HEARING ON 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, D.C.

Committee Hearings

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The committee met, pursuant to call, at 10:15 a.m. in room 2154, Rayburn House Office Building, the Honorable 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, 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, Minority Senior Professional Staff Member; Susie Schulte, Minority Senior Professional Staff Member; 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 one 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, or 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 nine 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.

[Prepared statement of Chairman Waxman and referenced information follow:]

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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.

[Prepared statement of Mr. Davis of Virginia follows:]

********** INSERT **********

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 Katie, Texas.

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 two and a half 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 the 1st or 2nd, as indicated by the Washington, D.C., 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 the 1st and July the 3rd, 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.

[Prepared statement of Mr. McCaul follows:]

********** COMMITTEE INSERT **********

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 two minute opening, we will be glad to recognize the Members.

Ms. Watson?

Ms. WATSON. Thank you so much for this hearing. I will take one 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 Committee 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.

[Prepared statement of Ms. Watson follows:]

********** COMMITTEE INSERT **********

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.

[The information follows:]

********** COMMITTEE INSERT **********

Chairman WAXMAN. 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.

[Prepared statement of Ms. McCollum follows:]

********** COMMITTEE INSERT **********

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, Iowa.

Eleven years after he died, my brother, who works at the VA hospital in Knoxville, Iowa, 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.

[Prepared statement of Mr. Braley follows:]

********** COMMITTEE INSERT **********

Chairman WAXMAN. Thank you, Mr. Braley.

Any other Members wish to be recognized for a two 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.

[Prepared statement of Mr. Issa follows:]

********** COMMITTEE INSERT **********

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 got 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.

[Prepared statement of Mr. Cummings follows:]

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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.

[Prepared statement of Mr. Welch follows:]

********** INSERT **********

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 may 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.

[Prepared statement of Mr. Kucinich follows:]

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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 stated at Fort Collins, Colorado. The LeComptes are members of the Lower Brule Sioux Tribe of South Dakota.

Army Specialist Thomas Smith is a native of Lexington, North Carolina. 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, Georgia.

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 hand.

[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 five 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 okay.

STATEMENTS OF ARMY SPECIALIST THOMAS SMITH; ARMY SPECIALIST MICHAEL BLOODWORTH; RICHARD AND CAROL COONS, PARENTS OF ARMY MASTER SERGEANT JAMES COONS; 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 of 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 of 2004 I was injured during a training. I hurt my back. I continued to seek help for this injury for the next two 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 22nd of 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 27th, 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 of 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. I was explained that I might soon be experiencing some adverse reactions to the war such as nightmares, flashbacks, et cetera, 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 apartment 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 of 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 9th, 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.

[Prepared statement of Spc. Smith follows:]

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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 of 2005, when I was trained for six months in Camp Shelby, and in March of 2006 my squadron reached its area of operations in Iraq, where our mission was to provide convoy security.

During the course of the 11 and a half 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 16th of 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 time frame 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 secondly 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 one 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.

[Prepared statement of Spc. Bloodworth follows:]

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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 13th, 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 United States 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 five-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 3rd, 1968, in a small town in Texas. He died in July, 2003, under the care of Walter Reed Army Medical Center in Washington, D.C. 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, Texas, 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 of 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 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 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 three-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 30th of 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 follow up 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 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

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 three 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 the 4th of July 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 9:00 a.m.

Now the story gets interesting. Our casualty officer was not informed of the cause of death, and we were not being told 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.

[Prepared statement of Mr. and Mrs. Coons follows:]

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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. Okay. 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 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 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 pre-deployment 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 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 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 of 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 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 of 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 four 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 four weeks to three 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;

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.

[Prepared statement of Mrs. LeCompte follows:]

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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 ten 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, Wyoming, 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 time frames 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 of 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 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 follow up 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, California, 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 2:00 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. Okay. 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 one 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 United States 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 six 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. Okay. 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 got it right here, sir. According to this profile, I cannot carry or file an individual weapon, I am not able to move fighting gear at least two miles, I am not able to construct an individual fighting position, I am not able to do three to five second rushes under direct or indirect fire.

Mr. ISSA. Specialist, I think I have got 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. Okay. 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, I 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 11 and a half 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 five 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. Okay, 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 one 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 three to six 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 ten-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 three to six 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 three to six 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 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 whenever 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 second deployment [sic]. bit 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, five days, six days, seven days without time off. That goes beyond six or seven 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 the 1st of January of 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 or 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 mission, 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 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 an other three months, especially when, like, the R&R leave, I have got 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 okay, 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 towards 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 five 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 to that 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 quit 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 become 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 time frame.

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 two years at your home bases, and during those two 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 two years at home, and four brigades that have

deployed with less than one 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 two-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 two 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 and 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 eight 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 one 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 follows 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 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 follow-up 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 got 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 two weeks later. For that two 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 follow up 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 one-year tour, that other units such as Navy, not the Corpsmen, but other than Navy Corpsmen, were serving four 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 aware from your family and that is three 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 three 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 five-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 five minutes. We have a clock. It will turn yellow when you have gone one minute left and then red when five 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; 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 a participation 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 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 19th of 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 non-combat 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 one 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 three to six months after people get home from these world-wide 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 priority 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.

[Prepared statement of Dr. Kilpatrick follows:]

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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 de-stigmatize 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 on-site 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 two 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 follow-up. 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.

[Prepared statement of Dr. Zeiss follows:]

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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.

[Prepared statement of Dr. Insel follows:]

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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 United States 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 five 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 build upon 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, North Carolina, 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 website 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 I 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

[Prepared statement of General Pollock follows:]

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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, or 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 decision-making process.

Early 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.

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 1980s, 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.

[Prepared statement of Dr. Fairbank follows:]

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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 are 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 that percentage needs to the hen 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 at 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 three to six 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, et cetera, et cetera, 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 of the envelope, and you have got 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 follow-up 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 got 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 got 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 two 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 eight 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 two 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.--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 probability 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 follows:]

********** COMMITTEE INSERT **********

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.]

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