INVISIBLE CASUALTIES: THE INCIDENCE AND TREATMENT OF MENTAL HEALTH PROBLEMS BY THE U.S. MILITARY

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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INVISIBLE CASUALTIES: THE INCIDENCE AND TREATMENT OF MENTAL HEALTH PROBLEMS BY THE U.S. MILITARY

THURSDAY, MAY 24, 2007

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 10:15 a.m. in room 2154, Rayburn House Office Building, Hon. Henry A. Waxman (chairman of the committee) presiding.

Present: Representatives Waxman, Maloney, Cummings, Kucinich, Davis of Illinois, Tierney, Clay, Watson, Yarmuth, Braley, McCollum, Hodes, Murphy, Sarbanes, Welch, Davis of Virginia, Platts, Issa, Sali, and Jordan.

Also present: Representative McCaul.

Staff present: Phil Schiliro, chief of staff; Phil Barnett, staff director and chief counsel; Karen Lightfoot, communications director and senior policy advisor; Sarah Despres, senior health counsel; Brian Cohen, senior investigator and policy advisor; David Leviss, senior investigative counsel; Susanne Sachsman, counsel; Molly Gulland, assistant communications director; Earley Green, chief clerk; Teresa Coufal, deputy clerk; Matt Siegler, special assistant; Caren Auchman, press assistant; Zhongrui "JR" Deng, chief information officer; Leneal Scott, information systems manager; David Marin, minority staff director; Larry Halloran, minority deputy staff director; Jennifer Safavian, minority chief counsel for oversight and investigations; Keith Ausbrook, minority general counsel; Ellen Brown, minority legislative director and senior policy counsel; Charles Phillips, minority counsel; Grace Washbourne and Susie Schulte, minority senior professional staff members; John Cuaderes, minority senior investigator and policy advisor; Patrick Lyden, minority parliamentarian and member services coordinator; Brian McNicoll, minority communications director; Benjamin Chance, minority clerk; and Ali Ahmad, staff assistant and online communications coordinator.

Chairman WAXMAN. The committee will please come to order.

Today Congress is scheduled to go home for the annual Memorial Day recess. This is a time for special reflection on the sacrifices made by generations of American soldiers and for giving special thanks to our brave troops fighting in Iraq and Afghanistan.

Today's hearing is about this new generation of heroes and the invisible injuries that will afflict many of these brave men and women. We are going to examine startling new figures about the

number of troops that are suffering from post-traumatic stress disorder and other mental illnesses, and we will focus on whether the Defense Department and the Veterans Administration are meeting the need of providing basic levels of care.

This committee has a longstanding interest in the welfare of our troops. Long before the American public knew about the problems at Walter Reed, our Ranking Member Tom Davis was asking questions, writing letters, and holding hearings about problems that the Guard and Reserve troops encountered obtaining health care and military benefits.

John Tierney, the chairman of our National Security Subcommittee, held the first hearing at Walter Reed, and he continues to take the lead as our committee examines problems with the military's health care system.

The most recent statistics on the number of soldiers suffering from mental illnesses caused by the war are staggering. Dr. Zeiss, the VA's top psychologist, will testify today about 100,000 soldiers that have already sought mental health care, while Dr. Insel, the Director of the National Institute of Mental Health, predicts that many more will return from Iraq and Afghanistan with post-traumatic stress disorder.

Recent figures from the Defense Department indicate that up to 40 percent of soldiers will report psychological concerns. With almost 1 million soldiers and Marines having served in Iraq or Afghanistan during the course of this war, hundreds of thousands of troops will need screening or treatment for combat-related mental illnesses such as clinical depression, anxiety disorder, and post-traumatic stress disorder [PTSD].

Yesterday I received a memorandum from the Los Angeles County Department of Mental Health about the impact of combat-related mental health problems in my District and the surrounding area. According to the Mental Health Department, some Los Angeles area veterans' service providers are reporting PTSD incidence rates for returning veterans that are as high as 80 percent. The Department has also described case studies of area veterans who returned from Iraq with mental health problems. One involved a 24 year old veteran who served two tours of duty in Iraq but came home with PTSD and saw his life enter a downward spiral of substance abuse, homelessness, and crime. I would like to make this memo part of the hearing record.

As these accounts demonstrate, we are facing a public health problem of enormous magnitude. While often invisible, these mental health injuries are real, and, if left untreated, they can devastate soldiers and their families.

We will hear today from witnesses who experience combat-related mental illnesses, themselves, or through a family member. Their stories are heartbreaking, and they remind us that behind each statistic lies a soldier and a family struggling to cope.

I want to particularly thank the soldiers and their families for being here today. I know that the stories you have to tell us are not easy. This will be difficult to relive. But they will help us to understand the magnitude of the problem and, I think, make a true difference.

In our second panel we will hear from the Defense Department and the Veterans Administration about their readiness for the tremendous challenges that these mental illnesses will pose to the system. I know these agencies are working hard to address these problems, but I remain concerned they are not ready for the impending crisis. Indeed, the Defense Department's Mental Health Task Force has flatly stated, "The military system does not have enough resources or fully trained people to fulfill its broad mission of supporting psychological health in peacetime, and fulfill the greater requirements during times of conflict."

One of my greatest concerns is that the problem is getting worse, not better. Mental health professionals have identified three important factors that put our troops at risk of returning with mental problems: longer deployment times, shorter rest periods at home, and multiple deployments. And they say that all three are now happening at once, creating a growing epidemic of mental health injuries.

Just last month, Secretary Gates announced he was extending tours of Army soldiers deployed in Iraq to an unprecedented 15 months. Some units have found that their time at home has been cut to as few as 9 months. Many of our troops are now on their second or even third deployment. There are even disturbing accounts of soldiers being ordered back to Iraq despite severe mental and/or physical injuries. These are dangerous practices that imperil the health of our troops.

We have sent hundreds of thousands of troops to Iraq and Afghanistan and we can never thank them enough for their service. As we approach Memorial Day, we need to recognize that it is a moral imperative that we do everything possible to prevent and treat their injuries, whether physical or mental, and give these soldiers and their families the support and care they need when they return home.

I hope this oversight hearing will help make this happen.

[The prepared statement of Chairman Henry A. Waxman and referenced information follow:]

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Statement of Rep. Henry A. Waxman
Chairman, Committee on Oversight and Government Reform
Hearing on the Incidence and Treatment of Mental Health Problems by the U.S. Military
May 24, 2007

Today, Congress is scheduled to head home for the annual Memorial Day recess. This is a time for special reflection on the sacrifices made by generations of American soldiers and for giving special thanks to our brave troops fighting in Iraq and Afghanistan.

Today's hearing is about this new generation of heroes, and the invisible injuries that will afflict many of these brave men and women. We are going to examine startling new figures about the number of troops that are suffering from post-traumatic stress disorder and other mental illnesses. And we will focus on whether the Defense Department and the Veterans Administration are meeting the need of providing basic levels of care.

This Committee has a long-standing interest in the welfare of our troops. Long before the American public knew about the problems at Walter Reed, our Ranking Member, Tom Davis, was asking questions, writing letters, and holding hearings about problems that Guard and Reserve troops encounter obtaining health care and military benefits. John Tierney, the Chairman of our National Security Subcommittee, held the first hearings at Walter Reed, and he continues to take the lead as our Committee examines problems with the military's health care system.

The most recent statistics on the numbers of soldiers suffering from mental illnesses caused by the war are staggering. Dr. Zeiss, the VA's top psychologist, will testify today that almost 100,000 soldiers have already sought mental health care, while Dr. Insel, the Director of the National Institute of Mental Health, predicts that many more will return from Iraq and Afghanistan with post-traumatic stress disorder. Recent figures from the Defense Department indicate that up to 40% of soldiers report psychological concerns. With almost one million soldiers and marines having served in Iraq or Afghanistan during the course of the war, hundreds of thousands of troops will need screening or treatment for combat related mental illnesses such as clinical depression, anxiety disorder, and post-traumatic stress disorder (PTSD).

Yesterday, I received a memorandum from the Los Angeles County Department of Mental Health about the impact of combat-related mental health problems in my district and the surrounding area. According to the Mental Health Department, some Los Angeles-area veterans'

service providers are reporting PTSD incidence rates for returning veterans that are as high as 80%.

The Department also described case studies of area veterans who returned from Iraq with mental health problems. One involved a 24-year old veteran who served two tours of duty in Iraq, but came home with PTSD, and saw his life enter a downward spiral of substance abuse, homelessness, and crime. I'd like to make this memo part of the hearing record.

As these accounts demonstrate, we are facing a public health problem of enormous magnitude.

While often invisible, these mental health injuries are real, and if left untreated, they can devastate soldiers and their families. We'll hear today from witnesses who experienced combat-related mental illnesses themselves or through a family member. Their stories are heartbreaking, and they remind us that behind each statistic lies a soldier and a family struggling to cope.

I want to particularly thank these soldiers and their families for being here today. I know that the stories you have to tell us today will be difficult to relive. But they will help us understand the magnitude of the problem and make a true difference.

In our second panel, we'll hear from the Defense Department and the VA about their readiness for the tremendous challenges that these mental illnesses will pose to the system. I know these agencies are working hard to address these problems, but I remain concerned they are not ready for the impending crisis. Indeed, the Defense Department's Mental Health Task Force has flatly stated — and I quote — "the military system does not have enough resources or fully trained people to fulfill its broad mission of supporting psychological health in peacetime and fulfill the greater requirements during times of conflict."

One of my greatest concerns is that the problem is getting worse, not better.

Mental health professionals have identified three important factors that put our troops at risk of returning with mental health problems: longer deployment times; shorter rest periods at home; and multiple deployments. And they say that all three are now happening at once, creating a growing epidemic of mental health injuries.

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We've sent hundreds of thousands of troops to Iraq and Afghanistan, and we can never thank them enough for their service. As we approach Memorial Day, we need to recognize that it is a moral imperative that we do everything possible to prevent and treat their injuries, whether

physical or mental, and to give these soldiers and their families the support and care they need when they return from war.

I hope this oversight hearing will help make this happen.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

ISSUES RELATED TO VETERANS ACCESS TO MENTAL HEALTH SERVICES

Between 2003 and 2005, approximately 5,000 active duty military personnel, national guard personnel and reservists, who are residents of Los Angeles County, were deployed and returned from combat in Afghanistan and Iraq. A 2005 New England Journal of Medicine study found that 4 months post-deployment 15 -17% of troops met criteria for Post Traumatic Stress Disorder (PTSD), 12 months out the same troops' rates had jumped to 21%.[1] With repeated tours of duty this percentage grows even more. A Pentagon report released May 4, 2007 showed that 27% of soldiers who had been on multiple tours experienced mental health problems, compared with 17% who were serving in Iraq for the first time.[2] Because of the delayed onset of PTSD symptoms as well as the repeated deployments of many of Los Angeles County's service personnel, the real scope of the need for treatment is yet to be seen. Current estimates by local service providers that work exclusively with veterans run as high as an 80% incidence rate.

The situation is further aggravated by the fact that many veterans suffering from PTSD are reluctant to seek treatment. This appears to be related to the stigma attached to mental illness, the perception among some veterans that seeking treatment might be seen as an admission of weakness, and reluctance to have mental health treatment reflected in their health records. When treatment is sought, veterans are faced with the challenges of establishing eligibility, particularly daunting for the diagnosis of PTSD, as detailed in a recent report by a combined committee from the Institute of Medicine and National Research Council. The report recommended the Veterans Administration (VA) establish diagnostic criteria based on the standards of the American Psychiatric Association and establish training programs for their personnel that deal with PTSD claims.[3]

Nationally, of the over 500,000 Americans who have served in Afghanistan and Iraq and been discharged back into civilian life, nearly a third experience problems they "have identified but can neither comprehend, control, nor get beyond. Thoughts of suicide, terrifying flashbacks, sudden outbursts of reckless and aggressive behavior, anxiety, problem drinking, depression, nightmares and relationship difficulties, a panoply of Traumatic Stress Disorders, and the results of catastrophic bodily injury from combat wounds have all been presented in a wide range of combinations. . . . Families of those veterans must also try to come to grips with loved ones who have returned home changed in so many unfathomable and even life-threatening ways."[4] Some veterans recognize problems early and seek help from the VA, others turn to local doctors and county health and mental health providers while still others end up in the criminal justice system.

Many veterans struggling with PTSD turn to drugs and alcohol, compounding their illness with a co-occurring disorder, making it even more difficult to obtain and maintain treatment that will enable them to regain their lives, and often leading to homelessness. Those who do seek treatment, either through the VA or public mental health departments, often encounter significant obstacles related to establishing eligibility for services. The following stories, one from Los Angeles and the second from elsewhere in California, exemplify these challenges:

- John, age 24, was interviewed in the Los Angeles County Jail mental health housing area by an outreach worker from a Community Based Organization that provides residential alcohol and drug treatment programs, including services for persons with co-occurring mental illness. John, a former serviceman, had served two tours of duty in Iraq. His mother reported he was his usual self upon return from his first deployment with no indication of a substance abuse problem. However, upon his return from his redeployment it was obvious that he had hit his breaking point and was "completely not there anymore". He suffered from PTSD and substance abuse disorder but received no comprehensive services for his co-occurring disorders. John left his home and family, traveling to California. He became homeless, wandering the streets of Santa Monica and Westwood and staying in cold weather shelters on winter nights. Eventually he was arrested for a drug offense. John was released from jail with the recommendation that he enter a residential program for his co-occurring disorder. He has not reported to the program and his whereabouts are unknown.

- "A.B. is a combat veteran who was a Navy Corpsman during Desert Storm. Suffering from combat-related PTSD, A.B. was discharged from the military without receiving a service-connected rating for his disability. He has spent the years since his military service in a continuous cycle of finding employment, only to lose it when the symptoms of his PTSD flared up and made it impossible to keep his job. As a result of losing his employment, he has often been homeless.

  "During his periods of employment, he had medical insurance that covered the costs of treatment and medications for his PTSD-related symptoms. When he lost his job two years ago, he also lost his health insurance, and with it, access to his medication. He applied for assistance from the county, but was denied because of his veteran status. He applied for treatment at the VA Mental Health Clinic at Mather, but was denied because he doesn't have a service-connected rating for a mental health condition. Without medication, he has not been able to stay employed at any one job long enough to qualify for employer-provided health care benefits.

> "He has applied for compensation from the VA, and is trying to establish his service connected disability. However, this is a time-consuming process, and may take many months – or even years – to complete. Should he be successful, he would have access to mental health care from the VA. In the meantime, he is going without medication or treatment. Should he be unsuccessful in proving his claim, he may spend the rest of his life caught in the gap between two bureaucracies."[5]

In September 2006 the Los Angeles County Department of Mental Health (LACDMH) received a Substance Abuse and Mental Health Services Administration (SAMHSA) grant award to better serve veterans with a serious mental illness. This grant was provided in response to a proposal developed collaboratively by the California Department of Mental Health, LACDMH, the California Association of Veterans Services Agencies (including two local agencies United States Veterans Initiative and New Directions) and the California Mental Health Directors' Association to pilot expanded, linked services in Los Angeles County for homeless veterans with mental illness, many of whom are also diagnosed with substance abuse disorders. The project provides outreach to homeless veterans with mental illness, referral for mental health treatment, case management, employment assistance and a linked residential service system that includes residential treatment for co-occurring disorders, transitional housing, and permanent affordable supported and independent housing. This collaborative project addresses the multiplicity of problems faced by our men and women returning from Afghanistan and Iraq and can serve as a model for replication on a larger scale in Los Angeles County, should additional funding be available,.

Footnotes

[1] "Combat Duty in Iraq and Afghanistan, Mental Health Problems and Barriers to Care" New England Journal of Medicine 351:13-22

[2] "Long tours in Iraq may be minefield for mental health", Julian E. Barnes, Los Angeles Times, May 5, 2007

[3] "Better stress tests are urged for vets", Associated Press, Los Angeles Times, May 9, 2007

[4] SAMHSA grant application submitted by the California Department of Mental Health, Los Angeles County Department of Mental Health, the California Association of Veterans Services Agencies and the California Mental Health Directors' Association

[5] Statewide California Association of Veteran Service Agencies Position Paper, January 2006

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Chairman WAXMAN. I now want to call on the ranking member of the committee, Mr. Davis.

Mr. DAVIS OF VIRGINIA. Thank you, Mr. Chairman, and thank you for holding this hearing. Let me also thank the soldiers and their families for sharing their stories with us today. It is going to be very, very helpful to this committee.

We also welcome some of our students from Thomas Jefferson High School for Science and Technology in Fairfax, as well, for being with us.

We convene to discuss the inevitable, in many ways normal, human response to that inhuman of all activities, war. Psychological damage suffered by some warriors has been noted throughout the violent history of our species. Civil war doctors named it soldier's heart. Since then it has been called shell shock, battle fatigue, combat stress, and post-traumatic stress disorder.

So the questions we confront today are both timely and timeless as we ask how our Nation prevents, detects, and treats the invisible but no less real wounds of modern warfare.

Thanks to medical advances and proactive military health programs, we have a greater ability to screen for risk factors, both before and after deployment, and provide diagnosis and treatment options for that subset of service members who suffer neurological damage or symptoms of mental trauma. The former may emerge as the signature casualty of this era, as superior leadership, training, and equipment produce unparalleled combat survival rates, while the survivors come home suffering traumatic brain injuries in unprecedented numbers.

Recent studies conclude up to 19 percent of returning combat veterans suffer some type of neurological damage or mental illness. Not surprisingly, similar studies find longer deployments and multiple tours correlate to much higher incidences of brain injury, post-traumatic stress disorder, and other mental health problems.

National Guard members may also be uniquely vulnerable to combat trauma effects. That means thousands of Americans returning from Afghanistan, Iraq, and elsewhere need care for symptoms and syndromes that can be treated, but if left undiagnosed could produce permanent health impairments.

So today we ask: are returning warriors screened and informed of the warning signs of mental injuries? How many seek the care they need? Are relevant, research-based treatments available to them? How do we sustain the mental resilience of a force engaged in the global struggle against terrorism?

Ironically, one of the steepest barriers to diagnosis and treatment of combat trauma injuries appears to be psychological. The stigma of being labeled a head case in the military culture prevents many from seeking help. It allows unenlightened officers to ignore the problem, threaten exposure as a malingerer, or counsel the sick to simply gut it out and drive on like good soldiers.

Less than half of those identifying a mental disorder on recent post-deployment surveys sought related treatment. Many cited stigmatization among the reasons they would not seek care. And those who do seek help often face institutional and bureaucratic hurdles in a system much more in tune to treating injuries of the body than the mind.

As we say in our investigation into problems at Walter Reed, the military health care system is overburdened and often lacks adequate resources to provide quality care. Both the Department of Defense and Veterans Affairs Departments are struggling to shift fundamental health care paradigms and the treatment of middle-aged and elderly adults to meet the needs of 18 to 30 year olds as the number of Iraq and Afghanistan veterans grows.

The success of those ongoing health reform efforts at DOD and VA will enhance our ability to assess and meet the mental health needs of active and Reserve members at home and abroad. That capacity is critical to assure the continued readiness of U.S. forces to meet global security demands.

Mr. Chairman, this is an important set of issues, and we thank you for convening this hearing. Every American we send into combat brings something of that experience back. We owe every one of them our respect and our gratitude and a compassionate embrace for any who come home bruised or broken in body or soul. If the war in Iraq ended tomorrow, our obligation to understand the mental battles of current and future warriors would not. Mindful of that enduring debt, I hope the testimony of our witnesses today will shed needed light on the mental stresses encountered by today's warriors and how we can better heal the inner wounds of modern warfare.

Thank you.

Chairman WAXMAN. Thank you very much, Mr. Davis.

Before we call on our witnesses and introduce them, I want to ask unanimous consent that Representative McCaul be permitted in this hearing. Without objection, we are pleased to have you with us.

A couple of our witnesses are Mr. McCaul's constituents, and we would like to call on you to introduce them, if you would, and then we will proceed.

Mr. MCCAUL. Thank you, Mr. Chairman, and good morning to you and Ranking Member Davis. I want to thank you for holding this hearing on this very important issue of mental health and our soldiers returning home.

It is an honor for me to introduce to you Richard and Carol Coons, constituents of my District from Katy, TX.

Today, among other things, you will hear the story of their heroic son, Master Sergeant James Coons, who served our Nation for more than 15 years. Despite his unconditional service, the United States, in my judgment, has yet to show the memory of Master Sergeant Coons or his family its appreciation or respect for that service.

As their Representative in Congress, I and my staff have spent the past 2½ years working on behalf of the Coons family to find answers to their questions about their son's death, many of which the Army, the Department of Defense, and the administration have yet to answer. Through my office, the Coons have repeatedly asked for a complete set of their son's medical records. The family has yet to receive them.

We have repeatedly asked that the Army provide Richard and Carol with all of their son's personal effects, and specifically Master Sergeant Coons' notebooks. The family has yet to receive them. We

have asked that the Department of Army change the date of Master Sergeant Coons' death, which is listed as July 4, 2003, to the more accurate date of either July 1st or 2nd, as indicated by the Washington, DC, medical examiner's report. The Department of Defense has yet to do so.

Most of all, this Nation has failed the Coons by not watching over their son the way he watched over all of us and our families for 16 years as a soldier in the Army.

Some time between July 1st and July 3, 2003, Master Sergeant Coons took his own life, a victim of post-traumatic stress disorder, on the grounds of Walter Reed Army Medical Center. Despite repeated pleas to several different people at Walter Reed, no one went to check on Master Sergeant Coons until his death on July 4, 2003.

Mr. Chairman, my office has sent dozens of letters, followed up with hundreds of phone calls and e-mails, and to this very day the Department of the Army, Department of Defense, and the administration has yet to correct any of their mistakes or even apologize, despite overwhelming evidence of their failure.

Chairman WAXMAN. Mr. McCaul, what you are telling us is really very disturbing and I want to hear from them and the other witnesses, as well.

We want to welcome you to our panel today. I thank you very much for the introduction.

Mr. MCCAUL. Well, I would like to close, Mr. Chairman, by saying that I hope we can turn this tragic experience that my constituents have gone through and experienced into a positive one in working together in a bipartisan fashion to address this very important issue, and I want to thank you for holding this hearing.

Chairman WAXMAN. Thank you. We fully agree with you.

We hadn't suggested opening statements because we wanted to go right to the witnesses, but if any Member wishes to take a 2-minute opening, we will be glad to recognize the Members.

Ms. Watson.

Ms. WATSON. Thank you so much for this hearing. I will take 1 minute to introduce a young man, Todd Bowers, who is sitting in the second row to my left. He is the Director of Government Affairs. He met with the Domestic Policy Subcommittee this morning to talk about these issues that we are covering in this hearing. I do hope that he will then submit a statement according to your remarks that you made, Mr. Bowers, to our committee.

I just also want to add, Mr. Chairman, that I am carrying a piece of legislation, H.R. 1853, the Hosea Medina Veterans Affairs Police Training Act, and it is a bill that would force the Department of Veterans Affairs to better prepare its police force to interact with patients and visitors at the VA medical facility who suffer from mental illness. He went through a very traumatic affair when he was found on the floor in the VA hospital. More on that at another time, but I would hope that all Members would support the Hose Medina bill. It gets to the issue that we will cover today.

Thank you so much for the time.

Chairman WAXMAN. Thank you, Ms. Watson. We will hold the record open to receive a statement so that we can have that as part of our record.

I would like to now call on Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair. And I want to thank the families for being here today.

I requested the Chair, because many of us have been working on case work in which we have had a very similar response from the armed services when trying to get answers for our soldiers' families. Maybe the Chair and the ranking member would entertain a way to survey our congressional offices, keeping confidentiality always foremost in our minds, to find out just how pervasive this is, because it is quite evident we cannot ask the Department of Defense to turn over this information. I think the Chair and the ranking member are going to find out that these families are representing just a drop in the well of how many of our service men and women have been treated.

Thank you, Mr. Chair.

Chairman WAXMAN. Thank you, Ms. McCollum.

Mr. Braley, did you wish to be recognized?

Mr. BRALEY. Yes. Thank you, Mr. Chairman and Ranking Member Davis, for holding this important hearing.

This issue is very personal to me. My father enlisted in the Marine Corps when he was 17, served on Iwo Jima, came home and raised a family. When I was in high school he suffered two severe bouts of depression that nobody in our family could understand. This weekend I will be making my 26th annual trip to his grave in a tiny cemetery located in the country near York, IA.

Eleven years after he died, my brother, who works at the VA hospital in Knoxville, IA, was approached by a patient who recognized his name tag and told him about an incident that happened in 1946 right after my father returned from the war, totally unsolicited, where my father was working on a threshing crew and became overcome by the heat, was taken to the shade, and proceed to relate a flashback experience when one of his best, best friends was vaporized by a shall burst on Iwo Jima.

That is why I am so proud that this hearing is being held today, and I want to make a commitment to the witnesses who have taken time to appear before us that this body will do something to help get answers to the troubling questions that you have posed for us.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Braley.

Any other Members wish to be recognized for a 2-minute opening? Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman.

Certainly the Wounded Warriors Assistance Act that passed yesterday is incredibly important to what we are looking to do for, in fact, the men and women who put their life on the line. I believe, though, that we have to do one other thing in this committee, and that is that we have to seek very hard to be able to put the war in Iraq separate from, in fact, what we are doing here today.

I am looking forward to this hearing and the work we do as a committee to recognize that the best work we do is the work we do separate from the other committees and what often goes on on the floor. I look forward to testimony here today, and I look forward to working with the chairman to try to get beyond the things

we disagree on and take an issue we agree on like dealing favorably with those who have not made a political statement but, in fact, made a patriotic statement on behalf of our country, and work together to find good solutions for them.

I yield back.

Chairman WAXMAN. Thank you very much, Mr. Issa.

Other Members? Mr. Cummings.

Mr. CUMMINGS. Mr. Chairman, I wasn't going to say anything, but after I heard Mr. Issa I must say this. I sit on the Armed Services Committee and I also sit on the Readiness Subcommittee. I cannot separate what I heard about the Coons family and what I heard about Pat Tillman and so many others.

We have to have in this country trust, and that trust is earned. I think that when things like, on the one hand, I sit on Armed Services where we are trying to make sure that our soldiers are given every single thing they need, rested, trained, equipped, but then on the other hand we come to this committee and we are trying to figure out why they don't get what they need if they are injured, and something very fundamental that has nothing to do necessarily with military or committees, it is truth.

When the Coons family—and I am so interested to hear their testimony—cannot get the truth, there is a breach of trust. And when there is a breach of trust, that is a major problem. That is why I recommend the book The Speed of Trust, because it talks about how when we stop trusting, either with regard to integrity, or we stop trusting with regard to competence, then everything slows down and our country slows down.

So we cannot just separate. Mr. Issa is correct, we must find solutions, but first we have to figure out why we are not getting answers to questions with regard to wonderful Americans who stand up for their country, who shed their blood, their sweat, and their tears to be a part of making this country the very best it can be.

So I yield back and thank you, Mr. Chairman.

Chairman WAXMAN. Thank you very much, Mr. Cummings.

Mr. Welch, did you wish to be recognized?

Mr. WELCH. Just two points. I thank the chairman and the ranking member.

Point one, thank you in advance for coming in and sharing your story. It is hard to do, and Members of Congress appreciate it, the people of America appreciate it, and your loved ones appreciate it. We thank you very much.

Second, the cost of the war has to include the cost of caring for the warrior, and we know that. That is why we resisted exceeding the recommended cuts in the VA budget and we are proposing to put the money we need into Defense health care and the VA health care. Your coming in and testifying is helping us do the right thing. It is helping the American people understand what is really going on. So thank you very much.

Chairman WAXMAN. Thank you, Mr. Welch.

Does any other Member seek recognition? Mr. Kucinich.

Mr. KUCINICH. Mr. Chairman, thank you for holding this important hearing.

As is becoming more and more obvious, the effects of war are permanent. It is beyond tragic that the soldiers lucky enough to

survive the war run the risk of health problems that range from inconvenient to completely disabling or even fatal. Many of these problems are difficult to diagnose because they do not fit neatly into our clean medical categorizations. When they are hard to diagnose, disability benefits are hard to get. The awarding of benefits is delayed as the scientific literature catches up over many years to the reality of the pain experienced by the veterans on this daily basis.

I would ask the Chair to include my entire statement in the record.

I would just like to conclude by saying that the crushing burden of these health problems being born by our veterans is tragic enough, especially when you consider they were sent to war under false pretenses. But to abandon them after they have served their duty is inexcusable.

I know that our Members look forward to hearing what we can do to better serve our veterans at this hearing, and I thank the Chair very much.

Chairman WAXMAN. Thank you very much.

Are we ready to proceed to the witnesses?

I want to introduce three other witnesses in addition to Mr. and Mrs. Coons, who have been introduced to us already.

Mrs. Tammie LeCompte is the wife of Army Specialist Ryan LeCompte, who has completed two tours of duty in Iraq and is now stationed at Fort Collins, CO. The LeComptes are members of the Lower Brule Sioux Tribe of South Dakota.

Army Specialist Thomas Smith is a native of Lexington, NC. He joined the National Guard in 1999 and went on active duty in 2003. He was deployed to Iraq in late 2005 and served in the Ramadi area. He is currently stated at Fort Benning, GA.

Specialist Michael Bloodworth is a Kentucky National Guardsman. Before being deployed to Iraq in March 2006, Specialist Bloodworth studied science at Murray State University. He is currently being treated at a traumatic brain injury clinic at Walter Reed Army Medical Center.

We are pleased to have all of you with us. Thank you so much for being here.

It is the practice of this committee that all witnesses that appear before us take an oath, and so I would like to ask each of you to stand and please raise your right hands.

[Witnesses sworn.]

Chairman WAXMAN. The record will show that each of the witnesses answered in the affirmative.

We have the written statements that have been prepared for the record, and we will have that in the record in its entirety, but we would like—we won't be strict on this, but we are going to run a clock that will indicate when 5 minutes are up, and if you could possibly do it that would be a good signal to try to summarize the rest of the testimony.

Specialist Smith, why don't we start with you if that is OK.

STATEMENTS OF ARMY SPECIALIST THOMAS SMITH; ARMY SPECIALIST MICHAEL BLOODWORTH; RICHARD AND CAROL COONS, PARENTS OF ARMY MASTER SERGEANT JAMES COONS; AND TAMMIE LECOMPTE, WIFE OF ARMY SPECIALIST RYAN LECOMPTE

STATEMENT OF THOMAS SMITH

Mr. SMITH. Chairman Waxman, Congressman Davis, and distinguished members of the committee, thank you for inviting me to testify here today.

