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FINDINGS OF THE DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH

HEARING

BEFORE THE

MILITARY PERSONNEL SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

HEARING HELD
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FINDINGS OF THE DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Thursday, July 12, 2007.

The subcommittee met, pursuant to call, at 10:01 a.m. in room 2118, Rayburn House Office Building, Hon. Susan A. Davis (chairwoman of the subcommittee) presiding.

OPENING STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, MILITARY PERSONNEL SUBCOMMITTEE

Mrs. DAVIS OF CALIFORNIA. Good morning, everybody. It is my pleasure today to convene this meeting of the Military Personnel Subcommittee. I just want to acknowledge my colleagues, and thank them very much for their support. I am really honored to be chairing the committee, and particularly to be having this very important hearing this morning. We also asked that members come down a little closer to our witnesses today. When we have these subcommittee meetings, this is a very big room, and we want very much to enjoy a conversation with you to the best extent that we can so we can look at the report and have a chance for a really good exchange.

I appreciate the time and effort that you all have put into it. And I know that it is going to be a good meeting. The purpose of the hearing today is to receive the findings of the Department of Defense (DOD) Task Force on Mental Health. The Task Force was mandated by Congress in the 2006 National Defense Authorization Act, and which charged to, both assess the military mental health care system, and to make recommendations on how to improve it. We are so fortunate today to have both the co-chairs of the Task Force with us, Vice Admiral Donald Arthur, who is also the Surgeon General of the Navy, and Dr. Shelley MacDermid, the Director of the Center For Families at Purdue University, and also the Co-Director of the Military Family Research Institute.

We are also fortunate to have the new Assistant Secretary of Defense for Health Affairs, Dr. Ward Casscells, in his first appearance before the Military Personnel Subcommittee. Admiral Arthur and Dr. MacDermid will speak to the findings and recommendations of the Task Force, while Dr. Casscells will be able to tell us how the Department of Defense plans to improve the provision of mental health care.

Again, we welcome all of you to the hearing. My understanding is that our panel will make brief opening statements so that we

may quickly get to our members' questions. All the members of the subcommittee are unanimous in their support for our service members and their families. With multiple, long-term deployments now the norm for our military, mental health is more important than ever. Whether on the battlefield or back at home, the psychological resilience of our troops and their families plays a central role in the effectiveness of our armed forces.

The final report of the Task Force on Mental Health makes it clear that substantial changes need to be made to the military health care system to provide the proper care at the proper time and the proper place. So let's be clear that this will be a long process. It will take a sustained effort for the foreseeable future to make the required changes to the Defense Health Program. We will, indeed, face challenges in recruiting or training additional mental health providers. We will encounter institutional resistance from those who think the current system is adequate.

And finally, we will face fiscal challenges. These structural and cultural changes will require significant and continuing financial outlays. Improving and sustaining the mental health care system will be expensive, but we simply cannot afford not to do it. So finally, let me also mention that this may be Admiral Arthur's final hearing before the committee. He is retiring next month I know. And I am welcoming him, I hope, to San Diego after 33 years in uniform. Thank you, Admiral, for your many, many contributions and your faithful service to our Nation. Thank you very much, sir. And I am very delighted to turn the microphone over to my colleague, Mr. McHugh, for his opening remarks.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 35.]

STATEMENT OF HON. JOHN M. MCHUGH, A REPRESENTATIVE FROM NEW YORK, RANKING MEMBER, MILITARY PERSONNEL SUBCOMMITTEE

Mr. MCHUGH. Thank you very much, Madam Chair. Let me, again, congratulate you on your new position. I look forward to working with you. I know with your years of service on this subcommittee, you have a passion and a compassion that will lead us in very exciting directions. And if we get off track, we have still got the former chair, Dr. Snyder, watching over us very carefully, so I feel comforted. Also you made me feel 14 years younger. I don't look it. But moving back down here is kind of a different experience. And the acoustics are different as well. So thank you for that innovative approach. Let me add my words, too, of thanks and appreciation, best wishes to Admiral Arthur. And as you said, Madam Chair, he has been a tremendous leader, a leader of heroes really in his contributions over a great career. It cannot be adequately described.

But I know, Admiral, you take with you our deepest thanks for all that you have done. And I know that the men and women in uniform that you served for these many years feel very similarly. And thank you, too, to both of you as co-chairs of this Task Force that has put together the report that has gathered us here together.

We are looking forward to your comments. And of course to Dr. Casscells, welcome, your first appearance, to the new and friendlier Personnel Subcommittee. We wish you all the best, and am looking forward to meeting with you. And I know you follow too in the footsteps of a gentleman who did good work, Dr. Winkenwerder, who brought with him a real devotion and dedication. So we wish you the best.

Madam Chair, rather than just to keep rambling and read what I wrote, the statement that we have prepared here, I would ask for unanimous consent it be entered in its entirety into the record. And without that objection, I would just say in brief, as you said, mental health is an ongoing problem. It is not a new one. This subcommittee just two years ago held a hearing to talk about what kinds of services were available to our military personnel, to their families.

And we find ourselves here again today recognizing, as the Task Force report I think shows, that there are many challenges and unmet needs that we must pursue to a successful end. And I am certain that we all carry with us that devotion and that dedication. So without delaying any more, let me yield back to you, and I look forward to today's hearing.

[The prepared statement of Mr. McHugh can be found in the Appendix on page 37.]

Mrs. DAVIS OF CALIFORNIA. Thank you, Mr. McHugh. And thank you for your encouraging words.

Admiral Arthur, would you like to start?

STATEMENT OF VICE ADM. DONALD C. ARTHUR, CO-CHAIR, DEFENSE HEALTH BOARD TASK FORCE ON MENTAL HEALTH, SURGEON GENERAL OF THE NAVY, U.S. NAVY

Admiral ARTHUR. Yes. Good morning, Madam Chair, and distinguished members of the subcommittee. Thank you very much, first, for your great and undying support for all of our military services. It is greatly appreciated. I am honored to be one of the co-chairs, along with Dr. Shelley MacDermid. I would like to say, though, that for the first ten months of the Task Force, Kevin Kiley, the former Surgeon General of the Army, was the military co-chair. And I would like to recognize his contributions over those many months. They were phenomenal.

Mrs. DAVIS OF CALIFORNIA. Excuse me, Admiral, could you move your microphone just a little bit closer? Thank you.

Admiral ARTHUR. Is that better? Can you hear me now?

Mrs. DAVIS OF CALIFORNIA. Yes. Thank you very much.

Admiral ARTHUR. You are welcome. Well, thank you again for having us here. We have, I think, given you a very honest appraisal of where we are and some frank talk about what needs to be done in the future in ways different than we have thought about mental health in the past. We have organized the report into four sections. The first talks about building a culture of support for psychological health within the military. The second talks about ensuring the full continuum of care for service members, their families, and those retirees who are affected by psychological issues. Third is the issue of providing sufficient resources, both financial and personnel, for these mental health services. And fifth—I am

sorry, fourth is to empower the leaderships of the military to take on these issues and be proactive, not just keeping psychological health in the realm of our physicians, doctors, nurses, social workers and others, but to take it as a call for line leadership. We present many innovative topics in the report. But I would tell you if you were to ask me what needs to be done today, what are the most pressing issues, I would say it is to identify and treat those who are currently affected.

There are many people who have difficulty getting access, who have issues with stigma that prevent them from seeking psychological health. And I think the thrust of our activities should be aimed immediately at identification and treatment of those who are encountering psychological stresses and are significantly affected by them. I would say parenthetically that having been in combat, I know that no one goes into combat and comes out without being significantly affected by the experience.

There is nothing like it anywhere else in the world. We see combat often in the movie theatres, 90 minutes of combat followed by parades and victory by our heroes. That is not how it happens in real life. In real life, there are challenges, there are frightening times day after day, and they profoundly affect those who are in combat. But there is more to military life than just combat. There are routine deployments, such as on the *USS Frank Cable,* several months ago, where a steam pipe broke, seven people were severely burned, two died. And those people are as significantly affected by their military experience as anyone in Iraq and Afghanistan.

Families, likewise throughout the history of their military career, spend times when their spouses are deployed, their fathers, their mothers are deployed. And those are significantly challenging times that have no similar experience in the civilian sector.

We feel that families are a very, very important part of the psychological health of the service members, and that they need to have the unfettered access to help and resources that will support their military service member. Two very important concepts that have come out of our research were the concept of resilience and the concept of vulnerability to post-traumatic stress disorder (PTSD). Let me talk about resilience for just a moment. We have not—not just in the military, but in psychological circles worldwide—we have not paid much attention to what is resilience? How does one person become affected less than another in similar circumstances? How is it that someone like General Chesty Puller can get five Navy Crosses and continue to go into battle with great courage and great leadership skills while others would be so severely affected that they would be unable to pick up the task?

We have not identified resilience factors. We have not identified which of our service members are more or less resilient. We think that if we can measure resilience in some way and discover those factors which would help us to train our service members to be more resilient we would have better service members, we would have better mothers and fathers, we would have better parents. We would also be able to identify people who have the least resilience, and perhaps ask them to undergo more training than others in how to adapt to the stresses of military life.

Currently, we enter boot camps and officer indoctrination schools and we make everybody a sailor, a Marine, a soldier, or an airman without regard to their particular needs. This is also applicable to post-traumatic stress. There are men and women who come into the military who have had very, very difficult childhoods. We don't assess their prior experiences or their current vulnerability to stress. And I think the second thing we need to do is identify those who either, because of their prior experiences or their psychological makeup, are more susceptible to post-traumatic stress than others. And if we can find those who are more susceptible, then we would like to not put them into situations—I think it is our duty to not put them into situations—where they would be severely affected. We could say to someone, "We would like you to be a jet mechanic," a perfectly acceptable military occupational specialty, but we may not want them to carry a rifle down the streets of Fallujah, where they would be psychologically affected.

I think we have the capability, and we should identify those people. We should also be very, very aware that the individual's response to psychological stress is largely inborn. I think that there can be training that will affect it, but we don't fault people who break legs. We don't fault people who get cancer. We don't fault people who get sore throats. But we tend to blame people who have post-traumatic stress disorder. It is not your fault if you get cancer. It is not your fault if you are severely affected by post-traumatic stress of having been in combat.

It is an extraordinary stressor. And that is the kind of psychological framework that we need to imbue in our leadership. One of the other important concepts in the report is the concept that psychological health is as important as physical health. We currently measure pushups and pullups and how fast can you do a mile run. And they are great markers of our fitness for combat. And we don't often consider, in fact, seldom consider the psychological health of our service members because we don't have good markers.

We would like to imbue in the leadership, the trainers of our officers and enlisted leaders, that psychological health is just as important and should be exercised and trained just as much as physical health, because it will endure one in combat situations. We also focus on access. And that is not just at our military treatment facilities, but it is also in the Department of Veterans Affairs (VA) facilities, it is facilities for our Reserves, who don't have access to military treatment facilities, as well as those who get out of the military and need to come back to us for care, or at least access to the VA system.

One of our recommendations is to ask all of our recruit centers, which you can find at many shopping malls around the country, to be a point of information access and a point of contact so that they—a service member, former service member, can walk into a recruit training center or recruiting depot and say I need some help. Can you guide me? And they will have the literature and they will be able to make some phone calls to properly guide that former service member.

There are some programs which we currently do in the military—we have—I don't mean to give the impression that the military is not way ahead of many of the civilian sector programs in

mental health. They certainly are. But I would frame this in a context of the last 30 years, where we have not been in combat. Not since Vietnam have we had a sustained military combat operation where we have required this extent of psychological services. We have through that 30 years, which is essentially my entire career, we have shaped our system to be exactly what it needed to be each year. And each year of that 30 years between major combat operations we have needed less and less psychological services. Now we need them in times of great stress on our combat arms. And now is the time when we need to take a full assessment of what we can do and beef up our system that has been allowed to atrophy because it hasn't been needed. There are some programs that we do now that are voluntary programs, the Key Wives, the Voluntary Ombudsmen, and other organizations that voluntarily support the military services.

One of our recommendations is that we codify those programs, that we make those programs not volunteer programs that are nonfunded by the services, but that they are mandatory programs that families need to be supported by the services when their spouses, their husbands, their wives, their fathers, their mothers go oversees. It shouldn't be something that is left to volunteers to be done on an ad hoc basis. And last, we have asked for an infrastructure within the Assistant Secretary of Defense's for Health Affairs purview that specifically addresses the psychological needs of our forces. That is someone in his office who will be tasked with overseeing the mental health of our forces, and each of the services having a greater infrastructure for looking at those. When we briefed this report, the Department of the Defense I think embraced it, as evidenced by Secretary Gates' statement that he wanted action plans within 60 to 90 days.

We have also had many meetings with Dr. Casscells and Ms. Embrey, who works with him as a principal deputy. And their response has been nothing short of extraordinary. They want to know not just what is in the report, but what can we do now? What more can we do? Where are the gaps that we need to fill? We have seen great compassion from our civilian leadership, for which I am very, very grateful. Let me stop there, and we will be happy to take further questions. I know Dr. MacDermid has some opening remarks as well. And thank you again.

Mrs. DAVIS OF CALIFORNIA. Thank you very much, Admiral Arthur.

[The prepared statement of Admiral Arthur can be found in the Appendix on page 48.]

Mrs. DAVIS OF CALIFORNIA. Dr. MacDermid.

STATEMENT OF SHELLEY MACDERMID, CO-CHAIR, DEFENSE HEALTH BOARD TASK FORCE ON MENTAL HEALTH, DIRECTOR, THE CENTER FOR FAMILIES AT PURDUE UNIVERSITY, CO-DIRECTOR, MILITARY FAMILY RESEARCH INSTITUTE

Dr. MACDERMID. Thank you. Chairwoman Davis, Mr. McHugh, distinguished members of the subcommittee, ladies and gentlemen, good morning. I am honored to join Dr. Casscells and Admiral Arthur in discussing with you the work of the Task Force. As you know, this group of professionals included distinguished experts

from both military and civilian organizations. For the record, I would like to commend to you the outstanding efforts extended by each Task Force member. I submitted for the record the report of the Task Force, and now would like to draw your attention to four areas of concern that Task Force members believe require legislative attention. First and foremost, additional funding is needed if adequate care for psychological health is to be provided. Task Force members would want me to emphasize to you that the shortcomings we observed in the military mental health system were exposed, but not caused by the protracted conflicts in which the United States is now engaged, and that these shortfalls are unlikely to disappear when the conflicts end. Thus, nonrecurring funds, while helpful, do not allow the fundamental challenges to be addressed.

I also must emphasize that the mental health landscape has many parts. Those parts do not all reside within the Health Affairs arm of DOD. There are many players, and funding attention needs to be distributed across the continuum of psychological health if all of the recommendations of the Task Force are to be carried out. Second, the Task Force found significant gaps in the mental health services provided to both service members and family members that cannot be fully remedied without increasing the numbers of military mental health professionals, including a critical mass of providers in uniform.

This conclusion is based on almost six months of site visits, briefings from military and civilian experts, and review of thousands of pages of evidence. An expanded supply would make it possible to more aggressively prevent mental illnesses and intervene early when they occur by embedding mental health professionals in military units and primary care settings, as well as conducting annual mental health checkups. Additional personnel would allow for professionals to be fully trained in the newest evidence-based treatments and prevention information, and to train military leaders and personnel how to maximize the psychological health and readiness of the force.

Finally, increased numbers would curtail potentially harmful delays and denials of service by reducing waiting times and giving family members the same access as service members to treatment by military mental health professionals who understand the demands of military life. The Task Force notes the necessity of your help in ensuring that aggressive efforts receive funding and are implemented to recruit and retain mental health professionals. Reimbursement programs need sufficient predictability to allow offers to be made to candidates for military mental health training programs and time to compete with other training programs. Realistic access to career advancement must be assured. And compensation packages must be competitive with other employers, especially today the VA.

The third set of issues I would like to bring to your attention pertains to the TRICARE network, the cornerstone of the military health system for service members and family members who cannot access military facilities. It is not without difficulties, however, and some solutions require legislative redress. Patients who receive mental health care via TRICARE have significantly less access to

treatment than patients treated at military facilities. One reason is that TRICARE cannot now reimburse for the treatment of bereavement, marriage difficulties, parenting problems or domestic abuse. TRICARE benefit coverage, and thus reimbursement, needs to be expanded to cover conditions labeled as V codes.

We found that TRICARE reimbursement rates for mental health diagnoses in particular may be systematically lower than those for other diagnoses. Providers told us this at every site visit. The limited hospital data we were able to examine revealed startlingly large gaps. TRICARE officials who testified before the Task Force in December 2006, told us that the average reimbursement for residential drug rehabilitation in the Health Net system is $380 per day, while the TRICARE rate is $80 per day, below the Medicaid standard in some states. Current quality assurance and reporting procedures do not appear to contain sufficient detail about mental health to regularly reveal the severity of the these problems.

TRICARE regulations currently prohibit adoption of some validated therapeutic best practices that are already well accepted in the civilian community. And they also impose the burden of extra certifications on providers who wish to join the network. TRICARE access standards also allow too many delays in treatment and should be revised. For some disorders, these restrictions create a hall of mirrors that effectively eliminates access to treatment.

Let me give you an example. Imagine the family of a soldier deployed to Iraq whose teenage child has developed a substance abuse problem. There is an accepted continuum of progressively more intensive and expensive care for substance abuse treatment that includes outpatient counseling, intensive outpatient programs which provide about 12 hours of care per week, partial hospitalization when a patient sleeps at home and spends the day in treatment, residential care in a special treatment facility, and inpatient care in a medical facility. TRICARE regulations require that outpatient counseling be provided only by counselors working at TRICARE-accredited partial or residential programs, but most people in the United States live too far from one of these to drive to counseling sessions. So the family would need to go up the continuum to intensive outpatient treatment. But TRICARE regulations do not permit coverage of any inpatient—sorry, intensive outpatient treatment at all, so they would need to go up the continuum again to partial hospitalization.

But TRICARE requires an extra certification, which providers find so burdensome that accredited programs exist in only 18 states, none near this family. So they would need to go up the continuum again to residential treatment. Unfortunately, the same problem applies. There are only 17 states with TRICARE-accredited programs, even though facilities offering each of these forms of treatment and accredited by national respected organizations are numerous in every state. For example, there is no TRICARE-certified mental health or substance abuse treatment facility in New York State or in Kansas. So the only service available to this family is inpatient detoxification, the most expensive form of care, and one which has been shown to be ineffective when not followed by other care. While all this is going on, the soldier sits in Iraq, worried and increasingly frustrated about her family.

Finally, I would like to draw your attention to the National Guard and the Reserves, who today are called to serve at levels not previously seen by anyone now in the military. There is no doubt that the challenges of providing health care for such a widely dispersed population are daunting, but there was also no doubt in the minds of Task Force members that the Guard and Reserve members deserve higher priority in both resources and infrastructure for the care of their psychological health. Too often, members of the National Guard and Reserves seek mental health care in their communities, only to find that providers are neither familiar with nor aware of best practices for dealing with the sequela of deployment. Across the country, no one seems to have the explicit ongoing responsibility for monitoring the psychological health status of service members in the National Guard and Reserves, for following up to ensure competent treatment is provided, and for advocating at senior departmental and service levels for resources to provide adequate care. The Department of Defense has made enormous progress in administering and following up on post-deployment health reassessments, but this does not address the ongoing infrastructure challenges.

We made several specific recommendations to address these challenges with new leadership positions, but legislative action is required to implement them.

In conclusion, chairwoman and distinguished members, Task Force members came away from their task with a strong sense of urgency about the challenges that military members and their families are facing today. They are waiting and watching for your response. That concludes my opening remarks. At your convenience, I would be delighted to respond to questions. Thank you.

[The information referred to can be found in the Appendix on page 59.]

Mrs. DAVIS OF CALIFORNIA. Thank you very much.

Secretary Casscells.

STATEMENT OF HON. S. WARD CASSCELLS, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. CASSCELLS. Thank you, Madam Chairwoman, distinguished members of the committee. I will be very brief. I am very grateful to you for taking an interest in this issue and to this committee, which has a track record in supporting the military, and particularly supporting enlisted personnel and their issues. And for taking the broad view. I think as Admiral Arthur alluded to, this is not just a medical issue, it is an issue about communities, families, and a whole culture. And so we know you have got a bunch of work to do here. The Task Force has given us a great start. And on behalf of Secretary Gates, who takes this problem very, very seriously, and has tasked us with getting a response to him by September 12th, I can just say that our pressing need now is to get some surveys done to put numbers on the shortfalls that you just heard about, and then to gather all the ideas we can. And we are tiger teaming this now.

We have had a number of summits on this. We are reaching out to expert help from the National Institutes of Health, Institute of Medicine, and particularly working closely with the Veterans Ad-

ministration to be innovative, to do all we can through leadership, in addition to working with you on what things need legislative redress, what things may need funding. A lot of the data that we need will not be available for some months. But there is no doubt that there are shortages of access to care in some areas. We do have lots of authority to regionalize those reimbursements, but we know we have got to do—this is a tough recruiting climate. And it is tough to retain nurses, psychiatric social workers, psychologists, and psychiatrists. Having said all that, what is doable?

The stigma issue is a really tough nut throughout behavioral health worldwide. It is particularly difficult in the military because of the traditions and the special issues regarding security clearances, weapons clearances, and the absolute importance of being able to rely on the stability of the person next to you. Having said that, we are working closely with the lines, because they do know that we are talking about human beings here, and that we have to have a culture where being able to ask for help is a sign of integrity. It is your duty. It takes courage.

And to overcome the challenge is a sign of your success, and should mark you for leadership, not for, you know, sidelining of your career. And so the line has got to balance this. They have got to figure out, you know—they have got to recognize that having people in the—in service, whether it is as Admiral Arthur says, walking the streets of Fallujah with a rifle, or in some other capacity, having people who have dealt with mental challenges, who have demonstrated their own resilience is a tremendous asset. And Admiral Arthur and Dr. MacDermid have done the service members great favor by talking not just about the stigma and the access to services, but about incorporating psychological health from the beginning of one's military career through deployment, post-deployment, care and rehab if necessary in retirement, and making the continuum.

And the classic sound mind sound body, you know, tradition, which has not been the military tradition per se. But they are really being patientcentric and service membercentric here. And I think—I am happy to say the line commanders are listening. And the soldiers and sailors and airmen and Marines are responding to this. This concept that when your battle buddy is stressed it is your opportunity to grab that person before they do something rash. It is your opportunity to reorient their thinking before they turn inward.

Before I deployed to Iraq last summer, I was myself quite anxious. I woke up one night with a panic attack basically. I had never had a panic attack, but as a doctor, I knew what a panic attack was. And I turned to my wife and said, you know, we have got three young kids, a teenager, maybe I am more needed here. She said we have sent out the invitations for the good-bye party, you are going. Well, that helped me laugh. And then at Fort Bliss I met a psychologist, Colonel Carl Castro, an Army guy, and I mentioned to him I was a little bit nervous.

And he told me that he was a lot nervous. And then he started talking to me about experiences he had had with previous deployments. Well, these kinds of things are relatively easy for mature, middle aged doctors to share. But it is harder for young guys and

young gals. You know, my career is at a plateau. They are trying to make their mark. They really need encouragement to help each other. So you can help us help them in that way.

We appreciate any ideas you have. I wish I had more data. We are in the process of gathering the data to address these issues. But I just want to say we are absolutely committed to this. It is our top priority right now in our office. And in the military health care system mental health is now job one because of the people we lose from the force, because of the pain for the families, because of the long term financial obligations. This is something we have to put at the top of our priorities. I don't expect we will have a perfect solution because we are dealing with, you know, systems that have trouble recognizing that everyone is different. And not everyone is cut out to be a warfighter. But I always tell the soldiers in talking to them, and I start with this quiz. You know, what did Martin Luther, Gandhi, Churchill, Lincoln, van Gogh, Mozart, and a number of athletes, Bradshaw and others have in common? And they go, I don't know. I said depression. They struggled with depression all their life, but they overcame it and they went on to greatness.

So one of our jobs in the military is not to be a cookie cutter, but to find a position in the military where you can shine depending upon your background, your skills, your interests. And we will work with you on that. So there is a lot going on. And I want to take your questions and not belabor you with all our pilot studies and surveys, but please know that we are in this, you know, neck deep right now wading through it. Thank you.

[The prepared statement of Dr. Casscells can be found in the Appendix on page 40.]

Mrs. DAVIS OF CALIFORNIA. Thank you. Thank you very much. I just want to say I am sure my colleagues would agree, I think the sensitivity with which you have approached this issue is quite remarkable. And we are very fortunate to have the application of your sensitivities here today, and I really appreciate that. You know, you talked about it is really a shift of thinking in the services, and even to the civilian sector a little bit. I think that while we have certainly seen great gains in the way we think about mental health care today, at the same time, there are a lot of things that we don't know or that we try and put under the carpet all the time as well in the way we approach it in terms of insuring people who have mental health problems.

And so I think that what we learned over the course of time here should be very helpful. I appreciate the issue of resiliency as well. I know as a former school board member, we used to marvel at the fact that some kids could come out of the just an unbelievable situation and do very well. And you have to ask, you know, what is different here? Who are the mentors, who are the people that made such a difference in these kids' lives? And the same is true when we look at the military, and those who command young men and women in the services, and the tremendous role that they play. We need to try and capture that, you know, bottle it if we can, and to use it in the best way possible.

I wanted to turn for a minute, though, to some of the questions we have, because while the report makes a number of recommendations, excellent recommendations about increasing the number of

practitioners, ensuring an adequate supply of military providers, embedding additional uniform providers in military units, and making mental health professionals easily accessible, I think that begs the question for all of us.

And Secretary, you mentioned this, is trying to get a handle on what are we talking about here in terms of numbers, certainly in terms of cost, in terms of training, in terms of a pipeline of people who are going to be available?

So as you went about your discussions, could you share that with us? Do you have some ballpark figure, I guess, really about how many military providers you are talking about? Is it in the hundreds or the thousands? And how many of those might be new providers, too, that are not necessarily in the services today? But again, how many do we have that are in the services? And that is a matter of tapping some of the talent that is already there. Admiral, would you like to try and address that?

Admiral ARTHUR. You were about to say benchmark, and I think I would rather take the benchmark, Madam Chair. We have recommended that there be a risk-adjusted population-based model approach. Each of the services, in fact each of the units within services will have different requirements. And I think it is up to the services to assess their requirements for their operational units, how they operate, what kind of operations they have, what kind of support they will need. There are some common factors. Embedding providers in operational units I think has been shown by the Navy, Army, and Marine Corps to be very, very good ways of caring for service members in their units.

It is very different when you are in a combat situation or deployed situation and you can go to another member of your unit who happens to be a psychologist or social worker or psychiatrist and express that you have a problem than having to go up to a hospital to access that care. It is a very different flavor. We also have recommended putting psychologists in primary care clinics. Because most of the depression, most of the prescriptions for antidepressant medication in this country are not written by mental health professionals, they are written by primary care providers. And we would like to embed psychologists into those clinics to give them easy access to the environment, to have the patients immediately receive access to psychological support when they present to the primary care provider for depression.

We also tried to introduce into the report the concept that psychological services should be provided wherever the patient and his or her family needs them. And it could be a psychiatrist in a clinic in a military treatment facility, but it could also be the school nurse or the teacher in the grade schools who needs to be better, more adept at identifying the psychological needs of the children of deployed service members. I think wherever our families and service members can get the access to care is where we should provide it. We have downsized our military providers over time because the needs weren't there during times of relative peace. Now we have identified greater needs because there have been greater stress, and we are going to need more active duty providers, more contract providers, more access to TRICARE providers. They should be—yes, ma'am.

Mrs. DAVIS OF CALIFORNIA. Did the panel identify the challenges in terms of recruitment? Because we know that just bringing people into the services in the professions is difficult to do today.

Admiral ARTHUR. It is.

Mrs. DAVIS OF CALIFORNIA. How do they feel that that can be addressed?

Admiral ARTHUR. Well, we would like to be able to contract enough of our services in the TRICARE network and in other areas so that we don't have a large number of active duty people that we need currently but may not need in five years. That said, we feel strongly that the active duty providers, whether they are psychiatrists, psychologists, social workers or mental health technicians, nurse practitioners, many of them should be active duty to treat the active duty service member. And the reason is that active duty providers will have been in the military, they will likely have been in combat or close to combat situations, and understand the milieu, understand the challenges of service members and their families, and can be better prepared than a civilian provider who has had limited access to a military experience and never been in any combat. So we feel that military providers are the best for service members.

But the family members should be able to receive care wherever they feel they would like the access, especially when service members deploy and their spouses and children may go back home to Kansas or home to a grandparent. We feel that there needs to be access within the system, and that would be our TRICARE system for those needs.

Mrs. DAVIS OF CALIFORNIA. Thank you. Mr. Secretary, does that seem reasonable to you? To try and, I think, develop within the services perhaps more people that are going into the behavioral health fields who may not have been thinking about that right now or may be doing something else?

Dr. CASSCELLS. Madam Chair, it does. And we are looking right now at this in a new light. One of the issues is whether—is how we can improve recruiting of psychologists, psychiatrists, for example. But equally important is our recruitment of psychiatric social workers, and the use of other caregivers, other stakeholders, the chaplains, the family practitioners, the internists, the nurses, the first sergeants, platoon leader, lieutenants, for example, and incorporating this kind of approach just as Admiral Arthur has recommended, where everyone is looking after the welfare of other people. We have done it with combat casualty care.

Everyone gets the basic combat lifesaver course before they go over there. Now we must go back and get people to recognize that if your buddy is staring off into space and picking at his food or her food and not laughing at the dumb jokes, maybe that is a sign that that person needs to get back to base and get, you know, three hot meals and a couple of good nights sleep and then a chance to talk to someone confidentially and so forth.

So this kind of thinking has got to be incorporated very quickly, because the recruiting, it is not easy to get people in the military. It seems like every person I am able to help recruit—and we want everyone to be a recruiter these days—there are nine who get part way through the process and it stalls, they get frustrated or some-

thing. So this is a tough issue. We cannot hire 200 Army psychologists, which is the number that General Pollack wants to do, we can't get those overnight. So right now we need everyone to be thinking about this issue and watching out for our service members.

Mrs. DAVIS OF CALIFORNIA. Thank you. If I could turn now to my colleague, Mr. McHugh. And again, thank you for your leadership on this committee, Mr. McHugh.

Mr. MCHUGH. Thank you, Madam Chair. I tried to play close attention. I may have missed the batting of the ball, if you will, but I believe the Chair asked about estimates on funding as such. You have all talked about dollars. This has got to be significant dollars. Were you able to quantify any of the recommendations with respect to numbers of professionals and such, expansion of TRICARE, all of those things? Because at the end of the day, it is our responsibility, and I think a very important one, that we start talking about authorization appropriation.

Admiral ARTHUR. Yes, sir. The committee members didn't specifically have the expertise in financial management. And it was a huge challenge with just the year we had to do this job to collate all of these recommendations. And the committee felt that we would be best to provide a clear vision of where we needed to go, and use that population base risk-adjusted model to allow the services to quantify their requirements and allow the services latitude to vet that through their chains of command.

We didn't feel that we were necessarily qualified to do that. There was so much of the vision that we wanted to project. And I think all of these have to be taken in the context of service requirements and current funding and all of the decision-making that goes on in balancing the funding. So we did not quantify that, but I think that is one of the things that the services, especially through the coordination of the Assistant Secretary of Defense (ASD) Health Affairs Office, will need to be doing in the short term.

Mr. MCHUGH. Fair enough. You have got a seven-page list of recommendations here, and they are broken out into three different categories. Some do require legislation, others are policy and action. I think they all require money, or certainly most of them require money. So let me ask you, and you did define, and Dr. MacDermid defined what she felt were some of the most important things that the Congress do.

Let me ask you to tick off, if you can, if you agree, three or four of the more important off of this list, because my understanding is this is not really prioritized in any particular way, so that we can get a focus in an area and think about translating policy into dollars, which is the ultimate challenge for us, frankly. Would that be possible today?

Admiral ARTHUR. Yes, sir.

Mr. MCHUGH. Okay.

Admiral ARTHUR. Maybe not today, but certainly we can get back to you very quickly. I constructed that list. And that is just a list as the recommendations are in the report. They are just a collation. And we attempted to make—put the X's in the boxes of the things that we can do right now that don't require legislation or policy—

and Dr. Casscells has taken many of those things for action immediately—and to give people an idea of where their responsibilities lie.

[The information referred to can be found in the Appendix beginning on page 161.]

Mr. MCHUGH. Okay. And I agree with that. However, when you can, and you certainly feel free to take this for the record, I think it would be helpful for us to hear amongst this collation of proposals which you feel are the most important so that we can begin to focus on it. They are all important, don't misunderstand me. But out of seven pages, Congress has a tough time focusing that broad a vision, quite honestly. And I would like, at least for my own use, to have a list of some sort of top ten, for example, that you feel are of the greatest urgency for the greatest good. I know over time, all of these are integral to an effective mental health policy, and I am not trying to minimize any. I am just trying to help focus at least my attention.

Admiral ARTHUR. Sure. The things that we will choose are undoubtedly those things that immediately improve access to care for service members and their families, both in the Medical Treatment Facilities (MTF) and in the TRICARE network system.

Mr. MCHUGH. I don't want to prejudice your answer, but that sounds logical to me, and we will await that. And I deeply appreciate it. Dr. Casscells—and I will be yielding back here because we do have other members—I took to heart your comments about recruitment. And the Army has been in the news lately. They failed to meet their last two months' recruiting goals. And the environment has been tough across the board for a number of reasons. And clearly it is compounded when you get into the question of mental health care professionals.

I mentioned a hearing we had on this two years ago, but we have also had budget hearings. And in one of Dr. Winkenwerder's last appearances, he and I had a discussion about some of the military to civilian conversions that have been occurring across the services. Since 2005, about 5,500, a few more, conversions, and about 406 of those were military mental health care professionals. I was concerned about that just from the numerical perspective. Dr. Winkenwerder, I think, said the right thing. He goes, well, "they," meaning the Department, were fully willing to reconsider that. We have put language in the 2008 Authorization Bill in the House version that would freeze those civilian conversions, to civilian conversions for a variety of reasons, not the least of which is the concerns that we have about the erosive effect in the mental health care area.

But in the meantime—and I am sure the Senate in its great wisdom will accept that version if we get a bill—but in the meantime, I am curious, has the Department reconsidered that military to civilian strategy.

Dr. CASSCELLS. Congressman McHugh, we have been talking about this with the personnel and readiness experts. And I have asked them this very same question, because it seems to me that there are some people who should—could certainly be civilian, say a radiation oncologist who will not deploy to Iraq. But when we are asking psychological health care providers to go to the sand and to

take those risks and to be gone from their family and so forth, the civilians obviously cannot do that.

So we have got to have a strong core of people who are willing to go and have dealt with these problems. The personnel and readiness experts who live at the DOD have numbers which suggest that they have not forced conversion of these deployable types of specialists. So I have asked that these numbers be reexamined, because the surgeons are uniform in feeling that we have gone far enough with military to civilian conversions. So this is the kind of honest disagreement which I think just needs data, because if we try to make the decisions by anecdotes, whether they are poignant or stirring or what have you, we are going to lead to a law or legislative redress that we might have to reverse.

And so it would be premature to say whether we are—whether we have gone too far with military to civilian conversions or not far enough. I suspect as we get the data back we will find in lots of specialties we have done all the converting and efficiency wedging we can do. But there are others where there may be efficiencies to be had. And I think the principle that needs to be set out clearly is when the services, which are individual, independent engines of innovation, when they innovate and compete, quality improves, efficiency should improve, and they should retain those dollars for other uses that they identify. This message hasn't gotten out very clearly. And I want to say how important that is.

So we will have more data on mil-civ conversions, but the principle of pay for performance, which is now permeating through the personnel system, is I think a good one and will put us in a good position for the future.

Mr. MCHUGH. Well, we could have a spirited conversation about that particular factor, but for the moment my concern is not across—for the moment my concern is not across the board on military to civilian conversions initially, it is in the mental health care professions. What kind of radiation personnel did you say you don't want to deploy? I missed the second word.

Dr. CASSCELLS. A radiation oncologist.

Mr. MCHUGH. I thought you said psychiatrist.

Dr. CASSCELLS. No, I don't think—we haven't gotten to radiation psychologists yet, although sunshine is a very important therapy.

Mr. MCHUGH. Yes. Yes, it is. That is why I was confused. There are many reasons why, but that is one of them. But in the mental health care area, by all means, I would like to see the data behind that number. The number is troubling, because unlike the broader spectrum of civilian positions, and probably you could argue across most medical health care fields, in the mental health services you don't really have four-dozen categories of workers. I mean, they are rather specific in the task. And so when you get that I think that is important, and those data need to be looked at. And when it is appropriate, I would appreciate you sharing those with us as well. The other thing I would say, though, is deployability is more than a factor in just who is doing what.

You have to hire an individual into a slot, regardless of what that slot is. The fact that that individual is civilian, and therefore cannot be deployed, is a determinant factor. Because that is somebody you aren't going to hire who can't be deployed. I know you un-

derstand. The services do. They have been extraordinarily creative with it over the last several years. So I just don't want that factor to be pushed aside. And I am sure you will give it your consideration. So thank you, Madam Chair.

Dr. CASSCELLS. Yes, sir. Thank you. I agree with what you said, sir.

Mrs. DAVIS OF CALIFORNIA. Thank you for those questions, Mr. McHugh. And Mr. Snyder, again, I want to thank you for your leadership on this committee and for being such a good mentor and friend.

Dr. SNYDER. Thank you, Madam Chair, and I want to say even though I am on a five-minute clock, I think it is great for the country and great for men and women in uniform that you are going to be the chairperson of this subcommittee, and one of the great members of this Congress. Admiral Arthur, I want to pick up and continue on Mr. McHugh's line of questioning somewhat.

On page 41 of the study, the top sentence says, "The single finding that underpins all others in this report is that DOD currently lacks the resources—both funding and personnel—to adequately support the psychological health of service members and their families in times of peace and conflict. Unless Congress provides sufficient new funds to allow adequate staffing to provide a full continuum of services, including enhancing the resilience of the force, prevention, assessment and treatment, few of the recommendations of this Task Force can be implemented." That is the end of the quote.

My specific question for you is, when you were putting this report together did you consider saying that what is really needed is a really strong efficiency wedge?

Admiral ARTHUR. I wouldn't use strong and efficiency wedge in the same sentence.

Dr. SNYDER. Did you consider saying what is really needed is no more funds, but a really strict group or innovative new group and setting in providing the care? Isn't it clear what is going on is we haven't had adequate funding in this area for years? And on top of that, we have had these mandates come down from on high in the Pentagon saying you had to find cuts in services? Isn't that the reality of what has gone on in the last several years?

Admiral ARTHUR. I find myself in an awkward position being the co-chair of a task force and also the Surgeon General.

Dr. MACDERMID. Would you like me to answer the question?

Dr. SNYDER. As Surgeon General, Admiral Arthur, you have been pretty candid about what you thought about the efficiency wedges. The point is made. You all very clearly say that unless more funding comes, few of the recommendations of this task force can be discussed.

The second point I want to pick on—

Admiral ARTHUR. May I make one comment, Dr. Snyder?

My comment before about the 30-year interim between real sustained deployed combat operations has really honed our psychological and some of our other services to be what they are today. We are not capable today of meeting all of the needs we should because we have honed them to where we thought they should be during a long, extended period of peacetime.

So while the assets, the required personnel and other services are not adequate today, it is not because we have not been providing the services that we should have over that 30 years. It is because this is a combat operation that is creating workload for us and a psychological debt of the servicemen and women who are in extraordinary circumstances.

Dr. SNYDER. I think the evidence is pretty clear, the President's budget has been inadequate for more than just the recent year.

Which brings us to the second point. You all say here right after that recommendation, 5.3.1.1 on page 41, "Congress should provide and the military services should allocate sufficient and continuing funding to fully implement and properly staff an effective system supporting the psychological health of service members and their families."

Dr. Casscells, if I was writing that, I would have said, "the President must request and the Congress should fully fund." I hope that you will take back from this report that this committee and the full committee and the Congress is not going to be at all receptive to another President's budget that comes down and says, Oh, by the way, you are $2.1 billion behind from the get-go.

This report clearly says, you all have got to budget better for mental health services. Is that not the take-home of this language on page 41?

Dr. CASSCELLS. Yes, sir, Dr. Snyder, I read it the way you do.

Dr. SNYDER. That is a good answer. Let's stop there.

I yield back. Thank you.

Dr. CASSCELLS. I would just like to say that we appreciate the Congress filling that hole this year with generous support for PTSD and traumatic brain injury (TBI). The President's budget, as you know, must balance lots of important issues. And as someone for whom mental health is a high priority, I have to recognize I probably won't get all the funds all of our providers could want. We will be in a position of being as innovative as we can and deputizing as many people as possible to make mental health a priority; and to recognize that it is not all a matter of psychotropic drugs, and it is not all a matter of psychiatrists, but it is regular doctors like yourself and me and the nurses and everybody who has got to make this part of their business. We need all hands on deck here for this.

Pardon me. I am an Army guy, I shouldn't use those kinds of terms. But—we won't have every nickel that everybody has requested in the military health system I inspect, but we are certainly going to do everything we can to do it.

