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HEARING

ON

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2009

AND

OVERSIGHT OF PREVIOUSLY AUTHORIZED PROGRAMS

BEFORE THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MILITARY PERSONNEL SUBCOMMITTEE HEARING

ON

BUDGET REQUEST ON THE MENTAL HEALTH OVERVIEW

HEARING HELD
MARCH 14, 2008

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FISCAL YEAR 2009 NATIONAL DEFENSE AUTHORIZATION ACT—BUDGET REQUEST ON THE MENTAL HEALTH OVERVIEW

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Friday, March 14, 2008.

The subcommittee met, pursuant to call, at 9:06 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. The meeting will come to order.

I want to welcome you all to this hearing today. The purposes of our hearing are many and diverse.

First, we will receive an update on how the Department of Defense (DOD) has implemented the recommendations of the Defense Task Force on Mental Health. The Task Force was mandated by Congress in the 2006 National Defense Authorization Act (NDAA), and was charged to both assess the military mental health care system and to make recommendations on how to improve it.

Second, we will have an opportunity to hear about the findings of the Army's Mental Health Advisory Team (MHAT)–V. The results of other MHATs have provided great insight into the mental health needs of our military because the teams conduct their research and interviews on the ground in Afghanistan and Iraq.

Finally, we will have the opportunity to hear about what individual mental health needs are and are not being met from service members and family members.

Today, we will have two panels, and we greatly welcome both of these panels here today.

The first panel before us now includes Dr. Ward Casscells, the Assistant Secretary of Defense for Health Affairs; Lieutenant General Eric Schoomaker, Surgeon General of the Army; Vice Admiral Adam Robinson, Surgeon General of the Navy; Lieutenant General James Roudebush, Surgeon General of the Air Force; and Dr. Shelley MacDermid, the Director of the Center for Families at Purdue University, the Co-Director of the Military Family Research Institute and the Co-Chair of the Department of Defense Task Force on Mental Health.

These senior medical leaders will tell us what has changed since our last hearing and what they are doing now and what they have planned for the future. Dr. MacDermid will help frame these re-

sponses in relation to the findings and recommendations of the Task Force.

Welcome to you all. I do want to say that, if you can stay for the second panel, we would greatly appreciate that, and we certainly do not want anyone to think that our second panel is under any influence from the first, but we really would appreciate it, if it is possible, for you would stay. Perhaps there would be some questions that would be directed to you after they have had a chance to speak, as well.

The second panel will have two currently serving soldiers—Chief Warrant Officer IV Richard Gutteridge and Major General Gannaway, who have been treated for mental health conditions and are willing to share their experiences.

Thank you both for your courage and for being willing to testify.

We are also very fortunate that we will hear from the spouse of one of these soldiers, Mrs. Sarah Gannaway, so we can understand the experience from the family's point of view as well as we can learn what mental health services our family members require.

Finally, Mr. Christopher Scheuerman will share with us a story of his son, Private First Class (PFC) Jason Scheuerman, who committed suicide in Iraq in 2005. I think this story is very painful for all of us to hear, but it is illustrative of how the system failed a soldier, and it will provide us some insights into just how comprehensive and integrated military mental health services need to be.

To all of the witnesses on the second panel, again, thank you so much for your willingness to share such intimate and painful experiences with us and to help ensure that others do not have to suffer as much.

All of the members of this subcommittee remain unanimous in their support for our service members and for their families. With multiple, long-term deployments now the norm for our military, mental health is more important than ever. It weighs heavily upon the readiness of our force, on our ability to retain combat veterans and on our obligation to care for those who volunteer to serve our Nation.

At our last mental health hearing, I made it clear that this was going to be a long process. It will take a sustained effort from all concerned for the foreseeable future to make 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. We will also face fiscal challenges, great fiscal challenges. The structural and cultural changes needed will require significant and continuing financial outlays, but our service members and their families deserve no less.

Finally, I would like to make mention of the fact that all of the second panel witnesses and many of the topics for the first panel are in some way connected to the Army, and this is not because we feel that the Army is the only service that faces mental health challenges. Far from it. We feel that all of the services need to be better. In fact, we will hear from all of the services about the different programs that they have.

So why then is the Army figuring so prominently in hearing?

Well, first, the Army has the largest number of personnel in both Afghanistan and in Iraq. Second, the Army has undertaken a number of self-assessments on mental health issues and has unselfishly shared them. Finally, when the staff of the subcommittee interviewed potential witnesses, there were those with experiences that really stood out as excellent examples of what improvements have been made and of what still needs to be done. By random chance, those happen to be in connection to the Army.

It would be a disservice to the Army to assume that these coincidences single it out as having more problems than any other services. Instead, I think we need to be grateful to the Army that so much information is available to help us guide our discussions.

Once again, I welcome you all today. I look forward to a very fruitful discussion.

I would like to turn to the ranking chair, Mr. McHugh, for his introductory remarks.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 59.]

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

Mr. MCHUGH. Thank you very much, Madam Chairman.

I have an extensive opening statement that I will submit for the record for its inclusion in its entirety.

I just want to very briefly echo your words of welcome. Some of our panelists are appearing for the second time this week. That seems to me to be beyond cruel and unusual punishment, but I think it speaks very well of their devotion to these mental health and health concerns that we all share. We are very grateful to have such a distinguished first panel.

Dr. MacDermid, particularly, thank you for your work on the Task Force. We look forward to hearing your comments, of course, and look forward to hearing from our good Secretary, as well as the Surgeons General, as to how we can work together and provide these very critical services.

I would echo the statements and the Chair's remarks about our particular appreciation for the second panel. These good folks will provide us with a particularly important, a particularly unique perspective on, I know, what we all recognize as a challenge. Recognition is critical; it is the first step in providing these services.

But we have got a ways to go. Hopefully, today's hearing can help us take a few more steps down that path.

So, with that, again thank you for being here. I look forward to everyone's comments.

Madam Chair, I will yield back.

Mrs. DAVIS. Thank you, Mr. McHugh.

[The prepared statement of Mr. McHugh can be found in the Appendix on page 62.]

Mrs. DAVIS. Dr. Casscells, would you like to begin?

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

Dr. CASSCELLS. Thank you, Madam Chairwoman and Mr. McHugh. We appreciate the opportunity to come before you again and report on our response to the problems which have manifested themselves and, particularly, to respond to the guidance we got from you almost a year ago.

As you say, Mr. McHugh, we are making progress, and we do have a ways to go. We are pleased that we on our end, on the military side, at least, have agreement on the road by which to get there, and we have had plenty of advice, particularly from Dr. MacDermid and her colleagues on the Task Force and throughout the academic world. I think we are grappling with this about as hard as we can.

We have been generously funded by Congress. We hope to reach a place where our program that we have stood up now will begin at the earliest stage of a member's career, as Dr. MacDermid recommended in her report, in the Mental Health Task Force report, and will continue throughout the career and will include improved screening, because not everyone needs to be a warfighter. People can serve in other ways.

It will include what we call resiliency training, so that people can become stronger in mind as they do in body. It will include better monitoring so that we can begin to find people, identify them when they are struggling. Currently, we are already charging their battle buddies, their enlisted leaders and their company commanders to identify people who are struggling; and we are pleased that the line has recognized that this is important.

But early detection is important so that people can get three hots and a cot, or even medications in some cases, recover, and return to the fight. You know, sometimes it is just a misunderstanding that needs to be clarified. So this is terribly important, early detection.

Treatment is a struggle. We do not really know very well what treatments work. We recognize this, and we are committed now to taking a hard look at these treatments and comparing them. In the fields of psychology, psychiatry, psychiatric social work, we have struggled in reaching common definitions and standards and in agreeing on the way ahead and in agreeing on how to collect data, what data to collect, and we are making major progress in this, led by Colonel (Promotable) Loree Sutton, M.D., an Army doctor, who is coordinating these efforts.

So treatment needs a lot of work, and then rehabilitation and reintegration. This is the spectrum of the things we are trying to do.

It is my job as the cheerleader and coach to make sure we have got the right players in the field, that they have got the right playbook, that they understand the playbook. Occasionally, of course, if we are not scoring goals, I have got to shuffle the play and call in some plays from the sidelines. That is my job as the steward of quality and oversight responsibility.

I am pleased to tell you, ma'am and sir, that we have a terrific team on the field now, and we are moving down the field. We are going to have, I think, a standard in mental health care over the next few years, which will be the best in the world, back in the

days when the military led the world in mental health, and we will be defining "trauma" as a continuum of mind and body. In so doing, by intervening early, we will actually reduce costs because we recognize now that depression and post-tramatic stress disorder (PTSD), while they only affect about 20 percent of the returning soldiers and marines and sailors and airmen, actually account for about 80 percent of the problems and the costs.

When you look at the operational errors that you alluded to, ma'am, these can be very expensive indeed. So, with this early intervention and with these programs that you have helped us with, I think we are on the edge of a new era in military psychology and psychiatry, and we are pleased today to take your questions and answer them to the best of our ability and to get your advice.

Thank you very much.

Mrs. DAVIS. Thank you.

[The prepared statement of Dr. Casscells can be found in the Appendix on page 64.]

Mrs. DAVIS. General Schoomaker.

STATEMENT OF LT. GEN. ERIC B. SCHOOMAKER, USA, M.D., PH.D., THE SURGEON GENERAL OF THE U.S. ARMY AND COMMANDER, U.S. ARMY MEDICAL COMMAND

General SCHOOMAKER. Well, Chairwoman Davis, and Ranking Member McHugh and distinguished members of the personnel subcommittee, thank you for this opportunity to come here today and to discuss the Army's efforts to improve mental health care for our soldiers and family members.

Army leadership strongly supports efforts to improve the quality and access to mental health services, and they have been actively leading to eliminate the stigma associated with seeking mental health care. As you know, this stigma is not just found in the Army. It is not just found in the military. It is a national concern that needs to be addressed across all communities.

Ma'am, I really appreciate your earlier comments about, although this appears to be centered on Army patients and Army issues, this is really a problem for the Nation as a whole.

Our soldiers in our Army are doing truly amazing work. It is demanding. It has a high operational tempo, as you know, today, but our soldiers and our families are stressed. We appreciate your bringing soldiers and families here for this hearing today, and I want to personally extend my appreciation to these soldiers for publicly coming forward and for discussing their experiences.

I am often asked why I cannot order soldiers to come forward and talk to you about their issues, and of course, I cannot do that. But when experienced soldiers and families want to come forward and give us their issues, it helps us to dispel stigma; it helps us to identify problems, resistant problems, that we can overcome. So I extend my admiration and appreciation to them.

The global war on terror has placed increased operational demands on our military force. We know that repeated and extended deployments have led to increased stress on families and on individual soldiers and have led to other psychological effects of war, such as depression, anxiety, withdrawal, and social isolation or

have led to symptoms of post-traumatic stress, which we also know, if not identified and addressed promptly—as we learned in prior wars, notably in Vietnam—may evolve into a more resistant psychological——

Mrs. DAVIS. General, excuse me. If you could just bring the mike a little closer——

General SCHOOMAKER. Yes, ma'am.

Mrs. DAVIS. Thank you.

General SCHOOMAKER. Post-traumatic stress—that is post-combat stress and stresses of trauma—if not addressed promptly will result in a much more resistant psychological injury known as post-traumatic stress disorder.

Let me assure you that the Army is absolutely committed to ensuring that all soldiers and families are healthy, both physically and psychologically, as Dr. Casscells has addressed.

