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OPENING STATEMENT OF HON. BOB FILNER, CHAIRMAN, FULL COMMITTEE ON VETERANS' AFFAIRS

Good morning. The Committee on Veterans' Affairs will now come to order.

In 2007, this Committee held a hearing to explore the problem of the Department of Defense (DoD) improperly discharging service members with pre-existing personality disorders rather than mental health conditions resulting from the stresses of war such as Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI).

This means that service members with personality disorder discharges are generally denied key military disability benefits and DoD is conveniently relieved from the responsibility of caring for our service members in the long-term. These men and women continue to face an uphill battle when they seek benefits and services at the Department of Veterans Affairs (VA) because they must somehow prove that the so called pre-existing condition was aggravated or worsened by their military service.

Following the 2007 hearing on personality disorder discharges, the National Defense Authorization Act for Fiscal Year 2008 included a provision requiring DoD to submit a report to Congress on this issue. DoD reported that from 2002 to 2007, the Department discharged 22,600 service members with personality disorders.

DoD policy further stated that service members must be counseled, be given the opportunity to overcome said deficiencies, and must receive written notification prior to being involuntarily separated on the basis of a personality disorder. DoD also added rigor to their policy guidance by authorizing such separations only if service members are diagnosed by a psychiatrist or Ph.D. level psychologists of the personality disorder.

It has been over three years since we first exposed this issue at our hearing in 2007. It is my understanding that DoD's use of personality disorder discharges has decreased and that they concluded that no soldiers have been wrongly discharged.

I am deeply puzzled by this conclusion and would like to better understand the process and the criteria that were used to review the files of the thousands of service members who were discharged with personality disorders. I cannot help but suspect that our men and women are not getting the help that they need and are struggling with PTSD, TBI, and other stresses of war on their own because of wrongful personality disorder discharges.

Stresses of war such as PTSD and TBI are debilitating and its impact can be far-reaching. We know of the negative impact that PTSD and TBI can have on the individual's mental health, physical health, work, and relationships. We also know that veterans attempt to self-medicate using alcohol and drugs. This means that PTSD and TBI can lead veterans on a downward spiral towards suicide attempts and homelessness.

Just this past summer, we all heard the United States Army reporting suicide rates of 20.2 per 100,000 which now exceeds the national suicide rate of 19.2 per 100,000 in the general population. And, when high-risk behaviors such as drinking and driving and drug overdoses are taken into account, it is said that more soldiers are dying by their own hand than in combat. Similarly, we know that homelessness continues to be a significant problem for our veterans, especially those suffering with PTSD and TBI.

Three years later, the Committee continues to hear of accounts of wrongful personality disorder discharges. This begs the question of how many soldiers have to commit suicide, go bankrupt, and end up homeless before real action is taken to remedy this problem? Clearly, our veterans must not be made to wait longer and must not be denied the benefits that they are entitled to.

I look forward to hearing from our witnesses today as we further expose the problem of personality disorder discharges, better understand the steps that DoD has taken to deal with this problem, and forge a path forward to help our service members who were improperly discharged with personality disorders.

Statement of Sergeant Chuck Luther

Killeen, TX

Mr. Chairman, Committee members, and guests, thank you for the opportunity to speak and help my fellow soldiers and veterans by telling my story.
I am here today to say that wearing the uniform for the U.S. Army is what defined me. I was and still am very proud of the service that I gave to my country. I entered the service on active duty training status in February of 1988. I served 5 months and then went on to 8 years of Honorable Reserve service. I had a break in service and reentered the Reserves in 2003, and after serving 8 months honorably, I enlisted into the active duty Army in October 2004. I was stationed at Fort Hood Texas. I served as an admin specialist for three years and was given several awards for my leadership and service. I then went to retrain to become a 19D cavalry scout, upon finishing school at Fort Knox, KY. I returned to Fort Hood and was assigned to Comanche Troop, 1-7 CAV, 1st Brigade, and 1st Cavalry Division. I held the rank of specialist (E4) when we left for Taji, Iraq, for a 15 month combat deployment.

We arrived in Iraq in November of 2006. We found ourselves in a very violent area at the beginning of the surge. On December 16, 2006, I was working in the company radio area monitoring the group that we had outside the FOB on an escort mission. I remember that day very clearly. The call came in from one of our Staff sergeants in that patrol that they had been attacked and one of our vehicles had been destroyed and that we had three killed-in-action and one wounded-in-action. As we were receiving the information we could hear the small arms fire in the background as they tried to recover the dead and wounded soldiers. I served as the training room noncommissioned officer, so I was asked to translate the combat numbers given over the radio to my commander and first sergeant for identity. As the information came over, I instantly realized that the truck that had been destroyed contained one of my closest friends, SSG David Staats, and one of the soldiers that I had taken under my wing, PFC Joe Baines. I focused on the mission at hand and that evening drove the first sergeant and the platoon sergeant of these soldiers, to the mortuary affairs and helped unload their bodies from the vehicles bringing them home. I pushed through and the next morning we got word. as we were preparing to head to Baghdad to see the wounded soldier that he had died. For the next 2 months, we lost several other soldiers from our squadron and two Iraq interpreters.

On February 16, 2007, I was a member of a convoy that drove out 4 boats and members of our troop to conduct a river recon/mosque monitoring mission. After an uneventful drive out, unload boats, troops and soldiers, we headed back to FOB Taji. As we pulled back on FOB Taji, the call came over the radio that the unit of soldiers had been ambushed mission. We had to quickly gather up troops and head back to the drop off location to assist. Upon arriving, we received small arms and large scale fire from the enemy, we found one of our SSG's (SSG Thompson) lying in the middle of the beach bleeding from the legs, one of our Lieutenants had been shot in the arm, and two Iraq police officers had been killed. We quickly put together two boats of troops and ammo to retrieve our soldiers. After heading up river we had received fire and our boat had capsized and we were stranded on an island for approximately 14 hours before being picked up. We had limited ammunition and no radio communications. We all thought that we were going to die that day.

Fourteen days to the day after that event, I was sent home for R and R leave. I was very angry, had severe headaches, was depressed and would cry at times. I fought with my wife and family while I was home. I had an episode where I broke my hand punching walls. After not being able to cope, I welcomed the trip back to Iraq. Upon returning to Iraq, I was promoted to SGT and received my Combat Action Badge for my part in the river mission firefights. After returning from R and R leave, several people in my unit said that something had changed in me. I tried to pull it together but had trouble sleeping, had anger problems, severe headaches, nose bleeds and chronic chest pain. I was living at the combat outpost x-ray. While there I went to see the medics to get my inhaler for asthma filled. I was sent back to the FOB, upon returning to the FOB aid station, the squadron aide station doctor, CPT Aaron Dewees was not present. I was told he was busy preparing for his triathlon that he was going to be in after deployment. I came back the next day and was seen. I asked to see the chaplain because I was feeling very depressed and needed to talk. After talking to the chaplain, I was sent to quarters for 2 days and then I was allowed to go back to the combat outpost. Around the first of April I was in guard tower 1 alpha when a mortar landed between the tower and the wall around the combat outpost. When it exploded it threw me down and I hit my right shoulder and head. I had severe ringing in my right ear with clear fluid coming from it and had problems seeing out of my right eye. After a few minutes, I went to the medics on the outpost and was given ibuprofen and water and sent back to duty.

I started to have worse headaches and could not sleep. They sent me back to the FOB and I was seen by the aid station doctors and medics and then sent to the mental health center. I spoke with a LTC there who was a licensed clinical social worker. He had a 15-minute talk with me and they gave me celexia and ambien. I was sent back to my quarters. The next 2 days I began to get angry and hostile (due to the meds) and was sent back to the LTC. He informed me that if I did not stop acting like this that they were going to chapter me out under a 5-13. I tried and went back to the aid station. After several days on suicide watch for making the comment that "if I had to live like this I would rather be dead," I asked to be sent somewhere where I could get help and to be able to understand what was wrong with me. I was told I could not go and I then demanded that I be taken to the Inspector General of the FOB. I was told by CPT Dewees that I was not going anywhere and he called for all the medics, roughly 6 to 10. I was assaulted, held down, and had my pants ripped off my left thigh and given an injection of something that put me to sleep. When I awoke, I was strapped down to a combat litter and had a black eye and cuts on my wrists from the zip ties. I eventually was untied and from that point forward for 5 weeks I was held in a room that was 6 feet by 8 feet that had bed pans, old blankets and other old supplies. I had to sleep on a combat litter and had a wool blanket. I was under guard 24/7 and on several occasions was told I was not allowed to use the phone or internet, and when I would take my meds and fall asleep I was not awakened to get food. On one occasion, I had slept through chow and asked to be taken to the chow hall or PX to get some food. I was told no and given a fuel soaked MRE to eat. I was constantly called a piece of crap, a faker, and other derogatory things. They kept the lights on and played all sorts of music from rap to heavy metal very loud all night, the medics worked in shifts, therefore, they didn't sleep; they rotated. These are some of the same tactics that we would use on insurgents that we captured to break them to get information or confessions. I went through this for 4 weeks and the HHC Commander, CPT Wehri told me to sign this discharge and that if I didn't that they would keep me there for 6 more months and then kick me out when we got back to Fort Hood anyway, I said I didn't have a personality disorder and he told me that if I signed the paperwork that I would get back home

and get help and I would have all my benefits. After the endless nights of sleep deprivation, harassment and abuse I finally signed just to get out of there. I was broken.

It took 2 more weeks before I was flown out and brought to Fort Hood. Upon returning I was told by the rear detachment acting 1SG and Commander to stay out of trouble and they would get me out of there. I was sent out to wait on my wife in the rain with 2 duffle bags and another carry bag. This was my welcome home from war. I went home and went to sleep only to be awakened by three sergeants at my door saying I had to go back to mental health due to me being suicidal and they hadn't had me checked out. I went to the R and R center at Fort Hood and was seen by LTC Baker, who was a psychologist. He asked why I was brought back from Iraq, I explained they said I had a personality disorder and he disagreed, he shook his head and said that I had severe PTSD and combat exhaustion. He told me to get some sleep and rest and follow up in a week with him. I was never allowed to go back to see him. The ironic thing is that in my military records I held 3 Army jobs and had a total of 8 mental health screenings that all found me fit for duty. Also, I had never had a negative counseling or negative incident in my 12 years of Reserve and active duty career. Two weeks after getting back, I was discharged from the Army, I had my pay held and they took my saved up leave from me for repayment of my unearned reenlistment bonus. I received a notice in the mail 3 week after my discharge from the department of finance that I owed the Army $1501. Three months later, I went to the VA and was told they could not see me for mental health due to my preexisting disorder. I went back the next week and was seen by a psychologist, after an hour with her she scheduled me an appointment with a caseworker and then I had several follow-up mental health appointments. I was given my VA rating a year later in 2008 of 70 percent for PTSD, knee injury, headaches, right shoulder and asthma. Six months later after several emergency room visits and neurology appointments, my rating was upgraded to 90 percent and I was given service-connection for Traumatic Brian Injury. In June of this year, after 2 years from the date that I filed a request with the Military Boards of Correction to have my discharge changed from a Chapter 5-13 to a medical retirement, I was denied, even after the 3 years of VA medical documents and evidence from people who know me. I demand that my discharge be changed and that I receive the proper discharge for my service.

I have since founded Disposable Warriors and have assisted many veterans and soldiers in a range of issues from Personality Disorder diagnosis to soldiers on active duty with diagnosed PTSD that are not being treated or being discharged for misconduct under other than honorable or bad conduct discharge (which does not entitle them to VA benefits either). I want to say that it has been hell to just get my mind somewhat back on track and to exist; I have bouts of memory loss, agitation, flashbacks, paranoia, problems sleeping and depression. I get angry every time I look at my DD-214 with the fraudulent personality disorder discharge. It cost me contract jobs for private security after my exit from the Army. I had to get a job 3 days after I was kicked out of the Army to feed my wife and three children. I was taught for years in the Army the definition of Integrity, Honor, Respect and Selfless Service, all of which I did I have given to the Army, but did not get in return.

I hold two things very dear to me to this day. It comes from the NCO Creed, the accomplishment of my mission and the welfare of my soldiers. I am on a new battlefield, with a new mission, and I will at all cost take care of soldiers and their families. I love my country, I love my Army but we cannot stand by and watch this continue to happen. At the very same time

that this Committee was having SPC Jon Town testify in front of them in July of 2007, I was abused, broken and discharged for the very same thing that he testified about. Please do not let us be here in 3 years again with another story of shame. The lack of care and concern, coupled with the stigma of weakness for asking for help that we have allowed to be put on us, has to be totally removed. Then, and only then, will we see the veterans homelessness rate drop, the active duty and veteran suicide rate drop, and the skyrocketing rate of divorce decrease. The senior level of the armed forces gets it, but they can talk about it, design plans for it, make PowerPoint's of it, but if it is not being enforced at the soldier's level, it is worthless.

In closing I would like to state that I do not have, nor have I ever had, a personality disorder. I suffer from PTSD and Traumatic Brian Injury from my service to my country while at war in Iraq. I raised my right hand on several occasions and swore to protect the Constitution at all cost. I did my part and now it is time for the military to keep its part of the agreement that if I were injured they would help me get back on my feet. Please help stop these wrongful discharges and help get our wounded servicemen and women back to service or back home to their families.

Thank you for your time.

Statement of Joshua Kors
Investigative Reporter
The Nation. *Magazine*

Good morning. I've been reporting on personality disorder for several years, and I'm here today to talk about the thousands of soldiers discharged with that condition since 2001.

A personality disorder discharge is a contradiction in terms. Recruits who have a severe, pre-existing illness like a personality disorder do not pass the rigorous screening process and are not accepted into the Army.

In the three and a half years I've been reporting on this story, I've interviewed dozens of soldiers discharged with personality disorder. All of them passed that original screening and were accepted into the Army. They were deemed physically and psychologically fit in a second screening as well, before being deployed to Iraq and Afghanistan, and served honorably there in combat. In each case, it was only when they became physically wounded and sought benefits that their pre-existing condition was discovered.

The consequences of a personality disorder discharge are severe. Because PD is a pre-existing condition, soldiers discharged with it cannot collect disability benefits. They cannot receive long-term medical care like other wounded soldiers. And they have to give back a slice of their signing bonus. As a result, on the day of their discharge, thousands of injured vets learn they actually owe the Army several thousand dollars.

Sergeant Chuck Luther is a disturbing example of a how the Army applies a personality disorder discharge. Luther was manning a guard tower in the Sunni Triangle, north of Baghdad, when a mortar blast tossed him to the ground, slamming his head against the concrete, leaving him with migraine headaches so severe that vision would shut down in one eye. The other, he said, felt like someone was stabbing him in the eye with a knife. When Luther sought medical care, doctors at Camp Taji told him his blindness was caused by pre-existing personality disorder.

Luther had served a dozen years, passing eight screenings and winning 22 honors for his performance. When he rejected that diagnosis, Luther's doctors ordered him confined to a closet. The sergeant was held in that closet for over a month, monitored around the clock by armed guards who enforced sleep deprivation: keeping the lights on all night, blasting heavy metal music at him all through the night. When the sergeant tried to escape, he was pinned down, injected with sleeping medication and dragged back to the closet. Finally, after over a month, Luther was willing to sign anything—and he did, signing his name to a personality disorder discharge.

The sergeant was then whisked back to Fort Hood, where the he learned the disturbing consequences of a PD discharge: no disability pays for the rest of his life, no long-term medical care, and he would now have to pay back a large chunk of his signing bonus. Luther was given a bill for $1,500 and told that if he did not pay it, the Army would garnish his wages and start assessing interest.

