kaisernetwork.org Health Policy As It Happens
Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation[1]
(Tip: Click on the binocular icon to search this document)

President's New Freedom Commission on Mental Health Campaign for Mental Health Reform: Returning War Veterans and Mental Health March 29, 2006

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

MIKE FITZPATRICK: Welcome. My name is Mike Fitzpatrick [misspelled?] I'm the current president of the Campaign for the Mental Health Reform and the Executive Director of the National Alliance on Mental Illness. And I'd like to say before I start I would like to thank Kaiser for Web casting this event today and to let you know as of Friday this will be permanently on the campaign's Web site.

I'm speaking today on behalf of 16 national organizations that comprised the campaign and I want to welcome you to the convening of the former members of President Bush's New Freedom Commission on Mental Health. In October 2002 the commission issued an interim report that's been widely quoted because it hit the nail on the head. The commission described the nation's public mental health system as fragmented, in disarray, leading to unnecessary costly disability, homelessness, school failure, and incarceration. In his final report issued in July 2003, the commission called for nothing less than a fundamental transformation of the mental health system in America and provided for a blueprint for achieving this change. The campaign for mental health reform was created to translate that call to action and provide a unified voice on mental health policy. The campaign released a report in July 2005 entitled "Emergency Response, A Roadmap for Federal Action

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

on America's Mental Health Crisis." This report proposed 28 action steps necessary to achieve this transformation. While some states are working very hard to achieve that transformation, quality treatment and services for people with serious mental illness remain unavailable in many parts of the country. In a March 2006 report entitled "Grading the States" a report on America's mental health care system for serious mental illness NAMI [misspelled?] an average grade of D. No matter where you live, no matter where you go to school a D is not acceptable. We still have a long way to go.

Thus today's reconvening of the new Freedom Commission is particularly timely. Nearly three years after the release of the Commission's report, it is time to bring together members of the commission to further discuss its vision and what needs to happen to make transformation a reality. I want to thank the commissioners for agreeing to participate in this historic meeting. I also want to take a minute to thank Chuck Konigsberg, the campaign's Executive Director who has worked tirelessly to organize this meeting. It's now my honor to turn the microphone over to Dr. Mike Hogan, the chair of the New Freedom Commission on Mental Health and the Mental Health Commissioner for the state of Ohio.

MICHAEL HOGAN, PH.D.: Thanks Mike, very much. All of us on the commission who are reconvening here today want to thank you and all of the members of the campaign for

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

mental health reform for coming together to speak frequently but not always with one voice on behalf of the cause of people recovering from mental illness and to carry our work forward. I note that the campaign was formed as the commission was wrapping up to do those two thing; to advance the recommendations that we had made but also to bring together a sometimes fractious mental health community to highlight the cause of mental health. I will just say on behalf of the members who had an extraordinary time and worked very hard during our year in service that we found a number of paradoxes in looking at mental health and mental illness in the United States. We found, on the one hand, as Mr. Fitzpatrick has said a system that might be characterized as being in shambles but in which thousands of extraordinarily dedicated and committed people, worked to provide care to support family members and each other and to advance in their own recovery. After meetings in Washington and Chicago, in California, testimony from hundreds of people and feedback from thousands, we emerged with a sense that recovery both in terms of spirit and in terms of outcome is realistic goal in mental health but only if parties work together better and more effectively than they have in the past. So the paradox is that recovery possible on the one hand while on the other hand mental illness stands as the leading cause of disability, indeed as we'll hear today of death.

Another paradox that we found is that the work of mental health care is done in the states and is done in local

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

communities and we have really been gratified since we completed our work at the response in many states and communities and advance the cause of mental health care. Yet at the same time leadership has to be exercised here in Washington and a federal commitment to this cause is essential. And that brings me to the last paradox and that is that mental illness, although it affects so many people and touches so many families, is still too often invisible to the larger community. And that's one of the reasons why we particularly appreciate the opportunity to come back together to put a little bit of a face and to remind those who work in and around this building of the importance of this issue.

To put some of these concerns in a broader perspective, I'm pleased to introduce Thom Bornemann. Tom is former Deputy Director of the Center for Mental Health Service in the federal government and has been for the last several years the director of the Carter Center's Program on Mental Health under the leadership of former first lady Rosalynn Carter. Thom thank you for your support and for being with us here today.

THOM BORNEMANN, ED.D.: Thank you very much Mike and thank you for your leadership in this entire process and to the commissioners giving so generously of their time and their considerable talent to something important and absolutely critical to all of us. I bring you greetings from my boss, Mrs. Carter regrets that she wasn't going to be able to be here this afternoon but certainly wanted me today – her commitment to the achievement of the goals that were outlined

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

in the New Freedom Commission Report. As a program we certainly took the report very seriously. We see it as an important first step and wonderful platform from which to launch the kind of reform that all of us in this room I think would like to see happen. We thought so much of it that we dedicated two years, two consecutive years, of our Annual Rosalynn Carter Symposium on Mental Health Policy to the New Freedom Commission Report. That is rare in the 23 years that we've been doing that type of work and that's how important we felt it was and frankly we feel it is. We can't let these three years build too much ground between the energy and creativity and commitment that people had at the launch and now we're getting into the weeds, getting into the hard work, building some distance from the original report and we need to make sure that we can keep our vision clear and crisp and compelling.

I was asked to speak a little bit about the contrast the last presidential commission before this one and that would have been in the Carter Administration in the late 70s. Some of you may have been around long enough to remember that commission. It was another ambitious attempt to get a handle on America's mental healthy system. And if you recall what was happening in the late 70s we had major reform under way then. We were moving out of institutions and into the community. We were beginning to understand how those services need to be delivered in communities and we saw at that point, I think, maybe with a little myopia that good services was the outcome. That was our goal to create a

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

system of good community based services where people could receive optimal care in the communities and in their families when in fact what the new commission report has taught us, and I think taught us in a compelling way is that good service delivery is not the outcome, recovery is. And if we think about that and stay with it a little while, what it says to us is a complete reframing of the way in which we organize and deliver services and a complete change in the type of relationship we have with the people we serve. And I think that was capture well in the new commission report. As a community I think we need to continuously challenge ourselves to make better arguments. Our arguments haven't worked and I think we need to have a very candid discussion about that. They simply have not worked. And I think there are arguments that we can begin to extend that will be talked about by the panelists who are about to follow me that I hope will give us some ideas on ways we can go. For example I think it's very important to turn the national discussion about mental health from simply an issue around expenditures and talk about it more in terms of an investment. That we are an investment in the future of this country and in the many people whose talents and abilities are thwarted by an illness that's treatable and manageable in the community. We recognize the work of the commission, I look forward to the discussions here and we at the Carter center will lend our voice in whatever ways we may be helpful. Thank you.