Today, on your second panel, you are going to hear from two members of the Walter Reed Warrior Transition Brigade, Major Bruce Gannaway and Chief Warrant Officer IV Richard Gutteridge, as well as from Sarah Gannaway, Major Gannaway's wife. As I have said, I really appreciate their coming forward and talking to you about their issues and about our continued problems.

I believe that as an Army and as a Department of Defense we have embraced the recommendations of the DOD Task Force on Mental Health and of the Mental Health Advisory Teams that we have now sent out for the past five years. We are striving to truly provide the best mental health care for our soldiers and for their families. I would like to touch upon just a few of those initiatives that I know are making a profound impact on soldiers and families.

First of all, you have already alluded to these Mental Health Advisory Teams. These are a groundbreaking achievement. Never before has a military or a fighting force studied the psychological strains of combat as intensely during the conflict. Sometimes it is not pleasant to hear what we have found—self-assessment is not often pleasant—but it is important that we hear their unvarnished feedback so that we can take the necessary steps to improve; and we have done that.

Second, the Army's unprecedented leaders' chain teaching was a powerful initiative that started at the very top of the Army. It simultaneously and powerfully addresses leadership, our culture and advocacy. We have trained over 900,000 soldiers in a massive educational effort that began in the summer and fall of 2007. We are now incorporating that into all of our soldier and leader training programs.

Next, we have the Battlemind Training program. This is an outgrowth of our Mental Health Advisory Teams. It focuses on building fitness and resilience. The findings of the latest MHAT–V indicate that Battlemind is hitting the target and is making soldiers less susceptible to combat stress and is building resilience. Finally, we have our Re-Engineering Systems for the Primary Care Treatment of Depression and PTSD in the Military (RESPECT-MIL) program, which addresses access from different perspectives to include primary care.

I do not bring up these points to say that we are solving everything, but we do have a focused, reasoned approach.

I applaud Congress and this committee for standing up the Task Force on Mental Health in 2006. I applaud Congress for directing the establishment of our Center of Excellence for Psychological Health and Traumatic Brain Injury. I look forward to continuing to work with you in improving the delivery of mental health services and in answering your questions today. Thank you.

Mrs. DAVIS. Thank you very much.

[The prepared statement of General Schoomaker can be found in the Appendix on page 82.]

Mrs. DAVIS. Admiral Robinson.

STATEMENT OF VICE ADM. ADAM M. ROBINSON, USN, SURGEON GENERAL, U.S. NAVY

Admiral ROBINSON. Madam Chairwoman, Representative McHugh and distinguished members of the committee, I appreciate the opportunity to share with you Navy Medicine's efforts in preventing, diagnosing and treating psychological health issues affecting our active duty and Reserve sailors and marines and their families.

As the provider of medical services for both the Marines and Navy, we have to be prepared to meet the needs of these similar and yet unique military populations. My colleague, Rear Admiral Bill Roberts, who is seated behind me, currently serves as the Medical Officer of the Marine Corps. We share a vision on how to meet the needs of marines both in theater and in garrison. We also work very closely with our aligned leadership, the Chief of Naval Operations and the Commandant, to implement Navy/Marine centered care initiatives to address everything from combat stress to predeployment training and wounded marine care.

Since the beginning of the global war on terror, Navy Medicine has been continuously adapting to meet the short- and long-term psychological health needs of service members and of their families before, during, and after deployment. We are well aware of the fact that the number and length of deployments have the potential to impact the mental health of service members as well as the well-being of their families.

The current operational tempo is unprecedented. Our experiences in previous conflicts, most notably Vietnam, suggest that delays in seeking mental health services increase the risks of developing mental illness and may exacerbate physiological symptoms. This is also the case for individuals who may be considering suicide. Although suicide rates in the Navy and Marine Corps have not significantly fluctuated in recent years, we remain vigilant of the potential long-term impact our mission requirements will have on the physical and mental health of our sailors and marines and their families.

In response to the recommendation by the DOD Mental Health Task Force, Navy Medicine expanded or, when necessary, developed programs to address the four interconnected goals outlined in the report. The goals include, one, build a culture of support for psychological health; two, ensure a full continuum of care is available; three, allocate sufficient and appropriate resources; four, empower the leadership to advocate for a culture of psychological health.

Reducing the stigma associated with seeking psychological health services is a critical component of our efforts to build and to strengthen the culture that supports psychological health. To reduce stigma, we have expanded our training efforts in collaboration with the Chief of Naval Personnel. These training programs are available at each career training point and help educate service members on the importance of not delaying psychological health services. The same way physical conditioning prepares sailors and marines for the rigors and challenges of high-tempo operational deployments, we are psychologically preparing service members and their leaders to build resiliency, which will help manage the physical and psychological stresses of battle.

The Marine Corps' Marine Operational Stress Surveillance and Training Program, MOSST, includes briefings, health assessments and tools to deal with combat and operational stress. The MOSST Program includes warrior preparation, warrior sustainment, warrior transition which happens immediately before marines return home, and warrior resetting.

In addition to training sailors, marines and their families to identify the signs of stress in themselves and in their colleagues, we are expanding caring-for-the-caregiver training programs for psychological health, traumatic brain injury and post-traumatic stress disorder. To ensure the full continuum of mental health care services are available to sailors and marines, we have made psychological health screening an effective and normal part of military life before, during, and after deployments.

Since the late 1990's, Navy Medicine has embedded mental health professionals with operational components of the Navy and of the Marine Corps. Clinical psychologists have been regularly embarked aboard all of our aircraft carriers and have become a valuable member of ship's company. Not only have mental health assets helped crews deal with the stresses associated with living in isolated and unique conditions, but medevacs and administrative discharges for conditions typically managed by mental health personnel have decreased. Having a mental health professional who is easily accessible and who is going through many of the same challenges has increased operational and battle readiness aboard these floating platforms, saving lives as well as hundreds of thousands of dollars in operational costs.

For the Marines, Navy Medicine Division psychiatrists who are stationed with marines developed OSCAR teams, Operational Stress Control and Readiness, which embed mental health professionals as organic assets in operational units. OSCAR teams provide early intervention and prevention support through all of the phases of deployment. The same team providing care in garrison also deploys with the unit, which improves cohesion and helps to minimize stigma.

Since the beginning of Operations Enduring Freedom and Iraqi Freedom, mental health-related medical evacuations for marines have been significantly lower among units supported by OSCAR. Currently, there is strong support for making these programs permanent and for ensuring that they are resourced with the right staff and funding.

To meet the goals of allocating sufficient and appropriate resources to address the mental health needs of sailors and marines, we have made mental health professionals more easily accessible by bringing the portals of care closer to the service members. Beginning in 2006, Navy Medicine established deployment health centers to serve as nonstigmatizing points of entry at high fleet and Marine Corps concentration areas and to augment primary care services offered at the Military Treatment Facility (MTFs) or in garrison. Staffed by primary care providers and mental health teams, the centers are designed to provide care for marines and sailors who self-identify mental health concerns on the post-deployment assessment and reassessment. We now have 17 such clinics up from 14 last year.

In urgent or extraordinary situations, Navy Medicine meets the psychological health needs of sailors and marines in their communities by deploying Special Psychiatric Rapid Intervention Response Teams, SPRINT. These teams have been in existence for over 15 years, and provide short-term mental health and emotional support immediately after a disaster, with the goal of preventing long-term psychiatric dysfunction or disability. The team may provide educational and consultative services to local supporting agencies for long-term problem resolution.

A new program for Navy SEALS, seabees and marines is called FOCUS. Families Overcome and Coping Under Stress is aimed at families most at risk, and it will be located at marine bases at Camp Pendleton, Camp Lejeune, Twentynine Palms, and Okinawa. This program is a prevention, very early intervention program consisting of 10 to 12 counseling sessions with a team of specially trained counselors.

Mrs. DAVIS. Admiral, could I ask you to try and wrap up quickly? We have to rush because we have a vote coming, and I want to be sure we get everybody in. Thank you.

Admiral ROBINSON. Yes, ma'am.

In summary, let me say that we in Navy Medicine and in the Marine Corps are doing everything to make sure that we look at the behavioral health needs of our service members and of their families, that we have a culture that is of psychological health, that we destigmatize as much as possible the effects of seeking psychological help, and that we think that patient- and family-centered care is the essence of the standard of care that we give to our patients.

Thank you.

Mrs. DAVIS. Thank you very much.

[The prepared statement of Admiral Robinson can be found in the Appendix on page 92.]

Mrs. DAVIS. Dr. MacDermid.

Dr. MACDERMID. I do not want to make you late for your vote.

Mrs. DAVIS. Oh, I am sorry. General Roudebush.

Go ahead, General. I am sorry.

STATEMENT OF LT. GEN. (DR.) JAMES G. ROUDEBUSH, USAF, SURGEON GENERAL, U.S. AIR FORCE

General ROUDEBUSH. Madam Chairwoman, Ranking Member McHugh and distinguished members of this subcommittee, I wel-

come the opportunity to speak with you today concerning the Air Force and the Air Force's medical focus on the operational stress that our airmen are enduring both at home and in harm's way in combat, and our efforts and activities to, one, prevent and, two, to treat as quickly and as effectively as possible when these do occur.

Your Air Force is America's force of first and last resort to guard and to protect our Nation. To that end, we Air Force medics work directly for our line to address our Air Force's top priorities—winning today's fight, taking care of our people and preparing for tomorrow's challenges. The future strategic environment is complex and uncertain, but be assured that your Air Force and your Air Force Medical Service are ready for today's challenges and are preparing for tomorrow.

It is important to understand that every Air Force base, at home station and deployed, is an operational platform; and Air Force medicine supports warfighting capabilities at each of our bases. It begins with our Air Force medical treatment facilities that provide combatant commanders a healthy, fit force, capable of withstanding the physical and mental rigors associated with combat and with other military missions.

Our emphasis on fitness and prevention has led to the lowest disease, nonbattle injury rate in history. The daily delivery of health care at our medical treatment facilities maintains critical skills that guarantee our readiness to provide that healthy, fit force and to care for our families, to respond to our Nation's call supporting our warriors in harm's way, and to provide humanitarian assistance to countries around the world.

To execute these broad missions, the services—the Air Force, the Navy and the Army—must work together interoperably and interdependently. Every day, together, we earn the trust of our All-Volunteer Force and their families, and we value that trust above all else.

Today, we are here to address the psychological health needs of our airmen and of their families. The Air Force and the Air Force Medical Service is focused on the psychological needs of our airmen and reducing the effects of operational stress. Post-traumatic stress disorder is low in the Air Force, diagnosed at less than one percent of our deployers, but it is no less important. Every airman affected deserves the best care available.

The Air Force Suicide Prevention Program is also a commander's program that has achieved a 28 percent decrease in Air Force suicides since its inception in 1996. All airmen receive annual suicide training. This year, we released the front lines supervisors' course as an added tool for commanders.

We continue to use a community approach centered on effective detection and treatment, and it is working. The entire constellation of our psychological health programs are continuously being refined for better support to our airmen and to their families.

In closing, Madam Chairwoman, I am humbled by and am intensely proud of the daily accomplishments of the men and women of the United States Air Force Medical Service. The superior care routinely delivered by Air Force medics and our joint partners, the Army and the Navy, is a product of preeminent medical research training programs and a culture of personal and professional ac-

countability. With your help and the help of this committee, the Air Force will continue our focus on the health of our warfighters and of their families.

I thank you and look forward to your questions.

Mrs. DAVIS. Thank you, General.

[The prepared statement of General Roudebush can be found in the Appendix on page 108.]

