

VETERANS FOR AMERICA

TRENDS IN TREATMENT OF AMERICA'S WOUNDED WARRIORS

Psychological Trauma and Traumatic Brain Injuries:
The Signature Wounds of Operation Iraqi Freedom and
Operation Enduring Freedom

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VFA's report, "Trends in Treatment of America's Wounded Warriors," contains all the right information. It demonstrates the enormous needs of and responsibilities to our wounded servicemembers and their families. That need far exceeds our current capability. VFA provides much-needed, first-hand information on the scope of the problems and steps needed to address them.

*—Brigadier General Dr. Stephen N. Xenakis,
U.S. Army, Ret., former Commanding General of
the Southeast Regional Army Medical Command*

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INTRODUCTION

The primary mission of Veterans for America (VFA) is to ensure that our country meets the needs of service members and veterans who have served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). VFA focuses especially on the signature wounds of these conflicts: psychological traumas and traumatic brain injuries. Unlike most other veterans' organizations, VFA concentrates much of its attention on the needs of those who are currently serving in the military (i.e., service members) since a majority of those who have seen combat in Iraq and Afghanistan are still in the U.S. military.

Each conflict brings with it new, devastating realities. The conflicts in Iraq and Afghanistan are marked by roadside bombs, a large inhospitable battlefield, inadequate dwell time, and the repeated deployment of a large number of troops. Together, these factors pose new challenges to which the massive bureaucracies of the Department of Defense and the Department of Veterans Affairs have been slow to respond.

The conditions wounded service members endure received considerable national attention following a series of articles published by the *Washington Post* in February 2007. The ensuing national discussion—which in turn brought to light other troubling information—has shown that the challenges facing America's wounded warriors go beyond problems such as mice, mold, and peeling paint.

One of the key components of VFA's work is an aggressive investigative program aimed at identifying any deficiencies in the treatment of service-connected mental health or neurological problems. VFA investigators have visited every demobilization site in the United States and

overseas, where they have monitored the quality of treatment, family support, rehabilitation, and other services that should enable a wounded service member to readjust to civilian life.

As a result of VFA's investigations—particularly at Fort Carson, Colorado; Camp Pendleton, California; Fort Stewart, Georgia; Fort Benning, Georgia; Fort Wainright, Alaska; and Fort Richardson, Alaska—and its advocacy on behalf of service members whose needs are not being met, VFA has identified three patterns indicative of significant shortcomings in the military's treatment of wounded warriors. The three overarching trends are inadequate medical care, misapplication of military justice, and leadership deficiencies.

The specific problems in medical care include the screening and treatment of traumatic brain injury (TBI); the delivery of care and continuity of treatment to those with psychological wounds; responses to alcohol and substance abuse; and the conduct of Medical Evaluation Boards (MEBs) and Physical Evaluation Boards (PEBs). Military justice problems encompass the discharge process, domestic violence, access to and quality of the Warrior Transition Units (WTUs), and the delegation of general court martial authority. Key leadership deficiencies include lack of capabilities, the broken Congressional inquiry process, and the inability or unwillingness to identify, recognize, and/or address problems.

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THE BIG PICTURE

Almost 1.6 million American service members have deployed to OIF and OEF, and over 525,000 have deployed more than once.¹ The demographics of these men and women are fundamentally different from those who served in America's previous conflicts. The average age of an active component service member deployed since September 11, 2001, is 27, and the average age of someone serving in the National Guard or Reserves in Iraq or Afghanistan is 33. In contrast, the average age of an American service member serving in combat in Vietnam was 19. Most service members in previous wars were single men who deployed only once. Today 60 percent of those deployed have family obligations; ten percent of those deployed are women; 16,000 women who have deployed are single mothers.²

As of October 29, 2007, at least 3,839 U.S. service members have died in Iraq and 453 U.S. service members have died in Afghanistan.³ Tens of thousands of service members have suffered physical wounds. Hundreds of thousands more have sustained mental injuries and/or mild traumatic brain injuries, many of which have not been properly diagnosed.⁴ Of those who have given their lives in OIF or OEF, 47 percent have left spouses and/or children behind.⁵ Two hundred and twenty-nine thousand veterans of OIF and OEF sought treatment from the Department of Veterans Affairs between 2002 and December 2006.⁶

According to military mental health experts, if current trends continue, over 75 percent of Soldiers and Marines in Iraq will be in a situation where they could be seriously injured or killed. Nearly two-thirds of them will know someone seriously injured or killed.⁷ Thirty percent of Soldiers and Marines in high combat situations

(those who spend over 56 percent of their time off base⁸) will develop a mental health problem, such as depression or post-traumatic stress disorder (PTSD)⁹; for members of the National Guard, the rate rises to 49 percent.¹⁰

A crisis in the DoD mental health treatment system compounds these problems. Given the lack of qualified mental health practitioners, the high rates of mental health problems among returning troops, and the effects of stigma within the military, the DoD Task Force on Mental Health has stated: "The psychological health needs of service members, their families and their survivors are daunting and growing."¹¹ The shameful situation is obvious once service members return home since most military mental health professionals are deployed overseas. In other words, after service members come home, the time when many mental health wounds are manifested, wounded service members have few professionals available for them to turn to for professional assistance.

