

VETERANS FOR AMERICA

FORT DRUM: A GREAT BURDEN, INADEQUATE ASSISTANCE

By Veterans for America Wounded Warrior Outreach Program

February 13, 2008



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INTRODUCTION

Soldiers from Fort Drum are bearing a disproportionate burden of the costs of our wars in Iraq and Afghanistan. Unfortunately, the mental health care system at Fort Drum is not meeting the demands of this burden.

Of all U.S. Army divisions, the 10th Mountain Division, based at Fort Drum, New York, has been the most affected by our country's crushing recent deployment cycle. Since September 11, 2001, the 2nd Brigade Combat Team (BCT)¹ is *the* most deployed brigade in the Army, having recently completed its fourth tour (the Appendix contains the 2nd BCT's post-9/11 deployment history). In all, the 2nd BCT has been deployed for more than 40 months since 9/11.²

Compounding the difficulties facing members of the 2nd BCT is the Army-wide problem of inadequate dwell time (i.e., the time between deployments to readjust, rest, retrain, reconstitute, visit family and friends, and integrate new unit members). None of the 2nd BCT's three dwell periods has risen to the Army's traditional goal of a 2:1 dwell time to deployed time ratio for active Army units. One of the dwell periods for the 2nd BCT was only six months, after having been deployed to Afghanistan for eight months and before being deployed to Iraq for another 12 months. Fortunately, Army leadership—most notably General George Casey, Jr., the current Chief of Staff of the Army—has been vocal in stating that the problem of inadequate dwell time must be fixed. In his words: "...it's so important to extend the time that they [Soldiers] spend at home... [Current deployment policies are] not something that we can sustain over time, and that's one of the key elements of putting ourselves back in balance, to get to 18 months or so dwell [time]..."³

Further complicating the challenges facing members of the 2nd BCT is the regrettable decision, announced in April 2007 by Secretary of Defense Robert Gates, to extend Army tours in Iraq from 12 to 15 months. Soldiers from the 2nd BCT noted the greatly dispiriting effect of this policy shift, which was announced shortly after the BCT had passed what it assumed was its half-way deployment mark. Mental health experts have informed Veterans for America (VFA) that "shifting the goalposts" on a Soldier's deployment period greatly contributes to an increase in mental health problems within units.

Finally, the intensity of the combat experienced by the 2nd BCT is remarkable. During its most recent deployment, 52 members of the 2nd BCT were killed in action (KIA), 270 others were listed as non-fatality casualties, and two members of the unit remain missing in action (MIA). When compared to all who have served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), the intensity of combat for the 2nd BCT is quite clear. On their most recent deployment, members of the 2nd BCT were more than five times as likely to be killed as others who have been deployed to OEF and OIF and more than four times likely to be wounded. This level of combat will bring with it considerably higher rates of mental health challenges for members of the 2nd BCT than other units that have served in OEF and OIF and will merit considerably closer attention by Army and Pentagon leadership to reduce the likelihood that these Soldiers are failed by the already-overburdened mental health treatment system.

The 1st BCT of the 10th Mountain Division is also among the most deployed Army brigades. Being heavily deployed is nothing new for the

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10th Mountain Division. In the 1990s, units from the division were also among the most deployed in the Army.

In recent months, VFA has been contacted by a number of Soldiers based at Fort Drum who are concerned about their mental health as well as that of members of their units. For this reason, VFA launched an investigation of conditions at Fort Drum, focusing especially on the mental health treatment capacity there and the needs of Soldiers who have served in combat.

As discussed in a recent VFA report—*Trends in Treatment of America's Wounded Warriors*⁴—VFA has visited every major military facility in and out of the United States. Our work has revealed a military mental health treatment system that is under severe stress. Leaders of the military mental health treatment system have taken steps in recent years to warn DoD leadership of the magnitude of the crisis that is brewing in this area, as well as steps that need to be taken to manage, if not avoid, this crisis. VFA is proud to work with those who have given these warnings—as well as with a group of bipartisan allies on Capitol Hill and responsive leaders in the Pentagon and on military bases—to create a world-class system for treating combat-related mental health issues. Given the magnitude of the challenges facing Soldiers who been in combat—as well as their families—there remains a great deal of work to be done, but VFA remains quite hopeful that with the considerable attention that has been placed on the needs of our honorable servicemembers that progress will continue to be made toward this goal.