MICHAEL HOGAN, PH.D.: Thom, thank you and we thank you as well as Tom Bryant [misspelled?] and Mrs. Carter for

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

your guidance of our efforts during the process. I think many of us will remember the evening that Mrs. Carter spent with us as one of our most extraordinary experiences during the whole year that we worked together. One of the very nice things that was at times challenging but ended up really enriching the process of this commission when we did our work was the dialogue between a number of a people from around the country from every perspective on mental health, in their mental illness in their family or responsibilities as clinicians or judges or administrators, so this diverse group of people from outside the beltway who were appointed members with a number of senior federal officials who were exofficio [misspelled?] members of the commission and that dialogue was at times contentious but always in the end, productive. One of the things that was also nice about the timing of our process is that right about when we were completing our work, Gail Hutchings [misspelled?] who is at your left who had been acting as the administrator of The Center for Mental Health Service and was one of the critical go to people for us in the federal government and Catherine Power [misspelled?] seated to my immediate right came in as the director for Mental Health Service. Catherine took as her primary charge to catch the ball in a sense that the commission had thrown, and coming from her previous work including multiple private sector as well as state leadership positions in the state of Rhode Island, has provided enormously focused and energetic leadership on the federal level and we thought that one of the things that would be helpful before we turn to the panels

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

that are the real core of our meeting today would be to hear from Catherine a little bit on her leadership efforts the advance the cause of mental health and mental health transformation. So Catherine we're delighted that you're with us today.

CATHERINE POWER: Thank you very much Chairman Hogan. I really appreciate the opportunity. I thank the members of the commission and I also thank the Campaign for Mental Health for this gracious opportunity. Good afternoon. As you all know SAMSA [misspelled?] is the federal agency that has been charged by the president through the US Department of Health and Human and Services to create what is known as a new reality in mental health care. And that reality frankly is the one that was envisioned by this new freedom commission in its final report. A future in which mental illnesses can be prevented and everyone with a mental illness will recover. SAMSA is moving toward this reality through mental health transformation. This is the name we've given to our initiative to introduce fundamental change in the way mental health services are perceived, the way in which they're accessed, they way in which they're delivered, and the way in which they're financed in this country.

Our approach is based on the evidence of other transformative organizations. On noted scholar and researcher headed up the Pentagon's Office of Force Transformation. This is the advice he handed down recently to those who would lead transformation. "Be bold," he said. "Pick up the things that look really hard. Other people will

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

have done everything else. Be fast," he added. "No transformational leader ever looks back and regrets moving too fast."

SAMSA's agenda for mental health transformation is bold. At the federal level we have engaged nine departments and 13 agencies within HHS to carry out a broad, collaborative federal action agenda. Why do we need this broad based coalition for mental health? Look at our prisons, our homeless shelters, and our child welfare system. Look at our returning war veterans. The burden of mental illnesses and the responsibility for protecting mental health and promoting recovery crosses all organizational boundaries. SAMSA is demanding unprecedented collaboration, accountability, and leadership from all involved. Just recently we convened the federal executive steering committee to guide and monitor the federal government's process of transforming health care. Who is on this committee? Twenty-one assistant secretaries and deputy commissioners representing the nine federal departments and agencies. We have engaged these senior level individuals with providing consumer access to effective services by identifying and eliminating regulatory and funding barriers. SAMSA also is proceeding rapidly to facilitate and compel the kind of transformation that is necessary by the states. The greatest opportunities for change, as Chairman Hogan indicated, lie at the state level where the decisions about service availability and funding are made. We have been facilitating and working with the states to begin taking bold action at

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

their level and we're backing up our efforts with funding and technical assistance. By the end of this fiscal year SAMSA will have awarded almost $36,000,000.00 to seven states to begin developing the infrastructure needed to support the systemic changes that are called for, such as linking together the efforts of education and justice, children's services, labor and others.

We are supporting state efforts through our new transformation action initiative which will broker technical assistance to help those states meet the needs of their plan and their constituents. We, however, will not stop with these seven states, nor will we wait for additional successive fiscal funding to promote state level transformation further. We will use the experiences of the seven grant states to advise other states on how strategies in developing comprehensive service systems, together with the national governor's association and the national association of state mental health program directors we will continue to host regional transformation meetings. Last year we began to meet with teams of senior state officials to help them assess their mental health systems and to adjust their policy and funding priorities accordingly. So far 25 states, the District of Columbia, and four territories have attended three regional meetings on transformation. An additional thirteen southeastern states are invited to the fourth and final meetings to take place in New Orleans this coming June 15th. We are doing more than calling for change by the states. We also are insuring that they have the strategic

tools in partnership with us and supportive leadership to make change possible.

Subrowski [misspelled?] shared this advice about transformational leadership. He also said, "Be specific. If you lack specificity your subordinates will be able to change your message to suit their own purposes." At SAMSA we are modeling the behavior that we want others throughout the mental health system to adopt. Think of it is as radiant leadership, changing ourselves first as a way to encourage others to make similar changes. We are incorporating the concept of recovery in every aspect of our work. At CMHS we have declared 2006 as the year of the consumer. We are surrounding ourselves with experiences and images of mental illnesses and recovery. This year SAMSA hosted a traveling exhibit by photographer Michael Nye [misspelled?]. The exhibit called, "Fine Line, Mental Health, Mental Illness" is a documentary of voices and stories and portraits of individuals living with mental illness. In this manner we are driving ourselves to experience personal change so that each of us will have the courage and conviction to take risks necessary in moving from old methods to bold actions.

One of our most important activities and I'm sure the commission discovered this as well, both internally and externally is to change the language of mental health. As Subroswki noted, "Language conveys culture. You cannot expect old language to carry new ideas." We have launched a national anti-stigma to educated Americans about mental illnesses and recovery and to encourage those who need help

to seek it. We've created the Voice Awards, this program recognizes writers and producers of television, radio, and film whose words portray individuals with mental illnesses with dignity and respect.