Nearly 65 percent of all service members wounded in action in Iraq are injured by a blast injury, which often causes traumatic brain injury (TBI)¹². Almost one-third of service members treated at Walter Reed Army Medical Center for injuries sustained in Iraq are diagnosed with service-connected TBI.¹³ There are varying degrees of severity of TBI, determined by the extent of the trauma to the head. Mild TBI may lead to loss of consciousness, headache, confusion, dizziness, behavioral or mood changes, and difficulty with memory, concentration, or thinking. Moderate and severe cases of TBI can also show these symptoms, but usually also include a headache that does not go away, repeated vomiting, convulsions, slurred speech,

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and/or weakness in the extremities.¹⁴ To date, the military has done an inadequate job of ensuring that those who are deployed are given the neurological analysis needed to establish a baseline of brain functioning and once service members return home, inadequate resources have been devoted to diagnosing mild service-connected TBI's.

An additional problem for many wounded service members is that the symptoms of TBI and PTSD often are the same. Without adequate screening, the injury or injuries at the root of a service member's problems cannot be determined.

With many service members deploying multiple times after having had insufficient time at home, more attention needs to be devoted to determining the effects of such policies on service member health. For instance, Soldiers on their second tour in Iraq are 50 percent more likely to develop a mental health problem than those on their first tour because they do not have time to "reset" between deployments given the current ratio of 15 months deployed to 12 months at home.¹⁵ As the Army's Mental Health Advisory (MHAT) IV Report states, inadequate dwell time contributes to higher rates of mental health problems for service members. Compounding these problems is the fact that 58 percent of Soldiers and Marines in Iraq who develop mental health problems will not seek treatment.¹⁶

Meeting the needs of the family members of America's service members—especially those who are struggling to deal with psychological wounds and mild service-connected TBI—is one of the largest challenges facing America. It is universally admitted that there is inadequate assistance available for spouses and dependents. In particular, the mental health needs of family members are not addressed, and they generally

lack the awareness required to assist their wounded family members.

At Fort Carson, VFA has spoken with mental health care providers who have, on an *ad hoc* basis, established support groups for spouses and dependents of those who have been deployed. Until such outreach is standard practice throughout Fort Carson as well as the dozens of other military installations throughout the country and overseas, the mental health needs of military family members will continue to be unaddressed. One data point further highlights the effects of these inter-connected problems: thirty-one percent of married Soldiers deployed for more than six months will have problems with their marriages.¹⁷

This reality will be a considerable impediment to sustaining the all-volunteer force. During a recent visit with service members, Admiral Mike Mullen, the new Chairman of the Joint Chiefs of Staff, heard from numerous troops who said that the stresses placed on spouses and dependents are often so great that troops do not plan to re-enlist.¹⁸

Members of the Guard and Reserve who have served in Iraq and Afghanistan also deserve special attention. Our country never expected to use these troops as heavily as we have in Iraq and Afghanistan; consequently, after having been deployed, sometimes multiple times, these troops are experiencing rates of mental health problems 44 percent higher than their active-duty counterparts. Based on available evidence, VFA believes that a considerable percentage of members of the Guard and Reserve have undiagnosed—and hence untreated—service-connected TBI's. Since our country did not expect to use these service members to the degree that we have, we do not have sufficient programs in place to help these service members when they

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come home. Among other disconcerting signs, when compared to active-duty service members, members of the Guard and Reserve are half as likely to file a VA claim and are twice as likely to have their claim rejected. Urgent action is required to ensure that the service-connected mental health and TBI needs of these warriors are met.

Women comprise about 10 percent of the U.S. force in Iraq and Afghanistan. This is markedly higher than has served in previous U.S. conflicts. For instance, women comprised less than 0.01 percent of U.S. forces in Vietnam. In addition, more than 16,000 single mothers have served in our recent wars.¹⁹ These new realities are, again, challenging existing DoD and VA structures. For instance, the VA only has two inpatient facilities devoted solely to treating service-connected PTSD for female veterans.

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INADEQUATE MEDICAL CARE

Traumatic Brain Injuries

Through our extensive investigative work, VFA has found that inadequate treatment of mild service-connected traumatic brain injuries (TBI) is one of the key challenges emerging from our wars in Iraq and Afghanistan. Unfortunately, DoD was slow to react to the prevalence of mild TBI among our troops. VFA is working to ensure that mild service-connected TBI does not go undetected and that treatment plans are implemented to ensure that any service member suffering from service-connected TBI receives the assistance that their honorable sacrifice merits.