Since 2001, the military has pressed 22,600 soldiers into signing these personality disorder documents, at a savings to the military of over $12.5 billion in disability and medical benefits.

The sergeant's story was Part 3 in my series on personality disorder. In Part 2, I interviewed military doctors who talked about the pressure on them to purposely misdiagnose wounded soldiers. One told the story of a soldier that came back with a chunk missing from his leg. His superiors pressured him to diagnose that as personality disorder.

In 2008, after several congressmen expressed outrage at these discharges, President Bush signed a law requiring the Pentagon to study PD discharges. Five months later the Pentagon delivered its report. Its conclusion: not a single soldier had been wrongly diagnosed, and not a single soldier had been wrongly discharged. During this five-month review, Pentagon officials interviewed no one, not even the soldiers whose cases they were reviewing.

Three years ago, during a hearing on personality disorder discharges, military officials sat in these seats and vowed to this committee to fix this problem. Three years later nothing has changed.

Key Links

Personality Disorder series: **www.joshuakors.com/military**
Sgt. Luther article: **www.joshuakors.com/part3**
Luther on BBC: **http://bit.ly/BBC1interview**
ABC News on Personality Disorder: **www.joshuakors.com/abcnews.mov**
Personality Disorder discharge stats: **www.joshuakors.com/statistics**
Personality Disorder legislation: **www.joshuakors.com/legislation**

The Nation.

April 26, 2010

"Disposable Soldiers: How the Pentagon is Cheating Wounded Vets"

By Joshua Kors

The mortar shell that wrecked Chuck Luther's life exploded at the base of the guard tower. Luther heard the brief whistling, followed by a flash of fire, a plume of smoke and a deafening bang that shook the tower and threw him to the floor. The Army sergeant's head slammed against the concrete, and he lay there in the Iraqi heat, his nose leaking clear fluid.

"I remember laying there in a daze, looking around, trying to figure out where I was at," he says. "I was nauseous. My teeth hurt. My shoulder hurt. And my right ear was killing me." Luther picked himself up and finished his shift, then took some ibuprofen to dull the pain. The sergeant was seven months into his deployment at Camp Taji, in the volatile Sunni Triangle, twenty miles north of Baghdad. He was determined, he says, to complete his mission. But the short, muscular frame that had guided him to twenty-two honors—including three Army Achievement Medals and a Combat Action Badge—was basically broken. The shoulder pain persisted, and the hearing in his right ear, which evaporated on impact, never returned, replaced by the maddening hum of tinnitus.

Then came the headaches. "They'd start with a speckling in the corner of my vision, then grow worse and worse until finally the right eye would just shut down and go blank," he says. "The left one felt like someone was stabbing me over and over in the eye."

Doctors at Camp Taji's aid station told Luther he was faking his symptoms. When he insisted he wasn't, they presented a new diagnosis for his blindness: personality disorder.

"To be told that I was lying, that was a real smack in the face," says Luther. "Then when they said 'personality disorder,' I was really confused. I didn't understand how a problem with my personality could cause deafness or blindness or shoulder pain."

For three years *The Nation* has been reporting on military doctors' fraudulent use of personality disorder to discharge wounded soldiers. PD is a severe mental illness that emerges during childhood and is listed in military regulations as a pre-existing condition, not a result of combat.

Thus those who are discharged with PD are denied a lifetime of disability benefits, which the military is required to provide to soldiers wounded during service. Soldiers discharged with PD are also denied long-term medical care. And they have to give back a slice of their re-enlistment

bonus. That amount is often larger than the soldier's final paycheck. As a result, on the day of their discharge, many injured vets learn that they owe the Army several thousand dollars.

According to figures from the Pentagon and a Harvard University study, the military is saving billions by discharging soldiers from Iraq and Afghanistan with personality disorder.

In July 2007 the House Committee on Veterans' Affairs called a hearing to investigate PD discharges. Barack Obama, then a senator, put forward a bill to halt all PD discharges. And before leaving office, President Bush signed a law requiring the defense secretary to conduct his own investigation of the PD discharge system. But Obama's bill did not pass, and the Defense Department concluded that no soldiers had been wrongly discharged. The PD dismissals have continued. Since 2001 more than 22,600 soldiers have been discharged with personality disorder. That number includes soldiers who have served two and three tours in Iraq and Afghanistan.

"This should have been resolved during the Bush administration. And it should have been stopped now by the Obama administration," says Paul Sullivan, executive director of Veterans for Common Sense. "The fact that it hasn't is a national disgrace."

On Capitol Hill, the fight is not over. In October four senators wrote a letter to President Obama to underline their continuing concern over PD discharges. The president, almost three years after presenting his personality disorder bill, says he remains concerned as well.

Veterans' leaders say they're particularly disturbed by Luther's case because it highlights the severe consequences a soldier can face if he questions his diagnosis and opposes his PD discharge.

Luther insisted to doctors at Camp Taji that he did not have personality disorder, that the idea of developing a childhood mental illness at the age of 36, after passing eight psychological screenings, was ridiculous. The sergeant used a vivid expression to convey how much pain he was in. "I told them that some days, the pain was so bad, I felt like dying." Doctors declared him a suicide risk. They collected his shoelaces, his belt and his rifle and ordered him confined to an isolation chamber.

Extensive medical records written by Luther's doctors' document his confinement in the aid station for more than a month. The sergeant was kept under twenty-four-hour guard. Most nights, he says, guards enforced sleep deprivation, keeping the lights on and blasting heavy metal music. When Luther rebelled, he was pinned down and injected with sleeping medication.

Eventually Luther was brought to his commander, who told him he had a choice: he could sign papers saying his medical problems stemmed from personality disorder or face more time in isolation.

'Every Night It Was Megadeth'

Luther entered the Army in 1988, following in the footsteps of his grandfathers, both decorated World War II veterans. In 2005, after Hurricane Katrina, he and his unit were deployed to New Orleans, where he helped evacuate residents and dispose of bodies left in the street. In 2006 he was deployed from Fort Hood in Texas to Camp Taji, where he performed reconnaissance with the First Squadron, Seventh Cavalry Regiment, led by Maj. Christopher Wehri. "Luther was

older and more mature than most of the soldiers. He was forthcoming, very polite," says Wehri. "He seemed to have a good head on his shoulders."

Doctors at the aid station didn't see him that way. Following the May 2007 mortar attack, Luther entered the base's clinic and described his concussion symptoms to Capt. Aaron Dewees. Dewees, a pediatrician charged with caring for soldiers in the 1-7 Cavalry, grew suspicious of Luther's self-report. "It is my professional opinion," Dewees wrote in his medical records, "that Sgt. Charles F. Luther Jr. has been misrepresenting himself and his self-described medical conditions for secondary gain." The doctor suggested that Luther was faking his ailments to avoid reconnaissance duty. He called the sergeant "narcissistic" and said Luther's descriptions of his injuries were a mixture of "exaggeration and flat-out fabrication."

Luther's medical records document severe nosebleeds and "sharp and burning" pain. Still, the sergeant says he could sense that his doctors didn't believe him. It was at that point—frustrated, plagued by blinding migraines—that he spoke of pain so severe he wished he were dead. "I made clear that I was not going to kill myself, that it was just a colorful expression to explain how much pain I was in." Dewees agreed. In their records, Luther's doctors note a "suicide gesture" and "'off-handed' comments" that the sergeant was going to kill himself, but Dewees said those gestures were "unlikely to have been a serious attempt" at self-harm. Nonetheless, Dewees wrote, such statements "must be taken seriously and treated as such," that Luther "remains a threat to himself and others given his need for attention, narcissistic tendencies and impulsive behavior."

Luther was taken to an isolation chamber and told this was his new sleeping quarters. The room, which Luther captured on his digital camera, served as a walk-in closet. It was slightly larger than an Army cot and was crammed with cardboard boxes, a desk and a bedpan. Through a small, cracked window, he could look out onto the base. Through the open doorway, the sergeant was monitored by armed guards.

Both Dewees and Lt. Col. Larry Applewhite, an aid station social worker, declared Luther mentally ill, suffering from a personality disorder. The next step was to remove him from the military as fast as possible. "It is strongly recommended that Sgt. Luther be administratively separated via Chapter 5-13," wrote Applewhite, citing the official discharge code for personality disorder. In a separate statement, Dewees endorsed the 5-13 discharge and urged that it be handled rapidly. "I feel the safest course of action," he wrote, "is to expedite his departure from theater."

That didn't happen. For more than a month Luther remained in his six-by-eight-foot isolation chamber, weeks he describes as "the hardest of my life." He says the guards would ridicule him and most nights enforced sleep deprivation, keeping the lights on all night and using a nearby Xbox and TV speakers to blast heavy metal into his room. "Every night it was Megadeth, Saliva, Disturbed." The sergeant pulled a blanket over his head to block out the noise and the light, but it was no use.

"They told me I wasn't a real soldier, that I was a piece of crap. All I wanted was to be treated for my injuries. Now suddenly I'm not a soldier. I'm a prisoner, by my own people," says Luther, his voice tightening. "I felt like a caged animal in that room. That's when I started to lose it."

Isolated, exhausted, the sergeant who had been confined for being mentally ill says he began feeling exactly that. Finally Luther snapped. He stepped out of his room and was walking toward a senior official's office when an altercation broke out. In the ensuing scuffle, Luther bit one of his guards, then spit in the face of the aid station chaplain. The sergeant was pinned to the floor and injected with five milligrams of Haldol, an antipsychotic medication. Sedated, Luther was returned to isolation.

Staff Sgt. James Byington, who was serving at Camp Taji with the 1-7 Cavalry, walked the half-mile to the aid station to visit his fellow soldier. Byington says that off the battlefield, Sergeant Luther was "animated and peppy," the comedian of the chow hall. During combat, he says, Luther was focused and prepared, a key component in a farmland raid just outside Taji that discovered a cache of weapons and money. The man he found in the isolation chamber was neither the soldier nor the comedian, he says, but something altogether odd and decrepit. "He wasn't energetic like he used to be. He wasn't cutting jokes. Chuck's one of those guys that talks with his hands. You go into a room with twenty guys, and you're going to hear Chuck Luther," says Byington. "Now he seemed half-asleep. He looked worn out."

A few hours after Byington's visit, Luther was called to his commander's office. Major Wehri was frank. He held the personality disorder discharge papers in his hand. "And he said, 'Sign this paperwork, and we'll get you out.' I said, 'I don't have a personality disorder.' But it was like that didn't matter," says Luther. "He said, 'If you don't sign this, you're going to be here a lot longer.'"

The sergeant signed. "They had me broke down," he says. "At that point, I just wanted to get home." Luther's voice grows quiet as he recounts that final meeting. "I still remember Wehri's face," he says. "He was smiling."

Wehri confirms his statements to Luther. He says he pressed the sergeant to sign because he felt it was in Luther's best interest and in the best interest of the Army. The sergeant, he says, "had gotten so belligerent. If we had returned him to his unit, he would have been a danger to himself and to others. His behavior was not suitable to military service. And he wanted to get home. So I told him, 'If your goal is to get home, and we've diagnosed you with personality disorder, your fastest way is to sign the papers. If you don't sign, you're just subjecting yourself to further anguish and discomfort.'"

Wehri insists that his comments to Luther were not pivotal to the sergeant's discharge. Even without a soldier's signature, a PD dismissal can proceed. But the papers would then move to an Army lawyer, and the process would be delayed. "You can't force anyone to sign," he says. "But if you're going to be stubborn and not sign, try to play hardball, you run the risk of a dishonorable discharge. With Luther's biting and spitting, I could have court-martialed him out right there for failure to perform in a military manner."

The major says Luther's real story is that of a good soldier who came home for leave, saw his wife's new haircut and slimmed figure and was driven mad by fears of her infidelity. "When he came back to Iraq, something had changed. He had a negative attitude. He wouldn't respond to direct orders. His head wasn't in the game." Wehri says it became clear to him that Luther was intent on returning home right away, a realization that left him disappointed but not shocked. "Soldiers are conniving," he says. "They are manipulative. If they get in their minds they want to do something for personal gain, including going home, they'll go to any lengths to get it."

Wehri rejects the idea that the mortar attack and subsequent concussion could have triggered Luther's woes. "That mortar attack was nothing," he says. "Insignificant. Maybe he fell down. Sure. I've fallen down lots of times." The major wonders aloud whether Luther is using that injury to justify his instability. He says if he thought the attack was significant, he would have investigated it fully and gotten the ball rolling for a Purple Heart.

The major confirms that Luther was confined to the aid station for several weeks and that his room was minuscule. But he says those circumstances were unavoidable. "Discharging a soldier with personality disorder is a very long and drawn-out process," he says. "And Luther was a danger to himself and others. He needed to be watched. The aid station, that's where they had 24-7 supervision."

Wehri says he marvels at the idea that Luther could be a poster child for false personality disorder discharges. He has seen seven personality disorder cases in his career, he says. "And Chuck Luther was by far the clearest one." The major says that when Luther's troubles began, the sergeant's behavior confounded him. Then, says Wehri, he heard from a commander who said Luther's family had spoken with him and revealed that Luther had suffered from psychiatric problems before entering the military and had been treated with medication. "Then suddenly it made sense to me," says Wehri. "This was not new. His symptoms were just popping up now, after he'd kept a lid on them for many years. It all clicked into place."

But Luther's wife and his mother say that story is flatly false. Both say they never had such a conversation with an Army commander and are emphatic that the sergeant never faced any psychiatric problems before entering the military. "Hearing that makes me really angry," says Luther's mother, Barbara Guignard. "Chuck was an all-American boy. He never took any medication, and he never had a problem."

How Dewees and Applewhite came to the conclusion that Luther was suffering from a pre-existing mental illness remains unclear. They declined to elaborate on their notes or discuss the diagnosis of personality disorder in general. What is clear is that neither Dewees nor Applewhite spoke with Luther's family before determining that his problems existed before his military service. The sergeant's wife and his mother say that had they been asked, both could have provided key information demonstrating Luther's stability and health before the mortar attack.

Spec. Angel Sandoval says he could have helped as well. Sandoval, who was stationed at Camp Taji and served under Luther in the 1-7 Cavalry, laughs at the idea that the sergeant was mentally ill. "Chuck was a lot more than 'not mentally ill,'" he says. "He saved my life." Sandoval describes heading into combat under Luther's command. The specialist was ready to dump his side-SAPIs, large ceramic plates that strap to the side of a bulletproof vest, protecting the kidneys from machine-gun fire. "They're bulky and kinda heavy, but he said, 'No way, you have to wear them,'" says Sandoval. "Two days later I got shot right there, under my arm. It could have killed me."

Luther, he says, was "one of the greatest leaders I had. He never steered me wrong. If they thought he was ill and needed medical help, they should have given it to him instead of kicking him out of the Army."

But it was Wehri and Applewhite's view that mattered. Soon after signing the personality disorder papers, Luther was placed in a DC-10 and whisked back to Fort Hood. There he would

learn about Chapter 5-13's fine print: he was ineligible for disability benefits, since his condition was pre-existing. He would not be receiving the lifetime of medical care given to severely wounded soldiers. And because he did not complete his contract, he would have to return a slice of his signing bonus.

At the base, a Fort Hood discharge specialist laid out the details. "He said I now owed the Army $1,500. And if I did not pay, they'd garnish my wages and assess interest on my debt," Luther says.

Luther was then released into a pelting Texas rain. He called his wife, Nicki, to pick him up. "When I got to Fort Hood he was in the parking lot, alone, wet, sitting on his duffel bag," Nicki recalls. "He had lost a lot of weight. He looked like...a little boy. I remember thinking, My God, what have they done to my husband?"