The language we recognize speaks of hope and of recovery. I'm proud to say that I believe SAMSA's own voice is being heard. We recently received the only community service Emmy that the National Academy of Television Arts and Sciences awards each year. Our 15 plus make time to listen take time to talk about bullying multimedia campaign was selected from among hundreds of entries as the best example of outstanding messages and services for our communities. SAMSA also convened – [applause] thank you. You should see this Emmy it's unbelievable, it's unbelievable, it weights a lot. SAMSA has convened a national panel to develop a consensus statement defining the principles of recovery what it means and how it can become real in practice. A draft statement recently has been released to all of you. The language of this statement will be just as important to changing the attitudes and beliefs of consumers as it is to changing those of program administrators and providers. Consumers are the reason we all must do the difficult but necessary work of transformation. They too, must be ready to change and willing to risk because it is their needs, their expectations, and their potential that should shape the new reality of mental health care. Each of these activities I've described represents profound change by those affected. In an essay entitled "Reflections on Deep Change" Tom Merrik

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[misspelled?] of the Maryland Department of Disabilities, one of our six states, explored the concept of recovery as it applies to consumers and mental health organizations undergoing change. He wrote, "In many respects, recovery as experienced by the mental health consumer can be viewed as a kind of a personal transformation. While a broadly brushed picture of system transformation can be viewed as recovery; that is recovery of a system that is badly out of alignment with current changing. Our goal at SAMSA is to align our national expectations of mental health care. We are transforming our mental health system so that its reality matches the reality of more than 20 million Americans who currently have a diagnosable mental illness. We know that recovery is a real possibility, the commission stated it, we saw it, we believe it. But it hinges on the ability of consumers to obtain the necessary services when and where they need them. SAMSA and its federal state and private sector partners are progressing in transformation. The programs and policies that SAMSA promotes are those meant to embed transformation across and within mental health systems and other systems and yet we know many issues remain unaddressed, many collaborations have yet to be formed, and much work lies ahead. The reality is that we must continually seize the many opportunities for progress that exist. We work within the following equation; transformation equals vision, plus belief, plus action times quality improvement squared. The New Freedom Commission gave us the vision and we thank you for that. Now it is up to all of us

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

to complete the equation so that we will maintain the current momentum for change. SAMSA will continue to motivate, to partnership, to facilitate, and to compel changes across the mental health system. We all need each other's mutual support and I urge every individual and organization in this room to join together in achieving the promise of a care system that offers hope in recovery and a life in the community for everyone. Thank you very much.

MICHAEL HOGAN, PH.D.: Thank you Catherine. Now we've had introductory perspectives from advocates, from the federal government, a little bit of perspective from the commission, we're going to turn to the core of our agenda. An additional paradox it seems to me in mental health care is that mental health issues are often affected not so much by mental health officials but by those in the broader community. So we know for example the changes in Medicare, or Medicaid, or education or housing policy or Social Security end up having the most significant effect on people that are living with and recovering from mental illness. Yet often deliberations about those broad issues are not necessarily fully aware of the implications for those folks that are wrestling with these challenges.

So in that context our main agenda today is to learn about the significance of mental illness as it's experienced and as it's addressed in three areas that are of great concern in our nation these days. The first is challenges faced by men and women in our armed forces who are both frequently separated from family and support by very long

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

distance and subject to extraordinary stresses that most of the rest of us can only imagine. The second panel today will address mental illness as a driver of suicide and of self harm, a much more significant source of lost life and disability than is frequently recognized. And finally the last panel will focus on challenges of mental illness and mental health care in the work place and among families of workers. Our format will be that we have three extraordinary panels. Each will speak concisely and I think passionately as well and each of the panel presentations will be followed by some questions from commission members and to the extent time permits some questions that may be brought forward by members of the audience.

So I want to turn with that to our first panel and start by welcoming back one of our members, Dr. Fran Murphy who will lead off this panel. Dr. Murphy is Deputy Under Secretary for Health Policy in the Veterans Administration on the commission both served as a key member and also took back our ideas and recommendations to the Veterans Administration to extraordinary effect in terms of improving mental health care and beginning to reorient a veterans health system that sometimes can be a little stodgy in the direction of recovery. In recognition of her extraordinary leadership, Dr. Murphy has received numerous awards including a good housekeeping award for leadership of women in government in 2005. And I think Fran, I’ll introduce your other two panel members and then ask all three of you to go.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Dr. Murphy will be followed by Joy Ilem who is an Army veteran, served as a combat medic as well as an EMT and who has brought that experience to service with the Disabled American Veterans for the last ten years and thus speaks from personal experience as well a broad experience of disabled veterans with these challenges.

And finally Stefanie Pelkey who while in the military herself served as the first female in the 9rth Field Artillery Battalion in Germany then was married in 2001 to her late husband, Michael Pelkey. She will tell us more of that story.

So with that, Fran it's great to see you again, and welcome.

DFRANCES MURPHY, M.D., M.P.H.: Mike I note your warning about not being too verbose. I'm just going to launch into my statement this afternoon. Good afternoon everybody. Mr. Chairman, colleagues, and friends, it's truly an honor and a privilege to be here with you today to discuss the mental health needs of returning combat veterans. In July of 2003, you the members of the President's New Freedom Commission on Mental Health, released a report entitled, "Achieving the Promise, Transforming Mental Health Care in America." The overall message of the commission was full of hope and simplicity. That is that mental illness and emotional disturbances are treatable and that recovery is the expectation. However the solutions are far from simple and in fact are extremely complex. We at VA took up the call for fundamental change and developed a transformation action

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

agenda for the Veteran's Mental Health Care System. VA's action agenda incorporated the six commission goals and formed the basis for the development of a comprehensive mental health strategic plan. That mental health strategic plan is VA's long term national commitment to develop a high quality veteran's centered system of mental health and substance abuse care based on recovery principles. We're also pleased to be active members of the Federal Partners Mental Health Action Agenda Work Group which is led by Catherine Power at SAMSA.

In July of 2005 on the second anniversary of the New Freedom Commission's finding the Campaign for Mental Health Reform responded to the crisis by forming an unprecedented coalition and releasing its report. We were delighted when the campaign highlighted our nation's special obligation to the men and women who bravely serve our nation in military combat. During the brief time I have today I will address VA's role in providing health care and particularly dealing with the mental health needs of veterans returning from service in operations Iraqi Freedom and Enduring Freedom in Afghanistan.

