F4, F5 fusions and I've been diagnosed  
21 numerous diseases and problems. And I don't know  
22 if anyone is really addressing the issue about

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1 certain treatments or services that are being  
2 provided for some of the soldiers that are coming  
3 back from Iraq. I was speaking with one of the  
4 young ladies in the back earlier. And me and her  
5 were speaking and we were referring to some of the  
6 mental issues that is necessary that we think it  
7 should be mandatory when soldiers return from Iraq  
8 that those services are provided for them.  
9 Because I can remember when I came back, I mean,  
10 you went through the process of getting your shots

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11 and stuff, but there was nothing else after that.  
12 I remind you this is in 2003. I came back in  
13 November. And my concerns are: I feel as though  
14 I may not be -- I can't speak for every soldier, I  
15 feel that I might not be getting all the exact  
16 treatments that I may need to help my situation  
17 here. 2003, again I say I was diagnosed with  
18 cutaneous leishmaniasis, I received the treatment.  
19 In 2005, March 2005, they had done a 24-hour urine  
20 collection on me because my conditions were  
21 depreciating. They explained to me that the urine  
22 -- from the urine collection the antimony that was

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1 in the treatment was still in my body, in my  
2 system. So my concerns were then why is the  
3 treatment still in my system? And during the  
4 duration of the treatment in my system I received  
5 numerous side effects and for the most part the  
6 problems I'm having is getting the proper  
7 documentations, which most soldiers are not  
8 getting and the proper services I feel I might  
9 need to get to help me. Like I said, I don't know  
10 if any of you guys are even familiar with the  
11 treatment. It was an investigatable treatment,  
12 which meant you can't donate anymore blood, that's  
13 from FDA and Red Cross and certain other military  
14 officials. And my concern is my living activity

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15 has depreciated enormously and I'm having problems  
16 with getting certain treatments that I feel that I  
17 might need and for most soldiers, they're not  
18 getting it as well. Like I said, I speak to  
19 soldiers every day. I'm there with them and I  
20 hear their arguments. And I can only tell them as  
21 a non-commissioned officer you have to -- you have  
22 those rights to be treated. And the problems that

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1 I also encounter is that being transferred to  
2 certain facilities, whether throughout Texas,  
3 whether it be Austin or back to Walter Reed, most  
4 soldiers are not getting the treatment that they  
5 need as far as if they need some type of pain  
6 management. The problem I'm hearing from most,  
7 even most doctors, that the problems that I'm even  
8 having is that if they put you in a pain  
9 management program where only certain people are  
10 dealing with you rather than every other doctor is  
11 seeing you based off your condition, it will help  
12 your condition a lot better. But as long as they  
13 continue to send you here, send you there, send  
14 you here, then no one is going to really track or  
15 keep up what's going on with you. And my personal  
16 issues are based off of that right there. I do  
17 see psychiatrist and I do attend some of the group  
18 therapies for the PTSD and stuff like that.

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19 I am right now, currently, going through  
20 a med board right now, which is also depressing to  
21 me because, I mean, I only have 14 years in the  
22 service and I would like to of course continue,

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1 but I guess that's not going to be up to me. But  
2 my concern is transitioning from the military to  
3 the civilian world. By hearing some of the things  
4 that the VA provides or most soldiers are not  
5 actually getting the proper information as far as  
6 -- even those are transitioning from the military  
7 to the civilian world. And I've been to some of  
8 the VA briefings and I can tell you that they're  
9 not giving a lot of information out to the  
10 soldiers, and every day I'm seeing soldiers being  
11 medically boarded out, and for the most part  
12 they're clueless on what's going on. And that's  
13 another issue in itself as far as information that  
14 soldiers do not have. And for the most part most  
15 of the soldiers that I even spoke with are scared  
16 or concerned about some of the services that they  
17 may need and I'm just getting a different vibe  
18 from them, that they're just really not getting  
19 the treatment. And like I say, personally myself  
20 I'm definitely not getting all the treatment that  
21 I would need. I've been back to Walter Reed for  
22 further evaluation because of my condition and

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1 some of the results were, well, it could be from  
2 your surgery or it could be from whatever. My  
3 opinion, I believe, maybe the treatment has a lot  
4 to do with it concerning the toxins, because the  
5 toxins were high. High levels every time they did  
6 the 24 urine collection on me. So now I'm just  
7 basically stuck with a lot of conditions from the  
8 neck down. A lot of other heart conditions and  
9 stuff that I probably didn't have at the time.  
10 And my concerns are, are there going to be any  
11 facilities or other treatments that's going to  
12 help soldiers that are going to follow me, as far  
13 as -- I mean, if some of them do encounter the  
14 same conditions that I have and I tell you I've  
15 seen some soldiers actually go with some of the  
16 conditions I have, and I still stay in contact  
17 with them and they're still complaining. And some  
18 of them are on TDLR from the military and they're  
19 having a hard time getting certain treatments.  
20 And my concern is that as well, getting the proper  
21 treatment and being sent to the proper facility to  
22 get that treatment. For my conditions, I mean, it

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1 kind of left with, there's nothing else we can do.  
2 And if that's what they say, that's what they say.  
3 I can't control what the military can't do anymore  
4 or even some of the outside referral facilities.  
5 I'm basically kind of left with nothing, I guess.  
6 So my concerns again are that are there going to  
7 be any other facilities or treatments to even  
8 assist some of the soldiers or even myself after  
9 the military or whatnot. That's all I have.  
10 Anyone have any questions?

11 LTG KILEY: Questions?

12 MS. FRYAR: Have you actually started  
13 the transition process out of the military?

14 WARE: No, ma'am. Right now I'm still  
15 currently going through the med board right now.  
16 As we speak, the doctor is supposed to be writing  
17 up the summary on me. And I tell you, I don't --  
18 I'm going on my fifth volume of medical records  
19 and I can tell you they only have one, the last  
20 copy. So it kind of bothers me to know that well,  
21 if you're going to take just one, how can you  
22 actually tell what's actually going on if you

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1 don't go back and determine what's going until now  
2 and my conditions didn't start until 2003 until

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3 now. From one volume to the fifth volume in three  
4 years is kind of -- I mean, I didn't get wounded  
5 or anything like that. Those are mainly my  
6 concerns.

7 DR. ZEISS: I heard you say that you  
8 talked with the VA already. Have you actually  
9 been to any of the transition briefings, and if  
10 you have what specific information have you been  
11 given about your benefits or your separation?

12 WARE: I recently spoke with a lady by  
13 the name of Jillian over at the -- what's the name  
14 of this place? Family -- some type of family  
15 assistance thing on Fort Hood off of Santa Fe.  
16 And they were trying to explain to me certain  
17 benefits that the VA offers, but they didn't  
18 really go too far in detail because of the time, I  
19 had to get back to an appointment. And that was  
20 actually day before yesterday I spoke with them.  
21 I'm just really concerned. Just my condition. I  
22 mean, my condition go from one page to the next.

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1 You're talking about two pages halfway down. And  
2 I really don't even know what's really going on,  
3 but I can tell you one thing is, I believe, my  
4 personal opinion is it goes back to maybe,  
5 possibly the treatment that I received. And this  
6 is what concerns me. If I'm not the only one

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7 that's going through the same problem. You what  
8 anyone's going to do about it to counteract or  
9 reverse the treatment or whatnot. Because just  
10 being Walter Reed, going back, I was practically a  
11 guinea pig that everybody wanted to test and see  
12 what was going on. In fact, they did another  
13 urine collection while I was up there and that was  
14 October 2005 which they stated everything was back  
15 down to normal levels. Receiving the packet from  
16 them, you can look at the last that still say the  
17 antimony was high. So it kind of just makes me  
18 wonder. Am I getting erroneous information or am  
19 I getting the proper service that I should be  
20 given.

21 DR. MacDERMID: You've given us some  
22 very good ideas of things that we should make sure

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1 we ask about in future site visits. This is only  
2 our second. So hopefully you've done a valuable  
3 service for others by giving us some tools that we  
4 can try to use as we go forward, and we thank you  
5 for that.

6 WARE: You're welcome.

7 LTG KILEY: Are you assigned to medical  
8 hold at Darnall; is that where you're assigned  
9 there or are you still assigned to the 4th ID?

10 WARE: I'm still assigned to 4th ID.

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11 LTG KILEY: You're still assigned to 4th  
12 ID. Do you have a case manager for your medical  
13 conditions that's working through the MAB for you?

14 WARE: Yes, sir. Her name is Ms. Dawn  
15 Hawks at Darnall. She's the only one right now  
16 other than my counselor.

17 LTG KILEY: So you've got a couple of  
18 issues it sounds like. You've got the issue of  
19 leishmaniasis and the Pentastam therapy and you're  
20 concerned that you may still have residual issues  
21 associated with that?

22 WARE: Yes, sir.

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1 LTG KILEY: Sounds like Walter Reed has  
2 brought you back at least once, or at least  
3 checked your urine for that, is there anything in  
4 your future where you're going to go back and see  
5 them again in the research group up there at  
6 Walter Reed?

7 WARE: As far as I know, sir, the  
8 infectious disease department here at Darnall  
9 explained to me that if there was any other issues  
10 that they can help me with to just call them. And  
11 to be honest with you, I just got the lab work  
12 back that's now saying that my antimony is back  
13 down to normal levels. Again, I say, that's just  
14 what they're saying. I don't know until I

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15 actually see documentation.

16 LTG KILEY: As far as the PTSD diagnosis  
17 that you have, you are seeing -- I thought I heard  
18 you say you're seeing a psychiatrist for that?

19 WARE: Yes, sir.

20 LTG KILEY: What's your assessment of  
21 the availability and the value of your visits and  
22 your therapy in that area? Is that helping you?

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1 Do you think that's something worthwhile?

2 WARE: Yes, sir. It does help to an  
3 extent. But I mean it's kind of hard to retrain  
4 the mind to think otherwise. I mean, being in the  
5 situations back in Iraq and coming back here, them  
6 showing you different techniques and what you can  
7 do to try to deviate from your situation that your  
8 in is kind of hard. I mean, if you're having  
9 nightmares, you're having nightmares. If you're  
10 having episodes, you're having episodes. I mean,  
11 it's kind of hard for anyone to stop that. The  
12 services have been good. I mean, I like the fact  
13 that I have to go to a group. You know, hear  
14 everyone else, their problems and the psychiatrist  
15 intervenes and they kind of explain to you what  
16 you're really going through. So for that part  
17 that's been okay. Now, as far as medication-wise,  
18 I mean different strokes for different folks.

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19 LTG KILEY: And you said you had your  
20 back operated on L4/L5. Did you have the back  
21 surgery also?

22 WARE: Yes, sir.

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1 LTG KILEY: Have you had some problems?  
2 I see you're still using a cane. Does that  
3 continue to be a problem for you?

4 WARE: Yes, sir. I had the surgery in  
5 August '04. And I had a failed back surgery. And  
6 I just believe from there everything kind of went  
7 downhill from there. From my back to my neck.  
8 Now I'm kind of dealing with cervical spondylosis,  
9 degenerative disk disease and that's actually from  
10 here all the way on down. So I do have a hard  
11 time.

12 LTG KILEY: Are you seeing doctors at  
13 Darnall for that too?

14 WARE: Yes, sir. I do see the  
15 orthopedic doctor and that's mainly who I see.  
16 And I see the Austin Pain Clinic doctor up there,  
17 which he resorted -- his conclusion was putting a  
18 pump and starting a pump in me.

19 LTG KILEY: For pain?

20 WARE: Yes. They kind of took me off  
21 all the medication. He said it wasn't doing any  
22 good. They did all the nerve blocks, the

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1 injections, all those things and they're just not  
2 helping. So that was his conclusion was -- I  
3 don't really want a pump in me. He kind of  
4 explained to me I'm too young to have it. You  
5 know and he also tells me you might be impotent.  
6 And that's something I don't -- And something  
7 else, sir, I'd like to comment on. When I went  
8 back to Walter Reed in 2005 of October, I received  
9 an epidural shot from a pain clinic. And they  
10 sent me home and then about two days after that I  
11 arrived back and I called them back and explained  
12 to them, hey, something ain't right. I'm having  
13 nerve problems flaring everywhere. And when I got  
14 back I received a phone call. They said it's kind  
15 of unusual, so I explained to my case manager and  
16 she was like you need to see a neurologist or  
17 something. I remind you it was October '05,  
18 today's day is the 20th of September and I haven't  
19 seen a neurologist yet. So that's what I mean by  
20 --

21 LTG KILEY: Well, we'll get you hooked  
22 up with the hospital commander and see if we can

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1 get some of these issues addressed for you.

2 WARE: I appreciate it, sir.

3 LTG KILEY: And I thank you for your  
4 service too and I also thank you for bringing  
5 forward these issues to the task force. They're  
6 very insightful. And the best of luck to you,  
7 too.

8 WARE: Thank you, sir.

9 MS. LEHMAN: Hopefully mine won't be  
10 very long. Can you hear me? My name is Mary  
11 Bufford Lehman and I work for the department of  
12 substance abuse services. And earlier I heard  
13 someone on the panel ask how do you get and keep  
14 professionals in the field? And I wanted to point  
15 out something that I think is now in Washington  
16 being looked at. And if you can help us with that  
17 it would be most graciously appreciated. At our  
18 agency, we have 15 master level counselors. And  
19 those counselors have LPCs. They're licensed  
20 professional counselors. Two of them are licensed  
21 marriage/family counselors and one is a licensed  
22 social work counselor. We are now being told that

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1 have to have a licensed marriage professional  
2 therapy license, which means out of the 15, we

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3 will have -- 12 of those will have to return back  
4 to school or give up their job. It also means  
5 that if those 12 people were to apply for the job  
6 in the field today, they wouldn't even qualify to  
7 work. But there is a bill now at the legislature  
8 to look at credentialing licensed professional  
9 counselors. That's our biggest, largest pocket of  
10 counselors in the field and of course this panel,  
11 I think to warrant justice to the LPCs we could  
12 have our panel to look at this and peers in the  
13 group to tell our story about how we do what we  
14 do, and that we would like to stay in the field  
15 servicing the soldiers that we work with, or even  
16 the civilians. So my proposal would be that  
17 someone would go back and have that bill looked at  
18 or put a plug in someone's ear to go ahead and  
19 credential those licensed professional counselor's  
20 so we can stay in the field.