Let me mention, though, that if you step back a little bit and look at our rates of PTSD, compared to Operation Desert Storm or Vietnam, we are actually doing better. If you look at our suicide rates compared to then and to the civilian world we are doing better. In Vietnam, as you recall, the military suicide rates were almost double civilian. We are below civilian and we have stayed below. The rates of soldiers getting involved in doing dumb things when they come home or malicious things are gratifyingly low.

Divorce, despite the enormous stress of this conflict and the protracted nature of it and the anguish about the whole mission, particularly among the American population stateside, the divorce rate

has maintained flat. I think it is a tribute to what the Army, Navy, Air Force and Marines have done in psychological resilience and in a community of caring that they are beginning to establish. We are developing service members who live a rubber-band defense; they stretch but they don't snap. We are developing soldiers who, by and large, are stronger, but not brittle; who are tougher, but not hardened.

I think there really is—when you step back and look at previous conflicts about the civilian world, there is a lot to be proud of. Having said that, we have got to improve, and with your help we can.

Dr. SNYDER. I hope this page 41 is something Secretary Gates and Dr. Chu and the people of Office of Management and Budget (OMB) have already read, because Congress just can't tolerate the kind of budgeting that has gone on with the military health care budget the last two or three years. Thank you.

Mrs. DAVIS OF CALIFORNIA. Thank you, Mr. Snyder.

Mrs. Drake.

Mrs. DRAKE. Thank you, Madam Chairwoman. First of all, congratulations on your chairmanship, and I look forward to your leadership.

Thank you all for being here, and I think you have all said it, that you know this subcommittee and this committee and this Congress agree with you that mental health issues are extremely important, and we want to do the best job we can do. And we want to find the money to do what needs to be done.

My first question is, in the *New England Journal of Medicine* they make the statement that 16 percent of our returning soldiers and Marines returning from Iraq have experienced mental health issues.

Do you agree with that number? And how do you think that compares with other conflicts? Or have you seen that number and given it any thought?

Admiral ARTHUR. I haven't seen that article, ma'am, but I can tell you that, as we expressed before you came in, no one, in my opinion, goes into combat and comes out without being significantly affected by the experience. And it runs the gamut, the spectrum, from post-traumatic stress disorder to just post-traumatic stress effects.

The entire spectrum is treatable. Just because you are labeled once as having a disorder doesn't mean that is a forever diagnosis. There are many people who come into the services already experiencing post-traumatic stress disorder. In the civilian sector, the rate is not in double digits, it is in single digits; but certainly people going into combat are significantly stressed by the experience.

Mrs. DRAKE. Have we ever looked at what is the comparison with our, I would call it active duty, regular duty, as compared to Special Operations Forces, when they return? Is there a greater percentage in either of those two groups?

Admiral ARTHUR. The correlation is really in the proximity to fearful events, proximity to combat. If you are in Kuwait in a relatively protected area, you have fewer post-traumatic stress issues than if you are in Fallujah or in Baghdad and going on the streets every day carrying a rifle; you are on the convoys wondering if you are going to be blown up by an improvised explosive device (IED),

or if you have seen somebody who has been killed or wounded, you have been affected by an IED blast. It is your proximity to the threat.

There is also a correlation with the resilience and the leadership qualities of the commanders, both the officers and enlisted members of the battalions, and the folks who are out there. Those who have leaders who are very resilient, very charismatic and very caring about their service members will see less post-traumatic stress disorder in their subordinate troops than those who are themselves significantly affected.

And that goes back to our concept of resilience and how we can perhaps shape the military training efforts to increase the resilience of all of our service members. But especially to focus our leaders on the importance of maintaining and improving psychological health as well as physical type of fitness.

Mrs. DRAKE. But my question on that was—in my own mind was, and you mentioned it in the beginning—was about training. You said it again.

Also, what is the mission and what is the expectation of that service member as they go into that battle? This is a big issue at home. I have talked to a lot of people about how we are going to deal with this. And one of the young men that has come back, he is guard, said that they were offered their exam where they could go home with their unit. So that seemed odd to me because, of course, you are going to say, Why would I wait two or three days here; I am going to go home with my unit. And it seems to me that we should rethink how we do that.

And maybe, just tying this to what another mental health professional in our city told me—she said, "Some come back by ship, Marines will come back with a Navy ship, and they have got that time between the battlefield and returning to their regular lifestyle to deal with some of the issues to recover."

You have talked about it—you did, Secretary Casscells—about getting some sleep, getting some food, being warm or cooling off if you are real hot. So I wondered if we have looked at that too. What is the difference if maybe people, rather than being given the choice, Are you going home today, or are you going to stay two or three days for this exam, if we don't give them a choice and we keep them or the longer trip of a marine to come home on a ship?

Admiral ARTHUR. Many units now are starting the decompression cycle in theater, and they are taking some time—days, a few days or many days, to decompress, have people come in and talk to them and try to go through that process.

One of the things we did mention in the report is, the immediate survey of people just coming out of theater about their stress reactions may not be very productive. Because we have heard many, many times, very consistently, that, Gosh, I am afraid if I check "yes" on anything, I won't get to see my family today, and I want to see my family today.

So one of our recommendations—and the services are already doing this—is to rethink the timing of that and to, especially for Guard and Reserve, rethink the reunification of the families and getting back together as a group, not taking six months off, but come back together in a month or three months, not to drill nec-

essarily, but just to get back together and form that unit integrity and go through the decompression process.

So there are a lot of things that we have thought about along those same lines.

Mrs. DRAKE. Thank you very much.

Thank you, Madam Chairwoman.

Mrs. DAVIS OF CALIFORNIA. Thank you.

Ms. Sanchez.

Ms. SANCHEZ. Thank you, Madam Chair. It is great to see you in that seat.

And thank you to our Task Force here. We really appreciate the work that you have done. We have been battling this whole issue of mental health, not just in the military, but as you know, also in just the general civilian population. We continue to have a bill in the House on mental parity and just can't seem to understand how important this whole issue of mental health can be to the future of our country.

And, of course, we have been working on this committee. I am glad that you acknowledge that this committee in particular has worked on this issue since before the war began. But, of course, we are very worried about this.

And I know that we have been pushing for more funds and programs, and I want to associate my words with both Mr. McHugh and Chairman Snyder with respect to how important it is to get the President to put funds and to acknowledge that this is a need, this is a real need, for our country.

But I want to go back to something that is important, which is the whole issue of stigma, which of course, you bring up in the report—mental stigma, health stigma. It is difficult in a civilian situation, and I figure it is even more difficult within the military.

I happen to have two friends, two family friends who are in the military. And one got—well, one particular soldier got out because she went to seek mental health services and had to go once a week and finally had to tell her superior why she was missing three hours in the morning on a Tuesday or what have you. And the next thing she knows, where she has had perfect promotions each and every time, the next time she gets passed over. And really when you look at the record it is due to the fact that in the writings of her superior, he commented that maybe she wasn't ready to keep going up the ranks.

And then I have a personal friend who is enlisted and has seen a dramatic change in the way the perception is toward him in the units he has been with because of having gone to seek mental health. What do we do to change that? I mean, I am reading here where you say structurally it is not really in the structure. I mean, under your combating structural stigma. But the reality is, it is in the military. This is.

Once you turn yourself over and say, I need to get some help for this, whether it is something from your previous life or whether it is something because you came back from the war. And you are seeing this when people find out it affects your career.

What do we do about that? This is not just about money. People don't want to go and seek help if it is going to affect their career.

Admiral ARTHUR. Yes, ma'am. Much of this is a leadership issue. I expressed earlier that if you get cancer, even if you get lung cancer and you smoke for 40 years, we don't blame you. We feel compassion for you and your family. Smoking is a habit, it causes lung cancer, but we don't blame. Yet we will blame people for having a natural reaction to incredible psychological stress.

Some are more capable than others. If you look at the military culture, all our advertisements, all our training point to people who are hardened. And I would ask, who else would go and walk down the streets of Fallujah carrying a rifle, or aim his or her F–18 at an adversary and know that she would be victorious, even though the odds are 50–50.

Ms. SANCHEZ. How do we change it? How do we decide to change it? How do we measure that change going on within our ranks?

Admiral ARTHUR. We change it by focusing our leadership on psychological health, and that the psychological health of our service members is as important as physical fitness, the psychological fitness. And we need to have some leaders stand up and say, "Boy, that was a frightening evolution that we just went on, you know, I am still shaking; I think I need to decompress, how do you feel about that?"

If a colonel or a first sergeant, sergeant major gets up and says, "Boy, I was scared, I have been so scared, and others are going to say, no problem, I can handle it, when they really can't."

As Dr. Casscells was saying, "We are all frightened, we are all changed by the experience." And my wife told me when I came back from combat in Desert Storm it took me six months to get back to baseline. She didn't say normal, but she said to get back to yourself, to get back to stop being inward, to stop being a bit sullen, to stop looking over my shoulder at loud noises. These are things that affect normal people. But our military needs some extraordinary people who can walk down the streets of Fallujah and know they can be victorious. And how you balance those things is a matter of leadership and recognition that even if you have post-traumatic stress, it is not your fault.

The other thing we can do that I mentioned before is to identify people who are most vulnerable, they are most vulnerable to post-traumatic stress, and not put them into those situations; give them military occupational specialties where they can contribute, but not be exposed to those extraordinary stresses.

But we have to be open to the fact that normal people will get lung cancer, normal people will get post-traumatic stress disorder. Neither of those disorders is their fault.

Putting on a uniform means you are a patriot, and you should be celebrated for your patriotism. And I think once you get to see psychological health as a component of each person's military specialty and something that can be trained, something that can be understood and rationalized, then we will destigmatize—but never entirely. Stigma has to do not only with other people's impressions of you, but your own self-worth. And everybody is different, everybody has different self-worth, and it will be difficult to totally do away with stigma.

But if you look at what the military has done with the integration and the racial equality, with the equality of women's rights

within the services—we have women flying in combat air patrol now, women commanding ships, and we think nothing of it. It is just how we do business.

I think to identify this as an issue that will be just how we do business in the future, we can do this. We are the military, and we have a society that we can better control than the general population. So we have handled very, very difficult social issues, and I think we can tackle this one too.

Ms. SANCHEZ. Doctor, did you have a comment?

Dr. MACDERMID. I was going to add one thought which has to do with what you mentioned about parity, and the example that you gave is a very good one. We suggest in the report much more extensive training for military members and for military leaders. And Admiral Arthur correctly points out that we each have a responsibility.

But all of us also are affected by stigma, and so we have to teach others, and we ourselves have to challenge ourselves. So when we write in fitness reports about someone's mental health, we have to challenge ourselves. Would we write the same thing if they had broken their leg and it was now repaired? Are we thinking about mental health in ways that acknowledge that illness can be treated, illness can be prevented, illness can be recovered from?

And so the parity issue that you raise, I think, is very, very important. And as you go on to review future budgets and future programs, it might be a very good question that you can ask when mental health is being treated differently from physical health. Why is that? Every time we think it is important to educate someone about physical health, that is also a moment that we can train someone about mental health, and perhaps we should be doing it.

Ms. SANCHEZ. Thank you.

Mrs. DAVIS OF CALIFORNIA. Thank you.

Mr. Jones.

Mr. JONES. Madam Chair, thank you and congratulations to you as well.

I wanted to be here for the full hearing. And I apologize. It is my fault. I didn't get here. I got here for the last ten minutes. But I look forward to carefully reading your recommendations and thank you for being here today.

I want to very quickly piggyback on what Ms. Sanchez was talking about. I hope you can—Admiral Arthur, I hope you can change the mind-set; and to the doctors to your left and right, I will tell you a quick story that is just ironic.

Three years ago I flew down with then-Secretary of the Navy Gordon England. And we were addressing, or he was addressing, I should say, a company of Marines that just got back from Iraq. And the company commander was standing at the podium with him, and I was on one side. And I will never forget, Gordon England said, If any of you Marines have any questions, I would hope you would step forward.

And the second Marine that stepped forward said, I need some counseling; where do I go? You could have heard a pin drop. Secretary England didn't know how to respond. The company commander was fumbling, trying to get an answer out. And I felt so sorry for the Marine, for Secretary England, and really, the com-

pany commander. And I know that they do at the theater, at the war front, try to help them understand.

But again, Ms. Sanchez is right; and I don't know if it will ever change or not, but I hope the Congress and people like yourselves, we can bring a different attitude. Because I am afraid—and your points have been well made, that we want to have men and women from Iraq and Afghanistan—especially Iraq, that they are going to need mental health counseling for 30 years.

It is not going to end. This is what I want to get to, and probably it is in your report, the families. I have told this story—my colleagues on the dais probably don't want to hear it again, but this has touched my heart so much that I will die and never forget this.

A year ago I asked to be at Camp Lejeune at the grammar school to read Dr. Seuss to about ten kids whose parents are over in Iraq and Afghanistan, and at the end of it—I had trouble reading Dr. Seuss, by the way. I told the teacher, I apologize I couldn't pronounce some of those words. And she said, don't worry about it; I have trouble too.

But anyway, I was letting the kids talk to me with questions or statements that they wanted to make. And it was pretty much, "Have you been to the zoo? What do you all do in Washington? Have you seen the President?" those kind of statements.

"I have been to Washington," a child said that.

But this one kid, and I never will forget it, he was just wanting to make a statement, and the statement was, "My daddy is not dead yet, my daddy is not dead yet." And I looked at the six-year-old child, and then I looked at the teacher. I don't know how I responded, but I responded, and it doesn't matter what I said.

But my point is, we know we have mental health counselors in the military, on the bases. But I am really concerned that the children, I don't know what type of program and certainly it is up to the teacher to say, I think this child needs to talk to a counselor, but I think that it may not be that these children have any problems 10 or 15 years from now, but I am very concerned about the children who have their moms and dads deploying 3 and 4 and 5 times.

You can't get away from the news. Whether you are for the war or against the war, you can't get away from the news.

But this kid just really touched my heart; I will never forget it, "My daddy is not dead yet." I mean, if you heard that child say that, would that bother you?

Admiral ARTHUR. Congressman Jones, first, thanks for your support of the Marines. You supported me at Cherry Point when I was in command of the hospital there.

Mr. JONES. Yes, sir. I enjoyed seeing you, sir.

Admiral ARTHUR. I have repeated that story dozens of times already when I heard you say that in a full hearing in which I testified. It profoundly affected me. I get goose bumps now. I repeated it to the Task Force. And that story is the reason some of these recommendations are in there, that access anywhere, that the family members need them.

Particularly, there are some recommendations and some prose in there about the teachers. And not just the teachers in the DOD schools at Camp Lejeune, but teachers around military bases that

we can provide classes, educational material on what is a military family, what are the stressors that these young children are encountering with their military families; to train the school nurses, the guidance counselors and others, so that they get access to those mental health services—they don't have to go to a hospital; they get them—that teachers are more in tune to what these young, growing children are going to need.

And that story is the reason that those are in this report.

Mr. JONES. Thank you, sir. That is very encouraging. I look forward to reading the report. Thank you, sir.

I yield.

Mrs. DAVIS OF CALIFORNIA. Mrs. Boyda.

Mrs. BOYDA. Thank you, Chairwoman, I am so pleased to say. Thank you for your leadership.

Chairman Snyder, I certainly have learned a great deal under you as a freshman, but I am of course thrilled to see a woman sitting in the chair. So, congratulations.

I represent three districts or three military bases in the Second District of Kansas. And we are all telling our stories, so I will tell one of mine that touched my heart as well. And that was just speaking to a colonel who was stationed there. And this good, tough guy, you know, cares about the military and loves the military. And when we started talking about mental health services and things, and I was really questioning him about what we are doing, the man teared up and said, My son is serving over in Iraq right now, and I worry about his mental health.

And his point to me was that everyone is very well aware of what is going on; that so many of our officers are needing the resources, that they are worried that we don't have the facilities to take care and the resources to take care, as they are active duty and certainly as they are in VA.

So I had a couple of specific questions on Kansas. As I understand, and I apologize for having been late, but we don't have accredited health care, mental health care in Kansas. Can you speak to me specifically about what that means and how we are taking care of that?

Dr. MACDERMID. Sure. I am certainly not the most expert person on TRICARE in the world, but I will tell you what I do know.

The specific type of treatment that I was referring to was residential and partial hospitalization treatment for substance abuse in particular. And even though that is not necessarily a large number of the patient population, it is obviously one that is a big concern if you have a teenage kid, during deployment, who needs treatment. It is going to be pretty hard for somebody to drive their kid every week to a neighboring state, which is what would be necessary in Kansas.

Part of the issue is that TRICARE has very high standards, and for some services, TRICARE imposes an extra accreditation requirement. And providers testify to us that when that is combined with the low reimbursement rates for particular mental health diagnoses, it is a losing proposition and it is just not worth it.

Mrs. BOYDA. Are we working to untangle that web or what are we doing about that?

Dr. MACDERMID. That is a question I cannot answer. I shall look to my colleagues.

Dr. CASSCELLS. Congresswoman Boyda, on behalf of TRICARE, I would have to ask for your forbearance to get back to you about the specific services in your district. But please know that we have opportunities to make reasonable adjustments and reimbursement for services if we recognize an inadequacy.

And General Granger who runs this program, runs TRICARE, he responds usually within 24 hours to a query, and not just from a Congresswoman. Patients send me e-mails, and he gets on them immediately and we look into it.

And sometimes the anecdotes are out of date. It is from someone who tried to get a referral from a psychologist a year ago, when there was a temporary shortage, and they have now got enough people contracted with TRICARE. Or it is someone who didn't realize that they could go to a provider more than 30 miles away.

[The information referred to can be found in the Appendix beginning on page 162.]

Mrs. BOYDA. I hear about TRICARE reimbursements all over the place and how that really impacts access. In your opinion, or could I have some feedback at some time, is the accreditation on top of that? Is it a good balance? Are we pleased with that balance when we look at it today, or does that balance need to be looked at?

And then as we—again, I apologize for not having been here at the outset, but where are we with working with the VA and not only making that transfer seamless, hopefully, but to utilize resources and co-utilize?

Dr. CASSCELLS. Thank you. I misunderstood your question. The accreditation is a tough issue since we responded to Congress's calls for quality by raising the bar. And this has had the effect of limiting people's access to less traditional providers.

Mrs. BOYDA. So when was the last time we actually looked at that balance?

Dr. CASSCELLS. Well, we have a big survey under way to look at this. And we had a number of complaints. For example, in the State of Washington, there has been an issue where some of the less traditional providers, maybe they are nutritionally oriented or oriented to Eastern approaches to therapy and have not been credited. So we are looking at ways we can utilize those providers.

So we are reexamining this issue because standards evolve, and the needs of the service members evolve; their preferences evolve, and we increasingly are trying to recognize people have legitimate preferences.

The traditional way in the military, of course, is a bunch of 18-year-old guys in their underwear, and they all get shots, and they don't get a chance to ask what shots they are getting. Well, this is really changing. People have rights. They have choices. They have preferences.

We have much more diversity in the services than was true a couple of generations ago, and people are there by choice, so we have to honor choices. And that is the kind of thing that doesn't necessarily require legislation, it doesn't necessarily require that Congress throw money at it. It is a leadership and cultural issue. So we are struggling through that. Cultural change is slow.

But if I could just point out a couple of things, because your committee has taken a broad view in the past under Dr. Snyder. I have looked back through the history of the committee, and I know that it has not just been medically focused, which I think is terrific, because so many things impact mental health.

I am still kind of focused on theater, because I just got back from there a few months ago, but I am going again for a visit this coming month. But when General Casey abolished alcohol in theater, you know, that had a big impact, I think. But we can't say, because we don't really know how many of our problems were alcohol related in Desert Storm. We learned from Desert Storm that we needed more data, and even in this conflict we haven't gotten all the data we need.

What about when guys and gals have cell phones in theater? They can be assured that their mom and dad are okay and their kids are okay. But then you get the phone call, like I did, that the kids' grades are going down. You are glad your kids are okay, but you are not happy about their grades going down while you are deployed.

So, on balance, I think it is good not to have alcohol in theater. I think it is good to have cell phones.

Cultural change is slow, but some things are happening. The Army yesterday announced that they are going to launch a big program, a required educational program about stigma and psychological care. This is going to be the biggest, most intense program since the sexual harassment program. Within five days they put together a program in All Army Activities (ALARACT) where everyone got training.

Now, if this works in the Army, we obviously are going to ask the Navy and Marines and Air Force what they think of it, because this is unprecedented.

Other little things, if I could address Ms. Sanchez's—I know she is gone—question of stigma. May I just say a couple things about that, Madam Chair?

As you leave theater, you fill out the post-deployment health assessment on a Personal Digital Assistant (PDA), you know, a BlackBerry in theater. And we are changing that now so that it says at the top, if you give an answer suggesting you are highly stressed, it is okay, you will still get on the plane; we are not going to keep you in the sand, it is okay to fill it out honestly.

Second, at six months not everyone has gotten back to us on the post-deployment health reassessment. So we are trying to build a network of people who would contact those people; maybe it is retired personnel, maybe it is chaplains, volunteers. We will be talking to the military families' organization about that, because it is not enough that half the people fill out the six-month post-deployment health reassessment. We need everybody filling that out.

Another issue I have asked the line commanders to look at is, when your battle buddy dies in theater—and this is what I learned at Fort Bragg recently—the spouse really would love to have someone come home with the deceased and say how he or she died. And they want to know, of course, that the person died quickly, painlessly, that they were doing their duty. They would like to know the circumstances, they would like to visualize it.

And it is very helpful, of course, if the battle buddy happens to have something to say about how they were doing and felt good about things and talking about their family. That helps enormously. It helps the family put things to rest; and it also helps the battle buddy, who otherwise feels that they have not done everything they could.

So the line commanders are rethinking this, I am proud to say, and I have asked them, "Please let the battle buddy go home with the deceased and attend the funeral and speak," and so forth.

Last, whatever the committee can do to nudge the military health system in the direction of patient privacy and patient choice, these are important. And I am not sure they are financial, but they are cultural. In the military, the confidentiality of talking to your chaplain is absolute. The confidentiality of talking to your doctor is not; the line commander is entitled to get those records. I think it is worth reexamining.

Thank you.

Mrs. DAVIS OF CALIFORNIA. Thank you very much. As you can see, we are going to have some votes. But I want to take a few minutes to wrap up for everyone's benefit. I believe it is one 15-minute vote and two 5-minute votes.

You have all been terrific. I have really appreciated listening. We obviously haven't gone by the clock today so much, because it has been important to have the breadth of your comments.

I had the opportunity to just come back from Iraq. A snapshot always; it is not something that you can do any major survey by. One thing that I did pick up in numerous conversations with troops and walking around was basically that people were more open to the issue.

I can remember, and even when I have traveled in my own community of San Diego and gone to Balboa Hospital and asked to speak to a number of troops that were there—I have gone to the mental health wards both there and at Walter Reed—and it was kind of like nervousness around even having a member want to speak to the troops in that regard.

And I certainly have a better sense of openness now. If you asked a question, people talked about it, and commanders said how important it was for them to sensitive. They didn't want to have full responsibility; they wanted to have somebody nearby. They wanted to be sure that if somebody brought up an issue and they needed help, that they were seen, that there was somebody there. They wanted to have information, but they didn't want to be the one who had to deliver any kind of therapy, if you will, in quotes.

I had a different sense this time, and maybe because I was a little bit more focused on it, as well, but a real openness. And maybe that is a good thing; maybe we are moving in that culture.

One of the things I wanted to just come back to very quickly, because we are going to want to look at the priorities in terms of legislation and what we can do. One of the issues that I believe Dr. MacDermid brought up was the derating and how that is done, how we are able to capture, I guess, value-added even, if you will, on forms for the DOD and for TRICARE.

We know that when we begin to assess the relative value of a unit-based system, how much money needs to be there for the num-

ber of individuals that are being served. Do we take into account the fact that people have had multiple deployments? Are we really understanding what that means not just in terms of the quality of care, but the number of visits, in fact, that might be required? Is that part of the system today? How do we readjust that? Is that something that you think we should be looking at? Would that be one of the priorities that you would suggest?

Admiral ARTHUR. Yes, I think it should be prospectively. It is not only the number of deployments. But as I said before, the amount of combat stress, the time between deployments that they have. And there are many, many factors that are involved. How close are you to the actual fearful events that cause post-traumatic stress? Yes, all those factors are considered.

Dr. MACDERMID. I would like to add that one concern I have is that I am not sure that we are gathering enough data to know the answers to your questions with regard to families. Our report contains a number of recommendations about research related to families. Their needs have not figured prominently in the lists of funded projects in recent years, at least on the medical side; and it is self-serving of me to point it out perhaps, but I think it is relevant to your question.

Mrs. DAVIS OF CALIFORNIA. Thank you.

Mr. McHugh, did you have a wrap-up question?

Mr. MCHUGH. A wrap-up comment, Madam Chair. Thank you. And I share your appreciation for the panelists.

And we look forward to a very grand body of work, because this is a grand challenge. And the Task Force report, I think, in the seven pages it lists very, very adequately all of the important points we need to cover.

The only other thing I would say is, I was heartened, Dr. Casscells, that you are looking at the issue of accreditation, TRICARE accreditation, on mental health beds. The fact that the State of New York—and I imagine Kansas is in a similar situation—but the fact that the State of New York does not have any of these facilities that could be possibly accredited suggests that accreditation needs to be reexamined. Jayco is the widely accepted process for that; and TRICARE goes beyond, and I understand the need and the interest of TRICARE maintaining the highest possible quality. But I think we are in a real bind here that can be worked through. So I commend you for that.

The other thing I would say is, part of the problem we have now is that military treatment facilities don't have these beds any longer, because at that time the judgment was made the civilian community can do it. Well, the civilian community isn't doing it. It goes back to TRICARE. But it is a cautionary tale about military and civilian conversions and writ large, if you will.

So with that editorialization, again my deepest thanks.

And again, Madam Chair, congratulations, and a pretty good job on your first voyage.

Mrs. DAVIS OF CALIFORNIA. Thank you very much.

You all made this morning very beneficial to all of us, I think; and your insights are greatly appreciated. But we look forward to the next steps. And I think part of the question is, at what point are we able to come back and really put the numbers in place to

understand better really the dynamic from leadership's perspective, from filling in those positions, in fact, if that is what is needed, having people who actually are accountable for what is happening in this particular arena that we can look to. And that would be very important for us.

And I wanted to ask you, do you have a time frame, Secretary Casscells, in terms of when we will begin to better understand the numbers and how we can work with those?

Dr. CASSCELLS. Madam Chair, we will have a set of numbers for the Secretary of Defense; September 12 is my deadline. I suppose he will study that, and he has a six-month period to get back to Congress.

He has stated very clearly, he intends to do it in half that or so, so I think he will have had a chance to look these numbers over by the end of September and have some thoughts about it.

Mrs. DAVIS OF CALIFORNIA. Thank you. We look forward to bringing together a piece of legislation that addresses all the good work that you did. Thank you very much for being here.

[Whereupon, at 11:48 a.m., the subcommittee was adjourned.]

A P P E N D I X

JULY 12, 2007

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

JULY 12, 2007

Chairwoman Davis
Opening Statement
Hearing on Mental Health
July 12, 2007

The purpose of today's hearing is to receive the findings of the Department of Defense Task Force on Mental Health. The Task Force was mandated by Congress in the 2006 National Defense Authorization Act, and was charged to both assess the military mental health care system and to make recommendations on how to improve it.

We are fortunate today to have both co-chairs of the Task Force with us: Vice Admiral Donald Arthur, who is also the Surgeon General of the Navy, and Dr. Shelley MacDermid, the Director of the Center for Families at Purdue University and also the Co-Director of the Military Family Research Institute. We are also fortunate to have the new Assistant Secretary of Defense for Health Affairs, Dr. Ward Casscells, in his first appearance before the Military Personnel Subcommittee. Admiral Arthur and Dr. MacDermid will speak to the findings and recommendations of the Task Force, while Dr. Casscells will be able to tell us how the Department of Defense plans to improve the provision of mental health care. Welcome to you all.

My understanding is that our panel will make brief opening statements so that we may quickly get to members' questions.

All of the members of this subcommittee are unanimous in their support for our service members and their families. With multiple, long-term deployments now the norm for our military, mental health is now more important than ever. Whether on the battlefield or back at home, the psychological resilience of our troops and their families plays a central role in the effectiveness of our armed

forces. The Final Report of the Task Force on Mental Health makes it clear that substantial changes need to be made to the Military Health System to provide the proper care at the proper time and the proper place

Let us be clear that this will be a long process. It will take a sustained effort for the foreseeable future to make the required changes to the Defense Health Program. We will face challenges in recruiting or training additional mental health providers. We will encounter institutional resistance from those who think the current system is adequate. Finally, we will face fiscal challenges. These structural and cultural changes will require significant and continuing financial outlays. Improving and sustaining the mental health care system will be expensive, but we simply cannot afford not to.

Finally, let me also mention that this may be Admiral Arthur's final hearing before the committee. He is retiring next month after 33 years in uniform. Thank you admiral, for your many contributions and your faithful service to our nation.

Mr. McHugh, . . .

Opening Remarks – Congressman McHugh
Military Personnel Subcommittee Hearing
Mental Health
July 12, 2007

I begin my comments by congratulating Ms. Davis for being selected as the Chair of the Military Personnel subcommittee. Chairwoman Davis has served for many years on this subcommittee and brings her insight and compassion for service members and their families to her new role. I look forward to working with her.

The issue of mental health is not new to this subcommittee. Two years ago, we held a hearing on the mental health services that were available to our military personnel and their families. I am struck, however, by the difference between the testimony then and the testimony we will hear today. Then the testimony expressed a sense that DOD was prepared to meet and address the mental health challenges of the global war on terrorism. Today, the testimony will reflect the findings of the

task force that found significant shortcomings in the Department's efforts. I can't help but wonder why the conclusions of the task force weren't evident to the Department of Defense two years ago.

With that being said, I want to acknowledge the members of the task force for the Herculean effort they put into their assessment of the Department's mental health services and the detailed findings and recommendations for improving the mental health programs and policies that support our troops and their families before, during and after deployment to Iraq and Afghanistan.

It is clear from the task force report that although there are a myriad of programs to assist service members and their families deal with the emotional trauma of combat, the Department of Defense has not invested the resources and funding required to make the necessary services available when and where they are needed.

I also think that the task force's conclusions suggest that the challenge of successfully dealing with the emotional stresses of combat, with traumatic brain injuries and PTSD is more than just a DOD challenge. I believe that to comprehensively address the full scope of the issues, a national effort will be required that will involve DOD, the Department of Veterans Affairs, and a large segment of the civilian mental health community.

I look forward to hearing from Dr. Casscells this morning, how DOD plans to close the gaps identified by the task force.

THE MILITARY HEALTH SYSTEM

PREPARED STATEMENT

OF THE HONORABLE S. WARD CASSCELLS, MD

ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

ARMED SERVICES COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

JULY 12, 2007

NOT FOR PUBLIC RELEASE UNTIL
RELEASED BY COMMITTEE

Mr. Chairman, distinguished members of this committee, thank you for the opportunity to discuss the fact that psychological health care is a major issue for our Service members, and their families, who make great sacrifices in the Global War on Terrorism. Thank you also for the tremendous support you have provided to military medicine and the people we serve. Today, I will give you a snapshot of where the Military Health System stands on a number of psychological health initiatives for Service members and their families. The following is a snapshot of how we will try to improve.

The Department of Defense (DoD) has a broad range of programs designed to sustain the health and well-being of each and every military and family member in the total military community. All Service members must meet the particular standards of their Service branch upon entry. These include rigorous requirements for such career fields as aviation or other special operations. The Services enhance a member's preparedness for operational challenges by continuous, realistic specialized training in each career field. Detailed, rigorous training within an organizational unit engenders resilience, creates confidence and fosters esprit de corps that ultimately serve as protective factors against the multiple stressors Service members encounter in the course of combat and military operations. The organizational culture, military values and traditions, effective leadership, peer and commander support, competence that comes from training, and confidence in military equipment and weaponry provide a foundation of overall well-being on which community and health care support rests.

During a Service member's career – and particularly before, during, and after a deployment – the Military Health System provides a wide array of programs to active and Reserve component Service members and their families. The Military Health System continuum of care encompasses the following: 1) prevention and community support services; 2) early intervention and prevention to reduce the incidence and chronicity of potential health concerns; 3) Service-specific deployment-related preventive and clinical care before, during and after deployment; 4) sustained, high-quality, readily available clinical care, along with specialized rehabilitative care for severe injuries or chronic illness, and transition of care for veterans to and from the VA system of care; and 5) a strong foundation of epidemiological, clinical and field research.

DoD also provides a broad array of support systems and services to the military community. Services available at military installations include health and wellness programs, stress management, family readiness and community support centers, family readiness groups, ombudsmen, volunteer programs, legal and educational programs, and chaplains of diverse faiths, among many other community programs.

Early intervention and prevention programs include pre-deployment education and training, suicide prevention training, Military OneSource, the Mental Health Self Assessment Program, National Depression and Alcohol Day Screening, and health fairs. To increase the awareness of DoD's outreach and prevention programs available to the Reserve component members, DoD formed a strong partnership with the VA and other federal agencies as well as professional advocacy groups.

The Military Health System repeatedly assesses medical conditions that may limit or disqualify deployed Service members, while offering screening, assessment and educational programs across the entire deployment cycle. A spectrum of prevention, stress control, and psychological health care is available in theater. In November 2006, we clarified deployment limitations for psychological health conditions and limitations for those prescribed psychotropic medications to ensure consistent standards across all branches of Service.

We initiate a post-deployment health assessment (PDHA) and education process upon a Service member's return from deployment to identify health concerns that might have arisen since deployment. We perform a post-deployment health re-assessment (PDHRA) with additional education 90 to 180 days after deployment to identify any issues that might arise in that time frame. In addition, we conduct periodic health assessments (PHA) annually to identify any health issues a person might have.

A Web-based Mental Health Self-Assessment is available 24/7 as an additional tool for family members and Service members. This program is not intended to take the place of traditional health care services nor is it a replacement for any of our existing extensive health assessment programs. It is designed solely to benefit the individual military member or family member in better understanding psychological health concerns. The program's greatest value is in education – taking the stigma out of psychological health.

The screening is absolutely anonymous. We do not identify individuals or monitor the individual use of these screening tools. Because we care about the psychological health of our military community, individuals can feel confident that this information is provided to assist them in maintaining and improving their health and well-being.

While other Web sites provide general information, this site lets users enter individual experiences and then provides feedback. If their concerns do not reach a level that would indicate the need for professional evaluation and treatment, then they have the peace of mind of knowing that. If they have mild symptoms, the program suggests that counseling might be helpful. If the symptoms are more significant, then it suggests that psychological health treatment may be warranted.

Each Service has specific combat stress and deployment psychological health support programs available before, during, and after the deployment cycle. These provide support tailored to the Service's mission and risk factors their personnel might face. In addition, cross-functional planning teams bring together subject matter experts from across the Services, the Joint Staff, and DoD.

The Military Health System is second to none in its ability to deliver timely, quality psychological health and behavioral health care. We offer the following: behavioral health in primary care; psychological health specialty care; clinical practice guidelines; and ready access to high-quality, occupationally relevant primary care, with model and demonstration programs designed to continuously improve the system of care delivery. Walk-in appointments are available in virtually all military psychological health clinics around the world.

Because no two individuals are exactly alike, we provide multiple avenues of care to our military community to create a broad safety net that meets the needs of the individual. We do not rely on one single method or program to care for our military members and families. Military treatment facilities deliver rehabilitative care and specialty care. DoD partners with VA to provide state-of-the-art polytrauma centers, traumatic brain injury (TBI) research and treatment, and transition assistance programs. Reserve component members may use a range of extended TRICARE health benefits.

The 2005 National Defense Authorization Act made permanent the 180-day TRICARE Transitional Health Care Benefit coverage. This will help ease the transition for military members separating from active duty, removing a potential barrier for returning veterans and their families needing psychological health care.

In addition to having access to many of the same support and psychological health programs available to the Service members, their families have available eight separate self-referred psychological health outpatient visits through their TRICARE benefit. This means that for whatever reason and without a physician referral they can make covered appointments with psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage/family therapists.

Our medical contract partners are assisting us in developing creative solutions. For example, one of our TRICARE Regional Offices (TROs) and HealthNet, established a new behavioral health clinic at Fort Drum, New York, which can serve as a model for other installations. Due to the limitations in the community, a Health Net Field Team partnered with the Fort Drum military treatment facility and the Fort Drum Regional Health Planning Organization to recruit behavioral health providers from outside the Fort Drum Prime Service Area. The Mountain Community TRICARE Behavioral Health Clinic opened on June 11, 2007. This behavioral health clinic is a TRICARE network facility that treats TRICARE beneficiaries exclusively, with a focus on 10th Mountain Division families. The clinic offers family resiliency training and other services to address stress, anxiety, grief and marital issues. These services will enable family member of active duty Service members to cope with the challenges that may accompany serving our nation.

In addition to TRICARE, Military OneSource offers 24/7 information and resources and can provide a referral to in-person counseling. When there is a need, a consultant can refer a Service member or eligible family member to a licensed professional counselor in the local community for six sessions per issue at no cost to the military or family member. The face-to-face counseling benefit addresses short-term concerns and is limited to six sessions per issue. It is not designed to address long-term issues such as child and spouse abuse, thoughts of suicide, and mental illness. People in need of long- term treatment are referred to a medical treatment facility and/or TRICARE for services. Using Military OneSource for 6 sessions does not limit the ability to access psychological health treatment under TRICARE.

We maintain quality of care through active quality assurance and national quality-management programs. Our deployment health program evaluation process provides further validation of effective practices and programs.

We perform psychological health deployment-related research at local, Service, and interagency collaborative levels to maintain quality care in an environment of expanding knowledge. At the present time, DoD, VA, Health and Human Services and other federal and academic organizations are conducting 67 deployment-related psychological health research projects. Of the 67 projects, 32 are focused on post-traumatic stress disorder. Since 1992, we initiated and completed an additional 57 psychological health research projects related to deployment health. During the past 14 years, DoD and our partners have published more than 120 articles in peer-reviewed medical and scientific journals on psychological health deployment-related research.

Mental Health Task Force

Section 723 of the National Defense Authorization Act (NDAA) for FY 2006 directed the Secretary of Defense to "establish within the Department of Defense a task force to examine matters relating to psychological health and the Armed Forces." The DoD Mental Health Task Force, established on May 15, 2006, was charged to "submit to the Secretary a report containing an assessment of, and recommendations for improving, the efficacy of psychological health services provided to members of the Armed Forces by the Department of Defense." In accordance with Congressional direction from Section 723, the DoD established the task force with 14 members: seven from the DoD and seven non-DoD, with expertise in a variety of fields relating to psychological health care, teaching, research, and support of military families.

The task force was a subcommittee of the Defense Health Board, a Federal Advisory Committee that advises the Secretary of Defense on a wide range of issues relating to the health of military personnel. Sixteen items of concern to Congress, as enumerated in Section 723 of the NDAA for FY 06, guided the task force's assessment. The scope of these elements was broad, and the scope of the task force's assessment was equally broad. The task force had one year to complete its assessment and deliver its findings and recommendations in a report to the Secretary of Defense.

The task force gathered information for its assessment in four ways: 1) direct observation via site visits at 38 military installations of all four Armed Services, engaging military commanders, Service members and their families, and military and civilian psychological health care providers and holding open town-hall format meetings at which members of the public were invited to make statements; 2) informational briefings from subject-matter experts on topics of concern to the task force; 3) reviews of the scientific and other literature; and 4) requests for data from the TRICARE Management Activity and the Services to support an assessment of the current level of psychological health care demand and supply within the direct and purchased psychological health care system.

The task force delivered its report, entitled *An Achievable Vision*, to the Deputy Secretary of Defense on June 12, 2007. The Secretary of Defense forwarded the report to Congress. At a press conference on June 21, 2007, Secretary Gates stated that the military psychological health system "can, must and will get fixed," adding that Service members "have done their duty; we must do ours." Noting that he has "no intention of waiting" the full six

months allotted by Congress for the development of a corrective action plan, Secretary Gates stated that he had ordered the completion of a plan to address problems with the military psychological health system within 60 to 90 days.

Implementation may require DoD to change laws, regulations, policies, doctrine, training, logistics, manpower, and resource allocation. Some changes DoD can make immediately – others will take time. Because of the breadth of the task force's purview, some issues will require further in-depth assessment before changes can be made we will work within the Administration and with the Congress to continue to tackle this critical issue.

Developing the Plan

The DoD convened a two-day Mental Health Summit on June 21–22, 2007. The Services selected psychological health, resource management, and personnel management representatives to attend, and their Office of the Secretary of Defense counterparts also attended. The VA member of the DoD Task Force on Mental Health represented the VA at the Summit. The Summit representatives reviewed the 95 recommendations of the DoD Task Force on Mental Health and initiated the process of formulating specific initiatives to address the recommendations.

- Summit participants developed a plan using the following:
    - A red cell made up of DoD and VA experts in psychological health
    - Collaborative "summits" of stakeholders, to be convened as needed
    - An office of primary responsibility for each initiative

Follow-up

The immediate action for each recommendation involves in-depth assessment and planning by the red cell. My office will make arrangements for the next summit, tentatively scheduled for the week of August 13, 2007. The red cell team will provide the draft White Paper to DoD senior leaders no later than September 12, 2007.