I, Specialist Thomas Smith, entered active duty in October 2003, and in the beginning of 2004 I was sent to 3rd Brigade Combat Team. My MOS is 88 Mike. That is a transportation specialist.

In August 2004 I was injured during a training. I hurt my back. I continued to seek help for this injury for the next 2 years. I was told that I would receive a P–3 profile in late 2006. I did not actually receive this profile until my Medical Board proceedings for my psychiatric problems were initiated. On May 22, 2007 I went to check on the status of my medical proceedings and the case worker told me that she had found my P–3 profile for my back then.

The date on this profile was November 27, 2006. Even with this non-deployable profile, I deployed to the National Training Center and was almost deployed to Iraq. I had already endured this injury during the first deployment. I deployed to Iraq in January 2005. Once in Kuwait I was switched from HHC–130 Infantry to Bravo Company 130 Infantry. While in Bravo Company 130 Infantry my duties were, as an 11-Bravo, to drive Bradley fighting vehicles, foot patrols, and guard duty. During this time, I served in Bacoo, Iraq, and also in Ramadia, Iraq.

After redeployment to the States I went through a brief mental health evaluation. It was explained that I might soon be experiencing some adverse reactions to the war such as nightmares, flashbacks, etc., but that they should go away and that was perfectly natural.

In September 2006, I was still experiencing symptoms, to include nightmares, flashbacks, excessive anger, irritability, and anxiety problems. These problems were and still continue to affect my daily life.

In September 2006, I called the Army One Source Hotline to get help. A representative set me up with an appointment with a psychologist in the community. This psychologist diagnosed me with PTSD, an anxiety disorder, and also depression. I continued to see a psychologist over the next few months. I reported to my immediate chain of command that I was seeking help from a psychologist.

In January 2007 I was deployed to the National Training Center, where I received no treatment for the month I was there. During my time there, I was not directly involved in the training, and yet still had adverse reactions to the sound of explosions in the distance.

After redeployment to Fort Benning after the National Training Center, I made an appointment to see my psychologist immediately. During our session she expressed her concern and referred me to Martin Army Hospital to seek more help. I then gave copies

of the letters of concern from my psychologist to my chain of command.

During my first visit with the psychologist at Fort Benning at Martin Army Hospital, the psychologist also expressed his concern for my mental health. The psychologist also diagnosed me with PTSD. After several visits with him he wrote a letter of recommendation to my chain of command. The letter of recommendation said that I should not be allowed to have a weapon and be left behind for a few months for further treatment before redeploying me to Iraq.

My company commander was contacted and he also visited my psychologist. My psychologist gave him a copy of this letter and expressed his concern for my mental health. My company commander said that he would take the issue to the colonel. I was not told of the colonel's decision until the day before deployment. Just hours away from the manifest, on March 9, 2007, I received a phone call from a sergeant in my platoon stating that the colonel said that I was deploying and I had to have my bags in at midnight that same night.

At this time I was already on my way to the hospital to have a talk with my psychologist. When I got there, and after speaking with him, the decision was made to put me in inpatient care. I was immediately sent to Anchor Hospital in Atlanta, due to the fact that there was no room for me at Martin Army.

The psychologist at Anchor Hospital also diagnosed me with PTSD and depression and an anxiety disorder. I was put on medication at Anchor Hospital upon getting there. I spent almost a week there until room was made for me at Martin Army Hospital. I was then shipped into the mental health floor at Martin Army hospital, where I was also diagnosed with PTSD and depression. I spent almost another week there and was released to outpatient care.

I am still continuing my care and medication, and, although it is a daily struggle, I am currently receiving excellent care.

That concludes my statement. I am looking forward to your questions.

Chairman WAXMAN. Thank you very much, Mr. Smith.

Mr. Bloodworth.

STATEMENT OF MICHAEL BLOODWORTH

Mr. BLOODWORTH. Thank you, Mr. Chairman, Representative Davis, and distinguished guests of the committee. I would like to extend my gratitude for being able to come here and share my experiences.

I am Specialist Michael Philip Bloodworth, and I was deployed to Iraq with the Kentucky Army National Guard, Charlie Company 2nd, 123rd Armor. I have been mobilized since November 2005, when I was trained for 6 months in Camp Shelby, and in March 2006 my squadron reached its area of operations in Iraq, where our mission was to provide convoy security.

During the course of the 11½ months that I was in country, I logged thousands of miles running convoys in places such as Tikrit and Baghdad. I was also a victim of five separate IED exposures

and multiple small arms ambushes during the course of that time span.

On January 16, 2007 I was injured as a result of an IED blast where I lost consciousness, and have since then suffered other symptoms of TBI, post-concussive syndrome, and PTSD. These injuries led to my medevac to Germany, where my further care continued here at Walter Reed Army Medical Center.

I arrived at Walter Reed Army Medical Center President's Day weekend, which is the same timeframe that the Washington Post made its story about Walter Reed Army Medical Center. Within the first few days I was in-processed into the system and was beginning to receive some care for my traumatic brain injury and PTSD, along with the physical problems with my left knee that I have been having.

I have been in the best of hands since my arrival here. Even though care has been slow, the people have been consistently trying to stay with me and make sure that every day, even though it is a struggle, I am on two feet and making it to my appointments and making a recovery. Even through the changing of hands through commander at the Walter Reed Army Medical Center with the Warrior Transition Brigade, everything has continued on track. The new leadership has definitely taken charge and well adapted to the needs of the soldiers and tried to better the system.

My treatment at Walter Reed Army Medical Center has been focused, first and foremost, on my traumatic brain injury, and second my symptoms of PTSD, such as night terrors, flashbacks, and inability to sleep unless on medication.

I have been involved with occupational therapies, a treatment for my TBI, and the current treatment for my PTSD has been seeing a psychiatrist at least twice a month and a steady regime of sedatives or narcotics to make me sleep at night.

I have been taking my treatment 1 day at a time. I try to remain on track through this difficult time. Through the aid of everyone at the traumatic brain injury clinic and the aid of my psychologist and the support of my platoon sergeants and squad leaders I am making progress. Progress is slow, but it is better than anything.

I have definitely needed help along the way, but it is getting better.

This concludes my opening remarks. Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you very much, Mr. Bloodworth.

Mr. and Mrs. Coons.

STATEMENT OF RICHARD AND CAROL COONS

Mr. COONS. Good morning, Chairman Waxman, Ranking Member Davis, and members of the committee. Carol and I would like to thank you for giving us the opportunity to provide you information on the treatment of our son, Master Sergeant James C. Coons.

There is nothing that can be done to help Jimmy now; however, with our information and that of the others present here today, change can and must be made in hopes of providing the proper care for our returning heroes so they may enjoy a healthy and productive life.

Our story: Thursday, February 13, 2003: "Don't sweat the small stuff. This is my life. I am a soldier. With that comes an inherent

amount of responsibility and self-sacrifice. All of my adult life has been spent as a soldier. I knew many years ago what I was getting myself into. I would not change anything. Yep, I'm dog tired and my body hurts, but there is not another place on the face of the planet earth that I want to be right now. What I do now is not for me; it is about the American flag. Some folks don't have a clue. They curse it. They spit at it. They burn it. Well, one day I will be buried with and under it. This is my generation's war, and if you are a soldier then it is your profession, the profession of arms. Now rest easy and tell everyone not to worry. I will find my way home again one day."

These words were from my son, a U.S. soldier, a proud soldier who loved his country, his God, and then his family. Master Sergeant James Curtis Coons was a true soldier through and through all of his life. At a very early age he was fascinated with anything military. Pass a truck hauling a tank or any military equipment and he would get excited. Drive by the Port of Beaumont, and you would have to stop so he could watch the gear being loaded for overseas shipments. Pass an Army surplus store, well, we had to stop. Who would think a 5-year-old kid would eat C-rations? He had to have a parachute hung above his bed. He took the harness off of it and tried to jump out of a small tree. Well, he did, and we had to cut him out of it.

My son, James, was born on April 3, 1968, in a small town in Texas. He died in July 2003, under the care of Walter Reed Army Medical Center in Washington, DC. Thirty-five years old, a military man happily married to a wonderful wife who had two beautiful daughters. Sixteen years of military service on a fast-track promotion and slated to attend sergeant major's academy at Fort Bliss in El Paso, TX, in August 2003.

What happened to my son? Does anyone really know? We began to wonder, and I wonder why, if they know, won't they tell us. What we did know is this: Jimmy was doing his tour of duty in Iraq. He was always rock steady. He was strong willed and a good spirit all of his life, but in April and May 2003 his e-mails and phone calls from Iraq took on a completely different tone, a tone that alarmed us.

On June 12, 2003, in an e-mail to his mother he said, "This place has really put a beating on me. I found myself struggling to understand and deal with my own personal demons. I don't know what started this downward fall I am in. I am just ready to come home. I love you. Jimmy."

This was the time he started complaining about not sleeping and seeing images of a dead soldier he had seen in the morgue. For some unknown reason, that image remained burned in his mind, an image he saw over and over again in his sleep and would wake him.

He sought help for the fatigue and anxiety he was experiencing and was only given medication. No one counseled him. No one sought to find out the underlying reason. Just take these sleeping pills. No followup, no more concern, just another soldier with a sleep disorder. No one cared enough to find out why.

The medicine did not help. On June 17, 2003, James called his OIC and asked for help. Captain Singleton and another soldier

raced to his quarters, where they had to break in to find him lying semi-conscious. He was then rushed to a medical facility at Camp DOHA for evaluation and treatment. He was diagnosed with PTSD, post-traumatic stress disorder.

During his 3-day stay at the medical facility he was unwilling to discuss his situation with medical staff. On June 21, 2003, he arrived in Landstuhl as an outpatient. He left on a medevac flight on June 29, 2003, arriving at Walter Reed Army Medical Center some time around June 30, 2003. He was evaluated upon his arrival, and the evaluation did not find that he was a threat to himself or others. He had a scheduled appointment the next day and was released to his own custody with instruction to followup at the outpatient clinic. He was sent to his room alone, had appointments set up. He never made one of those appointments. No one ever made an attempt, even after our calls, to check on him.

Records indicate that James checked into his room at the Malogne House. He never left his room again.

The next 4 to 5 days were a total nightmare. Carol and my daughter-in-law began calling Walter Reed the next day trying to find Jimmy. We have documentation of repeated calls to various departments trying to verify that Master Sergeant Coons had arrived at Walter Reed. No one had any information. They did have a room registered to a Master Sergeant James Coons, but no one could tell us if he was actually on the property.

During this time we were told that this was a holiday weekend and it would be difficult to get someone to check his room. Policy will not let us go into the room until 3 days if there is a do not disturb sign on the door.

I have since found in part of the investigation papers a letter from Base Commander Kiley saying that rooms would be entered daily to check on the well-being of guests. It is not dated, so I don't know if this was prior to James or afterwards.

We were passed around and around. A call to the hospital's clergy, a captain told us, "He's a senior noncommissioned officer. I cannot get into his business." Calls to the military police, and no one responded to us.

Finally, on July 4th someone took our calls seriously and went to check his room. We were still calling and now were really getting the run-around. They know something, they say, but they can't tell us until the Army officially notifies his wife. Well, thank God a worker at the Malogne House finally had enough compassion to tell my wife on the night of July 4th that James had passed away. The next day my daughter-in-law was notified of Jimmy's death at approximately 0630, and we were notified around 9 a.m.

Now the story gets interesting. Our casualty officer was not informed of the cause of death, and we were not being told a cause of death, either. We would not learn of it until after Jimmy had been buried. That is not quite true. We learned about it the day before we buried Jimmy.

No matter what we did, we were met by a stone wall. One bureaucrat or officer after another would say that they did not know, or would pass us to someone else who, in turn, would pass us on to another person. No one, it seemed, knew or were willing to tell

us the actual cause of our son's death. We are, to this day, still unsure of his actual date of death.

James' body was returned to us on July 13, 2003, and was buried on July 15, 2003. During the visitation on Monday, July 14th, the funeral home received a call from a retired colonel in the area saying that he had knowledge of how my son had died and he was on his way to the funeral home to inform the family. Our casualty officer, who still had not seen a death certificate, got a copy of the death certificate faxed to him, and he had the unfortunate task of taking me outside, telling me how my son died. I then had to gather my family into a room and tell them how James died.

We, Carol and I, are here today to relate our experience to you in hopes that some other soldier who is having problems won't be ignored, that he or she will be given the best care and treatment available.

This is a great country. Its greatest asset is our men and women in uniform. They deserve and we expect that they would receive the absolute best medical care this country can provide to its service people to whom those parents have entrusted their children and to whom this country turns to for protecting us and our country's values in times of need.

Don't sweep these people under the rug. Out of sight, out of mind. Not my problem. That is just not acceptable. They deserve so very much more. We, the parents who entrust our children to you, deserve more.

Thank you.

[The prepared statement of Mr. and Mrs. Coons follows:]

For the Record

Richard and Carol Coons
May 24, 2007

May 24, 2007

Good Morning Chairman Waxman, Ranking Member Davis and Members of the Committee. Carol and I would like to thank you for giving us the opportunity to provide you information on the treatment of our Son, Msg. James. C Coons. There's nothing that can be done to help Jimmy now, however, with our information and that of the others present here today, change can and must be made in hopes of providing the proper care for our returning Heroes so they may enjoy a healthy and productive life.

Our Story!

Thursday, February 13, 2003

"Don't sweat the small stuff.. This is my life. I'm a Soldier. With that comes an inherent amount of responsibility and self sacrifice. All of my adult life has been spent as a soldier.....I knew many years ago what I was getting myself into. I would not change anything. Yeap...I'm dog tired and my body hurts....But there is not another place on the face of the planet earth that I would want to be right now. What I do now is not about me. It's about the American Flag. Some folks don't have a clue. They curse it, they spit at it, they burn it....Well....one day I will be buried with and under it. This is my generations war.....and if you are a soldier then it's your profession-----the "Profession of Arms." Now, rest easy and tell everyone not to worry. I will find my way home again....one day."

These words were from my son, a United States soldier. A proud soldier who loved his country, his God and then his family. Msgt. James Curtis Coons was a true soldier through and through for all his life. At a very early age, he was fascinated with anything military. Pass a truck hauling a tank or any military equipment and he would get excited. Drive by the Port of Beaumont and you would have to stop so he could watch the gear being loaded for shipment overseas. Pass an Army Surplus .....You had to stop...Who would think a 5 year old kid would eat C rations. He had to have a parachute hung above his bed...He took the harness and tried to jump out of a small tree...well he did...we had to cut him out of that tree.

Our son James was born on April 3, 1968 in a small town in Texas. He died on July 2003, under the care of Walter Reed Army Medical Center, Washington D.C. 35 years old, a military man happily married to a wonderful wife with two beautiful daughters, 16 years of military service, on a fast track for promotions, and slated to attend Sergeant Majors Academy at Ft. Bliss, in El Paso, Texas in August, 2003.

What happened to my son???
Does anyone really know??

I began to wonder.
And I wondered why, if they know, won't they tell us?

What we did know is this. Jimmy was doing a tour in Iraq. He was always rock steady. He was strong willed and of good spirit all of his life but in April and May of 2003, his emails and phone calls from Iraq took on a completely different tone. A tone that alarmed us. On June 12, 2003 in an email to his mother he said, "This place has really put a beating on me.....I have found myself struggling to understand and deal w/my own personal demons...I don't know what started this downward fall I'm in...I'm just ready to come home....I love you....jimmy." This was the time he started complaining about not sleeping and seeing images of a dead soldier he had seen in the morgue. For some unknown reason that image remained burnt into his mind, an image he saw over and over again in his sleep and would wake him. He sought help for the fatigue and anxiety he was experiencing and was given only medication. No one counseled him, no one sought to find out the underlying reason. Just take these sleeping pills. No follow up. No more concern. Just another soldier with a sleep disorder. No one cared enough to find out why.

The medicine did not help. On June 17, 2003, James called is OIC and ask for help. Capt. Singleton and another solider raced to his quarters where they had to break in to find him laying on the floor semiconscious. He was then rushed to the medical facility at Camp DOHA for evaluation and treatment. He was diagnosed with PTSD. During his three day stay at the medical facility he was unwilling to discuss his situation with the medical staff. On June 21, 2003 he arrived in Landstuhl as an outpatient. He left on a medevac flight on June 29, 2003 arriving at Walter Reed Army Medical Center on June 30, 2003. He was evaluated upon arrival and the evaluation did not find that he was a threat to himself or others. He had a scheduled appointment the next day and was released to his own custody with instruction to follow up at the outpatient clinic. He was sent to a room, alone, had appointments set up for the following days that he never made and no one ever made any attempt, even after our calls to check on him.

Records indicate that James checked into his room at the Malogne House. He never left his room again.

The next four to five days were a total nightmare. Carol and my daughter-in-law began calling Walter Reed the next day trying to find Jimmy. We have documentation of repeated calls to various departments trying to verify that Mgt. Coons had arrived at Walter Reed. No luck. No one had any information. They did have a room registered to Msgt. James C. Coons, but no one could tell us if he was actually on the property. During this time we were told that this is a Holiday weekend and it would be difficult to get someone to check his room. Policy will not let us go in the room until three days if there is a "Do not Disturb" sign on the door. (A letter from the Base Commander Kiley says the rooms will be entered daily to check on the well being of the guest). We were passed around and around. A call to the Hospital's Clergy, a Captain, told us, "He's a Senior

Non Commissioned Officer, I can't get into his business." Calls to the Military Police and no one responded to us.

Finally, on July the 4th, someone took our calls seriously and went to check his room. We were still calling and now are really getting the run around. They know something they say but they can't tell us until the Army, "Officially" notify his wife. Well thank God a worker at the Malogne House finally had enough compassion to tell my wife that James had passed away. The next day my daughter-in- law was notified of Jimmy's death at 6:30 a.m. and Carol and I were notified around 9:00 a.m.

Now the story gets interesting. Our casualty officer was not informed of the cause of death and we were not being told the cause of death either. We would not learn of it until after Jimmy had been buried. No matter what we did we were met by a stone wall. One bureaucrat or officer after another would either say they did not know or would pass us to someone else who in turn would pass us on to another person. No one, it seemed, knew or were willing to tell us the actual cause of our own son's death. We are, to this day, still unsure of his actual date of death.

James' body was returned to us on July 13, 2003 and was buried on July 15, 2003. During the visitation on Monday July 14, the Funeral Home received a call from a retired Colonel saying that he had knowledge of how my son had died and he was on his way to inform the family. Our casualty officer got a copy of the Death Certificate faxed to him and he had the unfortunate task of telling me and I, in turn, 10 days after my son's death, had to gather the family and tell them how Jimmy died.

We, Carol and I, are here today to relate our experience to you in the hopes that some other soldier who is having a problem won't be ignored. That he or she will be given the best care and treatment available. This is a great country and its greatest asset is our men and women in uniform. They deserve, and we expect that they would receive the absolute best medical care this country can provide its service people, to whom those parents have entrusted their children, and to whom this country turns to for protecting us and our country's values in times of need.

Don't sweep these people under the rug. Out of sight, out of mind. Not my problem. That's just not acceptable.

They deserve so very much more. We, the parents who entrust our children to you, deserve more.

Thank you.

June 1 Kuwait hospital- stress anxiety
Ambian and Zoloft
June 12 sent email to mother about his on personal demons

June 17 Took sleeping pills wanted to sleep, seeing face of disfigured Sailor that he saw while giving respect in the Morgue

Called MSG Ferguson and CPT Singleton to come get him he was feeling strange, when they got there he was unconscious

June 18 Hospital in Kuwait treated for over dose being watch and he was worried about his career. Diagnosed with PTSD

June 20 noted on his medical records NO interaction with others only wanted to read Bible and wants to talk to Chaplain

June 21 Prepared for release to Germany.
Jimmy denied overdose and cooperates and ready for transfer
Given instructions on self med to take.

June 22 Germany
Dr. Bailey examined and says exposed to graphic casualty and typical early PTSD

NO attendant required
Germany Medical exams: Eye and Blood test.
NO TREATMENT IN GERMANY OUT PATIENT (Exhibit 13 page 66 of CID report)
James calls home two or three times concerned that army did not call family. (FEEL GOOD CALL)

June 26- 29 Air Vac Mechanical problems on plane . Slept in gym 3 nights

June 29 Walter Reid Hospital

Arrived late and was seen by 3rd year resident and was surprised to be in psychiatric ward. Dr reviewed his medical records and released him to the Malogne house.

June 29 Wife started calling Malogne House.

June 30 Checked in Malogne House.

OPENED ROOM DOOR ENTERED AND NEVER OPENED AGAIN.

July 1-4 Mother calls Walter Reid Hospital
Air Vac Admissions out Patients Malogne House

Repeated calls to every person and department.

Malogne House front desk - Night Manager

Chaplets office to Chaplen Hollis and mother pleaded for her to go and knock on MSG Coons door. Chaplain said she would call back and later denies talking to her.

Wife also talked to Chaplain and was told due to his rank could not get in his business

July 4 15 phone calls to Walter Reid 8:30 to 9:00 pm when mother was told I am so sorry no one has called you YOUR SON HAS PASSED

July 5 Wife notified of James death but not told how he died. 6:30
Father and Mother visited by Captain from local office.

SGT. Pigg was family casualty officer and didn't know how Jimmy died

July12 James arrived home to Houston

July 13 Wife, Father and mother to view body.
Still now answers!!!

July 14 Visitation - Found out how he died.

July 15 Funeral

Preparation for D. C. Trip

July 25 - Aug. 10
Contacted Kay Bailey Hutchinson office.
Referred to CID Jamison Lehn

Emails to CID of questions we need answered when we visited and the places we wanted to visit.

WIFE WAS INFORMED THAT IF WE CAUSED ANY PROBLEMS HE WOULD NOT HESITATE TO ARREST US

Aug.12 Meeting with CID 9am CID didn't show. MSG Kasey called CID Lehn and he said his day was to busy and MSG told him we would be in his office and the family would be his first priority.

Meeting with Lehn and his Boss we ask questions and were given no answers. Everything was under investigation.

Lunch we went to the Psychiatric Ward and it was the most depressing place.

CID Lehn very upset that we went to hospital without being escorted.

Chaplain's office: Head Chaplain and Chaplain Hollis very surprised family with CID. Talked to Chaplain and ask why we were not helped.

Wife asks Chaplain Hollis why she couldn't go to husbands' room and why she was told it was due to his rank.

Mother asks after the phone call why didn't she call back like she said and Chaplain Hollis denied talking.

Visiting James Room at the Malogne House

Wife, mother, MSG Kasey and CID Lehn went to room.

Walk over CID Lehn said he hoped he didn't upset family when he said he would not hesitate to arrest family if we caused any problems.

CID Meeting. More question of why James was allowed to be in morgue where he was not trained.

Ask a question if there were any note or writing to family, and if all of his personal things returned. We were told ever thing returned.

Ask about Day-Timer or a note book of notes that James wrote everything down and the reaction of CID officers led us to believe that there was something not being told.

Aug 13 Navy Dr. Donavan

Father request that CID not be in room when the family is questioned about son's early life. Lehn very upset and asks Dr. to talk out of room with him and Dr. as him to honor family wishes.

Sept 2003 to date requesting all medical records, Dated of death changed to July 1, 2003 and return all personal effects especially note book that was in his room.

Master Sergeant James C. Coons is a native of Katy Texas. He was born on April 3, 1968. He enlisted into the United States Army on July 22, 1987 and attended One Station Unit Training (OSUT) at Fort Sill, Oklahoma where he was trainined as a Field Artilleryman; PMOS 13B. He reclassified to the Signal Corps on May 4, 1990 and was re-trained as an Information Systems Operator; PMOS 74D.

MSG Coons has served at duty locations both CONUS and OCONUS including: Fort Hood, Texas; Okinawa, Japan; Houston, Texas Recruiting Battalion; Carlisle Barracks and the United States Army War College (USAWC) at Carlisle, Pennsylvania and Camp Doha, Kuwait.

Throughout his 15 year career, MSG Coons has held every key leadership, operational and technical position including: Artillery piece driver; Assistant Gunner; Gunner; Ammunition Team Chief; Assistant NCOIC---Special Weapons Section (Nuclear); Senior Information Systems Operator; Company Training NCO; Team Chief; Battalion Operations Sergeant; Field Recruiter; Station Commander (LPSC); Group Operations Sergeant; NCOIC, Systems Group (Automation Division); Platoon Sergeant; Senior Information Systems Chief; NCOIC, Post Directorate of Information Management (DOIM); Senior Enlisted Advisor; Garrison First Sergeant; Acting Installation Command Sergeant Major and NCOIC, Installation Directorate of Information Management (DOIM).

MSG Coons has participated in Combat operations and/or campaigns including: Operation Enduring Freedom (Kuwait, Afghanistan and Uzbekistan) and Operation Southern Watch (Kuwait).

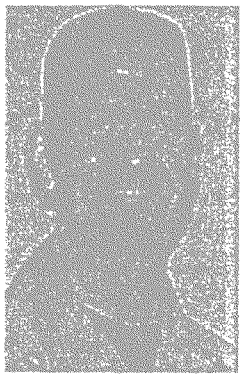
MSG Coons' military education includes the Primary Leadership Development Course (PLDC); Basic Non-Commissioned Officer's Course (BNCOC); Advanced Non-Commissioned Officer's Course (ANCOC) and the First Sergeant's Course. He is also a graduate of the Airborne Course; Air Assault Course; Department of the Army COMSEC Course; United States Marine Corps HAZMAT Course; United States Army Recruiter Course; 5th Recruiting Brigade Station Commander's Course and the Consideration of Others (C02) Facilitator Course.

MSG Coons has completed a Bachelor of Science degree while on active duty.

MSG Coons' awards and decorations include the Meritorious Service Medal with one oak leaf cluster; Army Commendation Medal with one oak leaf cluster; Army Achievement Medal with five oak leaf clusters; Army Good Conduct Medal with five bronze knots; National Defense Service Medal with one bronze service star; Armed Forces Expeditionary Medal; Military Outstanding Volunteer Service Medal; NCO Professional Development Ribbon with the numeral three; Army Service Ribbon; Overseas Service Ribbon with the numeral two; Army Superior Unit Award; Airborne Badge; Air Assault Badge; Gold Recruiter Badge with two Sapphires and the Drivers Badge with Wheel Bar. MSG Coons is also authorized to wear the Shoulder Sleeve Insignia for Former War Time Service (SSI-FWTS).

MSG Coons has been selected as a NCO of the Year, Recruiter of the Year, Honor Graduate of ANCOC and Leadership Award Recipient during MOS reclassification training in the 74D course. He is also a recipient of the Signal Corps Regimental Association (SCRA) "Bronze Order of Mercury."

MSG Coons is married to the former Ms. Robin (Rob) Martin of Willis, Texas. They have two daughters; Misaki and Chloe.



MSG James Curtis Coons

3 April 1968 to 4 July 2003

MSG James Coons was born in Texas the 3rd of April 1968. MSG Coons entered the US Army the 22nd of July 1987. He served as the Assistant Special Weapons NCOIC for Alpha Battery, 1/3 Field Artillery, 2nd Armored Division, Fort Hood, TX from June 1989 to July 1990.

MSG Coons then completed 2 tours in Okinawa, Japan from July 1990 to June 1997, where he served as the Senior Information Systems Operator, the 405th Signal Company Training NCO/Team Chief, C-E Operations Sergeant, and Battalion Operations Sergeant with the 58th Signal Battalion.

MSG Coons served with the Houston Recruiting Battalion from June 1997 to July 1999 in his home of record, Conroe, TX. He served as a Field Recruiter and the Station Commander LPSC.

In July 1999, MSG Coons transferred to the U.S. Army War College in Carlisle Barracks, PA. He served as the NCOIC for the Systems Group and Senior Information Systems Chief. In January 2001, he transferred to U.S. Army Garrison, Carlisle Barracks and served as the NCOIC for DOIM and Senior Enlisted Advisor and then as the Information Systems Chief.

MSG Coons arrived in Kuwait on the 20th of July 2002 and served as the NCOIC of the ARCENT-Kuwait DOIM in direct supervision of 185 contractors and 15 soldiers. He managed the largest C4/IT in the U.S. Army history within Southwest Asia during Operations ENDURING FREEDOM and IRAQI FREEDOM.

MSG Coons was on assignment for the Sergeants Major Academy in Fort Bliss, TX. He is survived by his wife, Robin and daughters, Misaki (11 y/o) and Chloe (2 y/o).

RECOMMENDATION FOR AWARD

For use of this form, see AR 600-8-22; the proponent agency is ODCSPER

For valor/heroism/wartime and all awards higher than MSM, refer to special instructions in Chapter 3, AR 600-8-22.

1. TO	2. FROM	3. DATE
CDR, 335th Theater Signal Command (FWD) Camp Doha, Kuwait APO AE 09889-9900	Commander, 385th Signal Company Camp Doha, Kuwait APO AE 09889-9900	25 MAY 03

PART I - SOLDIER DATA

4. NAME	5. RANK	6. SSN
Coons, James C.	MSG	[redacted]

7. ORGANIZATION	8. PREVIOUS AWARDS
385th Signal Company Camp Doha, Kuwait APO AE 09889-9900	MSM (2 OLC); ARCOM (1 OLC); AAM (5 OLC); MOVSM No previous awards during this tour

9. BRANCH OF SERVICE	10. RECOMMENDED AWARD	11. PERIOD OF AWARD a. FROM	b. TO
United States Army	BSM	19 MAR 03	31 MAY 03

12. REASON FOR AWARD		13. POSTHUMOUS
12a. INDICATE ACH, SVC, PCS, ETS, OR RET SVC	12b. INTERIM AWARD [ ] YES [X] NO IF YES, STATE AWARD GIVEN	YES [ ] NO [X]

PART II - RECOMMENDER DATA

14. NAME	15. ADDRESS
Michael R. Singleton	385th Signal Company (DOIM) Camp Doha, Kuwait APO AE 09889-9900

16. TITLE/POSITION	17. RANK
ARCENT-KU DOIM	CPT

18. RELATIONSHIP TO AWARDEE	19. SIGNATURE
Supervisor	//Signed/CPT Singleton/E-mail

PART III - JUSTIFICATION AND CITATION DATA *(Use specific bullet examples of meritorious acts or service)*

20. ACHIEVEMENTS

ACHIEVEMENT #1

MSG Coons performed magnificently as the ARCENT-Kuwait DOIM NCOIC during Operation Iraqi Freedom. While leading the largest forward deployed DOIM in the CENTCOM AOR, MSG Coons superbly managed 200 personnel, one of the largest computer networks in the DoD, a 40 million dollar hand receipt and a 3.8 million dollar IT budget residing on the ARCENT-Kuwait CSA and TAC-SWA contracts.