21 MS. RODRICK: General Kiley and task  
22 force members, I'd just like to say thank you for

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1 letting me come and address you today. I am  
2 Specialist Rodrick of HHD 2nd Chem and I went to  
3 Iraq in 2003 to 2004. I want to let you know that  
4 when we went back then we had no pre- screening  
5 for mental health and we had no post-screening for  
6 mental health. Luckily for me, when I got back, I

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7 went home to my sister. And her boyfriend is a  
8 Vietnam vet and he talked to me a lot about post  
9 traumatic stress disorder and I was having a few  
10 problems after the war with depression and I  
11 decided to seek help on my own. And I did and it  
12 was great and I had a very good experience.  
13 However, I would like to talk today about the  
14 command stigmata that there is of soldiers that  
15 seek help. Personal experience with myself and  
16 other soldiers I know in my unit, we've had  
17 problems being denied appointments, we've been  
18 ridiculed by our leadership, we've been held back  
19 from promotions. A commander in the unit that I  
20 was formerly was in has actually flushed a  
21 soldiers medications. Soldiers have been punished  
22 by Article 15 that sometimes will act up if

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1 they're denied medication because their conditions  
2 get worse. There's been threats of chapters. If  
3 you try to get help they often label you as crazy  
4 and it's even worse if you're a woman in the Army  
5 it's twice as bad. And I feel that these issues  
6 really need to be addressed. When we as soldiers  
7 talk to the IG or the E0 about these issues they  
8 seem to get ignored, pushed under the table. And  
9 I see a lot of problems in that the young soldiers  
10 today are really feeling that they're forced to

11 drown out their problems with alcohol and I see  
12 that this is going to be a continuing problem if  
13 we don't do something to settle this issue. Does  
14 anybody have any questions?

15 DR. MacDERMID: What is your impression  
16 of the degree to which the pre- and  
17 post-assessments, pre- and post-deployment  
18 assessments that have been place since you went,  
19 have they made any difference in your view?

20 MS. RODRICK: No, ma'am. I don't think  
21 so, because a lot of the soldiers, to be honest  
22 with you, you do it in an SRP forum where there's

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1 not really a lot of privacy and I think a lot of  
2 soldiers are afraid to speak up. God forbid my  
3 sergeant in the line next to me overhears.  
4 There's a lot of fear with that. I think the  
5 biggest fear with everybody is, like, God, I don't  
6 want anybody to know that I'm having these issues,  
7 because what is this going to do for my career.

8 COL ORMAN: Thanks for your service and  
9 for bringing your concerns forward. From your  
10 perspective, at what level of command are these  
11 issues sort of suppressed? Is it at the unit  
12 level or do you get the sense that the same  
13 attitude exists at the company level, battalion  
14 level?

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15 MS. RODRICK: I think the issues, sir  
16 are happening with the soldiers and it's happening  
17 at the NCO leadership and especially the  
18 commanders. There's a big problem with  
19 commanders.

20 COL ORMAN: So you're talking company  
21 level?

22 MS. RODRICK: Company level. But when

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1 the soldiers go ahead and they decide I'm going to  
2 bring this up to the IG or whatever, I feel it's  
3 gets suppressed. Nobody wants to deal with it  
4 because they're considering it an embarrassment  
5 issue, like we don't want to deal with the fact  
6 that some of our commanders are denying our  
7 soldiers mental health care.

8 COL ORMAN: And realizing this is  
9 speculation, do you think the attitude you  
10 perceive from the unit leadership is because  
11 they're concerned about the loss of the hours that  
12 you work or the mission you do for them? Or  
13 what's your perception of what's driving them on  
14 the part of the unit leadership?

15 MS. RODRICK: My perception of it, I  
16 think is ignorance to what these issues really  
17 are. I know for myself if I miss an appointment  
18 -- like my new chain of command that I'm in now is

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19 great and they always work with me. And if I'm  
20 behind, I'll stay and work late, we work together  
21 to solve the problem to get me the treatment that  
22 I need. The old unit that I was in and had to get

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1 removed from, it was, like, I could not go. I was  
2 constantly forced to cancel appointments. It was  
3 almost like they were ignorant to the whole thing,  
4 like I had a disease or something that they didn't  
5 want to address.

6 COL ORMAN: And do you think that  
7 attitude is remediable by more education for  
8 commanders or how would you like the task force to  
9 sort of make a recommendation about trying to  
10 address this concern.

11 MS. RODRICK: I think education would  
12 help a lot. I was diagnosed with depression after  
13 the war and I didn't even know what it was myself  
14 until I had adequately researched it. I think a  
15 lot of people think depression you can just kind  
16 of snap yourself out of it. They don't even  
17 realize it's a physiological illness as well as a  
18 mental illness, and I think those are some of the  
19 problems. A lot of commanders are, like, well  
20 your depressed you can just snap yourself out of  
21 it. You need medication? Why do you need  
22 medication? You know they just really don't

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1 understand. And this soldier in my unit that had  
2 his medication flushed, we were just completely  
3 shocked that this commander would think that that  
4 was okay to do. And then furthermore when we  
5 brought it to the IGs attention, nothing happened.  
6 And we were just shocked and amazed. So now we're  
7 sitting here wondering as a group, do we go and  
8 keep trying to get help or do we just try and take  
9 it on ourselves. And I think that's a big issue  
10 that we need to address with our commanders.

11 DR. ZEISS: This is certainly one of the  
12 issues that the issues that the task force has  
13 actually been charged to consider is education for  
14 commanders and throughout the system. So it's an  
15 important issue that you're bringing up. And  
16 certainly it's very troubling to hear about the  
17 things that have happened. What I want to look at  
18 is the flip side. You managed to get into a new  
19 command structure where you are actually being  
20 supported, which is wonderful to hear. Is there a  
21 way to use and possibly recommendations for us to  
22 focus on in terms of looking at those folks who

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1 are doing it well and using them in more effective  
2 ways?

3 MS. RODRICK: Well, I just have to say  
4 that I'm just very lucky. I was one of the lucky  
5 ones. A lot of times these soldiers that I talk  
6 to around, I live in the barracks, I talk to a lot  
7 of the guys and girls in the barracks that have  
8 been deployed with me, and they're just afraid.  
9 And I think we really need to get out and need to  
10 address that with the soldiers. It's okay if you  
11 seek mental health care. It doesn't mean your  
12 crazy, it doesn't mean you're incapable of  
13 service, and it's not going to hold you back from  
14 promotion. A lot of the soldiers in my unit and  
15 have seen the treatment that I've had and the  
16 treatment that I had gotten in the old unit and  
17 they're very much afraid to come forward and I can  
18 only hope through education, educate the  
19 commanders and the senior non-commissioned  
20 officers and the soldiers. These are not issues  
21 that we should be embarrassed to discuss. These  
22 are issues we need to discuss.

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1 DR. ZEISS: Thanks.

2 MS. RODRICK: Thank you.

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3 LTG KILEY: Thank you also for your  
4 service and for talking to us here at the task  
5 force Specialist Rodrick. I take your point very  
6 seriously about this group pre-deployment  
7 screening. Fill out the blocks and the concern  
8 about identifying issues. Now you deployed back  
9 in 2003; is that correct?

10 MS. RODRICK: 2004, sir.

11 LTG KILEY: 2004. Are you hearing, have  
12 you heard, talking to your friends who have  
13 deployed later and redeployed later about whether  
14 there's been any change, improvement or it's just  
15 the same as it's always been? Do you have any  
16 sense of that?

17 MS. RODRICK: Well, actually, thank you  
18 for asking, sir. My friend is recently deploying.  
19 Due to deploy at the end of this month and from  
20 what he's told me from his SRP process he has not  
21 had a mental health pre- screening deployment.

22 LTG KILEY: Is there an expectation or a

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1 recommendation or a thought that every soldier  
2 should have an individual mental health screen  
3 versus an individual pre-deployment screen that  
4 includes questions about mental health. Do you  
5 see those as being separate? Do you see what I'm  
6 driving at?

7 MS. RODRICK: Yes, sir. I think we  
8 should separate the mental health. I think the  
9 issue of privacy and the fear of the stigmata is  
10 really what's keeping a lot of soldiers from  
11 coming forward with potential mental health issues  
12 either before from a previous deployment or  
13 perhaps a home environment that they might bring  
14 with them into the combat situation or even when  
15 they get back. Nobody wants to be held back  
16 because of a mental illness and the potential  
17 stigmata with it. And I think the number one  
18 thing, if I can express anything is that so many  
19 soldiers are just afraid. They are afraid to seek  
20 help. They are afraid to talk about it. And I  
21 really just think we need to, as a collective  
22 Army, we really need to address this issue.

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1 LTG KILEY: One last question. No one  
2 in my experience, at the senior leadership  
3 position, would condone a commander flushing pills  
4 down the toilet or denying soldiers any kind of  
5 mental appointments, et cetera. When Dr. Orman  
6 was asking, it looked like we had kind of worked  
7 this down to the company level and I don't know  
8 whether this is when you were with the 2nd Chem  
9 and I'm not really interested in what the unit was  
10 except to ask you the question, how big was your

11 unit in terms of squads and platoons inside a  
12 company. Because what I'm looking for is your  
13 estimate or your assessment of the pervasiveness  
14 of this, I won't call it anti-mental health, but  
15 the pervasiveness of this attitude among the --  
16 you know you've only got one commander and you've  
17 got one first sergeant, but you may have platoon  
18 leaders, two, three, or four platoon leaders. You  
19 may have platoon sergeants and squad leaders and  
20 team leaders. And is your sense that it was maybe  
21 just your chain of command that was not helping  
22 you or was this pervasive across all the NCOs and

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1 the officers in the -- you may not be able to  
2 answer that, but what's your sense of it?  
3 MS. RODRICK: Well, I actually do attend  
4 a group session at Fort Hood. And talking with  
5 other soldiers in my group, they've told me  
6 they've experienced the same kind of things.  
7 Fortunately it's not prevalent in every unit,  
8 thank goodness, but there certainly is a lot of it  
9 going on. I know in my old company that I was in,  
10 there was NCOs denying appointments for whatever  
11 reason. It was brought to command by certain  
12 soldiers that were courageous to do so and nothing  
13 ever happened. Some soldiers actually were  
14 punished for even going to talk to the commander

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15 about it, which is really sad to say. I'm very  
16 thankful that I'm in a new supportive unit now.

17 LTG KILEY: Well, it certainly starts  
18 from the top in terms of creating the atmosphere  
19 that will support those kinds of quorums for  
20 soldiers. And that's part of what we're trying to  
21 assess. Do we have a major system-wide issue  
22 with NCO and office leadership who don't

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1 understand, or do we just have a couple of yet to  
2 be educated leaders that kind of make it bad for  
3 everybody and kind of ruin it for everybody. And  
4 that's part of my continuing question is. But I  
5 absolutely congratulate you on your ability to  
6 come up and talk to us about that too. It speaks  
7 volumes for you as a soldier. We wish you the  
8 very best of luck, too.

9 MS. RODRICK: Thank you. I just wanted  
10 to address one more quick thing if you guys don't  
11 mind, about the -- I've noticed a lot of soldiers  
12 that I deployed with have had some alcohol issues  
13 when we came back. And I currently do not believe  
14 that the current program that we have in place for  
15 alcohol and substance dependency is working. Most  
16 of those soldiers that I know have gone in for  
17 maybe a couple of two day treatments, some of them  
18 need outpatient treatment and they don't get it.

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19 I see good soldiers that just have certain  
20 problems with alcohol that could potentially be  
21 rehabilitated being put out due to lack of  
22 adequate care. I think if some of these

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1 individuals could get dry they would be some  
2 phenomenal soldiers and some phenomenal leaders.

3 LTG KILEY: Is that a resource issue or  
4 is it a process issue? Is it about the way we go  
5 about drug and alcohol rehabilitation and the  
6 rules, regulations and policies or is it that  
7 they're all okay and the issue really is that  
8 there isn't enough capability? Or is it again a  
9 problem with leadership prohibiting soldiers from  
10 accessing that kind of care?

11 MS. RODRICK: I would actually say all  
12 three, sir. I believe that the rules and  
13 regulations regarding substance abuse programs is  
14 holding back some soldiers from getting proper  
15 treatment. I think there's a shortage, definitely  
16 a shortage of providers. And I think again  
17 there's some stigmata with the alcohol as well.  
18 They think, you know, he's just an alcoholic, it's  
19 not related to anything possibly deployment  
20 related.

21 LTG KILEY: Okay. Thank you very, very  
22 much.

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1 MS. RODRICK: Thank you.  
2 LTG KILEY: Good luck to you.  
3 SGT HUNT: Sir, ladies and gentlemen of  
4 the council. My name is Sergeant First Class  
5 Charles Hunt. And I came to the council today to  
6 try to open up my eyes or figure out what's going  
7 on with me and all the other soldiers who are  
8 possibly going down the same trail that I got put  
9 on to travel down. And hearing the stories or  
10 what some of the other people come up here and  
11 say, I'm finding myself, bits and pieces of what  
12 they're going through or want to achieve -- I'm  
13 sorry. February 18th, I had a flash go off and my  
14 driver got instantly killed. I'm sorry. I'm  
15 sorry about that ma'am. One of the most  
16 devastating tools used against us the copper EFT  
17 came through his door and it instantly killed  
18 Charlie Matheny. And my gunner he just started to  
19 being able to walk because of his left leg as  
20 always having reconstructive operation on it. For  
21 me, for some reason, maybe it's a reason, I was  
22 the first one to get back and to understand and to

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1 try and find out to help these other soldiers  
2 because obviously the main thing is that everybody  
3 sees my left arm that it took seven hours to  
4 reconstruct it because of the copper that came  
5 into, or right up my jugular where I had a piece  
6 under my neck. But everything that most people  
7 can't understand or don't see when I'm initially  
8 speaking with them, I received a 39 centimeter  
9 incision on my head to have my cranium removed  
10 because of the hole that was in it and a piece of  
11 my brain from the frontal left temple area was  
12 removed because of the copper that was put inside  
13 of it. And the physicalness and the mentalness of  
14 everything that occurred, is occurring, or will  
15 occur, I don't know. I'm an old guy, 16 years in.  
16 Old infantry guy, ground pounder, grunt, whatever  
17 the names we want to be called or taken upon. I  
18 put down this road where I don't know what's going  
19 on. Because I don't know -- because there's a lot  
20 of other soldiers who don't know what else is  
21 going on for them. And it's taken me a while to  
22 come back to an understanding of myself. Even

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1 though it took 'til May 1st when I had my head  
2 reconstructed. Because every day before that

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3 walking past a mirror or anything that have a  
4 reflection, I could see my head was sunken in on  
5 the left side. And the people that I think about  
6 every day, Charlie Matheny who got cut in half, he  
7 stopped it for me. Why did he stop it for me?  
8 Because I was the guy who got hand picked to be in  
9 charge of these men. And I told them from day  
10 one, you're not in front of me, I'm in front of  
11 you. I'm the one looking out for you; I'm the one  
12 here to take care of y'all. And the 24 of us got  
13 put out from the regular battalion, who is over in  
14 Rustimyah, and we got put into the military  
15 transition team, the MTTs integrated into an Iraqi  
16 battalion at the infamous place FOB Hope which is  
17 right across the road from Sadr City. And for  
18 some reason us being so integrated into an Iraqi  
19 battalion we was the first truck within our  
20 regular battalion, my regular battalion 367 Armor  
21 who they came after, they went for and they took  
22 us out. Maybe to prove a point, maybe to make

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1 them understand what they can still do and  
2 accomplish to when out there before there was a  
3 regular infantry battalion on FOB Hope and it was  
4 replaced by an Iraqi battalion and 24 men who --  
5 there wasn't rank involved. It was eye contact  
6 involved. And that's what's eating me every day.