The President 'Continues to Be Concerned'

Luther's case is not an isolated incident. In the past three years, *The Nation* has uncovered more than two dozen cases like his from bases across the country. All the soldiers were examined, deemed physically and psychologically fit, then welcomed into the military. All performed honorably before being wounded during service. None had a documented history of psychological problems. Yet after seeking treatment for their wounds, each soldier was diagnosed with a pre-existing personality disorder, then discharged and denied benefits.

That group includes Sgt. Jose Rivera, whose hands and legs were punctured by grenade shrapnel during his second tour in Iraq. Army doctors said his wounds were caused by personality disorder. Sailor Samantha Stitz fractured her pelvis and two bones in her ankle. Navy doctors cited personality disorder as the cause. Spec. Bonnie Moore developed an inflamed uterus during her service. Army doctors said her profuse vaginal bleeding was caused by personality disorder. Civilian doctors disagreed: they performed emergency surgery to remove her uterus and appendix. After being discharged and denied benefits, Moore and her teenage daughter became homeless.

"The military is exacerbating an already bad situation," says Sullivan of Veterans for Common Sense. "This is more than neglect. It's malice." Sullivan's organization has spent the past few years pressing officials in Washington to take action on the personality disorder issue. In July 2007 he testified before the House Committee on Veterans' Affairs. Sullivan told the committee that PD discharges needed to be halted immediately.

That month Obama put forward his bill to do just that. The bill was matched in the House by legislation from Representative Phil Hare, and it had passionate support on both sides of the aisle, from prominent Democrats like Senator Barbara Boxer to high-ranking Republicans like Senator Kit Bond. Sullivan and other veterans' leaders say they were hopeful that Obama would use the spotlight of the presidential campaign to generate further momentum for his bill.

That didn't happen. In the twenty-one months of his presidential run, the Illinois senator never spoke publicly about PD discharges or his bill to halt them. Eventually, without widespread public knowledge or support, and facing opposition from senators who had never heard of personality disorder and worried the bill would open a floodgate of expensive benefits, Obama and Bond, the bill's co-author, were forced to reshape it into an amendment and water down its

contents. Their amendment did not halt PD discharges. Instead, it required the Pentagon to investigate PD dismissals and report back to Congress. The amendment, part of the Defense Authorization Act, was signed by President Bush in January 2008.

Five months later the report landed on Obama's and Bond's desks. The Pentagon's conclusion: no soldiers had been improperly diagnosed, and none had been wrongly discharged. The report praises the military's doctors as "competent professionals" and endorses continued use of pre-existing personality disorder to discharge soldiers whose "ability to function effectively" is impaired. The report's author, former Under Secretary of Defense David Chu, further notes that though the Navy's official label for the discharge is "Separation by Reason of Convenience of the Government," soldiers "are not wantonly discharged at the convenience of the Military."

It is unclear how Chu came to these conclusions. The report does not cite any interviews with soldiers discharged with personality disorder, or their families, doctors or commanders. That fact infuriated many military families, as it triggered memories of a 2007 study by former Army Surgeon General Gale Pollock. Pollock had been asked to examine a stack of PD cases. Five months later she released her report, saying her office had "thoughtfully and thoroughly" reviewed them. Like Chu, she commended the soldiers' doctors and determined that they all had been properly diagnosed. *The Nation* later revealed that Pollock's office did not interview anyone, not even the soldiers whose cases she was reviewing.

"He doesn't talk to soldiers, and he doesn't talk to their families?" says Nicki Luther, the sergeant's wife, her eyes welling with tears. "I heard the same thing from that surgeon general, and I thought, You haven't been in my house. You don't know what I've dealt with. How dare you sit there and say you've investigated thoroughly and found nothing. That's a crock."

The Chu report does recommend several changes to the PD discharge system, alterations, it says, that will protect soldiers from being wrongly discharged. Those protections include requiring that a doctor diagnose the soldier's personality disorder and a lawyer counsel him on the ramifications of the discharge. The report also recommends that the surgeon general review each soldier's case and endorse the PD discharge before releasing the soldier from the military.

Chu, a Bush appointee, left office in 2008 with the president. But his findings remain as the Defense Department's position on PD discharges. In early April the Pentagon released a statement saying that Clifford Stanley, the current under secretary, is implementing Chu's recommendations and fully embraces his findings.

That fact left many on Capitol Hill enraged. "This study, with the new requirement to have the upper-ups approve discharges—all it basically did was set up one more hurdle. As far as we can tell, the impact has been somewhere between zero and less," says Senator Bond. Bond says the Pentagon still hasn't explained the fundamental contradiction of a PD discharge: recruits who have a severe pre-existing mental illness could not pass the rigorous screening process and would not be accepted into the military in the first place. Yet he says his office is looking at several cases, like Luther's, in which the soldiers have been deemed physically and psychologically fit in several screenings before their personality disorder is diagnosed. "These men and women who have put their lives on the line, we owe them," says Bond. "We have a responsibility. Discharging them with personality disorder—it's just an easy way to duck that responsibility."

The Republican from Missouri says he's hopeful that Obama, his partner on the PD bill, will take action from the White House. "He has a unique chance now to change the whole operation, to alter the system from the inside." In October Bond gathered a small coalition of senators and wrote a letter to the president, asking him to confront the issue once again. "In 2007 we were partners in the fight against the military's misuse of personality disorder discharges," wrote the senators. "Today, we urge you to renew your commitment to address this critical issue."

The next week Senator Boxer, a co-sponsor of the original bill, submitted a statement of her own. "It is simply appalling that any combat veteran with a Traumatic Brain Injury [TBI] or Posttraumatic Stress Disorder would be denied medical care for injuries sustained during combat," Boxer wrote. Even with the reforms that followed the Chu report, "we must make sure that the new discharge process...is working."

The White House responded quickly, assuring the senators that the president still has his eye on personality disorder. President Obama "is determined to fulfill America's responsibility to our Armed Forces," says White House spokesman Nicholas Shapiro. "The president was concerned with personality disorder discharges as a senator, and he drafted a bill. He continues to be concerned as commander in chief."

Disposable Warriors

Luther hopes that concern will translate into action. The sergeant stands in his backyard, 1,500 miles from Washington, five miles from Fort Hood, talking about Obama's bill and watching his 7-year-old daughter floating high above the family's oversize trampoline, her face wild with joy. Luther looks on with sullen eyes. "Right now I can't worry about Washington, or even about fixing my discharge papers," he says. "First thing, I got to fix myself." He gestures to his daughter, a mop of blond hair leaping to and fro. "I used to be like that: a goofball, all this energy. Now... I don't know."

Some nights he doesn't sleep. Others he's back in Iraq, in the aid station, in endless isolation. The blinding headaches and piercing shoulder pain still plague him, he says, along with panic attacks and bursts of post-traumatic stress-fueled rage. Luther broke four bones in his hand punching a hole in his bedroom wall. His family's hallway is pocked with holes from similar incidents.

"He's not the man I married," says Nicki Luther. "And when I'm honest with myself, I don't think I'll ever have that man again. He wakes up screaming in the middle of the night, sweating, swearing." Nicki says he tries to be a good dad to their kids. "He used to wrestle around with them. But his body's like an old man's now. And he's so quick to anger. The kids say, 'We want our dad back.' I don't know what to tell them."

Three years after the mortar blast, Luther's life is still on shaky ground. Some days he's posting love notes on his wife's Facebook page and hand-delivering her favorite salad to her office at lunchtime. Another day, in the midst of an argument, he knocked down a family photo, then ripped the furniture out of the living room and dumped it in the garage, scaring his children. Soon after the birth of their fourth child, Marlee Grace, Luther and his wife separated. They reunited a few months later, in time for their eighteenth anniversary.

Luther knew he needed help. This time he sought it outside the military. He began seeing Troy Daniels, a psychologist, once a week. One fact was clear immediately, says Daniels. "He did not

have personality disorder. The symptoms we were looking at looked more like traumatic brain injury and post-traumatic stress disorder. To take a soldier having problems with vision, hearing and so forth—and to say he has personality disorder—that's a bogus kind of statement. I don't even think a master's student would make that kind of mistake."

While Daniels dismisses the Army doctors' diagnosis as a "gross error," he says he was not surprised by it. "I've treated hundreds of soldiers over the years, and I've seen a dozen personality disorder diagnoses. None of them," says the psychologist, "actually had personality disorder."

Yet all of those soldiers, he says, faced serious repercussions because of their discharge. "Many of the soldiers can't get hired anymore. Every time they go for a job, they'll have this paper that says they've been diagnosed with a personality disorder. Employers take one look at that and think, 'This guy's crazy. We can't hire him.' For most of the soldiers," says Daniels, "it becomes a lifetime label."

Luther luckily has secured a job, as a truck driver for Frito-Lay. Securing benefits has proved a bit tougher. Since being released from the Army, the sergeant has been locked in battle with the VA, fighting to prove that despite his PD discharge, his wounds are war related and thus worthy of disability and medical benefits.

Those efforts stumbled at first. In May 2008 the VA declared Luther "incompetent" and demanded that a fiduciary collect any disability benefits he may receive. Eventually, following a slew of paperwork and medical exams, the sergeant re-established his full standing. This past December—after VA doctors found Luther to be suffering from migraine headaches, vision problems, dizziness, nausea, difficulty hearing, numbness, anxiety and irritability—the VA cited traumatic brain injury and post-traumatic stress disorder and declared Luther 80 percent disabled. "PTSD, a consequence of the TBI," wrote one VA doctor, "is a clear diagnosis."

The VA rating cleared the way for the sergeant to receive disability benefits and a lifetime of medical care. But it hasn't changed the Army's view—or altered Luther's discharge papers, which still list the sergeant as suffering from personality disorder. The sergeant, in return, has refused to pay back the $1,500 of his signing bonus that the Army says he owes, despite threats to garnish his wages. "I told them, Let me put it this way: as long as I'm breathing of my own free will, I'm not paying you a dime."

Luther says what really boils his blood is having to accept that his military career is over while the careers of those who devised his discharge are flourishing. After Luther's dismissal, Wehri, a captain at the time, was promoted to major and selected to be an executive officer with NATO. Dr. Dewees returned to Kentucky, where he continues to serve with the National Guard. Social worker Applewhite is now an instructor at Fort Sam Houston, where he teaches a class on how to identify mental disorders.

With or without the Army, Luther says he will continue to serve. With his health gradually improving and the bulk of his battle over, the sergeant is taking on a new mission: fighting the military on behalf of other soldiers like himself. Luther is now the founder and executive director of Disposable Warriors, a one-man operation that assists soldiers who are fighting their discharge and veterans who are appealing their disability rating.

Luther's organization did not receive a hero's welcome. Soon after founding the group, he discovered a threatening note on his windshield. "Back off or you and your family will pay!!" it read, in careful, black ink cursive. Weeks later, thieves broke into the home of a veterans' organizer who worked closely with Luther, taking nothing but the files of the soldiers they were assisting.

The sergeant, characteristically, is undaunted. "This is the right path for me," he says, his voice resolute. "I got to be there for these other soldiers. I'm not the only one who needs help."

Statement of Paul Sullivan
Executive Director
Veterans for Common Sense

Veterans for Common Sense (VCS) thanks Committee Chairman Filner, Ranking Member Buyer, and Members of the Committee for inviting us to testify about the impact of improper Department of Defense (DoD) "personality disorder" discharges on our veterans seeking benefits from the Department of Veterans Affairs (VA).

VCS is here today because we remain alarmed DoD continues improperly discharging our service members who had entered the military in good health and served with honor while deployed to the Iraq and Afghanistan wars, only to be administratively discharged, often without access to medical care or benefits from DoD or VA.

We begin our testimony with an urgent request that Congress put an immediate stop to DoD's improper "personality disorder," "adjustment disorder," and "pattern of misconduct" discharges for service members deployed to war since 2001.

The main underlying cause of the improper discharge remains the enormous pressure from top Pentagon officials, including Secretary Robert Gates himself, to curb military spending. A recent news article by Noel Brinkerhoff at www.AllGov.com is a recent example of significant pressure to reduce military medical spending: "With the Department of Defense staring at enormous cost increases for its health care program, Defense Secretary Robert Gates is proposing raising premiums for the first time ever since the creation of the TRICARE system in 1996."

VCS believes the military's improper discharges will continue so long as there is pressure to reduce medical costs and so long as military recruitment standards remain artificially low due to strong public opposition to the current wars.

Our testimony today focuses on three areas. First, how many of our Iraq and Afghanistan war veterans were improperly released by the military? Second, what are the financial incentives for our military to continue the policy, and what does it cost our veterans in terms of lost benefits? And, third, what are the solutions Congress can implement to repair the damage, and how do we prevent this from happening again?

First, How Many Veterans are Impacted?

According to Army Times and U.S. Senator Christopher "Kit" Bond, discharges for "other designated physical or mental conditions not amounting to disability"—which includes adjustment disorder—have shot from 1,453 in 2006 to 3,844 in 2009 ("Adjustment disorder discharges soar; Military boots PTSD troops with no benefits, vets advocates say," Army Times, Kelly Kennedy, August 16, 2010, is included in testimony).

The increase in personality disorder discharges skyrocketed 165 percent in three years without any plausible explanation from the military. Now, *Army Times* observed, "Over the same time, personality disorder discharges dropped from a peak of 1,072 in 2006 to just 260 last year." In

2007, one estimate of the total number of improper discharges was as high as 20,000 based on an investigation by The Nation magazine.

Congress and advocates need additional accurate and consistent information in order to understand the full scope of this issue. VCS urges Congress to demand the military produce statistics on the number of "personality disorder," "adjustment disorder," and "pattern of misconduct" discharges, every year since 2001, sorted by deployment status and military branch. DoD's refusal to release all of the data to Senators speaks volumes about DoD's intent to conceal this problem from Congress, continue the improper discharges, and otherwise avoid a proper resolution.

Based on the limited statistics available, VCS believes the military switched from "personality disorder" discharges to "adjustment disorder discharges" after this committee exposed "personality disorder" discharges during a July 2007 hearing.

Again, quoting Army Times, "Jason Perry, a former Army judge advocate who helps troops going through medical retirement, said he has seen dozens of such cases. 'It's very common. And it's completely illegal.'" In our view, the military was caught by investigative reporter Joshua Kors at The Nation magazine. In response to his investigation, and subsequent Congressional hearings featuring veterans and advocates, the military did change the rules. Shortly thereafter, the military went back the department's old ways, simply changing a few words on service members' discharge forms and continuing the same shameful, outrageous, and improper practice.

From our 2007 testimony, VCS restates the obvious. Using the "personality disorder," "adjustment disorder," or "pattern of misconduct" discharges to remove service members who served honorably during war is wrong and a violation of military regulations. Our service members need medical exams and medical care, not improper discharges creating a cloud over their military service and access to VA care.

Second, Who Wins and Who Loses?

The answer is obvious. The military wins while our veterans and local governments lose. The military's illegal activity means DoD spends less on healthcare and benefits during a time of tight budgets. Our veterans and families lose because some won't receive urgently needed healthcare, disability payments, and other VA benefits. When VA does not provide care, then state and local governments pick up the tab.