ACHIEVEMENT #2

MSG Coons spearheaded the infrastructure setup for the AOR Blue Force Tracking (BFT) project. This project dramatically reduced the number of "Blue on Blue" incidences and loss of friendly vehicles during the war. MSG Coons saw to completion the entire 300K upgrad of the post Giant Voice. This project ensured the survival of soldiers during 28 alerts and 10 direct missile attacks on Camp Doha, Kuwai during the war. MSG Coons ensured that the CFLCC command center was stood up and operational for the war.

ACHIEVEMENT #3

MSG Coons provided immediate C4/IT support to U.S. Marines involved in a terrorist attack on the local training islands of Kuwait in which one Marine was killed in action and one Marine was wounded in action. MSG Coons ensured installation of the communication requirements for the Camp Doha mortuary affairs unit. His actions ensured that 145 sets of remains of fallen American heroes were expeditiously identified and returned to the states for proper burial.

ACHIEVEMENT #4

MSG Coons ensured that his Defense Red Switch Network (DRSN) section completed and managed the numerous requests for General Officer installs. His efforts ensured that General Officers could communicate to their subordinate commanders on a moments notice during Operation Iraqi Freedom. MSG Coons also ensured the complete implementation of Defense Messaging System (DMS). His efforts ensured that the command could receive classified message traffic in a timely and secure manner throughout the war.

21. PROPOSED CITATION

FOR EXCEPTIONALLY MERITORIOUS SERVICE IN CONNECTION WITH MILITARY OPERATIONS DURING OPERATION IRAQI FREEDOM. MSG COONS SERVED MAGNIFICENTLY AS NCOIC, ARCENT-KUWAIT DIRECTORATE OF INFORMATION MANAGEMENT (DOIM). HE FLAWLESSLY IMPLEMENTED THE C4/IT REQUIREMENTS FOR FORWARD DEPLOYED WARFIGHTERS. HIS ACTIONS ENSURED COMPLETE DOMINANCE AND VICTORY ON THE BATTLEFIELD. MSG COONS' DEVOTION TO DUTY REFLECTS CREDIT UPON HIMSELF, THE 11TH SIGNAL BRIGADE, THE 335TH THEATER SIGNAL COMMAND AND THE UNITED STATES ARMY.

Chairman WAXMAN. Thank you very much, Mr. Coons.

Mrs. Coons, did you want to add anything, or was your husband speaking for both of you?

Mrs. COONS. No, sir.

Chairman WAXMAN. OK. Thank you.

Mrs. LeCompte.

STATEMENT OF TAMMIE LECOMPTE

Mrs. LECOMPTE. Thank you, Mr. Chairman and Members here today.

My name is Tammie LeCompte, the proud wife of Soldier Member Specialist Ryan LeCompte from the Lower Brule Sioux Tribe out of South Dakota.

Ryan has been in the Army for 7 years and has served two full tours in Iraq. He had plans for a full military career and wanted to serve 20 years. Even though that seems impossible now, Ryan has many proud memories while serving this Nation. But today he only feels shame and embarrassment, mostly because Ryan's leaders did not understand his war injuries, and that is part of what has led to my being here today.

Ryan willingly put his life on the line for all of us, and the only thing we ask in return is understanding of his war-related conditions—no harassment from leaders who don't understand PTSD; proper and tailored mental health care; proper tracking, screening, and diagnosis of traumatic brain injury; and, finally, an appropriate discharge from the military if his condition does not improve.

In 2004, after Ryan returned home from his first tour from Iraq, he filled out his post-deployment health assessment form and indicated that he was having difficulties readjusting. He did not receive a referral to mental health. Then again in 2005 he filled out a predeployment health assessment form and asked for a referral to mental health. He did not receive this referral and was, instead, redeployed to Iraq in June 2005.

These unfortunate circumstances have impacted my family tremendously. When Ryan returned from his second tour in Iraq, he was a changed man. He again filled out his post-deployment health assessment form and again indicated that he was having difficulty readjusting. After Ryan's mandatory 90-day followup, he received an emergency referral to mental health; however, nobody followed up with him. Ryan needed help and could not get it.

This period of time was very difficult for me and my family. The changes in Ryan were apparent, and I wanted to do everything I could do get him the help that he needed.

In August 2006 Ryan unfortunately received a DUI and was referred to the Army's substance abuse program. During this period, Ryan was never diagnosed with PTSD, regardless of his repeated requests for help.

Finally, on March 22, 2007, Ryan was diagnosed with chronic post-traumatic stress disorder. Ryan's command claims that they were not notified of this diagnosis until May 18, 2007.

In April 2007, the abuse that Ryan received from his command worsened his condition to the point that his civilian mental health

care provider referred him to Cedar Springs for a 72 hour acute care facility. At this point I was completely discouraged.

I am not a PTSD expert, but let me tell you how PTSD and the lack of care impacted my family.

As a wife, it was hard to make sense of these changes with Ryan. I didn't understand the anger and the sudden outbursts. I didn't understand the lack of support from his chain of command. And I couldn't explain to my children why Daddy was the way he was—detached, distant, and someone that I didn't know at all.

My children were afraid. They were constantly asking why Ryan was acting the way he was, why he was yelling at me, or why was he always going away. It has even gotten to the point where my 4 year old daughter, Savannah, has made up songs about her Daddy being gone. She doesn't understand. I don't understand. And Ryan's leaders don't understand.

I was desperate and I was exhausted. These two binders on the desk represent the effort that I have made on behalf of my husband.

Finally, when I contacted Veterans for America, they were able to reach out to Congress, the mental health care providers at Evans Army Community Hospital, and the civilian clinicians at Cedar Springs, who indicated that Ryan needed to be in more comprehensive, individually tailored inpatient facility. Because of the VFA's pressure, the waiting time to get Ryan into an appropriate dual-track PTSD/substance abuse program with the VA went from 4 weeks to 3 days. Finally, Ryan is in an intensive program; however, he is living with patients primarily from the Vietnam War Area. DOD must create similar programs for the soldiers from our newest wars.

I am encouraged to hear from Veterans for America that Major General Hammond has recognized that mistakes have been made at Fort Carson and that major changes within the Army as a whole are required.

I also commend Brigadier General Tucker, who has been tasked by the Army to be the bureaucracy buster, that he has made a commitment to make the four following changes: That the Army records TBI and TBI-like events in the soldier's medical record immediately after the event, and that we screen for these events in the post-deployment health assessment and reassessment; that the Army institutes a leader teach program designed to teach Army leaders at all levels about TBI and PTSD so that they know how to identify symptoms in their soldiers, refer them to the appropriate care, and know how to lead and take care of these soldiers; that the Army develops a method that improves the commander's awareness of the soldiers in his or her unit with TBI and PTSD so that he can ensure the soldiers diagnosed with these conditions are appropriately taken care of; and institute a requirement that the medical facility review the physical exams of all soldiers undergoing administrative separation proceedings to ensure that no medical condition requiring a Medical Evaluation Board is overlooked.

I am encouraged when I hear leaders in the Army make these statements, because it means that another family won't have to suffer the way our family has suffered in understanding these illnesses.

Thank you.

[The prepared statement of Mrs. LeCompte follows:]

Statement of Tammie LeCompte,

Wife of Specialist Ryan LeCompte (U.S. Army)

Hearing on "Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military"

Committee on Oversight and Government Reform

U.S. House of Representatives

Thursday, May 24, 2007, 10:00AM

2154 Rayburn House Office Building

Chairman Waxman, Mr. Davis, Members of the Committee:

I am Tammie LeCompte, the proud wife of soldier Specialist Ryan LeCompte, from the Lower Brule Sioux Tribe of South Dakota.

Ryan has been in the Army for seven years and has served two full tours in Iraq. He had plans for a full military career and wanted to serve 20 years. Even though that seems impossible now, Ryan has many proud memories while serving this nation, but, today he only feels shame and embarrassment mostly because Ryan's leaders didn't understand his war injuries, and that is part of what has led to my being here today.

Ryan willingly put his life on the line for all of us and the only thing we ask in return is an understanding of his war-related conditions -- no harassment from leaders who don't understand PTSD; proper and tailored mental health care; proper tracking, screening and diagnosis of Traumatic Brain Injury; and finally, an appropriate discharge from the military if his condition does not improve.

In 2004, after Ryan returned from his first tour Iraq, he filled out his Post Deployment Health Assessment form and indicated that he was having difficulties readjusting. He did not receive a referral to mental health. Then again in 2005, he filled out a pre-deployment health assessment form and asked for a referral to mental health. He did not receive this referral and was instead re-deployed to Iraq in June of 2005.

These unfortunate circumstances have impacted my family tremendously.

When Ryan returned from his second tour in Iraq, he was a changed man. He again filled out his Post Deployment Health Assessment form and again indicated that he was having difficulty readjusting. After Ryan's mandatory 90 day follow-up, he received an emergency referral to mental health, however, nobody followed up with him. Ryan needed help and could not get it.

This period of time was very difficult for me and my family. The changes in Ryan were apparent, and I wanted to do everything I could to get him the help that he needed. In August 2006, Ryan, unfortunately, received a DUI and was referred to the Army Substance Abuse Program (ASAP). During this period, Ryan was never diagnosed with PTSD despite his repeated requests for help. Finally, on March 22nd, 2007, Ryan was diagnosed with Chronic Post Traumatic Stress Disorder. Ryan's command claims that they were not notified of this diagnosis until May 18th, 2007. In April, 2007, the abuse that Ryan received from his command exacerbated his condition to the point that his civilian mental health care provider referred him to Cedar Springs for a 72-hour acute care facility.

At this point, I was completely discouraged. I am not a PTSD expert, but, let me tell you how PTSD and the lack of care impacted my family. As a wife, it was hard to make sense of the changes with Ryan. I didn't understand the anger, the sudden outbursts; I didn't understand the lack of support from his chain of command. I couldn't explain to my children why Daddy was the way he was – detached, distant and someone that I didn't know him at all.

My children were afraid. They were constantly asking why Ryan was acting the way he was, why he was yelling at me, and why he was always away. I didn't have any answers for them.

It has even gotten to the point where Savannah, our four-year old daughter, has made up songs about her Daddy being gone. She doesn't understand; I don't understand, and Ryan's leaders don't understand.

I was desperate, and I was exhausted. These two binders on the desk represent the effort that I made on behalf of my husband. Finally, when I contacted Veterans for America, they were able to reach out to Congress, the mental health care providers at Evans Army Community Hospital and the civilian clinicians at Cedar Springs who indicated that Ryan needed to be in a more comprehensive individually-tailored inpatient facility. Because of this pressure, the waiting time to get Ryan into an appropriate VA dual-track PTSD/substance abuse program went from four weeks to three days.

Now, Ryan is in an intensive program. However, he is living with patients primarily from the Vietnam War. DoD must create similar programs with soldiers from our most recent wars.

I am encouraged to hear from Veterans for America that Major General Jeffery W. Hammond, Commander of the Fourth Infantry Division, has recognized that mistakes have been made at Ft. Carson and that major changes within the Army as a whole are required.

I also commend Brigadier General Michael Tucker, who has been tasked by the Army to be the bureaucracy buster, for his commitment to make the four following changes.

1. That the Army records TBI and TBI-like events in the Soldier's medical record immediately after the event, and that they screen for these events in the Post Deployment Health Assessment and Re-Assessment.

2. That the Army institutes a Leader Teach Program, designed to teach Army Leaders at all levels about TBI and PTSD, so that they know how to identify symptoms in their Soldiers, refer them for the appropriate care, and know how to lead and take care of these Soldiers.

3. That the Army develops a method that improves the commander's awareness of the Soldiers in his or her unit with TBI and PTSD so that he can ensure the Soldiers diagnosed with these conditions are appropriately taken care of.

4. That the Army institutes a requirement that the medical facility review the physical exams of all Soldiers undergoing Administrative separation proceedings to ensure that no medical condition requiring a medical evaluation board is overlooked.

I am encouraged when I hear Army leaders make these statements because it means that another family won't have to suffer the way our family has.

Chairman WAXMAN. Thank you very much, Mrs. LeCompte.

Before we start asking questions, I think the students were going to leave, and so I thought I would just give them the signal. This is a good time.

Mr. DAVIS OF VIRGINIA. Thank you, Mr. Chairman.

Thank you for that good testimony.

Chairman WAXMAN. Well, I thank you, each and every one of you, for a very important and powerful testimony that you have given us from your own experiences, from your family's experiences, what these illnesses have meant.

Oftentimes, post-traumatic stress disorder and other mental problems are completely invisible. People may not even realize what is happening to them. The system that is supposed to take care of them may not realize what is going on, or they may not be equipped to deal with it.

Mr. and Mrs. Coons, your son was certainly a remarkable man. He would have been doing today what you are doing. While he stood up and fought for his men, you're doing the same thing, because it is not just your son, it is a lot of other people's sons, husbands, fathers that experience what is going on. I know he would be very pleased and proud of the fact that you are carrying that message to us today, so thank you so much for being here.

Specialist Bloodworth, it sounds like you are getting the care you need. Do you feel that you are being responded to and getting help that you need?

Mr. BLOODWORTH. Yes, I do, Mr. Chairman. At first, no. At first, I really felt the system was kind of lax, but once they determined what the problem was they have been doing a good job. It was getting to the point and getting to the determination of what the issue was, Mr. Chairman.

Chairman WAXMAN. Yes. Specialist Smith, your experience has been very different. You were not diagnosed, or when you were diagnosed they still wanted to send you back to—was it Iraq or Afghanistan?

Mr. SMITH. It was back to Iraq, Mr. Chairman.

Chairman WAXMAN. Back to Iraq. And you tried to tell the military that you weren't ready to go back. Could you tell us more about that, what happened with you there?

Mr. SMITH. Yes, Mr. Chairman.

I made several attempts, taken letters of concern from my psychologist to my chain of command, even as far as my psychologist contacting my company commander personally saying this guy is not ready. He typed up a memorandum stating that I should not be allowed to be around weapons and that he just needed more time to work with me, and he believed that I would be ready to go again. And, according to what I was told, they were not willing to give me that time to get better. So following his recommendations and what we thought was best for me, I went into inpatient care so that I could start receiving medications and getting the proper treatment.

Chairman WAXMAN. So the medical system was helping you, but then the rest of the military system didn't seem to care what the medical system was doing? They wanted to send you back to Iraq, even though you weren't ready to go back?

Mr. SMITH. Yes, Mr. Chairman.

Chairman WAXMAN. Yes. Let me ask both specialists, a lot of men don't know what is happening to them. They know they are not sleeping well. They are experiencing all the symptoms you have described. And they may not understand what is happening. But is there a stigma that some of the men feel about even going and asking for help? Is this one of the problems we are seeing?

Mr. SMITH. Yes, Mr. Chairman. Even when I began seeking treatment, I kept it separate from the military. I went through Army One Source and started seeing a psychologist off post because I didn't really want anybody at work to know what was going on with me.

Chairman WAXMAN. Mr. Bloodworth.

Mr. BLOODWORTH. Yes, Mr. Chairman, actually, when I was in country we had a group there, the Combat Stress Team, at Camp Anaconda, and they had initially done a briefing with every company and squadron that was coming in and said, We are here for you. If you have any issues, come talk to us. Immediately after those doctors and specialists had left, you got the feeling that people were snickering, like people don't need to go see them. It is definitely a stigma, and especially in country because it deters from the mission and it deters from your mission.

Chairman WAXMAN. As I understand it, the way the Army finds out is putting out a questionnaire. Can you tell us, anybody on the panel, about those questionnaires and about whether that really gets to the issue?

Mr. BLOODWORTH. Mr. Chairman, I filled out one of those surveys during mid-deployment because the Combat Stress Team decided it was necessary to do that on our post. Very few questions. I think it was at least 10 questions. Do you feel like you are a threat to yourself and others? Do you feel like you want to hurt anyone? Questions like that. And you filled it out with your squad, and then your squad leader would read it, and then he would send it to the platoon sergeant, and so it is back to that stigma again.

Chairman WAXMAN. Yes.

Mr. BLOODWORTH. You don't want to let anybody know there is a problem.

Chairman WAXMAN. Well, I can see that stigma and the reluctance, but then the question is what does the Army do once you tell them you are having these problems. The Defense Department convened a Mental Health Task Force to study the way the armed forces are dealing with this PTSD and other mental health matters, and that task force put out a draft of its findings, and it concluded, "The current efforts fall significantly short in treating mental health problems, and the military system does not have enough resources or fully trained people to fulfill its broad mission of supporting psychological health." So, in effect, they concluded our system is in crisis and that soldiers who are suffering from PTSD and other mental health problems are not getting the care they need.

Mr. and Mrs. Coons or Ms. LeCompte, you certainly didn't find the system receptive and able to deal with the problems your son was having.

Mr. COONS. No, sir, Mr. Chairman, they didn't. We do have some documents that James did complete prior to being air-evaced out

and asking him these type questions: what would you say your health is? Do you have any medical or dental problems? Are you currently profiled for light duty? Have you sought or intend to seek counseling for care of your mental health?

I mean, he answered these and it was submitted. He said he had food poisoning, which is, I think, part of our issue is when this originally happened with James this stigma with him being a soldier, being a career soldier, he felt like he let people down. He felt like his career was going to be in jeopardy now with sergeant major academy coming up, and some of his peers said, well, we can log this as food poisoning and/or heat stress. So when he's filling out his forms, I mean, that is what he's putting down on them.

Chairman WAXMAN. And the system just failed him completely?

Mr. COONS. Well, this was back in 2003, also, Mr. Chairman.

Chairman WAXMAN. Maybe we know more. Maybe the system knows more to respond. I hope.

Mr. COONS. I hope so.

Chairman WAXMAN. I hope so.

Ms. LeCompte, tell us what your thoughts are about how this system has been working for you and your family?

Mrs. LECOMPTE. Well, in that situation on, like, the questionnaires that they were discussing, my husband's situation, he filled out his and he was flagged not to go over or back, and receive immediate help, and it was ignored. If it says refer to mental health and they don't have the staff or whatever it might be to help these soldiers, I mean, it really doesn't do any good to fill out these questionnaires.

Chairman WAXMAN. Thank you.

My time is up and I want to recognize Mr. Davis.

Mr. DAVIS OF VIRGINIA. Thank you, Mr. Chairman.

Specialist Bloodworth, let me ask you how would you rate the quality of care you have been receiving at Walter Reed? Have they made progress now on your treatments?

Mr. BLOODWORTH. They are making progress, sir. Actually, I am slotted to go on the community health care organization back in my home State within the next month, which means that they don't feel that I will at any point need to be an inpatient and I can receive my care at home through civilians or the VA.

Mr. DAVIS OF VIRGINIA. I don't know. I have a rough idea on statistics, but could you guess a percentage that just don't come forward because of the stigma approached to this? Is there talk in the barracks or guys saying something's wrong but I'm just afraid to step forward? Either one of you have any feel for that?

Mr. BLOODWORTH. Yes, sir. Overseas you see it because people see combat or people just being separated from home and you see everybody becoming depressed and everybody coping with it, but the ones who are having a hard time coping with it, you can see that they want help, and you have that stigma. I wouldn't know a percentage, but I would say it affects many people in the unit.

Mr. DAVIS OF VIRGINIA. Is there informal talk about it but people just don't want to come forward?

Mr. BLOODWORTH. Yes. I mean, there are people who have been saying I wish I had somebody to talk to somebody who wasn't my

squad leader, somebody who wasn't in the platoon, somebody that didn't see you every day.

Mr. DAVIS OF VIRGINIA. Seen as a sign of weakness, isn't it, if you are in the military to kind of come forth?

Mr. BLOODWORTH. Exactly.

Mr. DAVIS OF VIRGINIA. Specialist Smith?

Mr. SMITH. I would definitely say so. You can tell the people that are having the problems, because ones that have come forward, people will gather around them and talk to them more about it. But I definitely believe there are a lot of people that are scared to come forward. I couldn't say a percentage, either, but I believe there are a lot of people that are afraid it is going to hurt their career to step forward.

Mr. DAVIS OF VIRGINIA. Military is a macho culture. I mean, that is just part of it. I went through my active duty and OCS and everything else, and I understand it. It is seen as a sign of weakness, isn't it?

Mr. SMITH. Yes, sir.

Mr. DAVIS OF VIRGINIA. How is the care you are receiving now?

Mr. SMITH. The care I am receiving now is excellent, sir. They are really taking care of me, making sure that I get everything that I need.

Mr. DAVIS OF VIRGINIA. Mrs. LeCompte, what support networks are available now through the military or the VA to families and children of soldiers who are suffering from mental illness? Have you seen any?

Mrs. LECOMPTE. What was that first part again?

Mr. DAVIS OF VIRGINIA. What support networks are available through the military or the VA? Have you found any that are available for situations like yours?

Mrs. LECOMPTE. Well, my husband is in Sheridan, WY, right now at a VA facility. As far as the treatment there, I mean, it really doesn't——

Mr. DAVIS OF VIRGINIA. I'm talking about support groups for you.

Mrs. LECOMPTE. Well, there is a support group through Evans Army Hospital; however, there are only certain timeframes to attend.

Mr. DAVIS OF VIRGINIA. So it is there, but it is really not adequate?

Mrs. LECOMPTE. It is not beneficial. Correct.

Mr. DAVIS OF VIRGINIA. Have they given you any type of education on your husband's illness? Have they sat down and talked about what is involved and what you can expect and what the prognosis is?

Mrs. LECOMPTE. No, sir.

Mr. DAVIS OF VIRGINIA. How about resources available to your children to better understand their father's illness? The same thing?

Mrs. LECOMPTE. No, sir.

Mr. DAVIS OF VIRGINIA. We all hear from witnesses, and we are going to hear this on our second panel, untreated emotional trauma arising from combat situations leads to a host of other problems, including depression, suicidal thoughts, substance abuse. When

was your husband officially diagnosed with post-traumatic stress disorder?

Mrs. LECOMPTE. As far as Evans, in March 2007 was when they finally put it on paper. They would call it everything else but what it is.

Mr. DAVIS OF VIRGINIA. And during the time that he was deployed, nothing?

Mrs. LECOMPTE. Nothing.

Mr. DAVIS OF VIRGINIA. No diagnosis or anything else? Was he afraid to come forward, do you think, and admit that he was having some issues?

Mrs. LECOMPTE. I knew that, in a way, yes, I would say he was afraid to come forward, but he would still try to seek help, to get some help for this. But when he comes forward, a lot of the members of the chain of command, they ridicule these soldiers and just not do what they should to make sure these soldiers are taken care of.

Mr. DAVIS OF VIRGINIA. Thank you.

Mr. and Mrs. Coons, I just want to thank you for sharing your son's story with us. You don't know how many times this is repeated across when people are afraid to come forward sometimes and talk about it in a public setting. I know it is not easy to do. I hope that we can honor your son's life by acting on this, understanding it better, and trying to ensure that it doesn't happen again and take steps. I just want to thank you. I think the story speaks for itself. We just appreciate you coming forward.

Thank you, Mr. Waxman.

Chairman WAXMAN. Thank you very much, Mr. Davis.

Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

To all our witnesses, I thank you all for being here.

To Mr. and Mrs. Coons, Mr. Coons, you said that your son and others in matters of this nature should not be swept under the rug. I promise you that we will do everything in our power to make sure that does not happen. We thank you for being here.

We also thank Specialist Smith and Specialist Bloodworth and Mrs. LeCompte for your testimony.

To Specialists Smith and Bloodworth, as I was listening to the questions about stigma, I said to myself this must not be the easiest thing to do. It will probably be on national television with this testimony. That says a lot for you.

Back to Mr. and Mrs. Coons, and to all of you, I believe that one of the reasons why Specialist Smith and Specialist Bloodworth are getting the kind of treatment that they are now getting is because of people like you who stood up and said that there were problems earlier, and now we are seeing better treatment.

Specialist Smith, we have been told that soldiers with injuries, both mental and physical, are being sent back to fight in Iraq against their doctor's orders, and you testified to that. Just to followup on the chairman's questions, in fact, back in March you had recently returned from traveling with your unit to the National Training Center in Fort Irwin, CA, to participate in a pre-deployment training exercise. During that time you were at the training

center, I am told that you experienced a disturbing incident during which you attacked a fellow soldier; is that correct?

Mr. SMITH. Yes, sir. I had been having really bad nightmares and stuff, reactions to the mortars that they were setting off in the distance, and it just so happened about 2 a.m. one night a fellow soldier came walking in the tent, and my bunk was right next to the tent, and it was right around the same time that was happening, and I jumped up and grabbed him and slammed him up next to the tent. It was a pretty scary incident because if I had had a weapon or something, who is to say that I would not have actually hurt this guy.

Mr. CUMMINGS. So this was just in March?

Mr. SMITH. In January, sir.

Mr. CUMMINGS. OK. Was that part of the reason that you and your doctors did not think that you should return to Iraq?

Mr. SMITH. Yes, sir. Upon returning from that, I immediately saw my on-post psychologist and that is when she said that I needed to seek more help and get medications, and that is when she referred me to on post, and that is when the psychologist on post had made the recommendation that I not be deployed and not have weapons.

Mr. CUMMINGS. And did you share your doctor's letters with your unit commanders?

Mr. SMITH. Yes, sir, I did. My unit commander was even contacted by the psychologist and he had actually sat down and talked to my unit commander and gave him a copy personally.

Mr. CUMMINGS. Now, do you have any idea why your commander would have wanted to deploy you, even though your doctors felt that you were not fit for deployment? Go ahead.

Mr. SMITH. My company commander actually went to the colonel. I don't know which colonel. I don't know if it was the squadron colonel or if it was the brigade colonel, but he told me that he went to the colonel with the letters. He was actually fighting for me not to go.

Mr. CUMMINGS. Yes. And can you tell us, based on your doctor's instructions, what did you do to avoid being deployed to Iraq for a third time under the conditions that you just described?

Mr. SMITH. Whenever I went and sat down with my doctor, we discussed some things, and I told him that I would rather kill myself than to see and experience the things that I had been through when I was over there last time. I was not mentally healed and not prepared to go through this kind of thing again.

Mr. CUMMINGS. And you knew that?

Mr. SMITH. Yes, sir.

Mr. CUMMINGS. Do you still feel that way?

Mr. SMITH. No, sir. The treatment that I am getting now and with the medications and everything, it is really helping. I mean, I am a lot better now.

Mr. CUMMINGS. Well, we are glad that you are better.

Do you think other soldiers go through the same extreme measures, or did any of them just return and fight injured? I mean, do you know of situations?

Mr. SMITH. Yes, sir. I know of several other people that were also going through the same procedures as me, and I also know several

others that were actually deployed. There is actually some that have been sent back. They were deployed over there and then sent back because of this investigation.

Mr. CUMMINGS. These soldiers, do you think they are able to perform their duties, I mean, based on what you know? I know you are not a doctor. Do they put themselves and other soldiers at risk, do you think?

Mr. SMITH. In my opinion, yes, sir. Nobody wants anybody with a mental condition or a physical condition trying to fight on the front lines with them.

Mr. CUMMINGS. Did you want to say something, Specialist Bloodworth?

Mr. BLOODWORTH. No, sir.

Mr. CUMMINGS. Again, I want to thank you all for your testimony. Hopefully we will be able to use this testimony to help others. I thank you all so much.

You are right, Mr. Coons, this is a great country, and we are going to do our best to make it an even better country.

Thank you.

Chairman WAXMAN. Thank you, Mr. Cummings.

Mr. Issa, would you want to yield some time?

Mr. ISSA. Sure. I yield 1 minute to the gentleman.

Mr. MCCAUL. Thank you. I just want to thank my constituents, the Coons, for coming forward with your story. It takes enormous bravery and courage to do what you have done. It is unconscionable to me how someone who is on suicide watch can be put in an outpatient facility at Walter Reed.

I am glad that, because of what happened, that the Army has changed that policy, and because you have come forward you have changed some of the policies of the Army on this issue. Unfortunately, the Army has not apologized to you for your tragic experience, and I would like to, on behalf of the U.S. Government, make that apology to you and say that we are sorry and yield back.

Mr. ISSA. I thank the gentleman.

I think I would like to pick up exactly where the gentleman left off and say we make mistakes. We have made mistakes in every war. When we make mistakes, people die, and so you have my heartfelt apology for the mistakes that clearly were made in your son's case.

You didn't say what the death certificate said for your son. I would hope that it said service-connected death; that, in fact, just like the men and women who were added to the wall of the Vietnam Memorial because they died of injuries received in Vietnam, your son clearly is a fatality of his service. You have our deepest sympathy. All we can say is we will strive not to make this mistake again.

I am not going to tell you that we are not going to make mistakes and that young men and women are not going to die again or that bureaucracy isn't going to make a mistake.

Our next panel is going to, in fact, represent health care professionals who we are going to count on to be part of that change. We are going to ask them if they have the resources they need; if, in fact, the attitude necessary to ensure that every man and woman

gets the care they need and gets it in an expeditious fashion exists both in the medical professionals and in the chain of command.

We are going to ask if the organization needs to be changed, because that is what this committee does, it oversees the bureaucracy and the structure of Government.

Last, but not least, we are going to question the leadership at all levels, not just at Walter Reed but throughout the military structure, to find out whether or not leadership has, in fact, gotten the message that not all injuries can be seen from the outside.

It is very hard to ask questions in this kind of an environment, because each of you represents somebody who has fallen through the cracks of our system. Finding the right changes can be difficult.

Specialist Smith, I do have a couple of questions for you. If I understand correctly, your back injury occurred early on, before your first deployment?

Mr. SMITH. Yes, sir.

Mr. ISSA. And that still bothers you today?

Mr. SMITH. Yes, sir.

Mr. ISSA. And are you receiving physical therapy and other treatment to help with that?

Mr. SMITH. I did physical therapy for approximately 6 months, and they told me that I had reached the extent of my physical therapy.

Mr. ISSA. And have they diagnosed what the permanent portion of the disability is?

Mr. SMITH. Yes. I have a diffuse bulged disk between my L–4/L–5 vertebrae.

Mr. ISSA. And surgery won't do any more for it?

Mr. SMITH. No, sir. They said surgery could possibly make it worse.