As you know VA is the second largest of the 14 cabinet departments. As the second largest of the 14 cabinet departments, VA provides US veterans with the most comprehensive program of benefits and services of any nation. The veterans health administration is responsible for the management of the largest integrated health care system in the US, with a 196,000 employees at a 154 hospitals and more

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

than 850 outpatient clinics across the nation and 207 readjustment counseling centers. This year more than 5.4 million veterans will receive health care in facilities across the nation. The Department of Defense and VA share a unique obligation to provide health care for the men and women who serve in uniform.

Why is serving veterans so important? Well because each of us owes our way of life who endured the horrors of war to safeguard freedom for us. And because our nation recognizes one simple truth, the troops of tomorrow will only be as good as our commitment to veterans today. President Theodore Roosevelt understood this fact when in 1903 he said, "A man who is good enough to shed his blood for his question," and I would add a woman, "is good enough to be given a square deal afterwards." In order to meet the needs of returning combat veterans, we need to understand the exposures in the combat theater, investigate the health consequences of service in Iraq and Afghanistan, and design a full continuum of services to meet the identified mental health needs.

Currently we have a rather incomplete picture of the health of those who served in Iraq and Afghanistan. However, we have enough pieces of the puzzle to begin to discern the overall picture and to estimate the behavioral health needs of returning veterans. Historically military service members returning from combat deployments have been show to have an increased risk of physical and mental health problems. Previous research indicates that exposure to combat results

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

in increased risk of post traumatic stress disorder, major depression, substance abuse, functional impairment, and social and occupational settings and an increased use of health care services. Veterans with chronic health conditions eventually come to the attention of the health care system but often years after exposure. Delays in identification in treatment often result in significant costs, increased pain, disability, and social disruption. We've learned these painful lessons following both Vietnam and the 1991 Gulf War. Screening and early identification can assist veterans and their families with readjustment and it allows an earlier intervention and treating at more easily treatable stage of illness.

The wars in Afghanistan and Iraq are the largest and most sustained combat operation since the Vietnam War. Emerging evidence suggests that the burden of combat related mental illness will be high. In 2004 a comprehensive by Carl Hoag [misspelled?] and his colleagues from the Walter Reid [misspelled?] Army Institute of research examined the mental health impacts of OIF and OEF deployment on Army, soldiers, and Marines. The results of this study demonstrated that the estimated risk of PTSD from Iraq was 18% compared to an 11% estimated risk of PTSD from service in Afghanistan. However the military culture and stigma against mental health care kept many soldiers in this study from seeking needed care. The scientific literature indicates that the intensity of combat exposure with an increased risk of developing chronic PTSD and other associated mental health problems. Evidence

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

indicates that the combat operations in Iraq are very intense. In fact, 94% of soldiers in Iraq reported receiving small arms fire, in addition 86% of soldiers in Iraq reporting knowing someone who was seriously injured or killed and 68% saw dead or seriously injured Americans. Fighting the insurgency has resulted in a heightened degree of vigilance in the sense that there is no safe place and no safe role for US troops in Iraq.

In 2006 Hoag and his colleagues again published a study of health care utilization during the first year after return from service in Iraq or Afghanistan. They reported that the prevalence of reported mental health problems was 19% from Iraqi Freedom veterans versus 11.3% after returning from Afghanistan. As expected mental health problems were significantly associated with the degree of combat experience. It was also associated with attrition from the military within the first year after service. Over one third of Iraqi Freedom veterans accessed mental health care after returning home, while on 12% were subsequently diagnosed with a mental health problem. Active duty, reserve, or national guard status had no effect on the prevalence of the mental health conditions. However gender did influence the results, with 23.6% of women reporting a mental concern versus only 18% of their male counterparts. These high rates of utilization of mental health services among Operation Iraqi Freedom veterans after deployment should raise our awareness of the challenges likely to be faced in addressing the immediate and the long term needs of recent combat veterans.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Hoag also noted that the rates of mental health care use for the entire Army and Marine population has shown a linear increase over time since 2000. This provides further evidence that war is impacting the health care system at large. Another important window into the health care needs of returning veteran's needs is provided by an analysis of the VA data on health care utilization by those veterans who have left active duty service since serving in Iraq or Afghanistan. Of the over 500,000 veterans included in this database from fiscal year's 2002 through the first quarter of this year, approximately 144,400 again, almost a third of the separated southwest Asian veterans are already seeking health care within the VA facilities. The demographic characteristics of these veterans indicate that 87% are men, while 13% are women; 76% are between the ages of 20 - 39; and 92% served in an enlisted role in the military. The three most common health conditions of returning veterans treated by VA are musculoskeletal conditions, mental health conditions, and digestive system problems. Again, mental health problems are the second most common reason for veterans of this war era to seek health care in the VA.

32% of the VA patient encounters were coded as possible mental disorder. The most common mental health diagnoses were PTSD, non dependent drug abuse, depressive disorders, effective psychosis, and alcohol dependent syndrome. It's important to note that the number of veterans seeking VA care for behavioral conditions is rapidly increasing. For example, VA reports a 30% increase in the

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

diagnosis of PTSD just in the past three months. That's 15,000 veterans reported in October of 2005 versus 20,638 in January of '06. In addition through February of 2006 the vet centers, whose data is not included in the above data analysis, provided PTSD services to 6,800 veterans and readjustment counseling to 40,000 veterans. In 2006 vet centers programs also experienced rapidly increasing enrollment in their programs. Currently VA estimates that over 109,000 Iraqi Freedom and Enduring Freedom veterans will receive health care in VA facilities in 2007. Taken in combination the findings of Hoag and the latest VA data suggest that the current estimates of utilization of health care services including mental health and substance abuse, and the associated resources demands, may be significantly higher than were originally estimated.