Conclusion

The DoD Task Force on Mental Health has made numerous and far-reaching recommendations for improvements in the care that the DoD provides for the psychological health of Service members and their families. Defense leadership has demonstrated a clear commitment to making necessary changes to ensure these improvements are implemented. . As such, the task facing the Department is now to conduct the in-depth assessments for specific recommendations and to formulate the plans for enacting changes. This is truly a once-in-a-lifetime opportunity to improve the lives of soldiers, sailors, airmen, Marines and their families.

A red cell of both active duty and Reserve component subject matter experts in psychological health and traumatic brain injury was convened two-and-one-half weeks ago. Red cell members are assigned full-time to analyze the practical implications of the task force recommendations and to formulate policy and program options to respond effectively to them. They will deliver a detailed plan to enhance the psychological health of our Service and family members, and the military community as a whole, to meet the suspense established by the

Secretary of Defense within 60 to 90 days.

Top priorities include maximizing the availability of psychological health providers to our military community by adequately incentivizing recruitment and retention of our uniformed providers; contracting for or hiring government civilians to provide care in our military treatment facilities where appropriate; and ensuring our TRICARE provider network is robust and available for those seen off-post and off-base.

We will work closely with the VA to standardize our accession standards for psychological health care; ensure availability of medical records; ensure continuity of medical care; disseminate evidence-based methods of treatment; and together maintain up-to-date clinical practice guidelines for a variety of psychological health and post-deployment conditions.

We will build upon the solid foundation of research already engaged by DoD with the federal and academic community in both post-traumatic stress disorder and traumatic brain injury. We will continue the intensive pattern of deployment cycle assessments and update them as new medical information indicates. We will make further efforts to longitudinally follow our Service members long after they have left military service. And, we will intensify our efforts to both study the particular needs of our Service members and their families and provide to them the psychological health support they need to bear the burden of the challenges of sustained global operations.

In particular, we are reaching out to experts at the National Institutes of Health and the Institute of Medicine to help us study the mental health needs of Service members and their families. I have personally asked leaders in psychological health within DoD, the Services and the combatant commands to be as innovative as possible and consider all the ways we can empower patients through education and providing choices, maximizing confidentiality, including the impact on the family and balancing this with our obligations to our military missions.

Secretary of Defense Robert Gates has charged DoD to minimize the stigma that is still attached to seeking help and to specifically examine the psychological health criteria for security clearances. I have asked those who designed the PDHA to make it clear that an answer signifying stress will not delay a Service member's return from theater.

Because some Service members do not fill out the PDHRA at 90 – 180 days, I have asked our caregivers and chaplains to find ways to contact them, perhaps via a network of retired counselors and chaplains to make sure they are okay and to ask them to participate in the important PDHRA survey.

Finally, we must credit the line leaders and caregivers in theater with the lower-than-expected rates of domestic abuse and divorce, judicial violations, homicide and suicide, given the intensity and duration of current operations. Suicide rates exceeded the national average in the 1970s and 1980s. However, with the institution of programs by the Air Force and Army, suicide rates declined in the 1990s, and to this day remain below the 1970's and 1980's rates. The Army

emphasizes the duty of persuading a stressed battle buddy to get help by likening it to our ethic "no soldier left behind."

For my part in speaking with line commanders, combatant surgeons and deployed Service members, I emphasize that overcoming a problem, including a psychological challenge, is an important sign of leadership and potential for advancement.

Thank you again for this opportunity to discuss what I believe is my number one obligation at this time, namely, safeguarding and even strengthening the psychological well-being of our Service members and their families.

Many people in many places have very high expectations for this country's military health system. Our responsibility in the coming year and for years to come is to exceed these expectations.

On behalf of the Military Health System, I am grateful for the resources and encouragement you provide to all who serve, and I look forward to working with you in the coming year, as we formulate plans based on our in-depth assessments of our psychological health programs and initiatives.

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THE HOUSE ARMED SERVICES COMMITTEE

STATEMENT OF

VICE ADMIRAL DONALD C. ARTHUR

SURGEON GENERAL OF THE NAVY

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

HOUSE ARMED SERVICES COMMITTEE

SUBJECT:
DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH

12 JULY 2007

NOT FOR PUBLICATION UNTIL RELEASED BY
THE HOUSE ARMED SERVICES COMMITTEE

Introduction

As you know, last year the Congress directed the Department of Defense (DOD) to perform a comprehensive review of mental health service provision in the military services. I had the privilege of serving as the military co-chair of that Task Force from March, 2007, until the final release of the report in June. As you also know, Secretary Gates received the Task Force report on 14 June and directed the services to immediately develop strategies to implement its recommendations.

Also, in April of this year, I was named as the military spokesperson for DOD's initiatives to consolidate Traumatic Brain Injury (TBI) treatment across the services. My co-chair, Ms. Ellen Embrey, and I requested the military medical departments to work together to identify key gaps in our understanding and treatment of TBI. Since May, we have convened three large-scale meetings of military clinicians and researchers and their civilian clinical and academic counterparts who represented the most knowledgeable experts in this challenging field. Two weeks ago, these groups forwarded a series of recommendations to us, spanning areas from basic research on the effects of blast to recommendations for enhancing long-term care and rehabilitation. Ms. Embrey and I have accepted these recommendations and representatives from each of the services and the Department of Veterans Affairs are now working on implementation plans.

Overview of the DOD Mental Health Task Force

The findings of the Mental Health Task Force form the basis of much of the remainder of my testimony, so I will briefly reiterate these. The report points to significant shortfalls in providing mental health care to our service members and their

families. We made 94 recommendations aimed at accomplishing the following four major tasks:

a. Build a culture of support for psychological health.

b. Ensure a full continuum of excellent care for service members and their families.

c. Provide sufficient resources for mental health services and allocate them according to requirements, and

d. Empower leadership to establish advocacy for a culture of psychological health.

The Assistant Secretary of Defense (Health Affairs) has directed a large scale effort to address these and other findings.

Navy Medicine is an active participant in this initiative. Additionally, Navy Medicine has taken significant steps to address shortcomings in mental health and TBI service delivery. I will now detail some of these accomplishments.

Care for redeploying Sailors and Marines. Our Deployment Health Clinics (DHCs) serve as non-stigmatizing portals of entry in high fleet and Marine Corps concentration areas and augment primary care services offered at the military treatment facilities or in garrison. Staffed by primary care providers and mental health teams, they are designed to provide care for Marines and Sailors who identify mental health concerns on the Post Deployment Health Assessment and Reassessment but also provide treatment for other service members. We now have 13 such clinics and plan to open an additional four in FY08. Through June 2007,

DHCs had more than 14,000 visits, approximately 30 percent of which were for mental health issues.

Stigma reduction. In November 2006, I directed the establishment of a directorate at the Bureau of Medicine and Surgery specifically dedicated to addressing mental health stigma, training for combat stress control, and the development of non-stigmatizing care for returning deployers and support services for Navy caregivers. Other initiatives aimed at reducing stigma, which I wholeheartedly endorse, include the removal on SF 86, the Questionnaire for National Security Positions, the so-called "mental health question." This is but one example of actions our leaders can take to reduce stigma associated with seeking mental health services. We have also provided recommendations on other policy changes, resulting in a revision of OPNAV 3591.1E: Small Arms Qualifications, allowing a waiver mechanism for service members with mental health diagnoses to, with careful and appropriate screening, continue to serve in their rating. The recently revised DOD Policy Memorandum for Deployment-limiting Psychiatric Conditions and Medications establishes new guidelines for deployment of service members with mental health conditions which should also protect service members.

In-theater behavioral health needs assessment. An in-theater mental health assessment, the Behavioral Health Needs Assessment Survey, has provided data critical to Navy Medicine and senior leadership for evaluating the well-being of corpsmen, other Medical Department personnel, and Seabees. Over 950

assessments have been completed thus far and this effort continues for deployed Navy personnel.

Navy/Marine Corps Combat and Operational Stress Control Center of Excellence. We are standing up a Navy/Marine Corps Combat and Operational Stress Control (COSC) Center of Excellence at Naval Medical Center San Diego. Designed to identify best COSC practices, the Center of Excellence will develop combat stress training and resiliency programs, establish provider "Caring for the Caregiver" initiatives, and coordinate collaboration with other academic, clinical, and research activities. As the concept for a joint DOD/VA Center of Excellence develops, we will integrate, as appropriate, the work of this center.

Mental health training for medical department personnel and Caregiver Action Plan. Navy Medicine is developing a 'train the trainers' program offered to medical department personnel, providers and non-providers, officer and enlisted, as well as to our chaplain resources. The goal is standardized training in evidence based approaches to combat stress. This four-module approach addresses burnout in high-risk caregiver groups, such as our front-line corpsmen, independent duty corpsmen, forensic personnel and those providing services to detainees. Initial training will be offered in September 2007.

Expanded case management. Concurrent with the establishment of the Wounded Warrior Barracks, Marine for Life, and other initiatives, we have expanded USMC Liaison Offices at our major medical centers for the purpose of coordinating and supporting the needs of the Marines and their families. We have tremendously expanded our case management capabilities, increasing the number

of case managers from 85 in 2006 to 141 by July 2007. The DVA has established Liaison Offices at Navy MTFs for the purpose of coordinating follow-on care requirements and providing education on DVA benefits.

Conclusion

We have made significant strides towards addressing the shortcomings in services provided to military personnel with psychological health or TBI needs, their families and their caregivers. That said, much remains to be done. We must improve our ability to detect mild to moderate TBI, especially those forms of TBI in personnel who are exposed to blast but do not suffer other demonstrable physical injuries. Service members who return from deployment and have suffered such injuries may later manifest symptoms that do not have a readily identifiable cause, with potential negative effect on their military careers. As many of 20 percent of injured service members may have TBI in addition to their other injuries.

Navy Medicine, in concert with tri-service colleagues and civilian academic partners, is tackling the very difficult issue of universal neuro-cognitive screening. It is imperative to understand that such screening devices do not yet exist. It is incumbent upon us to devise a valid and reliable measure that can be cost-effectively administered and does not impose an additional burden on service members or commands to collect, and which has minimal risk of stigmatizing service members.

We must also enhance our capabilities for blast detection and mitigation. It is important to develop easily deployable assessment devices to allow field medical personnel to immediately detect the effects of exposure to blast or other hazards that might result in TBI. Such assessments will be of critical importance in making battlefield

determinations about the ability of combatants to return to the fight plus providing vital medical data. Along these lines, I have also directed Navy Medicine researchers, in partnership with civilian academic colleagues, to continue their work in developing a personnel-borne blast sensor that has the capability of detecting cumulative exposure to blasts so that TBI in personnel without observable physical injury can better be assessed and treated.

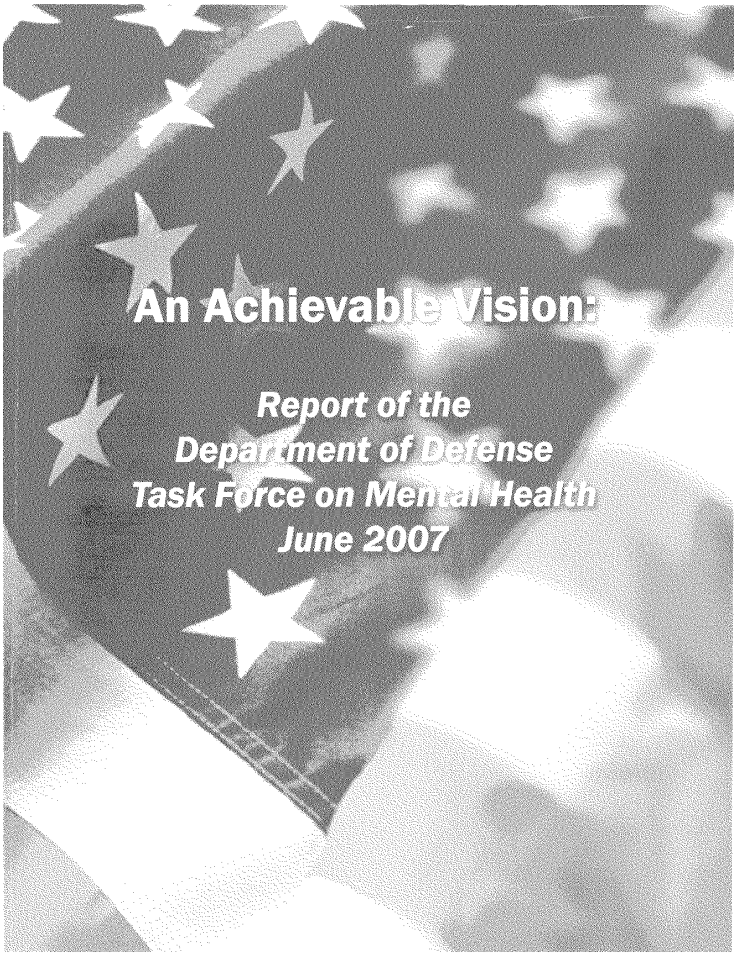
We must also address significant shortfalls in our active duty mental health community. Navy uniformed psychiatry and psychology communities continue to experience manning shortfalls. Our psychiatry community is at 92 percent manning, our clinical psychology community is at only 70 percent manning. The Navy social work community is currently fully manned, but has been slated for civilianization of all active duty social worker billets by FY 2010. Uniformed mental health providers, including psychiatrists, psychologists, advanced practice mental health nurses, and social workers are vital in our efforts to provide preventive and clinical services to deployed Marines and Sailors. We must continue to develop mechanisms, including consideration of accession and retention bonuses and special pays, to ensure an adequate complement of uniformed mental health providers.

Building a culture of psychological health requires an enduring commitment to the mental health needs of service members, their families, and those who provide their care. It requires a commitment to service provision in the operational environment, to expanded surveillance and detection capabilities, to equipping our providers with the best possible training, and to equitable access to non-stigmatizing interventions. But more fundamentally, building a culture of psychological health requires a focus on enhancing

the capabilities and resilience of the individual service member, and an understanding that in the end, this is less a question for medical science than a challenge that every leader must accept.

DOCUMENTS SUBMITTED FOR THE RECORD

JULY 12, 2007


An Achievable Vision:
Report of the
Department of Defense
Task Force on Mental Health
June 2007

Defense Health Board
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EXECUTIVE SUMMARY

Background

Section 723 of the National Defense Authorization Act for fiscal year 2006 directed the Secretary of Defense to "establish within the Department of Defense a task force to examine matters relating to mental health and the Armed Forces" and produce "a report containing an assessment of, and recommendations for improving, the efficacy of mental health services provided to members of the Armed Forces by the Department of Defense." Towards that end, the Department of Defense Task Force on Mental Health (Task Force) was established, comprising seven military and seven civilian professionals with mental health expertise. Task Force members were appointed in May 2006, with one military and one civilian member serving as co-chairs for the group. Lieutenant General Kevin C. Kiley, the Surgeon General of the Army, served as the military co-chair from the inception of the Task Force to March 2007. Vice Admiral Donald C. Arthur, the Surgeon General of the Navy, served as the military co-chair from April 2007 to June 2007. Dr. Shelley MacDermid, director of the Military Family Research Institute at Purdue University, served as the elected civilian co-chair for the duration of the Task Force, from May 2006 to June 2007.

The Task Force acknowledges the good-faith efforts currently being implemented by the Department of Defense and the military Services. In the history of warfare, no other nation or its leadership has invested such an intensive or sophisticated effort across all echelons to support the psychological health of its military service members and families as the Department of Defense has invested during the Global War on Terrorism. These laudable efforts acknowledged, the actual success of the overall effort must be evaluated as a function of the effectiveness of resource allocation and the design, execution, and refinement of strategies.

Introduction

The costs of military service are substantial. Many costs are readily apparent; others are less apparent but no less important. Among the most pervasive and potentially disabling consequences of these costs is the threat to the psychological health of our nation's fighting forces, their families, and their survivors. Our involvement in the Global War on Terrorism has created unforeseen demands not only on individual military service members and their families, but also on the Department of Defense itself, which must expand its capabilities to support the psychological health of its service members and their families.

The system of care for psychological health that has evolved over recent decades is insufficient to meet the needs of today's forces and their beneficiaries, and will not be sufficient to meet their needs in the future.

In particular, the system is being challenged by emergence of two "signature injuries" from the current conflict – post-traumatic stress disorder and traumatic brain injury. These two injuries often coincide, requiring integrated and interdisciplinary treatment methods. New demands have exposed shortfalls in a health care system that in previous decades had been oriented away from a wartime focus. Staffing levels were poorly matched to the high operational tempo even prior to the current conflict, and the system has become even more strained by the increased deployment of active duty providers with mental health expertise. As such, the system of care for psychological health that has evolved over recent decades is insufficient to meet the needs of today's forces and their beneficiaries, and will not be sufficient to meet their needs in the future.

Changes in the military mental health system and military medicine more generally, have mirrored trends in the landscape of American healthcare toward acute, short-term treatment models that may not provide optimal management of psychological disorders that tend to be more chronic in nature. As in the civilian sector, military mental health practices tend to emphasize identification and treatment of specific disorders over preventing and treating illness, enhancing coping, and maximizing resilience. Emerging lessons from recent deployments have

raised questions about the adequacy of this orientation, not only for treating psychological disorders, but also for achieving the goal of a healthy and resilient force.

The challenges are enormous and the consequences of non-performance are significant. Data from the Post-Deployment Health Re-Assessment, which is administered to service members 90 to 120 days after returning from deployment, indicate that 38 percent of Soldiers and 31 percent of Marines report psychological symptoms. Among members of the National Guard, the figure rises to 49 percent (U.S. Air Force, 2007; U.S. Army, 2007; U.S. Navy, 2007). Further, psychological concerns are significantly higher among those with repeated deployments, a rapidly growing cohort. Psychological concerns among family members of deployed and returning Operation Iraqi Freedom and Operation Enduring Freedom veterans, while yet to be fully quantified, are also an issue of concern. Hundreds of thousands of children have experienced the deployment of a parent.

Vision

Maintaining the psychological health, enhancing the resilience, and ensuring the recovery of service members and their families are essential to maintaining a ready and fully capable military force. Towards that end, the Task Force's vision for a transformed military system requires the fulfillment of four interconnected goals:

1) A culture of support for psychological health, wherein all service members and leaders will be educated to understand that psychological health is essential to overall health and performance, will be fostered. Early and non-stigmatizing psychological health assessments and referrals to services will be routine and expected.
2) Service members and their families will be psychologically prepared to carry out their missions. Service members and their families will receive a full continuum of excellent care in both peacetime and wartime, particularly when service members have been injured or wounded in the course of duty.
3) Sufficient and appropriate resources will be allocated to prevention, early intervention, and treatment in both the Direct Care and TRICARE Network systems, and will be distributed according to need.
4) At all levels, visible and empowered leaders will advocate, monitor, plan, coordinate and integrate prevention, early intervention, and treatment.

Together, these interconnected and interdependent objectives define an achievable future. Until each goal is fulfilled, service members and their families will be inadequately served.

Findings

In general, the Task Force found that current efforts fall significantly short of achieving each of the goals enumerated above. This assessment was based on a review of available research and survey data, additional data sought specifically by the Task Force, public testimony from experts and advocates, and site visits to 38 military installations throughout the world, including the largest deployment platforms, where thousands of service members, their family members, commanders, mental health professionals, and community partners were given the opportunity to provide their input.

The Task Force arrived at a single finding underpinning all others: The Military Health System lacks the fiscal resources and the fully-trained personnel to fulfill its mission to support psychological health in peacetime or fulfill the enhanced requirements imposed during times of conflict. The mission of caring for psychological health has fundamentally changed and the current system must be restructured to reflect these changes. This requires acknowledgement of new fiscal and personnel requirements necessary to meet current and future demands for a full spectrum of services including: resilience-building, assessment, prevention, early intervention, and provision of an

easily-accessible continuum of treatment for psychological health of service members and their families in both the Active and Reserve Components.

The Task Force's findings related to each of the four goals related to the vision discussed above are summarized briefly below:

1) *Building a culture of support for psychological health*

- Stigma in the military remains pervasive and often prevents service members from seeking needed care.
- Mental health professionals are not sufficiently accessible to service members.
- Leaders, family members, and medical personnel are insufficiently trained in matters relating to psychological health.
- Some Department of Defense policies, including those related to command notification or self-disclosure of psychological health issues, are overly conservative.
- Existing processes for psychological assessment are insufficient to overcome the stigma inherent in seeking mental health services.

2) *Ensuring a full continuum of excellent care for service members and their families*

- Significant gaps in the continuum of care for psychological health remain, specifically related to which services are offered, where services are offered, and who receives services.
- Continuity of care is often disrupted during transitions among providers.
- There are not sufficient mechanisms in place to assure the use of evidence-based treatments or the monitoring of treatment effectiveness
- Family members have difficulty obtaining adequate mental health treatment.

3) *Providing sufficient resources and allocating them according to requirements*

- The military system does not have enough fiscal or personnel resources to adequately support the psychological health of service members and their families in peace and during conflict.
- Military treatment facilities lack the resources to provide a full continuum of psychological health care services for active duty service members and their families.
- The number of active duty mental health professionals is insufficient and likely to decrease without substantial intervention.
- The TRICARE network benefit for psychological health is hindered by fragmented rules and policies, inadequate oversight, and insufficient reimbursement.

4) *Empowering leadership*

- Provision of a continuum of support for psychological health for military members and their families depends on the cooperation of many organizations with different authority structures and funding streams.
- The Task Force found insufficient collaboration among organizations at the installation, Service and Department of Defense levels to provide and coordinate care for the psychological health of service members and their families.

Recommendations

Actionable recommendations to address the shortfalls outlined above are presented and discussed in the body of this document. These recommendations are designed to address the needs of members of the Active and Reserve Components, their eligible beneficiaries, and other Department of Defense beneficiaries. The Task Force's recommendations are categorized and summarized briefly below:

1) *Building a culture of support for psychological health*
   - Dispel stigma
   - Make mental health professionals easily accessible
   - Embed psychological health training throughout military life
   - Revise military policies to reflect current knowledge about psychological health
   - Make psychological assessment procedures an effective, efficient, and normal part of military life
2) *Ensuring a full continuum of excellent care for service members and their families*
   - Make prevention, early intervention, and treatment universally available
   - Maintain continuity of care across transitions
   - Ensure high-quality care
   - Provide family members with access to excellent care
3) *Providing sufficient resources and allocating them according to requirements*
   - Provide adequate resources for mental health services
   - Allocate staff according to need
   - Ensure an adequate supply of military providers
   - Ensure TRICARE networks fulfill beneficiaries' mental health needs
4) *Empowering leadership*
   - Establish visible leadership and advocacy for psychological health
   - Formalize collaboration at the installation, Service and Department of Defense levels to coordinate care for the psychological health of military service members

Conclusion

Against the backdrop of the Global War on Terror, the psychological health needs of America's military service members, their families, and their survivors pose a daunting and growing challenge to the Department of Defense. Although it is acknowledged that the work of the Task Force is necessarily incomplete and that the recommendations presented herein provide only the groundwork for a comprehensive strategic plan to support the psychological health of service members and their families, the immediacy of these needs imparts a sense of urgency to this report. As such, the Task Force urges the Department of Defense to adopt a similar sense of urgency in rapidly developing and implementing a plan of action.

1. BACKGROUND, ORGANIZATION & ACTIVITIES OF THE TASK FORCE

Section 723 of the National Defense Authorization Act for fiscal year 2006 (FY06 NDAA) directed the Secretary of Defense to "establish within the Department of Defense a task force to examine matters relating to mental health and the Armed Forces." Towards that end, the Department of Defense (DOD) Task Force on Mental Health (Task Force) was established, comprising seven military and seven civilian professionals with military mental health expertise. The members were nominated from sources both within and outside of the DOD and approved for membership by the Secretary of Defense. Task Force members were appointed on 15 May 2006, with one military and one civilian member serving as co-chairs for the group. Lieutenant General Kevin C. Kiley, the Surgeon General of the Army, served as the military co-chair from the inception of the Task Force to March 2007. Vice Admiral Donald C. Arthur, the Surgeon General of the Navy, served as the military co-chair from April 2007 to June 2007. Dr. Shelley MacDermid, director of the Military Family Research Institute at Purdue University, served as the elected civilian co-chair for the duration of the Task Force, from May 2006 to June 2007. Further information on the membership of the Task Force is available in Appendix B. The Task Force was constituted as a subcommittee of the Armed Forces Epidemiological Board (AFEB, now the Defense Health Board (DHB)), a standing Federal Advisory Committee.

Per the FY06 NDAA, the Task Force was required to deliver a report to the Secretary of Defense containing "an assessment of, and recommendations for improving, the efficacy of mental health services provided to members of the Armed Forces by the Department of Defense" addressing specific elements enumerated in the Act, to which four additional elements were later added. (Text of the original legislation and the four additional elements appears in Appendix A.) The Secretary of Defense was allotted 90 days to review the report and transmit it to the Senate and House Committees on Armed Services and Veterans' Affairs. The Act also directed the Secretary of Defense to develop a plan based on the recommendations of the Task Force and submit the plan to the Congressional defense committees not later than six months after receipt of the Task Force report. The Task Force report was delivered 12 June 2007.

The Task Force gathered information from many sources through five primary operations:

1) Direct observation through site visits at military installations throughout the world;
2) Testimony from subject-matter experts;
3) Review of existing literature;
4) Public testimony and submissions to the Task Force web site; and
5) Task Force requests for specific data from military and civilian organizations.

Site Visits

The Task Force conducted thirty-eight site visits at Army, Navy, Air Force, and Marine Corps installations within the United States and throughout the world. (A complete list of the installations visited appears in Appendix C.) The Task Force was able to visit a variety of installations with varying levels of deployment activity; however, because of security considerations, no visits were made to the theaters of combat operations in southwest Asia. The Task Force obtained information regarding mental health care in theater from multiple sources, including research reports such as the Mental Health Assessment Team's (MHAT) reports, briefings provided by military and civilian mental health professionals, and testimony by service members who had been deployed. Site visits were conducted by delegations, usually comprising two to five Task Force members, both military and civilian. Site visits were two to three days in length and included:

- Interviews with commanders of installations, units, and military treatment facilities (MTFs);
- Discussion sessions with care providers from MTFs;
- Discussion sessions with personnel from family advocacy and substance abuse prevention offices, family support centers, chaplains, and volunteer family support workers;
- Visits to military units;
- Open "town hall" meetings with service members and families;
- Visits to civilian health care facilities that provide support to military personnel and their families through the purchased care system; and
- Discussions with civilian mental health care providers.

Task Force Meetings

The Task Force held monthly face-to-face meetings between July 2006 and April 2007 (with the exception of August 2006, during which the Task Force convened via teleconference). (A complete listing of the Task Force meetings is featured in Appendix D.) These plenary meetings provided an opportunity for Task Force members to receive informational briefings from subject-matter experts in a forum that facilitated discussion between the members and experts. The meetings also provided an opportunity for the Task Force to obtain statements from organizations and individuals regarding concerns about the mental health of members of the Armed Forces and their families. Time was allocated during the Task Force meetings for working sessions in which findings and recommendations were discussed and developed, upon which the Task Force's written report was based. The proceedings of each plenary Task Force meeting were captured and documented in an executive summary. All open meeting sessions were transcribed and transcriptions were posted on the Task Force website. Executive working sessions were closed to the public but were documented by meeting minutes.

Working Groups

The Task Force designated four working groups to focus on the elements assigned in the NDAA legislation. The working groups addressed the following areas: Active Duty Service Members, Family, Evaluation, and Continuity of Care. Task Force members assigned themselves to two of the four working groups. Each working group elected one military and one civilian chair. Working groups convened via teleconference and during Task Force meetings and site visits.

Task Force Support

The operations of the Task Force were supported by an Executive Secretary and a staff under contract to the DHB.

Scope of the Task Force

Following in the footsteps of several commissions and advisory groups that have considered the state of care in the civilian community (e.g., President's New Freedom Commission on Mental Health, Institute of Medicine's *Improving the Quality of Health Care for Mental and Substance-Use Conditions*), the Task Force identified the salient characteristics of systems capable of delivering excellent prevention, early intervention, and treatment to support psychological health, focusing on the needs of service members and their families. The Task Force was also informed by the findings of the ongoing activities of the Presidential Task Force on Returning Global War On Terror Heroes, the *Institutional Review Group Report on Rehabilitative Care at Walter Reed Army Medical Center and National Naval Medical Center*, the ongoing initiatives of the DOD/Department of Veterans' Affairs (DVA) Mental Health Work Group, and the work of the consolidation of TBI initiatives in the DOD and DVA Work Group.

In its deliberations, the Task Force adopted a definition of mental health originally developed for Healthy People 2010 (2000):

> Mental health is a state of subjective well-being and successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society.

Implicit in this definition is the notion that mental health is more than the mere absence of mental illness. Further, the definition suggests that a mental health care system must provide not only clinical treatment, but also prevention and early intervention.

Finally, a note about the term "mental health" is warranted. In the military, the term "mental health professional" is employed narrowly to refer to a specific set of providers with privileges to provide clinical treatment. Because the Task Force intentionally adopted a more holistic view of the continuum of care than this narrow conception of "mental health" implies, this report does not use the term "mental health" as a generic reference. Rather, the term "psychological health" is used generically, while "mental health" is used only when referring specifically to military mental health providers with clinical privileges for the care they provide.

Limitations of the Task Force and Report

The composition of the Task Force conformed to legal requirements, but did not represent the full range of providers and constituents who deal with psychological health issues in the military. The Task Force focused its attention on service members in the Active and Reserve Components and their families; this focus, however, excludes veterans already utilizing the Department of Veterans Affairs healthcare beyond the transition from active duty to veteran status. In addition, consideration of the Coast Guard fell outside the purview of the Task Force. Whereas the objective of the group was to examine services provided to members of the Armed Forces by the DOD, mental health services for Coast Guard personnel are provided by the Commissioned Corps of the Public Health Service.

2. INTRODUCTION

Over one million service members in the Active and Reserve Components of the U.S. military have been deployed in Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF), of whom 449,261 have been deployed more than once (DMDC, 2006). As of May 2007, more than 3,700 service members have died, primarily from hostile action, and more than 26,000 troops have been wounded.

Additional costs of military service may be less apparent, but are no less important. Among the most pervasive and potentially disabling of these costs is the threat to psychological health. Based on data in their 2004 study, Hoge and colleagues estimated that, using strict screening criteria, 17 percent of soldiers from brigade combat teams would be at risk for developing clinically significant symptoms of post-traumatic stress disorder (PTSD), major depression, or anxiety after deployment, and that an even higher percentage (28%) would experience symptoms if broader screening criteria were used (Hoge, Castro, Messer, McGurck, Cotting & Koffman, 2004). The prevalence of PTSD within a year of combat deployment was estimated to range from 10 to 25 percent (Hoge et al., 2004). More recent data from the Post-Deployment Health Re-Assessment (PDHRA), which is administered to service members 90 to 120 days after returning from deployment, indicate that 38 percent of Soldiers and 31 percent of Marines report psychological symptoms. Among members of the National Guard, the figure rises to 49 percent (U.S. Air Force, 2007; U.S. Army, 2007; U.S. Navy, 2007). Psychological concerns are also significantly higher among those with repeated deployments, a rapidly growing cohort. Psychological concerns among family members of deployed and returning Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans, while yet to be fully quantified, are also an issue of concern. Further, hundreds of thousands of U.S. children have experienced the deployment of a parent. Clearly, the challenges are enormous and the consequences of non-performance are significant.

The costs of military service do not dissipate after deployment. Indeed, a higher percentage of service members reported misusing alcohol after deployment compared with pre-deployment. Strains in family functioning have also been observed, particularly at the 12-month milestone after deployment. According to the Mental Health Advisory Team (MHAT) IV report, 20 percent of married soldiers planned to separate or divorce (2006), a 5 percent increase from the MHAT-III report of the prior year (2005).

Stigma, the shame or disgrace attached to something regarded as socially unacceptable, remains a critical barrier to accessing needed psychological care. Analysis of anonymous surveys and questionnaires conducted following deployment revealed that 20 to 50 percent of active duty service members and Reservists reported psychosocial problems, relationship problems, depression, and symptoms of stress reactions, but most report that they have not yet sought help for these problems (Wheeler, 2006). Fewer than 40 percent of those members who meet strict diagnostic criteria receive mental health services (Hoge et al., 2004).

DOD's mental health mission has fundamentally changed.

The cost of mental illnesses also extends beyond discharge from military service. Of the 686,306 OIF and OEF veterans separated from active duty service between 2002 and December 2006 who were eligible for DVA care, 229,015 (33%) accessed care at a DVA facility. Of those 229,015 veterans who accessed care since 2002, 83,889 (37%) received a diagnosis of or were evaluated for a mental disorder, including PTSD (39,243 or 17%), non-dependent abuse of drugs (33,099 or 14%), and depressive disorder (27,023 or 12%) (VHA Office of Public Health and Environment Hazards, 2006).

Involvement in combat imposes a psychological burden that affects all combatants, not only those vulnerable to emotional disorders or those who sustain physical wounds. Combat is a life-changing experience, imposing long-lasting emotional challenges for combatants. It is increasingly clear that efforts to enhance combatants' resilience and recovery in response to the emotional sequelae of combat must be undertaken by all members of the military community. Psychological health involves not only the detection and remediation of illness but also the provision of effective preventive strategies. Strategies to prevent other common problems, such as dental disease or orthopedic injuries, are well-developed. A similar capacity must be developed to prevent psychological dysfunction and enhance resilience to stress.

Increased reliance on members of the Reserve Component, for whom access to military medical services was previously limited, necessitates the development of new guidelines for caring for these personnel. In particular, commitment to these combatants requires that service delivery be enhanced to serve those who, despite their wounds, elect to remain on active duty. The

recognized need for extensive family involvement in the long-term process of rehabilitation and community reintegration also demands the close involvement of families in the recovery process of the service members and requires greater responsiveness in the treatment of family members' needs.

Profound changes in the method of healthcare delivery in the civilian sector have contributed to equally significant changes in military health care. Changes in the military mental health system and military medicine more generally, have mirrored trends in the landscape of American healthcare toward acute, short-term treatment models that may not provide optimal management of psychological disorders that tend to be more chronic in nature. The Military Health System (MHS) has transitioned from a model of largely unfettered access to a system that increasingly resembles the inadequate managed care models that prevail in the civilian healthcare sector. Although such changes have contributed to some increases in efficiency, some of its unintended consequences have impeded DOD's ability to fulfill its dual missions of national defense and benefit delivery.

DOD's mental health mission has fundamentally changed. Despite the dedicated work of its members, the current system is not structured to address these new challenges, leaving many psychological health needs unmet. Without a fundamental realignment of services, this situation will worsen. As such, the military health care system must be reshaped to support the psychological health of service members and their families. To achieve this objective, the DOD must, with the support and commitment of Service leadership, develop a unifying strategic plan to heighten awareness of psychological health issues and implement initiatives to ensure fulfillment of the achievable vision. In addition, the DOD and DVA should coordinate their initiatives to ensure continuity of care in addressing psychological needs.

3. A VISION FOR THE FUTURE

The military arts have continually evolved since the beginning of humankind. Over time, weapon systems have become increasingly more expensive, complex, and lethal. Some have even become capable of self-maintenance, automatically ordering replacement parts for components they sense have become excessively worn. This emphasis on the technology of warfare has often been to the exclusion of the human element of the military force: military service members. The military has thus far sought to improve human effectiveness primarily through better combat tactics, more highly lethal weaponry, and powerfully developed physical strength and endurance. Future combat, however, will demand more—more flexibility, more agility, and more resilience.

Although psychological resilience is well recognized as a characteristic of the military's most celebrated leaders, it is not generally appreciated as an attribute that can be taught or enhanced. Leaders' tactics are well-studied, yet their psychological approach to leadership in military service is largely ignored. Leaders are in a unique position to influence the resilience of their subordinates. More resilient leaders increase the psychological fitness of those they lead and are consequently more effective in combat. Psychologically hardy individuals tend to view crisis situations as less stressful, less threatening, and less painful. They learn from stressful situations and enhance their resilience to future crises. This is the essence of psychological combat readiness. Improving psychological resilience will enhance combat effectiveness and decrease the adverse effects of stress in all aspects of military service.

As a force composed entirely of volunteer patriots, the servicemen and women of the U.S. military will continue to reflect the social, cultural, religious, and ethnic diversity of the nation more generally. These service members come to the military with backgrounds and experiences as broad as those of the civilian population, with significant variation in terms of their prior exposure to psychological stressors. These men and women enter the military Services with varying levels of untrained and largely unexercised resilience, and varying degrees of vulnerability to psychological trauma. As such, it is necessary to assess service members' resilience and vulnerability to psychological trauma early in their careers and provide any requisite remediation to the maximum extent possible. Efforts to enhance psychological resilience beyond "entry-level" emotional performance constitute a significantly under-appreciated and untapped resource.

Just as service members differ in their professional abilities, so too do they differ in their psychological strengths and vulnerabilities. Differences in abilities – whether physical or psychological – must not be characterized as defects but as individual attributes to be cultivated and strengthened in each service member. This is an issue that must be addressed by each echelon of DOD leadership.

There currently is no mechanism within DOD for assessing the capacity for resilience in newly-accessed service members. The constructs of resilience and hardiness, while acknowledged to be core attributes of successful leaders, are incompletely operationalized. Devising reliable and valid measurement tools that can be administered in a cost-effective fashion will require extensive effort and coordination among the research and practice communities and line leadership. Nevertheless, the potential benefits of such screening tools are considerable and the feasibility of their implementation merits careful scrutiny. If this type of screening is approached from the vantage point of enhancing the capacity for resilience and optimizing individual performance, rather than the identification of weakness or pathology, such efforts are likely to result in overall enhancements to psychological health.

Every military leader must aggressively address the issue of stigma. Just as service members differ in their professional abilities, so too do they differ in their psychological strengths and vulnerabilities. Differences in abilities – whether physical or psychological – must not be characterized as defects but as individual attributes to be cultivated and strengthened in each service member. This is an issue that must be addressed by each echelon of DOD leadership.

The goal of the MHS is "to be a world-class health system that supports the military mission by fostering, protecting, sustaining, and restoring health." Likewise, the vision of the Task Force is that all systems involved in supporting the psychological health of military members and their families will also be world-class.

Goals of a World-Class System

Goal 1	A **culture of support for psychological health**, wherein all service members and leaders will be educated to understand that psychological health is essential to overall health and performance, will be fostered. Early and non-stigmatizing psychological health assessments and referrals to services will be routine and expected.

A culture of awareness, active prevention, and widespread responsibility mirroring the culture that currently supports the maintenance of physical health must also be developed for psychological health. Just as service members are taught to provide basic care for minor physical injuries, they should be taught to recognize the signs and symptoms of mental distress. Just as commanders and others understand today that physical illnesses or injuries can be treated and in most cases cured or repaired, in a world-class system everyone understands that the same is true for mental illnesses.

Goal 2	Service members and their families will be fully and psychologically prepared to carry out their missions. Service members and their families will receive a **full continuum of excellent care** in both peacetime and wartime, particularly when service members have been injured or wounded in the course of duty.

In a world-class system, all beneficiaries receive the care they need regardless of where they are located. As such, care must be not only available but also accessible, because individuals experiencing mental distress may be placed at risk when care is not user-friendly or easily accessible. The mental health system should not focus exclusively on treating pathology, but on building resilience, providing assistance to confront challenges to mental health, and assuring high-quality treatment when needed.

All care and services must be of the highest quality. In a world-class system, evidence-based practices are employed and updated as new evidence is discovered, outcomes are monitored, and service delivery is adjusted regularly.

The well-being of service members is inextricably linked to the well-being of their families. Frequent redeployments may strain even the strongest family bonds. In this era of instant communication, the service member remains in constant contact with his or her family. Such contact may compound the daily stresses of deployment with additional worries about a child or spouse struggling at home. Thus, a world-class military mental health system ensures optimal mental health among not only service members but also family members.

Goal 3	**Sufficient and appropriate resources** will be allocated to prevention, early intervention, and treatment in both the Direct Care and TRICARE Network systems, and will be distributed according to need.

A world-class system provides high-quality care for all beneficiaries in both peacetime and wartime, whether at home or deployed.

Goal 4	At all levels, **visible and empowered leaders** will advocate, monitor, plan, coordinate and integrate prevention, early intervention, and treatment.

A world-class system has leaders with sufficient authority and accountability to acquire and allocate diverse mental health care resources where they are needed to assure the quality of outcomes of care.