Mr. ISSA. OK. You said you have a P–3, so you have a limited ability to perform your duties; is that right?

Mr. SMITH. Yes, sir.

Mr. ISSA. What are those limitations?

Mr. SMITH. I have it right here, sir. According to this profile, I cannot carry or fire an individual weapon, I am not able to move fighting gear at least 2 miles, I am not able to construct an individual fighting position, I am not able to do 3 to 5 second rushes under direct or indirect fire.

Mr. ISSA. Specialist, I think I have it. You are not fit for combat?

Mr. SMITH. Yes, sir.

Mr. ISSA. And yet you were deployed. Now I guess I will ask the tough question. Have you ever been offered a discharge under medical conditions as a result of that injury?

Mr. SMITH. No, sir. The only medical board that I am getting is for my psychiatric care.

Mr. ISSA. Do you think that you should have been offered or should the military have evaluated, if you couldn't do the job—I will tell you the honest to goodness truth. I enlisted in the Army in 1970 to be a truck driver, so I ended up in bomb disposal because I wasn't good enough to be a truck driver, I suspect. But I, in fact, understand what it is like bouncing around in a military vehicle. Do you think that, in fact, that should have been the first

sign that, in fact, you were going to have difficulty performing in your multiple tours to Iraq?

Mr. SMITH. Yes, sir.

Mr. ISSA. OK. If there is a second round I would love to pick up on this. I thank the chairman and yield.

Chairman WAXMAN. Thank you very much, Mr. Issa.

Ms. Watson.

Ms. WATSON. Thank you so much, Mr. Chairman. I want to say to all of our witnesses that we appreciate your valor, your courage, and your bravery for coming here in front of this committee. It takes a lot of courage to tell the truth, and it is time now that we have people like yourselves come and tell the truth.

In the middle of this war that we are fighting, the casualties are a manifestation of the cracks in our system, and your coming and your articulating for us what the cracks in our system are, we are going to protect our homeland, we have to know where to fix these cracks along the way so that we can, indeed, protect the land that we love, we are committed to. I just want to thank you for being here.

One of the purposes of the hearing is to help people understand the conditions like post-traumatic stress disorder and traumatic brain injury. These are very serious injuries, even though they are invisible. They are injuries caused by real, real traumatic battlefield experiences.

Now, a number of studies have shown that the more time soldiers spend in combat, the more likely they are to develop PTSD when they come home. The soldiers most likely to develop these conditions are the soldiers who spend most time outside the wire, where they are exposed to sniper and mortar fire and IEDs.

I would like to direct this to Specialists Smith and Bloodworth. You both have had combat experience. I would like to ask each one of you to describe what soldiers experience when they are in Iraq. So Specialists Smith and Bloodworth, can you give us some description of your experiences for our committee? Let's start with Specialist Smith, please.

Mr. SMITH. Yes, ma'am. Whenever we were in Ramadi we were under constant fire. Every day we left the wire, every day we were mortared. We have seen RPGs, sniper fire on a constant basis. I was hit with six IEDs, or the vehicle that I was in was hit with at least six IEDs. Sniper fire, like I said, on a regular basis. It is really stressful. We have seen people blown apart. We have seen our own soldiers catch fire and burn right in front of us. These are all things that pretty much everybody in my whole company experienced.

Ms. WATSON. Specialist Bloodworth.

Mr. BLOODWORTH. Ma'am, you pretty much hit the nail on the head. I was running convoys, five on, one off. That was our routine. With that, I have seen friends and fellow soldiers injured, killed. Your friends will go out on a mission and then somebody doesn't come back. I was hit with five IEDs and so many small arms ambushes that I can't even count in 11½ months that I was there. It is a very nerve-wracking experience, even on your off time. On the day that you are supposed to be able to rest, you can't get the other 5 days that you just spent out on the road out of your head.

Ms. WATSON. I am looking at you in uniform and I know that your training, at least traditionally, has been to fight in a conventional way, correct?

Mr. SMITH. Yes, ma'am.

Mr. BLOODWORTH. Yes, ma'am.

Ms. WATSON. What you are finding in Iraq is a non-conventional kind of experience; is that correct?

Mr. BLOODWORTH. Yes, ma'am.

Mr. SMITH. Yes, ma'am.

Ms. WATSON. Do your enemies wear uniforms similar to what you have on?

Mr. BLOODWORTH. They had better not.

Ms. WATSON. Similar, I should say.

Mr. BLOODWORTH. It would make the job easier.

Ms. WATSON. They don't have patches indicating what countries they are from?

Mr. SMITH. No, ma'am. Most of the time they are dressed as civilians, and they will even just pop out of a crowd of people and just fire at you.

Ms. WATSON. So you never know who the enemy is?

Mr. SMITH. Yes, ma'am.

Ms. WATSON. Right. And were you trained to deal with IEDs?

Mr. SMITH. We had some brief training before we left. They went through some obstacle courses and they told us what we can expect, but the IEDs are constantly changing. Just in the time we were over there, they went through, like, two different kinds that they were using. They started out with pressure plates, and they were using them where they were putting them up on the telephone poles, so it is constantly changing, so it is hard to keep up with the training.

Ms. WATSON. When the other panel comes up, I want to know how we are training and preparing our troops to fight in an unconventional manner, and I think if we can get to that point maybe we can start addressing the results of the experiences that you have experienced.

I want to say to the Coons——

Chairman WAXMAN. Ms. Watson, your time is up. Would you conclude your sentence?

Ms. WATSON. OK, and they can respond maybe at another time, but I just want to say that until we can get to the point that we will understand what we are up against, we are going to see more cases like you are describing.

Thank you so much, Mr. Chairman. I appreciate it.

Chairman WAXMAN. Thank you, Ms. Watson.

Mr. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman.

I would also like to thank the panel for your testimony and for your sacrifices. Particular welcome to Specialist Bloodworth, a fellow Kentuckian. Welcome. It is nice to see you.

I think it is safe to say, and I think I can speak for everyone on this panel and probably everyone in Congress, that one of the toughest things we deal with is trying to suppress our own emotions when we hear stories like yours. It is a combination of anger and sympathy—sympathy for the quest that you have experienced,

but anger that the system is not handling your needs as well as at it could.

I would like to kind of proceed on somewhat of a corollary from what Congresswoman Watson was asking. Did any of you know what PTSD was before you got in the service?

Mr. BLOODWORTH. Sir, they had given us some briefings about depression and anxiety, and they gave it a face and called it PTSD, but didn't really explain what it was.

Mr. YARMUTH. Is there any way that you can prepare psychologically for what you experienced and what you saw?

Mr. BLOODWORTH. Take it 1 day at a time is the best thing to do.

Mr. YARMUTH. Specialist Smith.

Mr. SMITH. I always say that you can prepare for it but you can never be ready for it.

Mr. YARMUTH. Do you think that the preparation that you received as to the possible psychological impact of what you were going to experience could have been better, or do you think there is any way to make it better?

Mr. SMITH. I don't think there is any way to really make it better, because you don't know what you are going to see. All you can do is maybe watch videos and have it explained to you, what you might be experiencing, but I don't think there is any way to really prepare for it.

Mr. YARMUTH. Addressing the question of the stigma that has been talked about by several of the Members and you have addressed, do you think that it would be beneficial if everyone who came out of a combat zone, as you did, were forced to do more than answer a questionnaire so that there would be no question of you wimping out in seeking treatment?

Mr. SMITH. Yes, sir. I think it would be very beneficial for anywhere from 3 to 6 months for them to be forced to sit down and talk to somebody and talk about their experiences. That way they can be evaluated one-on-one. Nobody has to know who said what.

Mr. YARMUTH. Specialist Bloodworth, would you agree with that?

Mr. BLOODWORTH. I agree, that would definitely work for the active Army, but for the National Guard I don't see how. I mean, it is a good idea, but maybe a possibly longer demobilization time and retraining soldiers to live daily life and doing more than just a 10-question questionnaire.

Mr. YARMUTH. Mr. Coons, you were shaking your head. Did that indicate that you had a different response?

Mr. COONS. Well, through our Congressman's office we have been trying to get some questions answered, and just yesterday we were given a letter from the acting Secretary of the Army, and they bring up that subject that, in addition to post-deployment, health reassessment is given 3 to 6 months following a soldier's return from deployment.

I, as a citizen who has lost a son, find that deplorable. Some of these young people are going over there for their second and third tours. Why do we have to wait 3 to 6 months? That is normally too late. It should be one of the first things these people go through when they return.

I am no doctor, but, I mean, I just can't understand that.

Mr. YARMUTH. Mrs. LeCompte, do you have a comment on this issue as to whether mandatory screening following returning would have been helpful in your case?

Mrs. LECOMPTE. Yes, I do. I feel that it should have been done right away.

Mr. YARMUTH. One further question on Specialist Smith. You talked about the fact that when you were redeployed that you were possibly a threat to others and that is certainly a problem. Could you explain maybe what other ways your performance as a soldier changed, if it did, between deployments?

Mr. SMITH. Yes, sir. I lost a lot of initiative. I really didn't care to advance in the military any more, especially, I mean, I felt like I was getting looked down upon. I just started showing up to work late, where I was always one of the first ones there, and I just really didn't care to train any more. I was kind of out of it most of the time when I was there.

Mr. YARMUTH. Finally, I guess a quick question for both you specialists. Do you feel that you had to put any pressure on the system to get the attention that you needed?

Mr. SMITH. Yes, sir. Actually, whenever I was put into inpatient care, my mother had contacted a news reporter, and that is when all my care and all this got started for me.

Chairman WAXMAN. Thank you, Mr. Yarmuth.

Mr. YARMUTH. Thank you.

Chairman WAXMAN. Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman. I just have a few questions.

I would like to ask a few questions related to the stress that multiple deployments and increased duration of deployments may be having on our armed forces. We already know through studies that the rate of PTSD amongst soldiers returning from a second deployment is about 40 percent higher than it is for those returning from their first deployment. I had the chance to visit our soldiers in Iraq and Afghanistan in April, and I just happened to be there on the day that the Department of Defense announced that they would be extending the tours of duty from 12 months to 15 months for those soldiers. This is the first time in our military history when we have had a policy whereby soldiers are asked to serve on the front lines, as Specialist Smith has testified to, 5 days, 6 days, 7 days without time off. That goes beyond 6 or 7 months. Now we are having 12-month deployments extended to 15-month deployments.

I direct the question to Specialist Bloodworth first, because I believe that the unit that you served with in Iraq, the 34th Infantry Division, was extended, I think, recently by 125 days. Is that correct?

Mr. BLOODWORTH. Yes, sir. We received our extension orders on January 1, 2007.

Mr. MURPHY. Can you just talk for a moment how soldiers in the unit reacted to the extension and to what extent that affects the morale of the unit?

Mr. BLOODWORTH. Metaphorically you could have heard everybody's heart's breaking when the first sergeant handed us out our orders. That was the time when people really started to lose their cool, really started to lose their military bearing, and became

complacent even on missions, because who cares, we are here for another 125 days. We were actually in the process of packing our conexes and sending bags home and they just dropped the bomb on us.

Mr. MURPHY. And I would imagine, Specialist, that for those troops who have had mental illness or PTSD that has gone undiagnosed, that moment can be especially backbreaking?

Mr. BLOODWORTH. It worsened for a lot of people, and I was working with the Combat Stress Team. I was going and seeing them offline without my unit even knowing. Only one person in my unit knew, and they actually found out we were getting extended, and I had an e-mail to come see them immediately to talk about the issues, because my therapist there thought there would be an issue.

Mr. MURPHY. Specialist Smith, if I might ask that question to you, as well, your thoughts on how these announcements related to tour extensions have had an effect on both troop morale and on troops who may have undiagnosed or untreated PTSD and mental health issues.

Mr. SMITH. I agree with the specialist here. I mean, it is really heartbreaking to tell somebody that you are not going to see your family for another 3 months, especially when, like, the R&R leave, I have buddies that, we just deployed in March, they're already coming home on R&R, and they got another 12 months they have to spend in country before they can see their family again. I believe that plays a big role on it.

Mr. MURPHY. And I will actually turn that question over also to Mrs. LeCompte, because this is an issue that relates not only to the soldiers that may have their conditions exacerbated by an extension on their tour, but it also affects their support network, those expecting them to come home after 12 months. Realizing that is extended might just give you the opportunity to talk about how that affects families that you may know or be in contact with.

Mrs. LECOMPTE. It would definitely cause more stress to the family. I mean, of course, every day just sitting and waiting just to hear a phone call just to make sure they are OK, and for them to extend it even more, and still yet don't have a clue on how to fix what is happening to these soldiers is very detrimental. It is like an epidemic.

Mr. MURPHY. Thank you very much. I know there are those on this panel who might want to separate the issue of the policies directed toward the wars we are fighting now with the question of how we treat and how we prevent these illnesses from becoming exacerbated. I think this is an example in which the two cannot be separated, Mr. Chairman. I yield back the balance of my time.

Chairman WAXMAN. Thank you, Mr. Murphy.

Mr. Welch.

Mr. WELCH. Thank you. Taking up from where my colleague, Mr. Murphy, spoke, I was with him on the trip to Iraq and Afghanistan. It was the first time in my life where I spent 5 days with the soldiers in their world. I came away with enormous respect, and a lot of the respect was that what is being asked of you is really quite unbelievable. You are in danger constantly. And we have heard the testimony about the stress you have been under, the

change in your son and the tone of the letters that came back. I don't know what you think of this, but as I listened to this, there are issues about the Army and our services being responsive, and you are helping us focus on paying whatever attention we can so it is better, but there is also a situation there where you guys are just in incredible danger all the time. I mean, what you describe, how many IED events that you were involved with, sniper fire constantly, I mean, that takes its toll. And then having news that when you thought your deployment was going to end it is going to be extended. All the while there is significant questions about whether what you are doing over there is a civil war and you are caught in the middle of it. It is so incredibly stressful.

I just want to convey to you my appreciation for what you are doing, but I don't know anybody who could manage to serve a tour without a significant toll.

I would just like to maybe ask you, Specialist Bloodworth, to describe some of the additional day to day events that you experienced during your service.

Mr. BLOODWORTH. Day to day experience, I was a driver for the longest time, so my truck commander felt that it was necessary for me to sleep all the time unless we were on the road, so mission days it was, wake up, eat, get the truck ready, go on mission, try not to die, come back, go to sleep. On off days I usually just tried to hang out with some of my friends within our platoon and take off the uniform, put on some PTs, and try to forget the fact that you are in Iraq. Maybe barbecue. Maybe grill. Just talk. Go see a movie or something to try to escape that. That was day to day living off mission, because I think we both described what on-mission was like.

Mr. WELCH. Specialist Smith.

Mr. SMITH. My day to day living wasn't quite as comforting as his. We didn't have movie theaters or anything like that. We actually lived in a house that was taken over in Ramadi. We had people that lived around us, so we were constantly having to be on watch.

We had a big gas station across the street from us where there was people constantly in and out, so day to day living was really stressful even there. We were in close quarters. We had eight men in just a regular-sized bedroom. So it was really stressful and it was really hard to deal with people on a day to day basis living like that.

Mr. WELCH. I can imagine. And, Mr. and Mrs. Coons, you described the change in the tone of your letters. Your son sounded like a wonderful young boy, young man, and military person. And then you noticed a real stark change in the tone of the letters. I would be interested in I know you have given it a lot of thought, but do you have any thoughts that you can share with us about what accounted for his change in tone?

Mr. COONS. With James being a career soldier, I mean, and really I said in the beginning that even as a youth he always had the Army first and he was over getting prepared for the initial invasion and everything, and I guess if people can go back to 2003 it seems like we geared up and were getting ready to go, then we came back down. This happened two or three times. We would talk about that

in e-mails, and he said it is frustrating people. We're ready to go, let's go. Let's go. Let's get it over with.

I would say in April or May he has never said anything negative about his military career. For some reason, in April or May he became disillusioned. He said all I care about now is my 20 years and I'm getting out, where all we had heard in the past is I will probably be here 25 or 30 years. I want to be sergeant major of whatever division. That was his goal. And his whole attitude started changing about that timeframe.

I can't put my finger on it. I mean, comments we'd see. It is a numbers game. We're not respecting our deceased soldiers. I mean, just things like that from him on a constant basis.

Chairman WAXMAN. Thank you, Mr. Welch.

Mr. WELCH. I yield my time.

Chairman WAXMAN. Mr. Hodes.

Mr. HODES. Thank you, Mr. Chairman.

I also want to thank all the witnesses for being here today. This is very important testimony. If we are going to make the right kinds of changes to make sure the things that happened to your husband, your son, and you, the soldiers, are fixed, we really need to hear from you, so I appreciate your being here today.

One of the things that I would like to talk about is what the Army calls dwell time. It is the amount of time soldiers spend at home between deployments. Now, the Army policy has been that the ratio between dwell time and deployment time should be two-to-one. For example, for every year you spend deployed in Iraq, you should spend 2 years at your home bases, and during those 2 years soldiers have time to train, to recuperate, to spend time with their families that were interrupted by deployment.

The Army has recently had to change that policy for Iraq and Afghanistan. According to one recent study, there are currently fourteen brigade units in Iraq that are deployed with less than 2 years at home, and four brigades that have deployed with less than 1 year of dwell time.

Now, we have also heard a report that the Army is even considering paying bonuses to soldiers who agree to spend less time at home between deployments. I want to explore a little bit the importance of dwell time and why the 2-year policy is an important policy for soldiers and their families.

Let me ask first, Specialist Smith, how much dwell time did your brigade unit, the Third Brigade, Third Infantry Division, have between its Iraq deployments?

Mr. SMITH. Well, Third Brigade, they deployed in 2003, again in 2005, and now again in 2007.

Mr. HODES. Were there times when it was less than 2 years at home?

Mr. SMITH. Every time, sir.

Mr. HODES. And did you have discussions with your fellow soldiers about the dwell time issue and what it meant for you?

Mr. SMITH. Yes, sir. The time just passes so fast when you are back here in the States. Eight months goes by and you feel like you just got home, and then you are gearing up to go again. It is kind of depressing.

Mr. HODES. So it adds to the stress of the redeployment to have not enough dwell time at home?

Mr. SMITH. Yes, sir.

Mr. HODES. And if you had more dwell time, what do you think the effect would be on the mental health of the soldiers who are returning for redeployment?

Mr. SMITH. I believe it would allow more time to get evaluated, to get the things out of your mind, to be with the ones that you love. That is a big issue. By the time you get resituated with your family, you are gearing up to leave again, so you can never really fully adjust back to life, being with your family.

Mr. HODES. Mrs. LeCompte, from your standpoint as a family member, can you talk to us a little bit about what the dwell time means to you and having enough time to be with your husband in between deployments, and what impact, if any, having shrinking dwell time means for you and the family?

Mrs. LECOMPTE. My husband was only home approximately about 8 months before he went back out again. I mean, it is definitely hard to adjust, because it takes them so long to adjust, just coming from a hostile environment back to a home environment as it is. I just think that the shorter it gets the harder it would be on families, because, I mean, it just takes them so long, as we hear today, things are just now coming out about the PTSD issues already. You have a lot of problems home already, just from them coming home.

Mr. HODES. Mr. and Mrs. Coons, do you have anything to add to the question of the dwell time?

Mr. COONS. No, sir. Unfortunately, we didn't have that experience.

Mr. HODES. Thank you very much.

Mr. Chairman, before I yield back, I just want to say I think it is not right to treat our troops this way. We know our soldiers need more time at home to recuperate, preserve their health, get ready for redeployment, and deal with what they have been through, but in my judgment we went into this war without the proper preparations, we have shortchanged our troops, we are denying them the rest they need to do their jobs and keep themselves safe, and it is multiplying the issues that we are now facing with mental health problems, PTSD, that we are seeing. It is an issue that we are going to have to address.

Thank you, Mr. Chairman. I yield back.

Mr. ISSA. Would the gentleman yield?

Mr. HODES. Certainly.

Mr. ISSA. I would like to join the gentleman in recognizing that the dwell time is not enough, and that with approximately 1 million soldiers, sailors, and Marines, it is the inequity that many, many units have never been in theater in Afghanistan or Iraq while others are on their third deployment. I hope that this committee will join the chairman in trying to get to the bottom of why that inequity continues to exist.

I yield back.

Chairman WAXMAN. Thank you, Mr. Hodes.

I want to recognize Mr. Tierney, who is the subcommittee chairman who has worked so diligently on the issue of Walter Reed and

has been very involved in all of the questions on what we are doing for our returning military.

Mr. TIERNEY. Thank you very much, Mr. Chairman. Thank you for having this hearing.

Thank all the witnesses for coming forward and helping us out with this matter. I think it is going to make a significant difference.

I think, to a certain extent, Mr. and Mrs. Coons, in an unfortunate way you have already made a difference, and so has your son.

I was curious. As you were testifying I was looking through some of the records that we had produced as a result of some of the earlier hearings on that. How long had your son actually been separated from his family and in theater before his death?

Mrs. COONS. Around a year.

Mr. TIERNEY. About a year?

Mrs. COONS. Yes.

Mr. TIERNEY. And how long had he been home before he was sent in for that year?

Mrs. COONS. I'm sorry?

Mr. TIERNEY. Had he been in before and come home and was going in again, or was it his first deployment?

Mrs. COONS. This was his first deployment.

Mr. TIERNEY. I note in the reports the issues that are here, the change of attitude that you may have experienced seemed to follow his exposure to a number of killings in action. It was followed by nightmares and things of that nature. And then the acute stress disorder was compounded by the lengthy separation from his family. I think these are all issues that we are going to have to examine as we do more research into the matter on that.

There is nothing in the reports, however, about your constant contacts with the hospital once your son got home or whatever, and I think we are going to explore that as we go on in the hearings as to why there isn't a recording on that, why there wasn't enough attention paid to your efforts to get in touch with him. But there was an indication in the records that there was apparent confusion that existed when your son was sent home through the medical system, through the medical channels as an ambulatory patient as opposed to an inpatient. That is an indication that there was a policy clarification they note here, but that people ought to have an attendant with them, a supervisor with them when they come home, in that sense. And there is expensive paperwork here about reiterating that clarification and making sure that happens. So in that sense at least I want you to know that there has been a change made in that, and I think it is going to make a significant difference in the lives of other people.

I won't belabor this panel, Mr. Chairman. I think that the questioning has been pretty extensive and the answers have been very helpful.

I just want to again thank all of you for your service to country and give our serious condolences for your loss to the Coons.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Tierney.

Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

Thank all of your for your testimony. It demonstrates a lot of courage to be here.

I am struck by a couple of things at the outset. One is, looking at you and listening to you, I know that there are thousands of families and individuals and soldiers who are in a similar position, and that is what makes your testimony so powerful here today.

I am also very aware of the sheltered existence, the protected existence that I have, not having been in the situation you have been in, and aware that it is sheltered and protected by you, by what you are doing, so I thank you for that.

Mrs. LeCompte, I wanted to ask you a few questions based on your testimony about the impact that your husband's condition had on the family, but, in particular, the impact that the failure to get the help in a timely way that you were seeking had on your family. In other words, I can imagine that if there were regular appointments that had been established right from the beginning of his return, that would have helped you get from one day to the next, because you knew that relief, that help was coming, and the fact that it didn't come or you expected it to be there and then it wasn't there only added to the stress and the tension inside the home, so if you could speak to that.

Mrs. LECOMPTE. Definitely. I mean, these guys go over to protect the United States and they expect to be protected when they come home. I mean, the overall effect when you think that there is help and there is not, I mean, it is very detrimental to the whole family, the children. I mean, it has its ripple effects.

When these guys go in and ask for help or they are going through the SRPs or whatever, they expect the help, and when it is neglected they only deteriorate more.

Mr. SARBANES. Did you find yourself having to step in to a kind of support role that you felt should have been provided by other resources? And what was the effect of that?

Mrs. LECOMPTE. I mean, I feel that my husband was ignored and ridiculed, and so on, and so finally I had to become his voice and kind of step in. Even myself, as the military calls it being a civilian, it was even hard to get people to listen to me for that help, for plea, and it shouldn't have gotten this far.

Mr. SARBANES. Well, I salute you for not giving up and pushing on the system and beginning to get the results that you deserved right from the outset.

I would like to ask you, Specialist Smith and Specialist Bloodworth, this single question. This is a followup to the questioning about the extension of tours. Describe, if you can, how much a soldier invests psychologically in the end date of their tour. In other words, right from the beginning. Again, I don't know it from personal experience, but I have to believe that part of what allows you to steel yourself for what you are experiencing right from the first day is having that date when you know you are going to come home.

The contribution to technical support division that comes from the experiences you are having on the ground is one thing, but is it compounded? I mean, does it actually have an effect on your mental state when suddenly—and I think you said, Specialist Bloodworth, that you were packing at one point when you got word

of an extension, which represents sort of psychologically just pulling the rug.

Talk about from the beginning of a tour how important and how invested you get in, if it is the case, in that end date and what the effect of it is when it gets pulled away from you.

Mr. SMITH. Sir, I would say that mentally you have a whole lot invested in that. You are looking forward to it. Even when I was there, I was told I was leaving on a certain date and it was 2 weeks later. For that 2 weeks, I was just, like he said, I was complacent. I got, like, all right, whatever, I am just here. You invest a whole lot into that time they say this is when you are going home.

Mr. BLOODWORTH. And, just to finish up before time runs out, it is pretty much like seeing the light at the end of the tunnel and it turns out to be a freight train and you don't know what to do, because that time seems to grow indefinitely, and every day gets longer, so it is difficult, sir.

Mr. SARBANES. Thank you for your testimony.

Mr. Chairman, it just strikes me that the policy, itself, is contributing to the mental state, the negative mental state, that we are talking about here today.

Thank you.

Chairman WAXMAN. Thank you, Mr. Sarbanes.

Mr. Issa.

Mr. ISSA. I will be brief, but I think it is very important, since we have you here, to followup on that line of questioning. It is not related to the topic, but it is related to your service. Were you aware when you were in Iraq that, while you were serving, depending upon what time you were there, but let's just call it a 1-year tour, that other units such as Navy, not the Corpsmen, but other than Navy Corpsmen, were serving 4 months or less, that the Air Force routinely serves 120 days? You are shaking your head yes, Specialist? You were aware of that?

Mr. BLOODWORTH. Yes, sir. The camp I was at was actually an Air Force base, so we saw a changing of hands constantly. Very jealous.

Mr. ISSA. So they basically came in, got their combat time, their tax-free pay, and they were gone pretty quick, never having gone outside the wire?

Mr. BLOODWORTH. The only people from the Air Force that I was aware of that were going outside the wire was their EOD elements, but as for everyone else, that is pretty much it, sir.

Mr. ISSA. Well, as an EOD guy I appreciate that.

Last, but not least, it has been announced that for Army and Marine units already at 12 months, they are going to 15 months. What do you think that is going to do to the types of tours that you have already endured?

Mr. SMITH. I think it is going to make it much harder. Three months doesn't sound like much, but when you are over there it seems like a lifetime that you are away from your family and that is 3 months longer you have to deal with the same person day in and day out. You wake up, you look at them, and it makes it a lot harder.

Mr. BLOODWORTH. When they say extended and you have 3 months, to me that is almost 60 more missions. That is almost 60

more days that I am going to be out there strung out, stressed out. It is hard to look at things like that and still keep a cool head.

Mr. ISSA. Well, thank you for your service. Thank you for your testimony.

I yield back and thank the chairman.

Chairman WAXMAN. Thank you very much, Mr. Issa.

Let me again thank all of you for your presentation and your forthrightness in responding to questions and helping us understand what has happened in your cases and realizing your situations are magnified many times over by others who are experiencing the very same or very nearly the same kinds of situations. We are going to have to learn, as a country, to deal with all of this a lot better than we have.

Thank you so much.

We are going to take a 5-minute recess before we call the second panel.

We stand in recess.

[Recess.]

Chairman WAXMAN. The committee will come back to order.

For our second panel I want to welcome Dr. Michael Kilpatrick, the Deputy Director for Force Health Protection and Readiness Programs at the Department of Defense. Dr. Kilpatrick is accompanied by Dr. Jack Smith, the Acting Deputy Assistant Secretary of Defense for Clinical and Program Policy.

Dr. Antoinette Zeiss is Deputy Chief Consultant in the Office of Mental Health Services at the Department of Veterans Affairs. Dr. Zeiss is accompanied by Dr. Al Batres, the VA's Chief Officer at the Office of Readjustment Counseling.

Dr. Thomas Insel is the Director of the National Institute of Mental Health at the National Institutes of Health.

Major General Gale S. Pollock is the Commander of the U.S. Army Medical Command and is the Army's Acting Surgeon General.

Dr. John Fairbank is an associate professor of medical psychology at the Duke University Medical Center, and a member of the Institute of Medicine's Committee on Veterans Compensation for Post-Traumatic Stress Disorder.

I want to thank all of you for being here today.

As I mentioned earlier if you were here for the first panel, it is the practice of our committee to ask all witnesses to take an oath, and those, as well, who are accompanying those who are making the oral presentations, if you would also rise we would appreciate it.

[Witnesses sworn.]

Chairman WAXMAN. The record will indicate that each of the witnesses answered in the affirmative.

I want to start with Dr. Kilpatrick, if he would be our first witness. We have your prepared statements, and we will put those in the record in full, but we would like to ask each of you, if you would, to limit the oral presentation to 5 minutes. We have a clock. It will turn yellow when you have 1 minute left and then red when 5 minutes is up.

Dr. Kilpatrick.

STATEMENTS OF DR. MICHAEL E. KILPATRICK, DEPARTMENT OF DEFENSE, DEPUTY DIRECTOR, DEPLOYMENT HEALTH SUPPORT, ACCOMPANIED BY DR. JACK SMITH, ACTING DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR CLINICAL AND PROGRAM POLICY; DR. ANTONETTE ZEISS, DEPARTMENT OF VETERANS AFFAIRS, DEPUTY CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES, ACCOMPANIED BY DR. AL BATES, CHIEF OFFICER, OFFICE OF READJUSTMENT COUNSELING; DR. THOMAS INSEL, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; MAJOR GENERAL GALE POLLOCK, ARMY SURGEON GENERAL; AND DR. JOHN FAIRBANK, DUKE UNIVERSITY, MEMBER, INSTITUTE OF MEDICINE COMMITTEE ON VETERANS' COMPENSATION FOR POST-TRAUMATIC STRESS DISORDER

STATEMENT OF MICHAEL E. KILPATRICK

Dr. KILPATRICK. I would like to start by expressing my appreciation for the opportunity to hear the testimony of the first panel. Very compelling. Very courageous people. I thank them also.