THE CHALLENGES AT FORT DRUM—AND BEYOND

Generally speaking, winter conditions at Fort Drum are dreary, with snow piled high and spring still months away. More than a dozen Soldiers reported low morale, frequent DUI arrests, and rising AWOL, spousal abuse, and rates of attempted suicide.⁵ Soldiers also reported that given the financial realities of the Army, some of their fellow Soldiers had to resort to taking second jobs such as delivering pizzas to supplement their family income.

More than six years after large-scale military operations began in Afghanistan and, later, in Iraq, a casual observer might assume that programs would have been implemented to ensure access for Soldiers from the 10th Mountain Division to mental health services on base. Unfortunately, an investigation by VFA has revealed that these brave servicemembers who recently returned from Iraq must in fact wait for up to two months before a single appointment can be scheduled. In short, access to care for our returning warriors at Fort Drum is woefully inadequate.

Given the great amount of public attention that has been focused on the psychological needs of returning servicemembers, a casual observer might also assume that these needs would have been given a higher priority by Army leaders and the National Command Authority—the two entities with the greatest responsibility for ensuring the strength of our Armed Forces. These needs have long been acknowledged but there has been insufficient action.

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Shortly after Operation Iraqi Freedom (OIF) began, the Army fielded the first Mental Health Advisory Team (MHAT). This first team has since been followed by three others that have all released reports. The most recent of these reports, MHAT IV, was completed in November 2006 and released to the public in May 2007. MHAT IV found that the percentage of Soldiers with “severe stress, emotional, alcohol or family problem[s]” had risen more than 85 percent since the beginning of OIF.⁶ Even more disconcerting, MHAT IV found that 28 percent of Soldiers who had experienced high-intensity combat were screening positive for acute stress (i.e., Post-Traumatic Stress Disorder, PTSD).⁷

Further highlighting the shockingly high level of mental health problems of returning combat Soldiers, the Department of Defense’s Task Force on Mental Health reported in June 2007 that the psychological needs of combat servicemembers and their families was “daunting and growing.”⁸ The Task Force released findings that showed that more than one-third of members of the active Army who returned from combat experienced some mental health problems.⁹ The Task Force also noted that the Army had far too few qualified mental health professionals and that the future of Army mental health care was bleak. In addition, MHAT IV found that Soldiers who had deployed more than once were 60 percent more likely to screen positive for acute stress (i.e., PTSD) when compared to Soldiers on their first deployment.¹⁰ Psychological injuries have been described as the “signature injuries” of our wars in Iraq and Afghanistan for good reason.

THE GREAT NEEDS OF THE 2ND BCT

When VFA visited Fort Drum shortly after the 2nd BCT returned from Iraq, we found that even in the early days of the brigade’s return stateside some Soldiers requiring mental health treatment had to wait up to two months for a mental health appointment. This alone was greatly troubling, but VFA further feared that wait times would increase dramatically once the members of the 2nd BCT returned from block leave around the Thanksgiving and Christmas holidays. Generally speaking, members of the 2nd BCT were anxious to return home immediately after their deployment ended, which would further decrease the number of Soldiers manifesting and/or admitting symptoms of combat-related mental health problems. During VFA’s visit, Fort Drum officials stated that they were hoping to bring additional mental health specialists to the base, but given the harsh winters in the Fort Drum area and the considerable distance from major metropolitan areas, the officials admitted the considerable difficulty in recruiting mental health professionals.