An Unrealized Vision

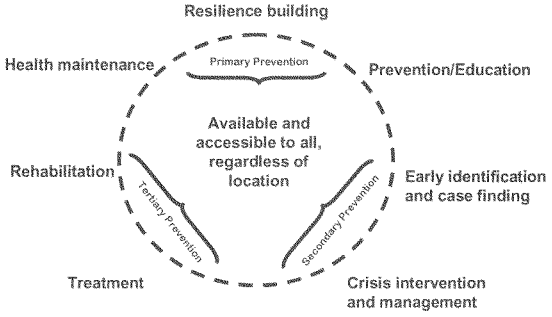
The current operational tempo has exposed fundamental weaknesses in the U.S. military's approach to psychological health. While there is evidence of excellence and many highly competent and hard-working professionals and volunteers, the system lacks the capacity to surge to meet the demands of all service members and their families, who are particularly vulnerable to system inadequacies. While progress has been made in intervening to ameliorate the long-term effects of stress, it has been

uneven across units and military Services. Despite the progressive recognition of the burden of mental illnesses and substance abuse and the development of many new and promising programs for their prevention and treatment, current efforts are inadequate to ensure the psychological health of our fighting forces. Repeated deployments of mental health providers to support operations have revealed and exacerbated pre-existing staffing inadequacies for providing services to military members and their families. New strategies to effectively provide services to members of the Reserve Components are required. Insufficient attention has been paid to the vital task of prevention.

4. TODAY'S LANDSCAPE

The Department of Defense has wisely recognized that fully supporting psychological health requires a public health approach emphasizing a continuum of care that includes not only effective treatment but also active prevention and early intervention (ASD(HA), 2007). Several national reports, such as the President's New Freedom Commission on Mental Health's *Achieving The Promise: Transforming Mental Health in America* (2003) and the United States Surgeon General's *Mental Health: A Report of the Surgeon General* (1999), have reinforced the scientific validity of such an approach. Prevention and early intervention efforts have been widely recognized as not only more compassionate but also more economical than delaying intervention until severe mental illness has developed (Davis, 2002). A complete continuum of care includes several key elements, as illustrated in the figure below.

- **Primary Prevention** is designed to reach all segments of the population regardless of whether or not indications of illness are present. In the military, examples of primary prevention are education (e.g., when family members are taught about coping with deployment) and health maintenance (e.g., when all members are provided with information about substance use) (ASD(HA), 2007; Davis, 2002).
- **Secondary Prevention** activities are typically provided to a subset of the population when there is good reason to believe that they are at elevated risk for difficulties. The early identification of problems through deployment-related assessment constitutes one military example of secondary prevention.
- **Tertiary Prevention** activities include clinical treatment for diagnosed illnesses and rehabilitation to prevent recurrences and manage chronic illness.



No single mental health program exists across DOD: Numerous programs related to psychological health are administered within and outside the confines of the Defense Health Program (DHP), with considerable variation in mental health service delivery among the military Services and TRICARE. In many respects, this is desirable. A number of programs operate outside the DHP, expanding leadership involvement and increasing accessibility to beneficiaries who cannot or do not desire to seek services via the direct care system. Chaplains, for example, often serve as the first point of access for service members experiencing distress. Suicide prevention, substance abuse prevention, and engenderment of resilience and the capacity to withstand the challenges of the combat environment are essential functions of command, in which military medicine plays a critical but supporting role. Family Advocacy and family support services, which include limited mental health counseling, are provided by entities funded by non-DHP funds and report directly to line leadership. Other programs that offer mental health counseling, such as Military OneSource, also operate independently of the DHP. While the multiplicity of programs, policies, and funding streams provides many points of access to support for psychological health, they may also lead to confusion about benefits and services, fragmented delivery of care, and gaps in service provision.

TRICARE

TRICARE comprises DOD's worldwide health care program for active duty and retired uniformed services members and their families. TRICARE contractual coverage of mental health is governed by both statute and regulation, including: Title 10, U.S. Code; Code of Federal Regulation 32.199; and the Mental Health Parity Act of 1996. TRICARE is comprised of TRICARE Prime, a managed care option; TRICARE Extra, a preferred provider option (PPO); and TRICARE Standard, a fee-for-service option. TRICARE for Life is also available for Medicare-eligible beneficiaries aged 65 and over, while TRICARE Reserve Select is available for members of the National Guard and Reserves, with care options similar to TRICARE Standard and Extra.

TRICARE Prime is a managed care option similar to a civilian health maintenance organization (HMO). Active duty service members are required to enroll in Prime, for which they do not pay enrollment fees, annual deductibles or co-payments. Retired service members pay an annual enrollment fee of $230 for an individual or $460 for a family and minimal co-pays apply for care within the TRICARE network. TRICARE Extra and TRICARE Standard are available for all TRICARE-eligible beneficiaries who are unable or elect not to enroll in TRICARE Prime. TRICARE Extra is a preferred provider option (PPO) in which beneficiaries choose a doctor, hospital, or other medical provider within the TRICARE provider network. As noted previously, TRICARE Standard is a fee-for-service option. Under TRICARE for Life, TRICARE acts as a second payer to Medicare for benefits payable by both Medicare and TRICARE.

Psychological health services are provided in the purchased care system via the TRICARE network. Patients have access to specialists and may in certain instances seek reimbursed services from mental health professionals. Non-active duty beneficiaries may obtain outpatient services without authorization for the first eight visits during a fiscal year, and may seek authorization for further visits. Some services, however, always require preauthorization, including psychoanalysis, psychological and neuropsychological testing, electroconvulsive therapy, and any therapy sessions in excess of one hour. With physician referral, beneficiaries may seek services from licensed mental health counselors and licensed professional counselors (see http://www.tricare.mil/mhshome.aspx#; ASD(HA), 2007; Donehoo, 2006).

The Military Health System

With 9.2 million eligible beneficiaries, the MHS is the one of the largest medical systems in the world, providing medical care to active duty service members, medically-eligible Guard and Reserve personnel, retirees, and dependents and dependent survivors. According to recent data from the Defense Enrollment Eligibility Reporting System (DEERS), the breakdown of beneficiaries in the MHS is as follows:

Beneficiary Type	Number
Active Duty	1,395,902
Dependents of Active Duty	1,946,658
Dependent survivors	540,496
Retirees	2,023,523
Dependents of retirees	2,410,668
Guard/Reserve (medically-eligible)	233,666
Dependents of medically-eligible Guard/Reserve	358,051
Inactive medically-eligible Guard/Reserve	47,463
Dependents of medically-eligible inactive Guard/Reserve	72,862
Other	46,385

Source: DEERS Data, 7 March 2007

Military medical services, including psychological health services, are provided in venues ranging from teaching hospitals to deployed environments. The MHS is charged not only with providing healthcare for all eligible military members and their beneficiaries, but is also accountable to DOD leadership and the combatant commanders of each Service for providing a fit force that is continually ready to deploy. If assigned to a military installation, active duty service members are required to seek services at a MTF when accessing non-emergency mental health care.

In the direct care system, psychological health services are provided by uniformed providers as well as civilian federal employees and contractors. As with other medical services, the Navy provides mental health services for its own beneficiaries as well as Marine Corps personnel. The MHS provides mental health specialty care, counseling, and preventive services. Mental health clinics are staffed by uniformed and civilian psychiatrists, psychologists, mental health nurses, social workers, and mental health technicians.

Substance Abuse Prevention and Treatment

Each military Service has substance abuse prevention and treatment programs designed to promote readiness and wellness through the prevention and treatment of substance misuse. These programs are organized differently within each of the Services. In the Navy and Marine Corps, line-sponsored substance abuse programs focus on prevention or aftercare, with most treatment being offered by medical assets. In the Air Force, the line and medical service share responsibilities for prevention/education, detection/deterrence, and assessment/treatment of substance misuse problems. Each Service assigns a unique name to these agencies (please see glossary under Substance Abuse Prevention and Treatment).

Family Support Centers

Though not a medical resource, each Service maintains Family Support Centers (FSCs) whose mission is to support family members. FSCs play a crucial role in helping families cope prior to, during, and following deployment. These organizations are operated by non-medical personnel, including non-professional and volunteer staff. Some FSCs offer counseling for clinical disorders, including marital problems. Financial and employment counseling services may also be available, as well as services such as support groups for new parents. FSCs also provide support for volunteers, including Family Readiness Group leaders, key volunteers, and ombudspersons involved in outreach work with families. Each Service assigns a unique name to these agencies (please see glossary under Family Support Centers).

Family Advocacy Programs

In the Department of Defense, the Family Advocacy Program (FAP) is the responsibility of the Principal Deputy Undersecretary of Defense for Personnel and Readiness (USD(P&R)). Each Service manages and supports a broad-based program designed to prevent, identify, report, treat, and follow-up cases of child and partner abuse. In the Navy and Marine Corps, the FAP is a line function operating closely with medical assets for consultation, evaluation, and treatment. In the Air Force, the FAP is integrated into the medical system. The Army FAP offers clinical services under the medical system, while prevention services are conducted by Army Community Service.

Military OneSource

Military OneSource is a DOD-funded initiative offering a 24-hour, 7-day-a-week, confidential non-medical information and referral system that can be accessed globally through the telephone, Internet, and e-mail. In addition, it offers confidential family and personal counseling in local communities to active duty and reserve component members and their families. Face-to-face counseling is provided at no cost for up to six sessions per person per problem per year. Military OneSource is programmatically limited to services for non-clinical problems. If care is sought for a clinical problem (defined as any disorder for which TRICARE provides reimbursement), Military OneSource facilitates referral to TRICARE or the nearest MTF.

Chaplains

Military mental health services are often delivered in partnership with services provided by military chaplains. This is especially true in deployed environments where mental health and pastoral services constitute an essential component of deployment support. Outside of the deployed environment, military chaplains provide marital and individual counseling, and are often sought because issues of stigma may be lessened and greater assurances of confidentiality may be offered in the context of pastoral counseling.

Other Organizations

A number of other organizations provide direct or indirect support for the psychological health of military members and their families. Although a complete description of each falls outside the scope of the report, examples of these organizations include,

but are not limited to: Health Promotions Offices, Sexual Assault Prevention and Response Offices, Exceptional Family Member Programs, Suicide Prevention Programs, and Combat Operational Stress Control programs.

Departments of Defense and Veterans Affairs Joint Initiatives

The DVA provides mental health care to former service members, including those who have been medically retired, as well as specialty care for some service members who remain on active duty. Under the auspices of the Joint Executive Council, the DOD and the DVA have initiated steps to integrate programs for treatment of service members with psychological disorders or co-morbid physical and psychological diagnoses. The DVA Office of Seamless Transition employs case managers at major MTFs to identify and assist service members whose care is being assumed by the DVA. A memorandum of agreement (MOA) between the two agencies, which was renewed on 1 Jan 2007, provides referrals to DVA medical facilities for health care and rehabilitation of active duty military personnel who have sustained spinal cord injury, TBI, or blindness.

5. FINDINGS AND RECOMMENDATIONS: AN ACHIEVABLE VISION

5.1 BUILDING A CULTURE OF SUPPORT FOR PSYCHOLOGICAL HEALTH

5.1.1 Dispel Stigma

Mental illness has been stigmatized throughout history, although recent decades have seen significant progress in revealing it as a common and treatable human condition. Stigma often prevents individuals from seeking help for mental health problems. Stigma also interferes with access to care (because individuals refuse to seek treatment), quality of care (because individuals seek care "off the books"), and continuity of care (because individuals may not inform military medical personnel about prior mental health treatment). In the military, stigma represents a critical failure of the community that prevents service members and their families from getting the help they need just when they may need it most. Further, stigma is of particular concern in the military because of the degree to which military members may bear responsibility for lives beyond their own. Every military leader bears responsibility for addressing stigma; leaders who fail to do so reduce the effectiveness of the service members they lead.

Every military leader bears responsibility for addressing stigma; leaders who fail to do so reduce the effectiveness of the service members they lead.

Evidence of stigma in the military is overwhelming. Four surveys of the MHAT have been conducted on service members deployed to Iraq and Afghanistan (i.e., MHAT-I, -II, -III & -IV). Results from the MHAT-IV report indicate that 59 percent of the Soldiers and 48 percent of the Marines surveyed thought they would be treated differently by leadership if they sought counseling (Office of the Surgeon Multinational Force-Iraq (OMNF-I) & Office of the Surgeon General (OTSG), US Army Medical Command, 2006; Hoge et al., 2004). These findings are corroborated by the Task Force's findings from public testimony, comments from service members and their families, and discussions with mental health professionals, commanders, and chaplains obtained via site visits.

Of even greater concern are recent findings that service members who screened positive for symptoms consistent with mental illness were twice as likely as those without symptoms to express concerns about stigma (Hoge et al., 2004). Over half of surveyed soldiers who met criteria for a psychological health problem thought they would be perceived as weak if they sought help (Hoge et al., 2004; OSMF-I & OTSG, 2006). Moreover, individuals exhibiting the greatest need were the most hesitant to seek care, even though empirical data from at least one military study indicates that most service members do not suffer any negative career impact from seeking services related to their psychological health (Rowan & Campise, 2006).

Stigma may be propagated by a number of factors including perceptions that seeking mental health care will lower the confidence of others in the service member's ability, threaten career advancement and security clearances, and possibly cause removal from one's unit. In a review of literature related to stigma in the military, Sammons (2005) noted three unique manifestations of stigma:

1) Public stigma—public (mis)perceptions of individuals with mental illnesses;
2) Self-stigma—individuals' perceptions of themselves; and
3) Structural stigma—institutional policies or practices that unnecessarily restrict opportunities because of psychological health issues.

The multiple manifestations of stigma require multiple targeted intervention strategies, which are discussed below.

Combating Public Stigma

Empirical evidence can be used to guide efforts to combat all forms of stigma (e.g., Corrigan & Gelb, 2006). Providing factual information about mental disorders is one method that has been found to be effective in reducing public stigma. Another is

promoting contact with individuals who have a mental illness (Greene-Shortridge, Britt, & Castro, 2007; Rüsch, Angermeyer & Corrigan, 2005).

Recommendation 5.1.1.1

The Department of Defense should implement an anti-stigma public education campaign, using evidence-based techniques to provide factual information about mental disorders.

In Section 5.1.3 (Embed Training About Psychological Health throughout Military Life), the Task Force also recommends educating the entire force that exposure to combat operations can wound the mind and disrupt the behavior of the best of service members, just as it can wound their bodies. The message must be clear to all: building and maintaining resilience through assertive, early interventions in times of stress are crucial to the health of service members and their families and to force readiness. Everyone in a position to recognize early symptoms and encourage change must know their role and be fully educated on the most effective approaches to ensuring successful rehabilitation (Greene-Shortridge, Britt, & Castro, 2007). Additional recommendations for civilian collaborators such as teachers, parents, and community mental health providers are included in Sections 5.2.4 (Provide Family Members with Excellent Access to Care) and 5.3.4 (Ensure TRICARE Networks Fulfill Beneficiaries' Psychological Health Needs). In Section 5.1.3, the Task Force also outlines recommendations to facilitate early identification of problems.

Combating Self-Stigma

Research has documented the complex process by which individuals change behaviors and address mental health concerns (Prochaska, Diclemente & Norcross, 1992). In this process, service members or family members must:

- Recognize that they have a problem and need to change;
- Come to the conclusion that the advantages of change outweigh the perceived costs;
- Believe that change is possible, and that they are capable of accomplishing it; and
- Have easy access to timely help.

Later sections of this report provide actionable recommendations to combat self-stigma:

Embedding uniformed providers in military units provides on-the-ground consultation that educates service members, builds confidence in the possibility of change, offers easy access to help, and increases familiarity with mental health professionals. In Sections 5.1.2 (Make Mental Health Professionals Easily Accessible to Service Members) and 5.3.3 (Ensure an Adequate Supply of Military Providers), the Task Force outlines recommendations for capitalizing on the lessons learned from existing efforts to embed mental health professionals into units.

Integrating mental health providers in primary medical care settings improves access at the critical point when change is first being considered. Often, mental health concerns are first raised in primary care clinics, where stigma is lower. The presence of a mental health professional serves to maximize the number of interventions that can be conducted in a primary care setting and can address stigma-related concerns in those who need to receive further services at a mental health clinic. In Section 5.1.2 (Make Mental Health Professionals Easily Accessible to Service Members), the Task Force formulates a recommendation that expands on current programs, such as in the Air Force, where mental health professionals are integrated with primary medical care clinicians.

Ensuring an easily-accessible full continuum of evidence-based care guarantees effective help is available when most needed. All efforts to dispel stigma are reduced to hollow promises if, when service members or family members reach the critical juncture where they recognize they need help, they encounter delays, bureaucratic roadblocks or frustration in accessing the services their often complex situation requires. In Sections 5.2.1 (Make Prevention, Early Intervention and Treatment Universally Available), 5.2.3 (Ensure High Quality of Care) and 5.3.1 (Provide Sufficient Resources for the Support of Psychological Health), the Task Force recommends a comprehensive agenda for assuring that every service member and family member has timely, easy access to world-class care.

Combating Structural Stigma

The widespread perception that seeking psychological health services is costly to an individual's career and acceptance within the unit must be challenged through thoughtful refinements in command notification policies. In Sections 5.1.4 (Revise Military Policies to Reflect Up-To-Date Knowledge about Psychological Health) and 5.2.3 (Ensure High Quality of Care) sections the Task Force makes recommendations designed to refine the balance between the need to encourage service members to seek help and the need for command to maintain force readiness.

Just as stigma pervades the military, so too must efforts to eradicate it. Building a first-class system for supporting psychological health is a necessary condition for change, but it will not be sufficient if stigma is allowed to persist.

5.1.2 Make Mental Health Professionals Easily Accessible to Service Members

The military model of service delivery often restricts the practice of mental health professionals to mental health specialty clinics. Service members who are unable to overcome their concerns about the stigma of seeking help and its potential career impact are unlikely to visit these clinics. As such, isolating mental health professionals in clinics ensures that a significant proportion of the psychological health needs in the population will be unknown and unmet.

In recent years, the military Services have laid the groundwork for a paradigm shift in how psychological services are delivered. The new paradigm recognizes that services must be brought to customers, which are broadly defined as not only those who present acutely for care, but the entire population of service members. Initial attempts at implementing this model have focused on two general approaches:

1) Embedding mental health providers in military units; and
2) Embedding mental health providers in primary care clinics.

Embed Mental Health Providers in Units

Each of the military Services has begun embedding mental health providers in units, wherein they are familiarized with the mission and culture of the unit, establish themselves as a known approachable resource for service members and command, and provide a full range of preventive and early intervention services that build resilience, improve recovery, and enhance the unit's mission. These providers are connected with the unit during deployment and in garrison. The Task Force found convergent evidence (e.g. MHAT-I, -II, -III & -IV) suggesting that this approach is crucial to the psychological health of service members, and has great potential for reducing stigma. Determining the proper ratio of embedded providers to service members would require additional research; however, evidence from site visits suggested that the Army's ratio of one psychologist or social worker and one psychiatric technician per 5,000 service members is probably not sufficient.

Not every Service is organized in a manner that facilitates efficiently embedding full-time mental health professionals within units. In such cases, a desirable alternative is to assign consultative mental health professionals to line units. On a regularly scheduled and consistent basis, the mental health professional would provide formal and informal consultation with leadership and service members at the unit's work site, provide preventive and educational services, and offer appointments for additional interventions at the mental health clinic.

...integrating mental health providers into primary care settings improves clinical outcomes, enhances the satisfaction of both patients and providers, and reduces healthcare costs

Recommendation 5.1.2.1

The military Services should embed mental health professionals as organic assets in line units.

Integrate Mental Health Professionals into Primary Care

In the military, as in civilian populations, the primary care setting is often the first setting in which psychological health problems are recognized (U.S. Air Force Primary Behavioral Health Care Service Practice Manual, 2002). Psychological factors play a role in physical complaints in 75 to 80 percent of all patients presenting to primary care (Blount, 1998). Further, non-psychiatric

primary care managers (PCMs) prescribe 75 percent of all psychotropic medications in the country (Beardsley, Gardocki, Larson & Hidalgo, 1998).

Primary care settings provide a rich opportunity for effective case identification and early treatment of mental health issues. Civilian studies have shown that integrating mental health providers into primary care settings improves clinical outcomes (Smit et al., 2006), enhances the satisfaction of both patients (Katon et al., 1996) and providers (Katon et al., 1995), and reduces healthcare costs (Blount, 1998). Research indicates significant improvement in clinical outcomes and reduced psychological distress among service members served by mental health providers in primary care settings (Cigrang Dobmeyer, Becknell, Roa-Navarrete & Yerian, 2006). During Task Force site visits, providers reported to the Task Force that patients followed through on referrals to mental health providers 90 to 100 percent of the time when the provider was located in primary care, but only 20 to 25 percent of the time when the provider was in a separate mental health clinic.

Mental health providers integrated into primary care settings are not substitutes for providers in mental health clinics. These are separate services with separate missions, each requiring sufficient numbers of personnel. The role of the embedded mental health provider is to serve as a consultant to primary care clinicians and assist them with assessment and management of psychological health needs. They provide short, focused assessments; brief interventions in support of the primary care treatment plan; skill training through psycho-education and patient education strategies; training in self-management skills and behavioral change plans; and on-the-spot consultation.

Integrating mental health staff into primary care is not a novel initiative. Over the past decade, civilian providers such as Kaiser Permanente, INOVA, the DVA and, to a lesser extent, the military Services have integrated mental health staff into the primary care setting. A staffing model that appears to be working well is the Air Force equation of integrating one full-time equivalent mental health provider into Primary Care for every 15,000 to 20,000 beneficiaries empanelled to the primary care clinic. On its site visits, the Task Force observed several examples of similar programs in the military that reported positive outcomes.

This model should be more widely adopted. In particular, the unique stigma-related barriers to seeking mental health care in the military support the expansion of this research-validated model.

Recommendation 5.1.2.2

The military Services should integrate mental health professionals into primary care settings.

5.1.3 Embed Training about Psychological Health throughout Military Life

Psychological health is a community responsibility. Leaders, front-line supervisors, peers, friends, family members, health care providers, and other helping agency members must all collaborate in building resilience, recognizing signs of distress and illness, serving as links to helping resources, and following up with those who have accepted or rejected assistance.

Psychological health is a community responsibility. Leaders, front-line supervisors, peers, friends, family members, health care providers, and other helping agency members must all collaborate in building resilience, recognizing signs of distress and illness, serving as links to helping resources, and following up with those who have accepted or rejected assistance.

The mental health needs of service members and family members can only be met by a DOD community that has received adequate training in building resilience and recognizing, responding to, and following up on distress and illness. Unfortunately, DOD's current training related to psychological health is insufficient and inconsistent both across and within the military Services. Too little training is evaluated for effectiveness. Too much training, according to consumers, is not effective because it is not sufficiently engaging or relevant. The answer is not simply more of the same, but training that uses methods that have been demonstrated to be effective. Promising examples of such training, though not yet fully evaluated, include the training accompanying the 2005 DOD Public Service Suicide Prevention Vignettes CD and the 2006 Army Battlemind Training (Air Force Management Operations Agency, 2005; Castro & Thomas, 2007; U.S. Department of the Army, 2006).

There is too little collaboration among the military Services to create training material, resulting in wasted time, money, and expertise. The military Services should combine efforts to create stellar outcome-driven training packages that can then be adapted to meet the unique needs of each Service. An excellent example of such Service collaboration is the Congressionally-

funded DOD Center for Deployment Psychology, which was created in 2005 to train and enhance the ability of mental health providers to meet the needs of deployers and their families throughout the deployment cycle. This tri-Service center is a resource and a best practice model that illustrates how collaboration among the Services can result in high-quality training material that enhances the care provided to service members and their families. Development of high-quality training materials can be accomplished through collaboration with each of the Services and the DOD Center for Deployment Psychology.

There is too little collaboration among the military Services to create training material, resulting in wasted time, money, and expertise.

DOD's strategy must also address suicide prevention. Relationship problems are the top risk factor for suicide; mental disorders, alcohol and substance use disorders, and significant stress are other significant risk factors. Despite these well-known associations, most providers receive very little suicide assessment and management training either in their residency or while on staff in the medical departments. This lack of training mirrors the situation in the civilian medical system. Factors such as perceptions of mental health stigma and low referral rates to substance abuse services also serve to reduce the number of high-risk service members who are identified and treated.

Training Leaders

Leaders play a pivotal role in creating an organizational climate that emphasizes resilience and encourages help-seeking. Among deployers who screened positive for a mental disorder, Hoge et al. (2004) found that 63 percent would avoid help-seeking because they believed that unit leaders might treat them differently and 50 percent would do so because they believed that leaders would blame them for the problem.

It is time to equip all leaders with the training and skills necessary to effectively support the psychological health of the service members for whom they are responsible. Leaders do not need to function as mental health counselors; however, they do need to become knowledgeable about building resilience, recognizing and responding appropriately to distress and illness, and collaborating with helping agencies to support service members and family members. Training must be based on the latest scientific evidence, especially regarding cutting-edge or emerging topics such as PTSD, TBI, suicide prevention, and other topics relevant to psychological well-being. Such training would enhance the military mission through higher-functioning service members, more effective commanders, and unity of effort between line leadership and helping agencies.

At each step in leaders' careers, the military provides additional training to equip them to assume new levels of responsibility. As such, psychological health training should be integrated into leadership training curricula throughout leaders' career cycles, beginning early in members' careers, such as at the Armed Forces Service Academies, Officer Training Schools, or Non-commissioned Officers (NCO) schools, and becoming more sophisticated as their careers advance.

Recommendation 5.1.3.1

Develop and implement Department of Defense-wide core curricula on psychological health as an integral part of all levels of leadership training.

Training Family Members

According to the 2005 DOD Survey of Health-Related Behaviors among Military Personnel (DSHRB), 74 percent of DOD active duty personnel cope with stress by talking to a friend or family member (Bray et al., 2006). Spouses and family members are often the first to recognize when service members require assistance. Further, families also play a key role in influencing service members to seek help. As such, family members need to be equipped with resilience-building skills, the ability to recognize distress, and the knowledge of how and where to refer loved ones for assistance.

As with leadership training materials, although some materials for training family members exist, there appear to be multiple versions of training materials and few evaluations of their effectiveness. The Task Force recognizes attempts have been made to include family members in various training venues and to make educational materials available to them on websites or in paper form, but the training and education materials are inconsistently available and often unknown to family members.

Recommendation 5.1.3.2

Develop and implement Department of Defense-wide core curricula on psychological health for family members. Effectively market these materials to all family members.

Training Medical Personnel

The typical service member's most frequent contact with the DOD health system is through providers of basic medical services, including medics, corpsmen and other primary care providers. Medical professionals should be trained to recognize and respond to distress and illness (AMEDD, 2006). As reported earlier, psychological factors play a role in physical complaints in 75 to 80 percent of patients presenting to primary care, and non-psychiatric PCMs prescribe 75 percent of all psychotropic drugs in the country (Beardsley, et al., 1998; Blount, 1998). Without adequate training, medical personnel cannot effectively recognize and engage individuals with psychological health issues.

Recommendation 5.1.3.3

Develop and implement a Department of Defense-wide core curriculum to train all medical staff on recognizing and responding to service members and family members in distress.

Though they are prepared to recognize and treat individuals in distress, DOD's mental health providers require additional training regarding current and new state-of-the-art practice guidelines. DOD and the DVA (2000; 2004) have combined to create evidence-based clinical practice guidelines (CPGs) for depression and the management of post-traumatic stress. DOD mental health providers should receive training on implementing these guidelines and any new guidelines or best practices as they are developed. It is especially important they receive additional training on the signature disorders of the current conflict (i.e., TBI and PTSD). The recent MHAT-IV report noted that few mental health professionals had attended Combat and Operational Stress Control training (OMNF-I & OTSG, 2006), and in another study 90% of the providers indicated they had received no training or supervision in clinical practice guidelines for PTSD (Russell, 2006a, 2006b).

Recommendation 5.1.3.4

Develop and implement a core curriculum to train all mental health personnel on current and emerging clinical practice guidelines.

5.1.4 Revise DOD Policies to Reflect Up-to-Date Knowledge about Psychological Health

The Task Force recognizes the need to balance the interests of individual service members with those of DOD in maintaining mission readiness. Commanders must be informed when service members are impaired to the extent that they cannot perform their duties. The ultimate goal, however, must be to ensure that service members who are potentially a risk to themselves or the mission are identified early and that appropriate command and therapeutic measures are taken to protect all concerned parties and restore the service members' psychological health. Current policies attempt to accomplish this by requiring that commanders be notified of or that members self-report past involvement with mental health services.

... current thresholds for command and security notifications are overly conservative and contribute to structural stigma.

It is the conclusion of the Task Force that current thresholds for command and security notifications are overly conservative and contribute to structural stigma. Concerns that self-identification will impede career advancement or effort to obtain a security clearance may lead service members to avoid needed care, even at early stages when problems are most remediable. The net result is that service members delay or avoid seeking services, and continue in their operational roles while their problems remain unidentified and untreated and become more severe. During Task Force site visits, active duty members, commanders and mental health professionals consistently cited this dilemma posed by current policies as problematic.

The scope of the problem is illustrated by discrepancies between rates of self-reported substance abuse and behavioral health concerns on anonymous DOD surveys and the actual number of service members seeking treatment for such problems. For example, on the most recent anonymous DSHRB (2005), the proportion of respondents acknowledging a significant alcohol

problem (23%) was well above the proportion actually seeking help for any mental health issue (15%; Bray et al., 2005). The Task Force also reviewed data from a large Army deployment platform and comparable data for the United States Army Forces Command that showed substantial increases in alcohol-related incidents (e.g., DUI, drunk and disorderly, alcohol related reckless driving) in just one year – from 1.73 per 1,000 soldiers in the third quarter of FY 2005 to 5.71 in the third quarter of FY 2006. But there was no noticeable increase in cases seen by the alcohol program, and only 41 percent of those soldiers involved in alcohol-related incidents were even referred to the alcohol program. Furthermore, suicidal attempts and gestures were markedly higher, and alcohol contributed to 65 percent of these cases. Alcohol was also a major factor in reported cases of sexual assault (Bruzese & Sutton, 2006).

Revise Policies on Command Notification and Self-Disclosure

The Task Force has identified two specific policies in need of modernization. These relate to command notification of alcohol-related problems and the mental health screening process for security clearances. In both cases the current thresholds for command notification or self-disclosure of psychological health problems do not appear to be based on a careful evaluation and weighing of the available evidence and are not optimal for reaching the ultimate goal of ensuring that appropriate command and therapeutic measures protect all concerned parties and obviate any adverse consequences.

These overly-conservative policies have the unintentional consequence of fueling erroneous beliefs that seeking psychological health care invariably results in permanent damage to one's military career. Such beliefs appear to be ubiquitous throughout the military Services and were mentioned at every Task Force site visit.

Recommendation 5.1.4.1

The Department of Defense should promote earlier recognition of alcohol problems to enhance early and appropriate self-referral. If, in the clinician's judgment, alcohol use does not warrant a diagnosis, mechanisms should exist to ensure that service members receive appropriate and non-prejudicial education and preventive services, without a requirement for command notification. Evaluations resulting in a diagnosis of substance abuse or dependence or entry into a formal outpatient or inpatient treatment program should continue to require command notification, as should reporting of alcohol-related incidents.

On Standard Form (SF) 86, the questionnaire for national security positions, applicants are asked if they have consulted with any mental health professional (e.g., psychiatrist, psychologist, counselor) within the past seven years or if they have consulted with another health care provider about a mental health-related condition. It is the opinion of the Task Force that this requirement is too broad.

Recommendation 5.1.4.2

Department of Defense medical assets, the security adjudication facilities of each Service, and the Defense Office of Hearings and Appeals should work to clarify those mental health conditions that must be reported because they are indicative of defects in judgment, reliability, or emotional stability that are potentially disqualifying or raise significant security concerns, and publish updated guidance accordingly.

Considering the importance of security to the military mission, DOD should, to the maximum extent possible, engage in education efforts designed to reassure applicants that most routine mental health consultations do not constitute an impediment to obtaining or retaining a security clearance.

Guarantee a Thorough Assessment of the Behavioral Symptoms When Evaluating Combat Veterans for Administrative/Legal Dismissal from the Military

The military has a legitimate need to maintain discipline and enforce a strict code of conduct. Moreover, it is appropriate for unit commanders to be concerned about having fully-functioning service members as part of the team. A service member who cannot adhere to these expectations may indeed need to be separated from the service, regardless of the cause of their psychological dysfunction. With this clear imperative acknowledged, the military also has a clear responsibility to restore to full level of function a service member damaged in the line of duty, and to be cognizant of and attentive to the psychological aftermath of deployment, manifested in hidden injuries of the brain and mind. If restoration cannot be attained through appropriate treatment, a Medical

Evaluation Board (MEB) process should be initiated to ensure the injured veteran will not be denied the opportunity to receive needed treatment and rehabilitation through the DVA.

Experiences in military service can result in injuries that are not immediately apparent to untrained commanders and fellow service members. Two clear examples of such injuries are **PTSD and non-penetrating concussive injuries resulting in mild to severe TBI**. Symptoms of these injuries often include complex disinhibitory behaviors such as:

- Difficulty controlling one's emotions, including irritability and anger;
- Limited attention span and difficulty in completing complex tasks owing to the inability to manage competing stimuli (In the case of PTSD, may also include intrusive thoughts of the inciting trauma.);
- Self-medicating with alcohol, other medications, or illicit drugs in an attempt to return to "normalcy";
- Thrill-seeking behavior such as driving too fast or other reckless/high-risk behaviors; and
- Disruption of the sleep cycle, in the case of PTSD aggravated by nightmares, which results in further declines in occupational performance.

The time of onset, severity and duration of disinhibitory behaviors vary significantly from patient to patient. Furthermore, the behavioral manifestations of these hidden injuries may not become evident until weeks or months after the battlefield injury or trauma

The time of onset, severity and duration of disinhibitory behaviors vary significantly from patient to patient. Furthermore, the behavioral manifestations of these hidden injuries may not become evident until weeks or months after the battlefield injury or trauma, and are frequently not associated with exposure to trauma by leadership, caregivers, or by the patient. The behavioral symptoms common across these conditions pose serious dilemmas for the management of returning combatants and other trauma victims. Data from an anonymous survey of Maine National Guard members revealed that among those who had been deployed, half reported disinhibitory symptoms such as problems with anger or concentration, double the percentage of those who had not deployed (Wheeler, 2007).

The Task Force found significant variation in how behavioral symptoms are managed across the military Services. Specifically, Services vary in terms of how well this dilemma is acknowledged and whether the behavioral symptoms that accompany these hidden injuries are taken into account during administrative, legal, or disciplinary action or adverse personnel actions (such as premature separations from service) attributable to disinhibitory behavior or declines in duty function. Two combatants with similar behavior may be handled in a markedly different manner depending on their unit of assignment or installation.

The Task Force was also informed of instances in which returning service members were pressured by commanders and peers to accept an administrative discharge so they could be expeditiously cleared from the unit and replaced with a fully functional person. Such incidents may be attributed in part to the complex and often protracted Physical Evaluation Board (PEB) process. In sites such as Europe, where there are no units designated as Medical Holding Companies, the dilemma of balancing the legitimate treatment needs of injured service members with the needs for current unit combat readiness is even more challenging. As an example of a way to manage the needs of service members awaiting the MEB/PEB process, the Marine Corps has recently established a Wounded Warrior Regiment. The regiment helps wounded Marines through medical and physical evaluation boards, assists them in making insurance claims, acts as a clearinghouse for charitable donations and works to ensure accountability and non-medical case management during their recovery. The regiment focuses on ensuring that the injured receive the same level of medical care, no matter where they live in the country. The regiment also oversees the transition from DOD to VA care.

Recommendation 5.1.4.3

The Department of Defense should carefully assess history of occupational exposure to conditions potentially resulting in post-traumatic stress disorder, traumatic brain injury, or related diagnoses in service members facing administrative or medical discharge. While such conditions are not exculpatory of misconduct, the need for treatment in members with a history of occupational exposure should be considered.

Revise Policies on Medical and Physical Evaluation Boards to Foster Psychological Health and Recovery of Service Members

DoD is responsible for thoroughly evaluating wounded service members' capacity to remain in military service. If they are judged incapable of remaining in service, a fair and thorough assessment must be accomplished to determine the degree of their disability. Many active duty members suffer from mental disorders, which often occur in conjunction with other more obvious physical wounds. For these service members, the process of assessing their capacity to remain in military service must be conducted in a manner that promotes recovery from mental conditions caused or aggravated by military service. Wounded service members are particularly vulnerable to the effects of additional stress, which can occur if the processes for assessing the capacity to remain in the service are unduly protracted or conducted in settings that do not promote psychological health.

Recommendation 5.1.4.4

The Department of Defense should revise Medical Evaluation Board and Physical Evaluation Board policies and processes to better adhere to the following principles aimed at fostering the psychological health of wounded service members:

- *Active duty members entering treatment for a mental disorder or TBI should be given an adequate opportunity to receive evidence-based treatments for their condition in an effort to return them to full functioning prior to referral for a Medical Evaluation Board.*
- *Adequate professional, support and supervisory manpower must be devoted to the Medical Evaluation Board process to eliminate unnecessary delays. Priority must be given to accomplishing the tests and evaluations that are integral to the overall evaluation.*
- *While undergoing the Medical Evaluation Board and Physical Evaluation Board processes, wounded service members must receive comprehensive psychological health treatment and rehabilitation services to facilitate their recovery, in a setting that supports recovery.*
- *Recognizing the importance of friends and family members to the recovery process, during the Medical Evaluation Board and Physical Evaluation Board processes wounded service members should be stationed or treated in a setting that optimizes involvement of family members and friends and emphasizes re- integration into the community.*

Revise DOD Directive 6490.1 and Instruction 6490.4

On site visits, as Task Force members researched barriers that prevented service members from seeking help, mental health providers repeatedly observed that DOD Directive (DODD) 6490.1 and its implementing DoD Instruction (DODI) were problematic. The Directive and the legislation on which it is based were intended to protect service members from punitive use of command referrals for mental health services. In practice, however, they are having the unintended consequence of interfering with the optimal communication and relationship between commanders and mental health providers. A key to reducing stigma is reinforcing in the minds of both service members and commanders that needing and receiving mental health services is normal. Commanders, from non-commissioned officers up, require the flexibility to discuss early signs of trouble with service members, and to urge them to seek help before problems get worse. They should be able to address psychological problems with service members in the same way that they would discuss a physical problem. In many cases early communication among the service member, his or her commander and a mental health professional can resolve problems in a manner that is not stigmatizing to the service member. The current policies interfere with the normalizing of mental health referrals, by imposing an excessively-formalized process.

The Task Force resonates with the importance of protecting service members, including whistle blowers, from the inappropriate, punitive use of command referrals for mental health services. There are other administrative and oversight options for accomplishing this goal, which would not contribute to stigma and increase barriers for the overwhelming majority of service members with psychological problems.

Recommendation 5.1.4.5

Revise Department of Defense Directive 6490.1, Department of Defense Instruction 6490.4 and, if necessary, their underlying legislation, in a manner that normalizes the process of command referral for and

communication about psychological problems. Use other administrative and oversight procedures to protect service members from the inappropriate use of command referrals for mental health services.

Redeployment of Military Personnel with Psychiatric Conditions Including PTSD

The Task Force carefully considered the complex issue of the redeployment of military personnel who have significant psychiatric symptomatology, including PTSD. The Task Force recognizes that trauma can be cumulative over the life cycle, and that re-traumatization of a person with untreated stress reactions can be detrimental to long-term adjustment. The Task Force also recognizes that mental disorders are treatable conditions, from which people can and do recover. There is also considerable individual variation in resilience that seems to protect some individuals and contribute to the variability in the success of treatment and readjustment across individuals.

The Task Force also repeatedly heard from service members who wished to remain in the military and with their units as they redeployed despite exhibiting some mental health symptomatology that they were working through. The support of fellow service members and the sense of identity with the unit and its mission can be positive factors in treatment and readjustment. Further, the guilt, however irrational, associated with abandoning one's unit can be a significant contributor to ongoing personal trauma.

*The Task Force endorses the DOD Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications with the crucial caveat that the policy guidance can accomplish its stated goals and purpose **only if** there are significant improvements in a number of areas integral to its successful implementation.*

The Task Force reviewed the new DOD Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications, dated 7 November 2006, concluding that the policy is well-balanced and thorough. It sets forth reasonable goals and expectations for all involved in the complex process of determining a service members' capacity for redeployment.

The Task Force endorses the Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications with the crucial caveat that the policy guidance can accomplish its stated goals and purpose **only if** there are significant improvements in a number of areas integral to its successful implementation. These have been addressed in detail elsewhere in this report and include:

- **Adequate training of all concerned in the recognition of PTSD and other psychological problems.** The Policy Guidance correctly stresses that "early identification and treatment are key…" and that "medical readiness is a shared responsibility of military commanders, military medical personnel, and individual service members". As detailed in earlier sections of this report, the current training of commanders and active duty members on recognition and intervention is uneven and generally inadequate. Training of key medical personnel at the smallest unit level, such as medics and corpsmen, is also inadequate.
- **Easy accessibility of evidence-based best practices for treatment of mental disorders including PTSD.** The Policy Guidance stresses these are treatable conditions, especially early in their progression, and that successful treatment is key to the health of the service member and the mission capability of the force. As noted throughout this report, current resources devoted to providing such treatment are inadequate. The three-month stability criterion specified in the Guidance is appropriate only if treatment can be implemented with the intensity required.
- **Recurring assessment to identify problems.** The Policy Guidance notes that "medical readiness follows a military lifecycle process that includes sustainment, pre-deployment, deployment and post deployment…" and that assessments must be recurrent and effective. As noted in this report, the assessment process requires significant improvement and must be better resourced to meet this challenge.
- **Further efforts to reduce stigma.**

Successful implementation of redeployment guidelines requires a well-trained triad of command, service members and medical personnel. Assessment programs must be robust and well-resourced. Psychological health treatment services must be high-quality and readily-accessible and must operate with the fundamental assumption that sequelae of operational stress are predictable and can be successfully addressed without damage to service members' careers. Until these goals are achieved, service members are at risk as they struggle to balance their own psychological needs with the current realities of military life in the face of recurring redeployments.