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7 I'm thinking about what I let go of those men. So  
8 we got there in the middle of December and this  
9 happened February 18th. 60 days, almost to the  
10 day that I got there on that ground. I don't know  
11 when, where, why, who it was. If they was  
12 involved with the battalion who we was involved  
13 with, the Iraqis and every day it eats me up. I  
14 think about it. And I've had days where I didn't  
15 know -- I just had to stop. I just had to pull  
16 off side the road and just relax. Call my wife,  
17 call some of the guys who I had their phone  
18 numbers or call somebody who was a previous combat  
19 veteran. My dad who '69, '70 was over in Vietnam  
20 and something that he's been through for a couple  
21 of decades that I'm going through within six,  
22 seven months after I -- it's in me. It's not on

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1 the outside, it's not physical, it's mental. It's  
2 past my bone, down my heart, down my soul, because  
3 maybe it's -- I'm not trying to be up here being  
4 an example of what's going on or the soldiers that  
5 are coming back, and unfortunately I am and I  
6 never was. But I wanted to speak hearing all  
7 these other people who got up here and spoke about  
8 events. Because one of the events that I was on  
9 the same line with, December 25, 1990, Private  
10 Hunt got on a plane in Bramburg, Germany and

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11 landed in Saudi Arabia. I was there, and I had  
12 came in March of 1990. That right there made me  
13 understand a lot of concepts going on. But then  
14 being in the middle of Baghdad and Sadr City it is  
15 -- it is two different worlds from what happened  
16 15, 16 years ago to what happens day-by-day here,  
17 now, in this time. Because it is beyond the  
18 reality point over there. I'm telling you ladies  
19 and gentlemen, I'm the guy who's on the ground in  
20 the middle of everything that's projected about  
21 giving families or villages, these little  
22 represents the toys or soccer balls or anything

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1 like that. It's not even day by day, it's hour by  
2 hour. Whether they want a soccer ball and they  
3 see where you're going so they can go set out the  
4 IED. That's what I think, that's how I feel. It  
5 burns me in the inside of knowing all that. But  
6 even though I had a physical piece of my brain  
7 taken out to get me back to this point that  
8 probably opened my eyes wider to understand  
9 everything, and it's in me. And I had a day here  
10 about a month and a half ago, where I lost  
11 control, I didn't know where I was at and I  
12 basically blacked out and the next thing I know I  
13 had four or five MPs around me taking me down.  
14 And they said the only thing that I was trying to

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15 do was fight back and just saying everything that  
16 I never would say anyway. And I ended up on the  
17 5th floor of BAMC and I couldn't believe it  
18 because in all my past years I would go visit some  
19 of the soldiers who needed that, but I completed  
20 the circle or whatever the concept of it, and I  
21 ended up there. But there's a lot of stuff that I  
22 understand from these other people that have

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1 spoken. And I'm probably the -- I don't know some  
2 days. I truly don't know. After being in an  
3 infantry platoon for 13 years and it just changes  
4 one day to where I don't know what's going on, the  
5 concept, the understanding about it. And I have  
6 bad days, and I'm not trying to use this as an  
7 excuse, I'm trying to bring it out of me so I can  
8 get it out of me. Because the two reasons I'm  
9 trying to is, one reason is five years old and the  
10 other reason is two years old. And the day they  
11 came down to BAMC and seen me half of my head was  
12 gone. I just can't believe that, that even though  
13 I love them so much when I left -- the day that I  
14 left here I had a new family. A new family to be  
15 involved in and to be with and that's what's in me  
16 now, I let down a family over there. And that  
17 just burns me up inside. And maybe I'm one of the  
18 ones that's out there that's pushing forward to

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19 try to get to this point where starting at the  
20 bottom and working up isn't working out. Maybe we  
21 get to start at the top and work sideways to get  
22 these aspects of us and everything like that

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1 pushed out. Yeah, there is a chain of commands  
2 where I know -- I talked to soldiers in a group  
3 where one of the soldiers was supposed to ETS  
4 about three weeks ago, because he's having a lot  
5 of traumatic TSD events that he's going through.  
6 He can't sleep with the light on and he can't do  
7 this and that and he was supposed to ETS and get  
8 put out, but his new chain of command said, "No,  
9 we'll put you on stop hold so you'll stay here for  
10 a year until we get back." Events like that, I  
11 mean -- oh, I feel for these soldiers. I feel for  
12 them. Even though I would before, because I was  
13 the type of NCO who would embed themselves into  
14 the soldiers and become one of them. But this  
15 part of being in there with them now, being an  
16 insider, it really, really makes me angry at  
17 hearing about events like this where if it's one  
18 soldier in this unit and he'd been going through  
19 psychiatric therapy for a long time. He should  
20 go, that's fine. Let him go. To keep him here --  
21 events like that burns into me, and I'm trying to  
22 figure out all this stuff. Tomorrow I'll wake up

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1 and I'll remember bits and pieces of what went on  
2 in here, because of my short term memory it's  
3 gone. But one of the things from my short term  
4 memory got burned into me was I couldn't get out  
5 of the truck and I was wondering why Charlie  
6 couldn't get out from behind this wheel. That's  
7 in me, that's past my heart, it's down to my soul  
8 and I have yet made the trip up to Tacoma and tell  
9 him that I'm sorry. Because I feel that I let him  
10 down. I feel that -- I don't know sometimes. I  
11 don't know sometimes what I'm feeling, why I'm  
12 going on, and I've even broken down to where it's  
13 just short periods of times where I need to get  
14 past to move on. This is one of the events that  
15 I'm making myself -- I've got to do this. So I'm  
16 just not finding out for myself to use an excuse  
17 about it, but I'm using it for the other soldiers  
18 I'm hearing about and finding out about. Yeah,  
19 PTSD, yeah there was a lot of combat it actually  
20 took them 20 years to figure it out so it should  
21 take you all a little bit longer. That's a lot of  
22 the concept that I found out initially. But then

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1 I start flipping out and getting -- having  
2 blackouts to where I don't know where I'm at and I  
3 don't understand it. And being inflamed on the  
4 inside. But, like I said, I'm here today to find  
5 out if this can get me this close to finding out  
6 that's great. I came this far, so I can pass the  
7 word to these other soldiers and help them come to  
8 these and put their word out and to put themselves  
9 up front. But there's just so many things and  
10 being out there on FOB Hope with just 25 of us  
11 imbedded into an Iraqi battalion -- no, we didn't  
12 have all the benefits of -- we had our two cooks,  
13 we had everybody wanting infantry, everybody was  
14 different jobs. That was there jobs, but we knew,  
15 we knew altogether, we are together. We didn't  
16 have anybody else and if we needed to have anybody  
17 else it would take a day or two days to come out  
18 to us because going from Rustimyah where we was at  
19 was a tough ride. A tough ride. But to be put in  
20 that type of environment and it's just a totally  
21 world environment different over there because we  
22 spend a week in Taji going through an integrated

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1 course, not on the U.S. forces side, but in the  
2 middle of the Iraqi's unit that was in there to

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3 start dealing with them more. And that was going  
4 in our mind, this is how we deal with them, this  
5 is how we do, this is how we conduct a training  
6 and conduct events with them. And that's going  
7 in. And then when we left going straight out  
8 there to Hope and that changed everything. And  
9 that's what made me put myself to a point, I'm  
10 here for you men, you're not here for me, I'm here  
11 for you. And that day by day it burns into me and  
12 I cannot get it off of my and I know I won't ever  
13 get it off of me because I was in the truck, the  
14 first truck that got taken out when we first got  
15 over there. And day by day I'm -- like I said  
16 sometimes it's day by day, other days it's not. I  
17 wake up and try to get along for a little bit or  
18 I'll drive onto the post and I can't stop. I have  
19 to keep going I have to drive off. I have to  
20 drive out into the farm roads or something just to  
21 get out so I can start thinking or stop and make a  
22 phone call. But I just cannot believe it took me

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1 16 years and I come to this point. Because  
2 physically I'm back, I'm up. My head's round  
3 again. But it's the mental part that is really  
4 pushing. It's the hardest thing that I can get an  
5 understanding on and try to help these other  
6 soldiers and I've got to make sure that if I'm

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7 trying to help them, don't go to some of these  
8 personnel who really doesn't understand it or  
9 whatnot, and don't get violent with them. Try to  
10 explain. Explain and let them understand why  
11 you're trying to help these other soldiers.

12 LTG KILEY: Sir, can I ask you a  
13 question because we're starting to run out of time  
14 and I would like you to give us at least one short  
15 comment on your observations or your assessment of  
16 not so much the physical, but the mental health  
17 and emotional services and support you either have  
18 received or haven't received here since you've  
19 been back and since you look like you're otherwise  
20 doing pretty well. I know you're struggling with  
21 a lot of these issues and we clearly, very much  
22 appreciate your service to the nation in both

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1 those wars and also the fact that you come and  
2 talk to us. Do you have an assessment of how the  
3 behavioral health, mental health community is  
4 helping you work your way through some of the  
5 issues you've talked about to us?

6 SGT HUNT: Well, sir, I was going  
7 through my care manager, talking one to one with  
8 her. And there was fliers up about them starting  
9 a support group. The first day went and talked to  
10 her in May. I told her, put there, I want to get

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11 in there, get me in there. Each week I went and  
12 talked with here when's it starting and they had a  
13 lot of problems organizing it and everything. It  
14 started the week after I had a bad day, and I  
15 ended up out there on the 5th floor and the next  
16 week it started up to be with integrated into the  
17 handful of other soldiers who was brought into it.  
18 So events like that it seems like they're  
19 projected but it takes a while to get them  
20 started. And I don't understand why it took so  
21 long on the administrative side of it. I mean, if  
22 it was just for me to get and start talking to

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1 other soldiers that are going down the same lane.  
2 Some of these guys have been in about a year, year  
3 and a half -- all the events of being re-deployed.  
4 So it did take a while, and I didn't go out to  
5 prove a point for it to start. Just had a bad day  
6 and then it started immediately after that.

7 LTG KILEY: Thank you. Any questions  
8 from the board? Well, thank you very much for  
9 your comments and we appreciate you being here and  
10 we wish you the very best of luck in the future  
11 and with time we hope you'll do even better than  
12 as miraculously as it looks like you're doing  
13 right now. And congratulations on that great  
14 progress. Best of luck to you, too.

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15 SGT HUNT: Thank you, sir.  
16 LTG KILEY: Mr. Love. Just quickly  
17 please because I want to -- we are pretty close to  
18 the hard stop at 12:30.  
19 MR. LOVE: No, I understand. I just  
20 wanted to real quickly. I just wanted to make a  
21 comment about earlier on the issue of substance  
22 abuse and it really -- eventually the conversation

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1 took a nearly punitive tone between yourselves and  
2 the gentleman. I would like it understood in the  
3 future while you're addressing this that there's a  
4 variety of degenerative disorders we're going to  
5 be dealing with in the future. Substance abuse a  
6 lot of times is self medicating in order to cope  
7 or to deal with some type of adjustment scenario.  
8 Not everybody is just abusing it because they  
9 can't handle life. Some people are medicating  
10 themselves because they're not receiving some type  
11 of medicinal treatment. The gentleman out here  
12 that has cutaneous leishmaniasis, I suspect it's  
13 probably actually visceral leishmaniasis at this  
14 time, and he's going to have adjustment issues  
15 like other people. But if you're going to be  
16 trying to bring veterans and soldiers in to talk  
17 to you about this issue, if you use the term abuse  
18 or abuser you're going to certainly drive people

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19 away. And I would like it if you were to use the  
20 terms like self medicating. It may be a  
21 technicality, it may be trivial, but a lot of  
22 these guys are afraid of being, basically an

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1 Article 15 or something along those lines for even  
2 discussing it. In fact, there are people in the  
3 audience right now that are afraid to talk because  
4 the media is right there to write something. And  
5 so you've got a situation here where you may need  
6 to take time with individuals outside the public  
7 environment to talk with them. And that's going  
8 to create probably a scheduling issue. But also  
9 other clinics, for instance, the war related  
10 illness and injury study clinic in Washington,  
11 D. C, which is part of a registry program, and  
12 believe it or not OIF troops qualify as gulf war  
13 veterans and gulf war registry and they can be  
14 sent to the risk clinic. But the risk clinic has  
15 also now turned out to be punitive and they're  
16 producing the diagnosis of neurotic depression.  
17 So we've got the problem where it seems punitive  
18 and the individuals are, like, why bother? Why  
19 talk to you about it? So at this point, I'm  
20 encouraging something here where either a two-fold  
21 type of conversation element or some way to  
22 approach individuals. But if you say the words

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1 "substance abuse," and you keep saying it for an  
2 hour straight, you're going to keep people at bay  
3 because they're certainly not going to want to  
4 come in here out of rear of that particular time.  
5 LTG KILEY: Okay. Thank you very much.  
6 COL PEREIRA: Thanks for that comment.  
7 I think that it's a very valid point that some  
8 people may not be comfortable to discuss certain  
9 issues in this forum. But we do encourage you to  
10 send up e-mail as well. Right now I think we do  
11 not have direct access to our website, but we are  
12 collecting, we are gathering information. There's  
13 a young lady standing outside by the table where  
14 you came in and signed in with a gold outfit on.  
15 If you stop by and get her e-mail address if you'd  
16 like to write us for some more information that  
17 you were not willing or didn't feel comfortable  
18 sharing here today, that would be very helpful for  
19 us.  
20 LTG KILEY: Okay. We have just about 10  
21 minutes if there's anyone else that would like to  
22 make some comments. And then we are going to

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1 break until 2:30 at which we will open up an open  
2 session again, and I believe we're going to have  
3 two presentations and then we will adjourn the  
4 open session at approximately 5:00 tonight. This  
5 afternoon's I believe is at least a couple of  
6 presentations and then I think if we have time and  
7 there are more that would like to address the task  
8 force, I think we'd be more than willing to hear.  
9 But -- please.