In early January 2008, about two months after the 2nd BCT returned from Iraq, three Army psychiatrists from Walter Reed Army Medical Center (WRAMC) were assigned to Fort Drum on a temporary basis to treat the large influx of Soldiers requiring mental health care. Along with the three psychiatrists on base, these doctors are working to greatly reduce the wait time for Soldiers requiring mental health care. Unfortunately, this is only a temporary fix, as the Walter Reed-based psychiatrists will likely return to Washington, DC, within a few weeks. Fort Drum will again be left with the task of treating thousands of Soldiers with far too few mental health specialists.¹¹ In addition, for those

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servicemembers who were initially treated by psychiatrists from Walter Reed, their care will suffer from discontinuity, as their cases will be assigned a new mental health professional on subsequent visits.¹²

One challenge facing Fort Drum Soldiers is the absence of a hospital on the base. To augment Fort Drum's mental health treatment capabilities, Samaritan Medical Center in Watertown, NY, provides in-patient mental health treatment for some Fort Drum soldiers.¹³ In the past year, Samaritan has increased the number of in-patient beds in its psychiatric unit from 24 to 32¹⁴— an increase of 33 percent. One concern identified by VFA in a recent conversation with a leading expert in treating combat psychological wounds is the sense that military commanders doubt the validity of mental health wounds in some Soldiers, thereby undermining treatment prescribed by civilian psychiatrists. In the estimation of this expert, military commanders have undue influence in the treatment of Soldiers with psychological wounds. Another point of general concern for VFA is that Samaritan also has a strong financial incentive to maintain business ties with Fort Drum (as will be discussed in the *Recommendations* section of this report, this dynamic deserves greater scrutiny). VFA's work across the country has confirmed that Soldiers often need for their doctors to be stronger advocates for improved treatment by their commanders and comrades. For instance, Soldiers need doctors who are willing to push back against commanders who doubt the legitimacy of combat-related mental health injuries.

A general challenge faced by Soldiers at Fort Drum returning from combat is that self-reporting and/or self-referral are the two most common means for Soldiers with combat-related psychological

injuries to come to the attention of mental health professionals on base. That is, when Soldiers return to Fort Drum, they are given the opportunity to complete a health screening questionnaire known as the Post-Deployment Health Assessment (PDHA).¹⁵ The PDHA (DD Form 2796) contains a number of questions, some of which are focused on the mental health needs of troops. Soldiers wishing to conceal their mental health problems can easily do so by providing false information to the questions posed.¹⁶ A number of variables can lead to such an outcome, including the considerable stigma against mental health treatment within the military and pressure within some units to deny mental health problems as a result of combat. In addition, a number of Soldiers interviewed by VFA stated that they had provided inaccurate answers so that they could quickly depart the base for leave. Others stated that they did this so that the paperwork process for leaving the military would not be slowed. Finally, some Soldiers who had been in the military for more than a decade stated that they did not wish to disclose possible post-combat mental health problems for fear that it would reduce their likelihood of being promoted. Adding to the complexity of this situation, some military mental health providers have argued that a number of Soldiers fake mental health injuries to increase the likelihood that they will be deemed unfit for combat and/or for further military service. For all these reasons—and, doubtless many more—the military should shift from a system that relies upon self-referral and should instead transition to a system where everyone receives proactive mental health care treatment. Basic requirements for such proactive care include face-to-face interaction and follow-on treatment, if needed, with the same mental health care

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provider if possible. A pilot program that could serve as a first step toward a new model of mental health care treatment is found in the *Recommendations* section of this report.

In meeting with Fort Drum Soldiers, VFA found a number of disconcerting examples of inadequate mental health care at Fort Drum. Some Soldiers reported that the leader of the mental health treatment clinic at Fort Drum asked Soldiers not to discuss their mental health problems with people outside the base. Attempts to keep matters “in house” foster an atmosphere of secrecy and shame that is not conducive to proper treatment for combat-related mental health injuries.

VFA was also told of some Soldiers seeking treatment after normal base business hours for mental health problems at a hospital in Syracuse, more than an hour’s drive from Watertown, rather than at Samaritan Hospital because they feared that Samaritan would side with base leadership, which had, in some cases, cast doubt on the legitimacy of combat-related mental health wounds. In one case, after a suicidal Soldier was taken to a Syracuse hospital, he was treated there for a week, indicating that his mental health concerns were legitimate. Unfortunately, mental health officials at Fort Drum had stated that they did not believe this Soldier’s problems were bona fide.