Mr. Chairman and distinguished members of the committee, thank you for the opportunity to discuss the Department's Force Health Protection and Readiness Program and programs in the military health system with the focus on the mental health aspects of those programs.

Two primary objectives of the military health system are to ensure a medically ready force and to provide world class care for those who become ill or injured. The Department of Defense is well aware of the stress that combat deployments place on our service members and their families. We have a multitude of proactive programs in place and underway to educate, screen, diagnose, and treat our service members and their families. We also have robust surveillance programs in place to monitor the health of our force before, during, and after deployments.

In theater, we have the smaller medical footprint that is agile, mobile, and responsive to the needs of the mission. This includes medical support for mental health in theater. Each branch of service has specific combat stress and deployment mental health support programs available before, during, and after the deployment cycle. These provide support tailored to the service's mission and risk factors that personnel might face.

Multi-faith chaplains deploy with units to maintain a ministry of presence. They offer confidential counseling and are safe havens for those who need someone to talk with during troubling times. They often facilitate access to other avenues of care.

Since March 19, 2003, there have been nearly 27,000 air medical transports out of Operation Iraqi Freedom theater, 20 percent of which are for combat injuries, 20 percent have been due to noncombat injuries, and the remaining 60 percent are due to medical conditions that need evaluation or treatment not available in theater. Mental health conditions have accounted for 7 percent of those transports.

We have over 1 million post-deployment health assessments done as people come out of theater from worldwide deployments. The active duty, 22 percent indicate medical concerns, 5 percent mental

health concerns, and 18 percent are referred for further evaluation after discussing their issues and concerns with a provider. All referrals are fairly equally divided between medical only, mental health only, and medical and mental health.

The Reserves, 41 percent have medical concerns, 6 percent have mental health concerns, and 24 percent are referred.

We have over 200,000 post-deployment health assessments done 3 to 6 months after people get home from these worldwide deployments. That started in June 2005. Of active duty, 33 percent have medical concerns on those assessments, 27 percent have mental health concerns, and 16 percent are referred for further medical evaluation.

The Reserve component, 56 percent have medical concerns, 42 percent have mental health concerns, and 51 percent are referred.

An important element of the post-deployment health assessments is education of the service members about medical conditions, both physical and mental, and the signs and symptoms that indicate the need for further evaluation.

To better understand the mental health needs of the deployed force, the Army sent its first mental health advisory team to theater in 2003. This was the first time that such an assessment was done during a war-time deployment to evaluate the adequacy of mental health support in theater and preparation of medical and support staff for mental health care.

Deployment-related mental health research projects are being conducted across DOD, VA, HHS, and other Federal and academic institutions. Of the 67 current projects, 32 are focused on PTSD.

In 2004, a Hogue study showed a direct relationship between the level of combat exposure and meeting screening criteria for major depression, generalized anxiety, or PTSD. The proportion of people who met the screening criteria for each mental health disorder was higher after OIF Iraq, than after OEF Afghanistan, and was higher in the post-deployment groups than in the pre-deployment group.

A review of post-deployment health assessment mental health data showed a positive mental health screening in 19 percent of people returning from OIF compared to 11 percent coming back from Afghanistan and 8 percent returning from other locations in the world.

Mental health concerns were significantly related to combat experiences. Among some 69,000 veterans of Iraq who accessed mental health in the year after coming home, only 35 percent actually received a mental health diagnosis. The military health system is second to none in its ability to deliver timely, quality mental health and behavioral care. This includes behavioral health and primary care, mental health specialty care, clinical practice guidelines, and ready access to high-quality, occupationally relevant primary care, along with different modeling and demonstration projects that are designed to help us continue to learn and improve the system of care delivery. In addition, walk-in appointments are available in virtually all military mental health clinics around the world.

The 2003 Millennium Cohort Study evaluates the long-term health effects of military service, specifically deployments. Almost 140,000 individuals have enrolled in this DOD/VA ground-breaking, 22-year study. As force health protection continues to be a pri-

ority for the future of military medicine, the Millennium Cohort Study will provide crucial steps in understanding the long-term health effects.

The Department of Defense is very concerned about the short and long-term health care. We look for ways to better serve our service members, and we look forward to outside expert advise. The Mental Health Task Force, as you have discussed, is making recommendations, and we are looking forward and committed to diligently working to incorporate their recommendations.

I thank you for your time.

[The prepared statement of Dr. Kilpatrick follows:]

STATEMENT BY

MICHAEL E. KILPATRICK, MD

DEPUTY DIRECTOR

FORCE HEALTH PROTECTION AND READINESS PROGRAMS

DEPARTMENT OF DEFENSE

HOUSE COMMITTEE ON OVERSIGHT ON GOVERNMENT REFORM

HEARING ON MENTAL HEALTH CONCERNS

MAY 24, 2007

NOT FOR PUBLIC RELEASE UNTIL RELEASED BY COMMITTEE

Mr. Chairman and distinguished members of the committee, thank you for the opportunity to discuss the Department of Defense's Force Health Protection and Readiness Program and the programs within the Military Health System, with a focus on the mental health aspects of those programs.

Two primary objectives of the Military Health System are to ensure a medically ready force and to provide world class care for those who become ill or injured. The importance of these objectives is recognized throughout the Department of Defense, and we have a multitude of proactive programs in place to educate our Service members and their families and our military leadership about these programs. We also have robust surveillance programs in place to monitor the health of our force and to provide information that allows us to continue to modify and improve them whenever indicated.

The continuum of medical care in the Military Health System begins with the accession of the Service member and continues through deployment and redeployment cycles until the member separates or retires. Pre-deployment and post deployment health assessments were begun in 1998, based on medical lessons learned from the 1990-1991 Gulf War. The post deployment health assessment was augmented in 2004 to collect a standardized set of information about medical

symptoms or concerns, again because of medical lessons learned from those returning home from deployments. The post deployment health reassessment was begun in January 2006 to re-evaluate the health of those who returned from deployments some three to six months after their return. This reassessment was initiated because of military medical research data showing increased physical and mental health symptoms and concerns among Service members after they were home and reintegrating with their families and their work.

The post deployment health assessment and the post deployment health reassessment were both designed to have a healthcare provider interact one-on-one with each Service member to review the concerns identified by the member on the assessment and to make a determination of the medical indications for referral for further evaluation and diagnostic work-up. The assessments are not medical diagnostic instruments, but are screening evaluation tools to identify the need for medical evaluation.

Since 1998, DoD has been doing a pre-deployment health assessment that includes a question that asks if the individual has received mental health care in the past year, a question that asks about all medications currently taken, and a question about any other medical concerns the individual may have. The information from

this pre-deployment health assessment is added to information from a review of the individual's medical record, which would show clinic visits, hospitalizations, medications prescribed, and diagnoses. The medical provider can then determine if any further medical evaluations are needed before making a medical recommendation on the individual's deployability. We are consistently finding that about four percent of those being evaluated at the pre-deployment processing centers have medical problems identified that preclude them from being deployable at that time.

In-theater we have a smaller medical footprint that is agile, mobile and responsive to the needs of the mission. The Far Forward Surgical Teams are doing life-saving surgical care where the injuries are occurring. Transportation to battalion aide stations and combat area surgical hospitals for resuscitation and stabilization is then supported by aeromedical transportation with intensive care capabilities in the air.

We also have medical support for mental health care in-theater. Each branch of Service has specific combat stress and deployment mental health support programs available before, during, and after the deployment cycle. These provide support tailored to the service's mission and risk factors their personnel might face. In

addition, cross-functional planning teams bring together subject matter experts from across the services, the Joint Staff, and DoD. The approach taken by the Army, Combat Stress Control (CSC), is multi-faceted, using unit consultations, system intervention, stress control briefings, suicide prevention briefings and unit needs assessments. These assessments are followed by individual or unit-level interventions, further prevention work, and clinical intake and evaluation when appropriate. The Air Force has a highly mobile, comprehensive system of combat stress and deployment mental health teams. Air Force mental health personnel are currently deployed to 11 locations. Approximately 15 Air Force mental health providers deploy every 4-6 months. The Navy and Marine Corps' approach is to educate and provide the necessary resources to leaders, Marines, and their families to create a community support system to address stressors early, and to prevent, identify, and treat combat/operational stress injuries before, during, and after deployment.

Multi-faith Chaplains are an integral part of the military community. They provide family counseling and care for the spiritual needs of the community. A chaplain is available to every military unit and provides a "ministry of presence" that includes getting to know the needs of the unit. They deploy with units to maintain that presence. Although Chaplains do not provide medical treatment, they offer

confidential counseling and are safe havens for those who need someone to talk with during troubling times. They often facilitate access to other avenues of care. They provide much of the return and reunion educational content for the Army and Marine Corps deployment cycle support program and are an important part of the suicide prevention efforts of each Service.

From March 19, 2003 to May 5, 2007, there have been 26,701 aeromedical transports out of Operation Iraqi Freedom (OIF) theater. Twenty percent have been due to combat injuries and 20 percent have been due to non-combat injuries. The remaining 60 percent have been due to medical conditions that needed evaluation or treatment not available in theater. Mental health conditions have accounted for 16 percent of the medical conditions that were transported out of theater. A study that evaluated the subsequent mental health evaluation and diagnoses in these patients found that fifty percent of patients evacuated for psychiatric reasons did not receive a psychiatric or adjustment disorder diagnosis, which suggested that substantial clinical improvement had occurred since a decision for evacuation was made.

We have 1,082,121 post deployment health assessments from the world wide deployments of Service members from January 1, 2003 to February 12, 2007.

Reviews of these assessments show that ninety-three percent of Active Duty Service members indicate their general health as "good", "very good" or "excellent", twenty-two percent indicate they have medical concerns and five percent indicate they have mental health concerns. Referral rates after discussion with a medical provider show that eighteen percent are referred for further medical evaluation. The referrals are fairly equally divided between "medical" only, "mental health" only and both "medical and mental health". For the Reserve component, ninety percent rate their health has good, very good, or excellent, forty-one percent indicate they have medical problems, and six percent indicate they have mental health concerns, and twenty-four percent are referred.

We have 237,735 post deployment health reassessments from the world wide deployments of Service members from June 2005 to March 2007. Reviews of these assessments show that eighty-five percent of Active Duty Service members indicate their general health as "good", "very good" or "excellent", thirty-three percent indicate they have medical concerns and twenty-seven percent indicate they have mental health concerns. Referral rates after discussion with a medical provider show that sixteen percent are referred for further medical evaluation. The referrals are fairly equally divided between "medical" only, "mental health" only and both "medical and mental health". For the Reserve component, eighty-two

percent indicate their health is good, very good or excellent, fifty-six percent indicate medical concerns, forty-two percent indicate mental health concerns and fifty-one percent are referred.

An important element of the PDHA and the PDHRA is education of the Service members about medical conditions, both physical and mental, and the signs and symptoms that indicate the need for further evaluation.

To better understand the mental health needs of the deployed forces, the Army sent a Mental Health Advisory Team (MHAT) to theater in September and October 2003. This was the first time that such an assessment was conducted during a wartime deployment. The Army has sent Mental Health Advisory Teams to theater three subsequent times, September and October 2004, October and November 2005, August and October 2006 to continue to evaluate adequacy of mental health support in theater and preparation of medical and support staff for mental health care.

Mental health deployment-related research is performed at local, Service, and interagency collaborative levels to maintain quality care in an environment of expanding knowledge. At the present time, 67 deployment-related mental health research projects are being conducted across various DoD, VA, HHS and other

federal and academic organizations. Thirty-two of the 67 projects are focused on Post Traumatic Stress Disorder. Since 1992 an additional 57 mental health research projects related to deployment health were initiated and completed. During the past 14 years more than 150 articles have been published in peer-reviewed medical and scientific journals on mental health deployment-related research.

The Department has also supported mental health research studies to understand responses over time, from pre-deployment to post deployment. These studies have been done anonymously, with the expectation that answers may be more forthright, so this research cannot be used to evaluate a cohort of individuals over time. However, these studies' findings have enabled the Department to make recommendations for improving health care approaches.

A research study on the mental health of Service members returning from OIF and OEF was published in the *New England Journal of Medicine* in 2004. The members of four combat infantry units were surveyed anonymously; 2,530 personnel before deploying to OIF, and another 3,671 personnel three to four months after returning from OIF or OEF. The surveys included screening questions about symptoms of major depression, generalized anxiety disorder, and

posttraumatic stress disorder (PTSD). These screening questions indicate a possible mental health problem, but they do not provide precise medical diagnoses. The study participants reported a very high level of combat experiences, and there was a direct relationship between the level of combat exposure and rate of PTSD. The proportion of personnel who met the screening criteria for each disorder was significantly higher after OIF than after OEF. The rates of each disorder were significantly higher in the post-deployment groups than in the pre-deployment group. In the pre-deployment group, the rates of depression, anxiety, and PTSD were five percent, six percent, and five percent, respectively. In the post-deployment group of Army soldiers deployed to OEF, the rates of depression, anxiety, and PTSD were seven percent, seven percent, and six percent, respectively. In the post-deployment group of Army soldiers deployed to OIF, the rates of depression, anxiety, and PTSD were eight percent, eight percent, and thirteen percent, respectively. In the post-deployment group of Marines deployed to OIF, the rates of depression, anxiety, and PTSD were seven percent, seven percent, and 12 percent, respectively. Personnel who screened positive for any one of these disorders were two times as likely to report concern about possible stigma and other barriers to seeking mental health care, compared to personnel who did not screen positive for a disorder. These barriers included concern about difficulties with getting time off of work for treatment, harm to the individual's

military career, leadership treating the individual differently, or perceptions of weakness.

A research study on the mental health of Service members returning from OIF and OEF was published in the *Journal of American Medical Association* in 2006. This study evaluated the responses on the post-deployment health assessments of all Army soldiers and Marines who completed it between May 1, 2003 and April 30, 2004. This included 222,620 individuals deployed to OIF, 16,318 deployed to OEF, and 64,967 deployed to other locations. The mental health concerns included symptoms of depression, symptoms of PTSD, ideas about suicide or hurting someone else, and serious interpersonal conflicts. The PDHA responses indicate a possible mental health problem, but they do not provide precise medical diagnoses. The prevalence of reporting a mental health problem was 19 percent among personnel returning from OIF, compared to 11 percent of personnel returning from OEF, and eight percent of personnel returning from other locations. Mental health problems were significantly related to combat experiences. More than 50 percent of the OIF personnel who were referred for mental health concerns identified during the PDHA were documented to have received mental health care during the following 12 months. 68,923 (35 percent) of all 222,620 OIF veterans accessed mental health services during the 12 months after they returned home. However,

among these 68,923 individuals who sought mental health care, only one-third received a mental health diagnosis. Only eight percent of the 68,923 individuals had been referred to mental health care during the PDHA screening process.

A research study on the health of Service members one year after returning from OIF was published in the *American Journal of Psychiatry* in 2007. The goal was to evaluate the relationship of PTSD symptoms with physical symptoms. 2,863 soldiers in Army combat units were surveyed anonymously. Physical symptoms included headaches, sleeping problems, stomach pains, back pain, and others (total of 15 symptoms). Soldiers were also asked the number of visits to sick call (primary care) and the number of missed work days in the past month. Sixteen percent of the soldiers met the screening criteria for PTSD. PTSD was significantly associated with each of the 15 physical symptoms. PTSD was also associated with more sick call visits and more missed work days. If the individual met screening criteria for other mental conditions (depression or alcohol misuse), in addition to PTSD, the number of physical symptoms increased. The authors recommended that combat veterans who are seen in medical care for substantial physical symptoms should be evaluated for PTSD and vice versa.

In 2006, Congress directed the Secretary of Defense to establish a task force to examine matters relating to mental health and the military. Task Force members, appointed in May, 2006, included equal numbers of military and civilian mental health professionals. The Task Force is completing a report based on their assessment of available research and survey data, public testimony from experts and advocates, and site visits to 38 military installations throughout the world, including the largest deployment platforms where thousands of Service members, family members, commanders, mental health professionals and community partners were given the opportunity to provide input.

The military health system is second to none in its ability to deliver timely, quality mental health and behavioral healthcare. This includes Behavioral Health in Primary Care, Mental Health Specialty Care, Clinical Practice Guidelines, and ready access to high quality, occupationally relevant primary care, along with model and demonstration programs designed to continuously learn and improve the system of care delivery. In addition, walk-in appointments are available in virtually all military mental health clinics around the world. Because no two individuals are exactly alike, multiple avenues of care are open to our military community to create a broad safety net that meets the preferences of the individual.

DoD does not rely on one single method or program to care for our military members and families.

Early intervention and prevention programs include pre-deployment education and training, suicide prevention training, Military OneSource (1-800-342-9647), the Mental Health Self Assessment Program, National Depression and Alcohol Day Screening, and health fairs (kits available at www.mentalhealthscreening.org). DoD has formed a strong partnership with the Department of Veterans Affairs (VA) and other federal agencies and professional advocacy groups to provide outreach and prevention programs available to Reserve and National Guard members.

Military OneSource is a 24-hour, 7-day-a-week, confidential non-medical counseling program that can be accessed through the telephone, Internet, and e-mail, in addition to confidential family and personal counseling services in local communities across the country. The purpose of Military OneSource counseling is to promote early identification and intervention into life's problems before they reach clinical significance.

The Mental Health Self-Assessment Program began in February 2006. The initial program was designed to serve family members affected by deployments, military members who did not deploy but experience pressures associated with heavy workloads and long hours, and the deploying force who may experience symptoms at a time other than during a formal assessment cycle.

The programs that DoD has put into place to educate and evaluate are intended to provide early recognition of mental health concerns, encourage early health care seeking, early diagnosis and early treatment. As with any medical condition, the expectation is that early intervention will result in better long-term outcomes.

One DoD-VA collaborative study, The Millennium Cohort Study, was designed to evaluate the long-term health effects of military service, specifically deployments. The Department of Defense realized after the 1991 Gulf War that there was a need to collect more information about the long-term health of service members. The Millennium Cohort Study was designed to address that critical need, and the study was underway by 2001.

Funded by the Department of Defense, and supported by military, Department of Veterans Affairs, and civilian researchers, almost 140,000 people have already participated in this groundbreaking study. As force health protection continues to

be a priority for the future of the United States military, the Millennium Cohort Study will be providing a crucial step towards enhancing the long-term health of military service members.

The Department of Defense is very concerned about the short-term and long-term health effects of deployments and military service for all of its Service members. Our ability to analyze medical data related to deployments in a proactive way is enabling us to develop and modify programs to better prepare our Service members and their families for the stressors of military service, to educate them and our leadership on recognizing when to seek medical evaluation for concerns and to make changes when medically indicated. The recent findings of the MHAT IV survey show that not all Soldiers and Marines deployed to Iraq are at equal risk for screening positive for a mental health problem. The level of combat is the main determinant of mental health status. Other factors which contribute to that are strength of leadership and duration of deployment. Since we continuously assess the health of our force, both physical and mental, we will continue to analyze the information to assure we are doing everything possible to protect their health and to provide the care and treatment they need and deserve while they are deployed and when they come home.

We are extremely interested in the upcoming report from the Mental Health Task Force and are committed to work diligently to incorporate their recommendations into the Military Health System's program to care for our warriors and all our beneficiaries. We also appreciate the work of the Independent Review Group on "Rehabilitative Care and Administrative processes at Walter Reed Army Medical Center and National Naval Medical Center," which made recommendations related to mental health care and treatment.

Mr. Chairman, I thank you for the opportunity to provide you and the members of the Committee with an overview of the Military Health System's program to provide mental health care for our Service members and their families. I am ready to answer your questions.

Chairman WAXMAN. Thank you very much, Dr. Kilpatrick.

Dr. Zeiss.

STATEMENT OF ANTONETTE ZEISS

Dr. ZEISS. Thank you, Mr. Chairman and members of the committee. I am pleased to be here today and to discuss the steps the Department of Veterans Affairs is taking to meet the mental health care needs of our Nation's veterans.

As you mentioned, I am accompanied by Dr. Alfonso Batres, Director of Veterans Readjustment Counseling.

I also was here for the entire first panel and agree with the power and importance of that information.

Rehabilitation for war-related PTSD and other military-related readjustment problems along with the treatment of the physical wounds of war, it is central to VA's continuum of health care programs.

Mental health services are provided in all VA medical facilities, including inpatient, outpatient, and substance abuse care. VA also provides services for homeless veterans, including transitional housing, paired with services to address the social, vocational, and mental health problems associated with homelessness.

VA's vet centers provide counseling and readjustment services to returning war veterans. The vet center's service mission goes beyond medical care in providing a holistic mix of services designed to treat each veteran as a whole person in the community setting. Vet centers provide an alternative to traditional access for some veterans who may be reluctant to come to our medical centers and clinics.

Care for Operation Enduring Freedom and Operation Iraqi Freedom veterans is among the high priorities in VA's mental health care system. Since the start of OEF/OIF through the end of the first quarter of fiscal year 2007, over 680,000 service members have been discharged and become eligible for VA care. Of those, over 229,000 have sought VA care. Of those who have sought care with VA, mental health problems are the second most commonly reported health concerns, with almost 37 percent reporting concerns suggesting a possible mental health diagnosis. Of those, PTSD was most frequently implicated, but non-dependent abusive drugs and depressive orders are the next most commonly indicated and are also frequent.

VA's data show that the proportion of new veterans seeking VA care who are identified as possibly having a mental health problem has climbed somewhat over the years. For example, the proportion with possible mental health problems at the end of fiscal year 2005 was 31 percent, compared to 37 percent in the most recent report. For possible PTSD, the proportions of those time points were 13 percent and 17 percent.

There are many possible explanations of this increase. We have discussed extended deployments, possibly more difficult combat circumstances. But we believe also that effective screening and outreach efforts help identify more with possible mental health problems, and VA has also taken and continues to make efforts to destigmatize seeking mental health services.

So, regardless of the causes, there is an increase, and VA is prepared to devote increasing resources to serving these growing mental health needs.

The mental health initiative provides funding for implementation of VA's comprehensive mental health strategic plan. The plan recognizes, as part of its broad vision for enhancement of mental health care, that ongoing war efforts necessitate special attention to the needs of OEF/OIF veterans. We have improved capacity and access, supporting hiring so far of over 1,000 new mental health professionals, with more in the pipeline. We have expanded mental health services in community-based outpatient clinics, with onsite staffing, or by tele-mental health. We have enhanced PTSD, homelessness, and substance abuse specialty care services and programs that recognize the common co-occurrence of these problems.

We are fostering integration of mental health and primary care in medical facility clinics as well as the CBOCs, and in the care of homebound veterans served by VA's home-based primary care program.

We have mental health staff well integrated in the polytrauma care sites, and we are expanding the number of vet centers over the next 2 years.

VA promotes early recognition of mental health problems with the goal of making evidence-based treatments available early to prevent chronicity and lasting impairment. Veterans are screened for PTSD on a routine basis through contact in primary care clinics. When there is a positive screen, patients are further evaluated and, when indicated, referred to a mental health provider for followup. Veterans also are routinely screened in primary care for depression, substance abuse, traumatic brain injury, and military sexual trauma. Screening for this array of mental health problems helps support effective identification of veterans needing mental health services.

I want to thank you again, Mr. Chairman, for having me here today. I will be happy to answer any questions when we come to time for that.

[The prepared statement of Dr. Zeiss follows:]

STATEMENT OF
ANTONETTE ZEISS, PH.D.
DEPUTY CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

MAY 24, 2007

Mr. Chairman and members of the committee, I am pleased to be here today to discuss the ongoing steps that the Department of Veterans Affairs (VA) is taking in order to meet the mental health care needs of our Nation's veterans. I am accompanied by Dr. Alfonso Batres, Director of Veterans Readjustment Counseling. I would like to take this opportunity to describe a general overview of the mental health services provided by VA. VA has devoted resources to develop appropriate programs, and closely follow emerging evidence to refine our understanding and program-development for these retuning veterans.

Overview of Mental Health Care in Medical Facilities

VA provides mental health services to veterans in all our medical facility patient care settings. I will provide an overview of all these services, since returning veterans will need this full array of VA services, and I will focus more specifically on some newly developed programs for our returning veterans.

Mental health services are provided in specialty mental health settings in all medical facilities, including inpatient, outpatient, and substance abuse care. VA also provides services for homeless veterans, including transitional housing paired with services to address the social, vocational, and mental health problems that contributed to becoming homeless. In addition, mental health care is being integrated into primary care clinics, community-based outpatient clinics, VA nursing homes, and residential care facilities. Veterans with PTSD are served by mental health professionals with specialized expertise in all medical facilities, and VA has inpatient and residential rehabilitation options across the country. Veterans with a serious mental illness are seen in specialized programs, such as mental health intensive case management, psychosocial rehabilitation and recovery day programs and work programs. VA employs full and part time psychiatrists and full and part time psychologists who work in

collaboration with social workers, mental health nurses, counselors, rehabilitation specialists, and other clinicians to provide a full continuum of mental health services for veterans. The numbers of these mental health professionals have been growing steadily in the last two and a half years as a result of focused efforts to build mental health staff and programs. Appropriate attention to the physical and mental health needs of veterans will have a positive impact on their successful re-integration into the U.S. economy and society as a whole. Accurate VA projections for staffing needs and funding costs will ensure ready access to adequate and timely mental health and social services.

We have seen that many returning veterans have injuries of the mind and spirit as well as the body. For veterans of prior eras, we have learned that mental disorders can increase the risk for certain physical illnesses, and vice versa. In addition, current returning veterans experience events that result in both physical and emotional injuries. Our goal is to treat a veteran as a whole patient – to treat a patient's physical illnesses as well as any mental disorders he or she may be facing.

Access To Mental Health Services Through Vet Centers

In addition to the care described in medical facilities and their related CBOCs, VA's Vet Centers provide counseling and readjustment services to returning war veterans. It is now well established that rehabilitation for war-related PTSD and other military-related readjustment problems, along with the treatment of the physical wounds of war, is central to VA's continuum of health care programs specific to the needs of veterans. The Vet Center service mission goes beyond medical care in providing a holistic mix of services designed to treat the veteran as a whole person in his/her community setting. Vet Centers provide an alternative to traditional access for mental health care some veterans may be reluctant to access in our medical centers and clinics. Vet Centers are staffed by interdisciplinary teams that include psychologists, nurses and social workers.

VA will be expanding the number of Vet Centers from 209 to 232 over the next two years. Some Vet Centers have established telehealth linkages with VA medical centers that extend VA mental health service delivery to remote areas to underserved

veteran populations, including Native Americans on reservations at some sites. Vet Centers also offer telehealth services to expand the reach to an even broader audience. Vet Centers address the psychological and social readjustment and rehabilitation process for veterans and support ongoing enhancements under the VA Mental Health Strategic Plan.

Vet Centers provided readjustment counseling services to over 228,000 all-era combat veterans in Fiscal Year 2006 and, of these, over 127,000 veterans were provided substantial face to face counseling services, and over 101,000 veterans were seen on outreach. The Vet Centers provided over one million visits to veterans in Fiscal Year 2006.

The Vet Center program addresses the veteran's full range of needs within the family and community. The service functions provided to veterans by the Vet Center program are as follows:

- Community-based service units emphasizing post-war rehabilitation in an informal setting;
- Extensive community outreach activities;
- A varied mix of direct counseling and supportive social services addressing the holistic psycho-social needs of veterans in their post-war readjustment;
- Assessment for war-related readjustment problems to include PTSD in all cases;
- Assessment and treatment of military related sexual trauma; and
- Family counseling when needed for the readjustment of the veteran.

Since 2003, the Vet Centers also provide bereavement services to surviving family members of service men and women killed while serving on active duty. The Vet Center strategy is to intervene early to facilitate a successful post-war readjustment in a safe and confidential setting. The bereavement program has seen over 1,200 family members of over 900 fallen warriors most of whom were killed in action in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF).

OEF/OIF Veterans

Care for OEF/OIF veterans is among the highest priorities in VA's mental health care system. For these veterans, VA has the opportunity to apply what has been learned through research and clinical experience about the diagnosis and treatment of mental health conditions to intervene early; and to work to prevent the chronic or persistent courses of illnesses that have occurred in veterans of prior eras.

In response to the growing numbers of veterans returning from combat in OEF/OIF, the Vet Centers initiated an aggressive outreach campaign to welcome home and educate returning service members at military demobilization and National Guard and Reserve sites. Through its community outreach and brokering efforts, the Vet Center program also provides many veterans the means of access to other Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) programs. To augment this effort, the Vet Center program recruited and hired 100 OEF/OIF veterans to provide the bulk of this outreach to their fellow veterans.

Medical facility programs also have been established to do "inreach" to OEF/OIF veterans and provide education, support, and mental health specialty services when needed. These programs are established in most facilities, beginning with sites that had the highest rates of returning veterans, and continue to be expanded each year. In addition, we have placed mental health specialists in all four of the initial national Polytrauma Centers and now in the 21 VISN Polytrauma programs. We recently funded a Transitional Housing program for veterans who have needed polytrauma care, with mental health staff fully represented. Throughout VHA, there is a sense of urgency about reaching out to OEF/OIF veterans, engaging them in care, screening them for mental health conditions, and making diagnoses when appropriate.

Since the start of OEF/OIF through the end of the first quarter of FY 2007, 686,306 service members have been discharged and become eligible for VA care. Of those, 229,015 (33%) have sought VA care. Of those that have sought care (33%), mental health problems are the second most common, with 37 percent (83,889)

reporting concerns that lead to a mental health diagnosis or indicate that one is possible and should be further evaluated.

While VA must be attentive to PTSD, we also must ensure that evaluation is comprehensive and attentive to mental health problems generally, so that we can provide the best evaluation, diagnosis, and treatment for returning veterans. Of those reporting a possible mental health concern, Post Traumatic Stress Disorder (PTSD) was most frequently implicated (39,243), with Nondependent Abuse of Drugs (33,099), and Depressive Disorders (27,023) the next most commonly suggested problems.

In addition, VA is aware that the proportion of new veterans seeking VA care who are identified as having a possible mental health problem has climbed over the years. For example, the proportion with mental health concerns in the report at the end of FY 2005 was 31 percent, compared to 37 percent in the most recent report. There are many possible explanations of this finding including: extended deployments, more difficult circumstances, and positive impact of efforts to destigmatize the seeking of mental health services. Regardless of the causes, VA is aware that there is an increasing demand for mental health-related services. VA is prepared to devote increasing resources to serving these growing mental health needs. The utilization pattern for war veterans from other eras indicates that these veterans will require sustained services and will increase in numbers over time.