Mrs. DAVIS. Dr. MacDermid.

STATEMENT OF DR. SHELLEY M. MACDERMID, MBA, PH.D., CO-CHAIR, DEFENSE HEALTH BOARD TASK FORCE ON MENTAL HEALTH, DIRECTOR, THE CENTER FOR FAMILIES AT PURDUE UNIVERSITY, AND DIRECTOR, MILITARY FAMILY RESEARCH INSTITUTE

Dr. MACDERMID. Good morning, ma'am.

Chairwoman Davis, Representative McHugh, distinguished members of the subcommittee, and others, I am honored to be here today. I must hasten to correct, however, the reference to my task force. I was one of only 14 people who worked long and hard on these issues, and I want to especially acknowledge the exemplary leadership demonstrated by both General Kiley and Admiral Arthur, who are not here today.

I have submitted a full report of the Task Force for the record. As you know, the report presented an achievable vision for supporting the psychological health of military members and their families.

[The information referred to is retained in the committee files and can be viewed upon request.]

Dr. MACDERMID. The Task Force made 95 recommendations, almost all of which were endorsed by the Secretary of Defense; and I know that many dedicated people have been working very hard on the recommendations, many of whom are in this room. Many of the recommendations were targeted for completion by May 2008, just a few short weeks from now. I would like to identify a few issues that I am especially eager to hear about in terms of progress.

The first is TRICARE. The Task Force recommended several specific changes needed to ensure that the TRICARE system could provide adequate care. I have prepared an example for you today, and I have learned in the period right before the testimony that I do not need that paragraph anymore. Dr. Casscells assured me that this particular issue will be taken care of shortly, so I will let that paragraph go, and we can talk about other things, if you wish, later.

The second issue I would like to address is the supply of professionals who are well prepared to provide the prevention, assessment, treatment, and follow-up services to military members and to their families who require care.

A question Admiral Arthur and I are often asked is, how many more professionals are needed to meet the need. The Task Force did not answer this question, and Admiral Arthur and I never answered this question because it required the development of a new model for allocating the staff who support psychological health, specifically a risk-adjusted, population-based system.

The existing staff allocation system is based on relative value units that undercount prevention activities and unmet demand. The Task Force recommended that staff, instead, be allocated according to the size of a population in a given area, be adjusted according to the presence of risks, such as combat deployments and other challenging conditions. According to the Secretary of Defense's work plan released in September, the new model has been designed, and that should make it possible to identify quite precisely where sufficient staff are in place to meet the estimated need, where the numbers are insufficient and by how much.

I am also eager to learn about successes in recruiting and in retaining mental health professionals. The Task Force received numerous indications that it is difficult to get and to keep highly qualified mental health professionals. I hope that the importance of the individuals who do that work is being recognized by very strong efforts to recruit and retain them, including incentives and opportunities for career development.

Also, in the area of staffing, I am eager to hear about changes in contracting procedures. The Task Force made site visits to 38 installations where we heard over and over again that contracting mechanisms were cumbersome and delayed, making it difficult to keep staff, and in general, it interfered with the ability to offer good care.

While Congress has been helpful in allocating funds, I am eager to hear whether the right mix has been provided. Substantial funds have been allocated on a nonrecurring basis, which makes it difficult to assess infrastructure issues and makes it difficult to hire the best staff.

The Task Force report emphasized that the shortcomings we observed were not caused by the protracted conflicts in which the United States is now engaged and are unlikely to disappear when they end. Nonrecurring funds, while helpful, do not allow the fundamental challenges to be addressed.

Finally, as someone who has devoted her life to studying and advocating for families, I will close by saying that I am especially eager to hear how services for family members have been improved since the Task Force submitted its report. We have made several specific recommendations in this area.

For example, we wanted to be sure that parents or others caring for wounded or injured service members could easily get access to installations' care managers or other services. Because they have no official status as family members within military systems, parents sometimes face barriers which systematically disadvantage young, unmarried service members.

We also recommended that the substantial delays many children were experiencing in accessing care be addressed.

We recommended that inequities between families who were nearby and who could receive their treatment at military treatment facilities and families who were far away and had to rely on TRICARE be eliminated. I am eager to hear about progress in all of these areas.

In conclusion, Madam Chairman and distinguished members, I appreciate your sustained attention to these issues. I also very much appreciated the prompt and detailed plans submitted by the

Secretary of Defense, but many weeks have elapsed, and I know the strong sense of urgency we all feel pales before the daily struggles that confront many military families. I am very much looking forward to the day the plans are fully implemented.

That concludes my remarks.

Mrs. DAVIS. Thank you very much.

[The prepared statement of Dr. MacDermid can be found in the Appendix on page 120.]

Mrs. DAVIS. Dr. MacDermid, you mentioned a number of things that you would like to hear. I think those are the same things that we also would be eager to hear. I wonder if, perhaps, our witnesses could—as quickly as possible, I think—just address—there are issues around processing and being able to get the mental health professionals out there without undue delays. I wonder if you could address that quickly, whether there was a better system or whether you think that those issues have been addressed.

I know there was another issue, I think around TRICARE and paperwork. I am assuming that, maybe, you had a conversation about that.

Dr. MACDERMID. Dr. Casscells assured me that issues regarding restrictions and intensive outpatient services are in the process of being removed, so that is one specific TRICARE recommendation that it sounds like has been taken care of.

Mrs. DAVIS. Okay. We will be eager to follow up on that as well. Then the access for families to receive mental health services as well.

Dr. Casscells, would you like to pick that up?

Dr. CASSCELLS. Madam Chairwoman, the biggest effort here is the Army's effort to hire 200 mental health workers. That has been an intense effort.

As you know, in the country at large, we have squeezed mental health for some time now, and getting people into uniform or getting them in as contractors is a challenge. The Army is over halfway there, and the Army Surgeon General will speak to that, Dr. Schoomaker.

I would say that we have been working to reduce barriers in the Pentagon of which there are numerous bureaucratic obstacles to identifying people, to getting policies in place that identify the characteristics of the people we need. Certainly, we have been looking to find alternatives—you know, deputizing people to be involved in care whether it is, you know, internists, such as myself, or nurses or medics.

I think Dr. Schoomaker could tell you we will be training the 68 Whiskeys shortly in Battlemind Training. So this has, by necessity, become everyone's job—the line officers', the enlisted leaders'—and we increasingly involve the family members. This is a communication effort.

Just last night, I got an e-mail from an enlisted soldier to her sergeant, and the sergeant had sent it up the chain, and it came over to me, saying, Why don't we have a website where family members of soldiers with PTSD can communicate with each other and share tips? Well, we have been developing that darned thing for months, and it is going to be launched soon.

So—in addition to MilitaryOneSource.com, we are developing these services, so we are on the move. We are a little more than halfway there in terms of hiring people. Further details that are Army-specific I will leave to General Schoomaker.

Mrs. DAVIS. Okay. Thank you.

Dr. Schoomaker.

General SCHOOMAKER. Really quickly, ma'am, there are three areas, that I think Dr. MacDermid raised, that we can talk about quickly.

The first is the supply of professionals. As the Secretary mentioned, we, the Army, last year went out with a risk-adjusted, population-based model across our communities. As you know, Army Medicine is organized into regional commands: The regions each have individual installations within them. Each of those regions then went out to individual installations center around communities and where our Army was. They were asked what additional mental health resources they needed.

In the continental United States, we estimated a need for about 268 mental health professionals. We at this point have contracted for about 150 of those who are at work around the Army, civilians.

Our problem in many of those places is, quite frankly, as Congressman McHugh knows from Fort Drum, that it is very difficult in some of our communities to hire and to recruit in these rural populations.

The second issue I would speak to is about access for family members, and especially nontraditional family members. One of the benefits and successes of the Army Medical Action Plan has been to identify nontraditional family members and to provide invitational travel orders and access to parents, to fiancees, to best friends, to buddies. That has been successful. In the NDAA 2008, you included some provisions for defining these family members in a nontraditional way, and we appreciate the help that you have given us on that.

Finally, I would just like to address the fact that, as my colleague Admiral Robinson talked about, we really focus on beginning at the primary care level in delivering care. So primary care providers, family medicine doctors, nurse practitioners, physician assistant (PAs), and internists are a part of this equation; and we are training those folks just as aggressively as we are acquiring mental health.

Mrs. DAVIS. Thank you. I think, perhaps, we will address later on in the hearing whether there is a special category that we might point to as well and think about, in terms of those who have served, who perhaps would entertain a different career than they had before, where they have some skills that could be utilized in this way.

I wonder if you could just take a look at how long it is taking in the application process for some of these mental health professionals to come into the system because, you know, there is a very important vetting process of looking at the prior experience that they have had; but that seems to be a prolonged process in many communities, and people will wait around just so long for that to be completed.

It concerns me. It seems to be taking a long time in several situations.

Thank you very much.

Mr. McHugh.

Mr. MCHUGH. Thank you, Madam Chair.

Let us talk a little bit more about recruiting. General Schoomaker just mentioned rural areas.

It seems that we have our challenges throughout the system. One of the recommendations of the Task Force was in noting that the Department has the authority to adjust reimbursement rates across the board. Yet, my understanding is, to this point, there have been no adjustments in the use of that authority to increase reimbursement rates for mental health services.

Dr. Casscells, have you had an opportunity to think about that a little bit? Might that not be helpful in gaining access?

Dr. CASSCELLS. Mr. McHugh, I think that we did adjust them in Fort Bragg, around Fayetteville, but many times when we have gotten calls about the lack of access in a given area, it has been a misunderstanding about the rules and about the fact that people are actually permitted to get coverage 25 miles away and so forth and so on. A lot of these things are miscommunications that get clarified.

So we have not made as many adjustments in the local—you know, in the micro-regional reimbursement rates as we thought we would when our effort began. There really have been just a few.

I can get back to you with more detail if you think that would be helpful. If we have overlooked some, we would like to hear about them.

[The information referred to can be found in the Appendix beginning on page 137.]

Mr. MCHUGH. Well, of course, we would very much appreciate your getting back to us.

I am reacting just intuitively. More money usually gets you more things—I do not know; that is the way I was brought up, I guess.

Clearly, what we do hear about TRICARE in general—and I know all of you are very well aware of this—is that reimbursement rates amongst medical professionals is a disincentive in many instances.

I would defer to Dr. MacDermid. That was kind of at the core of the Task Force recommendation, was it not?

Dr. MACDERMID. It was. Although, to be fair, I must report that this is what providers told us on our site visits.

We did not have the authority or the ability to really do a systematic comparison of data from hospitals. We were able to actually get data from one hospital about TRICARE versus other payers. This was not part of a negotiated rate, so we were given to believe that they were sort of the normal rates that you would expect from TRICARE.

The TRICARE rates were less than half of any of the other payers, which is very puzzling when you think about the legal requirements for how TRICARE rates are pegged. We do not understand it. It is possible that when mental health is a carve-out in the contract, that somehow that affects reimbursement rates. It is a puzzle.

So I believe that in that recommendation, we did not explicitly say rates should be raised. I think what we said was, it needs to be looked at carefully and that, in particular, there needs to be conscious scrutiny of mental health issues because there are certain gaps in procedures that mean that mental health does not get exactly the same kind of scrutiny that other kinds of medical care do.

Mr. MCHUGH. Okay. I appreciate that.

Mr. Secretary, if you get a chance to look a bit more in detail at what has happened in those areas where you have changed rates, I think that would be helpful to us.