5.1.5 Make Psychological Assessment an Effective, Efficient, and Normal Part of Military Life

DOD has made significant progress in recognizing the threat to the long-term psychological health of service members posed by exposure to trauma. Mandatory assessment that incorporates psychological health issues has been implemented for the past few years both prior to deployment (i.e., the Pre-Deployment Health Assessment) and immediately upon return (i.e., the Post-Deployment Health Assessment or PDHA). Assessments typically include completion by the military member of a brief set of screening questions, followed by review of those responses by a mental health professional and referral for additional services as needed. Recognizing that a service member's awareness of symptoms of deployment stress is cumulative, re-screening at a point several months following return has been recently mandated (i.e., the Post-Deployment Health Re-Assessment or PDHRA). Current PDRHA data indicate that a significant percentage of those screened report some psychological health concern: Approximately one-quarter of all active duty members screened since June 2005 report some concerns, as do 44% and 41% respectively of reservists and National Guard personnel (U.S. Air Force, 2007; U.S. Army, 2007 & U.S. Navy, 2007)

Although automated self-report screening instruments serve a useful purpose, the validity of general screens used in pre- and post-deployment assessments suffer from the predictable limitations of a self-report instrument heavily influenced by the environment and by expectations of the service member (Ostroff & Gibson, 2005). For example, Task Force members were told on multiple site visits that the validity of the Pre-Deployment Health Assessment suffers because service members underreport their mental health concerns if they are eager to deploy. Similarly, mental health concerns may be under-reported on the PDHA immediately following return from deployment because service members fear that reporting a concern will delay reunions with their family members while their concerns are assessed (McClure, 2007).

Challenges to Effective Assessment

Challenges with current deployment-related assessment procedures include the large number of repeated assessments that are perceived as excessive by many service members and leaders, difficulty in administering the multiple assessments at the required intervals, and uncertainty about the value added by each assessment. There is not yet sufficient evidence to determine the cost-effectiveness of deployment-based assessment relative to other practices (AMEDD, 2006). Assessment procedures built around deployment cycles also fail to reach active duty personnel who engage in highly-stressful activities even though they are not deployed. Many assessments, particularly post-deployment assessments, are administered in group settings that may limit confidentiality and full disclosure of symptoms (Novier, 2007).

Further, DOD's current process has not succeeded in overcoming the stigma associated with seeking mental health services. Many active duty members fear loss of security clearances, assignment to non-combat positions, damage to their promotion potential, and ridicule by peers if they seek help under the program's current implementation and extant policies.

In collaboration with the DVA, DOD has developed evidence-based practice guidelines for the conditions most prevalent among active duty members and their families, including PTSD, depression and substance abuse. These guidelines call for routine (at least annual) assessment for these conditions in primary care medical clinics utilizing brief, easily-administered screening tools and personal mental health interviews as needed. Annual assessment of psychological concerns, like annual assessment of physical concerns, is an essential element of psychological health maintenance. Conducting assessment in a primary care setting also helps alleviate some of the stigma associated with mental conditions. The DVA has mandated the universal use of screens as part of the primary care preventive health assessment process.

The Task Force was repeatedly told that the routine, universal availability of a mental health provider to conduct an annual mental health needs assessment in a private setting would have been a much more successful and desirable approach. It may be possible to incorporate such an approach with the Periodic Health Assessment (PHA), which was 'instituted by policy across DOD' in February 2006 (ASD(HA), 2007). The PHA is an annual process intended to identify and treat physical and mental health concerns well in advance of pre-deployment processing (ASD(HA), 2007), but is not yet fully implemented. The Soldier's Wellness Assessment Pilot Program (SWAPP) program at Fort Lewis uses the PHA as part of an extensive wellness assessment that includes face-to-face contact with a mental health professional (McClure, 2007).

Recommendation 5.1.5.1

Each service member should undergo an annual psychological health needs assessment addressing cognition, psychological functioning, and overall psychological readiness. The assessment should be

conducted in a setting that allows interpretation by a trained professional and prompt referral to a credentialed mental health provider, with a person-to-person handoff. Though challenging, the same procedure should apply to National Guard and Reserve members. The Task Force recognizes that the cost of such a policy represents a significant resource requirement on the part of the Department of Defense, but mirrors the level of care, concern, and preventive efforts required to maintain other mission-essential elements necessary for force readiness. The annual assessment should not be formulated as a search for pathology, but as an opportunity to identify a service member's psychological health needs and as a forum for enhancing resilience.

Recommendation 5.1.5.2

The Department of Defense should establish clear policy and procedures assuring privacy during all mental health assessments and have mental health professionals accessible at assessment locations

To the extent that existing deployment-related screens continue to be used, their content should be reviewed and coordinated wherever possible. Insufficient coordination of items raises questions about validity.

Recommendation 5.1.5.3

The items on the Pre-Deployment Health Assessment, the Post-Deployment Health Assessment, and the Post-Deployment Health Re-Assessment assessments should be coordinated to ensure maximum reliability and validity.

5.2 ENSURING SERVICE MEMBERS AND THEIR FAMILIES RECEIVE A FULL CONTINUUM OF EXCELLENT CARE

5.2.1 MAKE PREVENTION, EARLY INTERVENTION, AND TREATMENT UNIVERSALLY AVAILABLE

The Task Force found three systematic gaps in the continuum of care available to service members and their families.

1) Gaps in what services are offered;
2) Gaps in where services are offered; and
3) Gaps in to whom services are offered.

Gaps in What Services are Offered

The Task Force found that the system used to track performance of mental health professionals in MTFs and mental health specialty clinics constitutes a disincentive for providers in those facilities to engage in **prevention activities**. This substantially reduces the likelihood that psychological problems will be identified early and successfully treated, particularly among service members.

According to TRICARE Management Activity (TMA) a substantial proportion of the reasons given for seeking mental health treatment are for **V-codes** (2007). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the International Classification of Diseases, Ninth Edition (ICD-9), the major classifications of mental disorders, 'V-codes' are "other conditions or problems that may be a focus of clinical attention" and "factors influencing health status and contact with health services", respectively), which are not reimbursable according to TRICARE regulations. While family members served by MTFs with adequate resources to treat such diagnoses are not required to pay for their treatment, family members served by lower-capacity MTFs who must be sent to the TRICARE network for treatment are not eligible for reimbursement for their V-coded issues.

Intensive outpatient treatment programs have been adopted as standard practice in the private sector and the Veterans' Health Administration (VHA); TRICARE, however, does not reimburse for this care, requiring instead that patients be referred to more expensive residential or inpatient care, which is often situated farther from where they live. Intensive outpatient services are often the care of choice for more severely impaired patients (Timko, Sempel & Moos, 2003).

Gaps in Where Services are Offered

The Task Force found significant **geographic variation** in the provision of psychological health services to spouses and children that did not appear to match any geographic variation in need. Although some installations provided clinical psychological health care to all beneficiaries, most offered treatment only to active duty service members. This gap is especially problematic, in that many family members prefer to be served by uniformed providers who understand military life, or need to be served by the MTF because the installation is located in a rural area where there are few alternatives in the community. The 2005 Health Care Survey of DOD Beneficiaries revealed a 10 percent decline since 2003 in the percent of active duty families receiving most of their care from MTFs (Andrews et al., 2006).

The Task Force found significant geographic variation in the provision of psychological health services to spouses and children that did not appear to match any geographic variation in need.

At many locations, the Task Force found that service members and family members who rely on the **TRICARE network** have less access to care than TRICARE network provider lists suggest because the lists of mental health professionals were routinely populated by providers who were not accepting TRICARE patients. Providers reported that this was because low TRICARE reimbursement rates prevented them from taking more patients or because certification requirements were onerous. Although there are some mechanisms in the TRICARE system to assist those who have difficulty locating providers (e.g., web-based booking), these are relatively new innovations of which families were not generally aware. According to the 2005 Health Care Survey of DOD Beneficiaries, the proportion of active duty family members reporting difficulty in accessing treatment rose from

25 to 37 percent from 2002 to 2005. Further, beneficiaries relying on TRICARE coverage reported more problems than beneficiaries using other plans (Andrews et al., 2006).

Gaps in to Whom Services are Offered

The Task Force found that **children** had particularly constrained access to clinical treatment services, especially adolescents with substance abuse problems, who are often best treated through intensive outpatient or partial-hospitalization services. Outpatient and partial-hospitalization treatment for substance abuse are virtually non-existent in many geographic regions, requiring families to send their children two to four states away for more expensive inpatient treatment.

Children with special needs also faced long waiting periods for service. According to the 2005 Health Care Survey of DOD Beneficiaries, 36 to 43 percent of families of children with special needs reported problems finding a personal doctor or nurse; 15 to 28 percent reported problems accessing needed care. During site visits, parents frequently reported two- to six-month waits for their children's initial appointment with a psychiatrist. In one especially poignant situation, a deploying father reported his concerns over leaving his wife to struggle with their child with Down syndrome, who would not be seen for an initial child psychiatry appointment for another six months – four months after the father's departure for Iraq.

Members of the National Guard and Reserve also experience particularly constrained access to services.

Members of the National Guard and Reserve also experience particularly constrained access to services. They are more likely to rely upon TRICARE network providers than on MTFs. While on active duty, 72 percent of reservists and 61 percent of family members rely exclusively on TRICARE coverage. In the months following deactivation, 28 percent of reserve members and 38 percent of family members continue to rely exclusively on TRICARE coverage. Further, 29 percent of deactivated reservists and 17 percent of families rely partially on TRICARE coverage (Andrews et al., 2006). When reservists and family members who used civilian coverage exclusively were asked for their reasons, 41 percent of service members and 31 percent of family members reported that it was easier to access care through their civilian plan. Approximately one-third of both groups reported choosing civilian care because they live far from a MTF. A slightly smaller proportion reported that their civilian plan offered a wider selection of providers. Since a substantial proportion of reservists and family members reported no civilian coverage before deployment, and continue to rely exclusively on TRICARE thereafter, constraints in access to care are a real concern.

Outside the clinical treatment system, prevention and early intervention services are also constrained. Relative to active duty families, members of the National Guard and Reserves and their families have limited access to military chaplains, family support programs, and all the other parts of the military landscape designed to support psychological health. Unfortunately, community providers may not be sufficiently aware of or sufficiently trained to fulfill their needs.

During times of high operational tempo, the constraints in the capacity to deliver a full continuum of care to members of the National Guard and Reserves and their eligible family members is particularly problematic because it limits the degree to which they are adequately prepared for deployment, supported during deployment, assisted following deployment, and prepared for subsequent deployments.

Recommendation 5.2.1.1

The Department of Defense should ensure a full continuum of care to support psychological health is available and accessible to all service members and their eligible family members, regardless of location.

This recommendation will be accomplished by changes recommended in the sections on TRICARE, Resources, Staffing, Number of Providers, and Care Obligations.

5.2.2 MAINTAIN CONTINUITY OF CARE ACROSS TRANSITIONS

Continuity of care is essential across all transitions. Military service requires many transitions, including relocation from one base to another, an event that may occur as frequently as once a year in some career fields or as infrequently as every seven years for others, with seven to ten changes in station the norm during a twenty-year career. Other transitions occur in the context of

deployments, which may range from 30 days to 18 months. Another significant and complex transition involves members of the National Guard or Reserve who regularly transition between their military and civilian lives. Finally, the decision to separate or retire from the military is an especially significant transition point for service members and their families.

Military-to-Military Care Transitions Involving Service Members, Family Members and Retirees

This section applies to individuals who receive mental health care at a military installation and whose transition results in their re-initiating care at another military installation.

Military life necessitates moves from one location to another. Even when desired, these changes in location are stressful and they may pose an even greater challenge to those already receiving mental health care. Continuity of care is essential in such cases. However, terminating therapy at one's previous installation and re-establishing therapy at the new location often proves problematic. Often, this transition either does not occur, happens only because of the initiative of the mental health provider who has been seeing the patient, or is left up entirely to a patient who may lack the resources or perseverance to navigate the new system and re-initiate therapy. Few of the military Services have any written requirements delineating the responsibilities of mental health providers and clinics in ensuring continuity of care (for an exception, see *Air Force Instruction 41-210*, pp. 104-106).

Recommendation 5.2.2.1

For transferring service members, each military Service should issue policy and guidance outlining the responsibilities of mental health professionals at the losing and gaining installations to ensure seamless transitions in care from one mental health provider to another.

Provision of excellent mental health services by the gaining health care provider (whether mental health, primary care, or other) is aided by receipt of sufficient documentation of the individual's previous treatment. As there is no mental health module in AHLTA (the DOD electronic health record) at this time, electronic medical record transfer with detailed information on mental health diagnoses and care is not yet possible. This shortfall interferes with continuity across regular military transitions, especially for National Guard and Reserve members and impedes mission-readiness. The Army Automated Behavioral Health Clinic may be a model platform on which to build AHLTA's capacity regarding mental health records (Brown, Etherage & Rein, 2007).

Recommendation 5.2.2.2

The Department of Defense should accelerate development of a mental health module for AHLTA. This mental health module should have the capacity to include assessment results (e.g., the Post-Deployment Health Assessment and the Post-Deployment Health Re-Assessment or their successors as the system evolves) and to flag the need for follow-up of positive screens for mental health problems.

The transition of military service members between their home installations and the deployed environment deserves special attention. The DOD Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications details considerations necessary when military members receiving mental health treatment (therapy and/or medication) are being evaluated for deployment. Unfortunately, this guidance does not require the losing therapist to facilitate re-initiation of therapy with a gaining therapist in the deployed environment, or vice versa. In addition, there is great inter- and intra-Service variation in the disposition of mental health notes taken in the deployed environment—notes that have great relevance for continuity of care. In some cases, therapists reported shredding their mental health notes upon the individual's departure from the deployed environment.

Recommendation 5.2.2.3

The Department of Defense should issue policy and guidance that ensures continuity of care for those who transition to and from deployment and the transfer of deployment-related mental health notes.

Military-to-Civilian Health Care Transitions for Service Members

This section applies to service members receiving mental health care at a military installation whose transition results in their initiating (or re-initiating) care with a civilian organization.

Recommendation 5.2.2.4

The Department of Defense should ensure that patients who transition from military providers to civilian providers, including those in the Department of Veterans' Affairs, receive provider-to-provider handoffs.

According to current legislation (Public Law 105-368 [Title 38 USC 1710(d)(D)]), all veterans, including activated National Guard and Reserve members with combat service after 11 November 1998 are automatically eligible for DVA care related to deployment for up to two years after deployment without application of the eligibility categories that apply to other veterans. Veterans who enroll during this two-year window are rated with regard to eligibility at the conclusion of the period, and though they remain eligible for care, experience the benefits and limitations of their eligibility category. For those veterans who do not enroll with the DVA during this two-year post-discharge period, eligibility for enrollment and subsequent care is based on the process of determining eligibility that is applied to all other veterans and takes into consideration factors such as a compensable service connection rating, veteran pension status, catastrophic disability determination, or the veteran's financial circumstances. Veterans can request service-connected status at any time, which, if approved, places the veteran in one of the highest eligibility categories, based on the degree of their functional impairment.

Of particular concern is how the special two-year eligibility policy relates to the course of PTSD, which is known to have delayed onset in a significant proportion of cases. Decades of research and experience with thousands of Vietnam War, Gulf War and other veterans have established that the onset of severe symptoms of PTSD and other stress reactions may be significantly delayed. Some veterans experience onset of PTSD symptoms as a result of their experiences in OEF/OIF after the special two-year eligibility window has expired. These veterans will be eligible to enter the DVA system but will receive care based on the DVA's existing priority system. An additional concern is that someone may enter the system without special eligibility, be assigned low priority, and not be able to access mental health care while waiting for the outcome of the compensation and pension (C&P) process. The VHA has processes in place to allow treatment for urgent concerns during consideration of a claim for service-connected status, but it is not clear whether these are used consistently.

Recommendation 5.2.2.5

The Department of Veterans' Affairs should ensure that any veteran with diagnosed post-traumatic stress disorder (PTSD) can enroll and receive healthcare services, and any presentation of possible PTSD will be fully evaluated. For any veteran presenting with possible PTSD, a clinical evaluation to determine whether PTSD is an appropriate diagnosis will be conducted, independent of the evaluation done if the veteran is also submitting a claim for PTSD as a service-connected condition.

Later in this report it is recommended that access standards for mental health services provided at DOD facilities and through TRICARE contracts should be modified to allow more ready access to care. For individuals under stress, behavioral health problems may quickly deteriorate. Timely intervention can be crucial. Non-emergent mental health symptoms and disorders must be attended to as quickly as non-emergent medical problems. A comparable standard to that recommended for DOD should also apply to DVA care.

Recommendation 5.2.2.6

The Department of Veterans' Affairs should establish access standards for mental health care of seven days or fewer (depending on the acuteness of the presenting concern).

The adoption of a mental health module for AHLTA (recommended above for immediate action) or another electronic medical record system compatible with the Veterans' Health Information Systems and Technology Architecture (VistA) would support a smoother transition between DOD and DVA facilities. Even if the DOD and DVA medical databases cannot be seamlessly networked, full adoption of an electronic medical record system within DOD would ensure that records could be transferred between the two agencies.

Recommendation 5.2.2.7

The Department of Defense and the Department of Veterans' Affairs should ensure all medical records could be mutually transferred between their electronic medical record systems.

Military-to-Civilian Care for National Guard, Reserve Members, and Their Families

Reservists and National Guard members have been heavily deployed in recent years, and they may live a great distance from DVA or military treatment options. TRICARE mental health benefits could provide necessary mental health services for discharged members and their eligible family members, but based on data from the General Accounting Office (GAO, now the Government Accountability Office; 2003) and site visits, the Task Force is concerned that this care is not sufficiently affordable.

Recommendation 5.2.2.8

The Department of Defense should develop a robust low-cost TRICARE Reserve Select benefit to cover treatment for post-deployment mental health issues for National Guard and Reserve service members.

As a result of the geographic distance between their residences and military installations, Reservists and National Guard members often lack access to local information and referral offices that benefit many active duty members and their families. One potential solution to this problem may be using military recruiting offices as points of contact for current and former service members who need information or assistance. Recruiting is a high-stress job and the intent is not to further burden recruiters with another training-intensive requirement but merely to ensure that recruiters have on hand and are aware of referral sources for national hotlines and in the local area. The Services maintain approximately 13,500 recruiting facilities, often located in more remote geographic locations than military installations.

Recommendation 5.2.2.9

The military Services should ensure the staff of all recruiting centers are aware of, and have materials to distribute regarding, key resources for current or former service members who need assistance (e.g., Military OneSource, Veterans' Clinics).

Currently, National Guard units are prohibited from drilling for 90 days after a unit returns from deployment by a regulation intended to allow time for reintegration into community and family life. However, this regulation has had unintended negative consequences, since it precludes Guard unit members meeting to support each other, process experiences, and receive education and resources to support those having a difficult reintegration experience.

Recommendation 5.2.2.10

National Guard units should resume their usual 30-day drill interval immediately after deactivation. At least the first drill should focus on reintegration issues with attention to discussion of deployment experiences, aspects of reintegration into community life, coping strategies and resilience supports, and other appropriate topics.

Consent Issues during Transitions

Service members are expected to comply with all federal and DOD regulations regarding the member's responsibility to keep the military informed of all psychological health treatment and its impact on mission-readiness (Casciotti, 2007).

Recommendation 5.2.2.11

All individuals, regardless of status (e.g., active duty, Reserve, Guard, family member, retiree), should be briefed on the possible need for transfer of information upon transition as part of their initial orientation to treatment. This briefing should be provided verbally, documented in the clinical record, and incorporated into the confidentiality/consent to treatment forms reviewed and signed by the patient. Prior to their transition, the patient should be informed of the transfer of information and shall be scheduled for an appointment and given the name and contact information of the privileged provider at the gaining organization.

Although consent by active duty members for transfer of information to the provider at the gaining military facility is not required, every effort should be made to involve the patient in this process. Current DVA policies specifically prohibit transfer of clinical information about Reserve and National Guard patients who receive treatment at DVA facilities without patient consent to DOD.

These policies have the potential to allow the military Services to unknowingly recall a Reserve or National Guard service member who is currently not fit for activation or deployment. This is particularly important for matters involving PTSD.

Recommendation 5.2.2.12

The Department of Defense and the Department of Veterans' Affairs should establish a formal agreement for sharing clinical information concerning service members who are part of the National Guard or Reserve systems and subject to activation.

5.2.3 ENSURE HIGH-QUALITY CARE

The Task Force identified six desirable markers of high quality mental healthcare in the military setting, consistent with the Institute of Medicine's (IOM) indicators of high quality care (2001).

Accessibility	Care is easily accessible with minimal delays and minimal unmet need.
Content	A full continuum of care is provided, with routine use of evidence-based practices.
Effectiveness	Care maximizes psychological health, according to ongoing evaluation of outcomes.
Organization	Care is delivered using appropriate resources.
Processes	Care is efficiently delivered, providing timely and accurate clinical documentation to facilitate coordination.
Innovation	Care includes ongoing research to understand underlying psychological processes and develop new methods of prevention, early intervention, and treatment.

Accessibility

Results of the most recent survey of DOD beneficiaries indicate that the percent of respondents reporting they receive timely routine care is lower in MTFs than in civilian facilities. Section 5.2.2 (Maintain Continuity of Care across Transitions) identified gaps in which services are provided, where services are provided, and who receives services. These gaps must be systematically monitored in order to evaluate efforts to eliminate them.

Recommendation 5.2.3.1

The Department of Defense should solicit and fund research to assess barriers to accessing services to support psychological health, particularly in areas remote to military installations, with special emphasis on gaps in the continuum of care identified earlier in this report.

The Task Force commends the Army for conducting annual in-theater assessments of soldiers' and providers' perceptions of psychological concerns and supports.

Access to and Need for Care during Deployment. The Task Force commends the Army for conducting annual in-theater assessments of soldiers' and providers' perceptions of psychological concerns and supports (i.e., MHAT-I, -II, -III and -IV). Data from the MHAT reports show that soldiers' perceptions of mental health care availability have improved each year. The MHAT-III revealed significant improvement in the percent of soldiers who had received training in meeting the demands of deployment-combat-related stressors, which had been a concern in MHAT-II (Robinson, 2004). An especially concerning finding in the MHAT-IV is the increase in the percent of soldiers reporting symptoms consistent with depression and acute stress relative to the previous year. Also of concern is the finding that multiple deployers were significantly more likely to report symptoms consistent with depression, anxiety, acute stress, and concerns about deployment length and lower personal morale than first-time deployers.

Despite reports by mental health professionals suggesting improved confidence in their ability to treat psychological health problems, awareness of the standards for transfer of clinical information fell from a relatively low 35 percent in MHAT-II to 21 percent in MHAT-III (OMNF-1 & OTSG, 2004, 2005). Further, at Task Force meetings, recently returned mental health providers

testified that although deployed military members had ready access to mental health professionals in theater, psychiatrists' availability was sometimes limited because of travel restrictions.

Recommendation 5.2.3.2

The Department of Defense should regularly survey deployed service members and providers to monitor the quality of support for psychological health in the deployed environment.

Content of Care

Applying Evidence-Based Clinical Practice Guidelines. In conjunction with the DVA, DOD has developed comprehensive evidence-based CPGs for assessment and treatment of key psychological disorders, including PTSD, depression, substance abuse and psychosis. These guidelines are not consistently implemented across the DOD and the Task Force was unable to find any mechanism that ensures their widespread use. Furthermore, providers who were interested in utilizing evidence-based approaches complained during site visits that they did not have the time to implement them.

The Task Force was pleased to learn of ongoing efforts to develop evidence-based approaches to care and publish them as part of practice guidelines. However, assuring these practices and guidelines are actually implemented throughout the system is a daunting challenge that requires significant attention by mental health providers. An important component of this effort is research to identify the most effective mechanisms for ensuring the dissemination and implementation of evidence-based practices. An example of such an empirically-based treatment guideline is the Air Force Guide for Managing Suicidal Behavior (2004), which was awarded the American Association of Suicidologists award for Outstanding Contributions in Suicide Prevention.

Recommendation 5.2.3.3

The Department of Defense should ensure that mental health professionals apply evidence-based clinical practice guidelines.

Effectiveness of Care

Assessing quality of care is a resource-intensive enterprise. MTFs conduct patient satisfaction surveys and utilize peer reviews and process measures, but the Task Force found no consistent system for ongoing quality assessment and continuous improvement that includes substantial measurements of psychological health care outcomes. Regularly-scheduled, site-specific inspections by psychological health experts to evaluate the quality of psychological health care are not consistently conducted across DOD. For example, although it is the only Service in which mental health clinics are formally inspected at least once every two years, the Air Force inspection program focuses primarily on process indicators rather than outcomes.

Recommendation 5.2.3.4

The Department of Defense should routinely track and analyze patient outcomes to ensure treatment efficacy.

Based on its 2005 review, the DHB concluded there was "little evidence" for the value of pre- and post-deployment programs, such as pre-deployment and reintegration briefings, to prevent psychological problems (Ostroff & Gibson, 2005). We endorse the following DHB recommendation and suggest extending it to efforts to reduce stigma and interventions designed to treat psychological problems:

Recommendation 5.2.3.5

Current pre- and post-deployment programs and those planned for the future should be studied in controlled clinical trials. The logistics for managing such trials will be difficult. Nevertheless, every effort should be made to design trials that can document the potential short- and long-term efficacy of such programs (Ostroff & Gibson, 2005).

The Mental Health Self-Assessment Program (MHSAP) was recently implemented to provide mental health and alcohol screening and referral for service members and family members affected by deployment and mobilization. The voluntary and anonymous program is offered online, by phone, and through special events held at installations and reserve units. The Task Force applauds DOD's effort to provide this program. It is not yet widely used, however, and planned assessments of its effectiveness are yet to be completed.

Recommendation 5.2.3.6

The Department of Defense should complete an evaluation of the effectiveness of the Mental Health Self-Assessment Program.

Processes of Care

The Task Force was impressed with Fort Lewis's Automated Behavioral Health Clinic (ABHC), which facilitates the systematic collection and analysis of data on the processes and outcomes of care.

The Task Force was impressed with Fort Lewis' Automated Behavioral Health Clinic (ABHC), a pilot program for an electronic behavioral health record that facilitates the systematic collection and analysis of data on the processes and outcomes of care. The system provides outcome measures such as changes in levels of reported stress over the course of treatment and provides a foundation for outcomes tracking, improved clinic efficiency, and better patient care. Data were presented that demonstrated a substantial (18%) increase in the percentage of patients compliant with and completing treatment using the ABHC. Gains in efficiency since implementing the system have allowed the clinic to effectively utilize an open-access approach to care, allowing service members and their families to receive immediate appointments (Brown, Etherage & Rein, 2007).

Recommendation 5.2.3.7

The Department of Defense should expedite development of an electronic record that facilitates the systematic collection and analysis of data on the processes and outcomes of care.

Developing Innovations in Care

Innovations in care often arise through research to understand the processes that generate need and efforts to develop and test new interventions. DOD supports a broad spectrum of research related to psychological health, often in collaboration with DVA and academic partners (see http://www.deploymentlink.osd.mil/deploymed). A research budget that supports both intramural and extramural psychological health research related to military life is crucial. It assures conditions directly related to military service are continually studied and attracts academic partners in these studies. Further, it helps in recruiting of high-quality military mental health professionals who are interested in combining a career of service with academic pursuits.

Understanding Underlying Processes. Effective new interventions can only be developed when the underlying causal processes and the incidence, prevalence, and course of disorders are well understood. In 2005, the DHB reviewed DOD's mental health programs and research activities and recommended needed research (Ostroff & Gibson, 2005). The Task Force endorses their recommendations, and also urges the over-sampling of female service members in such studies to aid the detection of any gender differences.

The DHB also cautioned that most existing research on psychological health as it relates to deployment preclude definitive statements about causation, as it is generally limited to descriptive, retrospective, self-report methods. Such methods are also problematic in that the consequences of deployment may emerge immediately or may be delayed months or years. Thus, the Task Force joins the DHB in recommending research that uses rigorous longitudinal designs with appropriate control groups:

Recommendation 5.2.3.8

Current epidemiological studies designed to determine factors which mediate or modify the observed risk of mental health problems after deployment, such as the 2004 study by Hoge et al. and the Millennium Cohort Study (MCS; a project designed to assess the long-term health of military personnel via periodic surveys for

up to 21 years on approximately 140,000 U.S. military personnel during and after their military service), should be continued. In addition, new studies should focus on service members at increased risk due to special circumstances (such as prolonged deployment). Control groups for these studies must be carefully selected (Ostroff & Gibson, 2005).

Post-deployment longitudinal studies will require much closer collaboration between the Department of Defense and the Department of Veterans' Affairs. Current studies (e.g., MCS) and future studies should employ methods that will assist epidemiologists in tracking the mental health problems and health services utilization of personnel deployed to combat zones over many years. In addition, adequate surveillance should ensure that mortality can be tracked for these personnel and connected to the National Death Index. In the design of health services utilization studies, investigators must account for, even if they cannot document, utilization outside the Department of Defense and the Department of Veterans' Affairs healthcare systems, particularly utilization by service members who separate from military service and return to their private lives (Ostroff & Gibson, 2005).

Despite the acknowledged importance of family members in all phases of deployment and in caring for service members when they have been injured, wounded or disabled, and the high priority given to concerns about family members by deployed service members, family issues do not appear to figure prominently in the research priorities supported by the DOD (APATF, 2007). As such, there are several topics that would benefit from researchers' attention.

Recommendation 5.2.3.9

The Department of Defense should conduct research on the processes of post-deployment adjustment for family members.

Recent combat deployments have produced several thousand survivors of service members killed during deployment. They should be monitored to ensure their needs are being met.

Recommendation 5.2.3.10

The Department of Defense should study the long-term adjustment of survivors of service members killed during deployment, including their access to support for psychological health issues.

Recent combat deployments have also produced thousands of children who must re-establish relationships with parents from whom they have been separated for extended periods of time or who have been severely injured – both physically and psychologically. Little is known about the long-term effects of military service stressors on children's adjustment or on effective methods for assisting them in adjusting to their circumstances.

Recommendation 5.2.3.11

The Department of Defense should conduct research on children who have been separated from their parents by deployment and children whose parents have been severely wounded or injured as a result of military service.

Developing New Interventions. Every service member is characterized by psychological strengths, aptitudes and vulnerabilities. Little attention, however, has been paid to the individual psychological aspects of military service, which are an integral part of combat operations. Weapons proficiency is a relatively easily learned skill. Combat tactics are thoroughly taught and reinforced in war games. Physical fitness is extolled as the primary individual preparation for military service. However, little attention is paid to enhancing cognitive fitness and psychological resilience – the attributes most celebrated in the military's finest leaders and combat heroes. Many, especially young service members are vulnerable to psychological trauma. Their vulnerability should be assessed early in their careers and remediated to the maximum extent possible.

Recommendation 5.2.3.12

The Department of Defense should create (and continually validate) a measurement tool that will inform the military Services of service members' psychological strengths and weaknesses at accession. This tool will

help direct training and educational programs tailored to the service members' needs. It will also provide data for longitudinal studies assessing the efficacy of and guiding the improvement of training programs.

Recommendation 5.2.3.13

The Department of Defense should create a tri-Service center of excellence for the study of resilience. Goals of the center would be to study the origins and contributing factors for resilience, develop and evaluate methods for enhancing individual psychological fitness, and track the efficacy of such training and education programs.

The Special Case of TBI. A section at the end of this report addresses psychological health issues specifically related to TBI.

5.2.4 PROVIDE FAMILY MEMBERS WITH EXCELLENT ACCESS TO CARE

Family Members

The well-being of one's family affects a service member throughout his or her career and plays an integral role in readiness to deploy in a moment's notice. Steady increases in the tempo of military operations beginning long before the current conflict have exerted additional demands on families, with the current operational tempo taxing even the most resilient families. Some families have been separated as long as three years, in repeated increments of three, six, seven, twelve, and eighteen months. While military families are resilient (Bell & Schumm, 1998), they continue to confront barriers in access to mental health care, challenges receiving needed support during the deployment cycle, shortages of care for children, and difficulties in receiving services after a service member has been injured or killed.

Family members, service members, and service providers repeatedly told the Task Force that lengthy or multiple deployments strain marriages and other relationships.

Consistent with recent research (Hosek, Kavanagh & Miller, 2006; Huebner & Mancini, 2005; Jumper et al., 2006), service members, family members, and service providers reported during Task Force site visits that lengthy or multiple deployments strain marriages and other relationships, especially for single service members attempting to establish or maintain quality relationships. Many reported that their spouses would likely divorce them before enduring another deployment and separation. According to MHAT-IV data, 20 percent of married soldiers reported planning to separate or divorce (2006), a 5 percent increase from the prior year (MHAT-III, 2005). However, these reports are not consistent with recent analyses showing no measurable spike in marital dissolution since the beginning of current operations (Karney & Crown, 2007); as such, further investigation is needed. Service members also expressed concern about financial worries and apprehension about the long-term effects of the separation on their relationship with their children. Family members expressed anger about last-minute extensions of deployments, which were especially traumatic when the member's return was imminent (Hosek, Kavanagh & Miller, 2005).

Expanding the Military Definition of 'Family'

During deployment, especially in times of high operational tempo, military members rely on support systems of family and friends to provide both emotional and logistical support. DOD has heretofore regarded a service member's family as comprising only his or her spouse and children. Only slightly more than half of military members, however, are married (DMDC, 2006). For those who are not married, and many of those who are, parents and extended family members constitute key elements of the service member's support system. During deployment, parents often intervene when a single parent or both parents in a dual-military family need assistance with caring for their children. Following deployment, parents often step in when a service member is injured or wounded and needs an advocate in the hospital or a caregiver at home. For these family members, the process of gaining access to installations and other facilities is often unnecessarily cumbersome.

Recommendation 5.2.4.1

The Department of Defense should improve coordination of care by ensuring appropriate access to installations for designated family members who are caring for family members but who do not possess military identification cards. Caregivers such as grandparents and other designated guardians caring for

service members' children during a deployment and parents of wounded service members need access to installations to care for their loved one.

Extended family members are often the first to notice that a returning service member has symptoms that require attention from a health professional. Many parents of service members expect to have access to information about the whereabouts and well-being of their deployed children. Spouses and parents frequently expressed the desire to know more about mental health, specifically how to seek help for their loved ones and obtain support for themselves. Family members want more information and training on how to recognize signs of combat stress and PTSD and how to handle challenging situations that might arise after the service member's return. Family members are placing increased demands on military units and family readiness groups to include them in communication efforts during deployments, and during the return and reunion period (Hosek, Kavanagh & Miller, 2006). Service members are currently permitted to name only a very small number of persons who will be provided information in very specific circumstances.

Recommendation 5.2.4.2

Contact forms completed prior to deployment should be amended to permit service members to indicate names and contact information of multiple family members for whom they give permission for different levels of communication to occur (e.g., educational information, location information, emergency information).

Deployment Cycle Support

Preventive efforts to support families throughout the deployment cycle are provided by a number of military support programs, services and activities, but participation is low for a variety of reasons, including: event schedules that conflict with work schedules or school transportation arrangements, lack of child care, travel distance, and lack of awareness of existing services (DOD Advisory Committee on Women in the Service, 2003). These challenges apply to active duty families assigned to military installations and especially to families of National Guard and Reserve service members who often live at great distance from installations.

The Task Force commends the recently developed program for children, produced by Sesame Street: "Talk, Listen, Connect: Helping Families during Military Deployment." The collaboration between DOD, Sesame Street, Wal-Mart, the Military Child Education Coalition, the New York State Office of Mental Health and Military OneSource is an example of a proactive initiative appreciated by military families. Over 100,000 copies of these materials were requested during their first week of availability.

Juxtaposed with these reports of low participation were repeated reports during site visits and testimony that family members have a strong desire to receive information and reassurance, particularly during deployments. The Joint Task Force for Family Readiness Education on Deployment Customer Feedback Initiative recently conducted focus groups to identify concerns of family members. Psychological health was among the top concerns reported by respondents, with respondents indicating they:

- Want tools they can use to confidentially assess their own concerns;
- Are concerned about the fear and stigma associated with service members seeking help;
- Want access to confidential assistance;
- Want reassurance that what they are experiencing is normal; and
- Want Reserve centers to do a better job of informing service members and family members about deployment support and psychological health services.

Several initiatives within DOD are responsive to these priorities. Military OneSource offers confidential resource and referral services that can be accessed around the clock via telephone, the Internet, and e-mail, in addition to confidential family and personal counseling services in local communities across the country. Face-to-face counseling services are provided for all active duty and reserve component members and their families at no cost for up to six sessions per person per problem. The MHSAP (www.militarymentalhealth.org) offers anonymous self-administered assessments via the Internet, telephone or in person for depression, bipolar disorder, alcohol use, post-traumatic stress disorder, and generalized anxiety disorder.

Organizations in the civilian community also have made useful contributions to support military families during the deployment cycle. The Task Force commends the recently developed program for children, produced by Sesame Street: "Talk Listen, Connect: Helping Families during Military Deployment." The collaboration between DOD, Sesame Workshop, Wal-Mart, the Military Child Education Coalition, the New York State Office of Mental Health and Military OneSource is an example of a proactive initiative appreciated by military families. Over 100,000 copies of these materials were requested during their first week of availability.

Despite these positive steps, too many service members and family members in both the active and reserve components continue to lack sufficient knowledge of key issues and resources related to psychological health.

Recommendation 5.2.4.3

The Department of Defense should ensure needed deployment support information and resources are delivered to family members and stimulate family member participation through information-sharing activities. New delivery methods may need to be developed and additional resources may be required to encourage family members' attendance.

The Task Force is concerned that the needs of military families during times of high operational tempo are more substantial than volunteers and leaders of Family Readiness Groups (FRGs) can manage without greater support.

Recommendation 5.2.4.4

The military Services should formalize and fund volunteer family support services for the families of deployed service members. Current volunteer systems should be formalized and funded as a direct unit support function and command responsibility. These programs should be coordinated and monitored at the Service level.

The post-deployment period is of special concern for many families. All branches of military service recognize the importance of educating service members and their families and have taken steps to improve the return and reunion process. However, most return and reunion programs in both the Active and Reserve Components end soon after service members' return from deployment, long before families have completed their readjustment.

The Task Force learned about creative initiatives to address families' needs during the reunion period. For example, the Army's chaplain-led Strong Bonds program recognizes the unique needs of married couples and single service members in relationships. Several National Guard units have also planned and implemented return and reunion programs, such as the OHIOCARES program. Under the Minnesota Governor's leadership, a coalition of federal, state, county and local agencies are networked to assist combat veterans and their families. In addition, Minnesota is one of the few states that have developed a statewide program, called Family Reintegration Academies, to help National Guard Soldiers rejoin their families and return to life as a civilian. The program includes workshops for both Soldiers and their family members on TRICARE; Military OneSource; coping strategies; state and federal Departments of Veterans Affairs; marriage, parenting, and single Soldier issues; and the emotional effects of war. The program is conducted across the state, in every Minnesota community with a National Guard armory, to increase accessibility for all Minnesota Guard members and their families.

Although DOD is working to implement information and programs that support reintegration and reunion, there is a need for more information about families' experiences throughout the reunion period and for well-designed evaluations of return and reunion programs, focusing not just on service members (as is the case with most military research), but also on family members.

Recommendation 5.2.4.5

The military Services should develop effective evidence-based return and reunion programs for all service members, including National Guard and Reserve members, and their families.

Barriers to Mental Health Services

A consistent theme that emerged during Task Force site visits was that families perceive, and care providers confirm, that family members have difficulty obtaining mental health services in the existing system. During times of high operational tempo, the mental health infrastructure greatly expands its coverage area as mental health professionals deploy. At home, the remaining mental health professionals must prepare for and recover from their own deployments while serving other deploying service members and their family members. Beyond clinical treatment facilities, family members reported that chaplains (who also deploy) and family center staff were also in high demand.

Family members were especially frustrated when referred for off-base care that was frequently difficult to obtain. It was not unusual for a family member to be given a list of names and phone numbers for 30 to 100 community therapists. Family members reported that the results of each call were the same: Either the therapist was not accepting TRICARE patients at this time or the first available appointment was too far in the future. It was common for family members to report that they gave up after the tenth or eleventh call.

Although the number of care providers on installations is sharply reduced during deployments (as is the number of service members), the need for prevention, early intervention and treatment services remains high. Deployment challenges are stressful for children and parents remaining at home, which generate increases in requests for assistance. Quantitative data reviewed during our site visits showed, for example, that substance abuse cases on installations did not decrease, despite the deployment of several thousand members (Sutton, 2007).