Recognizing the complex challenges faced by the men and women who served in combat, federal programs have responded by initiating a full continuum of health care services and programs. The programs span a wide range of activities including outreach to veterans and families, post deployment screening, early interventions, readjustment counseling, assistance with reintegration into community, family and civilian jobs, and specialized medical and mental health services. DOD, VA, other federal agencies, and state organizations manage these diverse programs. One of the keys to success will be creating ongoing communication and collaborations between the multitude of programs and organizations serving returning veterans. When this first

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

was attempted after the first group of veterans from Iraq and Afghanistan, I have to tell you that the only analogy I can use is a sports analogy. It was like trying to play in the final four when you had no coach, the team had not practiced together, they spoke different languages, and they all had earmuffs on. In order to try to improve the communication to deliver services to returning veterans, VA and DOD have established a joint, seamless, transition office that is aggressively addressing this problem. We hope to create a no wrong door approach to post deployment health care, but that goal is not yet near to be achieved. Outreach for federal health care, focused on education of veterans and families, information sharing on services and benefits available, debriefing and early assessment. A number of barriers to care exist in the federal health care system. It can be very confusing for veterans and family members to understand the services available to them and to navigate through those systems. Effective education and outreach insures that veterans are aware of the range of programs, the methods for accessing care, and receive effective assistance in finding access to timely care and services. DOD and VA's health care and the vet center staff provide these outreach services. As an indication of the extensive efforts being made, to date the readjustment counseling service has hired 100 veteran outreach peer workers and provided outreach to more than 54,000 Iraqi Freedom and Enduring Freedom veterans. Combined state and federal efforts are a critical component of these programs with many states forming interagency coalitions to

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

support returning veterans. Those efforts are starting to bear fruit and I applaud the efforts in New Hampshire, in Washington state, in Ohio and in New York and many other areas of the country.

Another important program is that DOD administers both pre deployment and post deployment health assessments to service members prior to leaving the US and immediately after their return. Scientific indicates that health problems are frequently identified several months after returning from deployment. Therefore a post deployment health reassessment survey is beginning to be administered 90-180 days after return and that has augmented the previous post deployment process. This post deployment health reassessment attempts to reduce the stigma of seeking care for post deployment health concerns. It provides both an education and a health assessment program and is designed as a global screen. Based on the responses to this assessment the individuals are referred for appropriate medical and mental health evaluations. Early data suggests approximately 50% of service members who complete that assessment report medical, behavioral health, or a combination of symptoms requiring further assessment. DOD should be praised for their unprecedented efforts in post deployment screening, early assessment of the health consequences of combat service, and their commitment to provide exceptional care for returning veterans.

The Veterans Health Administration has achieved benchmark performance in quality patient safety, patient

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

satisfaction, and coordination of health care services. In decoding the DNA of the VHA health care system, it's clear that one of the reasons for that success is that VA created a community of health care managers and clinicians who perform like scientists. People who treat every problem as though it were a hypothesis to be tested and evidence based systems to be created. The Veterans Health Administration provides excellent, state of the art mental health and substance disorder care for veterans. Our clinical providers are highly dedicated individuals who are dedicated to serving the needs of veterans, both of past eras and current deployments. Mental illness, alcohol and substance abuse disorders are a major problem in our system, making up one in every five visits to the VA health care system. VA is a leader in the development for PTSD and military sexual trauma. However, the promise of our state of the art programs and scientific research will be a hollow one if veterans who are struggling with the aftermath of severe trauma do not have equitable and timely access to quality mental health care near their homes. In some communities VA clinics do not provide mental health or substance abuse care or waiting lists render that care virtually inaccessible. Addressing the disparities in access to due to racial, ethnic, gender, and geographic disparities must be given high priority by VHA leadership.

In conclusion Mr. Chairman I'd like to thank you and the campaign for Mental Health Reform for this opportunity to testify on behalf of America's heroes. I'd like to assure you that our department intends to do its utmost to insure

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

that we are achieving the promise and we are transforming mental health care for veterans. This will require sustained effort on a federal, state, and community partnership level and appropriate resource allocation. Military service members have been exposed to increased levels of violence, combat trauma, military sexual trauma, and separation from family and social supports in the past decade. We are committed to training our staff to communicating effectively with veterans and their families, involving veterans and their families in health care and recovery planning. We will support research and education to keep the best ideas bubbling up to advance evidence based frontiers of care. President Bush has said, "Government likes to begin things, to declare grand new programs and causes. But good beginnings are not the measure of success in government or any other pursuit, what matters in the end is completion, performance, results, not just making promises." VA will make good on its promises, we will continue to offer veterans the world class care we they have earned through their service to our nation. The men and women in uniform fought bravely to defend our freedoms. We are committed to insure that when they return home veterans do not need to fight for the health care services and benefits they've earned. Thank you very much.

MICHAEL HOGAN, PH.D.: Thank you Fran. It's really quite an extraordinary story in terms of numbers and scope and trends. But at some level the numbers and the trends are less critical than the meaning of this for individual men and

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

women in the armed forces and their families and so Joy, we’re pleased to hear from your perspective with DAV about these issues.

JOY ILEM: Thank you Mr. Chairman and former members of the New Freedom Commission. I’m pleased to join my colleagues today to assist in you evaluating the status of mental health care programs for veterans administered by the Department of Veterans Affairs with the focus on the quality and availability of those programs to support needs of older veterans as well as those now returning from military service.

I will begin by saying that the Veteran’s Health Administration has the most comprehensive mental programs in the country to treat veterans with readjustment issues stemming from military combat including post traumatic stress disorder. It also is the home to a cadre of highly skilled clinicians who specialize in and are dedicated to helping veterans dealing with the unique mental health challenges they faced as they return from combat theaters to civilian life. Although mental health services are a major component of VA health care, internal VA funding to underwrite a robust mental health program has been a continuing struggle, similar to that which occurs in the private sector. The ongoing wars in Iraq and Afghanistan are difficult, dangerous assignments for American troops whether they are regular active duty members, reserve, or National Guard. And VA and DOD are well aware that combat veterans of operations Iraqi and Enduring Freedom are at great risk for PTSD and other mental health

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

problems. The work done by Colonel Hoag and others highlights the relationship between combat deployment and mental health issues among our newest generation of war veterans. Like Colonel Hoag we see the challenges in insuring that there are adequate resources to meet the mental health needs of this group. VA reports that veterans of these current wars contact VA with a wide range of possible medical and psychological conditions including; adjustment disorder, anxiety, depression, PTSD, and the effects of substance abuse. We are pleased that VA has increased its outreach efforts in an internal mental health screening of OIF OEF veterans. However, we have continued concerns about VA's future projections for health care utilization among this group and funding levels needed to meet that demand.