Regardless of what the rates are, if you do not have the professionals in a particular geographic area, you are not going to be able to gain access. In fact, when Secretary Winter appeared before the full committee, he talked about the need for increased bonuses for doctors, nurses, et cetera. The Task Force mentions that very fact as well.

If you look at the recently passed National Defense Act, the 2008 act, if our math is correct, we currently have authorized bonuses. For a new board-certified doctor who signs to a four-year commitment, the pay for just that signing up is $824,000. What do we need to do beyond that?

Dr. CASSCELLS. Sir, I am sorry. I have taken down your last task there. Could you rephrase that?

Mr. MCHUGH. Okay. You have got to be able to recruit. The Task Force said and Secretary Winter mentioned in his testimony before the full committee that increased bonuses could be helpful in recruiting not just mental health care, but health care professionals across the board. The new 2008 National Defense Act authorizes a new board-certified doctor who makes a four-year commitment a signing bonus of $824,000.

What do we need to do beyond that kind of bonus option to help meet that recruiting need where the Task Force and others are telling us we need to put into place more bonuses?

Dr. CASSCELLS. Thank you, sir.

I agree with Secretary Winter. I did not hear his testimony.

As you know, the retention bonuses and the recruiting bonuses have both been pretty effective. We really got them there last year just in time. It has been effective for trauma surgery, for example.

We may well need to do more for psychiatry and psychology, not just in the bonuses but in letting people know about them, and also in signaling that this is a culture that really welcomes, you know, people to come in midcareer, that welcomes people who are passionate about mental health.

There is a cultural disconnect that we are trying to get past as well, so it is not just a matter of assigning some extra DOD dollars. There is also the issue of outreach here, and we are working hard on that—scheduling meetings with the American Psychological Association, with the psychiatrists, with the American Medical Association (AMA), and in going to campuses. We have a whole program that we are getting ready to launch in this, because we have got to get the word out.

Mr. MCHUGH. Well, I thank you. My time has expired.

I would just say, if I may, Madam Chair, that, obviously, we would value your guidance. I cannot speak for the subcommittee,

let alone for the full committee, but we do have a history of trying to be sensitive to those kinds of needs on targeted bonuses and pay. So specific recommendations would be of great value as we go forward.

Thank you, Madam Chair.

Mrs. DAVIS. Thank you, Mr. McHugh. I would echo your comments as well, though in terms of reimbursement, because that is an ongoing problem that I hear about, particularly in the San Diego community, as well as just the burden of paperwork. That does discourage people from getting involved and from getting into the system.

Ms. Boyda.

Mrs. BOYDA. Thank you, Madam Chairwoman.

I think, as my second year of Congress begins—you know, this was such an important issue back in the district. We have Fort Riley and Fort Leavenworth, so I feel like we are really coming together to address these issues; and understanding them is very important.

General Schoomaker, I very much appreciate your help in dealing with some very specific areas of concern that we have. At some other point—not right now—I would like to talk about some potential mental health provider issues that might be available as a good thing at Fort Riley, that we might be doing. It is not appropriate to talk about it now, but it would be when it is timely.

General SCHOOMAKER. Yes, ma'am.

Mrs. BOYDA. So I would like to talk about that sooner than later, if we could.

You know, I have heard that the Army did this—what do you call the training when you do it level by level?

General SCHOOMAKER. Our Battlemind Training, ma'am?

Mrs. BOYDA. Yes, but do you have a process when everybody trains somebody down——

General SCHOOMAKER. Oh, leader chain teaching.

Mrs. BOYDA. Chain teaching. Thank you very much.

That is complete at this point?

General SCHOOMAKER. Yes, ma'am. That was executed in the early fall of last year. It went through the entire force. The Chief and the Secretary then challenged me to institutionalize that.

What do we do next? We have done it once over the force. A considerable amount of the force, as you know, is deployed in Iraq and Afghanistan. Efforts were made to bring that right down into the deployed force.

What we need to do, now that new soldiers have come on board and that troops have rotated, is to institutionalize that across Army training; and we are doing exactly that with every soldier as they go through the non-commissioned officer (NCO) training program or officer training program. Every health professional, as well, goes through a series of individual Battlemind Training focused on resilience and mental health issues identification as well as group training.

Mrs. BOYDA. Are the other branches of service doing that as well? The Marines?

Admiral ROBINSON. We have a combat operational stress program that is similar, but we embed it from the recruitment all the

way through the war college. We have, as I labeled in my statement, the MOSST process, which is the Marine Operational Stress and Surveillance Training, which is a method to train the lowest level and also the midlevel commanders.

Also to make sure that the commanders are absolutely engaged and are also empowered to have a psychological health climate, additionally, we have embedded with our marine units psychological and psychiatric professionals who are there, who become a part of the unit, so that it is no longer a referral to medical. Those people are actually in the operational units.

We do the same thing on the Navy side by putting in psychologists and social workers, but particularly psychologists, on board our ships so we have them there.

We also have our chaplains who for the longest time have been quite effective here and who are still very effective. Every once in a while, I have to make sure that I mention them, because they have been doing this since the beginning of the Marine Corps and the Navy——

Mrs. BOYDA. Probably before that, too.

Admiral ROBINSON. Well, I am just talking about the services, but the key is that they have been doing it, and we continue to do that.

Mrs. BOYDA. Thank you very much.

Admiral ROBINSON. Yes, ma'am.

Mrs. BOYDA. What I was wondering, General Schoomaker, is, now that we have implemented that, is there any follow-up to see what its efficacy has been if we challenge the system or have we measured anything afterwards to see how effective that has been?

General SCHOOMAKER. Yes, ma'am. In the most recent Medical Health Advisory Team report, MHAT–V, you will see that there was a focused question. We did not do a formal scientific study, but we had a certain number of soldiers in that study who were deployed who had received Battlemind Training, and a certain number who had not; and it gave us an opportunity—it gave the team an opportunity to see, was there an outcome in improvement. In fact, there was. Those soldiers who received Battlemind Training self-reported that their anxiety and that the psychological consequences of the deployment in combat operations were less intrusive than——

Mrs. BOYDA. If there is a summary of that anywhere, I just would like to——

General SCHOOMAKER. Yes, ma'am. It is part of the MHAT–V.

Mrs. BOYDA. For the record, the whole thing about suicide rates.You know, I get a lot of questions, clearly about high school retention, or recruits, and all of these sorts of standard questions that we all get about this.

Just for the record, I would love to see what the suicide rates are for the Army and for the Marines and be able to compare it to what that was before we went into Iraq.

General SCHOOMAKER. Yes, ma'am. We will follow that closely.

[The information referred to can be found in the Appendix beginning on page 138.]

Mrs. BOYDA. Thank you.

Mrs. DAVIS. Thank you.

Mr. Murphy.

Mr. MURPHY. Thank you, Madam Chairman.

I saw that the 2004 New England Journal had the numbers of 16 percent of Iraq veterans have major depression, anxiety or post-traumatic stress disorder.

Would you all like to elaborate on that? Do you think that is an accurate number? Do you think it is higher? I would enjoy your comments.

General SCHOOMAKER. That was a derivative of, again, one of the earlier iterations of the mental health advisory team, and that alluded to the incidence among redeploying units of symptoms associated with post-traumatic stress. And in every one of these four, I try to make sure that we highlight the fact that this is post-traumatic stress symptoms, that it is not well-established post-traumatic stress disorder, which is what most political people and the press often reports on. That is a mental health diagnosis from unresolved, unidentified and untreated symptoms of post-traumatic stress, which can result from combat, from major childhood trauma, from national disaster, motor vehicles, any amount of—any cause of stress.

What that report showed us was that soldiers redeploying from a combat zone, depending upon their exposure to combat and trauma, had somewhere between 10 and 30 percent rates of symptoms associated with post-traumatic stress, but that if we do not screen for and promptly treat would, we feared, emerge or evolve into or mature into post-traumatic stress disorder. Our experience is that with good screening after the fact—and this is, in fact, why Dr. Casscells's predecessor mandated a policy of post-deployment health reassessment at the 90- to 180-day period. You will hear our soldiers talking later about the fact that at redeployment, frankly, the reintegration excitement obscures many of these symptoms, but 90 to 180 days later they emerge, and families see this, unit leaders see this. And so we screen for the symptoms and then address the symptoms through specific treatment.

Mr. MURPHY. And I apologize, General. I thought that Chief Gutteridge's written testimony so far has been very enlightening to us. But what do you think as far as the number; is that accurate?

General SCHOOMAKER. I think that accurately reflects it. I think it would be higher in units that have higher combat exposure, and it would be lower in those that don't. In the unit that may be restricted to the FOB, to a forward operating base, and not work outside the wire and not work in an area of intense combat, I think you would expect that it would be lower.

Mr. MURPHY. How about as far as the majority of our soldiers now and our troops and our marines are married, unlike in Vietnam, how about that it is not so—it is not just the individual trooper that is affected and that might suffer from this, but it is also the family members. What have we done as a Department of Defense to help and assist the families as well? I know I applaud the 90- to 120-day review for the troopers, but what are we doing for the families as well? If you could elaborate on that, I would appreciate it.

General SCHOOMAKER. I will say quickly, and then my colleagues can speak to the family center care, as the Army does, too, that we

extend battlemind training to the families. We recognize that families are often the first to identify problems with redeploying soldiers and try to make them obviously a part of the solution as well as a recipient for the services. Army has spent a fair amount of effort as well into providing marital and family counselors on our installations, and that has been very effective.

In other words, to go to the root causes of many of our problems, you spoke earlier, Madam Chairwoman, about suicide. We know that one of the major causes of—or precipitants of suicide is a ruptured relationship with the wife, husband, girlfriend and the like, or was the Army itself. We know that misconduct that results in, let's say, Uniform Code of Military Justice (UCMJ) can precipitate a suicidal gesture in a soldier who sees their relationship with the Army as one of their most important and fragile relationships.

Mr. MURPHY. Roger, sir, I am tracking that. But I think my question is more specific. Let me ask, is there some type of mandatory screening where we contact and be proactive in contacting the spouses to make sure that they are okay? I know the centers there that it seems like react to the ones who call or come to the doors or the website. But is there the screening of the spouses, of the loved ones of our troopers?

General SCHOOMAKER. I think the operative word there is "mandate." We don't have authority to mandate for family members, but we certainly offer the services to those families, and we make them—we sensitize them to the need for them to receive that care. Yes, sir.

General ROUDEBUSH. And I think we can speak to the activities particularly on departure and then reintegration. For the Air Force we used very much a community-based approach which is inclusive of the families. And the commanders are—that remain at the station of origin are also responsible for tracking with those family members during the period of deployment to assure that the needs are being met, that the issues are there.

I agree with General Schoomaker, there is not a mandate for that, but our programs are structured to do that. And I would offer, relative to the screening tools, the postdeployment survey and the resurvey 90 to 180 days out, those have been continually refined to increase the sensitivity to elicit any symptoms; to assure that if assistance is required, that we get those folks to the assistance that is needed in the most expeditious way.

Admiral ROBINSON. Congressman Murphy, the Navy has two programs, Navy Medicine—actually it is Navy/Marine Corps, because the Marine Corps key volunteer member and also the Navy ombudsman work with families and work with families predeployment and postdeployment. There is nothing mandated, but there is certainly a close relationship.

I think we are trying to get a little bit more proactive, especially in the Special Ops community which have huge numbers of deployments related to other folks, and that is the focus program which is the families overcoming and coping under stress. And that is a program we are trying to get into place that will do counseling and very, very early intervention with families, because we know that deployment time, length of deployment and also number of deploy-

ments are direct factors in psychological stress. And we—we are trying to deal with that using that program.