Specialized mental health care for children and adolescents appears to be in particularly short supply (Novier, 2007). It was not unusual for a parent to report waiting six to nine months for an initial child psychiatry outpatient appointment or for providers to report that children had to be sent to another state for inpatient treatment. Given the potential severity and long-term consequences of children's mental health problems, such as eating disorders and substance abuse, these gaps in availability are particularly worrisome. In the most recent survey of DOD beneficiaries, parents of children with special needs who rely on TRICARE were more likely to report problems getting the care needed by their children than parents whose children did not have special needs (Andrews et al., 2006).

Paradoxically, although the on-base capacity to support psychological health is reduced during deployment in an effort to devote resources to supporting the health of deployed service members, this reduction in service availability contributes to the distress and distraction of deployed service members who worry about family members at home who cannot obtain needed assistance. In a recent survey of deployed Army soldiers, family separation was one of the top two non-combat stressors for both Active and Reserve Component soldiers in the Army (OMNF-I & OTSG, 2005).

Later sections of this report contain specific recommendations about staffing the infrastructure for providing mental health services. Here, we focus on the end goal of those recommendations:

> Recommendation 5.2.4.6
>
> *The Department of Defense should ensure that spouses and children of service members on active duty have access to mental health care as readily as service members, including at military treatment facilities.*

Schools Serving Military Children

The President's New Freedom Commission on Mental Health (2003) recognized the critical role that schools can play in the continuum of mental health services. DOD Dependent Schools (DODDS), Domestic Dependent Elementary and Secondary Schools (DDESS) and community schools can be challenged when many students experience parental deployments. The Task Force was told that children's behavioral issues often escalate during a service parent's deployment. Although all schools deal with behavioral issues, schools with large representations of military children may deal with these behavioral and adjustment issues more regularly.

Many installations maintain good working relationships with their local school districts through their School Liaison Officer (SLO). SLOs serve a vital role in helping principals and parents work together to ensure that teachers are aware of students who have deployed parents. But the role of SLO is often an additional duty, and when this duty was marginally performed, it was readily

apparent. While SLOs appear to be able to interact with local communities adjacent to installations, it is not clear that National Guard and Reserve State Program Coordinators can provide all needed assistance to the schools of National Guard and Reserve children who are not located close to a military installation.

Recommendation 5.2.4.7

The Department of Defense should develop evidence-based educational materials to assist teachers and school administrators in supporting children of deployed parents.

Care for Survivors and Families of Wounded Service Members

The military Services have engaged in efforts to provide better training to Casualty Assistance Calls Officers (CACOs) and ensure survivors receive accurate information in a timely manner. The Army has established the Families First Casualty Call Center, a one-stop resolution center to assist surviving family members with questions concerning benefits, outreach, advocacy and support. This call center is available for immediate and extended family members. Also, the DOD/DVA Committee on Survivors meets regularly to review concerns as they arise. Despite these efforts, however, some widows and/or parent survivors of service members have reported that they still do not know whom to call regarding their concerns.

Few data are available to address the long-term mental health needs of the survivors of deceased service members. Many of the issues facing survivors also affect wounded service members and their families. Because many of these service members will be medically retired and continue to access military health benefits in addition to DVA assistance, appropriate mental health services must be available in both health care systems to assist them and their families. Counselors working with these families must understand the psychological effects of military Service and help them deal with the ongoing challenges involved in caring for wounded service members.

Recommendation 5.2.4.8

Each Service Casualty Assistance Calls Office should provide appropriate staff for long-term support and follow-up of survivors after the conclusion of Casualty Assistance Calls Officer responsibilities. These individuals would offer assistance in gaining access to resources and services such as grief counseling. These staff members would also be responsible for developing resources for families living in or moving to areas of the country not near a military base, including Reserve and National Guard families.

5.3 PROVIDING SUFFICIENT RESOURCES AND ALLOCATING THEM ACCORDING TO REQUIREMENTS

5.3.1 Provide Sufficient Resources for the Support of Psychological Health

The single finding that underpins all others in this report is that DOD currently lacks the resources – both funding and personnel – to adequately support the psychological health of service members and their families in times of peace and conflict. Unless Congress provides sufficient new funds to allow adequate staffing to provide a full continuum of services, including enhancing the resilience of the force, prevention, assessment and treatment, few of the recommendations of this Task Force can be implemented.

The single finding that underpins all others in this report is that DOD currently lacks the resources – both funding and personnel – to adequately support the psychological health of service members and their families in times of peace and conflict.

Recommendation 5.3.1.1

Congress should provide, and the military Services should allocate, sufficient and continuing funding to fully implement and properly staff an effective system supporting the psychological health of service members and their families.

As noted throughout this report, service members and their families experience unique stressors as part of the military experience. The delivery of high-quality care for psychological health, including prevention, early intervention and treatment, requires providers who are knowledgeable about and able to empathize with the military experience. The military recognizes the importance of a designated primary care provider for each service member and family member, and MTFs and medical components of combat units are generally staffed to assure such coverage. This is equally important for basic mental health services, where a personal connection between the provider and the recipient of services is crucial to the provision of high-quality services.

Recommendation 5.3.1.2

The Department of Defense should provide sufficient funding to support the full continuum of psychological health services for service members and their families.

Ensuring the successful readjustment of Reserve Component members is a DOD obligation. These military members incur psychological burdens at least as great as those of Active Component service members (Wheeler, 2007). Meeting the needs of Reserve Component members, however, presents unique challenges. One such challenge is their decentralized organizational structure.

Recommendation 5.3.1.3

Congress should provide, and the military Services should allocate, sufficient and continuing funding to fully implement and properly staff an effective system delivering a full continuum of psychological care to Reserve and National Guard service members and their eligible family members.

Congress and the DOD should immediately correct the systemic funding and personnel shortfalls that are adversely impacting service members in the Active and Reserve Components and their families. The Task Force recognizes that implementation of these recommendations will come at additional cost. The financial burden of this new Congressionally-mandated funding, however, is offset by the imperative to effectively treat the psychological needs of service members, their families, and survivors. Investments in prevention and early intervention will also produce savings by reducing untreated dysfunction and long-term costs in medical utilization and disability payments, attrition, and training. Additional resources will allow DOD to:

- Provide a full continuum of care to service members and their families.
- Restore injured service members and their families, and provide long-term care for survivors' psychological health.
- Retain and recruit active duty mental health professionals.

- Embed mental health professionals in locations where they can be approached with minimal stigma, such as uniformed professionals at the unit level and mental health professionals in primary care settings.
- Create and disseminate the "stigma-busting" educational programs needed to overcome existing barriers to seeking mental health services.
- Expand efforts to assure quality of care and develop effective new interventions.
- Transform the role and capacity of the provider community to better support building and maintaining the resilience of service members and their families through prevention, consultation with commanders at all levels, and other efforts to reduce stigma for seeking psychological health services.
- Reform TRICARE contractual services to assure readily-accessible and timely service for those service members and family members who live too far from an installation to receive services there. This is especially critical for National Guard and Reserve service members and their families.
- Provide a leadership structure for psychological health within DOD that will ensure the consistent implantation of a full continuum of care in all armed services, monitor quality, and provide advocacy for service members' mental health needs.

DOD cannot rely solely on current processes for hiring or contracting for staff, which are often cumbersome and time-consuming, to meet its mental health staffing goals. Only a fraction of the staff needed can be recruited in the near term. As such, immediate action must be taken to improve current efforts and create new initiatives to meet staffing goals.

Recommendation 5.3.1.4

The Department of Defense should immediately act on the recommendations in this report to refine recruiting programs for uniformed and civilian mental health providers and develop new programs to attract and retain mental health professionals in military service.

5.3.2 Provide Sufficient Staff and Allocate Them Properly

Mental health services housed within DOD's MTFs or assigned to combat units currently lack the resources required to provide a full continuum of clinical care for active duty members and their families...departments often fit their mission to their resources rather than designing their services to meet the actual need.

Mental health services housed within DOD's MTFs or assigned to combat units currently lack the resources required to provide a full continuum of clinical care for active duty members and their families, and to provide crucial preventive and resilience-building services for service members. A recent review of mental health care in 22 Army MTFs concluded:

> As a result of staff, funding, and space limitations, departments often fit their mission to their resources rather than designing their services to meet the actual need. They work to provide the level of care that they believe to be reasonable with the staff on hand (Novier, 2007, p. 31).

The lack of capacity at MTFs results in delays in care for service members and often requires family members living near or on a base to rely on uneven community services to meet their needs.

Care Must be Provided by Professionals Familiar with Military Life

While community contracts may be adequate for specialized medical and surgical services, they are inadequate for providing mental health services to service members and their families for the following reasons:

- Psychological health services, particularly psychiatric assessment and psychotherapeutic services, are best provided by a professional who fully understands the social and psychological context in which the patient functions. The military is a unique cultural context, and the psychological health problems experienced by service members and their families are inextricable from the unique experiences of military service.
- As detailed in our subsequent recommendations on contractual TRICARE services (Section 5.3.4, Ensure TRICARE Networks Fulfill Beneficiaries' Psychological Health Needs), the community-based network of providers is not

consistently knowledgeable about military life stressors, and is not readily accessible in many locales, particularly in rural communities where many military installations are located. This may be particularly evident for National Guard and Reserve Component members.

- Every service member and family member stationed at an installation is assigned a primary care provider for their basic medical care. Mental health concerns require comparable treatment, provided by someone easily accessible and thoroughly knowledgeable about the military.
- Access to uniformed mental health professionals or civilian mental health professionals who are full-time employees, especially those with recent military experience, is critical to decreasing the negative impact of stigma. Stigma remains pervasive and inhibits service members from seeking timely psychological health care. This finding is well documented in DOD research and anonymous survey data (Bray et al., 2006) and was openly and universally acknowledged by service members, family members, commanders and psychological health providers during our site visits.

There is an Inadequate Number of Providers

A thorough review of available staffing data and findings from site visits to 38 military installations around the world clearly established that current mental health staff are unable to provide services to active members and their families in a timely manner; do not have sufficient resources to provide newer evidence-based interventions in the manner prescribed; and do not have the resources to provide prevention and training for service members or leaders that could build resilience and ameliorate the long-term adverse effects of extreme stress (APATF, 2007). A comprehensive array of prevention, assessment and intervention services is necessary to build and maintain the resilience of service members and to ameliorate the inevitable effects of stress on service members and their families. This full spectrum of services critical to maintaining the mission readiness of the force would include:

A comprehensive array of prevention, assessment and intervention services is necessary to build and maintain resilience and to ameliorate the inevitable effects of stress on service members and their families.

Training in expected responses to battle stress, such as the Army's *"Battlemind"* Program, provided to both service members and their families prior to and following deployment, or the Marine Operational Stress Surveillance & Training (MOSST) program, an integrated progression of educational briefs, health assessments, and leadership tools designed to prevent, identify early, and effectively manage combat/operational stress injuries related to the deployment cycle.

- Suicide prevention programs and early interventions for those at greatest risk for suicidal behavior;
- Unit-based consultation and training with line leadership on the recognition and early management of psychological health issues, including combat stress;
- Face-to-face periodic psychological health assessment for all active duty members; and
- A full continuum of support for the psychological health of active duty members and their families.

Several national reports, including the President's New Freedom Commission Report and the Surgeon General's Report on Mental Health in America, have underscored the necessity of adopting a public health approach to mental health emphasizing prevention and early intervention. The DVA has recognized the critical role of basic mental health services to the health of veterans and mandated that all DVA community-based clinics provide both basic medical care **and** basic mental health care. The MHS already recognizes the importance of providing ready access to basic medical care through primary care providers in internal medicine, family medicine, and pediatrics, and military facilities are generally staffed to provide such care for all active duty members and their dependents. The nature of military duty—the stresses inherent in preparing for and conducting armed combat, and their impact on the long-term mental health of active duty members and their families and on military readiness—dictates that the MHS should adopt a similar policy.

Currently, mental health care is considered "specialty" care, and subject to the criteria and expectations of access for specialty care rather than basic or primary care. While dire emergencies are seen immediately, patients may wait up to 30 days for a mental health appointment. The policy of tolerating long waits for initial mental health clinic appointments is inconsistent with the frequency and magnitude of mental health problems in the military. The stressors inherent in military life make basic mental health services as critical and time-sensitive as basic medical care. For individuals under stress, psychological health problems may quickly deteriorate. Stigma may cause active duty members to delay seeking help. As such, timely intervention is crucial.

Fortunately, such a goal is achievable. On its site visits, the Task Force saw examples in all military Services of clinics that have successfully implemented an open access approach to basic mental health services that provides ready access.

Recommendation 5.3.2.1

The Department of Defense should ensure staffing levels are sufficient to permit service members and their families to receive timely mental health treatment services from staff assigned to military treatment facilities, and to permit service members to receive timely consultations in their line units.

Recommendation 5.3.2.2

The Department of Defense should establish access standards for mental health care at seven days or fewer (depending on the acuteness of the presenting concern), paralleling the access standards for primary care services.

Insufficient funding is exacerbated by a resource distribution system that fails to equitably distribute available resources. Too often, the psychological health services available to service members and their families depend on their location rather than their psychological health needs.

The Current Allocation System is Problematic

The distribution of resources for mental health programs within the DOD is currently based on a centralized system for evaluating the amount of workload produced. Relative value units (RVUs) are assigned to each outpatient procedure (e.g., group psychotherapy, initial psychiatric assessment) and the productivity of the program is calculated based on the sum of RVUs generated. There are a number of flaws inherent in the current allocation system (AMEDD, 2006). For example, suppressed demand is not tracked, and the incentives inherent in the system do not foster efficiency or adequately support the broad mission of psychological health, especially in the area of prevention (APATF, 2007; Novier, 2007). The RVU system is built on a model for narrowly-defined, billable mental health services. Inadequate credit is given for resilience-building duties, consultations with command, prevention efforts, or for services such as marital counseling.

Over the past two decades, both private and public sector mental health delivery systems have moved away from RVUs in determining and allocating resources (Elisha, Levinson and Grinshpoon, 2004). This is particularly true of systems with a clearly-defined service population, including staff model HMOs and some public systems (Dial, Bergsten, Haviland & Pincus, 1998; Scheffler & Ivey, 1998).

These systems assess both the need and demand for mental health services for a specified population of potential recipients of care (commonly termed "covered lives"), and then calculate the mental health resources that can most efficiently and effectively produce the services required (Faulkner & Goldman, 1997; Elisha, Levinson & Grinshpoon, 2004). In determining both need and demand, the unique characteristics of the population being served must be considered. These include demographic variables such as age, gender and socioeconomic status; risks for morbidity such as common stressors; and occupational risk factors (Jaffa, Lelliott, O'Herlihy Worrall, Hill & Banerjee, 2004; Taube, Goldman & Burns, 1998; Timko, Lesar, Calvi & Moos, 2003). In calculating the range of required behavioral health services, emphasis is placed on prevention and early interventions that decrease the ultimate utilization of costly intensive interventions.

A DOD mental health resource allocation system based on meeting the needs of a specified population of beneficiaries would be a significant improvement over the current RVU-based method for distributing resources for the following reasons:

- Psychological health programs are responsible for a clearly-delineated population of active duty members and their dependents.
- The covered population has well-defined, unique characteristics that can be factored into the allocation system as risk factors.
- DOD has conducted research useful in estimating the needs for mental health services, including new research on the incidence of post-deployment psychological health problems.

- Critical functions performed by mental health professionals that are not creditable under an RVU system can be factored into the population-based staffing formula. These include building resilience in service members and other preventive interventions to reduce the adverse effects of extreme stress.
- An appropriately adjusted population-based system would assure equity of access for service members and their families. The current RVU system has resulted in wide disparities in the availability of services among military installations of similar size.
- A capitated system promotes the use of effective short-term evidence-based approaches to care.
- Appropriate resources to fully implement newer evidence-based interventions can be factored into resource allocation.
- A demand-based system can more effectively manage surges in need, including surges related to combat trauma.
- A population-based system allows for adjustments for risk factors that suppress access such as stigma, which has been identified as a significant issue.

Ample data exist to craft a risk-adjusted population-based resource allocation system for mental health services in DOD. Data on the modal number of psychiatrists and other mental health professionals common in private and selected public sector populations are available for both outpatient and inpatient services, including for children (Faulkner & Goldman, 1997; Dial, Bergsten Haviland & Pincus, 1998; Jaffa, Lelliott, O'Herlihy Worrall, Hill & Banerjee, 2004). DOD has adequate expertise to adjust these figures according to the unique needs of a military population. DOD could simultaneously standardize the mix of mental health professionals across the military Services.

Workload-based metrics, such as RVUs, could continue to be used to monitor clinical direct care productivity and individual program and staff productivity within the population-based allocation system, but should be adapted to better account for prevention activities.

The Task Force conducted a preliminary analysis considering available published data on capitated mental health staffing in staff model HMOs and the additional responsibilities of military mental health workers for prevention, consultation, assessment and resilience-building functions, and the optimal embedded mental staffing for combat units. The Task Force's findings suggest a need for one psychiatrist full-time equivalent and four other mental health professional (e.g., psychologist and social worker) full-time equivalents per 5,000 to 8,000 covered lives. This would include active duty personnel and family members living in reasonable proximity to a military base. More detailed analyses of the impact of risk factors such as the rural nature of the base, the age of the targeted beneficiaries, and the deployment responsibilities of the combat units covered, should be conducted to further refine the population-based staffing model to assure an adequate array of services are available at smaller bases. The model must also be refined to specify which positions are the highest priority for the assignment of uniformed, rather than civilian, mental health professionals.

Recommendation 5.3.2.3

The Department of Defense should adopt a risk-adjusted population-based model for allocating resources to military mental health facilities and services embedded in line units. Allocations should be regularly reviewed to update risk assessments.

5.3.3 Ensure an Adequate Supply of Uniformed Providers

Uniformed Mental Health Professionals Are Critical Resources

Uniformed mental health workers are best able to consult with an educate commanders, and to make crucial judgments about deployment readiness and retention. Uniformed mental health professionals are cognizant of military culture, including the social context in which psychological problems arise and must be treated. Their uniform signifies their shared experience and provides credibility when consulting with and providing training to line officers and non-commissioned officers. Further, it helps build the confidence and trust that is central to the therapeutic relationship that underlies effective mental health treatment. A uniformed provider has the knowledge base necessary to make informed decisions regarding the deployment potential of a service member, and to inform the often complex decisions involved in a MEB to determine fitness for continued military service. These skills are equally important in theater and in garrison.

Recognizing the psychological stress that combat places on service members and the value of early detection and intervention, the Army and Marine Corps have begun assigning and deploying uniformed mental health professionals with specific combat units. DOD has conducted four large in-theater studies of mental health issues (i.e., MHAT-I, -II, -III, -IV) that underscore the need and value of combat mental health support. The recently released results of the fourth study (OMNF-I & OTSG, 2005, 2006) show that:

- The level of combat stress has increased steadily. In the most recent cohort, over 75 percent reported experiencing life-threatening situations, up from 45 percent in the prior study.
- 20 percent of soldiers reported depression, anxiety or acute stress.
- Multiple deployers reported significantly higher levels of stress than first-time deployers.
- In the MHAT-III, 30 percent of participants reported receiving mental health care during deployment.

During site visits, service members told the Task Force that they were more likely to approach a mental health professional in uniform and to see them as an integral part of the combat team. In sum, the psychological needs of deployed service members are great and uniformed military mental health providers embedded into the combat unit are best suited to meet these critical needs.

The Military Faces Significant Challenges in Recruiting and Retaining Active Duty Mental Health Professionals

The number of active duty mental health professionals is likely to continue to decrease unless incentives change. When uniformed mental health professionals were asked if they intended to remain in the military and what factors influenced that decision, the following common themes emerged:

- The strain of repeated and protracted deployments on family life.
- Frustrations with a promotion rating system they perceive does not sufficiently value excellence in providing clinical care. Many mental health professionals are evaluated in mixed cohorts judged by standards they feel are weighted to favor administrative duties.
- The perception that career advancement and financial incentives are greater outside of the military.
- Owing to overall shortages, uniformed mental health professionals in the Navy and Air Force are being required to deploy with Army units and to occupy roles that diverge from their traditional doctrine and training.

Uniformed mental health professionals consistently voiced the belief that they or their peers were less likely to remain in the military than previous generations of active duty professionals. This sentiment is reinforced by data demonstrating the dramatic decreases in the number of active duty mental health professionals. Data supplied by the Air Force (2007) indicate that from FY03 to FY07, the number of active duty mental health professionals dropped by 20 percent. Data from the Navy (2007) indicate a 15 percent decline from FY03 to FY06, with more than half that decline occurring between FY05 and FY06 (no FY07 data were provided). Army (2007) data revealed a decline of 8 percent from FY03 to FY05; however, no data were provided for the past two years, during which the decline was most pronounced in the other Services.

The military Services use undergraduate and graduate medical education (GME) support as the foundation of their efforts to supply an adequate number of new active duty psychiatrists and psychologists. Unfortunately, recent trends in these programs are not favorable at either the undergraduate or GME levels. For example, professional psychologists are a major component of the uniformed military cadre. A preponderance of the psychologists in uniform is drawn into the military through the psychology internship programs. Historically, these have been highly sought internship placements, attracting highly qualified applicants that far exceeded the number of slots available. On the site visits, the Task Force heard from Psychology Internship Coordinators that the number of highly-qualified applicants had dropped dramatically. In February, the results of the national match for psychology internships were announced. The Army filled only 13 of 36 slots, while the Air Force filled only 13 of 24 slots. Given the four-year military service commitment of these interns, this shortfall in the major pipeline feeding the psychology corps will have ramifications for years to come.

The Services have programs in place to provide financial incentives to recruit and retain mental health professionals, such as loan repayment programs and bonuses; however, the data clearly indicate that these programs are not accomplishing their goals. Loan repayment programs must be predictable and sustained. Bonuses must keep pace with community incentives, particularly in rural areas where many installations are situated, and for shortage specialties such as child psychiatry.

Recommendation 5.3.3.1

The Department of Defense should thoroughly review and increase the effectiveness of incentives to attract and retain highly-qualified active duty mental health professionals and initiate new programs to meet recruiting and retention goals.

A predictable career path, where excellence is rewarded for the full range of clinical and supervisory skills, is crucial for retention and recruitment of professionals. The career path in the military must be benchmarked to and competitive with community employers of mental health professionals.

Recommendation 5.3.3.2

The Department of Defense should ensure an adequate career path for professional development. Excellence in all aspects professional life, including clinical excellence, must be equitably rewarded.

The problem is aggravated by inconsistent patterns for staffing mental health teams across the military Services. There is inexplicable variation across Services in the mix of mental health professionals in uniform (DMDC, 2006a). For example, although clinical social workers represent the largest group of mental health practitioners in the nation, playing a vital role in providing the full array of approaches for assessment and treatment of psychological problems, the Navy allows social workers to work only within a small portion of their full scope of services. As such, the Navy has very few social workers assigned to mental health teams, in contrast with the community standards and practices within the Army and Air Force. During FY05, the most recent data available to the Task Force, social workers comprised 33 percent of the total of psychiatrists, psychologists, and social workers in the active duty Army, 38 percent in the active duty Air Force, and only 11 percent in the active duty Navy (DMDC, 2006b).

Recommendation 5.3.3.3

The Department of Defense should consistently use the full spectrum of mental health professionals, including social workers, to provide a comprehensive continuum of mental health care.

Maximize the Use of Uniformed Mental Health Technicians

The military Services invest heavily in the selection and training of enlisted mental health technicians. These technicians possess significant knowledge of the military context, have credibility with fellow enlisted men and women, and are able to empathize with the stressors they face. The Task Force repeatedly noted that these technicians are being underutilized, often spending their time performing clerical tasks rather than the therapeutic support roles for which they were trained and which they are expected to exercise competently when deployed. Technicians frequently expressed frustration with the limitations in their garrison roles and their impact on morale and retention.

Recommendation 5.3.3.4

The Department of Defense should fully utilize the skills and training of military mental health technicians. This would be facilitated by clinic staffing patterns that include hiring civilian support staff.

Decisions to reduce or civilianize the work force must consider how important it is that the position being considered be filled with a person in uniform. Military mental health providers have credibility with and acceptance from commanders and service members, are able to deploy to combat theatres, and are best able to make the complex determinations regarding deployability and retention.

DOD leadership must recognize the unique importance of uniformed mental health professionals. The Task Force recognizes there are pressures to "civilianize" the military work force. As previously noted, DOD has already dramatically reduced its number of active duty mental health professionals and there are proposals to further reduce active duty staffing. For example, the Air Force has announced plans to cut uniformed psychologist positions by an additional 10 percent from the FY07 levels, which are already down by 23 percent from FY03. The Air Force also plans to reduce the number of social workers by an additional 20 percent from the already deflated FY07 numbers (down 27% from FY03 levels) (DACOWITS, 2003). The shrinking complement

of uniformed mental health professionals is increasingly being used as a cross-Service resource. Consequently, a reduction by one Service adversely affects service members in all Services.

Decisions to reduce or civilianize the work force must consider how important it is that the position being considered be filled with a person in uniform. Military mental health providers have credibility with and acceptance from commanders and service members, are able to deploy to combat theaters, and are best positioned to make the complex determinations regarding deployability and retention.

Recommendation 5.3.3.5

The Department of Defense should make recruiting and retaining mental health professionals in the military a high priority in decisions to eliminate positions or convert positions to civilian status. An adequate number of billets must be allocated to mental health professionals to ensure the increase in providers recommended elsewhere in this report includes an adequate balance of military and civilian mental health professionals.

The hiring of civilian clinical social workers and clinical psychologists working in mental health, family advocacy, and other areas in MTFs has been hindered by their categorical placement in the new National Security Personnel System (NSPS). These professions have been placed into the NSPS "Standard Career Group" in the Professional/Analytical (YA) pay schedule, along with historians and geographers, rather than in the "Medical Career Group" in the Professional (YH) pay schedule, along with the other allied healthcare professionals such as optometrists, pharmacists, and speech pathologists. As a result, DOD compensation may not be competitive – Pay Bands 1 and 3 are the same for the YA and YH groups, but the maximum salary in Pay Band 2 (where most staff psychologists and social workers fall) is approximately $15,000 lower in the YA than the YH group. At present, the DVA has retained the existing government service (GS) system, thus increasing the likelihood that DOD will lose civilian providers to the DVA system as they learn that they can earn substantially higher salaries for performing essentially the same job. The NSPS needs to be changed so that DOD recognizes clinical social workers and clinical psychologists as healthcare providers and thereby remains competitive as an employer.

DOD should make recruiting and retaining mental health professionals in the military a high priority in decisions to eliminate positions or convert positions to civilian status.

Recommendation 5.3.3.6

The Department of Defense should move clinical psychologists and clinical social workers into the Professional (YH) pay career group in the National Security Personnel System.

Immediate Action is Needed to Address the Shortage of Uniformed Mental Health Professionals

Despite DOD's best efforts, shortages of uniformed mental health professionals will inevitably occur at some times or in some locations. Thus, it is imperative to offset the shortfall by recruiting and retaining civilian providers with the same characteristics that make uniformed mental health professionals a critical asset. On site visits, the Task Force interviewed many mental health professionals who were leaving the military. Some were willing and interested in continuing to work with active duty members and their families, as a civilian employee of the MTF. MTF commanders, however, lacked the authority and flexibility to present competitive employment packages. They had less flexibility than federal government counterparts in the DVA. Often they were only permitted to offer temporary positions or were forced to rely on contracts that offered only temporary commitments and limited benefits. The staffing model outlined in the staffing section of this report recommends that the core staffing for a military mental health facility be adequate to treat all service members and their families living in proximity to an installation. This model would give the MTF commander a stable planning horizon and allow for an optimal mix of permanent employees.

Recommendation 5.3.3.7

The Department of Defense should ensure local leadership has sufficient flexibility and financial resources to compete in recruiting highly-qualified civilian mental health professionals, including those with recent military experience.

5.3.4 Ensure TRICARE Networks Fulfill Beneficiaries' Psychological Health Needs

TRICARE networks have been tasked with providing an increasing volume and proportion of mental health services for families and retirees, as well as active duty members stationed far from installations. When active duty units are deployed, families often leave installations and must rely on the network, even if they were previously able to access services at MTFs. National Guard and Reserve members return home with time-limited TRICARE eligibility. Families of National Guard and Reserve members do not generally relocate near MTFs and must rely on TRICARE while the member is deployed if they have no other health coverage. With increased deployments, families of thousands of reservists have become eligible for TRICARE while the number of mental health professionals available on installations has been reduced by deployments.

While the Task Force recommends that mental health services for active duty service members and family members who live in close proximity to installations be provided by a dedicated military mental health system, the Task Force recognizes that TRICARE networks will continue be important providers of care in the civilian sector.

The system must be judged from the perspective of a family in crisis. Can the young spouse of a deployed junior service member easily access care in a crisis? Is the system user friendly? Does the system assure high quality, evidence-based care provided by professionals attuned to the special needs of military members and their families? Using these criteria, the TRICARE mental health system is inadequate.

While there are some areas where TRICARE seems to be providing an accessible continuum of mental health services, this is not generally the case. The TRICARE benefit for mental health services is hindered by:

- Fragmented rules and policies;
- Inadequate oversight; and
- Insufficient reimbursement.

It is unclear who bears responsibility at a local level to monitor the local TRICARE mental health network in order to ensure that it includes a full continuum of care and is accessible (i.e., that providers listed on the web site are actually accepting new patients and are within reasonable traveling distance, particularly on public transportation). While personnel at MTFs on some installations take the initiative to monitor the web listings, this is not a matter of policy across the Services, or across installations within a Service. TRICARE contractors have acknowledged that they bear responsibility for monitoring the network, but they only spot-check the listings. On site visits, the Task Force heard many examples of local MTFs checking the network, only to find that few providers listed on the TRICARE web site were willing to accept new TRICARE cases. In one instance, a mental health professional at the installation called over 100 mental health providers listed on the web site and found only 3 who would accept new TRICARE referrals.

The adequacy of this system must be judged from the perspective of a family in crisis, as active duty personnel or their family members will often try to access the system when they are in distress. Can the young spouse of a deployed junior service member easily access care in a crisis? Is the system user-friendly? Does the system assure high quality, evidence-based care provided by professionals attuned to the special needs of military members and their families? Frustration tolerance may be unusually low, and in the case of severe depression, the individual is less likely to have the energy or confidence to persevere in overcoming obstacles to provider access. Families of service members become overwhelmed by the lack of response and stop seeking help when they most need it. Based on these criteria, the TRICARE mental health system is currently inadequate and effectively limits care through a system that is inconvenient and cumbersome.

In 2003, following Congressional hearings where military beneficiary groups delineated problems in accessing care through TRICARE contractors, the GAO published report entitled *Oversight of the TRICARE Civilian Provider Network Should Be Improved* (GAO, 2003). The GAO found deficiencies in evaluation of contractor compliance with access standards and over-reliance on complaint data that were inconsistently collected and aggregated. In its response, DOD acknowledged severe problems and outlined steps to improve access.

In a subsequent study, GAO (2006) carefully evaluated one of DOD's primary initiatives to assess access via a survey of a sample of civilian TRICARE providers. Although the survey responses indicated that 60 to 70 percent of providers accept new TRICARE patients, the response rate was low (55%) and active TRICARE participants were likely overrepresented in the sample. Further, the survey results have limited applicability to mental health services because the database of providers obtained from the American Medical Association (AMA) included only physicians. Data from the managed mental health industry

show that over 80 percent of providers of mental health services are non-physicians (e.g., psychologists, clinical social workers, and other licensed counselors) (Dial, Bergsten, Haviland & Pincus, 1998; Scheffler & Ivey, 1998), who were excluded from the DOD survey. Further, psychiatrists historically are less active in the AMA than other specialties and may be underrepresented in the AMA database.

Recently, GAO released a report on the satisfaction of Reservists with TRICARE (GAO, 2007). Like its predecessors, this report does not specifically evaluate mental health benefits. Rather, it analyzed a survey of Reservists about their satisfaction with TRICARE compared to insurance coverage in the private sector. Most (80%) had prior experience with private insurance coverage. Only 12 percent felt that the availability of providers and specialists was better in TRICARE than in the private sector, contrasted with 50 percent who felt that availability was better in the private sector.

The Task Force finds that TRICARE contracts are not sufficiently explicit in requiring regular oversight of all local networks to assure that they are current and accessible.

Recommendation 5.3.4.1

The Department of Defense should require TRICARE contractors and subcontractors for mental health services to monitor, at least quarterly, whether network mental health providers are accepting new patients to ensure a continuum of mental health services is available in each locale.

Recommendation 5.3.4.2

The Department of Defense should require that TRICARE contracts include a case management system for mental health referrals. This should include a means for obtaining timely assistance in securing an appointment.

Recommendation 5.3.4.3

TRICARE regional offices should monitor access to mental health providers and require contractors to ensure a readily available continuum of care.

The stressors inherent in military life make basic mental health services as important and time-sensitive as basic health care. For individuals under stress, psychological health problems may quickly deteriorate. Timely intervention can be crucial. Currently, TRICARE access standards consider basic mental health care in the same category as medical specialty referrals. Under this standard, initial mental health appointments can be significantly delayed. Basic mental health care should be considered comparable to primary health care. Non-emergent mental health symptoms and disorders must be seen as quickly as non-emergent medical problems.

Recommendation 5.3.4.4

The Department of Defense should revise TRICARE access standards to equate access to basic mental health services with access for basic primary medical care – seven days or fewer (depending on the severity of the presenting concern).

TRICARE must be competitive with other payors in the local market, particularly in geographic areas with a shortage of providers and for high demand sub-specialties such as child psychiatry. This is often the case in rural areas where military bases tend to be located and where many military families reside. The Task Force repeatedly heard complaints that TRICARE rates for mental health providers, which are heavily discounted, were not locally competitive. These included testimony from mental health experts employed by TRICARE contractors in networks inside the U.S. and overseas. When TRICARE rates are not competitive, service members and their families may find that services are less available to them than to other residents of the community.

In two recent reports to Congress, the GAO (2003, 2006) also cited complaints that rates were not competitive and implicated in providers' decisions not to accept new TRICARE patients. In the recent survey of TRICARE civilian providers (which did not adequately sample mental health providers), low reimbursement was the most-cited reason for not taking TRICARE patients. TRICARE has the option of adjusting rates for specific provider categories and services to correct for serious access problems. In its December 2006 report, GAO lists the procedures for which this option has been used. Despite widespread consensus

among providers at MTFs, beneficiaries, and TRICARE officials that there are serious access problems with services such as child psychiatry, the option has not been used for any mental health services.

Recommendation 5.3.4.5

The Department of Defense should ensure TRICARE reimbursement rates for mental health services are competitive with local rates paid by other major payors to ensure military families are given priority by area providers.

Advances in health services research continually establish and update evidence-based best practices supporting psychological health. TRICARE regulations permit the benefit package for medical and surgical care to be modified and updated as technology advances and new best practices are established. They do not, however, permit updates due to practice advances for mental health services. This results in inefficient and sub-optimal care. For example, while intensive outpatient treatment programs have been adopted as standard practice in the private sector and the VHA, TRICARE still does not reimburse for intensive outpatient care, requiring instead that patients be referred to more expensive residential or inpatient care which is often situated further from where they live. TRICARE has approved psychiatric partial hospitalization programs, the next best alternative, in only 18 states, and within most of those the few facilities are far from the major population areas (TMA, 2007). Intensive outpatient services are often the care of choice for severely impaired patients (Timko, Sempel & Moos, 2003). The inability of TRICARE to alter its covered services has become increasingly problematic as research on mental health conditions continues to establish more effective approaches. Testimony from DOD TRICARE officials, TRICARE contractors, and local providers was consistent on this point.

Recommendation 5.3.4.6

The Department of Defense should modify TRICARE regulations to permit updates as new treatment approaches for psychological disorders emerge (e.g., intensive outpatient services). Policies should parallel those currently in place for medical conditions.

TRICARE officials acknowledged what the Task Force repeatedly heard: Accessing services for children and adolescents, especially for substance abuse problems, which are common among those age groups, is especially problematic. Part of the problem is in accessing residential services for children and adolescents. Few of these residential centers are willing to become TRICARE providers because TRICARE regulations require an additional accreditation by Maximus (the National Quality Monitoring contractor) above the community norm of accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Many facilities are unwilling to undertake the time-consuming process of obtaining multiple accreditations.

The most recent monthly report from TRICARE, prepared by Maximus, underscores the extent of the problem. In 32 states, including highly populous states and states with large military populations, there is no approved Psychiatric Partial Hospitalization Program, despite the fact that large numbers of facilities offering these services exist in every state. The expectation in these programs is that the patient will travel each day to receive intensive care; such facilities do not provide residence. Even in the few states that have approved programs, access is severely limited. For example, a single approved site in Pennsylvania is in Doylestown, located far from the metropolitan areas. There are no programs in southern Florida or within commuting distance of Dallas or Houston in Texas. Similarly, 38 states have no approved substance abuse residential facility, including heavily populous states (e.g., New York, Ohio, Illinois) and states with a large military presence (e.g., Washington; Maryland; Virginia; and Washington, DC). In 33 states, no psychiatric residential centers are approved (TMA, 2007).

TRICARE regulations allow outpatient substance abuse treatment to be provided only by staff at facilities accredited to provide day hospital or residential care. On Task Force site visits, local officials exhibited a substantial lack of unanimity and clarity on this point; however, it was verified by TRICARE officials in testimony. An official TRICARE publication on mental health services states that substance abuse outpatient care "must be provided by an approved substance use disorder facility in a group setting.... Individual outpatient care for substance use disorders is not covered" (see www.tricare.com). The preponderance of controlled clinical studies indicates that standard outpatient care for substance use disorders is highly effective and, for less complicated cases, more cost-effective than day hospital or residential care (Weisner et al., 2000; Coviello et al., 2001; Timko et al., 2003). Considering that only a few states have even one approved program, and that most major population centers in the country are more than three hours drive from an approved center, for most families of service members there is effectively no access to outpatient substance abuse care (TMA, 2007a). There can be no quality of care if there is no access.

Recommendation 5.3.4.7

TRICARE should accept accreditation of residential treatment facilities for children by any nationally-recognized accrediting body, as is the norm in the civilian sector.

Recommendation 5.3.4.8

TRICARE should allow outpatient substance abuse care to be provided by qualified professionals, regardless of whether they are affiliated with a day hospital or residential treatment program, including standard individual or group outpatient care.

Military service members and families present with a broad range of mental health issues, including high priority issues like combat-related PTSD that are unique to the military experience. TRICARE providers must be well trained in these issues and newer treatments for them. This is particularly important in geographic areas distant from a military community.

Recommendation 5.3.4.9

The Department of Defense should improve TRICARE providers' training in issues related to military experiences by:

- *Requiring that TRICARE mental health contractors offer mediated training packages to all network mental health providers similar to those available through the National Center for Post-Traumatic Stress Disorder, the Department of Defense Center for Deployment Psychology, and military mental health components.*
- *Requiring that TRICARE mental health contractors offer training packages for specific disorders and problems such as post-traumatic stress disorder and other combat stress syndromes each time a treatment plan is approved.*

Equity of access is a hallmark of an excellent mental health system. Active duty members and their families transition frequently from assignments with access to mental health services on an installation to ones where they do not. Their location should not significantly alter their access to services. At the request of the Task Force, TMA provided summary data on the top ten ICD-9 Mental Health Codes defining the problems for which active duty members sought at military health facilities. A substantial portion of the care in these tables was for V-codes, including up to 15 percent for relationship counseling (TMA, 2007). Site visits revealed that on installations where marital counseling was offered, it was a service in high demand.

As discussed previously, the TRICARE network does not reimburse for services associated with V-codes. As such, an active duty member stationed away from an installation, or a family member who cannot access services at the base mental health clinic, has no access to a broad array of mental health services. This constitutes a major inequity in access that does not adequately serve many service members and their families.

Recommendation 5.3.4.10

The Department of Defense should ensure that covered TRICARE mental health services include V-codes related to partner relational problems, physical/sexual abuse, bereavement, parent-child relational problems, and other appropriate services. TRICARE should authorize and approve payment for services appropriately provided by network mental health professionals within the scope of their practices and that are comparable to the services provided by mental health professionals at military treatment sites.

5.4 EMPOWERING LEADERSHIP

5.4.1 Establish Visible Leadership and Advocacy for Psychological Health

Provision of a full continuum of support for psychological health for military members and their families depends on many organizations. In addition to the services offered by clinical mental health providers at MTFs or mental health specialty clinics, services may be provided by counseling centers, religious programs, family services, health promotions, family advocacy, new parent support teams, substance abuse prevention and treatment programs and numerous others. Additional organizations outside installations, such as Military OneSource and the TRICARE Network, also provide services to military members and their families.

These services exist in different authority structures and funding streams. The Task Force found various degrees of segregation for these programs and no consistent plan for collaboration in promoting the psychological health of service members and their families. The services are stovepiped at the installation and Service levels (AMEDD, 2007).

Individuals requiring service are faced with a complex system of options that can be confusing to navigate. Military leaders may be unaware of where to begin with a particular referral and there may be no installation-level leader available to coordinate these disparate options to ensure the availability of a full continuum of care. Because of the stovepipes, referrals between organizations (e.g., chaplain to mental health; health promotions to substance abuse; mental health to family services) lack consistent procedures. The Task Force identified numerous barriers to successful transitions on site visits. One example of this is the assumption on some installations that when providers in the MTF are unable to meet the requirements of dependents for individual or marital services, they may refer to the counseling center, chaplains or the TRICARE network. On site visits, the Task Force learned this referral was sometimes made without awareness that the suggested organization could not provide the required intervention. Accordingly, Recommendation 5.4.1.1 proposes a new or transformed role for local leadership of issues related to psychological health that require coordination and accountability across the landscape of relevant services.