As has been widely noted, traumatic brain injury is one of the "signature wounds" of our wars in Iraq and Afghanistan.²⁰ Nearly two-thirds of the service members treated in Walter Reed Army Medical Center since 2001 were wounded by blast injuries, and 28 percent were diagnosed with service-connected TBI.²¹ In addition, a 22-month TBI study of all Soldiers who returned to Fort Carson, Colorado, found that more than 17 percent of all who had deployed had some form of TBI. Despite these large numbers, mild TBI that is caused by blasts is poorly understood compared to TBI resulting from impacts, such as car crashes and football injuries.²²

There are several methods used to scan for TBI, including computed tomography (CT), quantitative electroencephalography (QEEG), magnetic resonance imaging (MRI), single-photon emission computed tomography (SPECT), automated neurological assessment metrics (A-NAM), and positron emission tomography (PET).²³ MRIs are used most often in the military health system, but among the various types of MRI (e.g., different sequencing, fast spin/slow spin, high resolution/

low-resolution, 2 Tesla/4.5 Tesla), there is a wide range of diagnostic accuracy. Indeed, it is not uncommon for some instances of mild TBI to be missed. In the military, CT scans are used occasionally, and at Fort Carson SPECT scans are used in an ongoing research endeavor.

In cases uncovered by VFA, however, it is clear that there is an inadequate application of the different scans, and their resulting images, to the treatment of service members suffering from mild TBI. Scans are used to determine the presence or absence of TBI, after which a predetermined regimen of treatments is prescribed. The stated position of the U.S. military is that anyone who requests a TBI scan or who shows symptoms of TBI will receive an MRI. However, VFA has observed a wide range of accessibility issues that reduce the effectiveness of this policy, including long wait times for a scan and the willingness of primary care providers to refer a service member for scanning.

The early detection of TBI is further hindered by the fact that events that cause the injury are often not recorded on the battlefield.²⁴ As a Marine who was close to a mortar round explosion while serving in Fallujah has told VFA, "You get peppered with shrapnel, slap a Band-Aid on it, and keep going." Army Brigadier General Michael Tucker, deputy commander of Walter Reed Army Medical Center, announced in early 2007, four years into the Iraq war, that he was recommending that the Army begin comprehensively gathering TBI-related information on the battlefield. The Defense Health Board's Independent Review Group also made a similar recommendation. VFA, which has briefed both Brigadier General Michael Tucker and the IRG on the needs of wounded warriors, applauds General Tucker and the IRG for making these

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recommendations.²⁵ Unfortunately, the absence of such efforts in the past has impeded treatment and complicated the disability rating process, placing the onus on the service member to prove that wounds are combat-related. In short, many service members have suffered mild TBI's but have not been diagnosed with this injury, another example of inadequate care for our most recent wounded warriors.

VFA has observed that even when TBI events are properly recorded, they are often not acknowledged or the service member's records are not sufficiently examined to make the determination that the wound is a result of combat. The burden of proof is on the service member to review his or her combat records and make a case that the injury occurred in the line of duty, a burden many are not able to bear because of their injury.

The Army has begun other preliminary efforts to address these problems. Fort Campbell has instituted mandatory brain-function tests before units re-deploy to Iraq or Afghanistan, while those deploying from Fort Bragg are given the option to take the tests. Unfortunately, these basic cognitive tests are being administered after these units have already deployed to war zones, and it is unclear if the data gathered is being used to determine if service members are fit. Given the nature of the conflict in Iraq, it is certain that some of these Soldiers who will soon be redeployed are suffering from mild TBI.

Unfortunately, the Army did not establish a baseline of brain functioning before troops were deployed the first time. Without such a record, it is impossible to precisely say when a Soldier endured a TBI. To ensure that we are not failing Soldiers and Marines, DoD should institute a Department-wide policy that no Soldier or

Marine will be deployed until a baseline of brain functioning is established. In addition, to ensure that service members are not suffering from undiagnosed mild TBIs, DoD should have trained professionals conduct face-to-face screenings of all service members who have served—and are serving—in Iraq and Afghanistan. Any service member who has suffered a mild TBI deserves to know this, and DoD owes it to each service member to implement a TBI treatment plan.

The symptoms of TBI include anxiety, difficulty controlling urges, impulsiveness, irritability, difficulty concentrating, and difficulty sleeping, among others.²⁷ In a military environment, service members with undiagnosed mild service-connected TBI can and often are charged with insubordination when these symptoms manifest and/or interfere with their duties.²⁸ VFA has investigated a number of cases at Camp Pendleton where this has been an issue. Once sent to the brig, screening for TBI does not take place. In addition, there are no dedicated mental health care providers in the brig, and beyond medication prescribed prior to incarceration, there are no mental health care services such as counseling or rehabilitation. Despite the known correlation between the aforementioned symptoms and TBI from combat, Marines sent to the brig are not screened for this injury, thereby preventing them from receiving treatment and the opportunity to clear their records.