10 MS. MEDINA: My name is Biata Medina and  
11 I promise I'll make it short. I'm a widow. My  
12 husband died in Iraq on the 1st of May, 2004, and  
13 that's two and a half years now. I'm not just  
14 want to speak for maybe the widows that lose  
15 somebody in war; it's also for everybody losing a  
16 soldier. And I want to acknowledge power this  
17 word Army family has and how much it did for me.  
18 And when it happened, I pretty much had no  
19 expectations towards the Army because it was my  
20 husband's job. And I was, like, okay, now  
21 everything is like I have to move away, I have to  
22 give up, like, a lifestyle. The Army is like a

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1 lifestyle. And I have to say because of very  
2 people around me and my Army family, I had the

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3 strength to also go back, to go back to my  
4 (indiscernible) to be there when they came home,  
5 the soldiers came home. I had a luncheon with the  
6 ones that were in the convoy where the incident  
7 happened. I had a memorial with them together.  
8 And that was so important for me and I think also  
9 for the soldiers. Many came up to me. We had  
10 many conversations, and that was so important. I  
11 did not want to move, it was in Hawaii, we were  
12 stationed in Hawaii. I made my final move here to  
13 Fort Hood because that's what I knew from the  
14 mainland. And it was wonderful how my Army family  
15 or the Army family took me again basically and  
16 volunteering for AFTB, AFEB and everything. I'm  
17 still a part and that's so, so important for me.  
18 And I have to say that because I heard from the  
19 soldiers to get in the civilian life, and I'm  
20 basically called a civilian, and it's hard for me,  
21 so imagine how hard it will be for the soldiers.  
22 And also for the gentleman that talked two times

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1 before me, this survivor guile. It seems to be a  
2 very, very big issue and I saw that in many  
3 soldiers that came back and talked to me and where  
4 it came out, why not me, why your husband? And I  
5 tried to take their guilt a little bit, because  
6 I'm not mad at anybody or something. Or I'm not

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7 mad that it was my husband. He was proud to be a  
8 soldier, so I know he had the most honorable  
9 death. So, I think that's a big issue is the  
10 survivor guilt and I just want you to take care of  
11 the soldiers.

12 LTG KILEY: Thank you very much. Our  
13 condolences on your loss. It's very good news to  
14 hear that that Army, it sounds like its wrapped  
15 its arms around you to help take care of you. And  
16 I look for them to continue to do that for you,  
17 and we wish you the very best of luck.

18 MS. MEDINA: They do. Just real short.  
19 It's not the money we're getting. The money's not  
20 really -- I mean, it helps, yeah. But you know  
21 the most help is really that all the resources  
22 were still open for me and that I got the help

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1 from the chaplain that made clear to me also what  
2 the soldiers go through with their grief because  
3 they're grieving too. And so this is more  
4 important than money. Thank you.

5 LTG KILEY: Wonderful. Thank you, very  
6 much. Good luck to you. Okay. I think we're  
7 going to call it a morning here at 12:25. I'm  
8 going to let Dr. MacDermid make some comments, but  
9 on behalf of me and our task force, we very much  
10 appreciate all of the witnesses that have come

11 forward and given their testimony and their  
12 observations and we wish them all the very best of  
13 luck and thank them and you're all welcome to come  
14 back this afternoon and listen to a couple  
15 presentations we're going to have before we wrap  
16 things up tonight at about 5:00.

17 DR. MacDERMID: I can add my thanks to  
18 you all. Because of the way our site visits are  
19 structured and because our sites visits are mostly  
20 in places where people aren't deployed, we were  
21 talking yesterday about how we wanted to hear much  
22 more about the experiences of people who have

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1 recently returned from deployment and people  
2 during deployment and some of the aftermath, and  
3 we've certainly done that this morning. So we're  
4 very grateful for your willingness to share your  
5 experiences and we feel very strongly the burden  
6 and the opportunity that's been placed before us  
7 and we will do our very best to honor what you've  
8 told us and to honor the charge that we've been  
9 given. I hope you have a good day and thank you  
10 very much for being here.

11 LTG KILEY: All right. This session is  
12 closed.

13 (Lunch recess taken)

14 LTG KILEY: We're going to open the

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15 public session again and we have one testimonial,  
16 one witness that would like to address us and then  
17 he has to get back to protect the good people of  
18 Texas. So we're going to ask Dr. Sutton who was  
19 going to give us a presentation in just minute, if  
20 she'd just stand by. Our intent is to have the  
21 two presentations and if there are any other open  
22 statements that anyone would like to make, fine.

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1 And if there are none we will end the open  
2 sessions for today. And I believe we have open  
3 session tomorrow morning also, if I'm correct, and  
4 there will be some briefs back to the task force  
5 from those sub-working groups and anyone is more  
6 than welcome to sit in and listen onto it. So  
7 with that, I'd like to turn it over to the officer  
8 for your comments.

9 COL DAVIES: General Kiley, we do need  
10 to open this session again since they're recording  
11 it.

12 LTG KILEY: We do?

13 COL DAVIES: Yes, sir.

14 LTG KILEY: Are you sure of that?

15 COL DAVIES: And I thank you for that  
16 opportunity.

17 LTG KILEY: You're very welcome.

18 COL DAVIES: As the alternate designated

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19 federal official for the Armed Forces  
20 Epidemiological Board a federal advisory committee  
21 to the Secretary of Defense, which serves as a  
22 continuing scientific advisory to the Assistant

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1 Secretary of Defense and health affairs, and the  
2 surgeon's general of the military departments, I  
3 hereby call this meeting of the Congressionally  
4 directed Task Force on Mental Health, an Armed  
5 Forces Epidemiological Board subcommittee to  
6 order. General Kiley.

7 LTG KILEY: Very nicely done. Thank  
8 you. Sir, the floor is yours.

9 MR. FRANKLIN: Thank you for the  
10 opportunity to speak this afternoon. My name is  
11 Robert Franklin. I am a reserve officer with the  
12 United States Army. I was sent to Mosul from  
13 November of '04 through November of '05. Served  
14 with the 228th combat support hospital there at  
15 FOB Diamondback in Mosul.

16 What I'd like to address today, sir, and  
17 ladies and gentlemen of the panel; upon returning  
18 from active duty, we were sent through two  
19 different SRPs. One here at Fort Hood and one at  
20 Fort Sam down in San Antonio. Each time that we  
21 were given an opportunity to explain any problems  
22 that we may have had and that was unit wide, we

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1 were pretty much shipped on out to the VA. We  
2 weren't given the ability to see any specialists  
3 or anyone involved with medical care or  
4 psychiatric care while still under orders as  
5 active. I know that you folks are here to try to  
6 address any problems that you've identified with  
7 that process and try to correct them for the  
8 future, but they are still occurring. We're not  
9 getting soldiers here at the PDHRA site here at  
10 Fort Hood even today over for mental health  
11 referrals. We're not being able to get them to  
12 specialists to be seen for any other medical  
13 condition that they may have. I think a lot of it  
14 is the system itself.

15           Regarding the addressing of referrals  
16 from the different entities that they're being  
17 referred to, whether it be R & R or to the  
18 neurosurgeons or whichever group it is, based on  
19 their backlog, if you will, I guess it boils down  
20 to not enough people to take care a large amount  
21 of soldiers that are returning home. But I  
22 appreciate your time.

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1 I know that there's another issue on  
2 loss of medical records that keeps raising its  
3 ugly head. Where we're not able to get medical  
4 records, complete medical records on the soldiers.  
5 I myself lost every medical record I had while I  
6 was in country and haven't been able as yet to  
7 recover those.

8 The psychiatric issue for some of the  
9 soldiers returning regarding some issues of  
10 alcoholism are referred over to R & R or have  
11 been, and they're placed on a 10 to 12 week wait  
12 list. I don't know a whole lot about how a person  
13 would be able to deal with it on their own if  
14 they're having a problem for an additional 12  
15 weeks before getting any kind of care or  
16 assistance. I appreciate your time and I would  
17 hope that some of these issues, if not all of  
18 them, get addressed for the soldiers. It appears  
19 that each and every soldier that comes back gets a  
20 pat on the back, we appreciate your service, now  
21 please move on.

22 LTG KILEY: Do you have a couple minutes

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1 we can ask you some questions?

2 MR. FRANKLIN: Certainly.

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3                   LTG KILEY: Thank you for your service.  
4 I was actually at the 228th when you were there in  
5 the spring. You guys were doing an unbelievable  
6 job, really unbelievable. I was there one day  
7 when a firefight brought a couple injured troopers  
8 in including a young man with an injury and you  
9 guys took care of him and he was back at Walter  
10 Reed in about 36 hours. Absolutely amazing what  
11 you were doing.

12                   MR. FRANKLIN: Thank you.

13                   LTG KILEY: I congratulate you. I do  
14 share your concern about the idea that your unit  
15 comes back and gets de'mobed, you go through the  
16 post-deployment screening and assessment, soldiers  
17 say I'm having a problem. It could be a physical  
18 problem, a back ache, a sore shoulder, it could be  
19 headaches, it could be mental, emotional issues,  
20 nightmares, hypervigilance. And what I'm hearing  
21 you say is that even after checking that off and  
22 then doing a face-to-face with somebody, a PA, a

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1 nurse practitioner, a doc, your troops were kind  
2 of left to their own devices to find health care,  
3 or was it call the VA for health care because  
4 you're being refretted (phonetic) and activated?

5                   MR. FRANKLIN: It was basically a  
6 referral to the VA. Go get into the VA system.

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7 You've got six months until your Tri-Care goes out  
8 and let them deal with the problem for you. The  
9 issue with that is that a lot of the VA's,  
10 especially the one here in Temple, doesn't have a  
11 neurosurgeon or some of the other specialists that  
12 are needed. So then the soldiers are then forced  
13 to seek care at another facility or pay for it, as  
14 I've done, on your own.

15 LTG KILEY: The VA won't refer say to  
16 another facility that does have?

17 MR. FRANKLIN: Yes, sir. They will.

18 LTG KILEY: But you have to pay for it?

19 MR. FRANKLIN: Yes, sir.

20 COL ORMAN: Same line of questioning.  
21 Is part of the issue you're de'mobing too fast,  
22 and kid of independent of the wait lines for

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1 specialist or they're availability. Is part of  
2 that you're just sort of going off active duty so  
3 rapidly you can't get these issues addressed?

4 MR. FRANKLIN: Yes, sir. There's an  
5 issue on being placed on med hold. When we were  
6 de'mobing, there were close to 40 troops, both  
7 enlisted and officers that had some issues that  
8 needed to be dealt with. Everything ranging from  
9 dental to orthopedic. As far as I know only four  
10 people were allowed to stay on med hold. The rest

11 were told when their terminal leave would start  
12 and that's when they were placed on orders for  
13 deactivation.

14 LTG KILEY: Well, that's real  
15 interesting. Particularly distressing because  
16 you're a medical unit. You'd think we'd take care  
17 of our own.

18 MR. FRANKLIN: Yes, sir.

19 LTG KILEY: And particularly after the  
20 great job at the 228th that you guys just did a  
21 magnificent job over there. Well, thank you for  
22 coming over. I'm particularly pleased that we

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1 were able to get you up here and talk to us first  
2 before we started into this other brief. I keep  
3 hearing some of these same things about getting  
4 pushed through the post-deployment SRP, reverse  
5 SRP process pretty quickly and out the door. I  
6 think that's going to probably bear some more  
7 examination and discussion. So we appreciate that  
8 very much. That's very good insight.

9 MR. FRANKLIN: Thank you, sir.

10 LTG KILEY: Very best of luck to you,  
11 too.

12 MR. FRANKLIN: Thank you. Appreciate  
13 your time.

14 LTG KILEY: You bet. Be safe out there

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15 too, okay?

16 MR. FRANKLIN: Thank you. I'll try.

17 LTG KILEY: Okay. Very good. I think  
18 we're going to reposition ourselves for this  
19 presentation by Dr. Sutton. Colonel Davies, do  
20 you have to give us permission to reposition  
21 ourselves, or are we okay?

22 COL SUTTON: Can everyone hear me?

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1 Great. Good afternoon, General Kiley, Dr.  
2 MacDermid, other members of the task force as well  
3 as members of the audience. It's my privilege to  
4 be able to present to you this afternoon. My name  
5 is Colonel Lori Sutton. I'm the commander of the  
6 Carl R. Darnall Army Medical Center. And my  
7 intent this afternoon is to show a few slides that  
8 will demonstrate the services, the supports that  
9 we're providing around the deployment cycle, as  
10 well as then to talk about some of the issues and  
11 programs that we have here at Fort Hood, and then  
12 to open it up for questions and comments. Already  
13 today I've been able to learn so much from the  
14 comments and the various perspectives that have  
15 been shared with us, and I cannot tell you how  
16 much that means to me as the hospital commander  
17 here to take this to heart and go back and address  
18 some of the issues that have been raised. So I

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19 would encourage your continued candor. Next  
20 slide.

21 What's depicted on this slide is the  
22 deployment cycle. You can see in the far right,

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1 of course, our soldiers train to deploy and we've  
2 got a number in fact -- excuse me. I thought my  
3 middle-aged vision would a little better than  
4 this, but perhaps not. Thank you so much. Am I  
5 blocking anyone's view? Okay.

6 Here in the train cycle as folks are  
7 getting ready to deploy, you've heard folks talk  
8 about the SRP, that's the soldier readiness  
9 processing procedure, there's the final steps to  
10 getting a soldier ready to deploy. That includes  
11 the pre-deployment health questionnaire. And  
12 certainly there are some issues that have been  
13 brought up today that we will take to heart and  
14 make sure that we go back and address those with  
15 our providers, but this includes a number of  
16 different steps. The medical threat briefs,  
17 immunizations, briefing on mental health, risks,  
18 how to access various supports. Of course there's  
19 also the legal, finance, all of the different last  
20 steps towards preparing to deploy. Next, please.