Mr. MURPHY. Doctor—ma'am, can he just answer? He had his hand up real quick.

Dr. Casscells.

Dr. CASSCELLS. Thank you for your service. I can tell you are politely hinting at this issue that we have not yet got a rigorous program to identify all of the lost sheep, particularly among the Reserve who are drilling Individual Mobilization Augmentee (IMAs). I am one of them, Guard. Guardsmen, guardswomen. And they go home, and they sometimes either don't have a family, or the family has got plenty of other things for them to do besides, you know, offer a shoulder to cry on. So I am talking to all of our chaplains together in a few weeks and asking them for their help in reaching out to these people and making sure that the family is doing okay and that the servicemember is doing okay, because if we don't hear back from them on our postdeployment health reassessment tool, and we—about a quarter of them, they are—go home, and we don't hear from them. We have got to reach out and identify every single one of them. And how to do that, you know, because they move, it is not that easy. But we are working on it. So thank you.

Mr. MURPHY. Thank you.

Mrs. DAVIS. Thank you, Mr. Murphy.

Mr. Johnson, actually when we were at Camp Lejeune and in Mr. Jones's district there, we did see some aggressive follow-up. I think some of that can be done. And I think certainly that is a possibility.

Mr. Jones, thank you.

Mr. JONES. Madam Chairwoman, thank you very much.

Dr. Casscells, it is good to see you again as well as other members of the panel. I have got a question, but I will just read a couple things in this article that is in the *Post*.

"Care for Injured Vets Rises Questions"—I know a lot of this deals with the VA. You are not the Veterans Administration (VA), that I understand. But I want to make a point because of this article.

There is a book that I just ordered that I would hope I could recommend to anyone: *The Three Trillion Dollar War*. It is an analysis of the cost of the war and what the cost will be after the war. And I think any American, quite frankly, should read this book. I wish I could buy it for them, but I can't. But the point of this is that the—Dr. Cross with the VA said during this week, and this is March 8: Lawsuit hearings at 120,000 vets from Iraq and Afghanistan using VA care for potential mental health problems.

Obviously they are now under the care at the VA, but they were in the military. And that is the point that my colleagues have been making. And nearly 68,000 of them have potential PTSD. We did hear—and I agree with the Chairman, I think the committee that did attend, going out at Camp Lejeune, was very impressed with many good things that are happening. There are many challenges, as well as there are with you.

I want to know a little bit more about how you recruit. You mentioned this earlier that you were going to be more aggressive, but is it a problem for the Department of Defense to go on university

bases—Mr. Etheridge from North Carolina has joined us. He is not on this committee, but obviously he has an interest, or he wouldn't be here.

We have one of the strongest university systems in America in North Carolina, and the president of the university system is Erskine Bowles, who used to be the Chief of Staff to Bill Clinton, and he is a fine, fine gentleman.

I would like to know how you do recruit these mental health professionals or these graduates of mental health programs at the university. And is there good cooperation? Or do you have the stigma that you do at some universities, well, this is the military, and then they bring in this idea of the war, whether they are for or against it. Can you tell me, explain to the committee a little bit how you do recruit these health professionals at universities and colleges?

Dr. CASSCELLS. Congressman Jones, thanks for this. Recruiting is strong in North Carolina, I am happy to tell you, like it is in Texas, and we have trouble at my alma maters, both at Yale and Harvard, to get people to join up. I am working personally on that. And, you know, for a while there, some universities wanted to keep us off campus until they were reminded that they receive Federal funding, and that has been helpful.

Of course, we would rather have people enthusiastic and, you know, welcome our recruiters, and their recruiting is not done by Health Affairs or by the Surgeons General. We assist in that. And we are doing things like helping with a movie, you know, called *Fighting for Life*. It is just launching out nationwide about our medical school, for example.

So there are lots of ways we can be active in this. The bonuses, of course, are one of them. At the end of the day, a big part of it is individuals recruiting friends and colleagues. And so we are trying to get across the idea that everyone is a recruiter, everyone is a recruiter. And it is a privilege and an adventure to serve. And I will tell you, I love telling that story because, for me, joining the Army Reserve and being deployed at 53, 54 years old, and at 55, it has been the adventure of a lifetime, and it is so rewarding. It is the easiest story to tell.

But there is a lot of information out there, and getting through—getting the information out and getting heard is a challenge. But bonuses, bonuses are there. The recruiting dollars are there. Would more help? Sure, more would help. I don't know of any statutory barriers that you could help us with, but if you could think of some suggestions, my gosh, recruiting and retention are on the edge for us, on the edge, sir.

Mr. JONES. Well, General, would you like to speak to this as well?

General SCHOOMAKER. Well, I was going to say we can't promise any Army doctor who is recruited in the Army that they are going to eventually become the Assistant Secretary of Defense for Health Affairs, but we certainly want that as part of the career track.

So the Army and the Air Force, I will speak for the Army medical system, because you are really talking about two different programs. One is recruitment of civilian, government service employees. That is what we talked about earlier. That is a program that is done through the recruitment of any government service employ-

ees. We have done a targeting recruiting for those, and that really powered down contracting in the hiring of those folks, and vetting other credentials to individual treatment facilities in our regions.

For uniforms, we have a very aggressive program on recruiting that is linked to the recruiting community of the Army, but is increasingly carved out to address the specific markets of health professionals, because as Dr. Casscells said, it is a health professional that recruits another health professional. We are in over 100 medical schools, for example, in the country today and nursing schools. We have got great programs out there. We are very well supported. Some programs are obviously better than some other programs. But I think Army, Navy and Air Force all have very aggressive programs.

Quite frankly, frankly, the Health Professional Scholarship Program today for medical students is an example—for nursing students and dentists—is one of the most generous and best programs available and offers them careers that are unprecedented.

Mrs. DAVIS. Thank you.

Ms. Tsongas.

Ms. TSONGAS. Thank you for your testimony, and it is encouraging to hear the serious work you are putting in to addressing this.

The question I have—and again, this is to play off the recent trip we had to Camp Lejeune where we met with many who had been wounded—was the issue of how—as you recruit civilians into the military either in a contracted way or to become part of the military to deal with mental health, how do you sensitize these professionals to a world they may not understand? I heard from a young soldier that there is a hesitancy to go to physicians who have no understanding of what they experience, you know, who have not experienced war, who are not a product of the military, and who don't have the credibility to really help them with the challenges they face.

Is there a training program, something as you bring people in so that they do understand what a unique—post-traumatic stress syndrome is obviously a function of service in war, but if you haven't experienced war yourself, if you are not the product of the military, you may not really understand how to go about helping these young people. So I wondered, do you have something in place to work that through as you—so that these professionals can be effective in the work they are trying to do?

General SCHOOMAKER. Yes, ma'am. You said "soldier," but you have visited a Marine camp, so I am going to be real quick. I am the soldier up here, and the Marines are represented, of course, by Admiral Robinson.

Ms. TSONGAS. This just happened to be the particular young people we met with, but I am sure this is across all the services.

General SCHOOMAKER. Yes, ma'am. First of all, for the individual combatant, individual soldier, and his or her family, we talked earlier about the teaching that took place across the Army that has now touched 800,000 to 900,000 soldiers from the top of the Army, the Chief of Staff, to the newest private. For health care professionals, especially those who are going into deployment, we now require a combat operational stress training course that is conducted

at our Army Medical Department Center and school in San Antonio. This has been very successful. We have also piloted that program to be given to our combat medics, who we have now trained about 800 of our newest combat medics in identification of issues having to do with mental health in the theater of operation.

But that is an effort, as the Navy has done and others, to standardize the training that is given to professionals going into the theater of operation to sensitize them specifically to the challenges of mild concussive brain injury as well as post-traumatic stress and anxiety associated with it.

General ROUDEBUSH. Yes, ma'am. Likewise in the Air Force we perform that training for our uniform members, certainly, as part of their predeployment training, and for those that are going to be in theater specifically to be sure they are fully up on the traumatic brain injury and those activities.

For the civilian providers that we bring on, we train them as well in the diagnostic issues of post-traumatic stress disorder, tramatic brain injury (TBI). They are not left out of that at all. Now, there is not necessarily a formal enculturation process. But as we bring those folks into our clinics, hospitals and medical centers, they become very much part of the team. And everything that happens within that venue, they are a full-up round within it. So they are brought along as part of that health care delivery team.

Ms. TSONGAS. I guess a follow-up question might be, then, do you see a resistance on the part of those being treated to working with civilian—people who have been primarily in the civilian world to help them deal with their mental health challenges? Or is it—I mean, just given the lack of experience some of these professionals may not have had in a theater of war. I mean, is there a resistance, or can you supplement it, offset it in other ways, or is it just the reality that you have to—given the difficulty of recruiting and getting mental health professionals, finding the ones you need, that you have to make do with the best you can?

General ROUDEBUSH. Ma'am, I would turn that around. And as opposed to resistance, which there may be, I would suggest that there is a preference for these individuals to see parts of the team that they resonate with and identify with. Providers in uniform are within our direct care system. For those that we are not able, for whatever reason, to treat within the direct care system, I believe it is incumbent on us to manage their care and to assure that their needs are being met wherever that care is being delivered. And that is part of the responsibility of that medical group commander and staff.

Ms. TSONGAS. Thank you.

Admiral ROBINSON. Congresswoman Tsongas, there is no question that Marine Corps, Navy, Active Duty and families would rather see uniformed psychiatrists and uniform mental health providers. That is not always the case because we don't always have enough of them. But there is no question that they have made this clear to me as the Surgeon General of the Navy, and to the Medical Office of the Marine Corps and other leaders. That is number one.

Number two, if you read Heidi Kraft, who is a former Navy psychologist who has written a book, *Rule Number Two,* and she emphasizes that very point that you are making. There is a sensi-

tivity, and there is an understanding and there is a connection that you have. I think that as—and this is specifically civilian mental health workers who are coming into our facilities and working, and civilian mental health members who are through the TRICARE who are actually out.

Now, this is the heart of the problem because that is in the community. But people coming into our facilities can certainly get orientation and indoctrination into some of the stresses and some of the conditions that the patients and families have. But to be very honest with you, no one is going to give what someone in uniform can give you under comparable conditions. Someone in uniform that has experience and has been with you is going to be more effective.

Ms. TSONGAS. Thank you.

Mrs. DAVIS. Doctors, I am going to have to move because, we are going to really end up—run out of time, and we want our second panel to come forward.

Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you. And I will try to be very quick about this.

My question is what percentage of people who need treatment are falling through the cracks right now? I have read different estimates of the number of untreated or undertreated soldiers and family members. Would anyone like to take a guess at what you think the number we are missing?

Dr. CASSCELLS. Ms. Shea-Porter, we don't have an exact answer, as you might expect, because some of the people who most need care are most afraid because of the nature of mental stress. People who are not just stressed, as Dr. Schoomaker said, but have stress disorder are people who are not seeing clearly in many cases. They are blaming themselves. They are afraid that if they ask for help, they will be stigmatized, lose their security clearance, lose their, you know, weapon if they are in theater, for example. They are afraid of letting down the team. They are afraid that they won't be promoted. They are also afraid of losing their civilian job.

In the case of the reservists, this is terribly important, because one of the—some of the collateral damage of all this attention to psychological health and mental and combat stress is that some employers are using this as an excuse not to rehire, not to keep those jobs open. And I have to emphasize to them over and over again that even though, let's say, suicide rates have increased in this past year in the longest war in our history, they are still just below the civilian levels. And when our guys and gals come home, their rates of domestic abuse, of misdemeanors, felonies, broken marriages, and drug abuse, this all remains well below the civilian levels. We are very proud of this.