Veterans for America's Recommendations:

- Develop a gold standard for TBI treatment, which would include the most sophisticated scanning and surveillance possible to establish a neurological baseline, as well as the best treatment possible to ensure that once a service member has experienced a TBI, the injury is properly treated

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- DoD should institute a Department-wide policy that no Soldier or Marine will be deployed until a baseline of brain functioning is established.
- To ensure that service members are not suffering from undiagnosed mild TBIs, DoD should have trained professionals conduct face-to-face screenings of all service members who have served—and are serving—in Iraq and Afghanistan.
- Comprehensively record blast events from the battlefield and ensure that this information is noted in service members' medical records and that it is fully integrated into rehabilitation efforts

Psychological Wounds

Bobby Muller, President of Veterans for America, has noted that “[w]e are facing a massive mental health problem as a result of our wars in Iraq and Afghanistan. As a country, we have not responded adequately to this problem. Unless we act urgently and wisely, we’ll be dealing with an epidemic of service-connected psychological wounds for years to come.”

Unlike TBI, which is a neurological trauma observable by scanning the brain, post-traumatic stress disorder (PTSD), anxiety, and depression are psychological injuries of combat. PTSD is another of the current conflicts’ “signature injuries.”²⁹ The Army’s Mental Health Advisory Team (MHAT) IV estimates that 30 percent of Soldiers and Marines experiencing “high combat” environments in Iraq develop at least one of these mental health problems.³⁰ Symptoms of PTSD, such as strong memories and nightmares, feeling numb or detached, and difficulty sleeping, often develop late, usually within three months but up to a year or more after the traumatic event. Symptoms can persist and interfere with a service

member’s job and relationships.³¹ Of the 229,000 veterans of Operations Enduring Freedom and Iraqi Freedom who sought treatment from the Department of Veterans Affairs between 2002 and December 2006, 37 percent received a diagnosis of a mental health condition, including 17 percent for PTSD.³²

VFA has encountered numerous instances of the misdiagnosis and under-diagnosis of mental injuries, especially service-connected PTSD. Primary health care providers, often swamped with cases, tend to treat the symptoms rather than the illness.³³ For example, when a Soldier who has been in combat sees a doctor complaining of feeling anxious and having trouble sleeping—all common symptoms of PTSD—the doctor often prescribes a sleep-aid and an anti-anxiety medication. When the Soldier returns a month later complaining of the same problems, the doctor often only prescribes another medicine(s). (VFA has encountered numerous instances where service members had been prescribed over 20 different medications at once, by different doctors at different facilities.³⁴ This sometimes results in medicines being prescribed that are in conflict with each other.) After another month, the service member is still suffering the symptoms, but the underlying cause has still not been addressed. In some instances, service members at bases such as Fort Benning, Georgia, with recognized service-connected PTSD have been ordered to deploy to Iraq, akin to sending someone “down range that cannot wear a helmet, that cannot wear body armor.”³⁵

Over-medication of service members suffering from service-connected psychological injuries highlights a general deficiency in the manner that these wounds are diagnosed and treated. In general, the most effective regimen of treatment

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for psychological injuries is one-on-one therapy combined with other treatment means such as medication and group therapy. Given the dearth of mental health providers, service members with combat-related mental wounds are often primarily treated through medication rather than primarily through one-on-one care from the same mental health provider.

As noted earlier, several commissions and studies—including the DoD Mental Health Task Force—have concluded that the numbers of mental health care professionals in the military health care system are too low to meet current needs. This has an adverse effect on the quality of care available to service members. These studies uniformly suggest that the Service Secretaries must do a better job of retaining the mental health professionals already on staff and attracting additional qualified applicants.³⁶

This sequence of events is further complicated by the fact that many service members do not have a dedicated mental health care provider with whom to schedule follow-up examinations. VFA found at Fort Carson that it was common for service members to be treated by a different mental health professional on subsequent visits. Without continuity of care, these Soldiers receive treatment far below the standard of care available in the civilian sector. VFA has found that service members who have been diagnosed with chronic service-connected PTSD often receive approximately one hour of one-on-one therapy per month. Again, this standard of care is far below that of the civilian sector.

There are other consequences of this shortage. At Fort Richardson, AK, VFA found that current wait times are two to three weeks for a 45-minute appointment. Once the 25th Infantry Division's 4th Brigade Combat Team returns from Iraq in

December 2007, these waiting periods will be significantly longer.

These deficiencies have created a situation that often places the primary onus for recognizing a mental health problem on the service member or their spouse. Again, as a result of the inadequate number of mental health professionals, service members often have to serve as their own advocate to ensure that their mental health injuries are noticed. This is reflective of a broken system. Service members should not have to wait until a problem has manifested itself in, for instance, inappropriate behavior for treatment to be administered.