21 During deployment. You've heard talked  
22 about today some of the combat stress support

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1 units, some of the organic, meaning assigned  
2 mental health personnel throughout theater. This  
3 support includes certainly our medics at brigade  
4 level, our medical officers, PAs, chaplains, as  
5 well as the various mental health resources at  
6 brigade level as well as within the combat support  
7 control units. I will tell you during this last  
8 year, talking to some of the senior first cavalry  
9 division leaders, this one area in terms of  
10 providing such robust mental health support in  
11 theater has gone a long way towards addressing  
12 issues of mental health stigma. Leaders in  
13 theater have gotten very accustomed when on of  
14 their troops perhaps is stressed out and needs to  
15 have a few days away from the patrol, daily grind  
16 of operations, for them to see that soldier go to  
17 the CSC unit for a couple of days and be able to  
18 come back and get back in the swing of things.  
19 It's gone a long way towards helping us out on the  
20 stigma front. And of course, as we've heard  
21 today, we still have a ways to go. Next slide.  
22 Combat Stress Company as we've just

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1 talked about deploys teams forward; they augment  
2 the brigade and the forward mental health  
3 resources. Next slide.

4 And of course of the combat support  
5 hospitals. This is where more intensive help is  
6 available including, in necessary, inpatient stay.  
7 We have a much more robust staff including the  
8 embedded psychiatrists and the mental health  
9 non-commissioned officer. Next slide.

10 Rapid evacuation. This is always  
11 something that's always a balancing act because on  
12 the one had, if you have a soldier who can respond  
13 to a few days of supportive care and get back with  
14 his or her unit and stay on duty that's always  
15 preferred, but of course as a psychiatrist, one of  
16 our concerns is to make sure that we are  
17 absolutely attuned to the presence of a serious  
18 mental illness which would mean that that soldier  
19 would need to go back and rapidly be evacuated for  
20 further intensive care. And that service is  
21 available. Next slide.

22 When it gets time to redeploy, that's

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1 when the leaders engage again with briefings,  
2 various support measures to help folks understand

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3 some of the pressure, some of the reintegration  
4 issues to anticipate back on the home front.  
5 That's a shared team effort. Both medical  
6 leadership as well as the chaplains play a major  
7 role. The post-deployment health questionnaire,  
8 just as we talked about the pre-deployment health  
9 questionnaire, is generally given in theater.  
10 It's automated. The consultations that are  
11 required that will be needed once the soldier  
12 returns to the home front then are picked up at  
13 the reverse soldier readiness processing site here  
14 at Fort Hood, and then we work to arrange those  
15 consultations within the hospital setting. Next  
16 slide.

17 This is where once the soldier has  
18 redeployed to home station, they go through the  
19 reverse SRP process. I mentioned the  
20 questionnaire already. This identifies soldiers  
21 who need immediate mental health assistance as  
22 well as any other sort of health-related concerns.

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1 It also works to educate soldiers about, not only  
2 what they may be experiencing, but how they may  
3 access help. One of the issues has been described  
4 earlier is that there is certainly -- there is an  
5 eagerness, an urgency that's felt by soldiers  
6 coming back after being away from their loved ones

7 for a long period of time wanting to get back into  
8 the swing of these, get on block leave. Sometimes  
9 it's hard to get their attention during this  
10 period. And in the case of the reserve component  
11 troops is we just heard from our officer just a  
12 few minutes ago, there's a five-day window during  
13 which all of that must be accomplished. Next  
14 slide.

15 Reintegration. This is an ongoing  
16 period where during block leave, resetting  
17 training, there's a lot of activity that goes on  
18 during this period. We know from certainly the  
19 research that's been done by the Walter Reed Army  
20 Institute of Research that typically between the  
21 90 and 180-day window, that's when some of the  
22 problems that may have developed during the

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1 deployment may start to resurface. Next slide.  
2 And that's exactly why the  
3 post-deployment health reassessment program was  
4 put into place. Now, here at Fort Hood, we were  
5 designated as one of the pilot sites last August  
6 to start up this program. So we've been at it for  
7 a little over a year now. It was deployed  
8 Army-wide in January, thus far at Fort Hood we  
9 have processed over 9,000 soldiers and of those  
10 we've had about 35 percent of those soldiers have

11 been referred for some sort of medical attention.  
12 Be that a combination of mental health referrals  
13 as well as primary care and specialty referrals,  
14 including about five percent of those who have  
15 gone to Military One Source, that's been a very  
16 popular support tool here in the Fort Hood area.  
17 We've also had certainly a few referrals to  
18 chaplains, and a few referrals to substance abuse  
19 rehabilitation. One of our concerns as we've  
20 talked about with the mental health task force  
21 here this week, has been the fact that a number of  
22 soldiers are very reluctant to refer to that

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1 support service because it's a command-owned  
2 program and they're reluctant to have that  
3 visibility. But we're working to forward our  
4 concerns in that area through the task force.  
5 We're also working with the soldiers to make sure  
6 that we address their concerns and help them in  
7 this area. But it is an area of vital concern to  
8 us. Next slide.

9 And then ongoing through the rest of the  
10 deployment cycle as soldiers continue to train,  
11 reconfigure and get ready for the next deployment.  
12 Any questions about the deployment cycle support?  
13 Okay. Let's go on to the next slide, please.

14 One other comment on this slide and that

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15 is there's typically a 12-month cycle that's aimed  
16 for between deployment. Sometimes that's  
17 possible, sometimes that's not. It's variable  
18 depending upon your job assignment as well as the  
19 unit that you're assigned to. Here at Fort Hood,  
20 we've had some soldiers who have been deployed as  
21 many as three and even four times at this point.  
22 Next slide.

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1 Reintegration. I'd like to go into a  
2 little more detail here. You've heard a lot in  
3 the media lately as well the comments today about  
4 the concerns regarding post traumatic stress  
5 disorder. We certainly share those concerns and  
6 we put a number of measures in place to be able to  
7 reach out to our leaders as well as our troops.  
8 Last August we opened what we're calling the  
9 Resilience and Restoration Center, you've heard it  
10 referred to this morning as the R & R Center.  
11 This is a joint partnership between ourselves and  
12 the 1st Calvary Division, 4th Infantry Division  
13 mental health personnel, as well as the Temple VA.  
14 We recognize that with the increased troop  
15 populations here at Fort Hood and the increased  
16 need for coordination and collaboration, there  
17 would be some advantages to partnering with the  
18 VA, having a centralized location as well as to

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19 change our focus from what has historically been  
20 more of a medical model to focusing not only on  
21 covering the intensive perhaps psychiatric  
22 problems that are an issue for some soldiers, but

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1 also to focus on the issues of resilience and  
2 performance. We also have had a number of care  
3 managers, social workers that we've been able to  
4 bring onto our program here at Fort Hood. We've  
5 really positioned those social workers in our  
6 primary care settings to increase the awareness  
7 and the ability of our primary care folks to be  
8 able to recognize signs of post traumatic stress  
9 and to help soldiers who are having difficulties.  
10 Because there are, after all, many soldiers who  
11 will not go to the R & R Center, but who will  
12 certainly be seen by their primary care providers?  
13 So we're working increasingly to develop that  
14 program. We're looking forward to implementing  
15 what has been a pilot program at Fort Bragg this  
16 last year, the Respect Mil program. That's a  
17 formal program for training primary care providers  
18 to help them become much more adept at recognizing  
19 signs of post traumatic stress and other mental  
20 health issues, and to be able to meet those needs.  
21 Here at Fort Hood, we're very fortunate to have  
22 the family life chaplain program. We know that a

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1 number of our families are stressed by the  
2 deployments and repeat deployments and they've  
3 been vital in terms of helping to provide family  
4 and marital support. Family assistance center  
5 certainly plays a vital role in the every day life  
6 of our soldiers as well the complete reintegration  
7 with the installation and surrounding community.  
8 We have been fortunate here in the greater Fort  
9 Hood area just this last month, Killeen was  
10 recognized as the number one city in the country  
11 for providing military support to its soldiers.  
12 So we're very proud of that and very fortunate to  
13 be in this community. Transition of the soldiers  
14 care to the VA, we do position VA counselors here  
15 at Fort Hood so soldiers can be counseled on the  
16 benefits, the rights, the processes as well as the  
17 services that are available through the VA.  
18 They're stationed at the in and out processing  
19 center here at Fort Hood and we work very closely  
20 with them to make sure that soldiers get the  
21 information they need. As we heard this morning  
22 there may be some difficulty with that. We'll

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1 redouble our efforts to make sure that we've got  
2 those bases covered. Next slide.  
3 Don't want to scare you. We're not  
4 going to go over all of this slide. The point of  
5 sharing this with you is to show you the programs  
6 in blue are historical programs that were  
7 available here at Fort Hood before the start of  
8 the global war on terror. Those in red have been  
9 new programs. You can see we've added quite a bit  
10 over the last two to three years. Just a couple  
11 I'd like to highlight, we'll talk a little more in  
12 a moment about our well being and risk reduction  
13 program. That's built on the Army's historical  
14 risk reduction program. What we've built into it  
15 is an additional component that brings senior  
16 leaders to the counsel chaired by the commanding  
17 general, Lieutenant General O'Dearno (phonetic),  
18 brigade level leaders and our support agency  
19 personnel, both from the medic side, the medical  
20 side, as well as from the garrison side. Another  
21 thing I'd like to highlight here in terms of  
22 survivor's support. We have a pilot program at

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1 Fort Hood, the gold star bereavement center.  
2 Currently there are about 38 families who are

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3 being supported through this program. This is for  
4 family members who have lost a loved one and who  
5 are interested in receiving support. Ongoing  
6 support groups both for adults as well as for  
7 getting the children together as well. I  
8 mentioned already the resilience and restoration  
9 center as well as our PDHRA, the Post-deployment  
10 Health Reassessment program. I'd like to  
11 highlight one other program here. Our operation  
12 gentle landings. Over the last two and a half to  
13 three years we have received over 2500 casualties  
14 being evacuated from Iraq. We have a team that's  
15 on call 24/7 continually monitors flights coming  
16 back from Landstuhl coming from various parts of  
17 the country. Our team goes out to the air field  
18 and receives those soldiers, brings them in at any  
19 time of night or day. Gives them the medical  
20 evaluation that they need. If they need to be  
21 hospitalized they certainly hospitalized right  
22 then and there, otherwise they're given a medical

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1 appointment for follow up and they're released to  
2 their unit and to their family members. Next  
3 slide.

4 This just gives you an idea of some of  
5 the things that we've done over the last couple of  
6 years starting with way back in February of '04

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7 when we positioned the VA liaison counselors here  
8 at Fort Hood, there was also behavioral health  
9 forum back in February of 2005. General Kiley  
10 convened that at Fort Sam Houston. That was  
11 really using Fort Hood as a pilot looking at how  
12 we could best organize and position our behavioral  
13 health assets. We've done a variety of things  
14 since that time getting ready for the R & R  
15 counseling center, developing the memorandum of  
16 agreement with the VA as well as opening our  
17 military severely injured center, which opened  
18 just last June. This is a DoD program for those  
19 of you who perhaps have not heard about it, you  
20 may recall that early on in the global war on  
21 terror, the Army opened up a program called the  
22 disabled soldier support system, DS3. That then

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1 evolved into Army wounded warrior program. And  
2 DoD then also developed a back-stop program. The  
3 Army program it's available for soldiers who are  
4 at least 30 percent disabled. Provides a variety  
5 of services and support over time. The DoD  
6 program doesn't require any particular level of  
7 disability, provides access to all of the  
8 resources that have come DoD's way, both from the  
9 public and private sectors. We have them  
10 co-located in the lower level at Darnall and are

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11 working right now to make sure that leaders and  
12 soldiers alike are aware of these resources. I  
13 mentioned already the pilot project for the PDHRA  
14 back in last July and August as well as getting  
15 our first component of our VA personnel on board.  
16 Well, I'll tell you it's been tough to keep our VA  
17 personnel on board. They've been a great support  
18 to us. It's been a tough last year, however.  
19 We've struggled to keep enough folks on board.  
20 The workload is pretty tough as we've shared with  
21 the counsel this week. Next slide.  
22 Let's see. We opened the R & R Center

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1 in August, we then continued with the pilot, we  
2 mentioned the Army-wide implementation of PDHRA as  
3 well as this program that we'll go into a little  
4 more detail, the Well-being Risk Reduction  
5 program, as well as our efforts just within the  
6 last couple of months to reorganize our behavioral  
7 health team into a more unified and cohesive  
8 division. Lieutenant Colonel Michael Adams is  
9 here this afternoon. He's the chief of that  
10 division and we are getting some traction already  
11 in terms of organizing our assessment processes,  
12 our treatment processes, our services, and really  
13 increasing that communication, collaboration.  
14 Next slide.

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15           This is a slide to show you just sort of  
16 a road map template here. This risk reduction  
17 program is central to our efforts, but one of our  
18 concerns was with all of these various different  
19 agencies, both on the garrison side as well as on  
20 the MEDCOM side, as well as from the community and  
21 these various programs and services. You know if  
22 you're a young soldier or a young soldier's

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1 spouse, how do you figure out how do I assess what  
2 I need. So we developed a care line. This is  
3 manned by our care managers, the social workers I  
4 mentioned previously. It is not a hotline, if you  
5 call that number, the recording will tell you that  
6 it is not a hotline, and it will tell you how to  
7 call the hotline if that's what you need immediate  
8 services. But what it does do is it allows the  
9 soldier or a spouse or anyone who contacts that  
10 number to leave their name, their number and  
11 within that same business day they will receive a  
12 call back from one of our care manager who will  
13 then talk with the person, figure out together  
14 what is it that they really need and how can we  
15 best link them up with those resources. So that's  
16 been central to our efforts. It's one of the  
17 numbers that we give every soldier coming back,  
18 give them a welcome home soldier call that's got

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19 all of the relevant numbers and this is our  
20 deployment stress care line which has been a  
21 helpful tool for us to help soldiers and their  
22 family members navigate the various services and

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1 programs. Next slide.  
2 I mentioned before the Well-Being and  
3 Risk Reduction program. This slide may be  
4 familiar to some of you, it's been in the Army for  
5 quite some time, it's a program that really allows  
6 commanders to look at a variety of high risk  
7 behaviors. You can see from deaths to sexually  
8 transmitted diseases, to drug and alcohol offenses  
9 to various types of abuse. And you see these  
10 little marks here show, for a given unit, if  
11 you're green your level of incidents for that  
12 particular high-risk behavior is at or less than  
13 the Army average. All the way out here to where  
14 if you're in the red, you're over two times higher  
15 than the Army average. So this is one way of  
16 giving commanders, giving leaders a tool they can  
17 use to get an assessment, a holistic assessment of  
18 really what kinds of behavior are going on in  
19 their unit and how they can best focus their  
20 efforts. Next slide.