Ms. SHEA-PORTER. Well, I have to say, it is confusing, because I, too, am reading all of the numbers. And I know not too long ago a major newspaper had a headline saying that mental illness was the number two illness now for our troops who have seen combat.

Dr. CASSCELLS. Yes, ma'am. It is because we have just about eliminated most of these infectious causes. Accidents are way down, what we call disease and nonbattle injury way down, you know, a lot of better protective equipment. You know, prevention

is the best thing we have got. We have tried—trying harder to assign people to the right military occupational specialties, to identify them early when they are struggling. And the residue is—we do have people who really wanted to serve their country. They are young. They don't have much track record. They get into the situation of combat stress. It is hard for them, and they have—they struggle to recover from it.

Ms. SHEA-PORTER. Thank you. And I would agree with that, but I think we are missing a large number of them still.

Dr. CASSCELLS. We are.

Ms. SHEA-PORTER. What I am reading, and what I am hearing, and then what I am seeing in other reports, there seems to be a huge difference.

But anyway, the point I wanted to make is I know we are following traditional and some nontraditional methods of reaching out to troops and also to their families, but I think that we could extend this. And I was going to ask you, I know in my own State of New Hampshire, community organizations are working to find them. But I also wonder if we have a just kind of practical right-on-the-ground-level way of outreach by putting up information in places where these young soldiers and their young families tend to go, which is fast-food restaurants and laundromats and places where they might not have any connection with the military at all, but they are hanging around for a couple of minutes, and they have a chance to see—see a sign there for them. Is there any effort at all being made to reach out on a very basic level, which is where people tend to go today?

Dr. CASSCELLS. Yeah. We just asked our colleagues at Personnel and Readiness, for example, to put on every shopping bag in the Post Exchange (PX) and commissary a note about the website and telephone number where you can go to get help. We have not done it at McDonald's. This is the kind of thing we need to test and, you know——

Ms. SHEA-PORTER. I encourage you to do that because that is the common denominator where people gather, especially young families who might be afraid to approach the military.

General SCHOOMAKER. Ma'am, if I could make one point. I appreciate your question for a different reason, and it has to do with definitional. We are using words here that I think are highly charged. We talked earlier with Congressman Murphy about the fact that on the one hand we report symptoms, but they are interpreted as a full-blown mental illness. What we are being very, very sensitive about and going after very aggressively are the earliest symptoms of stress, which I think the public should not interpret as resistant forms of well-established and highly intrusive disorders and mental illness. I think that there is a problem there.

Ms. SHEA-PORTER. I understand the difference. So I do know what you are saying. And certainly most soldiers and their families are doing——

General SCHOOMAKER. The other thing I would say real quickly, and I think the Chief talked about this, a large number, in some cases the majority, of our most affected soldiers have not been deployed at all.

Ms. SHEA-PORTER. Yes.

General SCHOOMAKER. They were carrying into service these problems.

Ms. SHEA-PORTER. If I could make one last point, please. The other thing I would like to add is I do know there are some—some glitches on, say, pay and other problem areas that are causing extra stresses on these families and contribute to this sense of an ill ease or problems, and perhaps we need to look closer within our—their own structure and see if there are ways we can alleviate the pressure on these families who have a spouse or relative serving overseas and then have to struggle internally with pay issues or just problems, to help in that department, too. Thank you very much.

Mrs. DAVIS. Thank you.

Dr. Snyder.

Dr. SNYDER. Thank you, Madam Chairwoman. Sorry I was a little late getting here.

Dr. MacDermid, I would like to ask you a series of questions, a few questions comparing what your opinion is of the opportunities for quality care, comparing those opportunities between the military family today and a nonmilitary family in America, if that is a fair question. So if I am a military family with an autistic child, do I have a better chance or a less chance of finding care in the military versus not being a military family?

Dr. MACDERMID. Well, you are certainly asking me to stretch my area of expertise a little bit, but I think a very safe answer is it depends a great deal on where you are. As you know——

Dr. SNYDER. The problem with military families is they may be in 6 places in 10 years and get a great set of—we were talking about that the other day.

Dr. MACDERMID. Sure. I do know that the military does have explicit procedures in place to try to accommodate the needs of families with special needs children.

Dr. SNYDER. My second scenario is part of the same answer then. If I was a military family with a child with schizophrenia, say, a teenager with schizophrenia, would my opportunity be better or worse than if I was a nonmilitary family for getting care?

Dr. MACDERMID. I think, frankly, with schizophrenia it is tougher.

Dr. SNYDER. Tougher for a military family?

Dr. MACDERMID. It is tougher than autism, I think, because, for example, autism, schools are used to dealing with kids with autism, and they have individualized experience plans. And military and civilian kids both, because it is a much more common sort of disorder, schools are more used to dealing with it. Kids with diagnosable psychiatric disorders are in tough shape in both military and civilian worlds because there aren't that many child psychiatrists.

Dr. SNYDER. Excuse me for interrupting.

Dr. MACDERMID. Certainly.

Dr. SNYDER. We have short time. I want to ask—I appreciate your comments. If I am a military family, and I have a teenager with either an alcohol or a drug problem, what are my opportunities for appropriate rehabilitation and treatment for a military family compared with a nonmilitary family?

Dr. MACDERMID. Based on the task force's work, I am fairly confident in saying you have a more difficult time in the military, and in particular if you don't have access to a military treatment facility.

Dr. SNYDER. I wanted to ask—this will be my last question, Madam Chairman, and get a response from each person. And again, I think I missed a lot of this discussion about how we go about increasing our mental health providers. You need to recruit more military people, you can hire more civilian folks, or you contract. And I wanted to ask you all's opinion of the contracted aspects of it. I think there was some reference—General Schoomaker, I think you talked about some policy hurdles.

I want to know specifically what things need to be changed or improved either statutorily or by the policies that you all have control over to enhance and quicken your ability to have some agility with regard to contracting for mental health services. We will start with you, Admiral, and just go down the line.

Admiral ROBINSON. I think the first thing we would need to do is to make sure that we hire mental health or any other professionals that we have on more than one or two-year money. In other words, I can't retain people unless they understand that this is a job that they can have for a duration of time, duration that is longer than one or two years.

The second thing is part of the problem with mental health professionals, I think, is the longitudinal problem that we have in the longitudinal studies on health care professionals, and that is I am not sure that there are—there are—certainly is a shortage. I am not sure if we are going to be that successful in getting the numbers to come into the military even on the civilian side unless we have other incentive programs that make it nice for them to come in. In other words, they have opportunities, and they are doing just what our dentists are doing: They are looking at the other opportunities.

But I think that the major thing is that we need to have a career pathway for our contract professionals that shows that we are interested in them over a long period of time, and that when we bring them into our system, we have them for a period of time. And I don't think we have been able to do that very well. That is my one issue.

Dr. CASSCELLS. Dr. Snyder, as one doctor to another, I just say that our shortest route to getting services is to look beyond the M.D.'s and even beyond the Ph.D.'s and to get more nurse practitioners, more——

Dr. SNYDER. I am talking about the issue of contracting those.

Dr. CASSCELLS. Yes, sir. That relates to whether we are—what authorities we have and what restrictions we may have in terms of our credentialing and criteria. We have some barriers, I think, to getting more counselors involved, and I think this is terribly important because we have relatively few psychiatrists and psychologists. And we have a largely male structure in the military. And we have got a lot of young guys, and some of them from broken homes. We really need to—and we are looking at this now to getting the counselors we need, and they are not—they are not going

to typically be contracted M.D.'s and Ph.D.'s. It is going to be a broader group of counselors.

I am not sure we need any statutory relief on this. We are looking at this. The Army is doing a great job. They have got 150, as you have just heard, but we may need more. We are getting close to where we have enough, and that plus getting the family involved more, the battle buddies, the regular doctors, you know, deputy mental health people, may be enough. But we certainly need to take a broad look at this.

Contracting in general, you know, my feeling is that we don't need a whole lot more of this military-to-civilian conversion. What we need is help on our recruiting. And I am not sure this is a statutory issue. We just have to focus on it.

Mrs. DAVIS. Thank you.

I want to thank all of you very much for being here with the panel. As I said earlier, we welcome you to stay because there may be some questions that we have as a follow-up to any of the comments that the witnesses make. And I know that we have a lot more questions, and we will hope to follow up with those in the future. Clearly there has been progress, and we commend you all for that. We are in a different place. But we also know that we have a long way to go to be sure that we are taking proper care of the men and women who serve us. So thank you very much.

And if we can move as quickly as possible for the next panel, that would be terrific. We will get going.

Mr. JONES. Madam Chairman, before you start, could we ask Dr. Casscells to give to the committee a list of the universities and how many mental health professionals were hired from each university, say, going back to 2006—or 2005—I guess 2006 would be appropriate—just to get an idea, if you don't mind. Thank you.

[The information referred to can be found in the Appendix beginning on page 138.]

Mrs. DAVIS. I would be happy to, Mr. Jones. Thank you.

I am delighted that you are here. It is very important. I wanted to ask unanimous consent that Mr. Bob Etheridge, the Congressman from North Carolina, could introduce Mr. Scheuerman, who is on the panel. He is a constituent and a gentleman that Mr. Etheridge had a lot of opportunity to work with over the past few years.

So, Mr. Etheridge.

Mr. ETHERIDGE. Thank you, Madam Chair, and Chairwoman Davis, and Ranking Member and other members of the panel. Let me thank you for allowing me to be here with you today and sit in on this very important hearing on this very important subject. And I deeply appreciate your courtesy for allowing me to join you today and introduce my constituent Chris Scheuerman from Sanford, North Carolina.

Chris is a soldier's soldier and an American hero. He retired as a Special Forces master sergeant and continues to train soldiers at Fort Bragg. Chris Scheuerman represents the finest tradition of an American soldier where duty, honor, and country it is not a mere slogan, but a way of life.

Beyond his personal service, Chris continues to serve his country by raising a family of soldiers. The unspeakable pain, though, that

this family has endured highlights a troubling problem in today's Army where far too many soldiers conclude that suicide is their best option. On July 30, 2005, Private First Class Jason Scheuerman, deployed with the 3rd Infantry Division at Forward Operating Base Normandy in Iraq, died from a self-inflicted gunshot wound from his M–16 rifle. He was 20 years old. I am no expert in mental health care, but it is clear the system failed Private Scheuerman and is failing other soldiers.

The way the Army withheld information from the Scheuerman family about the circumstances surrounding Jason's death betrays his service, intent on treating this as a public relations problem rather than a mental health problem. I am hopeful that this is beginning to change, and I commend this committee for examining policy options to achieve that very change. And I thank you.

When I first talked to Chris about his son's case and read the documents that he was forced to obtain through the Freedom of Information Act, frankly I was flabbergasted. That is not the United States Army that I know. As a young man, I served as an enlisted man at Fort Bragg and several other bases, and for many years I have had the honor of representing that base and its surrounding communities.

Just last month I made my third trip to Iraq to visit with our troops in the field, and I made a point to meet with mental health professionals there to talk with them. I am extremely proud of our men and women in uniform. Of course, military life is tough, and necessarily so, yet the chain of command must always treasure the lives and well-being of individual soldiers. That system failed Jason Scheuerman in the most important way possible.