Another problem in post-combat mental health care faced by Soldiers at Fort Drum—as well as elsewhere in the Army—is the lack of confidentiality of information. If a Soldier seeks mental health treatment, this information is to be released to only a small number of that Soldier’s commanders. Unfortunately, some Soldiers at Fort Drum described a pervasive lack of confidentiality

for those seeking post-combat mental health treatment. Such a lack of confidentiality greatly undermines the efficacy of the mental health treatment being received.

Despite these examples, Fort Drum leaders—especially Major General Michael Oates—deserve commendation for setting the tone at Fort Drum that psychological wounds will be treated as legitimate combat wounds and that Soldiers should not hesitate to seek out such treatment. In addition, Admiral Michael G. Mullen, Chairman of the Joint Chiefs of Staff, recently stated that he will not allow the U.S. military to fail servicemembers in the aftermath of our wars in Iraq and Afghanistan, as occurred after the Vietnam War.¹⁷ Unfortunately, as both the DoD Task Force on Mental Health has reported and VFA found during investigative work at Fort Carson, Colorado, stigma often stands in the way of Soldiers receiving the mental health treatment they need. Signs of such stigma are still found at Fort Drum among some leaders of sub units within the 2nd BCT, such as at the company level. VFA encourages General Oates to continue his aggressive program of outreach to demonstrate the legitimacy of psychological wounds. When necessary, he should make it clear to commanders who violate his overall guidance that such behavior will not be tolerated.

Fort Drum is fortunate that the New York Congressional delegation takes wounded warrior issues seriously. Officials from the offices of both Senators Charles Schumer and Hillary Rodham Clinton were very receptive to the information unearthed by VFA, building upon the leading work that both senators have already accomplished to ensure that wounded servicemembers and their families receive the assistance that their honorable service merits.

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CLOSING

In conclusion, VFA stands ready to continue to work with leaders at Fort Drum, as well as those who have been placed under their command, to ensure that the considerable psychological needs of those who have seen combat on behalf of our nation receive high-quality care. VFA respectfully requests that the Army consider taking steps to give the members of the 2nd BCT more rest. This unit has served its country ably; it is now the country's turn to show its gratitude by allowing the unit more time at home so that members can "reset" mentally.

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VFA RECOMMENDATIONS FOR IMPROVING POST-COMBAT PSYCHOLOGICAL CARE

Fort Drum-specific

- Establish a pilot program for the 2nd BCT of the 10th Mountain Division that would create a more proactive mental health care treatment regimen before, during, and after deployment. This would include comprehensive one-on-one counseling for servicemembers; sophisticated brain scanning technology to assist in differentiating between neurological injuries such as mild traumatic brain injuries and psychological wounds such as PTSD; more attention devoted to the needs of spouses and dependents of combat Soldiers; face-to-face screening for all members of the unit immediately before redeployment, immediately after return to Fort Drum, and face-to-face screening every 30 days thereafter for three years.
- Provide considerably more funds to Fort Drum for mental health treatment, given the incredible burden shouldered by units of the 10th Mountain Division.
- Establish a special oversight panel to ensure that combat-related mental health treatment at Samaritan Medical Center is not negatively influenced by commanders or funding sources.

Army-wide

- The Army should create a publicly available database showing the fatality and casualty rates for units that have served in OEF/OIF. This will help outside organizations have a better understanding of the needs of these units and what might be done to improve their post-deployment mental health treatment. At present, the Army releases this information in a piecemeal fashion.
- In addition, the Army should maintain a public database of the number and percentage of Soldiers from a unit that have deployed multiple times. This will provide a better picture of the challenges facing members of units—and the resources required to address their post-combat mental health challenges. Again, the Army currently releases this information piecemeal.