Even when an initial diagnosis of PTSD is given, VFA has observed that, over the course of treatment, this legitimate combat injury is sometimes re-characterized—from service-connected PTSD to a diagnosis of severe anxiety and eventually to a diagnosis of a “pre-existing” personality disorder, which is grounds for being dismissed from the military without full VA benefits. Pre-existing personality disorders—of which there have been more than 22,000 since 2001—are especially troubling, given that after the service member is removed, he or she is deprived of the advanced care made available by the VA since the illness is not, in the government's eyes, combat-related.³⁷

In several cases investigated by VFA, Soldiers with combat-related psychological problems were given misleading information by their legal representatives, such as if the Soldier accepted the personality discharge, he would be able to keep his bonus and VA benefits, neither of which is true. As one official at Fort Carson stated: “[T]he doctors are telling them [that a personality discharge] will get you out quicker, and the VA will take care of you. To stay out of Iraq, a

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[wounded] soldier will take that in a heartbeat."³⁸ In testimony before the House Veterans' Affairs Committee, Jason Forrester, Director of Policy for VFA, stated: "Pre-existing personality disorder discharges remove the burden from our society to help the service member deal with their service-related injuries."³⁹ One Soldier whose case was investigated by VFA committed suicide after being given a pre-existing personality disorder diagnosis; a Marine whose case is being investigated by VFA attempted suicide after receiving a similar diagnosis.

Specialist Jonathan Town is one of the decorated combat veterans recently discharged from the military with a pre-existing personality disorder. As VFA brought to light, after Specialist Town served a tour in Iraq, where he received a Purple Heart, he was later discharged for a pre-existing personality disorder, thereby depriving him of all of his benefits. After much media attention was brought to the case, Town was given VA benefits, but the Army has still not admitted that his dismissal was in error.⁴⁰ After considerable work by VFA and Members of Congress, the Government Accountability Office (GAO) began an investigation of pre-existing personality disorder discharges. Their final report is expected within a few months. As of early November 2007, a measure calling for a moratorium on such dismissals was also being considered by the House and Senate conferees for the 2008 National Defense Authorization Act (H.R. 1585), after it was included in the Senate version of the bill.

Veterans for America's Recommendations:

- Develop a gold standard of treatment for service-connected psychological wounds. Use as point of reference treatment that would be received in civilian sector.

- Utilize every available resource to encourage mental health care providers to work in the military health care system
- Provide face-to-face screening for every service member for post-traumatic stress disorder before and after deployment
- Institute a moratorium on pre-existing personality disorder discharges

Alcohol and Substance Abuse

VFA is concerned that the military is ill-equipped to assist service members with undiagnosed service-connected mental health problems who are abusing alcohol and/or illegal substances. The abuse of alcohol and illegal substances are recognized symptoms of PTSD, as service members suffering from PTSD often attempt to "self-medicate" their condition.⁴¹ Researchers have found that alcohol misuse rises from 14 percent to 21 percent one year after service members return from Iraq.⁴² Fourteen percent of the 229,000 veterans of Operations Enduring Freedom and Iraqi Freedom who sought treatment from the Department of Veterans Affairs between 2002 and December 2006 received a diagnosis for non-dependent use of drugs.⁴³ VFA has discovered that rather than treating the abuse as a symptom of a combat-related injury, the first instinct of a wounded service member's commander is often to remove the problematic service member by means of a court martial. Several Soldiers whose cases are being investigated by VFA have recognized substance abuse problems and yet have not been placed in rehabilitation, as required by Army Regulation 600-85.

Army policy also requires that a Soldier with recognized service-connected PTSD and a substance abuse problem complete alcohol

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or drug rehabilitation before entering a PTSD rehabilitation program. However, since substance abuse is often used to relieve the symptoms of a mental injury, this approach is often ineffective. VFA believes that the two forms of rehabilitation should happen concurrently in order to accelerate the wounded service member's recovery. In the case of Private First Class (PFC) Ryan LeCompte, whose case was first brought to light by VFA and with whom VFA still works closely, Army doctors were convinced that his behavior was related to alcohol abuse, not service-connected PTSD or service-connected TBI.⁴⁴ Doctors at Fort Carson referred LeCompte to the Army Substance Abuse Program (ASAP) twice, to no effect. Despite repeatedly indicating that he was having problems readjusting after his second deployment in 2006, LeCompte was not screened for PTSD or TBI. After VFA's intervention, LeCompte was placed in a dual-track VA-run mental health-substance abuse program.⁴⁵ This was necessary because such programs do not exist in the Army. LeCompte was eventually diagnosed with PTSD by psychiatrists in the VA; upon his return from the VA, LeCompte was diagnosed with TBI at Fort Carson.

Soldiers serving at Fort Richardson are at even greater risk for alcohol and substance abuse. Due to long winter nights, seasonal affective disorder is an ongoing concern at military installations in Alaska.⁴⁶ Substance abuse, a recognized symptom of seasonal affective disorder, when combined with the predilection of returning service members to misuse alcohol, is a dangerous mix.⁴⁷ The Fort Richardson ASAP currently is unable to offer individual therapy for Soldiers abusing alcohol or illegal drugs due to a lack of funding and critical personnel shortages. Forty-six percent of the program's \$186,000 annual budget goes to drug and alcohol testing alone.