21 What we've done at Fort Hood, building  
22 on the program as it has existed in the Army over

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1 the past several years, we thought, you know what  
2 would really make this an ever stronger program  
3 would be if we were to build in a link that,  
4 number one, brings all of us together to look at  
5 the data holistically as opposed to the stovepipe  
6 councils that we have in the past, and that's what  
7 we do during this first month of the quarter.  
8 This is a risk reduction council, it's shared by  
9 the garrison commander, Colonel Tori Breseas  
10 (phonetic) as well as myself. It brings together  
11 our folks who have prepared for that meeting a  
12 variety of quad charts. There's one quad chart  
13 for every one of those high risk behaviors. And  
14 on that quad chart upper left hand corner is the  
15 definition of the high-risk behavior, then there's  
16 the data tracking both Fort Hood versus Force Com,  
17 Forces Command Data, lower left then is the  
18 analysis of that data, and then lower right  
19 recommendations for commanders. We had our second  
20 command council just this last week. In fact just  
21 yesterday, this is what happens on the second  
22 month of the quarter and that's shared by the

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1 commanding general, Lieutenant General Odereno  
2 (phonetic), brings together the division  
3 commanders, brigade-level leadership. Each one of  
4 those leaders then gets a target grid showing him  
5 or her where their unit lines up. And by the way,  
6 this is confidential. The CG, the commanding  
7 general gets an installation-wide score card to  
8 look at how the installation as a whole is doing,  
9 but does not get a breakdown of unit by unit.  
10 Each unit, each division commander gets a  
11 division-wide breakdown, but does not get unit by  
12 unit. So it's not a report card. It's a tool to  
13 help leaders understand what are the high risks  
14 that are associated with my unit and how can I  
15 marshal my assets and marshal the available  
16 resources to meet those needs. So what we do is  
17 we meet and we share with them the results of this  
18 group where we've identified whatever the  
19 patterns, trends, analysis. We prepare, we fine  
20 tune this quad chart, and then we meet with the  
21 commanders as well as all of the support agency  
22 chiefs so that there's a face with the name.

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1 There's a tremendous dialogue that goes on.  
2 Commanders then bring us needs if they need

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3 training materials in certain areas or they have  
4 questions about resources that are available.  
5 It's a wonderful dialogue that puts faces with  
6 names, establishes relationships and keeps that  
7 communication chain on going. And then the third  
8 month of the quarter then we spend that month  
9 really following up on all of the issues that came  
10 out of the meeting with the command leadership and  
11 then preparing for the risk reduction council the  
12 next month. This program has been a pilot, first  
13 approved through the community family support  
14 command, and is now just recently this last month  
15 been recognized as a best practice from the  
16 installation management agency and will likely be  
17 recommended as something for the rest of the Army  
18 to take a look at. Next slide.

19 That concludes my formal remarks for  
20 this afternoon. At this point I'd like to open it  
21 up to any questions or comments that you folks may  
22 have for me. Okay seeing none, I think I'll be --

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1 LTG KILEY: Oh, I have (off mi ke).  
2 Thanks Jeff, good point. We heard today a couple  
3 of things, one of which I know you have been  
4 working on here at Fort Hood with the  
5 redeployment, the reverse SRP process and the  
6 sense of urgency/completeness in having some

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7 face-to-face screens with soldiers as they're  
8 coming back to review their mental health status.  
9 I've told the task force at Fort Lewis, they had  
10 an experiment where they sent everyone to mental  
11 health screening whether they were having mental  
12 health issues, having physical issues or having no  
13 issues, they all went to mental health.

14 The second piece of that is the same  
15 issue outbound. 1st Cav gets ready to go and  
16 you're getting into these final SRPs, do you have  
17 a plan, do you have a process where you're doing  
18 some face-to-face mental health counseling or is  
19 it your solution that you tie that into the  
20 overall final face-to-face assessment?

21 COL SUTTON: Addressing the  
22 post-deployment health reassessment program first.

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1 The way we've structured that here at Fort Hood is  
2 that we have primary care providers so a  
3 combination of physicians, usually family practice  
4 physicians, PAs and nurse practitioners who will  
5 sit down with the soldier and review the survey  
6 that the soldier has filled out. And this is a  
7 survey that's automated. It's entered into a  
8 tablet. The provider sits down with that soldier  
9 and has anywhere from a 15- to 20-minute interview  
10 on average, going over the results of that survey

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11 and talking with the soldier face to face about  
12 any concerns or issues they may have. Based upon  
13 that interview then we have the ability to refer  
14 that soldier immediately to one of our care  
15 managers who are co-located on site at the PDHRA  
16 site. Now one of the issues that was mentioned  
17 previously in terms of privacy that certainly is  
18 an ongoing shared concern of ours as well. We're  
19 very fortunate so we're thrilled to have gotten  
20 some year-end money and we'll be building our own  
21 building for the PDHRA as well as for the SRP  
22 operations. And built into that is much better

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1 office space that will provide increased privacy  
2 for soldiers as they go through that process. For  
3 any soldier who has expressed a concern or who has  
4 endorsed items on that survey that are of a  
5 concern, they are referred immediately to a care  
6 manager. They're on site, that care manager then  
7 sits down with the soldier and together they  
8 access what's going on and determine what the next  
9 best step would be. That soldier then is given an  
10 appointment, usually to the R & R Center and then  
11 they follow up from there. Now in terms of our  
12 soldiers who are referred to the R & R Center,  
13 every soldier is monitored as to whether or not  
14 they make that referred appointment. At this

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15 point about 69, 70 percent of our soldiers do  
16 attend their R & R appointment for those 30  
17 percent that for whatever reason do not show up  
18 for that appointment we contact each of those  
19 soldiers to determine whether are things better  
20 now and you perhaps don't need to follow up for  
21 care or what's going on with you? How can we keep  
22 the door open and make sure that you get what you

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1 need. There was the issue that was brought up a  
2 little bit ago in terms of the wait time. We are  
3 stretched in terms of our personnel at the R & R  
4 Center. What we do, however, is that for any  
5 soldier that either comes as a walk in or contacts  
6 the R & R Center wanting to get help, they have  
7 the option of either that same day or within  
8 certainly the first 48 to 72 hours of having a  
9 full intake. So we're able to access risk and  
10 then prioritize accordingly. For any command  
11 referrals likewise. If they need to be seen the  
12 same day, we work with the commander to access the  
13 urgency, but those are done usually within either  
14 the same day or 48 to 72 hours. So that's how  
15 we've arranged our post-deployment health  
16 reassessment program. As far as the  
17 post-deployment health assessment, both pre and  
18 post, we worked very closely with our primary care

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19 providers who are there on site at the SRP site.  
20 We don't do a separate behavioral health screening  
21 with the behavioral provider. We don't do that at  
22 the PDHRA site either. But if a soldier going

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1 through SRP or reverse SRP expresses a concern, is  
2 clearly in need of some help then the referral is  
3 made on that basis and we assess as Major Duda  
4 referenced before in terms of their suitability  
5 for deployment or their needs for reintegration  
6 support coming back. Yes, sir.

7 MR. LOVE: In your screening process  
8 will you be looking into post-concussion syndrome  
9 or dealing with issues also as well as classified  
10 missions, things of that nature?

11 COL SUTTON: Yes. In fact we're  
12 fortunate. Lieutenant Colonel Adams has a  
13 previous life as a military intelligence officer.  
14 He has taken the lead for us in helping to support  
15 our efforts in working with just exactly those  
16 kinds of situations as you described. Soldiers  
17 were coming in from classified missions, sensitive  
18 missions, things that cannot be shared in open  
19 forum. You also asked about -- I'm sorry. The  
20 first part of that was?

21 MR. LOVE: Post concussion.

22 COL SUTTON: Yes. That is absolutely a

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1 concern of ours, and we're working right now to  
2 determine the best way of really assessing that  
3 population. Certainly those who come back both on  
4 the post-deployment health assessment as well as  
5 in particular the PDHRA, there's a questionnaire  
6 that talks about exposure to explosions. That's  
7 our key. If the soldier endorses that then we'll  
8 go into a little more detail with them to assess  
9 whether they're having difficulties with  
10 headaches, personality changes, emotional  
11 (indiscernible) some of the things that are most  
12 commonly associated with traumatic brain injury.  
13 We also have recently been very fortunate to add  
14 to our staff Major Hopewell who is a  
15 neuropsychologist and who has been able to work  
16 with the team down at Fort Sam Houston who is  
17 making a study of traumatic brain injury working  
18 also with the VA. So we're continuing to develop  
19 our efforts in that area and we absolutely share  
20 your concern. Given the nature of stressors and  
21 explosions, concussive insults that soldiers have  
22 been exposed to. Yes, sir.

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1           MR. BURKE: I'm Tom Burke. I'm the  
2 executive secretary for the task force. One of  
3 the issues that the task force has been working on  
4 recently is trying to define the scope of mental  
5 health and mental health care as it is  
6 differentiated from those organizations and in the  
7 community that provides support to mental health  
8 but don't provide mental health care. Your  
9 program seems to be very integrated with the  
10 community, very community based. How do you deal  
11 with the issue of defining the boundaries between  
12 what goes on inside the hospital, the health care  
13 aspects and those institutions that either feed  
14 into your health care system or enhanced mental  
15 health but aren't mental health care themselves.

16           COL SUTTON: That's a great question.  
17 And I'll address it from two different  
18 perspectives. One is, as an example, military one  
19 source is a great example of a program that is  
20 designed to provide supportive counseling, not  
21 necessarily mental health therapy or medical  
22 treatment, but supportive counseling. And of

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1 course in the process of doing that there will be  
2 providers in the community who come across issues

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3 that really are more severe and do need to cross  
4 that line back into the medical arena. And we've  
5 developed over these last probably 12 to 18 months  
6 much closer ties with our Military One Source  
7 network colleagues to make sure that they know  
8 exactly who to contact and how we can then bridge  
9 that referral consultation gap and make sure that  
10 that soldier or family member gets the support  
11 that they need. On the inpatient side of the  
12 house, interesting this last -- I guess it was  
13 within these last three to four months we had some  
14 renovation work going on at the hospital and we  
15 ended up for a period of time having to close our  
16 inpatient ward, which by the way is a fairly small  
17 ward. We're capped at eight beds, we're typically  
18 running an inpatient census of anywhere from four  
19 to six or seven soldiers. But we're fortunate to  
20 have Metroplex Community Hospital which is just  
21 five minutes outside of the Fort Hood gate.  
22 During this period of renovation we actually

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1 worked with their staff to make sure that all of  
2 our soldiers could be hospitalized at Metroplex  
3 during that period of time. While we had close  
4 relationships with them prior to that experience  
5 there's been nothing like having a complete  
6 program turned over for a period of several weeks

7 to really deepen and enhance those relationships.  
8 So we have further at this point been able to work  
9 very closely with our network providers to make  
10 sure that they know who we are, put a face with  
11 the name, to lower any resistance or any barriers  
12 that there may be to being able to contact us and  
13 for us to be able to get the records, for example,  
14 from a soldier who's hospitalized outside of our  
15 direct care system. It's also a challenge for us  
16 within our direct care system. So for example one  
17 of the things that we're actively engaged in right  
18 now is identifying high-risk soldiers. By that I  
19 mean soldiers who have been seen in a combination  
20 of either our substance treatment program, our R &  
21 R Center, or our inpatient ward, and looking to  
22 see how we can strengthen those consultation,

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1 referral and communication gaps between our own  
2 internal programs even. It is an ongoing  
3 challenge but one of the things that we are doing  
4 to help us bridge those communication challenges  
5 is to beef up, to bolster our case manager  
6 program. Because some of the cases we listen to  
7 this morning there's nothing like having a case  
8 manager who can help really do the legwork and  
9 help a soldiers navigate a very complex system and  
10 make sure that the communication, the information

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11 is shared on a timely basis to ensure continuity  
12 of care. So those are all areas that we likewise  
13 are concerned with and are working to continue to  
14 strengthen right now. Okay. Thank you very much  
15 for your questions, your time. At this time I'd  
16 like to turn it over to Lieutenant Colonel Larry  
17 Applewhite. I'll tell you I had a chance to work  
18 with Colonel Applewhite when I was the division  
19 surgeon with 4th Infantry division. He's a social  
20 worker. He was retired. He decided about six  
21 months ago that he wanted to raise his hand and  
22 come back on active duty and he's getting ready to

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1 deploy as you can see from his left arm there,  
2 with 1st Calvary division. And we're very pleased  
3 to welcome you back. Thanks so much. Colonel  
4 Applewhite.

5 COL APPLEWHITE: Thank you. General  
6 Kiley, members of the task force, distinguished  
7 audience; it really is a pleasure to be here. And  
8 as Colonel Sutton was saying, I did leave the  
9 force about three and a half years ago and I -- it  
10 was always a dream of mine and I almost hate to  
11 admit this, to be a member of the 1st Cav  
12 division. And have an opportunity to come back  
13 and be PROFIS to the 1st Cav and as of Monday  
14 signing into the 1st Cav, for me it truly is a

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15 great day. It's a great day to be here at Fort  
16 Hood and I appreciate the opportunity to speak  
17 with you all today.

18 I have been asked to address some of  
19 those issues, some of those pre-deployment  
20 challenges that we face from a mental health  
21 perspective. Now, the 1st Cav does not have  
22 ownership of these issues. We deploy a lot of

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1 soldiers off of Fort Hood. Certainly the 3 Corps  
2 command, they're moving. 13th Sustainment  
3 command, they're deploying. The 4th ID, they have  
4 already deployed. I have no doubt that they met  
5 some of these challenges as they were preparing to  
6 deploy this time last year. I see a lot of old  
7 soldiers in the crowd today. My guess is we talk  
8 about some of these issues; it may actually jog  
9 some memories of perhaps some of the deployments  
10 that you all have been on as well. We do not have  
11 an exhaustive list. The list that I'll be  
12 presenting to you all today are primarily those  
13 issues that are most prevalent, the ones that we  
14 hear most often from the Cav perspective. I would  
15 also like to let you all know that just because  
16 I'm the one up here doing the talking, I certainly  
17 do not want to take credit for the information  
18 that I am presenting. Slide, please.