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APPENDIX

Post-9/11 Deployment History of the 2nd Brigade Combat Team (BCT), 10th Mountain Division

Note: Dates are approximate

- Afghanistan: December 1, 2001 to April 5, 2002
(five-month deployment)

Dwell-time: Under 13 months

- Afghanistan: May 1, 2003 to December 15, 2003
(eight-month deployment)

Dwell-time: Six months

- Iraq: June 14, 2004 to June 23, 2005
(12-month deployment)

Dwell-time: 13.5 months

- Iraq: August 9, 2006 to November 8, 2007
(15-month deployment)

Casualties:

- 52 killed in action
- 270 wounded in action
- Two missing in action

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ENDNOTES

¹ There are approximately 3,500 Soldiers in the 2nd BCT.

² In its most recent deployment, the 2nd BCT sustained fatality and casualty rates that appear to be considerably higher than other units that have recently served in Iraq. Unfortunately, the Army does not maintain a database that is available to the public with comparative fatality/casualty figures of units that have deployed. This matter is discussed in the *Recommendations* section of this report.

³ "Maintaining Quality in the Force: A Briefing by General George W. Casey, Jr.," December 4, 2007, accessed at: <http://www.brookings.edu/events/2007/1204casey.aspx>, p. 38.

⁴ Veterans for America, "Trends in Treatment of America's Wounded Warriors: Psychological Traumas and Traumatic Brain Injuries: The Signature Wounds of Operation Iraqi Freedom and Operation Enduring Freedom," November 7, 2007, accessed at: <http://www.veteransforamerica.org/2007/11/06/trends-in-treatment-of-americas-wounded-warriors/>.

⁵ Veterans for America tried to determine the validity of these claims but did not receive data from the Fort Drum Public Affairs Office.

⁶ Office of the Surgeon, Multinational Force-Iraq (MNF-I) and Office of the Surgeon General, U.S. Army Medical Command (MEDCOM), "Mental Health Advisory Team (MHAT) IV, Operation Iraqi Freedom 05-07, Final Report," November 19, 2006, accessed at: www.armymedicine.army.mil/news/mhat/mhat_iv/MHAT_IV_Report_17NOV06.pdf, p. 19.

⁷ According to MHAT IV, "acute stress" is synonymous with Post Traumatic Stress Disorder, MHAT IV, p. 19. Data from MHAT IV, p. 20.

⁸ Department of Defense Mental Health Task Force, "An Achievable Vision: Report of the Department of Defense Task Force on Mental Health," June 2007, accessed at: <http://www.ha.osd.mil/dhb/mhtf/MHTF-Report-Final.pdf>, p. 5.

⁹ It should be noted that this rate is for all members of the active Army, including Soldiers who have not seen high-intensity combat.

¹⁰ MHAT IV, p. 23.

¹¹ In a classic case of "robbing Peter to pay Paul," it also bears noting that the Walter Reed-based doctors temporarily assigned to Fort Drum left crucial positions at Walter Reed, in some cases creating gaps in coverage and discontinuities in care for severely mentally wounded Soldiers at Walter Reed, the Army's most sophisticated psychiatric treatment facility.

¹² A general concern raised by Soldiers at Fort Drum was turnover of psychiatrists, which creates a lack of continuity of care.

¹³ Fort Drum Soldiers with the most complex mental health needs are handled by the in-patient facility at Walter Reed Army Medical Center, Washington, DC.

¹⁴ Norah Machia, "SMC mental health unit expansion is approved," *Watertown Daily Times*, June 8, 2007.

¹⁵ If they so choose, Soldiers can refuse to complete the PDHA.

¹⁶ In addition to the PDHA, Soldiers are requested, but not compelled, to complete the Post-Deployment Health Reassessment (PDHRA) (DD Form 2900) between 90 and 180 days after deployment.

¹⁷ "First Public Address by Admiral Mike Mullen, USN, Chairman of the Joint Chiefs of Staff," October 25, 2007, accessed at: <http://www.cnas.org/en/cev/?17>, pp. 16-17.

VETERANS FOR AMERICA

Veterans for America (VFA), formerly the Vietnam Veterans of American Foundation, unites a new generation of veterans with those from past wars to address the causes, conduct, and consequences of war in the 21st century.

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