Veterans for America's Recommendations:

- Screen service members who have served in combat and who are abusing alcohol or illegal substances for post-traumatic stress disorder and traumatic brain injury before disciplinary action is taken. Provide those who screen positive with treatment and rehabilitation
- Make dual-track alcohol and post-traumatic stress disorder treatment standard within the military

Medical Evaluation Boards and Physical Evaluation Boards

VFA is concerned that Medical Evaluation Boards and Physical Evaluation Boards are often not functioning in a manner that ensures fair treatment for service members with service-connected psychological traumas and/or TBI. Unless these processes are improved, a significant number of wounded service members will be treated unfairly.

A Medical Evaluation Board (MEB) determines whether a service member's injury or illness falls below military retention standards.⁴⁸ VFA has worked with several Soldiers who have combat-related TBI and/or PTSD and whose cases have not been referred to a MEB. This lapse is related to the exceedingly long time it is taking for service members to have a "permanent profile" issued. A permanent profile is required in order to initiate a MEB.⁴⁹ In VFA's experience, these delays are often related in cases of PTSD to the shifting of diagnoses and in cases of TBI to the long waits for screening and appointments with neurologists. During this time, service members are assigned "temporary profiles," but these are not sufficient to begin the MEB review.⁵⁰ At Fort Carson, Soldiers with temporary profiles also cannot join the Warrior Transition Unit.

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While service members are waiting to receive their permanent profiles, they remain with their regular units. It is during this time in limbo that many of the behavior problems outlined in this report manifest themselves including substance abuse, domestic violence, and misconduct. In many cases investigated by VFA, the ultimate result of the long wait for the MEB is that the service member is subjected to legal or administrative punishment and his or her service-connected injuries are never officially examined.

If a MEB is convened and it determines that the service member does not meet the military's retention standards, the case is forwarded to a Physical Evaluation Board (PEB). The PEB determines the service member's fitness for duty, and if found to be unfit, the PEB assigns a disability rating.⁵¹ This rating impacts the service member's ability to continue service, the amount of the pension received if the service member is separated or retired from service, and the VA benefits available to the service member for the rest of his or her life. VFA has assisted numerous service members on whom the burden of proving a service connection for injuries was placed during the PEB process, potentially impacting their rating and therefore the level of care they would receive from the VA.

Service members with TBI and/or PTSD are often in a compromised state of mind and therefore cannot adequately advocate for themselves during this process. The service member is only assigned representation if and when there is a final, formal PEB.⁵² Service members are often not aware that either the MEB or PEB has not taken into consideration all service-related injuries, that the disability rating is inadequate given the wounds suffered, and/or that there is a process of appealing decisions made by the MEB and PEB.

Veterans for America's Recommendations:

- Drastically reduce the time for converting temporary profiles to permanent profiles.
- Allow service members with temporary profiles to join Warrior Transition Units.
- Provide legal representation to an injured service member at the beginning of the Medical Evaluation Board Process.

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MISAPPLICATION OF MILITARY JUSTICE

A significant number of service members suffering from PTSD and/or mild TBI are simultaneously entering the military justice system. This raises the important question of whether it is fair to punish a service member suffering from service-connected PTSD and/or TBI for unacceptable behavior when the behavior is symptomatic of a wound(s) that the military has neglected to initially diagnose and treat.

VFA has investigated numerous cases where the determinations of a Medical Evaluation Board (MEB) and the decisions of an Article 15 proceeding (also known as non-judicial punishment) or court martial have been in conflict. For instance, VFA has identified a number of cases where service members were punished despite a MEB determination of war wounds. In several cases where MEB determinations found that service members did not meet retention standards due to a combat-related injury, the same injury was not considered relevant during the Article 15 or court martial process.

As a former VFA investigator observed, "[w]ithout help, people with PTSD turn to drinking and drugs. People with traumatic brain injury have discipline and anger issues. And yet [unit commanders] still say that PTSD and brain injury are not an excuse for bad behavior."⁵³ VFA is concerned that there is no mechanism for halting or reversing the discharge process once it has been initiated, no matter the mitigating circumstances, nor is there any review of discharges by an entity outside the chain of command.⁵⁴

At Fort Carson, VFA has investigated a number of cases involving domestic violence. According to the Walter Reed Army Institute of Research,

domestic violence by Soldiers returning from deployment is often a result of insufficiently resetting from the aggressive, controlling "battlemind" mental state, itself an aspect of service-connected PTSD and/or TBI.⁵⁵ In El Paso County, Colorado, where Fort Carson is located, the District Attorney has established a "fast track" process for misdemeanor domestic violence offenses in which a first-time offender can plead guilty and be ordered to complete 36 weeks of counseling, usually within a day of being arrested.⁵⁶ By doing so, however, the Soldier provides his or her commander with grounds for an other-than-honorable discharge, thereby depriving these Soldiers of treatment for service-connected PTSD or TBI, pension, and other benefits that they would otherwise receive for their service.