We recognize the many challenges that service members who have served in combat theater face returning to home to their families and communities. Some have been able to move forward with their lives, following a normal readjustment period, others have experienced significant mental health issues related to their military experience that persist causing them to claim disability compensation from VA for PTSD or many other mental health conditions.

DAV strongly believes that veterans should be fairly compensated for disabilities related to their military service and the highest quality health care services available to properly diagnose and treat such conditions. Likewise we are committed to ensuring restoration of all injured veterans to the greatest extent feasible. Mr.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Chairman, with all the challenges we face addressing mental health concerns for our nation's veterans it is clear that there are many professionals dedicated to understanding the unique health care concerns of this newest generation of war disabled veterans. We are pleased that there is increased attention from traumatic brain injury, or TBI, a serious condition resulting from physical trauma that damages the brain's functioning. Since not all providers are knowledgeable about TBI and the symptoms often mirror other mental health problems, we support recommendations for additional research in this field and the development of a new VA initiative to address the unique mental health needs of veterans with TBI. We are pleased that there is now an increased focus on early intervention and treatment of mental health problems among newly returning veterans. It appears DOD is now conducting more comprehensive pre and post deployment health assessments and is working to improve collaboration between itself and VA to insure this information is accessible to VA clinicians in real time through electronic medical records transfer. Likewise VA and DOD are to be commended for beginning to address the issue of stigma and the barriers that prevent service members and veterans from seeking mental health services when needed. Although there have been many improvements much more needs to be done. All of these goals toward a truly seamless transition will require unprecedented level of inter agency cooperation.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

VA operates a significant network of specialized mental health programs for PTSD within VA and over 200 community based vet centers providing a variety of readjustment counseling services. One of VA's most notable programs is its national center for post traumatic stress disorder. The center acts as a focal point to promote research into the causes and diagnosis of this disorder and to train health care professionals in diagnosis and treatment and to serve as an information resource for professional. The national center has an excellent web site which includes documents such as the "Iraq War Clinician Guide" and a guide for military personnel titled, "Returning from the War Zone" which focuses on post deployment readjustment issues. Congress has codified into law special safeguards to insure that VA gives a priority to the needs of veterans with mental illness. For fiscal year 2006 congress ear marked at least 2.2 billion from the VA Medical Services Appropriation Account to be used solely for mental health services. Such as an earmark was necessary because the VA health care system has had uneven record of availability of services to veterans with chronic and acute mental health needs. A primary example of this relates to VA's community based out patient clinics as Dr. Murphy indicated. As VA reduced its hospital bed capacity, including mental health beds, and expanded its primary health care out patient services to communities through an array of community based outpatient clinics it did not insure that mental health services were available at all these new sites. Likewise we have been concerned about the

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

decline and availability of VA's substance use disorder programs of all kinds over time including detoxification and residential treatment beds. Although additional funding has been dedicated to improving capacity in these programs, VA mental health providers continue to express concerns about veteran's access to these special services.

We are pleased to say that following the release of the report of the President's New Freedom Commission on Mental Health on July 2003 VA undertook its unprecedented critical examination of its mental health programs. It established a national mental health strategic plan as an outgrowth of the President's New Freedom Commission report and has committed $100,000,000.00 annually to its implementation. Unfortunately I understand that Vas internal policy on funding new rehabilitative and recovery oriented initiatives included in the strategic plan will be limited to two years. After that VA networks will be responsible for providing funding within in their normal allocations. We think this policy is ill advised considering the history of funding mental health services in VA. Clearly any transformation or major change from eliminating the long standing variability in VA mental health care to changing its mission from symptom management to recovery will take sustained leadership and support on the part of VA and congress.

While VA and congressional leaders have taken important initial steps to move VA toward better care for veterans with mental health problems, many serious challenges

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

still exist. In my written testimony I've included a series of recommendations to address gaps in services that we believe would help improve VA mental health programs. What needs to be done is clear, the system must continue to improve access to specialized services for veterans with mental illness, PTSD, traumatic brain injury, and substance use disorder, commensurate with their prevalence and must insure that recovery from mental illness with all the positive benefits this brings to veterans, their families, and to our society becomes the guiding beacon for VA mental health planning, programming, budgeting, and clinical care. There must be early recognition and intervention of war related acute mental health problems to prevent, when possible, the devastating of chronic mental illness.

We need to insure that veterans and their families are given the information they need to understand common and serious readjustment war veterans may face and where they can go to get help. Proper assessment, continued support, and timely access to mental health providers are critical. Primary care providers in DOD and VA should be trained to screen, recognize, and refer patients with potential mental health problems so that no one falls through the cracks. We also suggest that congress extend the two period of eligibility for VA health care that OEF OAF veterans are currently afforded to five years given the sometimes delayed onset or recognition of mental health issues including TBI and PTSD. The cost of caring for veterans is a continuing cost of national defense and most would agree that we should

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

do everything we can to assist in the adjustment and recovery of veterans suffering with physical and mental wounds of war. VA must be sufficiently funded to treat newly returning with mental health issues without displacing older veterans with chronic mental illnesses. Finally we must also insure that family members of veterans affected by PTSD and other readjustment issues have access to appropriate counseling and support services.

Mr. Chairman and former members of the commission I appreciate having been invited here today and I want you all to know that DAB stands ready to assist you and the campaign for mental health reform in bringing the hope of new freedom to veterans of military service who struggle with mental illness. Thank you.

MICHAEL HOGAN, PH.D.: Joy thank you [applause] I think you bring both the perspective of experience here and also some concerns about the realities of these challenges which cannot be addressed, as you point out, in just a short window of exuberance. And I think to underline the significance of these issues we're really honored to have with us Stefanie Pelkey who will tell her story and her family's story as it relates to these issues.

STEFANIE PELKEY: Mr. Chairman and fellow commissioners, I appreciate the opportunity to tell my husband's story and to be here. So thank you.

Blood. That was the only word that he would say as he touched his body for fear that he had been shot. Blood. Finally he awoke with a scream so loud that I believe there

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

was blood too. He ran to flip on the light switch as he covered his face with those big hands. I was startled so that I began to cry. "What happened?" I asked. He looked over with a glazed stare and then finally cracked that smile, that smile that reassured me that everything was going to be okay. "Just a dream," he would say. He climbed into bed again and I would cradle him like a baby. I could feel his heart pounding. "Just a dream," he would say again.