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19 I've got a lot of folks I'd like to  
20 acknowledge. Captain Wallace, who is in the  
21 audience today, one of our division social work  
22 officers, and Captain McClellan, he is one of our

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1 division psychologist. And I would also like to  
2 point out that both of them are getting ready to  
3 deploy back to Iraq for a second time. Ms. Stacey  
4 Nelson a former active duty Army social work  
5 officer who also deployed twice to Iraq. Once as  
6 a CAV mental health officer, she is now the  
7 supervisor of the care manager program that  
8 Colonel Sutton has talked about, and she is still  
9 dealing with issues around deployment. All three  
10 of these individuals were instrumental in helping  
11 me prepare the information today. Also I've got  
12 to acknowledge those soldiers and families of the  
13 1st CAV division. A lot of the information that  
14 we got today, we got from them. And so I hope  
15 that my presentation today is in a lot of ways  
16 telling their story. Slide, please.

17 Up front told soldier, I'm assuming  
18 we're still doing this. I think it's important to  
19 talk about the obvious. Put it out on the table  
20 up front. Pre-deployment is a stressful time.  
21 It's a stressful time for soldiers, for families  
22 and I would like to say for the mental health

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1 system that is designed and exists to take care of  
2 those soldiers and those families. Now, I have  
3 organized the information this way simply to  
4 provide a framework for us to think about this  
5 material today. I think all of us who are  
6 familiar with systems; we understand that if  
7 something is impacting that individual soldier it  
8 is going to have reverberations at home and vice  
9 versa. I would also like to say that those of us  
10 who are in the division mental health, we too are  
11 soldiers. We too have families. And we too are  
12 getting ready to deploy. So in some ways we are  
13 dealing with some of the same issues that the  
14 soldiers are dealing with. Our families are  
15 addressing some of those same challenges, and  
16 we're doing it at a time in which we are trying to  
17 work with our individual soldiers and their  
18 families. Slide, please.

19 Since 9/11, I believe our soldiers have  
20 been asked to do an awful lot. One of those  
21 things that they've been asked to do is to deploy  
22 frequently. We do briefings, the Force Com 58

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1 training, I'm going to address that a little bit  
2 later on but I really think that is actually some  
3 pretty progressive training, and I want to give  
4 kudos to the force come for mandating that. A  
5 piece of that is to the combat stress training.  
6 And whenever I have done the combat stress  
7 training, I always ask the soldiers by show of  
8 hands, how many of you have already deployed to a  
9 war zone. Inevitably, over half raise their  
10 hands. These individuals are going back for a  
11 second and third time. And one of the things that  
12 we're finding is that these soldiers, the time in  
13 between those deployments is becoming compressed.  
14 And we all are familiar with the phases of  
15 deployment where an individual is coming back and  
16 they're in that post-deployment phase of  
17 adjustment and just as they're probably getting  
18 comfortable at being back home, they have to very  
19 quickly shift gears into gearing up to go again.  
20 Now, this is one of those issues and challenges  
21 that I think is a very good one to point out that  
22 this impacts the families as well, because just as

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1 I'm getting used to having the soldier back home  
2 and reintegrated into the family, I now have to

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3 start preparing to say goodbye once again. Slide,  
4 please.  
5 Anxiety associated with deploying. I  
6 know That -- it seems to me, and once again this  
7 is anecdotally, the majority of the soldiers have  
8 been there, done that. But there's a whole bunch  
9 of them out there who are, like me, have never  
10 deployed to a war zone, and I've got to tell you  
11 that while we may be very good at going to JRTC  
12 and NTC and performing our job in garrison,  
13 there's still that sense of, am I going to be able  
14 to measure up when my soldiers need me the most.  
15 Am I going to be able to continue the mission and  
16 meet the mission under those stressful  
17 circumstances? That tinge of doubt as to whether  
18 or not an individual is going to be able to do  
19 their job when the country needs us to do it the  
20 most. I think that's sort of a normal self  
21 assessment that one has that may create a degree  
22 of anxiety. Now, also, just the day-to-day

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1 getting ready to go, and maybe this is sharing  
2 some of my own anxiety, but I get nervous when I  
3 have some place I need to be at a certain time and  
4 I have got to make sure that I have all of my  
5 equipment with me because if I don't that  
6 equipment might not get into the mil van and when

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7 I get over there I may not have something I need.  
8 Now, I'm a Lieutenant Colonel and as you all know,  
9 not many people are going to yell at me about not  
10 having my equipment when I'm supposed to be there.  
11 But if you've got a PVC that individual certainly  
12 the pressure on him or her is going to be greater.  
13 And I've got to tell you, I feel it so I can  
14 anticipate others feel it as well. Another  
15 component of the anxiety I think that's associated  
16 with preparing for deploy and that is, will my  
17 family be okay while I am gone? And I'm not there  
18 to take care of them, so will there be a system in  
19 place that I can trust to take care of that family  
20 in my absence? Slide, please.

21 We've all heard about PTSD. We're all  
22 very familiar with PTSD, and what I'm talking

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1 about here at this point is not necessarily that  
2 full-blown diagnosable PTSD. But I think that we  
3 have all seen soldiers over in the R & R Center,  
4 particularly some CAV soldiers recently, who may  
5 not be diagnosable with PTSD, but they have some  
6 PTSD-type symptoms. And perhaps some of those  
7 symptoms were more severe when they first came  
8 back during that post-deployment phase and the  
9 symptoms perhaps have been alleviated. The dreams  
10 aren't quite as often. The memories aren't quite

11 as vivid. But all of a sudden it's -- they're  
12 reminded it's time to go back. And I think that  
13 has a trigger in the sense that it brings some of  
14 those memories back, and make them a little  
15 fresher for them. And perhaps it triggers that  
16 the dreams now become more frequent. The  
17 depression and the sense of loss or grief,  
18 whatever the case may be, I think it reawakens  
19 some of those PTSD-type symptoms. And certainly I  
20 believe it's a normal reaction and sometimes  
21 that's all they need to hear from us is some  
22 reassurance. Slide, please, Jose.

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1 Frustration with delayed ETS. Some of  
2 the soldiers that we have seen, some that I have  
3 talked to were anticipating ETSing, and due to the  
4 needs of the service their ETS has been extended.  
5 Now that is particularly frustrating for those  
6 individuals who have made concrete plans for going  
7 back home. I've got my dream job lined up and  
8 concrete future plans and that can become  
9 extremely frustrating and oftentimes this happens  
10 to our younger folks, our younger generation, and  
11 I think that while it may be difficult for all of  
12 us in certain instances, I think delaying  
13 gratification is particularly stressful and  
14 frustrating for our younger adults. And we are

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15 seeing some of that. Slide, please.  
16 This point certainly isn't anything that  
17 is new, and it certainly isn't anything that is  
18 isolated or specific only to pre-deployment. That  
19 sense of divided loyalties. Good soldiers tend to  
20 be good parents, and good spouses, and they want  
21 to do a good job with all of their  
22 responsibilities. At pre-deployment time there's

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1 a lot to do and a lot of unit demands, and I think  
2 a lot of demand on their time. And keeping in  
3 mind these soldiers and families are also  
4 preparing to say goodbye for what will most likely  
5 be a lengthy separation and absence. And so the  
6 families want to maximize the amount the time they  
7 spend with one another. Now, we all know that  
8 families tend to be more forgiving than crusty old  
9 first sergeants. So if a soldier has some place  
10 that they need to be over at the drift site  
11 getting ready to move some equipment, then guess  
12 where that soldier's going to be. They're going  
13 to be meeting their mission first even though  
14 families are always. The family is going to be  
15 the one who will most likely miss out. He or she  
16 will miss the big game, or whatever the family  
17 event may be. And then that soldier is going to  
18 go home and try to explain and ask for

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19 forgiveness, and the families are very forgiving;  
20 however, I can't help but think that that  
21 generates a sense of guilt of having let down,  
22 perhaps the people that are most important in

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1 their lives. Slide, please.  
2 Which gets us to the next element and  
3 that's those challenges that our families are  
4 facing. Because I think this first bullet in a  
5 lot of ways is just a flip side of the same coin  
6 that were just talking about. If Mom or Dad  
7 missed out on that big game because they had to  
8 work late unexpectedly then the children or the  
9 spouse certainly it is normal, you would expect  
10 that they're going to feel disappointed and  
11 perhaps angry. And when mom or dad gets home then  
12 they may feel a little compelled to express those  
13 feelings and that anger; however, it's also being  
14 expressed within the context of knowing that mom  
15 or dad is going to be in harms way pretty soon and  
16 I'm going to be missing mom or dad and it may make  
17 that individual want to kind of sit on those  
18 feelings simply because they want to be as  
19 supportive to their soldier as they can during  
20 this particular stressful time. Slide, please.

21 One of the decisions that I think our  
22 families face, and to me, this is where people

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1 live is making those kinds of decisions, those are  
2 big decisions. And I think sometimes our families  
3 face, okay, well, if you're going to be gone for a  
4 year, then does it make sense for me to stay here  
5 in the Fort Hood area or would it make more sense  
6 for me to go back home where I can have the  
7 support of family and friends. I think -- and you  
8 all have had experience talking with soldiers. It  
9 seems to me that oftentimes it's those younger  
10 families, and what I mean by younger families are  
11 those families with younger children will  
12 oftentimes feel more comfortable going back home  
13 so that they can be closer to family and friends.  
14 Perhaps some of the more mature families,  
15 particularly those who have high school students  
16 will probably stay in this area. But it's a big  
17 decision to make. And if the decision is to  
18 return home, well, that's just another stressful  
19 event that a family has to endure. Anytime a  
20 person moves, that requires a lot of work, a lot  
21 of time, a lot of effort. It's got to be planned  
22 for and it's got to be planned within the context

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1 of when does that soldier actually go wheels up  
2 and fly. And next slide, please, it can be  
3 expensive.  
4 Moving can be expensive. And I think  
5 certainly for some of our junior families, our  
6 junior enlisted families and perhaps maybe some  
7 junior officers, money can get tight particularly  
8 if you've got student loans. Even under the best  
9 of circumstances, money can get tight. I think  
10 here in the Fort Hood area we're very fortunate in  
11 that we have a very reasonable cost of living, but  
12 it's still sometimes when you try to stretch that  
13 dollar particularly with expenses the way they are  
14 in some cases like gasoline, and you've already  
15 got a tight budget and you've got to squeeze in  
16 and move back home, then already a tight budget  
17 can perhaps get stretched to the limits, and as we  
18 go to the next slide I think we all know that  
19 finances is one of those things that couples can  
20 certainly have big conflicts over. And if during  
21 this stressful time money becomes an issue, then  
22 certainly the spouses can start having some of

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1 those conflicts that I think can challenge their  
2 ability to maintain effective communication at a

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3 time when I think it's most critical. I think  
4 that the communication that a couple has as  
5 they're getting ready to prepare to deploy sets  
6 that foundation for being able to keep that long  
7 distance relationship stable. One of the things  
8 I'm hearing and once again I do not have firsthand  
9 experience, but talking to soldiers, I hear that  
10 one of the things that we can look forward to in  
11 Iraq is the fact that there are a whole host of  
12 some high tech mechanisms for maintaining contact  
13 with back home. We no longer have to rely on the  
14 snail mail to maintain the long distance  
15 relationship. Not to say that getting a letter or  
16 care package isn't a nice thing to receive, but we  
17 no longer have to rely on it. It's nice to know  
18 that webcams are available, and I say that like I  
19 know how to use one. I've never used one, but I  
20 understand some of the younger soldiers are very  
21 comfortable with that type of technology, and it  
22 is probably nice to have that visual; however,

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1 those methods of communications are only as  
2 effective as the communication that's going across  
3 them. And so I think it's important that the  
4 young soldiers have the environment in which they  
5 can maintain that effective communication during  
6 this stressful time so that when the separation

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7 actually occurs that they're not already in a  
8 conflictual relationship, which we all know the  
9 long distance relationships can be difficult to  
10 maintain. Slide, please.

11 Children. Once again this is one of  
12 those obvious points. Soldiers who deploy, moms,  
13 dads, I think they feel a certain special pain  
14 separating from their children particularly the  
15 individuals who are separating from the young  
16 children. One of the comments I frequently hear  
17 is that by the time I get back, my daughter will  
18 already be walking or talking or some major  
19 developmental milestone. So I think it's  
20 important and incumbent upon us to make sure that  
21 we can reassure those soldiers that, yes, you are  
22 missing out on some very important moments in your

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1 child's life; however, there are a great number of  
2 resources available on Fort Hood to help children  
3 cope and understand why mom and dad aren't there.  
4 And certainly how that is communicated and with  
5 the children, it all depends on the child's age  
6 obviously. I've got to kind of send out a kudo to  
7 our media and I wish I remember which one it was,  
8 but just a couple of weeks ago there was a very  
9 nice article in one of our local papers. I don't  
10 know if it was the Fort Hood Sentinel, the Killeen

11 Daily Herald, but it was a very nice, almost a  
12 full-page article about a program on Fort Hood  
13 that is designed specifically for working with  
14 children. And it was just so nice to read that  
15 because I do remember back in the day of deploying  
16 to the Sinai back in the '80s when those programs  
17 did not exist. We did it on the fly. And  
18 intuitively we knew that we need to do something  
19 for the children but there wasn't anything  
20 actually instituted at that time to do it. So I  
21 think these programs have come a long way from  
22 back in the day. Also, I think it's worth

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1 mentioning about the schools. I think our schools  
2 have become very sensitive to the needs of  
3 military children, particularly the schools in our  
4 area. And I think that they are particularly  
5 sensitive to when we know that our moms and dads  
6 may not be there that our school systems are very  
7 supportive of our military children. Slide,  
8 please.