Since the beginning of hostilities in Afghanistan and Iraq, the Vet Centers have seen over 165,000 OEF/OIF veterans, of which almost 116,000 were outreach contacts seen primarily in group settings at military demobilization and National Guard and Reserve sites. A similar outreach program conducted during the first Gulf War received the commendation of the President's Advisory Committee on Gulf War Veterans' Illnesses.

Mental Health Strategic Plan and the Mental Health Initiative

VHA completed its Comprehensive Mental Health Strategic Plan (MHSP) in 2004 and began implementation in spring 2005. Our strategic plan reinforces that mental health is an important part of veterans' overall health. VA is committed to eliminating

barriers separating mental health from the rest of health care. The plan also recognizes the needs of our returning OEF/OIF veterans.

The Mental Health Initiative was established to provide funding to support the implementation of the MHSP outside of the Veterans Equitable Resource Allocation (VERA) model. To assist in planning the funding for the Mental Health Initiative, the MHSP was divided into four key areas—(1) enhancing capacity and access for mental health services; (2) integrating mental health and primary care; (3) transforming mental health specialty care to emphasize recovery and rehabilitation; and (4) implementation of evidence-based care. There are multiple funded programs in each of these areas. We have improved capacity and access in numerous ways, supporting hiring of new mental health professionals throughout the system. Moreover, we have expanded mental health services in Community Based Outreach Clinics either with on-site staffing or by telemental health, thus providing care closer to the homes of veterans in rural areas. We also have enhanced both PTSD and substance abuse specialty care services, and programs that recognize the common co-occurrence of these problems. We are fostering the integration of mental health and primary care by funding evidence-based programs in over 80 sites, with more being planning stages, as well as through the already-mentioned placement of mental health staff in CBOCs. In addition, we are extending this principle to the care of home-bound veterans by funding mental health positions in Home Based Primary Care. This program has traditionally served older veterans, but current needs show that it also will serve some seriously wounded OEF/OIF veterans. It can allow veterans to live at home, with their families, as an alternative to institutional long-term care, when injuries are profound and sustained rehabilitation and other care is needed. The mental health professionals who will work with these teams also can support the family caregivers, who provide heroic care for injured veterans.

VA will be working to emphasize recovery and rehabilitation in specialty mental health services by funding additional psychosocial rehabilitation programs, expanding residential rehabilitation services, increasing the number of beds and the degree of

coordination in homeless programs, extending Mental Health Intensive Case Management, and funding a recovery coordinator in each medical center.

Post Traumatic Stress Disorder

VA's approach to PTSD is to promote early recognition of this condition for those who meet formal criteria for diagnosis and those with partial symptoms. The goal is to make evidence-based treatments available early to prevent chronicity and lasting impairment. Screening veterans for PTSD is a vital first step towards helping veterans become resilient and recover from the psychological wounds of war. Veterans are screened on a routine basis through contact in Primary Care Clinics. In instances when there is a positive screen, patients are further evaluated and referred to a mental health provider for further follow-up, as necessary.

If a veteran first enters the system through a clinical program other than primary care, screening for PTSD will be done in that setting. In addition, screening occurs for depression, substance abuse, and military sexual trauma. Recently, screening for Traumatic Brain Injury (TBI) became a standard component of VA's screening. While TBI is not a mental health problem, it has many intersections with mental health problems and its recognition is an essential component of holistic care.

Screening is only valuable if the system is set up to note positive screens and conduct timely follow-up of them. When the follow-up reveals there is a likely diagnosis, or early signs that a veteran is having increasing mental health problems, timely treatment for those problems is necessary. VA has the capacity to provide screening, evaluation of positive screens, and appropriate treatment. As we continue to implement the Mental Health Strategic Plan, which has guided the efforts described, and continue to benefit from the funding available in the Mental Health Enhancement Initiative, our capacity will continue to grow, to enable us to continue serving a growing number of returning veterans.

In providing follow-up, we have outpatient and inpatient programs available (a total of over 220 programs and more in development). We have extensive training efforts in a variety of different approaches including Cognitive Processing Therapy and Prolonged Exposure Therapy. We are partnering with the Department of Defense (D0D) to make these training opportunities available to DoD mental health staff.

Medications can be an effective component of care for PTSD, but have not been shown to have the same level of effectiveness in both alleviating symptoms and restoring function and performance. Our integrated care system allows coordination of effective psychotherapy with needed medication supports.

Sometimes mild to moderate PTSD symptoms, without a full diagnosis, represent normal reactions to highly abnormal situations. Many returning veterans will recover without treatment, with support from their families, communities, and employers. In fact, what is most striking about our service members and veterans is not their vulnerability, but their resilience. When people prefer treatment, we encourage it. When they are reluctant, we watch them over time, and urge treatment if symptoms persist or worsen.

Suicide Prevention

Suicide prevention is a major priority for VA and we are on the watch for suicide among our veterans. Research about suicides among OEF/OIF returnees is currently under way to teach us more about how to address the issues surrounding this tragic event.

VA also set aside our first Suicide Prevention Awareness Day, which fell on March 1, 2007 this year. We plan on this becoming an annual event. During our first Suicide Prevention Awareness Day, VA staff members who come in contact with patients received training on how to assess and respond to crisis situations. Our goal is to make the point that in VA, suicide prevention is everyone's business—not just that of our mental health providers—everyone who comes into contact with our veterans and their families plays an important role.

Conclusion

The mental health needs of our veterans are as important as their physical needs. We acknowledge the need to reevaluate and improve the mental health care and services provided to our Nation's veterans and we are committed to ensuring that VA provides the highest quality of care possible. Thank you again Mr. Chairman for having me here today. I will answer any questions that you or other members may have.

Chairman WAXMAN. Thank you very much, Dr. Zeiss.

Dr. Insel.

STATEMENT OF THOMAS INSEL

Dr. INSEL. Thank you, Mr. Chairman. I am honored to be here and glad you thought to include someone from the NIH in this hearing.

You have my written testimony. I think, given the time and the number of witnesses here, I am going to just very quickly summarize what I think is most important for us to think about.

As you listened, and as I did, to the first panel, I think it is important to recognize there are kind of two classes of issues that we are hearing about. One class of issues has to do with what many of the people on the committee called the problems of stigma, the problems of the cracks in the system, the ripple effect of mental illness on family members and on others. Those are not unique to this war. They are not unique to this situation. They are really problems that we have for a range of mental illnesses throughout this society.

As we think about what the fix is here and how we address them, actually we may be able to learn some things from what DOD and the VA are doing which may, in fact, be ahead of the curve.

There are other issues, of course, that are going to be unique that have to do with the policies that came up in some of your questions, and there will be, I am sure, an opportunity to talk more about those. But I want to go back to this issue about whether this may be an example that we can learn from.

Your first comments this morning, Mr. Chairman, involved a memo that you received from the L.A. County Department of Mental Health, and I think that is an important signal to us that this is not simply a problem for the VA or for DOD. This is a problem for mental health care throughout the country. Much of what we call the burden of illness, the public health challenge here, will spill over to the public sector to mental health care in the civilian sector.

One of the questions I hope we will have a chance to think about is: are we prepared for that? What will that burden look like? How many people are we talking about, and what are the resources to address that?

I look forward to the questions and hopefully a chance to discuss those issues further.

[The prepared statement of Dr. Insel follows:]

Testimony
Before the Committee on Oversight and Government Reform
United States House of Representatives

Post-Traumatic Stress Disorder Research at the National Institute of Mental Health

Statement of
Thomas R. Insel, M.D.
Director
National Institute of Mental Health
National Institutes of Health
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 9:30 a.m.
May 24, 2007

Good morning Chairman Waxman and members of the Committee. I am pleased to present a brief review of the research activities in post-traumatic stress disorder research at the National Institutes of Mental Health (NIMH) at the National Institutes of Health, an agency of the Department of Health and Human Services (HHS).

What is Post-Traumatic Stress Disorder?

Post-traumatic Stress Disorder (PTSD) is a chronic medical disorder that follows exposure to an overwhelming traumatic event. The main features are intrusive thoughts including flashbacks, avoidance of things that recall the trauma, and hyperarousal (sleeplessness, restlessness, irritability). While some of these symptoms may be common for most people after a traumatic event, the hallmark of PTSD is a failure to recover psychologically from the trauma, with consequent impairment of normal functioning. The majority of those with PTSD meet the diagnostic criteria for several psychiatric disorders, especially depression and substance abuse, and many also attempt suicide. Significant health problems are also more likely to occur in individuals with PTSD than in those without the disorder, particularly hypertension, asthma, and gastrointestinal problems.

As many as 3.5% of Americans meet criteria for PTSD in any given year in the general population. Since World War II we have seen a wave of combat veterans with increased rates of PTSD. Much progress has been made since the Vietnam War, in which 18-20% of veterans were reported to be affected with PTSD. Scientists have developed effective therapies such as cognitive behavioral therapy and medications. We have learned much about the brain's fear circuitry and are currently developing new medications that will

help influence fear and related responses to highly stressful events. This new information on the brain's circuitry has led to a focus on prevention of PTSD as a realistic and important goal.

What is the PTSD Burden for Current Military Service Members?

Despite the high risk of mental health problems among veterans returning from Iraq and Afghanistan, we do not have a definitive picture of the prevalence of PTSD in this population. A recent study of Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) veterans first seen at Department of Veterans Affairs (VA) health care facilities found that 25% received mental health diagnoses, such as PTSD, depression, anxiety disorders, or substance abuse disorders. More than 50% of these had more than one co-occurring mental health disorder, but the most common mental disorder of all was PTSD, affecting 13% of all veterans, well above the rate of 3.5% found in the general American population.

While these numbers are of great concern, research to date with OIF/OEF veterans indicates that for those identified as having problems, most received their diagnosis within days of their first VA clinic visit – thus, early on, when the opportunity is greatest for providing early evidence-based treatments. However, we also know that the veterans who are experiencing mental health problems have a low rate of actually seeking mental health services, about 23-40% of those who need these services. Thus, as with other groups within the United States, many of those in need of mental health services do not actually obtain care.

Based on earlier research with the veterans of Vietnam, it is likely that the mental health burden for OIF/OEF will increase as time goes on, with new cases becoming evident and untreated problems becoming chronic. About 29% of OIF/OEF returned veterans have already enrolled in VA health care, a figure that exceeds the estimated 10% rate observed after the return of the Vietnam veterans. As the number of OIF/OEF veterans grows, their continued care will remain a national health care concern. It is important to remember that the burden of illness spans beyond symptoms to functional disability and applies not only to those who have served in the military and suffer from deployment-related problems, but also to their families, who may go from feelings of apprehension during deployment to a sense of confusion and helplessness when their loved one returns with PTSD.

How Does Co-Occurring Illness Add to Risk?

In the general population, about 75% of people with PTSD will have a co-occurring disorder, with the most common being depression, often complicated with alcohol or substance abuse. There are no comparable statistics yet for OIF/OEF veterans.

The risk of PTSD is increased in those with physical trauma and increases proportionally with the amount of direct exposure to combat-related trauma. More research is essential to determine what features of physical trauma predict the greatest adjustment-related problems. There is also a need to understand how traumatic brain injury (TBI), PTSD, and substance abuse interact, as all are associated with problems in attention, mood regulation, and impulse control, potentially reducing the effectiveness of current treatments for PTSD.

While each condition separately has received extensive study in other populations, there is very little data with respect to the interplay of PTSD and other medical conditions in service members in the initial phase following their return from deployment. There is limited epidemiologic research that examines the adjustment of service members with TBI, alcohol/substance abuse, and/or other mental and medical health conditions and that considers how these factors that might interact with stress exposure and could influence adjustment.

What Is NIMH Doing About PTSD?

The psychological consequences of war were an important focus when NIMH was created 60 years ago. In recent years, the NIMH has strengthened its ties to the VA and the Department of Defense (DoD) to coordinate what we know and need to know regarding the magnitude and nature of mental health needs related to deployment and war related trauma, identify determinants of help-seeking and care provision, accelerate the discovery of fundamental knowledge needed to improve treatment, prevent mental disorders, and ensure that all those who might benefit from mental health care receive it. NIMH's investment in PTSD research overall has gone from $15 million in FY 1997 to approximately $45 million in FY 2006. Of this, approximately $5.2 million in FY 2006 supported research grants specifically focused on PTSD with active duty or veteran populations.

Several recent activities involving NIMH, DoD and VA have helped to identify areas in which each agency might focus its own research agenda, as well as areas of mutual interest where collaboration is needed to improve problem identification, access, use and

effectiveness of services. For example, in September 2005, NIMH, DOD and VA issued a joint Request For Applications to accelerate research on the identification, prevention, and treatment of combat related post-traumatic psychopathology and similar adjustment problems. Together, NIMH and the VA awarded approximately $1.2 million to support six new projects in 2006 targeting mental health needs of Active Duty, Guard and Reserve personnel returning from Iraq or Afghanistan. In addition, NIMH maintains an active Program Announcement (PA-04-075 "Mental Health Consequences of Violence and Trauma") for DoD, VA, and civilian researchers to enhance scientific understanding about the etiology of psychopathology related to violence and trauma, as well as studies to develop and test effective treatments, services, and prevention strategies in this area. The following questions guide our research effort:

- Why are some individuals vulnerable and other resistant to PTSD following a traumatic event? How can we predict who will be at greatest risk?

One of the most important goals of current research is identifying risk factors, using powerful new tools such as genomics and neuroimaging. In one such effort, a collaborative study between the NIMH Intramural Program and DoD is studying soldiers who appear highly resilient to stress and trauma. In another study, individuals are followed after a traumatic event to identify biomarkers or risk factors that will predict PTSD.

- What can we do to prevent or preempt PTSD?

New initiatives in FY2008 include projects to advance the prevention of post-deployment mental health problems among members of high-risk occupations who regularly encounter traumatic situations, such as firefighters, police officers, rescue workers, and military personnel. Occupations that involve exposure to trauma at higher-than-average

frequency present unique opportunities to test the effectiveness of preventive interventions that target trauma-related mental disorders. From a public health and national security perspective, attending to the mental health of the men and women who respond to emergencies, defend our national interests, and maintain a civil society can be viewed as strengthening our national infrastructure.

- What are the opportunities for novel treatments or prevention of PTSD?

Several avenues for new treatments are currently being explored. New medications that appear to selectively affect the encoding of traumatic memories are being tested with promising results. While psychological treatments have been shown to be effective, not everyone will or can access these treatments. In partnership with VA, DoD, and civilian researchers, NIMH is actively trying to make effective psychosocial treatments such as cognitive behavioral therapy more widely available, along with Internet-based self-help therapy and telephone assisted therapy. In the last decade, rapid progress in research on the mental and biological foundations of PTSD has led scientists to focus on prevention. For example, NIMH-funded researchers are exploring new and orphan medications thought to target underlying causes of PTSD in an effort to prevent the disorder. Other research is attempting to enhance cognitive, personality, and social protective factors and to minimize risk factors to ward off full-blown PTSD after trauma.

Much has been learned about PTSD since the Vietnam War, when many in the general public doubted whether PTSD was a true disorder. We now understand PTSD as a brain disorder. As imaging technologies and genomic research improve, scientists are likely to be able to pinpoint individual risk, which may then lead to better personalized treatments as well as prevention. Thank you for the opportunity to present the progress we have

made to date and share with you the glimpse of new opportunities afforded by research in understanding and treating this serious illness. I look forward to answering your questions.

Chairman WAXMAN. Thank you very much, Dr. Insel.

Major General Gale Pollock.

STATEMENT OF MAJOR GENERAL GALE POLLOCK

General POLLOCK. Chairman Waxman and distinguished members of the committee, thank you for providing me the opportunity to address you on this very important subject.

I am Gale Pollock, acting Surgeon General of the Army and commander of the U.S. Army Medical Command. I am here today to discuss the array of behavioral health services designed to support our warriors and their families.

The U.S. Army Medical Command is an imperfect organization. The 34 military treatment facilities over which I exercise command authority are all imperfect organizations. They make mistakes. Despite cutting-edge technology, health care still remains as much art as science. Sometimes, despite our best efforts and the best care, our patients still have tragic outcomes.

Whenever we have less than optimal outcomes, it affects every one of us. To the soldiers and their family members on the first panel, I paused after the panel to extend my condolences for the pain and suffering that they have gone through and I thanked them for their courage to testify today, and I thank you, because, although the U.S. Army Medical Department is an imperfect organization, we are, more importantly, a striving organization, because we strive to be perfect. We strive to improve every day and with every patient encounter. These tragic stories give us the opportunity to examine our systems and processes and do everything possible to ensure that, whenever possible, these mistakes are not repeated.

After every sub-optimal outcome, our team can evaluate their performance, assess our processes, and determine if we can improve any aspect of the care we provide.

On the battlefield, we know that the majority of our casualties die from loss of blood. Our clinicians and researchers focus their considerable intellect and effort on this reality and developed equipment, techniques, and procedures to save lives. The result is that 91 percent of warriors injured on the battlefield survive their wounds, and this rate of survival is unprecedented in the history of warfare. Yet, it is still not perfect, and our researchers and experts continue to strive to find better ways to provide higher quality battlefield care, to develop better products to stop bleeding, and to conduct better training to save more lives.

We are equally committed to saving lives and improving lives where the injuries are not visible. Although an array of behavioral health services were available to our beneficiaries before the global war on terror began, we have steadily improved over the past 5 years as the identified needs of our populations have changed.

Since the attacks on 9/11, the post-deployment health assessment was revised and updated, and in the fall of 2003 we launched the first mental health advisory team into theater. Never before had the mental health of combatants been studied in a systematic manner during conflict. Three subsequent mental health advisory teams in 2004, 2005, and 2006 continued to buildupon the success

of the original and further influence our policies and procedures, not only in theater but before and after deployment, as well.

Based on those recommendations, we have increased the distribution of behavioral health providers and expertise throughout the combat theater, and access to care and quality of care have improved as a result.

In 2004, researchers at the Walter Reed Army Institute of Research published initial results of a ground-breaking land combat study which provided insights related to the care and treatment of soldiers upon return from combat experiences, and led to the development of the post-deployment health reassessment.

In 2005, the Army rolled out the post-deployment health reassessment to provide soldiers with the opportunity to identify any new physical or behavioral health concern that they were experiencing that was not present immediately after their redeployment. This assessment includes an interview with a health care provider and has been very effective for identifying more of the soldiers, but, unfortunately, not all, who are experiencing some of the symptoms of stress-related disorders, and getting them the care they need before their symptoms manifest into more serious problems.

We continue to review the effectiveness of this process and will add or edit questions as needed.

In 2006, we piloted a program at Fort Bragg, NC, intended to reduce the stigma, of which many of us are very aware. The RESPECT.MIL pilot program integrated behavioral health into the primary care setting, providing education, screening tools, and treatment guidelines to the primary care providers. It has been so successful at Fort Bragg that we are currently rolling that program out to 15 other sites across the Army.

Also in 2006 the Army incorporated the deployment cycle support program with a new training program called battle mind. Prior to this war, there had been no empirically validated studies to mitigate combat-related mental health problems, so we have been evaluating the post-deployment assessments and training now using scientifically rigorous methods with good initial results. It is a strength-based approach that highlights the skills that help soldiers survive in combat, instead of focusing on the negative effects of combat.

Our striving has continued in 2007, because we have expended battle mind training with modules for pre-deployment training and for spouses. Our behavioral health Web site went live in March, and I stood up a behavioral health proponency office specifically to deal with these issues. A new PTSD training course starts in June, and, as you noted, the preliminary recommendations of the Mental Health Task Force were released in May, with a final report expected this summer.

Traumatic brain injury is emerging as a common blast-related injury. An overwhelming majority of these patients have mild and moderate concussive syndromes with symptoms not different from those experienced by athletes with a history of concussion, but many of these symptoms are similar to post-traumatic stress symptoms, especially those of difficulty concentrating and irritability. However, we must not confuse TBI with PTSD. TBI is the result of physical damage to the brain, and, as such, requires different

screening, diagnosis, and treatment approaches. It is important that all providers are able to recognize these similarities and consider the effect of blast in their diagnosis.

The Congress has provided incredible financial support to allow us to better understand and treat both PTSD and TBI. Let me thank you for that and assure you that we will invest the money in a focused manner that allows us to make a difference in the lives of soldiers, sailors, marines, and airmen immediately.

The Army and the Army Medical Department are committed to provide a level of care, physical, emotional, and spiritual, that is equal to the quality of service provided by these great warriors. We recognize our imperfections and are striving daily to improve.

I look forward to your questions.

Chairman WAXMAN. Thank you very much.

Dr. Fairbank, before I call on you, you might have heard the bells. That indicates that a vote is on the House floor. We are going to have to respond to those votes. There are four votes. I think we had better anticipate reconvening at maybe 1:45. That will give you a chance to get something to eat, and then we will meet back in this room at 1:45. We will hear from you and then we will have questions for all of you.

Thank you. We stand in recess.

[Recess.]

Chairman WAXMAN. The committee will come back to order.

Dr. Fairbank, we would like to hear from you.

STATEMENT OF JOHN A. FAIRBANK

Dr. FAIRBANK. Thank you. Good afternoon, Mr. Chairman and members of the committee. Thank you for the opportunity to testify on behalf of the members of the National Academy of Science's Committee on Veterans Compensation for Post-Traumatic Stress Disorder.

Our committee recently completed a report entitled PTSD Compensation and Military Service that addresses topics under consideration in this hearing. I am here today to present a few of the conclusions of that report and to share my experience as a former VA psychologist and as a researcher on PTSD and veterans' health. These remarks are a summary of my written testimony.

I was asked to address whether there has been adequate preparation for the men and women returning home from Operation Iraqi Freedom and Operation Enduring Freedom. Our committee's report made several recommendations relevant to this question. Specifically, our review of the scientific literature and VA's current compensation and pension practices identifies areas where changes might result in more consistent and accurate ratings for disability associated with PTSD.

There are two primary steps in the disability compensation process for veterans. The first of these is a compensation and pension [C&P], examination. Testimony presented to my committee indicated that clinicians often feel pressured to severely constrain the time that they devote to conducting a PTSD examination. The committee believes that the key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced mental health professional.

Many of the problems and issues with the current process can be addressed by consistently allocating and applying the time and resources needed for a thorough examination. The committee recommended that a system-wide training program be implemented for the clinicians to conduct these exams in order to promote uniform and consistent evaluations.

The second primary step in the compensation process is a rating of the level of disability associated with a veteran's service connected disorders. The committee's review of VA's ratings practices found that the criteria used to evaluate the level of disability resulting from service-connected PTSD were, at best, crude and overly general. It recommended that new criteria be developed and applied.

As part of this effort, the committee suggested that VA take a broader and more comprehensive view of what constitutes PTSD disability. The committee believes that the current criteria unduly penalize veterans who may be capable of working but who are significantly symptomatic or impaired in other dimensions and may thus serve as a disincentive to both work and recovery.

In order to promote more accurate, consistent, and uniform PTSD disability ratings, the committee also recommended that VA establish a certification program for raters who deal with PTSD claims. Rater certification should foster greater confidence in ratings decisions and in the decisionmaking process.

Early in my career I was a co-principal investigator for the National Vietnam Veterans Readjustment Study [NVVRS], and served as a VA staff psychologist working primarily with Vietnam War combat veterans. I was asked to comment on what the lessons of Vietnam tell us about today.

First, I would like to make clear that our committee's report did not address this topic and that these are my own observations.

The intent of the NVVRS was to provide an empirical basis for the formulation of policy related to Vietnam veteran psycho-social health, especially PTSD. In a paper, my colleagues and I reported that families of veterans with PTSD were more likely to suffer domestic violence than the families of veterans without PTSD. In addition, we found that children of the veterans with PTSD manifested significantly higher levels of behavioral and emotional problems than children of veterans without PTSD, and that more than one-third of veterans with PTSD had a child with behavioral or emotional problems.

In my opinion, this finding of multiple severe problems in the families of veterans with PTSD made 15 years after the end of the Vietnam War has important implications for today's service men and women returning from OIF/OEF. Specifically, our Vietnam era findings suggest that a significant number of current members of our armed forces will need access to effective treatments for war-related PTSD and its co-morbid conditions, and, similarly, their spouses and children will need access to trauma informs, treatments, and services.

A hard lesson learned from our Nation's response to Vietnam veterans is that we do not want to delay doing our best to prevent war-related PTSD from wreaking havoc on the futures of our OIF/OEF veterans and their families.

An enduring and distressing memory of my work as a VA psychologist was trying to help veterans and their spouses process and recover from the shock, disappointment, anger, and sense of betrayal that so often accompanied denial of benefits or compensation for the psychological and emotional toll that war zone stress had taken on their lives in the form of PTSD. More often than not, a profound sense of unfairness lay at the heart of their reactions.

The PTSD C&P evaluation disability ratings process has improved considerably since the late 1980's, but, as our committee's report suggests, much more may be done to enhance confidence in PTSD compensation ratings decisions and ultimately to improve this process for veterans returning from combat and for their families.

Thank you for your attention. I am happy to respond to your questions.

[The prepared statement of Dr. Fairbank follows:]

OBSERVATIONS ON POSTTRAUMATIC STRESS DISORDER AND MILITARY SERVICE

Statement of

John A. Fairbank, Ph.D.
Associate Professor of Medical Psychology,
Co-Director of the UCLA–Duke University National Center for Child Traumatic Stress
Duke University Medical Center
and
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Institute of Medicine and National Research Council
The National Academies

before the

Committee on Oversight and Government Reform
U.S. House of Representatives

May 24, 2007

Good morning, Mr. Chairman and members of the Committee. My name is John Fairbank and I am Associate Professor of Medical Psychology in the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center and Co-Director of the National Center for Child Traumatic Stress. I want to thank you for the opportunity to testify on behalf of the members of the Committee on Veterans' Compensation for Posttraumatic Stress Disorder. The committee was convened under the auspices of the National Research Council and the Institute of Medicine. These institutions are operating arms of the National Academy of Sciences, which was chartered by Congress in 1863 to advise the government on matters of science and technology. The work of the committee was requested by the Department of Veterans Affairs (VA), which provided funding for the effort.

Our committee recently completed a report entitled *PTSD Compensation and Military Service* that addresses topics under discussion in this hearing. I'm pleased to be here today to present a few of the conclusions of that report and to share with you some observations drawn from my experience as a VA psychologist and as a researcher on PTSD and veterans' health.

I'd like to begin with some background information on posttraumatic stress disorder. PTSD, in brief, is a psychiatric disorder that can develop in a person who experiences, witnesses, or is confronted with a traumatic event, often one that is life-threatening. It is characterized by a cluster of symptoms that include:

- reexperiencing—specifically, intrusive recollections of a traumatic event, often through flashbacks or nightmares;
- avoidance or numbing—efforts to avoid anything associated with the trauma and a general numbing of emotions; and
- hyperarousal—often manifested by difficulty in sleeping and concentrating and by irritability.

PTSD is one of an interrelated and overlapping set of possible mental health responses to combat exposures and other traumas encountered in military service. While the term "posttraumatic stress disorder" has only been part of the lexicon since the 1980's, the symptoms associated with it have been reported for centuries. In the U.S., expressions including *shell shock*, *combat fatigue*, and *gross stress reaction* have been used to label what is now called PTSD.

I was asked to address whether there has been adequate preparation for the men and women returning home from Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF). Our committee's report makes several recommendations relevant to this question. Specifically, the committee's review of the scientific literature and VA's current compensation and pension practices identified areas where changes might result in more consistent and accurate ratings for disability associated with PTSD.

There are two primary steps in the disability compensation process for veterans. The first of these is a compensation and pension, or *C&P*, examination. These examinations are conducted by VA clinicians or outside professionals who meet certain education and

licensing requirements. Testimony presented to the committee indicated that clinicians often feel pressured to severely constrain the time that they devote to conducting a PTSD C&P examination—to as little as 20 minutes—even though the best practice manual for the exams specifies a protocol that can take three hours or more to properly complete. The committee believes that the key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced mental health professional. Many of the problems and issues with the current process can be addressed by consistently allocating and applying the time and resources needed for a thorough examination. The committee recommended that a system-wide training program be implemented for the clinicians who conduct these exams in order to promote uniform and consistent evaluations.

The second primary step in the compensation process for veterans is a rating of the level of disability associated with service-connected disorders identified in the clinical examination. This rating is performed by a VA employee using the information gathered in the C&P exam. The committee's review of these VA ratings practices found that the criteria used to evaluate the level of disability resulting from service-connected PTSD were, at best, crude and overly general. It recommended that new criteria be developed and applied that specifically address PTSD symptoms and that are firmly grounded in the standards set out in the *Diagnostic and Statistical Manual of Mental Disorders* used by mental health professionals. As part of this effort, the committee suggested that VA take a broader and more comprehensive view of what constitutes PTSD disability. In the current scheme, occupational impairment drives the determination of the rating level.

Under the committee's suggested framework, the psychosocial and occupational aspects of functional impairment would be separately evaluated, and the claimant would be rated on the dimension on which he or she is more affected. The committee believes that the emphasis on occupational impairment in the current criteria unduly penalizes veterans who may be capable of working, but who are significantly symptomatic or impaired in other dimensions, and it may thus serve as a disincentive to both work and recovery.

Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because of the inherently subjective nature of symptom reporting. In order to promote more accurate, consistent, and uniform PTSD disability ratings, the committee recommended that VA establish a certification program for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification. The committee believes that rater certification will foster greater confidence in ratings decisions and in the decision-making process.

Earlier in my career, I was a co-principal investigator for the National Vietnam Veterans Readjustment Study—the NVVRS—and served as a VA staff psychologist, working primarily with Vietnam War combat veterans. I was asked to comment on what the lessons of Vietnam tell us about today and how my experience provides perspective on this issue. I'd like to make clear at the outset that the committee's report did not directly address this topic and that these are my own observations.

Nearly 25 years ago, in response to unanswered questions about Vietnam veterans' postwar adjustment, the Congress enacted Public Law 98-160, which in part directed the VA to arrange for an independent, scientific study of the adjustment of Vietnam veterans. The intent of the study was to provide an empirical basis for the formulation of policy related to veterans' psychosocial health, especially PTSD. Findings from the National Vietnam Veterans Readjustment Study were first presented to Congress in 1988. Because of its important scientific strengths—including the comprehensive assessment of its subjects using psychological tests with well-established psychometric properties—NVVRS findings have been an important part of the empirical foundation of federal policy related to war veterans.