I personally spoke with Army Secretary Peter Geren about Jason's case, and to the great credit Secretary Geren immediately requested an investigation by the Army's inspector general into this case. This investigation is ongoing, and I thank you for that.

It is now the duty of Congress and especially this committee to examine the policies' shortcomings that this case brings to light. We must learn from the mistakes made here and go forward with better policies and systems to protect our soldiers in the field. So I implore the committee to listen to the words of this true patriot and to take actions to put in place a better system so that we can arrest the disturbing trends that soldiers' suicides have brought to us and prevent other families from suffering the pain that the Scheuermans have endured every day for 2–1/2 years.

Madam Chair, I stand ready to help, and I thank you for allowing me this courtesy.

Mrs. DAVIS. Thank you. I appreciate your being here as well and making the introduction of Mr. Scheuerman. And Major and Mrs. Gannaway, we are very happy to have you here, and Chief Gutteridge.

Mr. Scheuerman, would you like to start, please?

STATEMENT OF CHRISTOPHER M. SCHEUERMAN, SR., MASTER SGT. (RET.), U.S. ARMY

Mr. SCHEUERMAN. Thank you, ma'am. I would like to thank Chairwoman Davis, the distinguished members of the subcommittee for allowing me to testify on an issue that has tragically

been personalized in my life. I would like to thank Congressman Etheridge and his staff for their support and dedication.

In July of 2005, my son, PFC Jason Drew Scheuerman, after losing his battle with depression, decided to take his life while fighting the war on terrorism in Iraq. Jason was 20 at the time of his death. I address you today not only as a father of a soldier who took his own life while serving our Nation, but also as a veteran, a combat veteran, with 20 years of service as an enlisted man and an officer in Army medicine.

Though it is difficult to discuss the events proceeding my son's death, I believe it can serve as a catalyst to help us better understand and treat soldiers battling depression and mental illness.

Not all suicides caused by depression are preventable, but most of them are. In an article dated January this year, Colonel Richie, the consultant for psychiatry to the Surgeon General, stated, we have got multiple portals to care through chaplains, through primary care, through behavioral health and through leadership. We also need to make sure the family members know who to call if they are worried about their soldiers.

Three weeks prior to Jason's death, we called his unit after receiving a suicidal e-mail and pleaded for help, not knowing if our soldier was alive. We knew how to call. Jason was seen by his chaplain, who had earlier witnessed him sitting alone with his head bobbing up and down on his rifle. He later said in a sworn statement that he believed Jason to be possessed by demons and obsessed with suicide. He did nothing. Jason was ignored by his primary care provider.

It was common knowledge throughout the unit leadership that Jason was experiencing problems. The leadership had been told that Jason had been seen sitting in his bunk with the muzzle of his weapon in his mouth. He was never seen by his battalion medical officer. He did nothing.

After being on suicide watch, Jason was sent to an Army psychologist. The Army psychologist never contacted Jason's unit to hear of prior suicidal gestures. He relied solely on standardized tests; misdiagnosed and dismissed Jason back to his unit with recommendations that caused more harm than good. He made the situation worse.

All of the access to care portals that Colonel Richie speaks of today existed in 2005, and they failed miserably. The first step in reversing the growing trend in soldier suicide is accountability. If a soldier has an environmental injury such as frostbite or heat stroke, and a subsequent investigation shows that to be preventable, then a commander and a leader is relieved. The same standard or accountability should exist for suicide. If a suicide is shown to be preventable, then people need to be held accountable; leaders need to be relieved. I believe if we hold people accountable and leaders are relieved, at that point we will see a significant statistical decrease in soldier suicide. Any program that we execute is only as good as the people who are running the program. Without accountability, we are going to be doomed to failure.

Jason desperately needed a second opinion after his encounter with the Army psychologist. The Army did offer him that option, but at his own expense. How is a PFC in the middle of Iraq sup-

posed to get to a civilian mental health care provider at his own expense? How alone my son must have felt. He had nowhere to go.

I believe a soldier should be afforded the opportunity to a second opinion by a teleconference with a civilian mental health care provider of their own choice. Any standardized test that the soldiers take can be faxed or sent by secured e-mail to that provider, and then the soldier and the licensed mental health care provider can talk via webcam or other technology available. The civilian providers do not have to be in theater. They can be here, home in the States. This civilian provider can provide the checks-and-balances element from here. I know if that were available on the day Jason was seen, he would have most probably been with us today.

There was a great disparity between the observations made by Jason's chaplain and the psychologist. Jason's chaplain clearly believed him to be extremely troubled and told Jason's mother in a conversation after his death that they had been watching Jason for some time. Jason's psychologist stated that he was capable of feigning mental illness in order to manipulate his command.

There must be a mechanism put into place when there is such a discrepancy of opinion. A hotline should be established where a concerned member of the telecare team, be it the leadership, the chaplain or mental health care, can call when there is such a disagreement. And a board can be convened to review the specifics of the case, to ensure soldier safety, to make sure that no mistakes are made.

Additionally, when a provider is examining a potentially suicidal soldier, it should be mandatory for them to call the family to gather pertinent background information. Who knows their soldier better? Who better to recognize a change than a spouse or a parent? We knew Jason was having problems. If they had called us, there would have been a different outcome. I believe these two simple steps will save lives.

The last two years have been an ongoing struggle to gather documents and information to finally realize all the missed opportunities to save our son. None of these documents were given to us freely. I had to make multiple Freedom of Information Act requests in order to receive the documents. I would never know what would come when I got home from work, what I would receive in the mail. Initially the Army told me that Jason left no suicide note. I came home from work one day, there was a package in my mailbox. I opened it up. As I went through it, I found Jason's suicide note and read it. If we as a family were not willing to investigate the circumstances of Jason's death, we would never know how bad it had become for our son.

I propose an independent panel made up of professionals from outside the Department of Defense, both medical and psychological forensic experts and trained investigators, do a retrospective analysis of all theater suicides to find other mistakes and/or commonalities so we can learn and improve from our understandings. The document that the Army uses to learn from suicides, the Army's suicide event report, was filled out by the psychologist that failed my son.

Opportunities to learn from mistakes have been lost. Our family's loss could have been a powerful training tool for our soldiers

and their leaders. We could have used Jason's story to recognize both the obvious and subtle signs of depression, mental illness and suicidality. I believe we always learn more from our failures than our successes.

I would like to thank the committee for their efforts in providing funding, support, and bringing focus to this very important issue, something that I believe we as a Nation must get a grip on. Thank you.

Mrs. DAVIS. Thank you very much, Mr. Scheuerman.

[The prepared statement of Mr. Scheuerman can be found in the Appendix on page 126.]

Mrs. DAVIS. And Major Gannaway and then Mrs. Gannaway. Thank you.

STATEMENT OF MAJ. BRUCE GANNAWAY, U.S. ARMY

Major GANNAWAY. Good morning. My name is Bruce Gannaway. I am a wounded warrior recovering at Walter Reed Army Medical Center.

Mrs. DAVIS. Major, could you please bring the mic a little closer.

Major GANNAWAY. I am an infantry major that was in command of a cavalry troop when I was wounded on December 21, 2007, in south Baghdad. I apparently triggered an Improvised Explosive Device (IED) during dismounted operations. The injuries I suffered from the blast include an amputated left foot, a large vascular wound to my right leg, and the most difficult injury is the amputation of my left middle finger and multiple broken bones in my left hand. This is the most difficult wound because it affects everything that I do from typing, dressing, eating and a whole range of other daily living tasks.

My experience after I was wounded brought me through the medical evacuation system. I was initially treated at the combat support hospital in Baghdad. I was then evacuated from Baghdad, through Balad, Iraq, through Landstuhl, Germany, to Walter Reed. The trip took approximately four days from injury to my arrival in the United States.

I was an inpatient at Walter Reed on ward 57 from December 25 through January 18, 2008, when I became an outpatient and moved into the Malone House on the Walter Reed campus. Subsequently I chose to move to Silver Spring, Maryland, and I am currently renting a house in order to provide a better place for my family to raise our daughter. I am receiving care as an outpatient at the Military Advanced Training Center, or MATC.

Mrs. DAVIS. Major, could I ask you to move your mic just a little bit closer? We just really want to hear you. Thanks.

Major GANNAWAY. I am receiving care as an outpatient at the Military Advanced Training Center, or MATC, at Walter Reed, to include occupational and physical therapy.

Also while at Walter Reed, my wife and I decided to take advantage of the mental health services offered at Walter Reed. We have a good, strong and stable marriage with good communication between us. Even though my wife is a health care provider and is used to working with trauma, an amputation is still a life-changing event. We decided that we should take advantage of the therapy that is provided to facilitate our communication with each other

during this stressful time. We meet with a psychiatrist once a week, and occasionally either one of us will meet with him individually.

My initial encounter with mental health was as an inpatient at Walter Reed. Walter Reed has a Blast Protocol where every servicemember that has been injured due to a blast is screened by most of the major disciplines to include speech, dental, optometry, and, of course, mental health. However, my impression with mental health evaluation was a quick question and answer (Q&A) session that was conducted very early on in my hospitalization, and I was still pretty heavily sedated. This session is the litmus test to see if I needed additional mental health intervention other than the weekly walk-through of the ward by a mental health specialist prior to the weekend.

My peers in the MATC are all amputees. The typical population in the MATC is generally younger than I am. These soldiers or marines may or may not be married. Their faith, economic and social backgrounds are varied. Therefore, I am not the typical wounded warrior. I am too old, and I have too much rank. I have the self-confidence to be my own advocate to deal with the rotating providers who are carrying huge caseloads and to work with the supporting staff to get the appointments that I need. Many of the physicians that I see carry impractically large caseloads; consequently I often do not see the same provider from appointment to appointment and frequently need to get worked in because there is no scheduled time available.

I am married to a health care provider and I have a stable marriage. I also have previous experience with occupational and physical therapy due to a motorcycle accident that I was involved in approximately 10 years ago.

Again, my experience is with the amputee center, the MATC, at Walter Reed. I cannot speak to how mental health services interacts with other departments or wards at Walter Reed. I do want to state that I believe that I have received excellent health care during this recovery.

Recommendations for mental health: You are fighting a culture and a stigma. The wounded warrior population in the MATC is young, inexperienced with mental health, and does not want to be perceived as weak. The stigma is better than it was when I first joined the service. Had I stated that I was going to counseling, my peers would have assumed that I was either crazy or headed for divorce. Mental health needs to be brought to where the groups of wounded warriors already are. Make mental health a part of their normal routine or a part of something they are already required to do.

Mental health specialists should make early and frequent visits to the wounded warriors while they are an inpatient and follow them while they are an outpatient. A way to do this at the MATC would be just like the chaplain does. The chaplain makes routine visits to wounded warriors while they are an inpatient, and there he establishes a relationship with the soldiers and marines while they are on ward 57. The chaplain then follows us to the occupational and physical therapy rooms in the MATC while we are an outpatient.

I understand from speaking with a therapist at the MATC that mental health had previously attempted without much success to establish support groups that met on a weekly basis. I think the support groups are already established within the patient population. There are patients and family members that are always at therapy and interact with each other. Use that connection right there. There is a friendly group that already communicates and shares with each other. If a mental health specialist has already established a good, friendly relationship with the group, they will be able to easily move in and out of the group as they circulate the therapy rooms.

Thank you for your time here today. I am grateful for the care that I have received. It is truly a combat multiplier that soldiers and marines are confident that if injured, they will receive excellent medical care. Our wounded warriors deserve nothing less.

Mrs. DAVIS. Thank you, Major.

Mrs. Gannaway.