9 Mental health system. Those of us who  
10 are hopefully dedicated to take care of those  
11 children, those families, those soldiers, we have  
12 stress of our own. And one of it is out of our  
13 control, most of it is, the deployment schedule.  
14 50 percent of the 1st CAV division of mental

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15 health is in Iraq as we speak. They left a month  
16 ago, they left three of us back and the majority  
17 of the soldiers are still here. So it's as if we  
18 took half of our mental health resources and put  
19 them where they need to be, I'm not questioning  
20 that, they're where they need to be, but that  
21 certainly has strained us in the division of  
22 mental health. And I've got to say we could not

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1 do our job without the support of Colonel Sutton  
2 and the hospital. The fact that we are co-located  
3 with the R & R is a godsend for us at this point,  
4 because with all the CAV soldiers and in addition  
5 to the CAV soldiers the other soldiers that are  
6 coming into the R & R Center, the three of us  
7 could not do our job adequately and so I've got to  
8 say publicly, Colonel Sutton, thank you. We  
9 really do appreciate that. Slide, please.

10 Part of the reason there's an increased  
11 demand on us is the SRP and PDHRA process.  
12 Colonel Sutton described that in the sense that  
13 they do come over and see us from these sites.  
14 And during the SRP we talked about the multiple  
15 deployments and how the time between deployments  
16 can be compressed and that we can actually have  
17 soldiers going through an SRP -- no, I'm sorry. A  
18 PDHRA, and then less than a month later going

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19 through an SRP getting ready to go again. And we  
20 can literally have thousands of people processing  
21 through this. Seeing the schedule for October,  
22 there's a lot of folks coming through, and we can

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1 anticipate a large number of referrals coming over  
2 from those sites. And we do -- we work very hard  
3 to meet that 72-hour -- if not that day, within 72  
4 hours, and we take a lot of pride in that and  
5 perhaps there are some times we don't meet our  
6 standard, but it's not for a lack of effort. So  
7 that increases our workload at a time that we're,  
8 in the CAV, at least, working at a 50 percent  
9 capacity. So that certainly can stress and strain  
10 our system. First of all, I think the emphasis is  
11 being placed on mental health and the SRPs and the  
12 PDHRA absolutely. I think that's a great move,  
13 it's a progressive move, and if that just puts a  
14 little more stress and strain on us, so be it. I  
15 just appreciate the fact that it's getting the  
16 recognition that it deserves. Slide, please.

17 One point I would like to make because I  
18 think there is no bigger fan of the military one  
19 source or the Army one source than me. I think  
20 that's a great program. And I think here in the  
21 Fort Hood area that we have a very nice population  
22 of mental health providers that are aware of the

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1 needs of the military family. Most of them have  
2 probably been in the military previously anyway so  
3 they've lived it. However, there is a gap that  
4 concerns me a little bit. That if one of our CAV  
5 soldiers has chosen to use Army one source and  
6 they've been seen by a civilian provider, and it's  
7 -- and we don't know about that and we shouldn't  
8 know about it. We want to protect our soldier's  
9 privacy and their right to privacy and there's  
10 absolutely no reason for us to know about it on a  
11 routine basis. However, if the provider believes  
12 that there is a need for this soldier to continue  
13 to receive assistance while we're deployed, there  
14 needs to be some kind of a communication loop  
15 between that off-post provider and those of us in  
16 the division mental health. I want to make sure  
17 that we are aware of these individuals that may  
18 need assistance so that there isn't a gap created  
19 that they fall through that crack simply because  
20 there wasn't a prior coordination previous to  
21 deployment. And I don't know what the fix to that  
22 is, but I do have some concern about that. Slide,

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1 please.  
2 We just don't have enough time to do  
3 those prevention activities. I think that we're  
4 all big supporters of going out and being visible  
5 in our units. I truly enjoy going out and doing  
6 those stress management briefings. I enjoy going  
7 out and doing command consultation and I actually  
8 enjoy going to the motor pool and just talking to  
9 soldiers. I don't have a problem crawling  
10 underneath the humvee and doing PMCSs. I like to  
11 know what the soldiers are doing. I'd feel as if  
12 I can help them better if I can get out there and  
13 actually see what they're experiencing. And we  
14 just don't have enough time to do that because  
15 we're spending so much time providing direct care  
16 while at the same time preparing for deployment  
17 ourselves. I'm almost ashamed to say one of the  
18 areas that I believe that we slack on is that  
19 reach out, that prevention. And there just isn't  
20 enough time to get out there and do that, but I do  
21 want to say once again, because I think it's  
22 important to acknowledge Force Com and the

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1 mandatory training that a pre-deployment training  
2 that all soldiers have to go through. And a piece

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3 of that is combat stress. And I have got to say  
4 to our forefathers who -- and I'll say it, Colonel  
5 Jim Stokes who for combat stress and all of the  
6 advocacy that he did in getting combat stress and  
7 mental health recognized. And the fact that it is  
8 part of this critical, mandatory training that  
9 Force Com believe that it's important that these  
10 soldiers are aware of combat stress. And we are  
11 out going and doing that. That just speaks  
12 volumes of where I think combat stress is in terms  
13 of its recognition. Slide, please.

14 We have a reduced capacity to see family  
15 members. We spend a third of the time talking  
16 about families are going through these  
17 pre-deployment stressors just like soldiers are.  
18 The division of mental health, we're not really --  
19 our charter really isn't to see family members,  
20 but I would love for us over at the R & R Center  
21 to be able to just open our doors wide to be able  
22 to let those family members in. But reality is

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1 we've not been able to. Many of our family  
2 members are seen at other agencies on post.  
3 Certainly ACS, department of social work, the  
4 family life chaplains, and of course, the civilian  
5 network as well. Which once again, though, gets  
6 back to that point about communication with

7 off-post providers. Final slide, please.  
8 Before I open it up to questions, I  
9 would like to just make a comment that as  
10 challenging and as daunting as those  
11 pre-deployment activities and issues may seem, it  
12 never fails to amaze me the resiliency of our  
13 soldiers and our military families. Our soldiers  
14 and families always find some way to get through  
15 those challenges and they answer when the call is  
16 made. And I have no doubt that our soldiers will  
17 be ready this month. As we're getting ready to  
18 go, our soldiers are going to be ready, and they  
19 will meet these challenges. I just can't say  
20 enough about our young soldiers and the work  
21 they're doing today. That concludes my portion of  
22 the briefing, and would open it up for any

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1 questions. Yes, ma'am.  
2 COL PEREIRA: Good brief, Larry. You  
3 mentioned multiple deployments several times, and  
4 that's once issue that the task force has been  
5 concerned with. The additional stressors that you  
6 pile up on a soldier and families as time goes on.  
7 Have you seen or noticed a palpable difference in  
8 the strain on resources with multiple deployments,  
9 both in soldiers and in families?

10 COL APPLEWHITE: Well, I -- if I'm

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11 understanding correctly, I guess one way to answer  
12 that is the more mileage you put on a vehicle, the  
13 more maintenance it requires. And I think  
14 certainly the more that an individual is asked to  
15 do, unless there's proper maintenance and care of  
16 that individual, then they're going to wear out  
17 quicker. And certainly families -- and let me  
18 sort of get into, if we're going to talk about  
19 resources from the big picture, I've got to say  
20 that I think multiple deployments and I've talked  
21 to folks and they can certainly speak for  
22 themselves, that multiple deployments is one

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1 reason why I'm standing here. That the retention  
2 of Army social work officers and mental health  
3 officers, I think a lot of the young folks are  
4 getting out because they are being asked to go and  
5 go back and it's just not compatible with where  
6 they're at in their life. And so, thankfully, the  
7 Army is using other resources to fill that gap.  
8 But I think when you ask people to go back and to  
9 continue to go back, you're going to start losing  
10 resources because folks are going to start getting  
11 out and there's going to be a retention problem.  
12 And certainly I think part of why it could become  
13 a retention problem is because the family. The  
14 family back home gets worn out from having to say

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15 goodbye, reintegrate, and then say goodbye again.  
16 I think emotionally that's challenging to people  
17 to the point that I think it does sap their  
18 resources as individuals and as families, which  
19 eventually may have an impact on the Army as a  
20 whole. I hope that I've addressed the question.  
21 If not, I'll --

22 COL PEREIRA: I think I'm not being

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1 clear enough. I wonder if there's a way to  
2 quantify that just a little bit. Maybe not  
3 specifically, maybe percentage-wise, the numbers  
4 of soldiers, the numbers of families; have you  
5 seen that as deployments are piled on top of  
6 deployments, do you begin to see more of the  
7 percentage of a unit coming for services, and the  
8 same with families. Can you see that?

9 COL APPLEWHITE: I can address that  
10 again, but Colonel Combesque (phonetic) is raising  
11 his hand.

12 COL COMBESQUE: Without getting into  
13 specifics, I can share with you that we average at  
14 Ford Hood, let's say, X number of domestic  
15 violence cases each year. When 4th ID left the  
16 first time, you would think a-ha. AFAR is gone,  
17 about 20,000 soldiers left. The number of  
18 domestic violence cases that we should have to

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19 deal with should drop in half. It didn't. It  
20 only dropped about 20 percent. We saw a big rise  
21 this time as well 4th IDs been gone a second time.  
22 The number of neglect cases that went up. A lot

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1 of those cases and I think it's just because the  
2 families that are remaining are having issues. So  
3 -- and I can give you those numbers later, if you  
4 would like actual numbers, but we did not see a  
5 drop and we expected that it would drop at least  
6 in half.

7 DR. BLAZER: Thank you for an excellent  
8 presentation and I just wanted to pursue a little  
9 bit, it's a question I've actually asked before  
10 some other people, but I'm very interested in the  
11 ability of Fort Hood to use resources in the  
12 community, and specifically -- I mean, you've  
13 talked about a number of areas where children,  
14 family, as well as soldiers perhaps in certain  
15 situations. What I'm really interested in is we  
16 heard a presentation this morning in the open  
17 session suggesting that the mental health system  
18 in Texas, and this would be true in many other  
19 places in the United States, is really just  
20 becoming much more fragmented that the ability to  
21 deliver comprehensive mental health services  
22 period is really decreasing pretty dramatically,

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1 especially at the public level. And then again I  
2 think private psychiatric services are very sort  
3 of scattered and it's kind of hard to find exactly  
4 where the comprehensive services might be. What  
5 I'm interested in is to what extent -- it's kind  
6 of what many people have called a broken mental  
7 health system in general, potentially impacting on  
8 the delivery of mental health services to soldiers  
9 and families here at Fort Hood?

10 COL SUTTON: It is a concern. In fact,  
11 one of the notes that I took this morning, sir, I  
12 think the first speaker was from the public  
13 community mental health system and I jotted down  
14 contact TRICARE Humana, let's figure out how to  
15 get these folks plugged in, because certainly in  
16 this area, it's traditionally been a rural area.  
17 That complexion is starting to change, but still  
18 it's an area that does not have large numbers of  
19 mental health providers in the civilian community  
20 particularly in the areas of child psychiatry.  
21 That's particularly one very difficult area. And  
22 so it becomes incumbent upon us to insure that

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1 we're making full use of the services we have on  
2 post and then working to establish those  
3 relationships. I will tell you just this last  
4 year we were thrilled to have two new additions to  
5 our TRICARE prime network. Scott & White joined  
6 as of 1 June. And King's Daughters came back in  
7 the network as well at the same time. That in  
8 itself had opened up many more options not just of  
9 course on the mental health end, but across the  
10 entire spectrum of medical services. So things  
11 are difficult. We are working on a continual basis  
12 to develop that network, to increase it, to appeal  
13 to the patriotism of our community providers. And  
14 fortunately in this region that's something that's  
15 in strong supply, but there's also a demand here  
16 that they're working to deal with to deal with in  
17 the community as we heard this morning. So I  
18 don't have any immediate solutions for that.  
19 However, I am optimistic given our recent  
20 experience with these changes just in the last few  
21 months as well as the relationships that I  
22 referenced earlier that were continuing to build.

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1 And we will continue -- you know, working with our  
2 network partners, it's been a remarkable

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3 collaboration. And together right now actually  
4 we're brainstorming, how can we, together, put the  
5 word out, and what a wonderful place this is to  
6 live and to come work. One factor we hadn't  
7 really anticipated this as a factor that would  
8 increase our ability to draw providers. But for  
9 example, Highway 195, which is the most direct  
10 route from Killeen to Georgetown and Austin, now  
11 when I was stationed here the first time in 1998  
12 to 2000, that was actually called the highway of  
13 death and soldiers were forbidden from driving  
14 that highway because it was so dangerous. You  
15 know, two-lane road, no median, 70-miles- an-hour  
16 speed limit. Well, fortunately Governor Perry,  
17 this last couple of years has made this a real  
18 priority. It's now called in fact, the Phantom  
19 Warrior Highway, and it's not completely done yet,  
20 but most of the way now going through, it's  
21 separated, it's very well banked, it's much safer  
22 and it provides an avenue for providers who

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1 perhaps may live in Austin and Georgetown to much  
2 more readily access our area. And so we're  
3 noticing that as well. So I'm optimistic. Is it  
4 difficult? Yes. Is it bleak? No.

5 LTC LUKE: Thank you. I just wanted to  
6 make sure I understood that -- and I may have

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7 misheard you in your briefing but it follows up on  
8 this discussion right here. So did you say then  
9 that it's possible for an active duty soldier to  
10 get mental health care off-post from a TRICARE  
11 provider without -- and I guess you're from the  
12 mental health facility, without notifying you?  
13 Because I think you said, "I don't want to know."  
14 Do you remember that? I'm sorry go ahead.

15 COL APPLEWHITE: If they utilize the  
16 Army one source which they can do directly without  
17 coming through us. But currently active duty  
18 soldiers are not being seen off-post without --  
19 because we're taking care of our CAV soldiers.  
20 But unless they go directly to the Army one  
21 source.

22 LTG KILEY: (Off mike comment).

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1 COL APPLEWHITE: Correct, sir. And sort  
2 of my some of my concern.

3 LTG KILEY: Any other questions? Two  
4 great briefs. Thank you both, very much. (Off  
5 mike) wants to address the task force. So,  
6 effective -- with Colonel Davies permission, I so  
7 close the open session for the task force. I  
8 think the plan is to reconvene tomorrow morning at  
9 8:30 did we say? Yeah, we're doing 8:30 and  
10 there's going to be some sub working group back

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11 briefs from the task force to the task force full  
12 membership, open to the public. If there's anyone  
13 that comes in tomorrow that would like to make  
14 statements to the task force we'll take that on.  
15 And then I think our plan is to be done by 10:30  
16 tomorrow morning.

17 Okay. Having said all that, thank you  
18 all for attending and have a good and safe  
19 evening. Thank you.

20 (End of open session)

21 \* \* \* \* \*

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