The losses to our veterans are staggering. The average cost for VA care and benefits, over a period of 40 years, is between $500,000 to $1,000,000 per veteran. To date, DoD stands to illegally deny between $5 billion to $20 billion in lifetime healthcare and benefits to the estimated 10,000 to 20,000 veterans improperly kicked out by the military. This estimate is based on the academic research found in the book, The Three Trillion Dollar War, by Linda Bilmes and Joseph Stiglitz, published in 2008. The authors estimate the lifetime medical and benefit costs for our deployed Iraq and Afghanistan war veterans may be $500 billion or higher for nearly one million patients and claims.

Based on our conversations with veterans, those with "personality disorder" discharges frequently believe they are not entitled to full VA benefits. In many cases, that's partly true. VA

is supposed to provide five years of free medical care for veterans who deployed to a war zone after November 11, 1998 (except those with a dishonorable discharge). There are plenty of examples of veterans diagnosed with post traumatic stress disorder (PTSD) and/or traumatic brain injury (TBI) who urgently need VA care and benefits for those conditions. However, they either do not seek VA care, they are unreasonably delayed in obtaining care due to VA paperwork nightmares, or they are denied care by VA.

Some non-medical VA benefits may be lost by veterans with improper "personality disorder" discharges. For example, an early release from active duty may block access to VA's home loan guaranty and education benefits.

PTSD symptoms may mimic "personality disorder" discharges with anger, self-medicating, and minor infractions. A proper diagnosis by a psychologist or psychiatrist is imperative, rather than DoD's current process of rushing veterans through a non-medical administrative discharge. According to DoD and VA policy, if PTSD symptoms last longer than six months, then the veteran's diagnosis should be changed to PTSD. With a PTSD diagnosis, a veteran may be medically retired with an honorable discharge, a disability rating of at least 50 percent, and free medical care.

In the worst case examples of lost benefits among veterans, VA has improperly denied veterans' PTSD disability compensation claim because the veterans' DD-214 listed "personality disorder," even when the veterans had deployed to a war zone, were diagnosed with PTSD, and were clearly given an improper military discharge.

Third, what are the solutions?

VCS urges Congress to take several steps toward resolving the crisis of improper military discharges often preventing access to VA services for our Iraq and Afghanistan war veterans. These steps include modernizing military separation regulations, identifying and righting past inappropriate discharges, and dramatically improving oversight and accountability of military health surveillance. VCS encourages veterans to seek care and benefits at VA, without fear of discrimination or stigma. An improper discharge by the military may unfairly stigmatize a veteran and impede access to healthcare, benefits, and employment that are often vital for a smooth transition from combat to community.

Improve VA Training. VCS recommends that VA train staff to identify potential veterans at risk of falling in the cracks. While some veterans may have a properly issued "personality disorder," "adjustment disorder," or "pattern of misconduct" discharge, VA needs to look beyond that frequently incorrect DoD label. VA medical staff should be sure to welcome home deployed veterans with five years of free medical care. Similarly, VA claims adjudication staff should look beyond DoD's discharge documents and carefully review each veteran's mental health symptoms and diagnoses, especially those cases where the veteran deployed to a war zone.

Update DoD's Discharge Regulations. VCS recommends DoD modernize military separation regulations to provide protection against abuse of mental health related administrative discharges. Although the governing Department of Defense Instruction, DoDI 1332.14, was updated, the language fails to guarantee protection from abuses and retains loopholes which continue to contribute to this problem. Specifically, Enclosure 3, paragraph 3(8)(a) still permits

the individual services to authorize administrative separation for "other designated physical or mental conditions, not amounting to disability, that interfere with assignment to or performance of duty," without providing any new protections against abuse of this authority, *except* for the recent protections for "personality disorder."

Joshua Kors' article on this subject in The Nation contributed greatly to the political pressure that led the Senate to submit amendments to the 2008 National Defense Authorization Act preventing DoD from discharging returning veterans with a "personality disorder." While these strong protections against abuse were appropriate and beneficial, they have been effectively sidestepped merely by characterizing the early manifestations of mental health problems, such as PTSD, as "other...mental conditions, not amounting to disability." DoD has simply shifted from "personality disorder" discharges to "adjustment disorder" and "pattern of misconduct" discharges.

All mental health-related administrative separations under this section should be subject to the same rigid review and validation process as those for "personality disorder" discharges under subparagraphs (8)(a) through (d). VCS recommends that no service member previously deemed fit to deploy be processed for administrative separation for a mental condition unless such condition has been centrally reviewed and validated by the principal advisor for mental health issues of the component service.

Review All Administrative Discharges Since 2001. To ensure no veteran is left behind, VCS recommends Congress legislate a mandatory review of all administrative separations for mental health conditions made since the start of combat operations in 2001. DoD was supposed to contact the 22,000 personality disorder discharges to determine if the discharges were correct. Congress should mandate that DoD retroactively correct and properly characterize all such discharges in accordance with these new recommended revised guidelines. In cases where the DoD made an error, DoD would upgrade the veteran's discharge. Unfortunately, in the three years since the hearing, the military did not contact the veterans or conduct a review.

Enforce Stronger Oversight. VCS emphasizes how these episodes underscore the critical need to dramatically improve oversight and accountability for military health surveillance. Time and time again, DoD has proven itself a poor steward of military health information, failing to proactively identify disturbing and incriminating trends in patterns of administrative discharges, failing to release important information to Congress and the public, and as at least one recent episode suggests, engaging in outright lies in defense of its actions. For example, when the issue of improper discharges was first raised by Senator Kit Bond and then-Senator Barack Obama in 2007, DoD investigated itself. DoD fabricated a ghost written review and claimed the Department had done nothing wrong. After Acting Surgeon General Gale Pollack released the report to Congress, advocates Steve Robinson and Andrew Pogany revealed the Pentagon report was falsified. To the best of our knowledge, no military officials were held accountable.

Independent Review. Congress needs to create a method for an independent review of the overall health of our service members. As VCS has argued on numerous occasions, the lack of timely and accurate health data has a chilling effect on the ability of Congress to perform effective oversight in the best interests of our service members. On numerous occasions DoD has deeply troubling patterns of misconduct in relation to its sole ownership of this information: delaying the release of information; feigning confusion as to the meaning or accuracy of

information; and claiming requested analyses are not possible. Most often this happens with toxic exposures. This also happens with PTSD, TBI, and the improper discharges discussed at this hearing. DoD's actions serve to protect DoD's interests at the expense of service members, and are conducted in many instances with the purpose of stalling Congressional investigations and reform.

Conduct Universal, Mandatory Medical Exams. VCS urges Congress to order the military to implement mandatory, universal pre-deployment and post-deployment medical exams as required by the 1997 Force Health Protection Act. This means every soldier sits down, face-to-face, with a medical care provider before and after going to a war zone to identify—and then treat—identified medical conditions when care is more effective and less expensive. We support DoD's continued use of medical assessments six months after veterans return. This upholds our military's need to field a fit fighting force while protecting the health of our individual service members.

Fill Mental Health Professional Vacancies. VCS urges Congress to order the military to hire more medical professionals so our soldiers receive mandatory, universal exams. The creation of lifetime electronic records remains a superb and urgently needed reform for our service members and veterans. However, the new electronic records will be rendered useless if the military fails to include examination, exposure, and other salient medical information in the new records. Secretary Shinseki must make it very clear to Defense Secretary Gates that VA expects DoD to perform pre-deployment and post deployment medical exams as well as record toxic exposures. This military medical history, currently missing for many veterans, remains absolutely essential so VA may provide veterans with accurate claims decisions and healthcare.

Honor Medical Opinions. VCS urges Congress to eliminate the ability of line commanders to overrule the decisions made by medical professionals regarding the ability of a service member to deploy to a war zone or to remain in the military. In too many cases commanders override medical opinions and send unfit soldiers back into combat, recklessly endangering the service member, the unit, and the mission.

Expand Training and Anti-Stigma Education. VCS urges DoD and VA to expand the agencies' anti-stigma education program encouraging our service members with PTSD and/or TBI to seek care, beyond what has already been established. VCS also supports mandatory reintegration training for every service member, regardless of discharge, except for dishonorable discharges.

In conclusion, the problem of improper discharges is caused the military, yet the solution requires cooperation between Congress, the military, and VA.

News Articles Cited:

1. **Defense Secretary Gates Suggests Raising Health Care Premiums for Employed Veterans** by Noel Brinkerhoff, www.AllGov.com

September 08, 2010—With the Department of Defense staring at enormous cost increases for its health care program, Defense Secretary Robert Gates is proposing raising premiums for the first time ever since the creation of the TRICARE system in 1996.

Health care costs for the Pentagon have ballooned from $19 billion in 2000 to an estimated $50 billion for next year, and $65 billion by 2015. Gates wants to avoid increasing premiums for active-duty personnel and their families. Instead, he's suggesting charging higher premiums and co-pay fees for retired veterans using TRICARE who have access to private health care plans through their current employers.

Gates' idea is likely to have a tough time gaining approval in Congress, where both Democrats and Republicans have been reluctant to lift TRICARE premiums for any military personnel.

2. **'Adjustment disorder' discharges soar; Military boots PTSD troops with no benefits, vets advocates say** By Kelly Kennedy, *Army Times*

August 16, 2010—Two years ago, Congress enacted rules to curb the military's practice of separating troops with combat stress for pre-existing personality disorders—an administrative discharge that left those veterans without medical care or other benefits. Now, veterans' advocates say, the military is using a new means to the same end: giving stressed troops administrative discharges for "adjustment disorders," which also carry no benefits. And just as before, Congress appears poised to wade in. Senator Christopher "Kit" Bond, R-Mo., plans to ask President Obama to have the Pentagon provide details on discharges for adjustment disorder in recent years. In the meantime, Bond's office has been gathering more general data that show discharges for "other designated physical or mental conditions not amounting to disability"—which includes adjustment disorder—have shot from 1,453 in 2006 to 3,844 in 2009.Over the same time, personality disorder discharges dropped from a peak of 1,072 in 2006 to just 260 last year. Shana Marchio, an aide to Bond, said the issue was brought to the senator's attention by Steve Robinson, a former Army Ranger who is now a veterans' advocate.

"The good news is that the Pentagon has moved away from personality disorders, but we feel [adjustment disorder] could be another piece of the same problem," Marchio said. At press time, Pentagon officials had not responded to a request for comment about the recent rise in administrative discharges. According to the DSM-IV, the psychiatric manual for mental health issues, adjustment disorder may occur when someone has difficulty dealing with a life event, such as a new job or a divorce—or basic training. It also may occur after exposure to a traumatic event. The symptoms can be the same as for post-traumatic stress disorder: flashbacks, nightmares, anger, sleeplessness, irritability and avoidance. According to military and Veterans Affairs Department rules, if symptoms last longer than six months, the diagnosis should change to PTSD. Under the law enacted in 2008, that means medical retirement, an honorable discharge, a 50 percent disability rating and medical care. That is not always happening, Robinson said. "This is a case of inappropriate discharges. There are hundreds of cases."

'I could barely function' During a deployment to Iraq with the 4th Infantry Division in 2008, former Army Pfc. Michael Nahas, 22, said he survived two roadside bomb explosions and one rocket-propelled grenade attack, and watched people die in another explosion in Mosul. Two months after returning to Fort Carson, Colo., he began feeling anxious and guilty about people he believed had died needlessly. He went to the post mental health clinic. Over three weeks, he said he had three appointments—and a lot of medication, including 14 milligrams of Xanax a day. "I was drooling on myself," he said. "I could barely function." His mother and veterans advocates verified his doses. As enlisted supervisors in his unit chain found out he was going to behavioral health, Nahas said some made fun of him, calling him "crazy" and telling him to kill himself so

he would not be a problem. Veterans' advocates who worked on Nahas' case verified his information, citing police and medical records as well as conversations with commanders. Army Lt. Col. Steve Wollman, spokesman for the 4th Infantry Division, declined to comment on Nahas' specific charges. "The allegations … were thoroughly investigated," he said. "Some … were unsubstantiated and some of them were substantiated. Appropriate corrective actions were made, and the investigation is closed." In February, Nahas said he had a reaction to his medication that, coupled with the stress he was under, led him to try to commit suicide by sticking IV needles in his arms to bleed out. In a photo of the aftermath provided by Nahas' family, blood fills the bathtub and a red smiley face gazes from the tiles above. His wife found him and called for help, and Nahas survived. After his suicide attempt, he said he spent time in an inpatient clinic where he was diagnosed with PTSD, then went back to his unit. But rather than beginning the medical retirement process for PTSD, in late April his unit gave him an administrative discharge for adjustment disorder and sent him back to civilian life. "I was told I had PTSD, and then I was told I didn't," he said. His situation is not unique, according to people familiar with the military disability system. Jason Perry, a former Army judge advocate who helps troops going through medical retirement, said he has seen dozens of such cases. "It's very common," Perry said. "And it's completely illegal."

Statement of Thomas J. Berger, Ph.D.
Executive Director, Veterans Health Council
Vietnam Veterans of America

Chairman Filner, Ranking Member Buyer, and distinguished Members of the House Veterans' Affairs Committee, on behalf of President John Rowan, our Board of Directors, and our membership, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on discharges for personality disorders and their impact on veterans' benefits.

Some in this room may well remember that the issue of personality order discharges first surfaced publicly back in the spring of 2007 because of an article in "*The Nation*" by Joshua Kors and a subsequent *CBS Evening News* special. They reported that since the attacks of 9/11, more than 22,600 service members had been discharged for a "personality disorder". Nearly 3,400 of them, or 15 percent, had served in combat or imminent danger zones. Those numbers include personnel who had served multiple tours.

Now, please remember that a personality disorder is a severe mental illness that emerges during childhood and is listed in military regulations as a pre-existing condition, not a result of combat. Personality disorder contains symptoms that are enduring and play a major role in most, if not all, aspects of the person's life. While many disorders vacillate in terms of symptom presence and intensity, personality disorders typically remain relatively constant. In other words, according to the DSM-IV, to be diagnosed with a disorder in this category, the symptoms have been present for an extended period of time, are inflexible and pervasive, and are not a result of alcohol or drugs or another psychiatric disorder, and the history of symptoms can be traced back to childhood or adolescence. Thus, those who are discharged with a personality disorder are denied a lifetime of disability benefits. Soldiers discharged with a personality disorder are also denied long-term medical care, and they may have to give back a portion of their re-enlistment bonus.

At the time, VVA and other veterans' advocates contended that many of these service members were suffering from Post-traumatic Stress Disorder (PTSD) or traumatic brain injury (TBI), but that it was easier and less costly for the military to separate them under the rubric of "personality disorder", leading some to believe that such a large number of personality disorder discharges were in fact fabricated to save on the cost of other, more appropriate mental health treatments and disability benefits.

Then, after several Congressional hearings—including one before this committee—and criticism from VVA and other veterans' advocates on the overuse of personality disorder separation, a revised Department of Defense (DoD) instruction (No. 1332.14) took effect without public announcement on August 28, 2008. This revision only allows separation for personality disorder for members currently or formerly deployed to imminent danger areas if: (1) the diagnosis by a psychiatrist or a Ph.D.-level psychologist is corroborated by a peer or higher-level mental health professional; (2) if the diagnosis is endorsed by the surgeon general of the service; and (3) if the diagnosis took into account a possible tie or "co-morbidity" with symptoms of PTSD or war-related mental injury or illness. The DoD director of officer and enlisted personnel management

noted that "rigor and discipline" is "very important" when separating deployed members for personality, considering what is at stake for the service member.

In addition, the Senate also adopted an amendment to the fiscal 2008 defense authorization bill introduced by then-Senator Obama (D-Ill.), Senator Kit Bond (R-Mo.), and Senator Joseph Lieberman (ID-Ct.) that directed DoD officials to report on service use of personality disorder separations, and the Government Accountability Office (GAO) to study how well the services follow DoD's own rules for processing such separations.