Wounded Soldiers at Fort Carson are also prohibited from being assigned to the Warrior Transition Unit (WTU), which was designed to enable service members to achieve fast and full recoveries, if they have any pending legal or administrative issues. Again, Soldiers whose misbehavior may be related to service-connected PTSD and/or TBI are often denied proper treatment because of the inflexibility or unwillingness of commanders to consider the underlying cause(s).

At Camp Pendleton, VFA was disappointed to discover that the Marine Corps delegates general court martial authority to the battalion level. At Camp Pendleton, VFA found there is little to no use of disciplinary actions (either administrative or non-judicial) other than court martial for all classes of offenses and little consideration of combat-related neuropsychological problems in assessing misconduct.⁵⁷ The panels sitting to hear the courts martial are selected by the battalion

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commanders. Another troubling reality at Camp Pendleton is the lack of a dedicated Trial Defense Service, which creates a conflict of interest in the Judge Advocate General (JAG) officers assigned to defend the accused Marines and also allows for the reassignment of defense counsels mid-trial.

A trend observed by VFA in its investigations is the propensity for Marines to desert, that is, to go on an Unauthorized Absence (UA) for more than 30 days, especially when they are suffering from service-connected PTSD and/or TBI.⁵⁸ Knowing that they will be court-martialed and sent to the brig for their misbehavior, some wounded Marines nevertheless decide to take their chances by abandoning their posts.

Veterans for America's Recommendations:

- Before judicial or non-judicial proceedings begin, screen every service member for post-traumatic stress disorder and/or traumatic brain injury if they have served in combat.
- Provide treatment and rehabilitation for those who screen positive.
- Allow Soldiers to join Warrior Transition Units even if they have outstanding legal or administrative issues.
- Encourage the use of disciplinary tools other than courts martial within the Marine Corps.

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LEADERSHIP DEFICIENCIES

Lack of Capabilities and Resources

VFA has found considerable leadership shortcomings in dealing with the psychological and traumatic brain injuries suffered by those who have served in Iraq and Afghanistan. Unfortunately, our military and civilian leaders were not prepared to respond to the new challenges posed by these wars. Until these deficiencies are rectified, we, as a country, will continue to fail large numbers of wounded warriors.

Several base commanders have told VFA investigators that their facilities are simply not equipped to provide long-term care to service members suffering from service-connected PTSD and mild TBI, nor do they have the funds to provide rehabilitation services for these injuries. VFA has long recognized that the military health system does not have the capacity to handle all the mental health referrals it receives.⁵⁹

For instance, Fort Richardson has one psychologist (who cannot prescribe medication), three social workers, and two substance abuse counselors to serve almost 4,000 Soldiers. There is no psychiatrist on staff at Fort Richardson. Furthermore, dependents and family members of the base's Soldiers are not permitted on base, thereby depriving service members of important support systems. The few resources that are available will be further strained by the arrival of approximately 3,700 troops returning from Iraq in December 2007. A third of these returning Soldiers will likely experience some mental health issue. This statistic, combined with the fact that Fort Richardson will have only four hours of sunlight a day during the Arctic winter when the service members from the 4th BCT of the 25 Infantry Division arrive in December 2007,

has lead some mental health providers at Fort Richardson to predict that they will see signs and symptoms of service-connected PTSD in approximately 45 percent of those returning from deployment. As one medical officer said, "[t]he roof will cave in 90 days after the brigade returns" if drastic improvements are not made to the mental health care system.

Lack of capacity also plays a role in the misdiagnosis of pre-existing personality disorders, as described in the *Psychological Wounds* section. As a former VFA investigator explained to *The Nation*, military doctors, facing overflows of wounded Soldiers and shortages of supplies, rooms and time, find that discharging service members with pre-existing personality disorder ensures that scarce resources are available for others.⁶⁰

Veterans for America's Recommendations:

- Increase number of mental health care providers in the military health care system—both on the battlefield and at bases
- Ensure that those mental health care providers are well-trained in detecting, preventing, and treating service-connected psychological wounds and traumatic brain injuries

Congressional Inquiries

At Fort Carson, Congressional inquiries are answered by the base command, not through the Defense Department's Special Congressional Inquiries process, thereby removing independent oversight or review of the responses. In the well-publicized case of Private First Class (PFC) Ryan LeCompte, the Fort Carson commander replied to the Office of Senator Tim Johnson that LeCompte had received "extensive" treatment for his service-connected PTSD. In fact, LeCompte had been to the hospital four times and in each

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instance as a walk-in patient; each time, he only received medication for his symptoms rather than rehabilitation or counseling for his underlying injury.