But he knew better, I didn't. This testimony is on behalf of my husband, Captain Michael John Pelkey who can no longer tell his story. Although he was a brave veteran of Operation Iraqi Freedom he did not die in battle, at least not in Iraq. He died in a battle of his heart and mind. He passed away in our home at Fort Sill [misspelled?] Oklahoma from a gunshot wound to the chest. My Michael was diagnosed with post traumatic stress disorder, PTSD, only one week before his death. Ruled a suicide by the department of defense, I might believe that our stressful military and marital strife had caused him to end his life. Had I not experienced the harsh reality of post traumatic stress disorder and the toll that war costs a family long after a soldier returns, I might just believed he was tired of living. But I knew my husband and he was my best friend.

When I met my husband we were both officers in a field artillery unit in Eteroberstien [misspelled?], Germany. Michael was working as the assistant operations officer for the unit. He was responsible and hard working. He loved life, traveling, and having fun. And when I say he loved

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

life, I mean he loved life. His laugh was contagious. He was known for his corny jokes and his animated stories. He didn't care who was around when he laughed so hard that he snorted and then would laugh some more. He hailed from Wellcut [misspelled?], Connecticut and was one of six siblings. He received his commission as a field artillery second lieutenant from the University of Connecticut in 1999 and he was the first in his family to graduate from college. Being a soldier was Michael's childhood dream.

We were married in November 2001 and our journey as a military family began. Michael deployed for Iraq with the first armor division in March 2003, only three weeks after our son Benjamin was born. He left a happy and proud father. Michael returned in late July 2003. It seemed upon his return that our family was complete and we had made it through our first real war deployment. Aside from his lack of appetite and brief adjustment period he seemed happy to be home. He noted several concerns on his DD form 2796 post deployment health assessment to include diarrhea, frequent indigestion, ringing in the ears, feeling tired after sleeping, headaches, and strange rashes. He also noted on this form that he had felt he was in great danger of being killed while in Iraq and he witnessed the killings or dead coalition and civilians during this time. However, the most worrisome notation on this form was the admission of feeling down, depressed, and sometimes hopeless. He also noted that he was constantly on guard and easily startled after returning from his deployment. A few days after returning to

Germany he reported to his primary care condition on July 28, 2003 as part of a post deployment health assessment. He expressed concerns to his primary care physicians that he worried about having some serious conflicts with his spouse and close friends. The physician referred him to see a counsellor. However the mental health staff on our post was severely understaffed with only one or two psychiatrists. Michael was unable to get an appointment before we moved from our post in Germany to Fort Sill Oklahoma only five days later.

There was no time for therapy and doctor’s visits as we packing our home and taking care of our then 6-month-old son. It was time to settle back into family life and our son became the primary focus aside from work. When we got to Fort Sill we both settled into our assignments. Everything seemed normal for a while. Michael was in the officer’s advance course for field artillery and I was the chemical officer for a brigade. We settled into our home and about six months later the symptoms of PTSD started to surface. Only we did not know enough about PTSD to connect the dots. When my husband returned from Iraq there were no debriefings for family members, service members, or required evaluations from Army mental health in Germany. As a soldier and wife I never received any preparation on what to expect upon my husband’s return. If only the military community had reached out to family members to prepare them for and make them aware of the PTSD my family’s tragedy could have been averted. I believe that it is crucial that spouses be informed about the

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

symptoms and make a point in telling them that PTSD can happen long after what psychiatrists call an adjustment period. Spouses are sometimes the only ones who will encourage a soldier to seek help.

Most soldiers I know will not willingly seek help at military mental facility for fear of repercussions from commanders and even jibes from fellow soldiers. My husband worked around many high ranking officers and was most likely embarrassed about seeking help. What would they think of an officer having nightmares, being forgetful, and having to take antidepressants? Months after arriving in Oklahoma in which I found a fully loaded nine millimeter pistol under Michael's pillow or under his side of the bed. We had numerous arguments about the safety of our son and having a weapon in our home. Michael was adamant about keeping the pistol and he was convinced that someone would try to break into our home. I found the pistol under our mattress or in his night stand. I could not seem to get through him that having this weapon was not necessary and it posed a danger to our family. These episodes alone started to cause marital tension. Finally after about two months of arguing of the issue of this weapon Michael finally agreed to put his pistols away. In my mind, the situation was resolved. As a soldier myself, I could understand that having a weapon after being in a war might be somewhat habitual for him.

However, other symptoms started to arise including forgetfulness. Michael simple things. He would forget to mail bills, pick up prescriptions, and even skip physical

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

training in the morning because he was so tired. This became a great problem for him. How could a Captain in the US Army forget to mail bills and miss appointments? He was not like this before his deployment. One of the greatest tests PTSD posed to our marriage was that Michael to suffer from erectile dysfunction, which would cause him to break into tears.

He did not understand what was happening. I did not know what was happening to my husband, although it has been suggested several times that it was clearly my fault that my husband had died. How could a fellow captain in the army not know that her husband was suffering from post traumatic stress disorder? So I've posed questions of my own. Why did Michael's chain of command fail to question him about missing physical training on a weekly basis? Did they not notice the lack of concentration? The lack of interest in his work? I am not placing blame but simply noting that we are all consumed in our work and we were not trained in identifying a mental disorder. I was a mother, a military wife, an officer, and most important too close to my husband to see what was happening. On other occasions he would over react to simple things. One night we heard something in the garage, it was still fairly light outside, and it could have been simply a child or an animal. We lived in a small rural town with very little crime. Michael proceeded to run outside with a fully loaded nine millimeter pistol and almost fired on the neighbor's cat. These over reactions occurred on several occasions. They symptoms would come and go to a

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

point that they didn't seem like a problem at the time. We would later laugh about them and make jokes about the little scares we had had. He would always make excuses and tell me that we needed to be careful so unfortunately I let it go.