The Army, meanwhile, reviewed its own use of personality disorder separations for more than 800 soldiers who had wartime deployments. That review quickly found some "appalling" lapses, said an official, including incomplete files and missing counseling statements. In the following months, the Army claimed to have tightened its own rules for using personality disorder separations.

DoD then reported to Congress that it would add "rigor" to its personality disorder separation policy, previewing the changes implemented in late August. The Navy had strongly opposed the changes because it frequently uses personality disorder separations to remove sailors found too immature or undisciplined to cope with life at sea. Requiring their surgeon general to review every personality disorder separation from ships deployed in combat theaters would be too burdensome, the Navy argued. But DoD officials insisted on the changes.

DoD's report showed the Navy led all services in personality disorder separations. For fiscal years 2002 through 2007, the Navy total was 7,554 versus 5,923 for the Air Force, 5,652 for the Army, and 3,527 for the Marine Corps. The Army led in personality disorder separations of members who had wartime deployments, with a total of 1,480 over six years. The Navy total was 1,155, the Marine Corps 455 and the Air Force 282. But DoD said it found "no indication" that personality disorder diagnoses of deployed members "were prone to systematic or widespread error." Nor did internal studies show "a strong correlation" between personality disorder separations and PTSD, brain injury or other mental disorders. "Still, the Department shares Congress' concern regarding the possible use of personality disorder as the basis for administratively separating this class of service member," the report said.

In late October 2008, the GAO released its findings based on a review of service jackets for 312 members separated for personality disorder from four military installations. It concluded that the services were not reliably compliant even with the pre-August regulation governing separations. For example, only 40-78 percent of enlisted member separated for personality disorder had documents in their files showing that a psychiatrist or qualified psychologist determined that their disorder affected their ability to function in service.

After all that, the annual number of personality disorder cases dropped by 75 percent. Only 260 soldiers were discharged on those grounds in 2009. At the same time, the number of PTSD cases has soared. By 2008, more than 14,000 soldiers had been diagnosed with PTSD—twice as many as two years before.

Fast-forward to August 2010: the Army denies that any soldier was misdiagnosed before 2008, when it drastically cut the number of discharges due to personality disorders and diagnoses of PTSD skyrocketed. The Army attributes the sudden and sharp reduction in personality disorders to its policy change. Yet Army officials deny that soldiers was discharged unfairly, saying they reviewed the paperwork of all deployed soldiers dismissed with a personality disorder between 2001 and 2006. According to an AP report, "We did not find evidence that soldiers with PTSD had been inappropriately discharged with personality disorder," said Maria Tolleson, a spokeswoman at the U.S. Army Medical Command.

But with the problem apparently solved, the Army is still refusing to treat those discharged before 2008, insisting that their diagnoses of these personnel were correct. Army officials "reviewed the paperwork of all deployed soldiers dismissed with a personality disorder between 2001 and 2006″ and said they "did not find evidence that soldiers with PTSD had been inappropriately discharged with personality disorder." What does this mean? It means that thousands of soldiers, misdiagnosed as having a personality disorder, are still suffering without treatment in the wake of the U.S. military's mental health reform in 2008.

We at VVA are skeptical of the Army's claim that it didn't make any mistakes because symptoms of PTSD—anger, irritability, anxiety and depression—can easily be confused for the Army's description of a personality disorder. There is no reason to believe the number of personality discharges would decrease so quickly unless the Army had misdiagnosed hundreds of soldiers each year in the first place. That leaves us to ask this Committee to ascertain the following:

- During its review of previous cases, did the Army interview soldiers' families, who can often provide evidence of a shift in behavior that occurred after the soldier was sent into a war zone?

- Can the Army explain why the number of the personality disorder discharges doubled between 2006 and 2009 and how many of those qualified to retain their benefits?

- Is the Army now relying on a different designation—referred to as "adjustment disorder"—to dismiss soldiers?

It is absolutely clear, either through Congressional action or a Presidential directive, that the Army needs to conduct a thorough review of its personality disorder diagnoses prior to 2008, treat those who need help, and restore disability benefits where appropriate.

VVA thanks you, Mr. Chairman, for holding this hearing. And we thank you and the members of this committee for the opportunity to present our views on this very troubling mental health care issue. I shall be glad to answer any questions you might have.

Statement of Debra A. Draper, Ph.D., M.S.H.A.
Director, Health Care
U.S. Government Accountability Office

Defense Health Care: Status of Efforts to Address Lack of Compliance with Personality Disorder Separation Requirements

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the Department of Defense's (DoD) separation requirements for enlisted service members diagnosed with personality disorders and the military services' compliance with these requirements. DoD requires that all enlisted service members, including those serving in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), be physically and psychologically suitable for military service.[1] Enlisted service members who fail to meet this standard may be involuntarily separated from the military.[2] One psychological condition that can render an enlisted service member unsuitable for military service is a personality disorder, which is defined as a long-standing, inflexible pattern of behavior that deviates markedly from expected behavior, has an onset in adolescence or early adulthood, and leads to distress or impairment.[3] Although a personality disorder by itself does not make enlisted service members unsuitable for military service, DoD policy allows for involuntary separation from the military if a service member's disorder is severe enough that it interferes with his or her ability to function in the military.[4] DoD data show that from November 1, 2001, through June 30, 2007, about 26,000 enlisted service members were separated from the military because of a personality disorder. Of these 26,000 service members, about 2,800 had deployed at least once in support of OEF/OIF.

In 2007, your Committee held a hearing on how a personality disorder separation may affect a veteran's ability to receive support from the Department of Veterans Affairs (VA). Specifically, enlisted service members who receive only a diagnosis of personality disorder are ineligible to receive disability compensation benefits from VA after their military service because a personality disorder is not considered a service-connected mental health condition.[5] At the hearing, a representative from Veterans for America, a veterans' advocacy group, expressed concern that some enlisted service members may have been incorrectly diagnosed with a personality disorder, resulting in unfair denial of disability compensation.

Accurately diagnosing enlisted service members who have served in combat with a personality disorder can be challenging. Specifically, some personality disorder symptoms—irritability, feelings of detachment or estrangement from others, and aggressiveness—are similar to the symptoms of post-traumatic stress disorder (PTSD), a condition for which OEF/OIF enlisted service members may also be at risk. According to mental health experts and military mental health providers, one important difference between a personality disorder and PTSD is that a personality disorder is a long-standing condition, whereas PTSD is a condition that follows exposure to a traumatic event. According to the American Psychiatric Association and the American Psychological Association, the only way to distinguish a personality disorder from a combat-related mental health condition, such as PTSD, is by obtaining an in-depth medical and personal history from the enlisted service member that is corroborated, if possible, by others such as family members and friends.

DoD has three key requirements that the military services—Army, Air Force, Marine Corps, and Navy—must follow when separating enlisted service members because of a personality disorder. Specifically, before they are separated because of a personality disorder, enlisted service members

1. must receive notification of their impending separation because of a personality disorder;
2. must receive, prior to the notification, a diagnosis of personality disorder by a psychiatrist or psychologist[6] who determines that the personality disorder interferes with the enlisted service member's ability to function in the military; and
3. must receive formal counseling about their problem with functioning in the military.[7]

The separation process is typically initiated by an enlisted service member's commander, who must then follow the requirements established by DoD when separating an enlisted service member because of a personality disorder. Once an enlisted service member has been separated from military service, he or she receives a certificate of release from the military, which includes information on the reason for separation and an official characterization of his or her time in the service.[8]

In my statement today, I will provide information from a report we issued in 2008 on our review of personality disorder separations in the military services.[9] I will also update you on the actions DoD has taken since August 2008 related to the recommendations we made in that report.

To do the work for our 2008 report, we analyzed DoD data and identified installations that had the highest or second highest incidence of enlisted OEF/OIF service members separated because of a personality disorder from November 1, 2007, through June 30, 2007. We then selected four of these installations to visit—Fort Carson (Army), Fort Hood (Army), Davis-Monthan Air Force Base (Air Force), and Camp Pendleton (Marine Corps). We also reviewed the personnel records, which contain the separation packet—the documents necessary to separate a service member—for selected service members from the four installations we visited. In our review, we determined whether the packets contained documentation demonstrating that DoD's personality disorder separation requirements had been met. Our findings from the four installations that we visited can be generalized to each of these installations, but not to the military services. In addition to the four military installations from the Army, Air Force, and Marine Corps, we also visited Naval Base San Diego and reviewed the personnel records from service members who were identified to have been separated because of a personality disorder from this installation. Due to the structure of the Navy, we cannot attribute our findings to the particular installation we visited, and so we reported these results separately from the findings of the other four military installations.[10] In total, we examined 371 enlisted service members' personnel records for compliance with personality disorder requirements—312 for service members from the Army, Air Force, and Marine Corps installations we visited and 59 records for enlisted service members from the Navy. We also reviewed DoD and the military services' separation regulations and instructions and interviewed relevant officials to determine how DoD ensures the military services' compliance with its personality disorder separation requirements.

To obtain updated information on the actions DoD has taken related to the recommendations in our 2008 report, we reviewed documentation provided by DoD's Office of Inspector General

(OIG)—the DoD office responsible for following up and tracking the status of GAO recommendations. We also contacted DoD officials to clarify information in the documentation we reviewed. We conducted this performance audit from July 2010 through September 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, our 2008 review found that the documented compliance with DoD's requirements for personality disorder separations varied by requirement and by military installation. Additionally, we found that DoD did not have reasonable assurance that its key personality disorder separation requirements had been followed by the military services. Since our 2008 review, DoD has taken some action to implement our recommendations. However, we have not verified whether the actions the services planned or reported to DoD to increase compliance were actually realized. Because the military services have not demonstrated full compliance with DoD's personality disorder separation requirements, we reiterate the importance of DoD implementing our 2008 recommendations.

In 2008, we found that, while compliance with DoD's requirement that service members be notified of an impending personality disorder separation was high among the four installations, it varied considerably for the other two requirements. (See table 1.) Specifically, at the four installations, we found that

- compliance with the notification requirement was at or above 98 percent,
- compliance with the requirement related to the personality disorder diagnosis by a psychiatrist or psychologist ranged from 40 to 78 percent, and
- compliance with the requirement for formal counseling ranged from 40 to 99 percent.

Table 1: Rate of Documented Compliance at Selected Military Installations with Three Key Personality Disorder Separation Requirements, for Separations Completed from November 1, 2001, through June 30, 2007

Installation	Notification requirement[a]	Diagnosis-related requirement[b]	Formal counseling requirement[c]
Fort Carson (Army)	99%	73%	92%
Fort Hood (Army)	98%	57%	76%
Davis-Monthan Air Force Base (Air Force)	100%	40%d	40%
Camp Pendleton (Marine Corps)	99%	78%	99%

Source: GAO analysis of enlisted service members' personnel records obtained from the military services.

Note: We determined whether service members' records demonstrated compliance with the requirements that service members be diagnosed with a personality disorder by a psychiatrist or psychologist who determines that the personality disorder interferes with the service member's ability to function in the military and that the service members receive formal counseling only if the service members' records had documentation that the service members were notified of their impending separation because of a personality disorder. In total, four records did not indicate that the service members were notified of their separation as required.

[a] The Department of Defense (DoD) requires that before enlisted service members are separated because of a personality disorder they must receive notification of their impending separation because of a personality disorder.

[b] DoD requires that before enlisted service members are separated because of a personality disorder they must receive, prior to the notification, a diagnosis of personality disorder by a psychiatrist or psychologist who determines that the personality disorder interferes with the enlisted service member's ability to function in the military.

[c] DoD requires that before enlisted service members are separated because of a personality disorder they must receive formal counseling about their problem with functioning in the military.

[d] Air Force officials acknowledged that prior to October 2006 some enlisted service members with a mental health diagnosis other than a personality disorder, such as an adjustment disorder, were erroneously separated under the reason of a personality disorder. However in October 2006, Air Force officials stated that they took steps to correct this error. Some of the service members separated from the Air Force installation we visited may have been affected by this error.

We also found variation in the enlisted Navy service members' personnel records we reviewed. Ninety-five percent of these records demonstrated compliance with the notification requirement, 82 percent demonstrated compliance with the requirement related to the personality disorder diagnosis, and 77 percent demonstrated compliance with the requirement for formal counseling.[11]

Moreover, we found in our prior work that DoD did not have reasonable assurance that its key personality disorder separation requirements had been followed by the military services. To address this issue, we recommended that DoD (1) direct the military services to develop a system to ensure that personality disorder separations are conducted in accordance with DoD's requirements, and (2) monitor the military services' compliance with DoD's personality disorder separation requirements.

In August 2008, after our review was completed, DoD updated its requirements for personality disorder separations to clarify its three key requirements and include additional requirements to help ensure that service members are not incorrectly separated because of a personality disorder. DoD's revised requirements for personality disorder separations required that enlisted service members be advised that the diagnosis of a personality disorder does not qualify as a disability. Additionally, the revised policy specified additional requirements for enlisted service members who have or are currently serving in imminent danger pay areas.[12]
Specifically, for service members serving in these pay areas, their diagnosis of personality disorder must be corroborated by a psychiatrist or PhD-level psychologist, or a higher level mental health professional,[13] and the diagnosis must be endorsed by the Surgeon General of the respective military service prior to the separation. In addition, for these enlisted service members, the diagnosis of personality disorder must also discuss whether or not PTSD or other mental health conditions are present.

DoD has taken two actions in response to our 2008 recommendations. First, in a January 2009 memo, the Under Secretary of Defense directed each of the military services to provide reports on their compliance with DoD's personality disorder separation requirements for fiscal years 2008 and 2009. Regarding these reports, the memo specified the following.

- The first report, for fiscal year 2008, was due on June 30, 2009. The second report, for fiscal year 2009, was due on March 31, 2010.
- Both compliance reports were to include a random sample of at least 10 percent of all personality disorder separations in the fiscal year and were to document compliance with the three key requirements listed in our 2008 report as well as the requirements DoD added in August 2008.
- The military services were to report the total number of personality disorder separations for that fiscal year, as well as the total number of these separations that were for enlisted service members who had served in imminent danger pay areas at any time since September 11, 2001.

The DoD OIG has collected the services' fiscal year 2008 compliance reports, which were due June 30, 2009. Overall, these reports showed that in fiscal year 2008, three out of the four services were not in compliance with any of the personality disorder separation requirements. (See table 2.) Each military service reported their findings of compliance based on their review of a sample of personality disorder separations; the sample size for each service ranged from 10 to 35 percent of the respective service's total personality disorder separations for fiscal year 2008. In addition, in a summary of the services' compliance reports, the Office of the Under Secretary of Defense stated that the military services' compliance with the additional personality disorder separation requirements that DoD added in 2008 was generally well below 90 percent. The Office of the Under Secretary attributed this level of compliance to the services not revising their own requirements to reflect DoD's changes until after fiscal year 2008 was complete.[14]

Table 2: Number of Separations Because of a Personality Disorder and Compliance with Key Personality Disorder Separation Requirements, by Military Service, for Fiscal Year 2008

	Army	Air Force	Marine Corps	Navy
Total number of enlisted service members separated because of a personality disorder	567	86	409	946
Number of enlisted service members separated because of a personality disorder who served in imminent danger pay areas[a]	Not reported[b]	15	60	Not reported[c]
Compliance with requirement that enlisted service members receive notification of impending separation	✗	✓	✗	✗
Compliance with requirement that enlisted service members receive a diagnosis by an appropriate professional[d]	✗	✓	✗	✗
Compliance with requirement that enlisted service	✗	✗	✗	✗[e]

	Army	Air Force	Marine Corps	Navy
members receive formal counseling				

Source: GAO analysis of Department of Defense documents.