In the NVVRS paper entitled "Problems in the Families of Male Vietnam Veterans with Posttraumatic Stress Disorder", published in the *Journal of Consulting and Clinical Psychology* in 1992, my colleagues and I reported that families of veterans with PTSD were more likely to suffer domestic violence than the families of veterans without PTSD. In addition, the study found that children of the veterans with PTSD manifested significantly higher levels of behavioral and emotional problems than children of veterans without PTSD, and that more than one third of veterans with PTSD had a child with behavioral or emotional problems.

In my opinion, this NVVRS finding of multiple severe problems in the families of veterans with PTSD—made 15 years after the end of the Vietnam War—has important

implications for today's service men and women returning from OIF/OEF. Specifically, our Vietnam-era findings suggest that a significant number of current members of our Armed Forces will need access to effective treatments for war-related PTSD and its co-morbid conditions; similarly, their spouses and children will need access to trauma-informed treatments and services. A hard lesson learned from our nation's response to Vietnam veterans is that we do not want to delay doing our best to prevent war-related PTSD from wreaking havoc on the futures of our OIF/OEF veterans and their families.

As a psychologist at the VA Medical Center in Jackson, Mississippi from 1979 to 1987, I had the good fortune to work with and learn from scores of Vietnam veterans receiving psychological services for PTSD and other mental health problems. An enduring—and distressing—memory of working with these veterans was trying to help them and their spouses process and recover from the shock, disappointment, anger and sense of betrayal that so often accompanied denial of benefits or compensation for the psychological and emotional toll that war-zone stress had taken on their lives in the form of PTSD. More often than not, a profound sense of unfairness lay at the heart of their reactions. The PTSD C&P evaluation and disability ratings process has improved considerably since the late 1980s, but, as the *PTSD Compensation and Military Service* report suggests, much more may be done to enhance confidence in PTSD compensation ratings decisions and ultimately to improve this process for veterans returning from combat and for their families.

Thank you for your attention. I will be happy to answer your questions.

Chairman WAXMAN. Thank you very much, Dr. Fairbank.

I am going to start off the questions. I want to see if I can understand the scope of this problem and, of course, whether DOD and Veterans Administration are prepared for it.

The results of surveys done by the Army and the Department of Defense are alarming. A comprehensive analysis conducted in 2003 estimated 13 percent of soldiers returning from war in Iraq and Afghanistan had PTSD. Doctor Insel referred domain to this estimate in his testimony. We know that there are about 1.5 million troops that have been deployed to Iraq and Afghanistan. Just doing the simple math, this suggests that approximately 160,000 troops will return home needing treatment for PTSD.

Dr. Insel, does that figure sound right to you?

Dr. INSEL. As far as we know, I think that is right, but I want to point out that we are at the early stages. What we learned in Vietnam is this takes a sometimes unpredictable longitudinal course, and that there are people who developed the disorder sometimes months, sometimes years after they returned from service. So one needs to be a little cautious with any of the percentages that we are working with at this point.

Chairman WAXMAN. Yes.

Dr. Kilpatrick and General Pollock, is this consistent with the DOD and the Army, what you are seeing?

Dr. KILPATRICK. Again, I think it is very important to understand what the statistics that are being quoted. As we are taking a look at our screening processes, both the research studies done in theater and the studies on the post-deployment health assessment, we are looking at people answering questions in a positive way that would indicate that they need further evaluation to make a diagnosis of PTSD.

The screening questions that are being asked are not diagnostic questions, and so I think that percentage needs to then say the next step, what do we know as far as the number of those people who are actually diagnosed with PTSD. I think, as you just heard from Dr. Fairbank, that diagnosis is not one that can be done quickly. It may take an hour. It may take several days. I think, as Dr. Insel has just said, the symptoms today going through that diagnostic workup may not be diagnosed as PTSD, end up several years later perhaps being diagnosed as PTSD.

So I think that this is a very hard area to try to identify quickly. We have no——

Chairman WAXMAN. Identify it quickly or quantify the number that——

Dr. KILPATRICK. I think to try to quantify it is very difficult because it is going to be an evolving process. I think people screening positive we have to understand is different than people being diagnosed, and then people being diagnosed, we have to really understand the extent of their illness, how severe it is and whether it is in the chronic phase, or hopefully with our processes for identifying it early and being able to——

Chairman WAXMAN. What we heard from the first panel is that a lot of them feel it is a stigma to come forward and to indicate that they might be suffering from mental illness.

General Pollock, did you want to jump in on that?

General POLLOCK. Yes, sir. It is because of the stigma that I would be unwilling to even estimate what numbers are, because until we are able to eliminate the stigma, people who are suffering won't come forward, whether it is for fear of letting their buddies down, fear of being seen as weak, fear of what will happen to my career. If something happens to my career, how will I take care of my family? Well, I can just tough through this. I am Army strong.

There are so many factors right now that are affecting that, and, until we are able to reduce that stigma, those numbers are going to be, I am afraid, just guesses.

Chairman WAXMAN. Well, the stigma is a problem, but it seems to me the Army and the Veterans Administration need to figure out how to ask questions that go to the symptoms so that they are not stigmatizing by saying do you have post-traumatic syndrome of one sort of another.

General POLLOCK. I agree, sir. One of the things that we are doing now—and this is a new piece. I mentioned before we are always trying to add something new to make it better. We are working on a leader training program, a leader being because at any point in time a soldier can be placed into a leadership position, so it is not for senior leaders, it is for every soldier, to say these are the symptoms, these are some of the ways that another soldier, one of your buddies can manifest that they may be suffering from PTSD. This is how you can recognize it. This is what you can do to help them.

Just like you would watch their back if you were out on a battlefield, you continue to watch their back and help each other.

We are doing more work with the spouses now and encouraging the spouses to come in when we do the 3 to 6 month reassessment to say have you noticed anything different. Is it harder for you to get along? Is there more stress in the family? So we can really bring people in so they get permission to talk about it.

We are trying to move forward, but I submit the stigma piece will continue to be a challenge. And then, as we erase that, it will look like our numbers are much larger, because then people are willing to admit, yes, I think I would like some help.

But the point that Dr. Insel made early this morning with the fact that we have inadequate behavioral health professionals across our Nation, we can break down the stigma, but if we don't have people who can step up and assist, have we really done anything? I really think that we need as a Nation, not just as a military, to look at how can we get more people into behavioral health so that we can serve the needs of the men and women of America, not just the men and women in the military.

Chairman WAXMAN. Thank you very much.

Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman.

I am going to start with Dr. Kilpatrick. You had a lot of superlatives in your presentation, and I was a little surprised that there were quite as many of them as there were, terms like robust and touting surveillance programs, pre-deployment health assessments since 1998, mental health care in theater, the use of multi-faith chaplains, etc., is in your testimony.

How do you explain the first panel? General Pollock I think did a very good job of saying, look, we make mistakes, things fall through the cracks. You didn't do that in your testimony. I was a little surprised that, in light of what we are looking at here and some potentials for falling through the cracks, that it was sort of, gee, this thing says nothing is broken.

Dr. KILPATRICK. Again, let me kind of start with saying that the programs we have in place are programs that the DOD has never had before. In the Gulf war we had nothing electronic, and today we do. I think that is a major step forward. The fact that we are able to track and say where people are, what are their medical problems, I think is a major advance.

Mr. ISSA. I think it is important and it is major, but I did a little back on the envelope, and you have 400 psychiatrists and psychologists on staff at DOD?

Dr. KILPATRICK. If we look throughout DOD, you can see that number, but I think that——

Mr. ISSA. That would be approximately what it would take if you took a couple of hours for pre-deployment evaluation or base-level evaluation and then a followup post, without in theater and without any other psychiatric work, just short of doing 250 people a day or 250 days in the year, roughly four people a day.

I am going through the math and saying I bet you don't have 400 psychiatrists and psychologists that are doing it just for those before they deploy and after they get back, so what do you need and why is it you are not here saying that inherently the resources necessary to provide the kind of pre-evaluation where we wouldn't be deploying people who are at high risk and the kind of evaluation coming back so they wouldn't have tragedies like we saw in the first panel? Why is it you are not asking for those kind of resources?

Dr. KILPATRICK. Again, I think as we take a look at what are the resource requirements we are really looking at the Mental Health Task Force. We believe that they have spent a year and a half or over a year looking at this with all the data that we could make available to them. Their early report, as you have seen, says that there are inadequate resources—mainly people is what they are talking about—to be able to do this.

The question is, where do we have——

Mr. ISSA. Right, and I am thrilled that they have done this kind of work and I am thrilled that the Veterans Administration, which, as I understand, is the best health care delivery system in America, public or private, sought to make it better.

Again I am going to go on to General Pollock, but I would really hope that when you testify before Congress you come with the problems, not just the superlatives.

Dr. Pollock, or General Pollock—both titles are good, and you certainly earned the stars—in the first panel, which you were here for, what we saw were things that I remember from my days as an enlisted man and as a young officer. We saw people who had, in the case of Specialist Smith, he had a profile that kept him from performing his mission, then he was deployed, came back with symptoms, mental health problems that may or may not have been

IED related, and today he is still an active duty specialist and still in a sense in denial that he can't do the job.

The likelihood is that, as long as he can't carry a weapon and needs medication, he is not going to be able to do it. How are we getting people out of what I call the penalty box or the suspension box, the idea that you are on a profile, your promotions are going to be reduced, your ability to do the things it takes for a career aren't going to be there, and yet he has quite a few years in limbo, to use an old Catholic term.

General POLLOCK. I think we are making progress on that, and we started at Walter Reed. One of the things that we were very concerned about was the lack of continuity of care when they were outpatients. How were we really being accountable for them? That was also evidenced by the tragedy that the parents talked about.

So now we have put together a triad, so we have a nurse case manager to make sure that all the pieces and the appointments and the coordination that needs to be done for that soldier in their care is occurring.

We have either a sergeant or a company commander, so we will have a platoon sergeant and a squad sergeant so that we don't have more than 12 of the soldiers, warriors in transition. So whether they were battle injuries or other illnesses or a training injury, if they are going to require a profile and can't be immediately sent back to duty, they will be assigned to a warrior transition unit.

Mr. ISSA. Are these like the wounded warrior facilities at Camp Pendelton and Quantico?

General POLLOCK. Yes. And by doing that, their purpose then, the focus of their day will be to get well and to participate in the care that they need, and with the other staff there to help them get through the process and to understand why they are waiting 2 weeks between a behavioral health appointment. Is it that people aren't available? No. It is because you have homework that you have to do. There are pieces that you have to pay attention to.

So I think that we are going to fix that. And then the stress that Specialist Smith was under inside his unit—you need to go again, tough it up, let's go again—we are going to be allowing the commanders of those units to say this person is not deployable, they have a profile. We'd like to transition them to the warrior transition unit so that I can have the fill of my unit of the health, ready-to-go folks so that we can just train to go back and do what we need to do.

That is going to correct quite a bit of this problem.

Chairman WAXMAN. Thank you very much, General Pollock.

Mr. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman.

We have heard a lot today about the deployments, length of deployments and the redeployments and the shortened dwell time and, in the case of the specialist we had here, as short as 8 months between deployments, and the impact that has on families, but also on mental health.

I would like to address Dr. Fairbank. I know it is not your job to tell the military how to fight wars, but, from a clinical perspective, could you tell us what the impact of all of these lengthened deployments, shortened dwell times, and the multiple deployments

will have on the soldiers' mental health, whether or not they end up as clinically PTSD or in some other way affected mentally?

Dr. FAIRBANK. I can address it from two perspectives. What we know from the National Vietnam Veterans Readjustment Study, where we looked at the number of months that a service member served in the Vietnam theater of operations, when you start at the 12-month mark and go on out, there is basically a dose response relationship between time in theater and prevalence of TPSD.

So, for example, I believe the prevalence rate is about 13.5 percent for men and women who served—well, men primarily—who served 12 months. Thirteen months to 23 months, it is about 18.5 percent. Those who served 2 years or more, it starts to get up to 19, 20 percent PTSD prevalence.

So we even know from the Vietnam era that there is a strong relationship between time in theater and very likely the level of exposure to the types of traumatic events that are related to development of PTSD.

The second observation I would have is that, when I was working at the Jackson VA Medical Center from 1979 to 1987, basically every day working with Vietnam veterans and other era veterans with PTSD, the most complex and refractory cases that I saw were veterans with three or more tours. They were, by far, the most memorable cases of individuals that I worked with.

Mr. YARMUTH. Clarify something for me. When we are talking about PTSD, I am sure there is a wide range of the manifestation of PTSD in terms of how disabling it can be——

Dr. FAIRBANK. Right.

Mr. YARMUTH [continuing]. And the severity of symptoms, and so forth. I mean, not having served in combat, I would assume that anyone who has been in a combat situation, has seen what specialists Smith and Bloodworth described to us this morning, would be in some way affected adversely mentally, and I can't imagine the opposite.

So when we are talking about this, does prolonged experience increase the severity of it and the disabling aspects of it? For instance, when Specialist Smith was sent back and clearly was having a problem before his second deployment, how much does that exacerbate the situation?

Dr. FAIRBANK. Well, I think it was Mr. Smith who very vividly described what it was like being on patrol every day, the threat that he was facing each day, the sniper fire, the IEDs. That would clearly qualify as high level of exposure to war zone stress, traumatic stress.

So both of the service members who testified presented pretty clear evidence that, while they were there, they were under high levels of traumatic stress exposure.

What we do know from the research is that there is a dose response relationship that the higher the level of exposure to trauma, the greater the risk for developing not only PTSD but a wide range of other often co-morbid conditions like substance use, dependence, abuse, major depression, other types of anxiety disorders.

So there is a relationship between the level of exposure. So to the extent that these multiple tours and extended tours increase one's level of exposure to the types of things that they describe, the prob-

ability of developing these adverse psychological reactions increases.

Mr. YARMUTH. I have a quick question I want to get in for General Pollock. I appreciate your assessment of the imperfection of the system, and so forth. When we are talking about these deployments and the shortened dwell times, we all know, by reading news accounts and so forth, that our armed forces are strained. Because we don't have enough people to send to the theater, we are sending people in ways that we don't ordinarily do. Are we treating PTSD patients and affected soldiers and others differently than we would because of the fact that we are strained, we are stressed so much for our personnel in the service? Are we doing things that we ordinarily wouldn't do?

General POLLOCK. The way that we are treating the patients really depends on how they present. Again, I have great concerns that it is related to the stigma, because they are not often willing to tell us what is really going on for them. They are bonding with their soldier colleagues. If I go tell too many people about this, they will put me on a profile and I am going to have abandoned my buddies. I would rather stay with my buddies.

So they don't always tell us. That is why the different types of training that we are trying to get out now and the different venues to get through so that they are all supporting one another better I think will be helpful. But it is just going to be very, very difficult, but we are going to keep after it.

Mr. YARMUTH. Thank you.

Chairman WAXMAN. Thank you very much, Mr. Yarmuth.

We have votes on the House floor, and I gather this vote is a very close one. I was willing to miss it. But I don't want to ask the panel to stay here and wait for us to come back. I thank you for being here and giving us your testimony. We would like to send you additional questions in writing and have you respond in writing for the record.

[The information referred to follows:]

Questions for the Record

The Honorable Henry A. Waxman
Chairman
House Committee on Oversight and Government Reform

May 24, 2007

"Invisible Casualties" The Incidence and Treatment of Mental Health Problems by the U.S. Military."

Question 1: What are the Department of Veterans Affairs' estimates of the number of veterans who will require mental health screening and treatment by VA, over the next year and over the next decade? Please provide detailed estimates, and a description of the assumptions used in creating these estimates. How do these estimates differ compared to estimates from previous years?

Response: Projections of the demand for post traumatic stress disorder (PTSD) services are complex and subject to rates of deployment, redeployment and separation of service members. For this reason it is difficult to make precise projections of increased needs.

What the Department of Veterans Affairs (VA) does know is that since the start of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) combat, 686,306 service members have been discharged and have become eligible for VA care. Of those, 229,015 (33 percent) have sought VA medical care. Among those returning veterans, mental health problems are the second most commonly reported health concerns, with almost 37 percent (83,889) reporting systems suggesting a possible mental health diagnosis. VA data show that the proportion of new veterans seeking VA care who have a possible mental health problem has increased slightly over the past 2 years. The proportion with possible mental health problems at the end of fiscal year (FY) 2005 was 31 percent, compared to 37 percent in the most recent report, released April 2007. PTSD diagnoses during this same time frame went from 13 percent to 17 percent. Possible explanations of this increase include extended deployments, more difficult combat circumstances, effective screening and outreach efforts, and the positive impact of efforts to de-stigmatize seeking mental health services.

Veterans Health Administration (VHA) is working to enhance its ability to project the number of service members with PTSD through two mechanisms. The primary strategy has been to closely monitor trends over time for the total number of veterans treated for PTSD from each service era, with particularly detailed data on returning OEF/OIF veterans. This strategy emphasizes shorter-term projections, closely linked to current data.

Question 2: What are VA's estimates of the cost of screening and treating troops for mental health problems, over the next year and over the next decade? Please provide detailed estimates, and a description of the assumptions used in creating these estimates. How do these estimates differ compared to estimates from previous years?

Response: The costs to screen for mental health problems cannot be estimated, since this screening takes place as a natural part of primary care visits and has been integrated into the system for several years. Costs for such screening are captured as spending for primary care, not for mental health, per se. If the number of new veterans served continues to increase by approximately 100,000 per year, each will need screening, but again this should be absorbed in the system, as projected by planned increases in primary care spending.

Costs of treatment for PTSD and other mental health problems are more substantial. VA estimates that it needs $2.96 billion for mental health services in FY 2008.

Projections for the mental health budget for all enrolled veterans needing mental health care are based on the VA enrollee health care projection model, a demand based model which projects enrollment, usage and expenditures. Mental health service projections are developed for both conventional (psychiatric and substance abuse) services as well as mental health programs unique to VA, such as day treatment centers, mental health for the homeless, methadone treatment, mental health intensive case management (MHICM), work therapy, community residential care, sustained treatment and rehabilitation programs (STAR I, II, and III), psychiatric residential rehabilitation treatment programs (PRRTP), PTSD residential rehabilitation treatment programs, and substance abuse residential rehabilitation treatment programs. These projections are developed at a very detailed level and reflect the age, gender, morbidity and reliance of the enrolled veteran population.

The development of these projections is documented in the FY 2005 VA enrollee health care projection model report dated September 2005. Specific adjustments are made to some of the mental health programs to reflect VA's desire to ensure the model sufficiently projects mental health services for certain enrollee cohorts exposed to combat. Beginning with the FY 2007 budget submission, the projections reflect the resources associated with the mental health initiative which increases the level of mental health services provided and reflect policy goals for VA.

Question 3 (a): What are VA's estimates of staffing needs for screening and treating troops for mental health problems over the next year and over the next decade? Please provide detailed estimates, and a description of the assumptions used in creating these estimates. How do these estimates differ compared to estimates from previous years?

Response: Staffing for basic mental health services in FY 2004, before implementation of the Mental Health Strategic Plan (MHSP), were 1,570 psychologists, 1,878 psychiatrists, and 4,172 social workers (of whom about half are in mental health settings) in the VA system nationally.

Since implementation of the MHSP began in FY 2005, many new positions in these recovery-oriented programs have been funded; most have been hired and others are in process. Total new positions funded for the key mental health professions are:

- Psychologist 808
- Psychiatrist 403
- Social Work 1,075

- Nurse 490
- Addiction Therapist 159
- Vocational Rehabilitation Specialist 299
- Health Technician 136
- Recreation Therapist 32
- Occupational Therapist 29
- Peer Support Specialist 148

In addition a total of 612 positions are funded for other staff, such as administrative support, ward clerks, and similar support functions for mental health care. The total new positions funded are over 4,000.

Veterans integrated service networks (VISN) have been asked to identify additional staffing needs. We are focusing on near term staffing needs. For example, one area is staff to implement the recent directive that all new mental health requests and referrals must receive a triage evaluation within 24 hours and a full diagnostic and treatment planning evaluation within 24 hours. Some sites will be able to implement this without additional staffing; others will need more. Another need is for staff who can provide evidence-based psychotherapy for PTSD and other mental health problems. We are training current staff to provide new therapies as research support emerges. We also expect to bolster staffing in mental health outpatient clinics, mental health in primary care settings, and PTSD clinical teams, with individuals who can provide new psychotherapy.

In summary, our strategy is to work closely with VISNs to develop new staff full-time equivalent (FTE), using the mental health initiative funding. This strategy has resulted in an increase in mental health staffing, over a short period.

Question 3 (b): How many unfilled mental health positions currently exist at VA hospitals and clinics nationwide?

Response: Current mental health staff and unfilled vacancies for medical facilities and their associated community based outpatient clinics appear in the following table:

Mental Health Staff	Staff on Board	Vacancies
Psychologists	1,829	382
Social Workers	2,277	522
Psychiatrists	2,007	341

Question 4: What percentage of the VA budget is spent on diagnosing and treating PTSD and other mental health problems? Is this amount sufficient?

Response: Returning veterans present with many mental health concerns, and a large proportion of veterans with PTSD have other mental health and substance abuse problems. Some are homeless as well. We consider the entire mental health budget to support a spectrum of care that serves the mental health needs of returning veterans fully, as well as the needs of veterans of other eras. The budget figures include diagnosis and treatment of such mental health problems.

Mental health funding for each facility is derived from two separate funding streams. Most of the mental health funding comes to the VISNs through veteran's equitable resource allocations (VERA). They are based on complex models that include both past services provided, associated costs, and actuarial projections. The total projected costs for mental health services are $2.805 billion for FY 2007 and $2.960 billion for FY 2008. The nearly $3 billion for mental health services constitutes 8.7 percent of the appropriation request for medical care in 2008.

The other component, the mental health initiative to expand and enhance VA mental health care, is funded for $306 million in FY 2007, and projected for $360 million in FY 2008. In addition, Congress recently allocated another $100 million for mental health care and $20 million for substance abuse care, to be spent over coming years.

The adequacy of these funds are tracked through quality measures, by analyses conducted by the three program evaluation centers associated with the VHA's Office of Mental Health Services (OMHS), and through each VISNs evaluations of their own needs. For efficiency, the allocation of FY 2007 and FY 2008 funds was coordinated. A number of programs will be implemented and expanded during FY 2007, and continued funding for those programs during FY 2008 will ensure spending of the total amount of funding for the 2 years. Plans are currently being reviewed for spending of the additional Congressional supplemental budget for mental health and substance abuse. VA anticipates these funds will be sufficient to meet veterans' mental health needs.

Question 5: The Government Accountability Office (GAO), in their report entitled, *VA Health Care: Spending for Mental Health Strategic Plan Initiatives Was Substantially Less than Planned,* reported that the VA failed to spend nearly one out of every three dollars it budgeted in FY 2005 and FY 2006 to implement approved initiatives from its National Mental health Strategic Plan, returning $46 million and failing to adequately account for an additional $112 million in funding.

What accounts for *VA's* inability to allocate $46 million in funding? Why did GAO come to the conclusion that your agency couldn't account for the remaining $112 million that was spent? Can the VA assure Congress that money that is being allocated to implement strategic planning is being spent to efficiently implement the strategic plan?

Response: The GAO report addressed the use of funds for the mental health initiative to expand and enhance mental health care in VHA. It addressed delays in enhancing services, not limitations in services delivered. The delays were related to factors such as the time required to formulate new programs. Actions taken in FY 2007 to ensure efficient use of the mental health initiative funds include accelerated notices of award to the field and increased tracking of positions filled and workload generated.

Finally, GAO noted that VHA's tracking of allocated resources for Mental Health Strategic Plan Initiatives needs to be more systematic. VHA's Office of Patient Care Services has been working in coordination with the Office of Finance to develop strategies for better monitoring of actual dollars spent. The overall tracking of Mental Health Strategic Plan Initiatives has expanded significantly, and will continue to do so

during this fiscal year. Quarterly monitoring reports provided by the network offices highlight the development of clinical programs, with emphasis on progress being made in hiring new clinical staff who will implement service initiatives. These staffing figures translate into dollars spent and represent the bulk of Mental Health Strategic Plan initiative spending.

VHA is committed to ensuring that funds allocated for Mental Health Strategic Plan initiatives are spent judiciously and timely. VHA is focused on building permanent capacity and long-term programs that will be effective, high quality and sustainable.

Question 6: What are the national average waiting times for VA mental health screening and mental health appointments? How have average waiting times changed since FY 2002? Please provide detailed data, nationally and by Veterans Integrated Service Network (VISN).

Response: The average waiting time for all mental health appointments in April 2007 was 2.8 days, a decrease from 4.6 days in calendar year 2004. For new appointments at our mental health clinics, the average wait nationally in April 2007 was 15.4 days, compared to an average 25.7 days in FY 2004. VHA does not have comparable data going back to FY 2002. The low waiting time figures for all appointments reflects the vast majority of established patients who rarely have a wait beyond their expectation, while the longer waits for new patients more accurately reflects the experience of first visits to a mental health clinic.

Among the 21 VISNs, average waiting times for all mental health appointments for January through March, 2007 varies from 1.2 days (VISN 12) to 4.5 days (VISN 8). For new patients, the waiting times range from 8.9 days (VISN 1) to 26.3 days (VISN 23). There was more variation among VISNs in FY 2004 with waiting times for all appointments ranging from 1.4 days (VISN 3) to 7.6 days (VISN 4) and for new appointments to a mental health clinic ranging from 9.1 days (V(SN 3) to 35.4 days (VISN 6).

VHA recently initiated a requirement that all patients referred for mental health care be evaluated within 24 hours of that referral to determine need for urgent care. The new guidelines also specify that a full diagnostic and treatment planning evaluation will be completed within 14 days.

Specific data for each VISN appear below.

Average Waiting Times for Mental Health Appointments

	All MH Appointments (in days)		New MHC Appointments (in days)	
VISNs	April-07	FY 2004	April-07	FY 2004
1	2.3	5.6	8.9	13.1
2	2.5	4.5	19.8	18.1
3	1.9	1.4	14.5	9.1
4	4.1	7.6	18.3	31.2
5	1.7	2.4	11.2	13.9
6	3.4	5.9	16.6	35.4
7	3.2	5.3	22.4	24.5
8	4.5	7.3	11.2	26.8
9	2.1	4.8	12.4	24.4
10	3.1	6.1	13.7	17.5
11	3.4	6.7	14.1	22.8
12	1.2	4.6	12.9	19.0
15	2.6	3.2	17.0	27.0
16	2.7	3.4	16.2	22.7
17	2.7	7.5	19.5	32.4
18	3.2	3.6	18.9	30.7
19	3.9	7.5	15.8	23.2
20	3.5	4.4	15.5	26.3
21	2.8	3.6	10.7	16.9
22	2.7	3.6	12.8	15.5
23	2.3	3.1	26.3	16.7
National	2.8	4.6	15.4	25.7

Note that "All MH" (all mental health) appointments includes both new and established patients.

Question 7: The VA Inspector General recently completed a report entitled *Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention,* that identified several problems with VA's suicide prevention efforts, most prominently the fact that not all VA facilities had 24-hour crisis availability or mental health hotlines to help suicidal veterans.

Response: To ensure veterans with mental health crises have immediate access to trained coordinators, VA will establish a 24-hour, national suicide prevention hotline available to all veterans and those family members and friends of veterans who need immediate information on dealing with veterans in crisis. The hotline, which is scheduled to begin operations by August 31, 2007, will be based at the Canandaigua VA Medical Center in New York State. Callers wanting veteran related services will be routed to a VA crisis center staffed by professional VA employees who will be able to provide information based on the veteran's specific needs, have access to the veteran's medical record if the veteran agrees, and make immediate referrals to the veterans' local VA access point. Referrals will also be made to the local facilities suicide prevention coordinators so that follow-up and tracking will be seamless. Our goal is to identify these high risk veterans in order to provide on-going comprehensive treatment and care as well as immediate crisis intervention. Staffed by mental health

professionals, it will operate seven days a week, 24 hours a day. In addition to staffing the hotline, the suicide prevention coordinators will take part in training clinicians and non-clinicians on warning signs for suicide, guide veterans into care and work within facilities to identify veterans at risk for suicide. VA's Canandaigua facility is already a VA center of excellence focused on suicide prevention, mental health education and research.

Question 8: Thousands of families will be forced to cope with a family member that returns from war suffering from PTSD or other mental health problems. The American Psychological Association in their report entitled *The Psychological Needs of U.S. Military Service Members and their Families,* found that to the extent that the Department of Defense (DoD) has programs to treat mental health problems, they are "predominantly for service personnel rather than for their family members". What programs does VA have in place to assist families who are coping with PTSD or other mental health problems?

Response: VHA encourages the participation of the family in assessment and treatment of a veteran when this would improve care for the veteran. Different mandates guide the services offered to families by medical centers as compared to vet centers, so information is provided on each.

In medical centers, consistent with patients' preferences, families are treated and involved as integral participants in the care of veterans with PTSD in a number of ways beyond formal marital/family therapy. Examples include working with the patient in seeking care; providing information about the nature of symptoms, the associated disability, and the impact on quality of life; assisting with planning treatment and choosing between alternative therapies; evaluating the outcomes of care; and helping to decide when treatments should be modified or augmented. Families may also be involved as partners in psychosocial treatments. For example, family psycho-educational interventions have been demonstrated to be effective in other serious mental illnesses, and they are currently being extended to include patients with PTSD.

VA social workers, psychologists and psychiatrists in medical centers can and do provide services to assist families in association with the care of veteran patients. For example, a special survey of VA social workers conducted in February 2007 indicates that there are 834 VA social workers providing marital/family therapy in VA medical centers. Of those 834 social workers, 196 provide marital and family therapy in PTSD programs. Of note, 284 social workers provide marital/family therapy in community-based outpatient clinics, closer to home for many veterans and their families. Since FY 2005, VA PTSD programs and VA medical center based mental health programs specifically created to meet the needs of returning OEF/OIF veterans and their families have experienced significant expansions. OEF/OIF programs established in FY 2005, surveyed in the summer of 2006, reported having contacts with 140 returning veterans' families across 26 sites for psycho-educational support and related services. Clinical expansions of OEF/OIF and PTSD programs in FY 2005 -2007 have included at least nine specifically identified new family support focused staffing enhancements.