The lack of an organized system for installation-level management of psychological health is paralleled by the lack of a DOD or Service-level system for developing a strategic plan for the delivery of services to support psychological health.

This complexity is compounded when there are two or more installations from different military Services in the same geographic area. Although installations may share resources such as inpatient mental health services, residential substance abuse treatment and emergency mental health services, these services often lack coordination. The Task Force found that the services provided varied widely according to military Service policy, staffing resources, and local business practices, with little apparent connection to the needs of the beneficiary population.

The lack of an organized system for installation-level management of psychological health is paralleled by the lack of a DOD-wide or Service-level strategic plan for the delivery of services to support psychological health. A strategic plan should address all aspects of psychological well-being, such as access to a continuum of care, TRICARE network adequacy and access, staffing of uniformed and civilian personnel, retention and recruitment, family violence, suicides, substance abuse, and wait times.

Recommendation 5.4.1.1

The military Services should ensure that each military treatment facility has a Director of Psychological Health who serves as the installation commander's consultant for psychological health and has the authority to convene meetings of all resources on the installation that support psychological health. The position should be full-time and devoted to developing and implementing the strategic plan for psychological health. The responsibilities of the local Director of Psychological Health will include the following:

- *Apprise the military treatment facility and installation commander of the status of psychological health in the local beneficiary population, and the degree to which needs for prevention, early intervention and treatment are being met.*
- *Make recommendations to the military treatment facility commander about staffing requirements to meet the needs for supporting psychological health, and courses of action to ensure that services continue to be provided during times of deployment and other surge situations.*

- *Ensure coordination of services between the various programs providing support for psychological health, including, but not limited to, family advocacy, chaplains, family centers, Casualty Assistance Calls Offices, and TRICARE.*

Recommendation 5.4.1.2

Where installations of different military Services exist in close proximity, the Directors of Psychological Health should establish a standing committee to ensure coordination of services to facilitate equitable coverage and access to care for all service members and their families, regardless of Service affiliation.

Recommendation 5.4.1.3

Each military Service should establish a full-time Director of Psychological Health who reports directly to the Surgeon General or, for the Marine Corps, the Medical Officer of the Marine Corps. Appropriate staff should be assigned to assist the Director with the required duties. The Director of Psychological Health's responsibilities should include:

- *Strategic planning and leadership for implementing the strategic plan.*
- *Monitoring and reporting on the availability, accessibility, quality and effectiveness of the continuum of mental health services provided to service members and their families.*
- *Monitoring the psychological health of service members and their families.*
- *Ensuring communication with installation Director of Psychological Health to provide guidance, share best practices and support the resolution of emerging issues.*
- *Managing the development and coordination of training materials.*

Recommendation 5.4.1.4

The military Services should ensure coordination among the medical department specialty leaders/consultants and other military organizations that support psychological health.

Recommendation 5.4.1.5

Each Service Surgeon General's annual report to Congress should include data about the psychological health of service members and their families, and on the efforts to improve psychological health.

Recommendation 5.4.1.6

The Assistant Secretary of Defense for Health Affairs should establish a Department of Defense Psychological Health Council consisting of the Active Duty, National Guard and Reserve Directors of Psychological Health and other senior leaders as appropriate to develop a Department of Defense vision and strategic plan for supporting the psychological health of service members and their families. The Council should:

- *Provide policy and guidance to address psychological health for service members and their families.*
- *Develop a standardized set of indicators for each military Service to use in reporting the state of psychological well-being of service members and their families.*

Recommendation 5.4.1.7

The Defense Health Board should establish a standing sub-committee, including subject-matter experts, to focus on psychological health. One duty of this subcommittee should be to review the Department of Defense's progress in fulfilling the recommendations contained in this report.

The requirements of a robust system ensuring psychological health require many structural and functional changes. The command structure outlined in the above recommendations will support the new system required to meet the identified needs of service members and their families. The military has a history of successful reliance on the oversight of Inspectors General (IGs) in areas of critical importance. The recommended system would likewise benefit from the addition of subject-matter expertise in psychological health on the military Service IG and Medical IG staff.

Recommendation 5.4.1.8

Each military Service's Inspector General staff should include subject-matter experts on programs related to psychological health to ensure compliance with the strategic plan.

Recommendation 5.4.1.9

Each military Service's Medical Inspector General's staff should include subject-matter experts on programs related to psychological health to ensure compliance with the strategic plan.

Psychological Health Leadership in the National Guard and Reserves

The complexity of ensuring that a continuum of care is available to military Reservists, National Guard Members and their families is further compounded by the unique nature and needs of Guard and Reserve service members. High percentages of Army National Guard members and Marine Corps Reservists (49% and 43%, respectively) reported mental health concerns on the PDHRA conducted approximately three months after a return from deployment (DMSS, 2007). Evidence from Task Force site visits corroborates that Guard members and Reservists present the same or greater needs than their counterparts in the Active Component. However, the system in place was not designed to address such requirements.

Additional information on Reserve Component issues appears in Section 5.5.1 (Reserve Components: Special Considerations). Recommendations specific to leadership requirements to ensure the delivery of a continuum of accessible mental health care and services to support the psychological health of National Guard and Reserve service members and their families are outlined below.

National Guard Leadership

The Task Force found that only three (i.e., California, Texas and Pennsylvania) states are currently addressing the needs of their National Guard members with a full-time National Guard Psychological Health director or coordinator. These states and others provide models for state programs to address the needs of their current and veteran National Guard members and their families.

Recommendation 5.4.1.10

Each of the states and U.S. territories should appoint a full-time National Guard Director of Psychological Health to ensure that psychological health is effectively addressed.

Recommendation 5.4.1.11

Congress should adequately fund the National Guard Bureau to ensure the National Guard Director of Psychological Health is a permanent full-time position.

Recommendation 5.4.1.12

The National Guard Bureau should establish provisions for a council networking all state and territory National Guard Directors of Psychological Health.

Recommendation 5.4.1.13

Each state and territory should establish statewide psychological well-being programs and leverage existing community resources to provide robust access to care for National Guard members and their families.

Recommendation 5.4.1.14

The National Guard Bureau should establish a Director of Psychological Health who serves as a member of the Department of Defense Psychological Health Council. This Director's duties should parallel the duties of the Active Duty Service Directors of Psychological Health (see Recommendation 5.4.1.6).

Reserve Component Leadership

As reported in other sections, the current psychological health system was not designed to meet the new requirements of Reservists and their families, which can quickly overwhelm current resources. The psychological health leadership structure is not consistent across the military Services' Reserve Components. The Services differ widely in the structure, mission and utilization of Reservists. As such, the Reserve Components require a unique psychological health leadership structure to ensure the psychological health needs of Reservists and their families are met.

Recommendation 5.4.1.15

The Assistant Secretary of Defense for Reserve Affairs should appoint a Director of Psychological Health who serves as a member of the DOD Psychological Health Council. This Director's duties should parallel the duties of the Active Duty Service Directors of Psychological Health (see Recommendations 5.4.1.3 & 5.4.1.6).

Recommendation 5.4.1.16

Each Service Reserve Component should appoint a full-time Director of Psychological Health to the staff of the Reserve Component Surgeon. Where Reservists are organized by region, a full-time Regional Psychological Health Director should be appointed.

5.5 SPECIAL TOPICS

5.5.1 Reserve Components: Special Considerations

This report has frequently alluded to the unique and critical challenges in assessing and addressing the psychological health needs of members of the National Guard and Reserves and their families and survivors. These challenges must not be underestimated. This section summarizes our findings for Reserve Components.

Data on psychological health issues related to members of the Reserve Component are far scarcer than data available for their counterparts in the Active Component. But the data that exist strongly support the magnitude of their needs. Almost half (49%, Army National Guard; 43%, Marine Reserve) self-reported psychological health concerns on the PDHRA conducted approximately three months following deployment (DMSS, 2007). Considering the repeated reports received on site visits from service members who were reluctant to report mental health problems for fear of ridicule and negative effects on their careers, a finding consistent with the results of anonymous surveys conducted by DOD (U. S. Army, 2006), this high rate of self-report most likely understates the scope of the problem. Because of logistical problems and personnel limitations, it has proven difficult to administer and follow up post-deployment assessments for members of the Reserve Component. As of 16 May 16 2006, only 6.1 percent of PDHRA assessments had been completed in the National Guard; 1.4 percent had been completed in the Army Reserve.

A recent anonymous survey of 292 Maine Reservists administered after return from deployment provides a more detailed picture of the nature of the problems experienced (Wheeler, 2007):

- 36 percent reported relationship problems with spouse and children;
- 27 percent reported significant depression;
- 24 percent reported alcohol abuse; and
- 43 percent reported problems with anger and aggression.

Many of the recommendations in this report are aimed at strengthening the infrastructure at military installations, or within a larger force component such as a combat brigade. They leverage the daily cohesiveness of military life, where service members live together, train together, deploy together, and, often, remain together upon their return from deployment. Likewise, their families have the opportunity to be integrated into the military community. Reserve Component members and their families, however, live a very different life. They value the military component of their lives, but prior to and following deployment, they live the life of a civilian. They train once a month in a smaller unit that does not have embedded mental health workers. In general, they must rely on community resources to assist them in their readjustment.

In previous sections, the Task Force has made recommendations to:

- Strengthen the mental health infrastructure within the National Guard and Reserves (see Sections 5.1.2, Make Mental Health Professionals Easily Accessible to Service Members, 5.1.4, Revise Military Policies to Reflect Up-To-Date Knowledge about Psychological Health, 5.1.5, Make Psychological Assessments an Effective, Efficient, and Normal Part of Military Life, and 5.4.1 Establish Visible Leadership and Advocacy for Psychological Health).
- Improve the training of TRICARE contractual providers on the military experience and its sequelae, and make access to such providers more user-friendly (see Section 5.3.4, Ensure TRICARE Networks Fulfill Beneficiaries' Psychological Health Needs).
- Improve the interface between DOD and DVA (see Section 5.2.2, Maintain Continuity of Care across Transitions).
- Improve education on the early identification and management of mental health issues provided to commanders and enhance the basic medical resources (e.g., corpsmen and medics) assigned to Reserve Component units (see Section 5.2.1, Make Prevention, Early Intervention and Treatment Universally Available).
- Assure that Reserve Component policies foster a supportive approach to service members returning from deployment (see Section 5.1.4, Revise Military Policies to Reflect Up-To-Date Knowledge about Psychological Health).

Even if these changes are implemented, however, we cannot be sure that they will sufficiently address the enormous challenge of assuring that every member of the National Guard and Reserves, and their family members and survivors, has ready access to the help needed to successfully readjust to life with their families in their home communities. Currently, no one has responsibility for the ongoing assessment of what is working well for and what is failing these service members and their families. As such, there is no feedback loop to continuously improve our efforts in the face of these daunting challenges.

Recommendation 5.5.1.1

The Department of Defense should earmark sufficient funds for and mandate that the National Guard Bureau and Reserve Component Commands conduct regular anonymous surveys of National Guard and Reserve members, their families, and survivors assessing the following (at a minimum):

- *Barriers (i.e., structural, financial, personal) to access to a full array of psychological health services, including marital and family counseling;*
- *Satisfaction with such services, including the perceived empathy of providers for the military experience;*
- *Stigma surrounding mental health issues;*
- *Knowledge and understanding of commanders about mental health issues; and*
- *Adequacy of training for unit-level medics in psychological health issues.*

Recommendation 5.5.1.2

The Department of Defense should ensure problems uncovered by the above surveys result in timely action plans to improve access to and the quality of psychological health services for Reservists, their families and survivors. The Director of Psychological Health for each Guard element or Reserve command should draft action plans addressing these needs and forward them and regular progress reports to the National Guard Bureau or Central Reserve Command Office.

5.5.2 Female Service Members and Veterans

Female service members in combatant areas have had to fight the enemy in the same manner as their male counterparts: engaging in firefights, taking prisoners and possibly becoming casualties.

Current Public Law (NDAA 1994, HR 2401, Sec. 543) excludes active duty women from certain job categories including, but not limited to, ground combat operations (e.g., infantry, armor, artillery units). Despite this restriction, female military members are an integral part of the large support force for these and other operations. The lack of frontlines and the insurgent nature of the current conflicts have made avoidance of many combat situations very difficult. Female service members in combatant areas have had to fight the enemy in the same manner as their male counterparts: engaging in firefights, taking prisoners, and occasionally becoming casualties. In June 2005, Sergeant Leigh Ann Hester, of the 617th Military Police Company from the Richmond, Kentucky National Guard Unit, became the first woman to be awarded the Silver Star (the nation's third-highest medal for valor) since World War II. Her citation noted actions against the enemy including the killing of at least three insurgents (see http://www.defenselink.mil/news/newsarticle.aspx?id=16391).

Women comprise approximately 15 percent or approximately 210,000 out of 1.4 million active duty service members (DMDC, 2006). Since 2001, female service members have served in the combat areas in both Afghanistan and Iraq. OEF and OIF are the first combat operations where a large number of female service personnel have had the potential for repeated exposures to combat situations. Repeat deployments have also added to the exposure potential. Like their male counterparts, incidents affecting women have included, but have not been limited to, firefights, ambushes, security operations, mortar and grenade attacks, improvised explosive devices, and witnessing and/or experiencing severe injury and/or death. Overall, of the 229,015 OIF/OEF veterans who sought VA care between 2002 and 2006, 12 percent were women. As a result, the DVA will be providing services to more female veterans than in the past. It is estimated that by 2010, 14 percent of all veterans will be women (see http://www1.va.gov//wvhp/page.cfm?pg=26). As with male service members, female veterans are at risk for exposure to combat-related incidents and trauma, which have the potential to result in PTSD or other stress reactions at a higher incidence than previously thought.

Studies of how women are affected psychologically by combat are relatively recent and results to date are mixed. Hoge et al. (2004) reported, "Women serving in combat have about the same risk as men of getting PTSD or other mental health conditions." Studies conducted after the Gulf War concluded that female service members were more likely than their male counterparts to develop PTSD (Perconte, Wilson, Pontius, Deitrick & Spiro, 1993). This is consistent with the 2 to 1 ratio of female to male PTSD sufferers in the general population (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). A comparison of male and female veterans form the Vietnam and Gulf Wars, however, suggests that when controlling for the level of combat exposure, males are three times more likely to be given a diagnosis of PTSD than females (Pereira, 2002). One explanation for this may be cultural expectations that make it difficult for society and mental health providers to recognize women as combatants. Additionally, there is a tendency in the mental health profession to diagnose women as having depression, anxiety and borderline personality disorder instead of combat-related PTSD (Becker, 1994).

Treatment of PTSD in women has also recently begun to be studied. In 2005, the DVA conducted a study of PTSD among female veterans, the first DVA study to focus exclusively on a large number of female veterans. The study was designed to determine whether treatment with "Prolonged Exposure Therapy (PE)" was more effective than "Present-Centered Therapy (PCT)". PE was found to be significantly more effective than PCT for treating PTSD in active duty personnel and female veterans. After treatment, the PE group was more likely to no longer meet the diagnostic criteria for PTSD than the PCT group (41% vs. 27.8%). The PE group was also more likely to achieve total remission (15.2% vs. 6.9%; Schnurr et al., 2007). Based on these results, the DVA created two national initiatives in evidence-based practice in PTSD. The first will train and support 600 therapists to conduct related Cognitive Processing Therapy (CPT). The second will support the use of PE therapy as an alternative means of treatment.

Making such effective therapies available for women veterans is an important goal. A potential barrier for women needing treatment for mental health issues related to combat trauma is their need to show the emotional strength expected of military members. The self-image of the woman veteran may serve as an additional obstacle in obtaining treatment for military-related PTSD. After their military service, many women no longer see themselves as veterans. Moreover, they may not associate symptoms of trauma exposure with their military service. Despite such conjectures, at the end of FY06, female veterans of OEF and OIF sought DVA care at a higher rate than male veterans (17% vs. 11%). Further, thirty-seven percent of female veterans OEF/OIF have used the DVA for some type of health care at least once between 2002 and 2006. As the DVA continues to expand its programs for women, it is expected that female veterans will increasingly seek care there.

The DVA has made significant steps in its programs for female veterans. A Women's Veterans Program Manager is now located at every DVA medical center in the country. The Program Manager also functions as an advocate to assist women in finding and accessing DVA services, programs, community resources, and state and federal benefits. Increasing numbers of DVA facilities have specialized inpatient and outpatient mental health services and clinics. There are also programs for women who are homeless and those who are at risk of becoming homeless.

Another area of concern for the DVA is military sexual trauma (MST), which refers to a variety of sexual offenses ranging from verbal sexual harassment to assault and rape. Public Law 102-585, the Veterans Health Care Act of 1992, authorized new and expanded services for women veterans including outreach and counseling services for sexual trauma incurred while serving on active duty. The law was later amended, authorizing the DVA to provide counseling to men (see http://www1.va.gov//wvhp/page.cfm?pg=25). Each DVA medical center has an MST coordinator and trained sexual trauma counselors. There is also a DVA MST support team to ensure that these programs are in compliance with legally-mandated monitoring of MST screening and treatment. This team also coordinates and disseminates the latest education, training and best practices related to MST throughout the DVA healthcare system.

Both female service members and veterans have an increasing number of mental health services available to them. Research is continuing to find better methods of prevention, early intervention, and treatment for psychological problems. Overcoming the fear and misunderstanding that surrounds psychological care should not be overlooked and requires continued attention. The following recommendations capture the highest current priorities for such efforts:

Recommendation 5.5.2.1

The needs of women service members and veterans should remain a focus of high-level planning groups in the Department of Defense (with all military Services represented) and the Department of Veterans' Affairs. The Department of Defense Psychological Health Strategic Plan should include specific attention to the

psychological health needs of women. The annual report on the Status of Female Members of the Armed Forces should include information about the adequacy of support for psychological health of women.

Recommendation 5.5.2.2

The Department of Defense should develop treatment programs specifically geared towards the psychological health needs of female service members.

Recommendation 5.5.2.3

The Department of Defense should continue to aggressively conduct prevention, early identification and treatment of military sexual trauma among service members of both sexes. DOD should continue to evaluate the effectiveness of restricted reporting for domestic violence and sexual assault.

5.5.3 Traumatic Brain Injury and Its Psychological Health Implications

TBI can be a consequence of exposure to blast injuries, automobile crashes, blunt object force to the head, or a number of other sources of injury during combat. TBI injuries fall along an extremely broad spectrum, from very mild injuries with minimal functional implications and likely spontaneous recovery to profound brain injuries that result in multiple impaired cognitive functions that are unlikely to fully resolve. TBI is not a mental health problem; it is a neurological problem. At the same time, there are psychological health implications of TBI that warrant mention in this report.

Before exploring psychological health implications, some problems facing the military system in regard to TBI should be noted:

- Documentation of injury is not always available, given that the nature of combat is such that an injury can occur at any time and there may be no observer or person in a position to keep a record of the event(s). Thus, criteria for determining possible TBI must depend on self-report and evidence of functional limitations.
- Researchers are working to develop a reliable, valid screening tool for TBI that would trigger a more thorough evaluation. At present, however, there is no well-validated screening tool, and any efforts to carry out such assessment must address the fact that there will be a large number of false positive and/or false negative results.
- Sustainment of a TBI may increase the likelihood of sustaining an additional TBI, due to impaired response time, judgment, problem-solving capacity, etc. Even a mild TBI may increase risk for further injury.

Psychological Health Implications

The differential diagnosis of TBI and PTSD may be difficult, given some overlap in symptoms (e.g., irritability, distractibility, memory lapses). Nonetheless, *differential* diagnosis may be less important than attention to *co-occurring* diagnoses. The likelihood of such co-occurring disorders is high:

- Most individuals who sustained a TBI also were exposed to a situation that would fit the definition of events described in Criterion A for a diagnosis of PTSD – a dangerous event in which the person felt in danger of his/her life, felt helpless and powerless to prevent negative events, etc. Many of these individuals will have other PTSD symptoms and can best be understood as having both a TBI and PTSD resulting from the same event(s).
- Some individuals with TBI may have had exposure to events leading to PTSD prior to or subsequent to the TBI.
- Other mental health problems, such as substance abuse problems, may be present.
- Mental health problems may result from the experience of living with the sequelae of TBI (e.g., functional losses, changed vocational prospects, changed family roles and aspirations).
- Treatment for co-occurring mental health disorders will be influenced by TBI. For example, psychosocial approaches are currently the most effective treatments for PTSD, and they require cognitive capabilities such as learning and problem-solving. When medications are appropriate treatment, ability to follow a medication regimen is crucial. Mental

health care providers need to be aware of the challenges posed by TBI and must develop processes to adapt their treatment approaches to make them accessible and useful to these patients.

- TBI has garnered considerable media interest and is widely described as extremely prevalent, despite the absence of definitive data and assessment procedures. It is possible that former service members who have not incurred a TBI, but who have other problems leading to emotional distress, may read about TBI and erroneously infer that their problems are a result of TBI. This misidentification of the cause of problems may be exacerbated by the fact that mental health problems are still more stigmatized than brain injury.
- Caregivers of individuals with TBI are also under considerable stress and may develop mental health problems that need attention for that individual to stay in the caregiving role.

There are currently work groups in both the DOD and DVA examining needs for TBI services and development of policy recommendations for effective handling of these needs (e.g., IRG, 2007).

Recommendation 5.5.3.1

We suggest acceptance of the Independent Review Group's traumatic brain injury recommendations and endorse close examination of recommendations proposed by the other Department of Defense and Department of Veterans' Affairs traumatic brain injury working groups when they are issued.

6. THE WAY FORWARD

The psychological health needs of service members, their families and their survivors are daunting and growing. The evidence for this is substantial. Despite the suppressing effects of stigma, more than a third of active duty Soldiers and Marines self-report psychological health problems in the months following deployment, as do half of the members of the Reserve Component (DMSS, 2007). Rates of self-reported psychosocial and marital concerns are highest among service members exposed to the greatest degree of danger and who have repeatedly deployed. Further, the number of service members in these subgroups continues to grow (U. S. Army, 2006; Wheeler, 2007).

The time for action is now. The human and financial costs of un-addressed problems will rise dramatically over time. Our nation learned this lesson, at a tragic cost, in the years following the Vietnam War. Fully investing in prevention, early intervention, and effective treatment are responsibilities incumbent upon us as we endeavor to fulfill our obligation to our military service members.

The Task Force recognizes that some of the recommendations identified herein will require further planning and refinement. We do not have the luxury of time for protracted planning. We urge DOD and the military Services to adopt the proactive battlefield strategy of engaging the problem and adjusting plans while engaged. This strategy is equally imperative in addressing the needs highlighted throughout this report. The recommendations on adequately resourcing the system, which underpin many of the other recommendations, provide a crucial example of this point. The current complement of mental health professionals is woefully inadequate to provide the prevention, resilience building, unit-level command consultation, in-theater intervention services, and a full continuum of direct care services tailored to the needs of military members and their families. The process for recruiting additional trained mental health professionals, both uniformed and civilian, is time consuming and cumbersome. The number that could possibly be recruited within the next six months, for example, is well below the number required to ultimately address the need. The recruitment process should be initiated immediately, even as plans for an eventual staffing model and prioritizing of needs are underway.

We urge that as the Secretary of Defense approves a recommendation in principle, he also require the rapid drafting of an action plan that includes immediate steps, timelines, and firm deadlines to ensure its achievement.

While the current operational tempo has drawn attention to the need for services that build and maintain the resilience of our fighting forces, provide a full continuum of prevention, early intervention, and treatment for them and their families, and eliminate barriers such as stigma, the lessons learned will be equally applicable to the periods of time after we have recovered from the immediate effects of the current conflicts and prepare for the next. The solutions to the problems highlighted in this report are not short-term fixes that can be funded with the temporary allocation of resources. Rather, we must build and maintain a robust psychological health infrastructure that is capable of fulfilling the broad recovery and prevention mission outlined in this report.

While we recognize the work of this Task Force is necessarily incomplete and that our recommendations provide only the groundwork for a comprehensive strategic plan to support the psychological health of service members and their families, the immediacy of these needs imparts a sense of urgency to our report. We urge DOD to adopt a similar sense of urgency in rapidly developing and implementing a plan for action.

We urge that as the Secretary of Defense approves a recommendation in principle, he also require the rapid drafting of an action plan that includes immediate steps, timelines, and firm deadlines to ensure its achievement.

The true test of our nation's commitment to address the unseen needs highlighted in this report lies in how aggressively and expeditiously we act. Service members, their families and their survivors are bearing our burden. We owe them nothing less than to act immediately.

Appendix A: Summary of Findings Related to Task Force Elements

In this appendix, we summarize specific information related to each of the elements mandated for consideration by the Task Force. The elements are grouped according to the working groups of the Task Force and listed by letter from the original legislation.

Elements Dealing with Active Duty Service Members

(A) The awareness of the potential for mental health conditions among members of the Armed Forces.

The Task Force is unaware of any large-scale data collection efforts that assess awareness of the potential for mental health conditions among members of the Armed Forces. There are ongoing data collection efforts that assess the prevalence of specific symptoms related to mental health conditions – most notably the Pre- and Post-Deployment Health Assessments, and the Post-Deployment Health Reassessment. Based on information gathered during site visits, there is widespread awareness of the possibility of combat stress or PTSD, and to a lesser extent, traumatic brain injury. Awareness of other mental health conditions is much more limited.

Section 5.1.1 (Dispel Stigma) and 5.1.3 (Embed Training about Psychological Health throughout Military Life) contain findings and recommendations to raise awareness of mental health conditions.

(B) The access to and efficacy of existing programs in primary care and mental health care to prevent, identify, and treat mental health conditions among members of the Armed Forces, including programs for and with respect to forward-deployed troops.

Goals 2 (Ensure Service Members and their Families Receive a Full Continuum of Care) and 3 (Provide Sufficient Resources and Allocate Them According to Requirements) of the Task Force's vision focus in detail on these issues, and the corresponding sections of this report makes specific recommendations.

(E) The reduction or elimination of barriers to care, including the stigma associated with seeking help for mental health-related conditions, and the enhancement of confidentiality for members of the Armed Forces seeking care for such conditions.

Section 5.1.1 (Dispel Stigma) focuses in detail on this issue.

(H) The early identification and treatment of mental health and substance abuse problems through the use of internal mass media communications (including radio and television) and other education tools to change attitudes within the Armed Forces regarding mental health and substance abuse treatment.

The Armed Forces Radio and Television service runs Public Service Announcements (PSAs) on up to 42 different topics at a time on a rotating basis. Currently, about half of the topics related to support for service members, including stress, financial counseling, Military OneSource, domestic and sexual abuse, suicide, and chaplain services. These 'support' PSAs have become more common since large deployments began. Radio stations average 10 to 20 PSAs per week; television statements average 5 to 10 announcements. Evaluation data are not systematically gathered regarding the effectiveness of PSAs.

Sections 5.1.1 (Dispel Stigma) and 5.1.3 (Embed Training about Psychological Health throughout Military Life) of this report provide findings and recommendations regarding the use of media and education to change attitudes.

Elements Dealing with Evaluation

(C) Identification and means to evaluate the effectiveness of pilot projects authorized by section 722 with the objective of improving early diagnosis and treatment of post traumatic stress disorder and other mental health conditions.

To the best of our knowledge, these projects have not yet been implemented.

(M) The scope and efficacy of curricula and training on mental health matters for commanders in the Armed Forces.

Section 5.1.3 (Embed Training about Psychological Health throughout Military Life) provides specific recommendations about training for commanders and service members.

(N) The efficiency of pre- and post-deployment mental health screening, including mental health screenings for members who have experienced multiple deployments.

Section 5.1.5 (Make Psychological Assessments an Effective, Efficient and Normal Part if Military Life) provides specific recommendations.

(O) The effectiveness of mental health programs provided in languages other than English.

We are not aware of any assessments of the effectiveness of such programs. Such programs do not appear to be widespread. Military OneSource offers document translation into over 150 languages, and simultaneous interpretation in over 160 languages. Each military installation also maintains a list of individuals who speak languages other than English. The TRICARE South Region reports that 1404 providers have proficiency in at least one language other than English, with the five most common languages being Spanish, Hindi, French, German, and American Sign Language (Lupo & Proctor, 2006).

Elements Dealing with Family

(D) The access to and programs for family members of members of the Armed Forces, including family member overseas.

Sections 5.2.4 (Provide Family Members with Excellent Access to Care) and 5.3.4 (Ensure TRICAR Networks Fulfill Beneficiaries Psychological Health Needs) provide findings and recommendatior regarding this element.

(F) The <u>awareness of mental health services</u> available to dependents of members of the Armed Forces whose sponsors have been activated or deployed to a combat theater.

Section 5.2.4 (Provide Family Members with Excellent Access to Care) provides findings and recommendations regarding this element.

(G) The <u>adequacy of outreach, education, and support programs</u> on mental health matters for families of members of the Armed Forces.

Section 5.2.4 (Provide Family Members with Excellent Access to Care) provides findings and recommendations regarding this element.

Elements Dealing with Continuity of Care

(I) The <u>efficacy</u> of programs and mechanisms for ensuring a seamless transition from care of members of the Armed Forces on active duty for mental health conditions through the Department of Defense to care for such conditions through the Department of Veterans Affairs after such members are discharged or released from military, naval, or air service.

Section 5.2.2 (Maintain Continuity of Care across Transitions) provides findings and recommendations regarding this element.

(J) The availability of long-term follow-up and access to care for mental health conditions for members of the Individual Ready Reserve and the Selective Reserve and for discharged, separated, or retired members of the Armed Forces.

Sections 5.2.2 (Maintain Continuity of Care across Transitions) and 5.5.1 (Reserve Components: Special Considerations) contain findings and recommendations related to this element.

(K) Collaboration among organizations in the Department of Defense with responsibility for or jurisdiction over the provision of mental health services.

Section 5.4.1 (Establish Visible Leadership and Advocacy for Psychological Health) of this report provides findings and recommendations related to this element.

(L) Coordination between the Department of Defense and civilian communities, including local support organizations, with respect to mental health services.

Section 5.3.4 (Ensure TRICARE Networks Fulfill Beneficiaries' Psychological Health Needs) of this report provides findings and recommendations related to this element.

(P) Such other matters as the task force deems appropriate.

The Task Force spent considerable time considering members in the Reserve Components and their families. Relevant findings and recommendations appear throughout the report, in addition to special coverage within the "Special Topics" section.

Section 735. Additional Elements of Assessment of Department of Defense Task Force on Mental Health Relating to Mental Health Members who were deployed in Operations Iraqi Freedom and Operation Enduring Freedom.

Section 723c of the National Defense Authorization Act for Fiscal Year 2006 (Public Law 109-163; 119 Stat. 3348) is amended by adding at the end the following new paragraph:

Mental Health needs of members who were deployed in OIF or OEF. As part of the assessment required by paragraph (1) of the efficacy of mental health services provided to members of the Armed Forces by the Department of Defense, the task force shall consider the specific needs with respect to mental health of members who were deployed in Operation Iraqi Freedom or Operation Enduring Freedom upon their return from such deployment, including the following:

1) An identification of mental health conditions and disorders (including Post-Traumatic Stress Disorder, suicide attempts and suicide) occurring among members who have undergone multiple deployments in Operation Iraqi Freedom or Operation Enduring Freedom.

Data gathered by the MHATs indicate that multiple deployers were significantly more likely to report symptoms consistent with depression, anxiety, acute stress, and concerns about deployment length, and also significantly lower personal morale than first-time deployers.

2) An evaluation of the availability to members of assessments under the Mental Health Self-Assessment Program of the Department of Defense to ensure the long-term availability of the diagnostic mechanisms of the assessment to detect mental health conditions that may emerge in such members over time.

The Mental Health Self-Assessment Program (www.militarymentalhealth.org) offers anonymous self-administered assessments via Internet, telephone or in person for depression, bipolar disorder, alcohol use, post-traumatic stress disorder, and generalized anxiety disorder. To date, approximately 50,000 assessments have been completed. An evaluation project is planned.

3) **The availability of programs and services under the Mental Health Self-Assessment Program to address the mental health of dependent children of members who were deployed in Operation Iraqi Freedom or Operation Enduring Freedom.**

No assessments for children are currently available via the Mental Health Self-Assessment Program.

4) **Recommendations on mechanisms for improving the mental health services available to members who were deployed in Operation Iraqi Freedom or Operation Enduring Freedom, including members who have undergone multiple deployments.**

Goals 2 and 3 of the Task Force vision address quality of and access to care. The corresponding sections of this report provide findings and recommendations.

Appendix B: Members of the Task Force

VADM Donald C. Arthur, Medical Corps, U. S. Navy

VADM Arthur is the 35th Surgeon General of the Navy and Chief of the Navy's Bureau of Medicine and Surgery. Serving as the Chief Executive Officer for Navy Medicine, he is responsible for all aspects of medical and dental service delivery worldwide for the Navy, a workforce of 57,000 personnel, 30 military hospitals, 266 free standing clinics, and 6 major research centers with an annual budget of nearly $7 billion. VADM Arthur served as Deputy Surgeon General, Chief of the Navy Medical Corps and Chief Executive Officer of the National Naval Medical Center in Bethesda, Maryland and the Naval Hospital in Camp Lejeune, North Carolina. In 1991, Dr. Arthur served in combat operations with the Marine Corps in Desert Storm.

VADM Arthur obtained his B.A. from Northeastern University and his M.D. from the College of Medicine and Dentistry of New Jersey. He is residency-trained in emergency medicine and attained board certification in Emergency Medicine and Preventive Medicine (Aerospace). Dr. Arthur is a Fellow and Past President of the Aerospace Medical Association and was President of the Association of Military Surgeons of the U.S. Among VADM Arthur's numerous awards are the American College of Healthcare Executives', "Federal Excellence in Healthcare Leadership Award", the Federal Healthcare Executives Interagency Institute's "Distinguished Service Award", and the Association of Military Surgeons' "Outstanding Federal Healthcare Executive Award" as well as their "Founder's Award." VADM Arthur's military decorations include the Navy's Distinguished Service Medal, four Legions of Merit, and three Meritorious Service Medals.

Dan German Blazer, M.D., M.P.H., Ph.D.

Dr. Blazer is the J. P. Gibbons Professor of Psychiatry and Behavioral Sciences and Professor of Community and Family Medicine at Duke University Medical Center and past Dean of Medical Education, Duke University Medical Center. He is also the Head of the University Council on Aging and Human Development and serves as Adjunct Professor in the Department of Epidemiology, School of Public Health at the University of North Carolina.

Dr. Blazer received his B.A. from Vanderbilt University in 1965 (Biology), his M.D. from the University of Tennessee in 1959, his M.P.H. from the University of North Carolina – Chapel Hill in 1979 (Epidemiology), and his Ph.D. from UNC in 1980 (Epidemiology). Dr. Blazer was elected to the Institute of Medicine, National Academy of Sciences in 1995 and is a Diplomate of the American Board of Psychiatry and Neurology (with a Certificate of Added Qualifications in Geriatric Psychiatry), and a Fellow of numerous Associations and Societies including the American Psychiatric Association and the American College of Psychiatry. Among Dr. Blazer's numerous honors are the Research Career Development Award from the National Institute of Mental Health, the Honored Teaching Professor in the Dept. of Psychiatry, the Alex Haley National Award in 1985, the Distinguished Alumni Award at the School of Public Health, UNC in 1989, the Jack Weinberg Award from the American Psychiatric Association in 1992, the American Association of Geriatric Psychiatry Senior Investigator Award in 1994, the Milo Leavitt Award from the American Geriatrics Society for Life Contributors to education in geriatric medicine in 1997, the Pioneer Award in Geriatric Psychiatry in 2000, and the Rema LaPouse Award from the American Public Health Association in 2001.

Col Rick L. Campise, Ph.D., ABPP

Col Campise currently serves as the Chief of Air Force Deployment Behavioral Health and the Chief of Air Force Substance Abuse Prevention in the Air Force Medical Operations Agency within the Office of the Air Force Surgeon General. Col Campise also serves on the faculty of the USAF Clinical Psychology Internship at Andrews AFB and is a Clinical Assistant Professor of Medical and Clinical Psychology at the Uniformed Services University of the Health Sciences. Previously, Col Campise held a variety of appointments within the Air Force, serving as an Air Staff officer, deputy squadron commander, operations officer, program director, clinician, and researcher.

Col Campise completed a post-doctoral fellowship in Pediatric Psychology at Harvard University, received his Ph.D. in Counseling Psychology from the University of Kansas, and was awarded his B.A. in Psychology from Westmont College. He is board-certified in Counseling Psychology, a member of the American Psychological Association (Divisions 17, 19, and 54), and a member of the Air Force Society of Clinical Psychologists. Col Campise was a co-winner of the American Association of Suicidologists Presidential Citation for Outstanding Contributions to Suicide Prevention, was a finalist for the Joint Chiefs of Staff Award for excellence in Military Medicine, received the APA Division 19 Mid-Career Military Psychologist of the Year Award, and has been awarded four Meritorious Service Medals. Col Campise's AF/DOD Suicide Public Service Announcements were

finalists for a Freddie Award and the website he created for the Air Force Suicide Prevention Program received a Horizon Interactive Awards Silver Medal for Public Service.

LtCol Jonathan Douglas

LtCol Douglas currently serves as the Branch Head for Semper Fit Programs, HQMC M&RA, a position he has held since June 2005. Previously, LtCol Douglas served in the N8 as the Sea Strike and Sea basing requirements officer; as the assistant Operations Officer Marine Aircraft Group 36 Okinawa, Japan; and as the North East Asia Exercise Officer, III MEF Okinawa, Japan. At HMX-1 in Quantico, Virginia, LtCol Douglas served as a White House Liaison Officer and was designated a White House Aircraft Commander. Additionally, he served as Platoon Commander at Officer Candidate School. After attending The Basic School, LtCol Douglas was designated a Naval Aviator in December 1989, reporting to MCAS Tustin, California for training as a CH-53D Pilot. During his first fleet assignment, with HMH-362, LtCol Douglas held several billets including: Aviation Life Support Systems Officer, Ordnance Officer and Operations Training Officer. He deployed with the squadron in support of Operation Desert Shield/Desert Storm.

LtCol Douglas graduated from the University of Maryland and was commissioned as a Second Lieutenant in July 1987. LtCol Douglas was also selected to and attended the Marine Corps Command and Staff College, Amphibious Warfare School, and has an MBA from Touro University. LtCol Douglas' personal decorations include the Meritorious Service Medal with two gold stars, Air Medal with Strike/Flight Numeral "1", Joint Service Achievement Medal and Navy and Marine Corps Achievement Medal.

Deborah Kline Fryar

As a military family member, Ms. Fryar has worked to support families for many years. She has been involved with the National Military Family Association (NMFA) since 1996, and currently serves as an NMFA representative for Aberdeen Proving Ground, Maryland. In this position, she monitors issues relevant to the quality of life of families of the Uniformed Services and represents the Association at briefings and other meetings. Previously, Ms. Fryar served as Director of Government Relations for NMFA from March 2004 until June 2006, where she wrote and presented testimony concerning families before Congress. Ms. Fryar also currently serves on the DOD Beneficiary Advisory Panel for the Uniform Formulary. She has served on The Military Coalition's (TMC) Veterans and Health Care Committees and has represented military families on the Navy Force Management Oversight Committee (FMOC) Working Group of the Injured Marines and Sailors Program. She also works with the Joint Task Force for Family Readiness Education on Deployments (FRED).

Ms. Fryar earned a B.S. in Nursing from West Texas A&M University in Canyon, Texas and has spent the past seventeen years as a military spouse. She has been involved at all levels of family programs as a Core Instructor and Master Trainer for the Army Family Team Building Program. Ms. Fryar has also been involved in a myriad of other volunteer family programs, including Health Services Auxiliaries at various military hospitals, American Red Cross, Army Family Action Plan, Marines' Toys for Tots, Compassionate Ministries, Ladies Ministries and a Military and Uniformed Services Support Group at her church.

LTG (Ret) Kevin Kiley, M.D.

LTG Kiley served as the 41st Surgeon General of the Army and Commander, US Army Medical Command from September 2004 until his retirement in March 2007. Early in his career, LTG Kiley served as chief of OB/GYN services at the 121st Evacuation Hospital in Seoul and as Assigned Division Surgeon, 10th Mountain Division before returning to Beaumont as Assistant Chief, and later Chairman, of the Department of OB/GYN. In 1990, Kiley assumed command of the 15th Evacuation Hospital at Fort Polk and in 1991 deployed the hospital to Saudi Arabia in support of Operations Desert Shield/Storm. After graduating from the Army War College in 1994, LTG Kiley assumed command of the Landstuhl Regional Medical Center and the U.S. Army Europe Regional Medical Command in 1994, serving as the Command Surgeon, U.S. Army Europe and 7th Army. In 1998, LTG Kiley became Assistant Surgeon General for Force Protection, Deputy Chief of Staff for Operations, Health Policy and Services, U.S. Army Medical Command; and Chief, Medical Corps. In 2000, he became Commander of the U.S. Army Medical Department Center and School and Fort Sam Houston and continued as Chief of the Medical Corps. LTG Kiley assumed command of Walter Reed Army Medical Center and North Atlantic Regional Medical Command and Lead Agent for Region 1 in 2002, prior to his appointment as Surgeon General of the Army.