[a] An imminent danger pay area is defined by the Department of Defense (DoD) as an area in which enlisted service members were in imminent danger of being exposed to hostile fire or explosion of hostile mines and in which, during the period they were on duty in that area, other members of the uniformed services were subject to hostile fire or explosion of hostile mines. A foreign area in which enlisted service members were subject to the threat of physical harm or imminent danger on the basis of civil insurrection, civil war, terrorism, or wartime conditions is also considered an imminent danger pay area.

[b] The Army's report did not include the total number of service members separated for a personality disorder during fiscal year 2008 who had served in imminent danger pay areas. The report did note that of the 60 records reviewed for the compliance report, 21 service members (35 percent) had served in imminent danger pay areas.

[c] According to the Navy's report, the office performing the compliance analysis did not have the capability to screen records to see which individuals separated for a personality disorder served in an imminent danger pay area.

[d] According to DoD policy, an appropriate professional to diagnose a personality disorder is a psychiatrist or PhD-level psychologist. This professional must determine that the personality disorder interferes with the enlisted service member's ability to function in the military.

[e] The Navy attributes its noncompliance with this requirement to an error in its personality disorder separation regulations. The Navy regulation allowed for an exemption to the counseling requirement if service members were deemed a danger to themselves or others.

Key:
✓ = Military service met DoD's 90 percent compliance threshold for the personnel records reviewed of enlisted service members who were separated because of a personality disorder. The services' compliance rates were based on their review of a sample of personality disorder separations. The sample size for each service ranged from 10 to 35 percent of the respective service's total personality disorder separations for fiscal year 2008.

✗ = Military service did not meet DoD's 90 percent compliance threshold for the personnel records reviewed of enlisted service members who were separated because of a personality disorder. The services' compliance rates were based on their review of a sample of personality disorder separations. The sample size for each service ranged from 10 to 35 percent of the respective service's total personality disorder separations for fiscal year 2008.

According to DoD OIG officials with whom we spoke, as of August 31, 2010, the DoD OIG had not received copies of the military services' fiscal year 2009 compliance reports, which were due March 31, 2010. It is unclear if DoD will require the military services to report compliance beyond fiscal years 2008 and 2009.

Regarding DoD's second action to address our recommendations, in the January 2009 memo, DoD also required the military services to provide a plan for correcting compliance deficiencies if the services found that their compliance with any DoD personality disorder separation requirement was less than 90 percent. According to their fiscal year 2008 reports, each service has planned or taken corrective actions to improve compliance. For example, the Army's report stated that as of March 13, 2009, the Army's Office of the Surgeon General will review all personality disorder separation cases to ensure that each contains the required documentation.

Similarly, the Marine Corps will require the General Court Martial Convening Authority[15] to certify that the requirements have been met. The military services also reported actions they will

take to implement DoD's revised personality disorder separation requirements. For example, the Marine Corps will incorporate a checklist of the new requirements to be used with all personality disorder separations. We did not verify whether the actions the services planned or reported as of March 2009 were actually realized.

Since the military services have not demonstrated full compliance with DoD's personality disorder separation requirements, we reiterate the importance of DoD implementing our 2008 recommendations.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to respond to any questions you or other members of the committee may have.

Contacts and Acknowledgments

For further information about this testimony, please contact Debra Draper at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. GAO staff who made key contributions to this testimony include Randall B. Williamson, Director, Health Care; Mary Ann Curran, Assistant Director; Susannah Bloch; Rebecca Hendrickson; Lisa Motley; and Rebecca Rust.

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[1] Operation Enduring Freedom, which began in October 2001, supports combat operations in Afghanistan and other locations, and Operation Iraqi Freedom, which began in March 2003, supports combat operations in Iraq and other locations. In September 2010, Operation Iraqi Freedom became known as Operation New Dawn.

[2] We discuss only enlisted service members in this testimony because officers are generally able to resign at any time rather than be involuntarily separated.

[3] Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revision (Washington, D.C.: American Psychiatric Association, 2000).

[4] Department of Defense Instruction 1332.14, Enlisted Administrative Separations (Mar. 29, 2010).

[5] Enlisted service members who are separated because of a personality disorder may receive other support, such as medical services, from VA if they have other illnesses or injuries possibly related to their service.

[6] According to a DoD official, DoD does not hire psychologists who are not doctoral-level psychologists.

[7] Although DoD separation policy does not specify who needs to conduct the formal counseling session, according to a DoD separation policy official, the counseling should be conducted by the enlisted service member's supervisor. The counseling can occur at any time up until the enlisted service member is notified of the separation.

[8] Enlisted service members who are separated because of a personality disorder receive either an "honorable" or "general under honorable" characterization, or description, of service that is given at the time of separation.

[9] GAO, Defense Heath Care: Additional Efforts Needed to Ensure Compliance with Personality Disorder Separation Requirements, GAO-09-31 (Washington, D.C.: Oct. 31, 2008).

[10] We were told that the separation process for enlisted Navy service members may occur at various locations, such as on a ship or in a transition center at a naval base. Because of this, we could not attribute our findings to the particular installation we visited. Additionally, we could not generalize these findings to the Navy.

[11] If the psychiatrist or psychologist determines that service members are a threat to themselves or others, the Navy waives the requirement that service members must receive formal counseling. We considered enlisted service members' separation packets that included documentation of this waiver to indicate compliance with DoD's counseling requirement.

[12] An imminent danger pay area is defined by DoD as an area in which enlisted service members were in imminent danger of being exposed to hostile fire or explosion of hostile mines and in which, during the period they were on duty in that area, other members of the uniformed services were subject to hostile fire or explosion of hostile mines. A foreign area in which enlisted service members were subject to the threat of physical harm or imminent danger on the basis of civil insurrection, civil war, terrorism, or wartime conditions is also considered an imminent danger pay area.

[13] A higher level mental health professional generally refers to a mental health professional who is of higher rank than the diagnosing official.

[14] DoD's revisions to its personality disorder separation requirements became effective August 28, 2008.

[15] In the Marine Corps, the General Court Martial Convening Authority, typically a high ranking commanding officer, is designated as the official who approves personality disorder separations.

Statement of Lernes J. Hebert
Acting Director, Officer and Enlisted Personnel Management
Office of the Deputy Under Secretary of Defense (Military Personnel Policy)
U.S. Department of Defense

Mr. Chairman, Mr. Ranking Member, and Members of the Committee, thank you for the opportunity to testify on Personality Disorder discharges and the Department's progress in implementing recommendations made by the Government Accountability Office (GAO) to improve oversight of the Personality Disorder discharge process. In response to the October 2008, GAO audit, the Department implemented policy changes and established a reporting process to maintain oversight of the Military Departments' progress in carrying out these requirements. Today, I will report on those policy changes and how the Military Departments' compliance with those policy changes has progressed.

Separation Policy

Through the Department's separation policies, individuals are provided an orderly transition after service to the Nation and the Department can properly husband the forces under arms to meet national security needs. As the requirements for service are often physically demanding, fitness for duty is a key element of these policies.

Medical fitness determination is an area where great care must be taken to ensure accuracy and fairness. In that regard, the nature of the signature injuries sustained in Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) of Traumatic Brain Injuries (TBI) and Post Traumatic Stress Disorder (PTSD) has challenged the Department's understanding and treatment of those injuries. As the body of knowledge of PTSD and TBI has matured, personnel policies have also evolved to provide Service members a thorough evaluation prior to consideration of a discharge from military service. The Department's separation and transition policies offer multiple levels of oversight to tender the appropriate characterization of each service member's separation. This critical review by medical professionals is especially important in ensuring the proper diagnosis and treatment of wounded warriors with PTSD, TBI, or other physical and psychological conditions and initiate an appropriate, compensable, physical disability discharge when warranted.

Leadership awareness and understanding of PTSD and TBI, and accurate diagnosis of mental health conditions, as they relate to Personality Disorder separations, are Department priorities. On August 28, 2008, the Department issued new policy on personality disorders separations, which added greater rigor and oversight. The revised policy only permits a personality disorder separation if diagnosed by a psychiatrist or PhD-level psychologist. Implementation of this change has increased the Department's confidence in our ability to accurately diagnose personality disorders, which by themselves are not compensable. This change serves to help ensure accurate diagnoses of mental health conditions and improve the identification of any co-morbidity of PTSD or TBI, which are compensable disabilities.

In addition, members who have served in an imminent danger pay area must have their diagnosis corroborated by a peer psychiatrist, PhD-level psychologist, or higher level mental health professional and endorsed by The Surgeon General of the Military Service concerned. This change specifically addresses concerns early in the War that members suffering PTSD or TBI might be separated without proper treatment under the non-compensable, exclusive diagnosis of a personality disorder. To ensure continued monitoring of this critical process, the Department implemented oversight mechanisms to include an annual personality disorder report and periodic reviews of personality disorder separation data by the Department's Medical and Personnel (MedPers) Council.

By adding new requirements for personality disorder separations to the requirements that were already contained in Department of Defense Instruction 1332.14, *Enlisted Administrative Separations*, there are now eight requirements that must be met prior to separating a Service member for personality disorder.

Personality Disorder Separations Oversight and Compliance

On January 14, 2009, the Under Secretary of Defense for Personnel and Readiness directed the Secretaries of the Military Departments to report their compliance with the personality disorder separation requirements in DoDI 1332.14, for two fiscal years beginning with fiscal year 2008. The Services were directed to review, at a minimum, a random sampling of at least ten percent of all personality disorder separations for compliance with the eight DoD personality disorder separation requirements and report the total number of personality disorder separations for Service members who had served in an imminent danger pay area since September 11, 2001.

Of note is that fact that the early reports were impacted by the delay between when the Department issued new personality disorder separation policy and the incorporation of that new guidance into Military Service regulations. The Military Departments made considerable progress between FY2008 and FY2009 to fully comply with the personality disorder separation requirements in DoDI 1332.14. To ensure this progress is not lost, the Under Secretary of Defense for Personnel and Readiness has extended the requirement for the Military Departments to report their compliance until FY2012.

The number of personality disorder separations across the Department by more than a third since 2008 when the more rigorous processes were implemented. Each of the Military Services has similarly experienced decreases in personality disorder separations. While other factors may have contributed to this decrease, the increased oversight and awareness clearly supported this trend.

PTSD Disability Evaluation System (DES) Case Disposition Trends

The Military Departments combined reported 979 more PTSD DES case dispositions (a 47 percent increase) in FY 2009 versus FY2008. There were 3,063 PTSD DES case dispositions in FY2009 versus 2,084 PTSD DES case dispositions in FY2008. The Army accounted for 81 percent of all PTSD DES case dispositions.

The Military Departments reported they complied with requirements in the Veterans Affairs Schedule for Rating Disabilities (VASRD) when rating mental illness due to traumatic events. Conditions classified as mental disorders by the VASRD existed in 5,141 (27 percent) of 19,215 FY 2009 DES case dispositions.

PTSD DES case dispositions comprised 16 percent of the total 19,215 DES case dispositions in FY2009. In FY2008, PTSD DES case dispositions comprised 11 percent of the total 19,583 DES case dispositions.

In FY2009, 119 (3.9 percent) of the PTSD DES case dispositions resulted in the Service member being placed on the Permanent Disability Retirement List (PDRL). 2,936 (95.8 percent) of the FY2009 PTSD DES case dispositions resulted in the Service member being placed on the Temporary Disability Retirement List (TDRL). This represents 42 percent of the total of 6,965 Service members placed on the TDRL in FY2009. Six (.2 percent) case dispositions resulted in Separation with Severance Pay and three (.1 percent) case dispositions resulted in Separation without benefits.

In FY2008, 233 (11.2 percent) of the PTSD case dispositions resulted in the Service member being placed on the PDRL. 1,352 (64.9 percent) of the FY2008 PTSD DES case dispositions resulted in the Service member being placed on the TDRL. 489 (23.5 percent) case dispositions resulted in Separation with Severance Pay and two (.1 percent) case dispositions resulted in Separation without Benefits.

Mental Health Assessments

A Mental health assessment is a bio-psycho-social evaluation examining every aspect of the patient's life. A psychiatric diagnosis is made if the patient demonstrates symptoms that meet clinical criteria as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).

Symptoms that may be present in PTSD represent a challenge in the differential diagnosis and treatment of the disorder. Moreover, chronic PTSD is frequently complicated by co-morbid (dual diagnosis) psychiatric disorders including depression and other mood disorders, substance abuse, dissociative disorders, other anxiety disorders, and psychotic symptoms or disorders. These co-morbidities offer a further challenge in the diagnosis and management of PTSD. Concurrent (*pre-existing*) character pathology (personality disorders) is important to diagnose since it may affect the course, severity, and prognosis of PTSD. When personality changes (*newly*) emerge and persist after an individual has been exposed to extreme stress, a diagnosis of Posttraumatic Stress Disorder should be considered.

Policy issuances currently require an examination and multiple reviews by medical professionals prior to administrative separation for a Personality Disorder. Service members diagnosed with or reasonably asserting post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI) fall under guidance provisions for psychiatric and/or medical disorders, respectively (DoDI 1332.38). If a Service member is diagnosed with PTSD or TBI at the time of their separation examination, it is policy that a Medical Evaluation Board should be initiated. If a Personality

Disorder is diagnosed after all other medical and mental health disorders have been ruled out, and the patient is considered to be a hazard to themselves or others and unable to function in the military setting, one of the criteria for an administrative separation would be met. Ultimately, it is the Service member's commander, with the advice of medical professionals, who makes the final decision as whether the Service member should be processed for Administrative Separation.

PTSD and TBI Related Discharge Review Board and BCMR Request

The Department realizes that the new policies and body of knowledge of PTSD and TBI evolved too late to benefit many Service members. In that regard, the Department continues to encourage veterans who are later diagnosed with PTSD or other mitigating disorders to request review of their separations through their respective Military Department Discharge Review Board (DRB) and Board for Correction of Military Records (BCMR). As expected, the number of DRB and BCMR appeals related PTSD or TBI has increased. This process has worked well, and we continue to work with the Military Departments and the Department of Veterans Affairs to identify those with PTSD and TBI who may have transitioned prior to our current understanding of these conditions.

Conclusion

The Department is confident that given the positive trends Service members who experience or assert PTSD or TBI are being diagnosed and that those diagnoses are being considered prior to separation. Rigorous execution and oversight of the Department's separation policies is crucial to ensuring the proper transition of our veterans and the readiness of the military forces. The Department is committed to continue efforts to improve the accuracy and efficacy of these policies. I will be happy to answer any questions you might have at this time.

Statement of Major General Gina S. Farrisee

Director, Department of Military Personnel Management, G-1
Department of the Army, U.S. Department of Defense

Introduction

Chairman Filner, Representative Buyer, Distinguished Members of this Committee, thank you for the opportunity to appear before you on behalf of America's Army. Our greatest heroes are America's most precious resource—our Soldiers and Veterans. These Soldiers and Veterans represent the very best of America's values and ideals and faithfully shoulder the load that our nation asks of them. Their dedicated service and sacrifice are deserving of the very best services, programs, equipment, training, benefits, lifestyle, and leadership available.

Personality Disorder

The Army is dedicated to ensuring that all Soldiers with physical and mental conditions caused by wartime service receive the care they deserve. The Army remains committed to tracking personality disorder separations for our Soldiers. Our culture is shifting away from the stigma associated with having post traumatic stress disorder (PTSD) or traumatic brain injury (TBI) and ensuring Soldiers know that it is expected that they seek help for these hidden wounds to restore and maintain their health and readiness.