VFA requested that the Office of the Surgeon General of the Army investigate eighteen cases of Soldiers from Fort Carson found to have been incorrectly diagnosed and discharged for pre-existing personality disorders in April 2007. In May, VFA received a letter from the Surgeon General's Office stating that the cases had been "thoroughly and thoughtfully reviewed" and that the diagnoses were correct. These claims were made despite the fact that none of the 18 Soldiers, nor their family members, had been interviewed and none had been reexamined. In short, the Surgeon General's Office followed none of the necessary lines of inquiry to determine if the pre-existing personality disorder was a valid diagnosis. After six senators were notified of the situation, the Government Accountability Office (GAO) began investigating how the Army handles such mental health cases.⁶¹

Veterans for America's Recommendations:

- All Congressional inquiries must involve an impartial element such as the Special Congressional Inquiries process to ensure that service member needs are clearly communicated to Congress.
- In exercising its oversight responsibility, Congress should ensure that queries made regarding treatment of wounded service members are thoroughly and truthfully answered.
- GAO should conduct an investigation into the handling of previous inquiries regarding needs of wounded service members.

Identifying, Recognizing, and Addressing Problems

VFA has encountered a number of commanders who refuse to acknowledge that service-connected PTSD or/and TBI are the natural consequence of combat for some service members. VFA has further seen evidence of the intentional mis-designation of service members with service-connected PTSD and/or TBI in an attempt to "get rid of dead wood," as Colonel Steven Knorr, chief of Fort Carson's Behavioral Health Unit, put it in a memo to his staff.⁶² As a VFA official noted, "Fort Carson is overwhelmed with men and women coming home from Iraq with psychological injuries from war, and there are unit commanders here who don't understand these medical conditions."⁶³

In one Army base visited by a VFA investigator, the mental health care staff had been ordered not to work more than 40 hours per week and not to schedule any appointments after 3 pm. The primary mental health care provider at this location was further ordered by his commander to stop all neuropsychological testing for service-connected PTSD and TBI.

A persistent trend VFA has identified is the inadequacy of Warrior Transition Units (WTUs). These units are understaffed, both in terms of unit leaders and medical personnel, poorly organized, significantly lacking resources, and poorly integrated into the broader healthcare system, which includes VA hospitals. A recent GAO study found that 17 of the 32 WTUs had less than 50 percent of staff in place in one or more critical positions.⁶⁴

The Army's Mental Health Advisory Team (MHAT) IV found that stigma often prevents Soldiers and Marines from receiving the treatment for service-

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connected mental health problems. According to MHAT, 59 percent of Soldiers and 48 percent of Marines believe that seeking mental health care would cause their leaders to treat them differently; 55 percent of Soldiers and 48 percent of Marines believe that by doing so they would be seen as weak.⁶⁵ It is no surprise, given this stigma, that only 42 percent of Soldiers and 38 percent of Marines who screened positive for a mental health problem in Iraq sought treatment.⁶⁶

VFA believes that a concerted effort must be made to reduce the stigma of service-connected PTSD and/or mild TBI. In his final weeks as Chairman of the Joint Chiefs of Staff, during a visit with wounded warriors, Gen. Peter Pace (USMC) said, "it doesn't matter if it was psychological or physical, you were wounded in service to your country, and we need to do all we can to make you better."⁶⁷ Although the Army and Marine Corps have instituted programs to train officers and NCOs to recognize service-connected PTSD and mild TBI and reduce the stigma of these conditions,⁶⁸ VFA has seen little evidence that these efforts have had any significant impact at the level of individual service members who have service-connected mental health and neurological wounds.

Veterans for America's Recommendations:

- Fully staff and equip Warrior Transition Units
 - Make service in Warrior Transition Units beneficial for advancement.
 - Offer financial incentives for doctors and other professionals to serve in Warrior Transition Units
 - Allow them doctors and other professionals to serve part time in Warrior Transition Units
- Require all commanders—from the top echelon down—to become well versed in recognizing service-connected psychological trauma and traumatic brain injuries. In short, psychological wounds should be treated as seriously as physical wounds.
 - DoD should bolster efforts to destigmatize treatment for service-connected psychological trauma and traumatic brain injuries

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CONCLUSION

Our country owes a great debt to the men and women serving in our nation's Armed Forces. The foremost manner in which this debt can be repaid is by ensuring that service members and veterans who have served in Iraq and Afghanistan receive the treatment they need to heal their wounds. More than eight months after the Walter Reed scandal, there are far too many instances where these obligations are still not being met.

The U.S. Government and the American people must do everything possible to rectify the shortcomings in mental health and neurological care many service members face upon their return from duty. Treatment for service-connected traumatic brain injury (TBI) should be tailored to individual injuries. Service-connected post-traumatic stress disorder (PTSD) and its effects must be treated as seriously as physical wounds. The Disability Evaluation System must be modified to ensure that it serves the wounded. The military justice system must take into full account the negative impacts that TBI and PTSD have on an otherwise exemplary service member's mindset and actions. The leadership of the U.S. Armed Forces must realize the pivotal role it plays in providing proper care for America's wounded warriors. Once these steps are taken, our country can have greater confidence that our wounded service members are receiving the assistance that their honorable service merits.

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1025 Vermont Ave, NW, 7th Floor, Washington, DC 20005
P 202 483 9222 F 202 483 9312 W veteransforamerica.org