LTG Kiley graduated from the University of Scranton with a bachelor's in biology in 1972. He received his medical degree from Georgetown University School of Medicine in 1976, and completed a surgical internship and an obstetrics and gynecology residency at William Beaumont Army Medical Center in 1980. Among LTG Kiley's awards and decorations are the Distinguished

Service Medal, Legion of Merit (three Oak Leaf Clusters), Bronze Star Medal, Defense Meritorious Service Medal, Meritorious Service Medal (two Oak Leaf Clusters), Army Commendation Medal, the "A" designator, the Order of Military Medical Merit and the Expert Field Medical Badge.

CAPT Warren P. Klam, M.D., M.S.M.M.

Captain Warren Klam received his M.D. from Louisiana State University Medical School in 1971 before training in Pediatrics and in Adolescent Medicine. Upon completion of his training he entered the Navy and served as a Pediatrician and Adolescent Medicine specialist at the National Naval Medical Center. In 1981 he was released from Active Duty and entered into the private practice of Adolescent and Addiction Medicine in Northern Virginia. While in private practice he became one of the first physicians in Virginia to be certified in Addiction Medicine by the American Society for Addiction Medicine.

In 1993, CAPT Klam left private practice to reenter the United States Navy. He trained in General Psychiatry and in Child and Adolescent Psychiatry Following completion of his training CAPT Klam served at the Naval Hospital in Yokosuka Japan as Child Psychiatrist and as part of its senior leadership. Following his tour in Japan, CAPT Klam became the Force Medical Officer for the Seabees. In 2003 he transferred to Naval Medical Center San Diego where he now serves as the Director for Mental Health. Since 2004, he has also served as the Navy Psychiatry Specialty Leader. CAPT Klam is board certified in Pediatrics, General Psychiatry and Child and Adolescent Psychiatry.

Shelley M. MacDermid, M.B.A., Ph.D.

Shelley M. MacDermid is Associate Dean in the College of Consumer and Family Sciences, and Professor in the Department of Child Development and Family Studies at Purdue University. Since 1996, she has directed the Center for Families, and currently serves as director of the Military Family Research Institute (having served as co-director from 2000 to June 2007), also at Purdue. Dr. MacDermid earned an M.B.A. in Management in 1988 and a Ph.D. in Human Development and Family Studies in 1990 from The Pennsylvania State University. Her research focuses on relationships between job conditions and family life, with special interests in organizational size, adult development, and organizational policies, and has been published in scientific journals including the *Journal of Marriage and Family* and the *Academy of Management Journal*. Her research has been supported by the Alfred P. Sloan Foundation, the Henry A. Murray Center, the Department of Defense, and the state of Indiana; and has earned awards from the Groves Conference and Gamma Sigma Delta. She is a 2006 winner of the Work-Life Legacy Award from the Families and Work Institute. In 2005, Dr. MacDermid was named a fellow of the National Council on Family Relations. She serves on the editorial boards of the Journal of Family Issues, Family Relations, and Journal of Family and Economic Issues. Dr. MacDermid works extensively with corporations and serves as a faculty fellow to the Boston College Work-Family Roundtable.

CAPT Margaret A. McKeathern, M.D. (alternate member)

CAPT McKeathern currently serves as Director of Mental Health at National Naval Medical Center in Bethesda, having previously served as Associate Director of Behavioral Healthcare Service and Department Head of Child and Adolescent Behavioral Health Care at NNMC Bethesda. CAPT McKeathern also serves as Mental Health Representative to the Family Advocacy Headquarters Review Team and Child and Adolescent Psychiatry Consultant to the Armed Forces Center for Child Protection.

CAPT McKeathern received her M.D. from Virginia Commonwealth University in 1986, completing her internship in Internal Medicine at Eastern Virginia Graduate School of Medicine and her Psychiatry Residency at Portsmouth Naval Hospital. CAPT McKeathern also completed a fellowship in Child and Adolescent Psychiatry at Johns Hopkins Hospital. CAPT McKeathern also holds a B.S. in Chemistry, magna cum laude, from Hampton University (1982). CAPT McKeathern is a Diplomate of the American Board of Psychiatry and Neurology, and is board-certified in General Psychiatry and Child and Adolescent Psychiatry). CAPT McKeathern is also a member of the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, and the American Medical Association. CAPT McKeathern's military decorations include three Navy and Marine Corps Commendation Medals and two Navy and Marine Corps Achievement Medals.

Richard A. McCormick, Ph.D.

Dr. McCormick retired as the Director of the Mental Health Care Line for the DVA Healthcare System of Ohio. He was responsible for all DVA mental health services throughout most of Ohio and portions of surrounding states. While at DVA he was co-chair of the congressionally-mandated Committee on the Care of Severely Mentally Ill Veterans, a member of the DVA national task force charged with establishing evidence-based practice guidelines for a full range of conditions including substance abuse, depression and psychoses, chaired the oversight committee for the Serious Mental Illness Research and Treatment Center and was on the executive committee for the Mental Health Quality Enhancement Initiative. He was recently a Commissioner on the Department of Veterans Affairs CARES Commission, which set strategic clinical and capital asset-related goals for the Department for the next twenty years. He continues as a health services research consultant at Case Western Reserve University in the areas of substance use and PTSD. He has authored over 50 articles and book chapters focusing on pathological gambling, substance abuse, serious mental illness, suicide, PTSD and evidence-based care. Dr. McCormick is a clinical psychologist and continues to consult with health systems on mental health services.

Layton McCurdy, M.D.

Dr. McCurdy is Dean Emeritus and Distinguished University Professor at the Medical University of South Carolina. During his tenure at MUSC, Dr. McCurdy served as Vice President for Medical Affairs, Dean, Professor and Chairman of Psychiatry. Previously, Dr. McCurdy served as Psychiatrist-in-Chief at Pennsylvania Hospital and Professor at the University of Pennsylvania. Dr. McCurdy also worked at the National Institute of Mental Health (NIMH) and held a faculty appointment at Emory University Medical School in Atlanta. In 2005, Dr. McCurdy was appointed Chairman of the South Carolina Commission on Higher Education. A noted academician, Dr. McCurdy has made numerous contributions to the scientific literature in the areas of medical education, the social responsibility of physicians, addictions, and psychiatry.

Dr. McCurdy received his undergraduate education from the University of North Carolina – Chapel Hill, his M.D. from MUSC, and completed his psychiatric residency at UNC. Dr. McCurdy has served as President of the American Board of Psychiatry and Neurology (ABPN), the American College of Psychiatrists, the Association for Academic Psychiatry, the Association of Chairmen of Departments of Psychiatry, and as chair of the American Psychiatric Association's (APA) Committee on Diagnosis and Assessment. Dr. McCurdy has received numerous national and international recognitions including membership in Alpha Omega Alpha, the Distinguished Alumnus award for the Medical University of South Carolina (1988), appointment as a Fellow in the Royal College of Psychiatrists (United Kingdom), the Bowis Award for distinguished service to the American College of Psychiatrists, the Earl B. Higgins Award for Achievement in Diversity, the SELAM International Award in recognition of his support and dedication to the advancement of women in academic medicine, and La Societe Francaise Humanatati Award for life-long work to aid and better the human condition.

COL David T. Orman, M.D.

COL Orman currently travels and works full-time for the Army Surgeon General in support of the DOD Mental Health Task Force. He previously served as Director of Residency Training in Psychiatry at Tripler AMC, HI. Prior to that assignment, COL Orman served as Behavioral Health Policy Staff Officer at MEDCOM, Fort Sam Houston, as the Psychiatry Consultant to the US Army Surgeon General, and as Chief of the Department of Psychiatry at Darnall Army Community Hospital and Brooke Army Medical Center. Among his academic appointments, COL Orman has served as Assistant Director of Psychiatry Residency Training and Associate Professor of Psychiatry at Texas A&M Health Science Center College of Medicine, and as an Instructor in Psychiatry at the USUHS.

COL Orman received his MD from USUHS in 1982, completing his internship and residency in Psychiatry at Walter Reed AMC, serving as Chief Resident in 1985. COL Orman also holds a BS, summa cum laude, from Midwestern State University (1977). COL Orman is a diplomate of the National Board of Medical Examiners (1983) and is board certified in Psychiatry by the American Board of Psychiatry and Neurology (1988). COL Orman has authored numerous articles in peer-reviewed journals, and identified 13 peer-reviewed publications as representative of his body of work.

COL Angela Pereira, Ph.D.

COL Pereira is currently assigned to the Department of Behavioral Health at Dewitt Army Community Hospital, Fort Belvoir, VA. Previously, COL Pereira served as Chief of the Combat Stress Control/Mental Health Clinic of Task Force Medical 115/344 Prison Hospital at Abu Ghraib, Iraq; Chief of the Social Work/Family Advocacy Program at USAMEDDAC in Heidelberg, Germany; Chief of Education and Training at USACHPPM, Aberdeen Proving Ground, MD; and deployed as the Division Social Worker for the 3rd Armored Division during Operations Desert Shield/Storm. COL Pereira has also served in a broad range of Social Work Officer positions in Fort Jackson, SC; Frankfurt, Germany; and Fort Riley, KS.

COL Pereira received her Ph.D. in Social Work from the University of South Carolina in 1998. COL Pereira also holds an M.S.W. and a B.A. in Psychology from the University of California - Berkeley (1983 and 1978, respectively). COL Pereira is a Board Certified Diplomate in Clinical Social Work (2001) and certified as a licensed clinical social worker in Maryland (1998). COL Pereira is a member of the National Association of Social Workers and the International Society for Traumatic Stress Studies. COL Pereira has authored several articles in peer-reviewed journals and has given numerous presentations at national conferences. COL Pereira's many awards and decorations include the Bronze Star Medal, the Meritorious Service Medal, the Army Commendation Medal, the Meritorious Unit Citation, the Order of Military Medical Merit, the Combat Action Badge, and the Expert Field Medical Badge.

A. Kathryn Power, M.Ed.

A. Kathryn Power is Director of the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division of the US Department of Health and Human Services (DHHS). Prior to her appointment as Director of CMHS, Ms. Power served over 10 years as the Director of the Rhode Island Department of Mental Health, Retardation and Hospitals (DMHRH), a Cabinet position reporting to the Governor. Ms. Power previously directed the Rhode Island Office of Substance Abuse, the Governor's Drug Program, the Rhode Island Anti-Drug Coalition, and the Rhode Island Council of Community Mental Health Centers. Earlier professional experiences include teaching at elementary and secondary schools; providing counseling, leadership and advocacy for rape crisis and domestic violence agencies; and working as a computer systems analyst for the Department of Defense.

Director Power received her Bachelor's degree in education from St. Joseph's College in Emmitsburg, Maryland, and her Master's degree in education and counseling from Western Maryland College. She is a graduate of the Toll Fellowship program of the Council of State Governments, and completed programs in senior executive leadership development, mental health leadership, and substance abuse leadership at the Harvard University John F. Kennedy School of Government. In 2005, Director Power received the U.S. Department of Health and Human Services Secretary's Award for Distinguished Service for spearheading the Federal Mental Health Transformation Team, an unprecedented interdepartmental coalition that produced the first ever Federal Action Agenda for Mental Health Transformation. In 1997, Director Power served as President of the National Association of State Mental Health Program Directors (NASMHPD). Ms. Power has been recognized locally and nationally for her leadership and advocacy on behalf of individuals with disabilities and has served on the boards of directors of over 100 non-profit agencies, commissions, and task forces in both the public and private sectors. Ms. Power is currently a Captain serving in the U.S. Navy Reserve.

LCDR Aaron D. Werbel, Ph.D.

LCDR Werbel currently serves as Behavioral Health Affairs Officer and Suicide Prevention Program Manager at Headquarters, Marine Corps (Manpower and Reserve Affairs.) He is a member of the Department of Defense Suicide Prevention and Risk Reduction Committee. Previously, LCDR Werbel has served as Staff Psychologist in the Midshipman Counseling Center at the United States Naval Academy; Head of Behavioral Healthcare at the Branch Medical Clinic Capodichino in Naples, Italy; Head of the Substance Abuse Rehabilitation Program at the Naval Hospital in Naples, Italy; Head of HIV/AIDS Psychology Division and Staff Psychologist at the National Naval Medical Center in Bethesda, Maryland where he was a member of the training staff for the psychology internship program. LCDR Werbel is a highly sought-after speaker, having presented at national DVA conferences, national mental health association conferences, state sponsored suicide prevention conferences and numerous military conferences. He was the planning chair of the 2007 DOD Military Suicide Prevention Conference.

LCDR Werbel received his M.A. and Ph.D. in Clinical Psychology from Michigan State University in 1994 and 1998, respectively, and completed his APA-accredited internship at the National Naval Medical Center in Bethesda, Maryland. LCDR Werbel also received a B.S. with distinction in Psychology from the University of Michigan (1988). LCDR Werbel is a licensed Clinical

Psychologist and is a member of the American Association of Suicidology and the International Association of Suicide Prevention.

Antonette M. Zeiss, Ph.D.

Dr. Zeiss currently serves as Deputy Chief Consultant, Office of Mental Health Services at the Department of Veterans Affairs (DVA) Central Office. Prior to joining the DVA Central Office, Dr. Zeiss served as Assistant Chief and Director of Training at the DVA Palo Alto Health Care System. Among her academic appointments, Dr. Zeiss has served as Clinical Lecturer in the Stanford University Department of Medicine, Visiting Professor of Psychology at Stanford University, and Assistant Professor of Psychology at Arizona State University.

Dr. Zeiss received her M.A. and Ph.D. in Clinical Psychology from the University of Oregon in 1975 and 1977, respectively. Dr. Zeiss also holds a B.A. in Psychology from Stanford University (1966). Dr. Zeiss is currently licensed to practice psychology by the state of California. Dr. Zeiss' honors and awards include APA Division 12's Clinical Geropsychologist Distinguished Clinical Mentorship Award (2004), APA Division 18's Outstanding DVA Psychologist Training Director Award (2003), the Interdisciplinary Creativity in Practice and Education Award (2003), the APPIC Award for Excellence in Internship and Postdoctoral Training (2002), and the Arizona State University Psychology Department Faculty of the Year Award (1979).

Appendix C: Sites Visited by Task Force Delegations, Sept 2006 – Feb 2007

Date(s)	Installation(s)
6-7 SEP 06	Fort Drum, NY
18-19 SEP 06	Fort Hood, TX
27-28 SEP 06	Hawaii: • Hickam Air Force Base • Marine Corps Base Hawaii Kaneohe Bay • Tripler Army Medical Center • Naval Station Pearl Harbor • Schofield Army Barracks
2-3 OCT 06	Okinawa: • Marine Corps Base Camp Butler • Kadena Air Force Base • U.S. Naval Hospital Okinawa
5-6 OCT 06	Korea: • 121st General Hospital • Osan Air Base
16-17 OCT 06	Marine Corps Base Camp Pendleton, CA
20 OCT 06	Naval Base San Diego, CA
23 OCT 06	Marine Corps Air Station Miramar, CA
30-31 NOV 06	Fort Bragg, NC
1-2 OCT 06	Pope Air Force Base, NC
13-14 NOV 06	Nellis Air Force Base, NV
16-17 NOV 06	Travis Air Force Base, CA
20 NOV 06	National Center for PTSD, Palo Alto, CA
21 NOV 06	VA Hospital, San Francisco, CA
29-30 NOV 06	Maxwell Air Force Base, AL
4-5 DEC 06	Naval Construction Battalion Center Gulfport, MS
7-8 DEC 06	Naval Station Norfolk, VA
11 -12 DEC 06	Marine Corps Base Camp LeJeune, NC
15 DEC 06	Marine Corps Air Ground Combat Center Twentynine Palms, CA
14-15 DEC 06	Marine Corps Air Station Cherry Point, NC
5-6 JAN 07	Sheppard Air Force Base, TX
8-10 JAN 06	Lackland Air Force Base, TX
11-12 JAN 07	Fort Riley, KS
18-19 JAN 07	Fort Lewis, WA
25-26 JAN 07	Fort Carson, CO
31 JAN-8 FEB 07	Germany: • Landstuhl Regional Medical Center • Ramstein Air Base • U.S. Army Garrison Baumholder • Geilenkirchen NATO Air Base
20-21 FEB 07	Fort Stewart, GA
22-23 FEB 07	Warner-Robbins Air Force Base, GA
17 FEB 07	Ohio Marine Corps Reserve

Appendix D: Task Force Meetings, July 2006 – April 2007

Date(s)	Location
15-16 JUL 06	Walter Reed Army Medical Center, Washington DC
20-21 SEP 06	Fort Hood, TX
19-20 OCT 06	San Diego, CA
20-21 NOV 06	San Francisco, CA
18-20 DEC 06	Crystal City, VA
22-23 JAN 07	Tacoma, WA
26-28 FEB 07	Arlington, VA
19-21 MAR 07	Arlington, VA
16-18 APR 07	San Antonio, TX

Appendix E: Briefings Received at Task Force Meetings

Date(s)	Speaker(s)/Briefing Title
15-16 JUL 06	Elspeth Cameron Ritchie, MD, MPH, COL, MC – *Army Medical Department: Behavioral Health*
	Charles Hoge, MD, COL, MC – *Summary of Data on the Mental Health of the Force*
	Patricia Buss, CAPT, MC, USN – *TRICARE Mental Health Benefit*
	Terry Washam, COL – *VA Office of Seamless Transition: Leaning Forward in Serving Veterans*
	Col Schuyler K. Geller, MD, SFS & LtCol Rick L. Campise, PhD, ABPP – *United States Air Force Behavioral Health*
	Aaron D. Werbel, PhD, LCDR, MSC, USN – *Behavioral Health in the U.S. Marine Corps*
	Morgan T. Sammons, CAPT, MSC, USN – *Mental Health in the U.S. Navy: Key Trends and Initiatives*
20-21 SEP 06	Larry Applewhite, LtCol, PhD, LCSW – *Pre and Post Deployment Screening: Fort Hood*
	Division Behavioral Health, 1Cav – *Pre-Deployment Mental Health Issues*
19-20 OCT 06	Mark Russell, PhD, CDR, MSC, USN – *The future of Mental Health Care in the DOD: Carpe Diem*
	John Sparks, Kris Large, Sherilyn Curry, LTC, Marge Crowl, & Jim Chandler, MD – *TRICARE West: Behavioral Health*
20-21 NOV 06	Kerry Childress – *Traumatic Brain Injury*
	Steven Fetrow, PhD, MAJ – *Mental Health Programs, California National Guard*
18-20 DEC 06	Nancy Fortin, COL – *Programmatic Considerations of Mental Health in the Army National Guard*
	Barbara Thompson – *Military Community & Family Policy: Non-Medical Counseling Support, Military OneSource and Military & Family Life*
	Charles Engel, MD, COL – *Respect-Mil: The Army Surgeon General's Program to Improve the Mental Health Services for Soldiers Receiving Primary Care*
	Jody W. Donehoo, PhD – *Continuation of Health Coverage for Guard/Reserve Members and TRICARE Reserve Select*
	Jack Wagoner, MD, PhD & Lois W. Krysa, RN, MSN, CPHQ – *TRO North/Health Net Federal Services*
	Martha Lupo & Gary Proctor, MD – *TRICARE Region South*
	Michael O'Bar, Christine Coure & Stan Regensburg – *TRICARE Reimbursement* (conference call)
	Steven Robertson – Veterans For America
	Barbara Thompson – *Military OneSource*
	Robert Ireland, MD, Col – *DOD Mental Health Policy*

Date(s)	Speaker(s)/Briefing Title
	Kenneth Cox, USAF, MC, SFS – *DOD Health Surveillance: Across the Continuum of Care* Ana Smythe – *Military Officers Association of America*
22-23 JAN 07	Millard Brown, MD, MAJ, Joseph Etherage, PsyD, & Matthew Rein – *Automated Behavioral Health: A Technological Solution for Building a Quality Mental Health Care System* Mark Reger, PhD; Gregory Gahm, PhD, COL; Debi Harris & Kristin Onorati – *Improving Behavioral Health Surveillance: An Example from the Suicide Risk Management & Surveillance Office* Robert Ciuella, MD & Josef Ruzek, MD – *Post-Deployment On-line: PTSD Project* Gregory M. Reger, PhD, CPT & Albert Rizzo, MD– *Virtual Reality in Operational Psychology* Charles Marmar, MD – *Predicting PTSD: Prospective Studies off Risk and Resilience Factors*
26-28 FEB 07	Sumathy Reddy, COL, MC, FS & Clemens Presogna, MAJ, AN – *Mental Health in the Army Reserve* Jeff Thomas, MAJ – *Battlemind Training System* Mary Carstensen, COL – *Army Wounded Warrior Program* John A. Casciotti – *Confidentiality of Mental Health Records in the Military* Gerald Cross, MD – *Veterans Health Affairs (VHA): Overview* Ira Katz, MD – *VHA: Mental Health Programs* David W. Niebuhr, MD, MPH, MSc, LTC(P) – *Accession Medical Standards Analysis & Research Activity (AMSARA)* Tania Glenn, PsyD, LCSW, CTS – *Readiness-Resilience-Recovery: The 4th Marine Aircraft Wing Combat and Operational Stress Control Program*

Appendix F: Glossary

Activation – Order to active duty (other than for training).

Active Duty – Full time duty in the active service of a Uniformed Service including active duty training (full-time training duty, annual training duty and full-time attendance at a school designated as a military Service School, e.g., United States Military Academy).

AHLTA – DOD's electronic medical record/information system, formerly Armed Forces Health Longitudinal Technology Application.

Army Wounded Warrior Program – Formerly known as the Disabled Soldier Support Program (DS3), this program provides support and coordination of care to the soldier and his/her family through all phases of recovery and rehabilitation from injury.

Automated Behavioral Health Clinic – A computer application that uses software to automate the patient intake process and improve access to data relevant to patient care. It screens patients while they wait to see a mental health provider using a comprehensive questionnaire. It generates results to assist mental health providers and clinic managers.

Beneficiary – Individual eligible to receive medical care provided by military medical facilities and the TRICARE network, and can include Active Duty personnel, active duty dependents, military retirees and their dependents, and survivors of deceased service members.

Battlemind Training – Army program utilizing resiliency training that assists the soldiers transitioning from the combat-zone to the "home-zone". War-fighting skills and the "battle" frame of reference sustain the soldier in the operational setting. It is critical to transition successfully as effectiveness at home is as important as effectiveness in combat.

Billet – A personnel position or assignment that may be filled by one person.

Casualty Assistance Officer – Specially trained officer and enlisted personnel who are charged with personally notifying family members of the death of an active duty service member. They provide initial guidance and support in assisting families in dealing with the loss of a military member.

Chain of Command – The succession of commanding officers from a superior to a subordinate through which command is exercised.

Coordinating Authority – A commander or individual assigned responsibility for coordinating specific functions or activities involving forces of two or more military departments, two or more point force components or two or more forces of the same Service. The commander or individual has the authority to compel agreement. In the event that the essential agreement cannot be obtained, the matter shall be referred to the appointing authority. Coordinating authority is more applicable to planning and similar activities than to operations.

Dependent/Immediate Family – A service member's spouse, children who are unmarried and under 21 years of age or who, regardless of age, are physically or mentally incapable of self-support; dependent parents; including step and legally adoptive parents of the Service members spouse; and dependent brothers and sisters including step and legally adoptive brothers and sisters. See also Beneficiary.

Direct Care – Health care active duty and other classes of beneficiaries provided inside the MTF system, e.g. care received at National Naval Medical Center Bethesda, Landstuhl Regional Medical Center, health care provided to forces deployed to combatant sites and other locations overseas.

Family Member(s) – Relatives of Service members who may or may not be beneficiaries. This group can include, but is not limited to Service member parents, step-parents, grandparents, siblings, aunts, uncles, nieces, nephews, cousins, etc.

Family Support Centers (FSC) – FSCs are designed to offer family members of soldiers with a range of information including but not limited to provision of services provided by the installations, community resources and other necessary information unique to service members' families. Each Service has oversight of their respective FSCs. The Army is U.S. Army Community

and Family Support Center (CFSC), the Navy is the Fleet and Family Support Center, the Air Force is referred to as Airmen and Family Readiness Center, and the Marine Corps is the Marine and Family Services.

Health Care Provider – A broad term encompassing licensed clinical professionals (e.g., physicians, psychologists, advanced practice nurses, licensed clinical social workers). Commonly, health care providers have prescription writing privileges. Health care providers may also include trained and licensed professional including registered nurses

Individual Medical Readiness (IMR) – A means to assess an individual Service member's readiness level against established metrics to determine medical deployability in support of contingency operations.

Installation – A grouping of facilities located in the same vicinity, which support particular functions. Installations may be elements of a base.

Marine For Life (M4L) – Program provides transition assistance to Marines who honorably leave active service and return to civilian life and support to injured Marines and their families.

Marine Operational Stress & Surveillance Program (MOSSP) - an integrated progression of deployment cycle-specific educational briefs, health assessments and leadership tolls designed to prevent, identify early and effectively manage combat/operational stress injuries at all levels.

Medical Evaluation Board (MEB) – Physical and /or mental health problems that are expected to render a Service member unable to fully perform his/her duties exceeding 90 days require an MEB. A Limited Duty Board is a type of MEB that places a member in a less than full duty status for 6 months. If a Service member has a condition that is incompatible with military duty or that results in disqualification from world-wide deployment for more than 12 months, he/she will be referred to a Physical Evaluation Board (PEB).

Medical Holdover – Demobilized Reserve Component soldiers with medical conditions and/or injuries sustained in the line of duty that render them non-deployable but volunteer to remain on active duty as they are treated medically.

Medical Regulating – The actions and coordination necessary to arrange for the movement of patients through the levels of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities and available bed space.

Military Treatment Facility (MTF) – A military hospital or clinic on or near a military base.

Military Health System – A health system that supports the military mission by fostering, protecting, sustaining and restoring health.

Military One Source – A toll-free, 24/7 clearinghouse service that provides information and resources to active duty personnel and their beneficiaries.

Network – The health care services available through TRICARE outside the Direct (e.g. Medical Treatment Facility) Care System.

Operational Stress Control and Restoration Program (OSCAR) – Program where Navy behavioral health personnel are embedded with Marine Corps personnel involved in direct operational combat settings.

Palace Helping Airmen Recover Together (HART) – U.S. Air Force program that provides resources and support for severely injured active airmen and officers and their families.

Physical Evaluation Board (PEB) – This process provides a formal fitness-for-duty and disability determination that may return the service member to duty (with or without assignment limitations), place the member on the temporary disabled/retirement list, separate the Service member from active duty or medically retire the member. These recommendations are forwarded to a central medical board and can be appealed by the Service member, who is permitted to have legal counsel at these hearings.

Post-Deployment Health Assessment (PDHA) – A mandatory procedure for each service member redeploying from combatant operations. It is composed of two parts. Each returning service member must fill out form DD 2796, entitled the PDHA. In addition to the completion of the form, the Service member must also have a face-to-face interview with a trained health care provider. This is to be completed within five days before of after redeployment. If this is not possible, the member's commander should ensure that it is completed, processed and filed in the permanent medical record within thirty days of the member's return.

Post-Deployment Health Re-Assessment (PDHRA) – A mandatory program designed to identify and address health concerns with a specific emphasis on mental health issues that may have emerged over time since deployment and redeployment. The PDHRA form (DD 2900) which is also web-based and can be filled out online, provides a second health assessment for the three to six month period after redeployment. These forms must be reviewed by a health care provider and any follow-up with the service member must be undertaken.

Pre-Deployment Health Assessment – A required form (DD Form 2795) that allows military personnel to record information about their general health and share concerns they may have prior to deployment. It also assists health care providers identify issues and provide medical care before, during and after deployments It is mandatory for all deploying military personnel to fill out the form. It is to be completed and validated within 30 days prior to deployment. This is not to be confused with the Periodic Health Assessment.

Post-Traumatic Stress Disorder (PTSD) – An anxiety disorder that can occur following the experience or witnessing of a traumatic event. A traumatic event is a life-threatening event such as military combat, natural disasters, terrorist incidents, serious accidents or sexual assault in adult or childhood. Most survivors of trauma return to normal given a little time. However, some people will have stress reactions that do not go away on their own or may even get worse over time. These individuals may develop PTSD.

Purchased Care – Health services provided through a TRICARE contract that utilizes for civilian resources.

Redeployment – The withdrawal and redistribution of forces; to transfer to another place or job.

Reserve Component – The Army National Guard, Army Reserve, Naval Reserve, Marine Corps Reserve, Air National Guard, Air Force Reserve, Coast Guard Reserve and the Reserve Corps of the United States Public Health Service.

Service member – A person appointed, enlisted or inducted into a branch of the military Services including Reserve Components (includes National Guard), cadets, or midshipmen of the Military Service Academies.

Substance Abuse Prevention and Treatment – Programs designed to address the substance use, abuse and dependency needs of service members. Each Service has oversight over their substance abuse prevention and treatment programs. The Army's is referred to as Army Substance Abuse Program (ASAP). The Navy treatment program is referred to as Substance Abuse and Rehabilitation Program (SARP), while prevention activities are conducted by Navy Alcohol and Drug Abuse Prevention (NADAP). The Air Force program is titled Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program. In the Marine Corps, treatment programs are conducted by Substance Abuse Counseling Centers (SACC) and Drug Demand Reduction (DDR) is the prevention program.

Stigma – The shame or disgrace attached to something regarded as socially unacceptable.

Traumatic Brain Injury (TBI) – A blow or jolt to the head or a penetrating head injury. The injury may be caused by falls, motor vehicle accidents, assaults and/or other incidents. Blast and concussive events are a leading cause of TBI for active duty military personnel involved in war zones. TBI can temporarily or permanently impair a person's cognitive skills, interfere with emotional well- being and diminish physical abilities. Persons with TBI also remain at high risk for the development of delayed symptoms.

TRICARE – DOD's health care plan for active duty, active duty beneficiaries, retirees and their beneficiaries.

Veterans Health Information Systems and Technology Architecture (VistA) – The Veterans' Health Administration electronic medical information /record system.

Appendix G: Acronyms

ABHC	Automated Behavioral Health Clinic
AC	Active Component
ADAPT	Alcohol and Drug Abuse Prevention and Treatment Program (Air Force)
ASAP	Army Substance Abuse Program
ASD(HA)	Assistant Secretary of Defense Health Affairs
CAO/CACO	Casualty Assistance Calls Officer
CARF	Commission on the Accreditation of Rehabilitation Facilities
CCHSA	Calgary Health Region Mental Health and Addictions Services Continuum
COSC	Combat Operational Stress Control
CPG	Clinical Practice Guidelines
CPT	Cognitive Processing Therapy
CSP	Community Support Program
C&P	Compensation and Pension
DACOWITS	Department of Defense Advisory Committee on Women in the Services
DDESS	Domestic Dependent Elementary Secondary School
DDR	Drug Demand Reduction
DEERS	Defense Enrollment and Eligibility Reporting System
DHB	Defense Health Board (formerly the Armed Forces Epidemiological Board)
DHP	Defense Health Program
DOD	Department of Defense
DODCDP	Department of Defense Center for Deployment Psychology
DODD	Department of the Defense Directive
DODDS	Department of Defense Dependent Schools
DODI	Department of the Defense Instruction
DSHRB	Defense Survey of Health Related Behaviors
DSM-IV	Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition
DVA	Department of Veterans' Affairs
FAP	Family Advocacy Program
FLC	Family Life Consultant
FM	Family Member
FRG	Family Readiness Group
FSC	Family Support Center
FY	Fiscal Year (e.g. FY 2006)
GAO	Government Accountability Office (formerly Government Accounting Office)
GME	Graduate Medical Education
GS	Government Service
GWOT	Global War on Terror
HA	Health Affairs
HART	Palace Helping Airmen Recover Together
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases, Ninth Edition
IG	Inspector General
IMR	Individual Medical Readiness
IOM	Institute of Medicine
IRG	Independent Review Group
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
LCSW	Licensed Clinical Social Worker
M4L	Marine For Life

MEB	Medical Evaluation Board
MHS	Military Health System
MHAT	Mental Health Advisory Team
MHSAP	Mental Health Self Assessment Program
MOA	Memorandum of Agreement
MOSST	Marine Operational Stress and Surveillance Program
MST	Military Sexual Trauma
MTF	Military Treatment Facility
NADAP	Navy Alcohol and Drug Abuse Prevention
NDAA	National Defense Authorization Act
NCO	Non-Commissioned Officer
NG	National Guard
NSPS	National Security Personnel System
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OMNF-I	Office of the Surgeon Multinational Force – Iraq
OSD	Office of the Secretary of Defense
OTSG	Office of the Surgeon General
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
PCP	Primary Care Provider
PDHA	Post-Deployment Health Assessment
PDHRA	Post-Deployment Health Re-Assessment
PHA	Periodic Health Assessment
PE	Prolonged Exposure Therapy
PEB	Physical Evaluation Board
PCM	Primary Care Manager
PCT	Present Centered Therapy
PEB	Physical Evaluation Board
PSA	Public Service Announcement
PTSD	Post-Traumatic Stress Disorder
RC	Reserve Component
RVU	Relative Value Unit
SACC	Substance Abuse Counseling Centers (Marine Corps)
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPRO	Sexual Assault Prevention and Response Office
SF	Standard Form
SLO	School Liaison Officer
SPRRC	Suicide Prevention and Risk Reduction Committee
TBI	Traumatic Brain Injury
TMA	TRICARE Management Activity
VHA	Veterans' Health Administration
VistA	Veterans' Health Information Systems and Technology Architecture
YA	'Professional/Analytical' Pay Scale
YH	'Professional' Pay Scale

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Appendix I: Acknowledgements

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We also are very grateful to the commanders, points of contact, and participants who made it possible for us to complete thirty-eight visits to military installations around the world. The wide range of information candidly shared during those meetings had a powerful impact on the conclusions of the Task Force. We especially appreciate the care and concern demonstrated by the many mental health providers, counselors, therapist and chaplains with whom we met.

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Last but not least, we wish to gratefully acknowledge the energetic and enthusiastic leadership demonstrated by Lieutenant General C. Kiley during his tenure as co-chair of the Task Force. In every way, the service of LTG Kiley and his staff members, Colonel Jeffrey Davies and Major Anthony Cooper was exemplary.

QUESTIONS AND ANSWERS SUBMITTED FOR THE RECORD

JULY 12, 2007

QUESTIONS SUBMITTED BY MRS. DAVIS OF CALIFORNIA

Mrs. DAVIS. Please provide the subcommittee with a copy of the "Risk-Adjusted Population-Based Model" used to determine staffing and resource allocation levels.

Admiral ARTHUR. A Risk-Adjusted Population-Based model for determining Mental Health staffing within DOD does not yet exist. Elements within Health Affairs have been tasked with the development of such a model. This is an extraordinarily complex undertaking that involves an assessment of individual and group risk factors (such as deployment, the area to which one is being deployed, the frequency and length of deployment, and the intensity of combat in a particular deployment issue). We know that individuals exposed to more intense combat experiences are at higher risk for the development of combat stress related disorders. We also know that the incidence of such disorders increases with the number of deployments any particular service member has experienced. We do not know the effects of these factors on family members, nor do we know how such risks affect overall utilization of mental health services.

We have solicited proposals for assistance in the development of a definitive model. We are in the process of currently reviewing some of those proposals. Our timeline is to have a model constructed in the next 7 to 12 months.

Mrs. DAVIS. Please provide the subcommittee with a discussion (with specific examples) on how it would improve access to care by making certain mental health-related ICD–9 diagnosis codes (specifically "V" codes) reimbursable by TRICARE, which currently are not reimbursable.

Admiral ARTHUR. V codes refer to problems in living or adjustment that are not attributable to a specific mental health disorder. In other words, they may be construed as life problems for which counseling may be of assistance but which do not connote the presence of mental illness. Mental Health V codes are not reimbursable under current TRICARE policy, as their treatment is not deemed medically necessary. Some examples of V codes for which clinical attention may be sought in a deployment related situation are (using DSM–IV categorizations):

V61.20—Parent-Child Relational Problem
V61.10—Partner Relational Problem
V61.8—Sibling Relational Problem
V62.81—Relational Problem Not Otherwise Specified, Problems Related to Abuse or Neglect
V71.02—Child or Adolescent Antisocial Behavior
V62.82—Bereavement
V62.2—Occupational Problem
V62.89—Phase of Life Problem

Available evidence informs us that readjustment problems, particularly with family members, and occupational problems are significant for returning combatants. Family members may also experience similar adjustment difficulties. While service members and their families may seek care for such difficulties in military treatment facilities, or via Fleet and Family Support Centers or Military One-Source, these resources may be unavailable or of limited availability. The ability of service members or their families to seek counseling for such difficulties in non-DOD facilities will be enhanced if reimbursement were permissible for these problems.

QUESTIONS SUBMITTED BY MR. MCHUGH

Mr. MCHUGH. You have got a seven-page list of recommendations here, and they are broken out into three different categories. Some do require legislation, others are policy and action. I think they all require money, or certainly most of them require money. So let me ask you, and you did define, and Dr. MacDermid defined what she felt were some of the most important things that the Congress do.

Let me ask you to tick off, if you can, if you agree, three or four of the more important off of this list, because my understanding is this is not really prioritized in any particular way, so that we can get a focus in an area and think about translat-

ing policy into dollars, which is the ultimate challenge for us, frankly. Would that be possible today?

Admiral ARTHUR. The accompanying Excel spreadsheet lists VADM Arthur's and Dr. MacDermid's recommendations for top/priority issues to be considered by the House Armed Services Committee when drafting legislation to enact the Mental Health Task Force's recommendations.

The list is a combination of items that may require legislation, policy, and/or other action. The reason for this was to identify issues that are a priority, but that may not be fully accomplished without legislation.

QUESTIONS SUBMITTED BY MRS. BOYDA

Mrs. BOYDA. We don't have accredited health care, mental health care in Kansas. Can you speak to me specifically about what that means and how we are taking care of that?

Dr. CASSCELLS. There are currently no TRICARE certified residential treatment centers (RTCs) or partial hospitalization programs (PHPs) in the State of Kansas.

The TRICARE Management Activity (TMA) is aggressively pursuing initiatives to improve beneficiaries' access to these facilities.

(1) Access—TMA is comparing the physical location of TRICARE authorized behavioral health providers (both in network and outside network) to the physical location of TRICARE beneficiaries. Where deficiencies are identified, TMA will develop and implement process improvements to close gaps.

(2) PHP Certification—TMA is revising the Code of Federal Regulations, TRICARE Reimbursement Manual, managed care support contracts, and the National Quality Monitoring Contract so that Joint Commission accreditation of a hospital will be sufficient for it to be a TRICARE authorized provider of psychiatric PHP services. This initiative is expected to be completed late 2008/early 2009. Upon completion, TRICARE certification of hospital-based psychiatric PHPs would no longer be required.

(3) RTC Certification—TMA is reviewing TRICARE certification standards for RTCs to determine the advisability of modifying or eliminating some or all of them. The timeline for completion is March 2008.

The number of network outpatient mental health providers for the State of Kansas is 915, broken out as follows:

Psychiatrists: 116
Psychologists: 140
Masters' Level Behavioral Health Professionals: 659

Mrs. BOYDA. Why is there a need for TRICARE to require higher provider standards for mental health services than is required by the state of Kansas?

Dr. CASSCELLS. Title 32 of the Code of Federal Regulations, Part 199.6 implements the statutory authority under title 10, United States Code, section 1079(j) for institutional providers, and states that providers of health services are required to meet all licensing, certification and participation requirements to be an authorized provider eligible to receive payment for services provided to TRICARE beneficiaries.

The strict certification standards adopted by TRICARE were the result of a review of the mental health care system in response to allegations of abuse and fraud in mental health facilities during the late 1980's and early 1990's. TRICARE recognizes that the certification standards may impose a burden on potential providers. However, standards for these facilities were developed in consultation with national mental health professional organizations including the American Psychological Association, the American Psychiatric Association, and the National Academy of Child and Adolescent Psychiatry. When these standards were developed, they were referred to as the "gold standard in the industry."

Substance abuse disorder rehabilitation facilities that are part of TRICARE authorized hospitals only need behavioral health accreditation certification from the Joint Commission on Accreditation of Healthcare Organizations to participate in TRICARE; they do not require the additional TRICARE certification performed by the National Quality Management Contract. Currently, there are 196 TRICARE authorized hospital-based rehabilitation facilities in the TRICARE West region.

An internal review by the TRICARE Management Activity (TMA) and recommendations of the Department of Defense Task Force on Mental Health cited issues related to beneficiary access to residential treatment centers, partial hospital programs, and substance abuse disorder rehabilitation facilities. Actions are under way to improve access to partial hospitalization programs and treatment for substance abuse disorders. Finally, TMA requested that the Joint Commission prepare a side-by-side comparison of their standards and TRICARE standards for residential

treatment center. The comparison will provide a foundation for a detailed examination of TRICARE certification standards for these facilities from clinical, administrative, and patient safety perspectives. Moreover, the comparison will provide a basis for recommendations on the future of those standards.

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