A personality disorder is a deeply ingrained maladaptive pattern of behavior of long duration that interferes with a Soldier's ability to perform duty. The onset of a personality disorder is frequently manifested in the early adult years and may reflect an inability to adapt to the military environment as opposed to an inability to perform the requirements of specific jobs or tasks. As such, observed behavior of specific deficiencies are documented in appropriate military counseling records to include history from sources such as supervisors, peers, and others, as necessary to establish that the behavior is persistent, interferes with assignment to or performance of duty, and has continued after the Service member has been counseled and afforded the opportunity to overcome the deficiencies.

In 2006 and 2007, public concern arose that some Soldiers returning from combat tours who were also suffering from PTSD or TBI as a result of their combat experiences had been discharged from the military for personality disorder. To address these concerns, the Army's Office of the Surgeon General issued policies in August 2007 and May 2008 requiring higher-level review of recommendations to administratively separate Soldiers for personality disorder and requiring screening for PTSD and TBI for administrative separation for personality disorder and other types of administrative separation. In August 2008, the Department of Defense (DoD) mandated similar requirements across DoD including the requirement that the diagnosis of personality disorder for Service members who had served or were serving in imminent danger pay areas must be endorsed by the Military Department's Surgeon General.

Army administrative separations policy was subsequently updated implementing the recommendations of the Government Accountability Office, the requirements of Department of Defense Instruction 1332.14 and the National Defense Authorization Act for Fiscal Year 2010. Included were the requirements that a psychiatrist or PhD-level psychologist be the mental health professional diagnosing the personality disorder, that a Personality Disorder diagnosis be

corroborated by a peer or higher-level mental health professional (Medical Treatment Facility Chief of Behavioral Health or equivalent official), that the Personality Disorder diagnosis be endorsed by the Director, Proponency of Behavioral Health, Office of The Surgeon General, and that the diagnosis address PTSD or other co-morbid mental illness, if present. The Army also provided for the distinction between Soldiers who were separated for Personality Disorder who had less than 2 years time in service (Chapter 5-13/ Personality Disorder) with Soldiers with 2 or more years of service (Chapter 5-17/ Other Designated Physical or Mental Conditions).

Commanders make maximum use of counseling and rehabilitation before determining that a Soldier has limited potential for further military service and, therefore, should be separated. When a Soldier's conduct or performance becomes unacceptable, the commander will ensure that the Soldier is formally counseled on his or her deficiencies and given a reasonable opportunity to overcome or correct them. If the commander believes a medical issue may be the basis of the misconduct or poor performance, the commander refers the Soldier for a medical evaluation. Separation for personality disorder is authorized only if the diagnosis concludes that the disorder is so severe that the Soldier's ability to function effectively in the military environment is significantly impaired. The Soldier is counseled that the diagnosis of a personality disorder does not qualify as a disability. When it is determined that separation for personality disorder is appropriate, the unit commander takes action to notify the Soldier. Separation authority for personality disorder for Soldiers who are or have been deployed to an area designated as an imminent danger pay area is the General Court Martial Convening Authority (General Officer-level commander). In all other cases, the separation authority is the Special Court Martial Convening Authority (Colonel-level commander).

Separated Soldiers may request review and change of their discharge by petitioning the Army Review Boards Agency (ARBA). ARBA's case management division screening team hand carries these cases to the Army Discharge Review Board (ADRB), which prioritizes review and boarding of applications for upgrades or changes in discharges where either PTSD or TBI is diagnosed. ARBA's Medical Advisor serves as a voting board member when PTSD/TBI cases are boarded by the ADRB.

Army Career and Alumni Program

Soldiers who are separated from Active Duty prior to their actual separation date, also known as unanticipated losses, are fully eligible for all transition services provided by the Army Career and Alumni Program (ACAP). Programs available for Soldiers within ACAP include pre-separation counseling, employment assistance, Veterans Benefits Briefing, and the Disabled Transition Assistance Program (DTAP).

Pre-separation counseling provides Soldiers information about services and benefits they have earned while on active duty. The following areas are covered in this counseling: effects of a career change, employment assistance, relocation assistance, education and training, health and life Insurance, finances, Reserve affiliation, Veterans benefits, Disabled Veterans benefits, post government service employment restriction and an Individual Transition Plan. Each of these areas have several items that support the specific area. This pre-separation counseling is mandatory for all separating Soldiers who have at least 180 days of active duty upon time of separation.

Employment assistance consists of individual one-on-one counseling, attending a Department of Labor two-and-a-half day long employment workshop, finalizing a resume, practice employment interviews, using various automated employment tools and using the internet to access job data banks. This is strictly voluntary; Soldiers do not have to participate.

The Veterans Benefits Briefing is a four-hour long briefing provided by Veterans Affairs (VA) counselors covering all VA-controlled services and benefits that a Soldier can receive or may be eligible for after separation. Transition counselors strongly encourage separating Soldiers to attend.

The Disabled Transition Assistance Program (DTAP) is a two-hour long briefing provided by VA counselors. Soldiers who are separated due to medical or physical injuries, as well as Soldiers who believe that they will file a VA Disability Claim, are highly encouraged to attend this briefing.

Soldiers out-processing as an unanticipated loss normally have limited time remaining on active duty and will in almost all cases have insufficient time to take advantage of the above programs except for the legally-mandated pre-separation counseling. However, these Soldiers are fully eligible to receive these services for up to 180 days after separation. Additionally, they are referred by the transition counselor to go to the nearest Department of Labor Career One Stop after separation for assistance in obtaining employment and are instructed to use the VA E-benefits Web site to obtain information concerning their eligibility for VA benefits.

Congressional Assistance

The Army remains dedicated to making sure that all Soldiers with physical and mental conditions caused by wartime service receive the care they deserve. The Army is grateful for the continued support of Congress for providing for the well-being of the best Army in the world.

Conclusion

The Army leadership has confidence in our behavioral health providers and the policies in place to ensure proper treatment for our Soldiers. We continue to monitor these processes to ensure the accurate diagnosis of PTSD and TBI and to further corroborate each diagnosis of personality disorder. Veterans who feel that they were discharged inappropriately are encouraged to seek a remedy through the Army Review Boards Agency (ARBA).

The mental and physical well-being of our Soldiers and Veterans depends on your tremendous support. We must continue to maintain an appropriate level of oversight on PTSD and TBI, wounds all too frequently associated with the signature weapon of this war, the improvised explosive device. The men and women of our Army deserve this; we owe this to them. The Army is committed to continuing to improve the accuracy and efficiency of these policies and their implementation. Thank you for the opportunity to appear before you this morning. I look forward to answering any questions you may have.

STATEMENT OF ANTONETTE M. ZEISS, PH.D.
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Good morning Chairman Filner, Ranking Member Buyer, and Members of the Committee. Thank you for inviting me to discuss the mental health services the Department of Veterans Affairs (VA) provides our Veterans, and how a Veteran's discharge for a personality disorder affects his or her access to key VA benefits. I am accompanied today by Mr. Tom Murphy, Director of the Compensation &Pension Service (VBA).

A personality disorder is defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (Text Revision, or DSM-IV-TR) as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, manifested in cognition (ways of perceiving or interpreting events and others' behavior), affect (including the range, intensity, ability to manifest, or appropriateness of emotional responses), interpersonal functioning, and impulse control. Essentially, this means that a person with a personality disorder displays behavior and attitude that is a consistent, long-term characteristic of the individual and that differs from cultural norms in problematic ways.

In DSM-IV-TR, personality disorders differ fundamentally from other types of mental health disorders. DSM-IV-TR requires that a new diagnosis of a personality disorder should only be made after considering the possibility that there may be other causes of the behavioral change, such as another mental disorder, the physiological effect of a substance (such as medication), or a general medical condition like head trauma. Primarily, these requirements exist because many of the problems exhibited by individuals with personality disorders can also be symptoms of other mental health disorders or other health problems, and without a prior personality disorder diagnosis, the clinician cannot assume that these symptoms represent long-standing, enduring characteristics of the individual. For example, traumatic brain injuries (TBI) and Post-Traumatic Stress Disorder (PTSD) can have effects similar to the symptoms of some personality disorders.

Given the complexity associated with personality disorders and other cognitive and behavioral issues, VA has developed a comprehensive system involving outreach, screening and treatment for Veterans to determine if they have mental health disorders or TBI. Our intensive programs ensure that any problems are recognized, diagnosed, and treated, and our benefits programs provide compensation and support for Veterans whose conditions were the result of service in the military. My testimony today will begin by discussing Veterans' eligibility for benefits from VBA and health care. I will then describe the process by which Veterans are screened for cognitive and behavioral problems and discuss three conditions: personality disorders, TBI and PTSD. Finally, I will cover the health care benefits and services available to Veterans in VA health care facilities and Vet Centers.

Veteran Benefits Administration

Veterans' eligibility for benefits under title 38 is generally conditioned on two factors: 1) the character of discharge, and 2) the completion of an enlistment or period to which called. Title 38 U.S.C. §101(2) and 38 C.F.R. § 3.1(d) define a Veteran "as a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable." The uniformed services, when separating a Service member, characterize his or her service as one of the following: honorable; general, under honorable conditions; under other than honorable conditions; bad conduct; dishonorable; or, uncharacterized.

VA accepts discharges that are characterized as honorable or general, under honorable conditions, as "other than dishonorable" for VA purposes. Such discharges generally do not disqualify a Veteran for health care, disability compensation and pension, educational assistance, vocational rehabilitation and employment services, home loan guaranty, and burial and memorial benefits offered by VA as long as the Veteran meets the minimum active duty requirement of two years of service or "the period called" to service if activated for less than two years. Service "for the period called" would be applicable in the situation of a Reservist or National Guard member called to active duty by a Federal Order (for other than training purposes) and completing the full call-up period. If VA determines that a Veteran has a service-connected disability the minimum active duty requirement does not apply. In addition, for purposes of the Montgomery GI Bill and the Post-9/11 GI Bill, a Veteran must have received an honorable discharge.

VA uses the process outlined in 38 C.F.R. § 3.12 to determine whether other than honorable and bad conduct discharges may be considered "other than dishonorable" for VA purposes. Dishonorable discharges are all disqualifying. A separation resulting from a reported personality disorder is of potential significance to VA only if it results in a separation that is less than honorable or if it results in a separation before completion of the minimum active duty requirement.

Personality disorders are considered constitutional or developmental abnormalities and thus are not service-connected. Therefore the law does not permit payment of compensation for a personality disorder. However, Veterans who are eligible to enroll for VA health care can be examined by VA clinicians, who may diagnose other mental health disorders. Veterans are not bound by any diagnosis from the Department of Defense (DoD) when seeking treatment from VA or when submitting a claim for service connection.

Veterans Health Administration

- Eligible Veterans may enroll in the VA health care system. Once enrolled, they are provided all needed care set forth in the medical benefits package. VA's enrollment system manages the enrollment of Veterans in accordance with priority categories. Currently, the following Veterans are eligible to enroll:

- The Veteran was a former Prisoner of War;

- The Veteran received a Purple Heart Medal;

- The Veteran is determined to have a compensable service-connected disability;
- The Veteran receives a VA pension;
- The Veteran received a Medal of Honor;
- The Veteran is determined to be catastrophically disabled;
- The Veteran has an annual household income below applicable income thresholds.

In addition, Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) combat Veterans may enroll and receive free VA medical care for any condition related to their service. Under the "Combat Veteran" authority, VA provides cost-free health care services and nursing home care for conditions possibly related to military service to:

- Combat Veterans who were discharged or released from active service on or after January 28, 2003, for 5 years from the date of discharge or release if they enroll for VA health care during this period.
- Combat Veterans who were discharged from active duty before January 28, 2003, but who did not enroll in VA health care system now have until January 27, 2011 to enroll and receive care as combat veterans. Veterans who enroll with VA under this authority will continue to be enrolled even after their combat-Veteran eligibility period ends but may be required to make applicable copayments.

Screening for Cognitive and Behavioral Conditions

VA clinicians routinely and systematically screen enrolled Veterans for a range of health concerns. Every Veteran who visits a VA health care facility is screened initially and periodically for PTSD, problem drinking, and depression, and all Veterans receive a one-time screening for Military Sexual Trauma (MST). Veterans from OEF/OIF are screened for possible TBI as well. Any Veteran who screens positive for any of these conditions is referred for further assessment and care. With the widespread integration of mental health into primary care settings, this process has become easier for Veterans, and the potential stigma of being referred to an exclusively mental health environment has been reduced.

VA's universal screens are primarily health assessments meant to ensure that appropriate care is delivered, but such assessments may be relevant to service connection claims as well. VA clinicians, including psychologists or psychiatrists, conduct detailed assessments when Veterans apply for disability benefits for a mental health condition connected to their military service. These experts review medical records, including screening and further test results, as part of this assessment.

Compensation and pension (C&P) examinations for mental health disorders follow established guidelines and cover psychosocial functioning, as well as self-reports of symptoms of mental disorders that manifested before, during, or after military service. VA clinicians also assess the

Veteran's individual military experience, including exposure to traumatic events or other stressful experiences that could trigger a mental health problem, and compare this information with the timing of symptoms to determine if the condition is likely to be connected to military service. If the Veteran exhibited a pattern of maladaptive behavior prior to military service, VA must determine whether there has been a change in behavior connected to and a result of military service. All VA clinicians, including those responsible for completing C&P evaluations, adhere to the DSM-IV-TR, which is widely recognized as the most current and authoritative source for mental health conditions.

Personality Disorders, TBI, and PTSD

As I stated earlier, some personality disorders, TBI, and PTSD can share common symptoms. Behavioral changes may be the result of physical or psychological injuries, or both, and it is our responsibility to properly identify which condition a Veteran has to ensure an accurate record for benefits administration and effective treatment planning. For this reason, I will spend some time describing the similarities and differences of these conditions.

Personality Disorders

At the beginning of my testimony, I provided an overview of the DSM-IV-TR definition of a personality disorder. For a VA clinician to make a diagnosis that a Veteran meets criteria for a personality disorder, the clinician must use the full definition and establish each component. Generally speaking, this means that a personality disorder is not situational, temporary, or recently acquired, and that the person's behavior has been adversely affected and cannot be explained by other disorders.

Events characterized by repeated exposure to traumatic stress can result in symptoms and behaviors that appear, on the surface, to resemble some of these personality disorders. In addition to a comprehensive psychological assessment of the individual, VA advises clinicians to consult with family members or others with knowledge of the individual prior to his or her military service when considering whether a Veteran should be diagnosed with a personality disorder.

TRAUMATIC BRAIN INJURY

Traumatic brain injury is the result of a severe or moderate force to the head, where physical portions of the brain are damaged and functioning is impaired. Depending upon where the injury is sustained and its severity, the effects of a TBI on a person's behavior will vary. A mild TBI, which is also commonly called a concussion, may simply require some time to recover. Short term effects might include dizziness, nausea, memory lapses, or other conditions, and in many cases, there are no long term effects. Moderate and severe TBI can have more lasting effects and may impact a person's behavior. For example, a person may be more irritable or aggressive as a result of a brain injury.

Due to the severity and complexity of their injuries, Service members and Veterans with moderate to severe TBI require an extraordinary level of coordination and integration of clinical

and other support services. Veterans who screen positive for TBI are referred for a comprehensive evaluation at one of 22 Polytrauma Network Sites or one of 83 Polytrauma Support Clinic Teams. This comprehensive evaluation assesses the Veteran's current physical, behavioral, emotional, and cognitive status. The evaluation includes a 22-item Neurobehavioral Symptom Inventory, which allows for systematic assessment of a wide array of potential current problems. This diagnostic tool allows VA to develop an appropriate diagnosis of current TBI-related symptoms and problems and to contribute to developing an interdisciplinary plan for care.