There were times that everything seemed just right in our home and he seemed capable enough. He was succeeding in his career as the only captain in the research and development unit at Fort Sill. It was a job in which he entrusted with researching and contributing to the army's latest in targeting developments. We soon bought a new house and he was so proud of it. We were finally getting settled. Then the high blood pressure and severe chest pains surfaced along with the erectile dysfunction. Finally the nightmares began. This would be the last symptom of PTSD to arise and it was the one symptom that I feel ultimately contributed to my husband's death. These nightmares were so disturbing that Michael would sometimes kick me in his sleep or wake up running to turn on the lights. He would wake up covered in sweat and I would hold him until he went back to sleep. He was almost child like in these moments. In the moment he would joke around about the nightmares and sadly we both laughed them off. However at this time I do want to point out that Michael was seeking help for all of the symptoms I have discussed. He was put on high blood pressure medication. He also complained of chest pains and was seen on three occasions in the month preceding his death. He even sought a prescription for Viagra to ease marital tensions. However, no military physician ever connected the dots

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

between his physical symptoms and PTSD. No doctor ever asked him about his depression or linked his symptoms to the war. And this also raises a point that something needs to be done to bridge the gap between the primary care physicians and the mental health professionals on posts and military communities. I believe this could have saved my husband's life had there been some program in place to do that. Michael tried to seek help from the Ft. Sill mental health facility but was discouraged that the appointments he was given were sometimes a month away. So he called TriCare [misspelled?] and was told that he could receive outside therapy if it was family therapy so we took it. Family therapy, marital counseling, or whatever they wanted to call it we were desperate to save our marriage. After all, the symptoms of PTSD were causing most of our heartaches. In the two weeks prior to his death we saw a therapist authorized by TriCare as a couple and individually. This therapist told Michael that he had PTSD and that she would recommend to his primary care physician that he be put on medication. She also told him that she had a method of treating PTSD and she felt that she could help him because he was open to receiving help.

He was so excited and finally expressed to me that he could see a light at the end of the tunnel. He finally had an answer to all of his problems and some of our marital troubles. It was an exciting day for us, not to mention two weeks before his death he interviewed for a position in which he would be running the staff of a general officer. He was

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

so proud that he was given the job after speaking with the General for only 15 minutes. He was beaming with pride and so excited about his new job. Things were looking up for him. He met with the therapist on Monday. Tuesday we celebrated our third wedding anniversary. It was a happy time. I felt hope and relief with the recent positive events. Michael must have felt something else.

Friday my parents were visiting. I was at a church function and my father returned from playing golf to find Michael. He looked as if he were peacefully sleeping except for the wet spot on his chest. His pain was finally over. Michael had lost his battle with PTSD. Just as some soldiers perish from the infection of bullet wounds or loss of limbs, Michael perished. No he wasn’t in Iraq, but in his mind he was there day in and day out. Although Michael would never discuss the details of his experiences in Iraq, I know he saw causalities, children suffering, dead civilians, and soldiers perish. For my soft hearted Michael that was enough. Every man’s heart it was different, for my Michael it may have not taken much but it changed his heart and his mind forever. There was no indication of suicidality but plenty of signs to indicate PTSD. He suffered greatly from the classic symptoms of PTSD, it is plain to see in retrospect. His weapon became a great source of comfort for him. He endured sleepless nights due to nightmares and images of suffering that only Michael knew. My husband served the Army and his country with honor. He was a hard worker, a wonderful husband and father, and he leaves behind a now three year old son,

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Benjamin. One day I would like to tell my son what a hero his father was. He went to war and came back with an illness, a wound. Although PTSD is evident in his medical records in my experiences with Michael, the army has chosen to rule Michael's death without documenting the serious illness. I have been told by the investigator that any PTSD diagnosis must be documented by an army mental health psychiatrist to be considered valid. At the time Michael sought help, he knew it was an urgent matter and was not willing to wait a month or even a few days. He didn't want to wait anymore. He knew it was time. Michael sought the help TriCare offered us and took it. Due to the fact that were in family therapy and the fact that it was coded as family therapy my husband is not going to get the credit that he deserves. He is a casualty of war. I have heard this spoken from the mouths of two generals. He came home from war with an injured mind and to let him become just a suicide is an injustice to someone who served their country so bravely. He loved being a soldier. He put his heart into it. Michael deserves the same honors but more importantly until the senior leaders of our country start recognizing the deaths outside of theatre of operations soldiers will not want to come forward with their own battles with PTSD. When I say senior leaders I mean the president, the joint chiefs, they must recognize this disorder. In the years I was an officer in the army I always heard, "Lead from the front." So I challenge the senior leaders of our country to lead from the front, take care of your soldiers that so bravely are

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

giving their hearts, their minds, and their lives. Look at my son and tell him that his father is not a hero. The evidence is here and the funding is not. My family is forever changed, my best friend is gone. He was a fine officer, one of the best, and his story lives on. He is still his helping his soldiers by his powerful story.

There are so many soldiers suffering from this disorder and so many families suffering the aftermath. I don’t want my Michael to have died in vain. He had a purposed in this life and that was to watch his over his soldiers and I intend to keep helping him do so by spreading his story. But I feel the lessons have not be learned in my travels to Fort Benning and Fort Sill Oklahoma they have programs in place that are working. They’re working for these soldiers. They’re not expensive programs, but they’re working and it’s not so from base to base. You will go to different posts and the programs differ greatly and sometimes there aren’t programs at all for national guard and reserves or even active duty soldiers. It needs to be centralized so that all soldiers that can benefit from these programs, that are working, they’re clearly working. So my husband died of wounds sustained in battle. That is the bottom line. The war does not end when they come home. Thank you [applause].

MICHAEL HOGAN, PH.D.: Stefanie we all want to thank you. It takes extraordinary to tell this story and obviously it brings forth pain to do it but I think all of us believe that the telling of this story will make a difference, that it’s being told in this building, in this town and that maybe

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

some of those steps that Dr. Murphy described and as you point out are present in some places but not others can be taken to save other lives. Michael's story illustrates the breadth as well the depth of these challenges, how the burden of stigma is not something that people just talk about but in fact can be a concrete wall to getting care and how hard it is to, as you put it so well, to connect the dots for individual people to connect the dots, for family members to connect the dots, and then for this fragmented system to connect the dots and why that good care is so important. So we thank you for coming to share this with us. And I'd like to, although we're running a little bit behind open the floor to brief comments or questions from other commission members. I guess this is a statement that can no words that can add anything to the words that you've shared with us. So I thank the members of this panel and ask you to change to places and the members of our panel on suicide and suicide prevention to come forward.

[END RECORDING]

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.