The law authorizes vet centers to serve family members of eligible combat veterans as a core part of its readjustment counseling mission. As provided at vet centers, family

counseling is available as necessary in connection with any psychological, social or other military-related readjustment problems, whether service connected or not. By law, veterans' eligibility for readjustment counseling is determined by military service in a combat theater and does not require the veteran to be enrolled at the medical center. Additionally, providing family services at vet centers is not time limited, but rather available as necessary for the veteran's readjustment throughout the life of the veteran. Family readjustment services include outreach, early intervention educational services, and family counseling. Through the end of the second quarter, 2007, the Vet Centers cumulatively saw a total of 227,728 OEF/OIF veterans. Of that total, 54,451 were provided with substantive readjustment counseling at a vet center. Of the total served in vet centers, 4,405 were provided with family readjustment services with a family member present.

Question 9: The Institute of Medicine (IOM) recently released a report on PTSD compensation and military service. IOM issued a series of recommendations for the VA to improve its compensation practice for PTSD. What steps has VA taken to implement those recommendations specifically regarding examination and provision of care? Does the VA plan to make systemic changes to promote uniform and consistent evaluations of veterans being screened for PTSD- such as creating training programs for health care professionals?

Response: VHA is collaborating with the Veterans Benefits Administration (VBA) to respond to all of the recommendations made by the IOM. Activities are planned to provide training and conduct research to ensure that the improvements in the PTSD compensation and pension (C&P) examination process recommended in the IOM report are implemented.

VHA, working with VBA has developed detailed training and testing materials that will include procedures for conducting:

- an initial exam to determine whether PTSD can be diagnosed, deemed service-connected, and if so, the level of disability,
- a follow-up exam to determine any change in the level of disability for those deemed service-connected for PTSD,
- an initial exam to determine whether some other mental health disorder can be diagnosed, deemed service-connected, and if so, the level of disability,
- a follow-up exam to determine any change in the level of disability for those deemed service- connected for another mental health disorder.

These materials will be the basis for VA C&P examiner certification in these areas. This recently developed training includes PTSD diagnostic criteria and co-morbid conditions. The materials are being extended to include examples of cases that illustrate appropriate documentation. The Office of Mental Health Services (OMHS)-Military Sexual Trauma Resource Center will provide additional information for this effort. The issue of standard time for examinations will be covered in this training. The training is expected to be in the field no later than December 2007.

In addition, training will take place in the Fall of 2007 on use of the global assessment of functioning (GAF) scale with veterans being evaluated for PTSD, as recommended by

the IOM. That training is being planned with the active participation of VBA and VHA, including the OMHS and its component, the National Center for PTSD (NCPTSD).

Research support is being provided on several of the IOM recommendations: the VA Quality Enhancement Research Initiative (QUERI) project assessing the utility of the clinician assisted PTSD scale (CAPS) and the World Health Organization disability assessment scale (WHODAS-II) as potential replacements or complementary assessment tools with the GAF. The NCPTSD is collaborating with VBA on reviewing how other nations assess evaluation of PTSD and also on methods of determining if reexamination for PTSD is appropriate. A VA Health Services Research and Development Service (HSR&D) study on the value of conducting a structured interview for the PTSD C&P exam as opposed to usual practice is underway. Finally, a range of studies supported by Office of Research and Development (ORD) are investigating gender differences in PTSD.

Question 10: The transition between the DoD and VA health care systems has been identified as a problem by many analysts. Last month, GAO testified before the Oversight and Investigations Subcommittee of the Veterans' Affairs Committee that the VA and DoD "have not given the Government Accountability Office a certain end date" as to when your agencies will complete work on modernized electronic health records systems that can seamlessly exchange medical data. When does VA project completing work on this effort? Please provide project milestones, and your target dates for achieving them.

Response: VA and DoD have achieved a significant level of success and are currently using interoperable electronic health records that are standards-based and bidirectional to share clinical data. Pursuant to the joint electronic health interoperability plan (JEHRI), our long term strategy to achieve interoperability, and the guidance and leadership of the DoD/VA Joint Executive Council, VA and DoD are presently sharing almost all of the electronic health data that are available and clinically pertinent to the care of our beneficiaries from both departments.

VA receives these electronic data through successful one-way and bidirectional data exchange initiatives between existing legacy VA and DoD systems. These data exchanges support the care of separated and retired service members who seek treatment and benefits from the VA and the care of shared patients who use both VA and DoD health systems to receive care.

Since beginning transfer of electronic health records to VA, DoD has transferred data on more than 3.8 million unique separated service members to VA clinicians treating patients and claims staff adjudicating disability claims. Of these individuals, VA has provided care or benefits to more than 2.2 million veterans. These data include outpatient pharmacy (government and retail), inpatient and outpatient laboratory and radiology results data, consults, admission, disposition and transfer data, and ambulatory coding data. In September 2005, DoD began transferring pre-and post-deployment health assessment data. Post-deployment health reassessment data on separated members and demobilized National Guard and Reserve members began in November 2006. Leveraging some of the technical capability to transfer records one-way, VA and DoD began the bidirectional sharing of electronic health records on shared

patients. Data shared bi-directionally include outpatient pharmacy, allergy, and inpatient and outpatient laboratory and radiology results data. This capability is now available at all VA sites of care and is currently installed at 25 DoD host locations. These 25 locations consist of 15 DoD medical centers, 18 DoD hospitals and over 190 DoD outpatient clinics and include Walter Reed Army Medical Center, Bethesda National Naval Center, and Landstuhl Regional Medical Center. VA is working closely with DoD to expand this capability and by August 2007, bidirectional health information exchange data will be available from all DoD locations. VA also is working with DoD to increase the types of data shared bi-directionally. Successful pilot projects demonstrated the capability to share narrative documents such as discharge summaries. This capability is now being used at seven locations and will be expanded to others in fourth quarter FY 2007. Additional work scheduled for the remainder of FY 2007 and 2008 will add data such as operative notes, inpatient consultations, encounter/clinical notes, procedures, and problem lists to the set of information that is shared bi-directionally between DoD and VA facilities.

VA and DoD also have accomplished the ground-breaking ability to share bidirectional computable allergy and pharmacy data between next-generation systems and data repositories. This capability permits VA and DoD systems to conduct automatic drug-drug and drug-allergy interaction check to improve patient safety of those active dual consumers of VA and DoD healthcare who might receive prescriptions and other treatment from both VA and DoD facilities. At present, we have implemented this capability at seven locations and are working on enterprise implementation schedules.

Whereas our earliest efforts focused on the sharing of outpatient data, VA and DoD also have made significant progress toward the sharing of inpatient data. Most recently, we began sharing significant amounts of inpatient data on our most critically wounded warriors. Previously, these data were only available to VA from DoD in paper format. DoD is currently sharing medical digital images from the Walter Reed Army Medical Center, Brooke Army Medical Center and Bethesda National Naval Medical Center with all four level 1 VA polytrauma centers located in Tampa, Richmond, Palo Alto and Minneapolis. DoD also has begun sending scanned inpatient documents from Walter Reed to the polytrauma centers. VA and DoD are working to expand the scanning capability beyond Walter Reed to Bethesda and Brooke. VA and DoD are finalizing a long-term strategy that will facilitate the expansion of this work across the enterprise systems of each department.

In addition to our joint work to share scanned documents and digital radiology images, VA and DoD have undertaken a groundbreaking challenge to collaborate on a common inpatient electronic health record. On January 24, 2007, the Secretaries of VA and DoD agreed to study the feasibility of a new common in-patient electronic health record system. During the initial phase of this work, expected to last between 6 and 12 months, VA and DoD are working to identify the requirements that will define the common VA/DoD inpatient electronic health record. The Departments are working to conduct the joint study and report findings as expeditiously as possible. At the conclusion of the study, we hope to begin work to develop the common solution.

Chairman WAXMAN. We need to, of course, deal with this problem. It is an enormous public health threat. Our brave men and women are putting their lives on the line, need us to be there for them. I know you are all trying to do the best you can. We are here to work with you to be sure we do the job. Working with you may be to give you a push, but also to give you the resources and ability to follow through.

Thank you very much for being here. That concludes our hearing and we stand adjourned.

[Whereupon, at 2:15 p.m., the committee was adjourned.]

[Additional information submitted for the hearing record follows:]

I ask unanimous consent that this letter sent from my constituent, Peter Vogt, to the House Committee on Veterans Affairs be included in the official hearing record.

Tom Jones

March 1, 2007

Honorable Bob Filner, Chairman
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Subject: Medical Care and Compensation for Service members injured in Iraq

Dear Chairman Filner:

I watched ABC news last night only to cry for another disabled Marine who is not getting the proper care he deserves to rehabilitate himself back to his pre-Iraq mental and physical condition (if possible). This Marine was injured as a result of an exploded IED and sustained serious brain damage and other organ injuries while assigned to combat duty in Iraq.

As an honorably discharged disabled Veteran (1977-1984), I did not endure some of the hardships I am witnessing on the nightly news. But I understand the problem. I am writing to you as it has become my duty to speak out in dismay and utter disbelief at the pre and post military care some active duty service members (and Veterans) are receiving due to politics and the Military or Veteran's Affair bureaucracy and the lack of proper planning or staffing of qualified Government employee's capable of addressing this single issue: Caring for our injured service members.

I can understand glitches in the system. However, how can this Government tell the servicemen and families to accept that some of the most severely injured servicemen and women of any war in history (who survive as a result of modern medicine and treatment) are sent back to their families without a 100% bona fide solution to provide immediate continued care, rehabilitation, and compensation for their injuries? I am so dismayed and embarrassed at what I see nightly that it is becoming very hard to continue to support President Bush and the Republican agenda on terrorism. Maybe it is time to bring them all home and say to Iraq you're on your own.

There needs to be a major overhaul to provide an immediate stop gap measure to ensure that before any of our injured servicemen/women (physical or mental) are discharged from the military hospitals, regardless of cost to the Federal Government a rehabilitation plan is fully developed and incorporated with all future medical appointments, physical and mental therapy implemented and scheduled prior to return or discharged from active duty. We owe this to each and every single injured service member.

In this age of technology, we can begin by streamlining from the start, the application, submission and approval process required to sustain a comfortable recovery, free of fear, confusion, or lack of qualified or required medical care and with minimal worry of being able to provide Maslow's basic needs (physiological, safety, esteem) to themselves or their family members.

I also suggest that the military branches along with the VA organize liaisons and staff satellite offices at every single military hospital (where the injured reside) to establish the ways and means to prepare and submit all required paperwork for requesting Military (medical discharge) or Veteran's benefits (disability compensation, medical care, education, etc.) as part of the hospital discharge policy and procedures.
This newly appointed staff will interface with the Veteran or responsible family member to assure all paperwork is properly and completely filled out, signed and notarized (if required) and incorporated into the Military or VA database for a 1 month turn around with the nearest regional military or VA office of the Veteran's planned residence. In the event of a military medical discharge and pension, the military member cannot be discharged from activity duty until all events are set to provide for the injured service member. In the case of a service member who will need to use Veteran's benefits, the VA approves or disapproves the request prior to being discharged from active duty. (This way all medical services can be retained or continue as required therapy or treatment pursuant to the recommending Doctor's order of treatment.)

Any and all medical examinations required to determine compensation will be provided by the current active duty medical staff (Dr. and RN's) assigned to the injured service member. **Eliminate all current board members of non-medically qualified experts currently making these decisions regardless of their military rank or civil servant pay grade. Newly assigned Board members or review panels may only be convened with licensed medical professionals. Individual cases shall only be reviewed by board members (medical professionals) who specialize in the treatment of injuries sustained by the service member (i.e. A podiatrist cannot be on a panel to evaluate a service member with a brain injury or an Optometrist for internal organ injuries).**

The VA only needs to understand the severity of the injury, the treatment or diagnosis in order to continue to treat the injury, and to provide correct assignment of disability compensation, and/or medical treatment for the wounded service member recovering from their injuries.

On a separate note: The VA should immediately overhaul the criteria for compensation percentages for the injuries (i.e. Due to Lost limbs, eyes, brain function, paralysis etc.) since it appears that the severity of injuries and magnitude of the problem is not fully understood based on the method of sustaining the injury (trauma due to IED's) and the recovery period is not fully realized until data can be collected to understand the full impact of these types of injuries.

I have seen Congressional and Senate committee protocols and recommend that the pomp and ceremony and egos be put aside to take care of this noble cause. The recovering service member could care less who is a Republican or Democrat. Politics need to put aside to correct this injustice and to pass law to take care of our Veterans.

I respectfully request you pass law revamping the current system that basically states upon discharge, it is the Veteran's responsibility to apply for disability or continued treatment. Too many survivors are not getting adequate compensation or medical care due to their socio-economic status once discharged from active duty. I would argue that

due to medication and injury many may not have the capacity to fight for what is truly owed them.

I beg you to devise a method and pass a law that provides corrective action to allow for the protection and care of the veterans and active duty servicemen and women (enlisted or officer) who are injured as a result serving this cause. There is no option only dishonor in the fact we are not providing better service and immediate care.

Please don't reply with a form letter from some aide stating you will look into this and get back to me.

I am just a Veteran, and a citizen who is concerned and very troubled by this issue. I have no connections or lobbyist group that can get an appointment with you or your staff. But if you would like to contact me I would request an appointment.

Respectfully,
Peter M. Vogt

CHARRTS No.: HOGR-01-001
House Government Reform Committee
Hearing Date: May 24, 2007
Subject: Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military
Congressman: Congressman Waxman
Witness: Major General Pollock
Question: #1

Question: What are the Army's estimates of the number of troops who will require mental health screening and treatment over the next year and over the next decade? Please provide detailed estimates and a description of the assumptions used in these estimates. How do these estimates differ compared to estimates from previous years?

Answer: Data are now available from surveys conducted among combat units, the population-based post deployment health assessment (PDHA) and post-deployment health reassessment (PDHRA), as well as health care utilization data from military treatment facilities and the Department of Veterans Affairs. The data consistently indicate that one-third of troops returning from Iraq and Afghanistan need further evaluation for mental health problems in the first year or so of their return. It is not known how many will go on to need long term treatment over subsequent years, but it is likely to be a considerable percentage of those initially requiring treatment. Given the well established chronic nature of mental health problems, the fact that many service members don't seek care because of stigma and barriers, and the average effectiveness of treatment, a rough estimate is that 15% of all returning veterans will need long term treatment for war-related mental health problems.

CHARRTS No.: HOGR-01-002
House Government Reform Committee
Hearing Date: May 24, 2007
Subject: Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military
Congressman: Congressman Waxman
Witness: Major General Pollock
Question: #2

Question: What are the Army's estimates of the cost of screening and treating troops for mental health problems over the next year and over the next decade? Please provide detailed estimates and a description of the assumptions used in creating these estimates. How do these estimates differ compared to estimates from previous years?

Answer: The Military Health System does not budget by product line or by clinical specialty. However, the Army is initiating numerous programs to address the increasing numbers of psychological health issues faced by our Soldiers. Each of these programs is in addition to mental health services currently provided to our beneficiaries. Start-up costs for these new programs have been determined under 3 broad categories— education, treatment, and program management —and are expected to total $167 million in Fiscal Year 2008. On a recurring annual basis we expect these initiatives to cost about $90 million.

- For psychological health education programs, we forecast $4 million in start-up costs for 2008 and $1 million annually after that. These costs primarily fund the expansion and further development of the Battlemind Training System and the Army's new Leader Chain Teaching program.
- We forecast the treatment costs for new psychological health programs to exceed $150 million in 2008 and $80 million annually. These costs include expanding our tele-psychiatry capability to all regional medical commands, creating or expanding treatment programs at selected sites, bringing outpatient programs to full staffing in accordance with enhanced staffing models, expanding or renovating inpatient psychiatry units, expanding the RESPECT-MIL program to all Army hospitals, staffing our Warrior Transition Units with social workers, and increasing case management for Soldiers receiving care on the TRICARE network.
- Program management costs are expected to exceed $13 million in 2008 and approximately $10 million annually. Program management includes the establishment of a Psychological Health Program Management Office, fully staffing the Surgeon General's Proponency Office for Behavioral Health, implementing recommendations at five pilot sites, and establishing a consortium for mental health.

In determining the above costs the key assumption is that our staffing model adequately reflects the needs of our population. Our population needs drive our staffing which in turn drives our cost estimates. Details of our staffing model are laid out in question number 3.

CHARRTS No.: HOGR-01-003
House Government Reform Committee
Hearing Date: May 24, 2007
Subject: Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military
Congressman: Congressman Waxman
Witness: Major General Pollock
Question: #3

Question: What are the Army's estimates of staffing needs for screening and treating troops for mental health problems over the next year and over the next decade? Please provide detailed estimates and a description of the assumptions used in creating these estimates. How do these estimates differ compared to estimates from previous years?

Answer: The staffing model that most accurately meets the needs of our military beneficiary population is a forward looking demand prediction model. This model takes rates of disorder as predicted from epidemiological studies to predict future demand, then calculates needs based upon that workload.

- Active Duty:
  - 20% of Soldiers who have served in OIF/OEF have Mental Health (MH) problems (PTSD, depression, anxiety per WRAIR Land Combat Study)
  - An estimated 10% of 4000 AD serious cases require 6 visits at 1760 visits per provider per year
  - An estimated 10% of 4000 AD moderate cases require 3 visits at 1760 visits per provider per year
  - Additional 1-2 providers (2 per Brigade Combat Team (BCT), 1 per other AD) for outreach/command consultation/unit training or clinical work so that BDE BH Officer can do training

Outcome = 2 Social Worker; 1 Psychologist; 1 Psychiatrist per 4000 AD in BCT/UA's; or 1 Social Worker; 1 Psychologist; 1 Psychiatrist per 4000 AD. (These are in addition to existing Brigade and Division BH assets.)

- Families:
  - Adult FM Care
    - Prevalence of marital problems = 25%
    - 20% of 2000 marriages (etc) at 6 visits = 1.5 Social Workers per 2000 spouses [would also provide outreach to Family Readiness Groups (FRG)]
    - Prevalence of significant MH problems in spouses = 20%
    - 10% of 2000 spouses at 6 visits and 10% of 2000 spouses at 3 visits = 0.5 psychologist + 0.5 psychiatrist
    - Staffing would allow 1) new capacity to provide on-post marital and spouse BH care; 2) improved access leading to earlier care and less family

morbidity e.g. spouse abuse & divorce; 3) clinical liaison with FRG groups

- Child & Adolescent Care
  - Prevalence of MH problems in children is 20% (WRAIR LCS); baseline rate in literature 20%
  - 10% of 2000 children at 6 visits and 10% of 2000 children at 3 visits = .0.5 psychologist + 0.5 child psychiatrist
  - Staffing would allow: 1) new capacity for on-post child BH care; 2) capacity for school based consults at on post schools; 3) child psychiatry presence in pediatrics

This staffing model leads to higher manpower levels to support an Army at war than previous peacetime staffing models. Peacetime staffing levels have been set by a combination of a retrospective workload model and a population-based model. The shortfall between the peacetime models and the new demand prediction model is about 200 providers. Supplemental funding is being used to hire the additional providers to meet the new staffing levels established by the demand prediction model.

What the demand prediction model does not account for is the potential impact of Army efforts to reduce the stigma associated with seeking mental health care. As the Army rolls out our mandatory PTSD/TBI Chain Teaching Program, we expect that more Soldiers and Family members will be inclined to talk about their concerns and potentially seek care. If we are successful at reducing stigma, the demand predicted by epidemiological studies may no longer be accurate and projected behavioral health resources may be inadequate. We will actively monitor our system to ensure our Soldiers and their Families have ready access to behavioral health care.

CHARRTS No.: HOGR-01-004
House Government Reform Committee
Hearing Date: May 24, 2007
Subject: Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military
Congressman: Congressman Waxman
Witness: Major General Pollock
Question: #4

Question: In February 2007, the American Psychological Association reported that 40% of Army and Navy clinical psychologist positions were not filled. What is the Army's best estimate of the number of psychologists or mental health professionals needed to treat and screen returning troops with mental health problems? How many of those positions are presently unfilled? If there are unfilled psychologist positions what affect is this having on waits for care and other aspects of treatment and what actions is the Army taking to fill open psychologist positions?

Answer: The extended war is straining our behavioral health system. The number of uniformed providers, especially psychologists, has decreased due to attrition related to the extended war and repeat deployments. The Army inventory for psychologists is presently 96 Assigned for 118 Positions. Despite aggressive recruiting for psychologists there is still a significant shortage. Although we have doubled the number of officers attending our internship training programs this year, we will not benefit until another two years when they complete their training. Several initiatives are underway to attract and retain psychologists to include the Health Professions Loan Repayment Program which recently assisted 13 officers who otherwise may have left active duty.

We have also identified a need for more civilian psychologists and mental health professionals. We intend to maximize use of the three Rs—recruiting, relocation, and retention bonuses—to keep our current providers and to attract more. We are attempting to recruit over 300 civilian credentialed providers, including psychiatrists, psychologists, social workers and psychiatric nurses. The estimated value of the contract exceeds $50 million dollars. Unfortunately, given the nationwide shortage of behavioral health providers, especially in remote and rural locations, we anticipate that recruitment will be difficult and we will not fill all of our requirements.

To help expedite the hiring process and reduce the hassle factor for prospective hires, the AMEDD is seeking to expand Direct Hire Authority for direct patient care positions from the current 14 healthcare occupations to 45. Additionally, we want this authority made permanent so that we aren't bound by the annual renewal process and its routine delays. This initiative will significantly reduce the fill-time for civilian healthcare occupations and allow us to compete more evenly with the rest of the health care industry.

CHARRTS No.: HOGR-01-005
House Government Reform Committee
Hearing Date: May 24, 2007
Subject: Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military
Congressman: Congressman Waxman
Witness: Major General Pollock
Question: #5

Question: The American Psychological Association also reported that high numbers of military behavioral health care personnel were suffering from burnout, or "compassion fatigue." Have turnover rates among mental health professionals changed in recent years, and if so, have they increased or decreased, and by how much? What is the Army doing to avoid burnout among medical staff?

Answer: Compassion fatigue or "burnout" is unquestionably a challenge throughout our medical system. We have developed a number of training products, known as provider resiliency training, which are offered before, during and after deployment. All Army health care providers now receive this training during their initial educational courses. All deploying behavioral health providers are now receiving a "train the trainer" module at the new Combat and Operational Stress Control course. Compassion Fatigue (CF) is not new in either the civilian or military settings. Landstuhl AMC had a program in place prior to the development of an Army Medical Department Center and School (AMEDDC&S) CF module. In late 2004, prior to the 2005 MHAT-II findings, the AMEDDC&S began development of a Compassion Fatigue training module to address concerns for healthcare providers enduring prolonged deployment demands while delivering continued services to Wounded Warriors. This resulted in a U.S. Army Compassion Fatigue (CF) training module that included a didactic presentation and corresponding CD-ROM. A CF link was added to the AMEDDC&S Deployment Relevant Training webpage at: https://www.cs.amedd.army.mil/deployment2.aspx#.

The Mental Health Advisory Team II reported in January 2005 that 33% percent of BH personnel reported high burnout, 27% reported low motivation, and 22% reported low morale. Fifteen percent agreed that the stressors of deployment impaired their job performance. If our providers are impaired, our ability to intervene early and assist Soldiers with their problems will also be degraded.

In recent years, the turn over rate among mental health professionals has changed. For all BH professionals, which include Psychiatry, MH Nurse, Psychology, Social Work and Occupational Therapy, overall attrition rates from FY02 thru FY06 have increased from 7.34 % in FY02 to 10.59% in FY06. By comparison, the overall AMEDD rate in the same year groups has increased 1.8%. It is unclear as to how large a role provider fatigue and burn out play in the decision to separate from active service. However, attrition rates do show a decline from FY05 to FY06 for all BH professions, and we will continue to monitor these rates closely.

CHARRTS No.: HOGR-01-006
House Government Reform Committee
Hearing Date: May 24, 2007
Subject: Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military
Congressman: Congressman Waxman
Witness: Major General Pollock
Question: #6

Question: Thousands of families will be forced to cope with a family member that returns from war suffering from PTSD or other mental health problems. The American Psychological Association in their report entitled "The Psychological Needs of U.S. Military Service Members and Their Families," found that to the extent that the Department of Defense (DOD) has programs to treat mental health problems, they are "predominantly for service personnel rather than for their family members." What programs does the Army have in place to assist families who are coping with PTSD or other mental health problems?

Answer: We are extremely concerned about the behavioral health care needs of our Families. In many parts of the country, our military treatment facilities need to prioritize active duty care, yet there are few or no civilian providers willing to accept TRICARE.

There are several programs that are in place to support Family Members who are coping with PTSD and other mental health problems. Below is a description of programs available to Family Members.

1. Military One Source: After an initial telephone intake and assessment it may be determined that a family member of a Soldier is in need of mental health counseling. If so, a referral will be made to a contracted mental health practitioner within a 25 mile radius of the Soldier's home. Counseling sessions will begin within 3 business days of the referral. The family member is eligible for 6 sessions at no cost, after which a referral is made to follow up with a TRICARE provider or with a local community-based mental health provider. If a Soldier completes the 6 sessions and it is determined that there is a family member in need of services or there is a need for family therapy, a re-assessment is initiated for an additional 6 individual sessions for the family member or family therapy sessions.

2. Child & Adolescent Psychiatric Services (CAPS): This service is available at Military Treatment Facilities for children of service members on active duty. With this service, medication treatment is coordinated with psychotherapeutic services through the Behavioral Health and Social Work departments.

3. TRICARE: The TRICARE Behavioral Health Network is utilized when family members are referred off post. This group of providers can see the family members of military service members without a referral from a primary care physician for up to 8 appointments, after which the patient is re-evaluated for longer-term care. The TRICARE network is inadequate in many locales across the country, particularly in terms of mental health.

4. Social Work Services: This service is officered on most military installations through the Medical Treatment Facility. It offers family therapy, individual counseling, parental support and family support groups or active-duty service members.

5. Family Advocacy Program: This program has two components, prevention and treatment. The prevention component falls under the Army Community Services located under Installation Management Command. It offers parenting classes and New Parent Support services for parents of newborns. It offers deployment education for family members of Soldiers deploying/redeploying. The treatment component falls under the local MTF and is part of Social Work Services. It offers group and individual counseling for Families and children who have been physically, emotionally and sexually abused.

6. DOD Military Life Consultants: Department of Defense mental health consultants that are located at several installations and provide support and referral to Families and Soldiers who are experiencing problems from the Global War on Terrorism.

7. Materials to assist parents, teachers and mental health providers are available at www.behavioralhealth.army.mil. These materials include a Sesame Street Video for younger children, booklets for young teens and other media designed for varying age groups. Topics include dealing with separation from parents during deployment, coping with traumatic events and other issues relevant to children of military service members.

8. ZERO TO THREE (DOD sponsored initiative) has launched a new campaign, Coming Together Around Military Separation: Supporting our Babies and Toddlers. The campaign kicked off in October 2006 on the Fort Riley, KS, military installation. It is designed to address ways that parents and caregivers can support their young children through military-specific challenges, such as deployment and relocation. The campaign includes posters, flyers and a children's boardbook.

9. Child and Youth Services (CYS) Kissing Hand Initiative Date Posted: 3/28/2005 Army CYS <http://www.armymwr.com/portal/family/childandyouth/> purchased copies of the book Kissing Hand by Audrey Penn from the Child Welfare League of America. This book is one of several Army CYS initiatives in place to reduce the stress on children impacted by the Global War on Terror.

10. MyArmylifeToo: FMWRC site MyArmyLifeToo serves as the web site of choice for Army Families, providing accurate and up-to-date articles and information on various topics.

11. EFMP (ACS): Provides information and referral for locally available resources to support children and Families with special needs. Ft. Hood has an initiative that coordinates support and resources for Families of Soldiers KIA.

12. Community-Based Healthcare Organizations: Psychological support to wounded Soldiers and Families at the Community-Based Healthcare Organizations (CBHCO) has been expanded, to include screening for PTSD.

CHARRTS No.: HOGR-01-007
House Government Reform Committee
Hearing Date: May 24, 2007
Subject: Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military
Congressman: Congressman Waxman
Witness: Major General Pollock
Question: #7

Question: Finally, the American Psychological Association found that while most military mental health professionals were highly skilled, many had not received appropriate specialty training needed to treat the special needs of military personnel. What percentage of Army Psychologists has received appropriate training in PTSD treatment? What additional actions has the army taken to insure that army mental health professionals are adequately trained?

Answer: Of the 300 full time psychologists working in the US Army Medical Command today, less than 100 are active duty. A large and growing percentage of our manpower is made up of Government Service or Contract personnel. All uniformed psychologists are trained in PTSD treatment. Whereas civilian psychologists are also familiar with PTSD, combat related PTSD is not part of the curriculum at civilian training institutions. Our best estimate is that two thirds of our present workforce is appropriately trained in this area.

There is a push to provide immediate training to BH providers who have limited and or no PTSD treatment experience. The AMEDDC&S and MEDCOM will host several iterations of training courses conducted by the Department of Veterans Affairs in San Antonio, Texas during the remainder of 2007. The AMEDDC&S is developing more advanced PTSD training to sustain lifecycle educational requirements for BH providers.

Continuing education is also offered our civilian workforce through our annual Force Protection Conference.

CHARRTS No.: HOGR-01-008
House Government Reform Committee
Hearing Date: May 24, 2007
Subject: Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military
Congressman: Congressman Waxman
Witness: Major General Pollock
Question: #8

Question: The Army's Mental Health Advisory Team conducted surveys in the Central Command theater of operations in September and October 2003, September and October 2004, October and November 2005 and in August and October 2006. What were the key lessons learned by the Army from those trips and, based on these lessons, what corrective actions has the Army taken to improve health service to our military service members?

Answer: Key findings from the MHAT missions include:

1) 15-20% of combat troops deployed to Iraq experience significant symptoms of acute stress / PTSD or depression and 20% of married service members experience marital concerns.

2) Longer deployments, multiple deployments, greater time away from the base camp, and combat frequency and intensity all contribute to higher rates of PTSD, depression, and marital problems.

3) Combat frequency and mental health problems are associated with ethical mistreatment of non-combatants.

4) Good unit leadership is key to sustaining mental health and well-being among combat troops.

As a result of these findings, the Army has revised the Combat and Operational Stress Control (COSC) doctrine and training, mandated COSC training for all deployment mental heath professionals, and ensured that there are sufficient mental health personnel in theater (credentialed providers and mental health technicians). The findings have led to the development of new training initiatives for Soldiers, Leaders, and Family members to include Battlemind training and the new PTSD and TBI Chain-Teaching program.

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