PTSD

According to the DSM-IV-TR clinical criteria, PTSD can follow exposure to a severely traumatic stressor that involves personal experience of an event involving actual or threatened death or serious injury. It can also be triggered by witnessing an event that involves death, injury, or a threat to the physical integrity of another. The person's response to the event must involve intense fear, helplessness or horror. The symptoms characteristic of PTSD include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma, numbing of general responsiveness, and persistent symptoms of increased arousal. It is extremely rare that an individual would display all of these symptoms, and a diagnosis requires a combination of a sufficient number of symptoms, while recognizing that individual patterns will vary.

PTSD can be experienced in many ways. Symptoms must last for more than 1 month, and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Military combat certainly can create situations that fit the DSM-IV-TR description of a severe stressor event that can result in PTSD, and VA recognizes that being stationed in a combat area where there is constant danger and inability to predict or control the threat of danger also can meet the description of a severe stressor event. The likelihood of developing PTSD is known to increase as the proximity to, intensity of, and number of exposures to such stressors increase. In addition, PTSD can be a result of many other experiences besides combat exposure, such as sexual assault, life-threatening accidents, or natural disasters.

PTSD is associated with increased rates of other mental health conditions, including Major Depressive Disorder, Substance-Related Disorders, Generalized Anxiety Disorder, and others. PTSD can directly or indirectly contribute to other medical conditions. Duration and intensity of symptoms can vary across individuals and within individuals over time. Symptoms may be brief or persistent; the course of PTSD may ebb and return over time, and PTSD can have a delayed onset. Clinicians use these criteria and discussions with patients to identify cases of PTSD, sometimes in combination with additional psychological testing.

COMPARING AND CONTRASTING PERSONALITY DISORDERS, TBI, AND PTSD

The significance of an accurate diagnosis cannot be underestimated, as the diagnosis will inform our approach to treatment and care, and a person can meet criteria for more than one problem at a time. For example, a Veteran could have experienced events that led to both PTSD and TBI.

A person previously able to function in spite of a long-standing mild-to moderate personality disorder can develop PTSD after trauma. Such a person could also have sustained a TBI, which could contribute to aggression, poor impulse control, or suspiciousness.

Since the onset of personality disorders by definition occurs by late adolescence or early adulthood, there typically should be evidence of the behavior pattern prior to adulthood. A history of solid adjustment and good psychosocial functioning prior to adulthood would not be expected in an individual with a personality disorder. Following an extended event characterized by traumatic stressors, it is particularly important to determine if problematic behaviors are due to PTSD. The DSM-IV-TR explicitly states, "When personality changes emerge and persist after an individual has been exposed to extreme stress, a diagnosis of Post-Traumatic Stress Disorder should be considered" (p. 632). PTSD can induce irritability or outbursts of anger, feelings of detachment or estrangement from others, and restricted range of affect (unable to experience feelings such as love). In addition, PTSD may increase the risk of self-destructive and impulsive behavior, social withdrawal, hyper-vigilance, and impaired relationships with others.

Many Veterans who screen positive for possible TBI and who are seen for a comprehensive evaluation have co-occurring conditions, including PTSD. A Veteran may exhibit significant interpersonal difficulties that were not present prior to the TBI. Inability to control anger, trouble with social tact, and other interpersonal difficulties are examples, and these occur more frequently in those with moderate to severe TBI. Clinicians are able to distinguish a TBI-related interpersonal change by taking a thorough history and obtaining collateral interview data. Pinpointing the onset of interpersonal and personality change to the time of sustaining a TBI provides evidence of acquired interpersonal dysfunction and rules out a longstanding personality disorder.

The symptoms and problems related to TBI and PTSD can be particularly challenging to differentiate for several reasons, most notably because the same event may have resulted in TBI *and* led to the development of PTSD. However, specific criteria in the DSM-IV-TR guide clinicians in distinguishing between the two conditions by looking for symptoms that are specific to one or the other disorder, such as persistent re-experiencing of a traumatic event and avoidance of stimuli associated with the trauma, which would only be related to PTSD.

To address this, VA uses interdisciplinary polytrauma rehabilitation teams and neuropsychologists and rehabilitation psychologists to determine if a Veteran with TBI also has PTSD. Standardized questionnaires such as the PTSD Checklist—Military Version (PCL-M) and structured interviews such as the Clinically Administered PTSD Scale (CAPS) also aid VA clinicians in determining whether a Veteran meets criteria for PTSD, with or without TBI. VA clinicians consider factors such as symptom presentation and a psychosocial history from the Veteran that creates a timeline of symptom development. Clinicians also conduct a medical record review, a psychological and neuropsychological assessment, and interviews. Following a thorough evaluation, the polytrauma rehabilitation team, often in concert with mental health providers, collaborates to develop and execute a comprehensive treatment plan.

According to the DSM-IV-TR classification system, these clinical scenarios involving personality change after a TBI are diagnostically distinct from Personality Disorders and are coded as such. Most frequently, they fall under the category of Mental Disorders Due to a General Medical Condition (i.e., diagnostic code 310.1 - Personality Disorder Due to General Medical Condition) or Relational Problem Related to a General Medical Condition (code V61.9). When these diagnostic codes are used, TBI also must be coded as the relevant medical condition.

TREATMENT

VA offers mental health services to Veterans through medical facilities, community-based outpatient clinics (CBOC), and in VA's Vet Centers, discussed later in my testimony. VA has been making significant enhancements to its mental health services since 2005, through the VA Comprehensive Mental Health Strategic Plan and special purpose funds available through the Mental Health Enhancement Initiative from fiscal years 2005 to 2009. In 2007, VA approved the *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics* to define what mental health services should be available to all enrolled Veterans who need them, no matter where they receive care, and to sustain the enhancements made in recent years.

VA's enhanced mental health activities include outreach to help those in need to access services, a comprehensive program of treatment and rehabilitation for those with mental health conditions, and programs established specifically to care for those at high risk of suicide. To reduce the stigma of seeking care and to improve access, VA has integrated mental health into primary care settings to provide much of the care that is needed for those with the most common mental health conditions. In parallel with the implementation of these programs, VA has been modifying its specialty mental health care services to emphasize psychosocial as well as pharmacological treatments and to focus on principles of rehabilitation and recovery. VA is ensuring that treatment of mental health conditions includes attention to the benefits as well as the risks of the full range of effective interventions. Making these treatments available responds to the principle that when there is evidence for the effectiveness of a number of different treatment strategies, the choice of treatment should be based on the Veteran's values and preferences, as well as the clinical judgment of the provider.

Veterans with TBI seen in VA receive some of the best care available. The VA Polytrauma System of Care, which is composed of 4 regional Polytrauma/TBI Rehabilitation Centers, 22 Polytrauma Network Sites, and 83 Polytrauma Support Clinic Teams, currently provides specialty rehabilitation care. Veterans with TBI can also be seen at other VA facilities for treatment, including via telehealth.

VET CENTER SERVICES

In addition to the clinical care and diagnostic services discussed previously, VA's Vet Centers offer an important complement that assists Veterans with readjustment issues. Vet Centers provide quality outreach and readjustment counseling services to returning war Veterans of all eras and their family members in confidential, easy to access community-based sites. The Vet Centers' mission goes beyond medical care in providing a holistic mix of services designed to

treat the Veteran as a whole person in his or her community setting. Vet Centers provide an alternative to receiving treatment in traditional mental health care settings that helps many combat Veterans overcome the stigma and fear related to accessing professional assistance for military-related problems. Vet Centers are staffed by interdisciplinary teams that include psychologists, nurses and social workers, many of whom are Veterans themselves.

Vet Center care consists of a continuum of social and psychological services including community outreach to special populations, professional readjustment counseling to Veterans and families, and brokering of services with community agencies that provides a key access link between the Veteran and other needed services both in and outside of the VA. Readjustment counseling offered at Vet Centers may address problems such as war-related psychological readjustment, PTSD counseling, family or relationship problems, lack of adequate employment or career goals, lack of educational achievement, social isolation, homelessness and lack of adequate resources, and other psychological problems such as depression or substance use disorders. Vet Centers also provide military-related sexual trauma counseling, bereavement counseling, employment counseling and job referrals, preventive health care information, and referrals to other VA and non-VA medical and benefits facilities.

The Vet Center program promotes early intervention and ease of access to services by helping combat Veterans and families overcome all barriers of care. To facilitate access to services for Veterans in hard to reach outlying areas, 50 mobile Vet Centers have been deployed across the country to provide assistance to Veterans, military service personnel, and family members. There are currently 267 operational Vet Centers nationwide, with another 33 expected to open in 2011, for a total of 300.

In addition to the wide range of services and increased accessibility for Veterans to access these services, Vet Centers provide assistance and support for combat Veterans through referrals to other agencies. Section 402 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163) provides VA the authority to assist Veterans with problematic discharges through referral to services outside VA or referral for assistance with discharge upgrades when appropriate. Until 1996, VA had specific statutory authority to refer ineligible Veterans to non-VA resources and to advise such individuals of the right to apply for review of the individual's discharge or release. With this renewal, the Vet Centers have the authority to help combat Veterans with problem discharges that may be related to traumatic war-time stress. We appreciate the renewal of this provision, and VA has advised its readjustment counselors that they should provide such help to Veterans when needed.

CONCLUSION

Thank you again for this opportunity to speak about VA's role in providing care for all our Veterans, including those with personality disorders, PTSD, or TBI. VA recognizes the sacrifice all of our Veterans have made, and we seek to ensure we offer the right diagnosis in all clinical settings, whether for a compensation and pension examination or as part of a standard mental health assessment and treatment plan. Once a Veteran is enrolled in the VA health care system, it does not matter when or where the condition developed; we will deliver appropriate, Veteran-

centered care as set forth in the medical benefits package. We are prepared to answer your questions at this time.

Statement of Amy Fairweather
Policy Director
Swords to Plowshares

Thank you Chairman Filner, Congressman Buyer and the members of the House Veterans Affairs Committee for the opportunity to submit testimony on this important topic; Personality Disorder discharges and their impact on our veterans.

Founded in 1974, Swords to Plowshares is a community-based not-for-profit organization that provides counseling and case management, employment and training, housing and legal assistance to homeless and low-income veterans in the San Francisco Bay Area. We promote and protect the rights of veterans through advocacy, public education, and partnerships with local, state and national entities. Swords to Plowshares is a Congressionally recognized Veteran Service Organization which represents veterans in VA Compensation and Pension claims as well as discharge review matters. As such we have represented many veterans who have unjustly received inappropriate personality disorder (PD), adjustment disorder (AD) and pattern of misconduct discharges and been denied treatment for their PTSD.

The purpose of this testimony is to emphasize how the inappropriate use of personality disorder, adjustment disorder and pattern of misconduct impact our veteran clients on the ground. Such discharges have a tremendously negative impact on our veteran clients. We will not go into data on a broader scale as our colleagues at Veterans for Common Sense have done an excellent job framing the issues. Instead, we can tell you that client after client with PTSD and traumatic brain injury and inappropriate PD discharges come to us feeling that they have been branded as damaged goods, their combat service has been invalidated, and their identity and self worth as once proud warriors destroyed. The fallout can be tragic, this practice exacerbates PTSD, depression, homelessness and suicidality, and creates obstacles to employment, and access to healthcare and benefits.

At Swords to Plowshares we have 35 years experience in picking up the pieces and pulling our Vietnam era clients out of poverty, and chronic homelessness, mental health need and substance abuse stemming from their military service. We hope that we have learned lessons and may be proactive, prevent future homelessness and suffering by ensuring that this generation of combat veterans are afforded the honor, care and support they need for successful outcomes.

The following are some of our observations regarding personality disorder, adjustment disorder and pattern of misconduct discharges for veterans with PTSD, TBI and other mental health needs.

The Impact of Misdiagnosis

Many of our clients served honorably and without any disciplinary or mental health concerns for several years prior to receiving a personality disorder or adjustment disorder discharge. Unlike PTSD, schizophrenia and psychosis, personality disorder does not develop following a traumatic stressor or deployment. It does not manifest suddenly. Instead it is a pre-existing condition and

was allegedly present at the time the service member joined the military. If the service member had a pre-existing personality disorder which led to such a discharge it should have been identifiable in the preceding years of service. Indeed, it should be identified in boot camp or A school. We are seeing and hearing from veterans who have been diagnosed with personality disorder after multiple deployments. The military is simply not following the diagnostic criteria set forth in the DSM-IV, and its failure to do so should not forever punish former service members.

The DoD is shirking their responsibility to treat PTSD to the VA and the community-based system of care. If these service members were properly and legally discharged they should receive medical retirement, an honorable discharge, a 50 percent disability rating and medical care. Instead they are kicked out of the military with a less than honorable discharge status with no readily available means of support or healthcare. Veterans come to Swords to Plowshares in financial and psychological crisis, many believe that they are not eligible for VA care and benefits because personality disorder, as a pre-existing condition is not service connectable. Even with the help of our legal and social services staff, this status causes significant delays in care, causing unnecessary exacerbation of their symptoms. The cost of care should never have been externalized to our communities. Further the cost in suffering, poverty, and the shame inflicted on warriors is immeasurable.

The DoD is taking advantage of vulnerable disabled service members. Many of our clients have signed away their right to a just and proper discharge because they are suffering from PTSD or TBI and cannot bear remaining in the military environment. Some because their PTSD and depression are too acute, others because of the stigma and mistreatment they receive in seeking care. In other cases, their symptoms have led to some diminished capacity which interferes with performance or have engaged in some degree of misconduct symptomatic of their true diagnosis and are being met with discipline rather than care. These service members will sign anything to escape a hostile environment and do not have the capacity for informed consent in signing away their right to a proper medical discharge.

Personality, adjustment and pattern of misconduct discharges can unjustly strip veterans of their GI Bill benefits. A personality disorder discharge in itself is not a bar to benefits however, in our experience; they often arise in the context of a pattern of misconduct and disciplinary action. If the veteran received an other than honorable discharge they are barred from the GI Bill benefits. This unjustly throws more obstacles in their path to healing, employment, housing and economic stability.

To assign a PD, AD or BCD discharge to a mentally ill warrior is a devastating betrayal. It is a cruel injustice to service members who have served their country for some years, deployed to combat, been exposed to trauma and injury, witnessed the deaths of friends, and struggled with the demons of PTSD. Rather than honoring their service and healing their wounds, the military with which they have identified and sacrificed for has labeled them 'crazy' and sent them packing. This overwhelming psychic blow to our clients cannot be overstated. The military is a not just a job, it is an all-encompassing culture of its own, and these injured veterans are in essence banished from society.

There is virtually no access to justice for disabled veterans who have illegally and unjustly received PD, AD and BCD discharge. There are very very few attorneys who specialize in discharge upgrades and corrections. And only a handful in the country that provide this service free of charge. Our own funding for discharge review has been cut back and we have had to severely restrict our client representation in these matters. Without competent affordable representation too many combat veterans will fall into a life of chronic mental illness, poverty and homelessness due to the military's illegal and inexcusable mistreatment of wounded service members.

In closing, we urge the HVAC committee will ensure that service members with mental health needs receive appropriate discharges and streamlined access to all the benefits and care they have earned. To that end, we fully concur with the recommendations of Veterans for Common Sense.