STATEMENT OF SARAH GANNAWAY

Mrs. GANNAWAY. My name is Sarah Tate Gannaway. I am here today with a dual role. I am an Army spouse, military family member, and I am also a health care provider. I am an occupational therapist with expertise in critical care medicine. I also have been active in the Army life of my soldier. I have been involved with the Readiness Group, with Army family team building, and with a host of other military programs. I consider myself fairly experienced in the Army lifestyle. And I have also chosen to seek out more information about the health care that I do receive within the Army medical system. This is both personal and professional interests.

My comments today pick up some on what has already been discussed by the previous panel. The challenges that I see within the Army medical system are some of what I would like to discuss today. I also do want to give—I have a short discussion about some of the improvements that I have seen over the years within the Army medical system, specifically within mental health.

I am going to use the term "TRICARE" as a universal for Army medical care. I use the term "TRICARE" because that is what our insurance is called. TRICARE has both military uniformed providers, the civilian contractors, and a component of health care insurance on the economy, which would be a civilian provider who is not connected to a military treatment facility.

Some of the challenges that I see in TRICARE are both for the mental health care services, but also for the physical health care services, some of the family medical providers that were discussed earlier today. Probably the biggest challenge that I see within TRICARE is the issue of reimbursement, as was discussed earlier. I am not privy to the information of what the dollar-for-dollar reimbursement is for health care services or civilian providers on the economy, but as Dr. MacDermid mentioned, it is somewhat lower than some of what the other insurance companies do provide.

The perception within civilian providers on the economy is that TRICARE does not pay, and since TRICARE does not pay, why should we see military families? That proves to be a large challenge for military families because the military health care system

is overworked, extremely understaffed. It is difficult to recruit civilian providers to become TRICARE providers if you don't reimburse. And the reimbursement is not comparable to what other private insurance companies pay.

Within the uniformed services and the military treatment facilities, there is difficulty getting connected to military providers. There just are not enough of them. The hiring process to become a contract provider is onerous. It takes a very long period of time. You have to be extremely persistent. And while many of these contract providers do have a heart for Army families, having a heart for Army families only takes you so far. If you can go to your local hospital or go to your local group practice and make more money and work fewer hours and have a smaller, more manageable caseload, it is ridiculous not to.

Most of the contract providers within military families just struggle. The caseloads are enormous, upwards of 800 people in some cases. It is very difficult to establish a patient/physician relationship when you have 800 people that you are responsible for. It is also very difficult to establish that relationship when you don't see the same provider from appointment to appointment. That is something that family members struggle with, but it is also something that our uniform services struggle with, and it is simply a product of uniformed providers deploying and there not being enough contract providers.

These guys have to have a break, and if you are able to get an appointment, you take what you can get. The consequence of that is that you spend a lot of time telling your story over and over again. Without a physician relationship and some continuity, you waste a lot of time, and that is unfortunate.

The referral process for care, specialty care, is very slow and very cumbersome. This is applicable both for mental health care services on the outside, but also getting physical specialty care referrals. There are some rather unusual policies within some of the military treatment facilities that do make it a little bit more complicated to get care. At the facility where we were most recently stationed, you could not get a physician—or a prescription refill or a lab result unless you had an office visit, and that is wasteful for the patient's time, but it is also wasteful for the physician's time if you have to go to see the physician just to get a refill on something innocuous, like a prenatal vitamin. That does combine to make a shortage of office visits.

I have personally had the experience of calling day after day after day, attempting to get an appointment, and being told that no appointments were available, call again tomorrow. This is complicated by the reluctance of some military treatment facilities to provide referrals to receive care on the economy, which is also complicated by the fact that you sometimes struggle to find a physician on the economy who will see you because the reimbursement is low.

One of the things that I have noticed in the last several years is TRICARE used to have a nurse call line, a 1-(800) number, to call in if you had a question or if you had a concern or if you had a sick child and you needed to get a little bit of guidance from an experienced professional about whether or not you need to take

your child to a doctor. That nurse call line has been dissolved. Consequently, people are bringing their children to the emergency room, taking themselves to the emergency room, attempting to get a same-day appointment for things that maybe were not necessarily needed for an office visit.

There are some improvements that are already in place specifically related to military health care, military mental services that were mentioned earlier. Military OneSource is a great resource that offers six office visits without a need for a referral from a physician. All you do is call Military OneSource, and they refer you out to a provider in your community. It is a little bit like an Employee Assistance Program. Military OneSource offers six visits. They do need to be renewed, which means you have to be able to get an appointment with your primary care physician in order to get the renewal, which brings you back to the cycle of trying to get an appointment.

TRICARE has recently developed a self-referral process so that you can call your local psychologist or licensed professional counselor and ask for an appointment. Through that program, you can get 8 to 12 visits. That is a vast improvement over what had been in place before, because you self-refer. You do not need to get a referral from your physician. After those 8 to 12 visits, though, you do have to get a renewal from a primary care physician.

There are some recommendations that I offer for you today, specifically—well, broadly for military medicine but also specifically for the mental health care. Streamlining the hiring process will make it easier to get contractors, not just contract physicians but also allied health professionals, your licensed clinical social workers, your masters in social work (MSWs), even allied health people—the therapists and the nurses.

Offering a competitive salary to compete with the facilities in the community is very helpful because it makes it easier to get physicians and to get allied health professionals. There was some discussion earlier about a large signing bonus for physicians, but those programs are harder to come by if you are allied health, and there are more allied health people than there are physicians.

Streamlining the referral process to make it easier to get care on the economy when a military treatment facility cannot offer care would be very useful. Receiving a referral is time-consuming. It has to be done very specifically, and it has to be done by name. If the civilian provider that you request by name is no longer accepting new TRICARE patients, then you start your referral process over, and that lengthens the time that it takes to get your care.

I would recommend that the military treatment facilities each reexamine their local policies to determine if there are some policies in place that make it more difficult for families to receive care, an example being the necessity to have an office visit in order to get a referral for prescriptions.

Increasing reimbursement to civilian providers on the economy would make it more appealing to them to see military families. When I received my obstetrical care when I was pregnant with my daughter, the physician practice that I used had 10 physicians. They were all listed as TRICARE providers on the TRICARE Web site. However, only one of them was accepting new TRICARE pa-

tients, and that was not the one I wanted to see. So my choice was find another physician or change the physician in the practice that I was willing to see.

Reinstating the nurse care line would be beneficial for families just as a resource, but also to help alleviate some of the burden of same-day appointments or of the seeking of same-day appointments within military treatment facilities.

Finally, increasing the number of authorized visits for mental health services offered through Military OneSource and through the TRICARE self-referral program would also be useful to families and would take some of the burden off the military treatment facilities.

Mrs. DAVIS. Thank you very much. I appreciate it. Your recommendations are helpful.

Chief Gutteridge.

STATEMENT OF CHIEF WARRANT OFFICER IV RICHARD G. GUTTERIDGE, U.S. ARMY

Chief GUTTERIDGE. Chairwoman Davis, Ranking Member McHugh, distinguished members, especially Congressmen Snyder and Murphy, and fellow veterans—Mr. Scheuerman, I am sorry for your loss. It was nice hearing from you, Major Gannaway, as well as from your spouse. I wish my wife of 18 years, Kathrin, were here, but she cannot join me.

I returned from my latest Iraqi Freedom tour in February of 2007. I was very happy to return to my wife and two sons in Germany. The homecoming was very sweet. I was required to complete a post-deployment health assessment during the post-deployment phase after returning. At that point, I did not have problems that needed immediate attention. Completing the needed forms was a ticket to begin leave. I did not want to be delayed in starting my leave. I had plans.

I began to clear my unit in Freiburg, Germany. The 1st Brigade of the 1st Army Division was casing its colors and returning to the States. Freiburg was closing. While on my stay in Germany, I executed a consecutive overseas tour, COT, and moved to Ansbach, Germany. While I was in-processing my new unit, I was informed that I failed to complete the 90-day post-deployment health reassessment (PDHRA). At this point, I was required to complete the survey. I now had been back from Iraq for about four months. I had started to have nightmares, and I was constantly reminded of being back in Iraq. I had intrusive, horrible thoughts about what happened in Iraq. I was finding myself easily becoming angry at little things. I was also having trouble sleeping, and I began to withdraw from my family. I considered the PDHRA more honestly this time. A medical doctor in Ansbach reviewed this assessment.

As a result of reviewing this document with me, the doctor told me that I had chronic PTSD and combat stress. I was then referred to behavioral health in Ansbach. I then called and made an appointment. I began therapy sessions with a nurse practitioner psychiatrist in early August of 2007. I was pleased with the one-on-one therapy I was receiving.

As a result of one of my earliest sessions, the nurse practitioner recommended that I adjust my Citalopram, otherwise known as

Celexa, medication. I was told to call the clinic, if needed, after this adjustment. My condition worsened. I continued to have nightmares, and I felt as though I was losing control. I called the clinic in Ansbach a week later to see the nurse again. The nurse was on leave, and her next appointment was not for 20 days. I then inquired about seeing a doctor, and I was told that the next available appointment was 21 days from then. I then told the receptionist that I would drive to Landstuhl Hospital to see a doctor 2.5 hours away. I was told that was not possible. She then told me that she would place a telephonic referral for me to speak to a doctor who is deploying soon from Vilseck, Germany and who has 72 hours to contact me.

I was then asked if I was suicidal. The only way to get immediate help was to be suicidal. I was not suicidal, and I told her so. At this point, I was very frustrated and angry. I then e-mailed the wounded warrior hotline—the Wounded Soldier Family hotline is what it is actually called—and stated that I need help now. I expressed the fact that I was a senior warrant officer with 24 years of Active Duty and that I had served in Iraq during Desert Storm and that I had two extended Iraqi Freedom tours. If this is how I was being treated, I asked how a young infantry soldier would be treated.

Shortly thereafter, I received a phone call from the hotline. I then received a phone call that evening from the doctor who had my telephonic referral. We discussed my condition, and he made recommendations concerning my medication. I began to feel better.

Weeks later, I continued my one-on-one care with the nurse practitioner. As time went on, anniversaries of traumatic events that occurred in Iraq began to come around. October and November were particularly disturbing. Reliving the horrors of evacuating fallen soldiers' and marines' remains, as well as searching through body bags for dog tags and watching soldiers die, was too much. I became more withdrawn and distant from my family. I was having what I was later told to be suicidal ideations. I also began to increase my use of alcohol to cope. I am not proud of this, and it is very difficult to admit.

My life almost ended on Christmas Day. I no longer had a desire to continue. I felt as though my condition would never change. I just wanted to be like before, but I could not fathom this. Late Christmas evening, I found my nurse practitioner at home, and told her what was going on. I felt relieved in calling her, but I knew that, as soon as I placed the call, my career would be over. After I assured her that I was safe, she told me to come see her the following morning in her office.

I drove to her office alone, and we met. She then told me that I needed help that she could not give. I was then advised that I could go to Landstuhl on my own or else I would be forced to. Seeing no way out, I gave in. I then opened her office door to see my wife with one of my suitcases. She was accompanied by my brigade commander and a chaplain. Reality kicked in. I was on my way to Landstuhl in a van with my brigade commander and the chaplain. I was very sad to leave my wife in the parking lot on such short notice. I never felt more alone in my life.

Upon arriving at Landstuhl, I was admitted to the inpatient psychiatry ward, Ward IX Charlie. I was issued a hospital gown and socks that had tread woven into the soles. My entire belongings were inventoried. Once I snapped on the hospital bracelet, reality really set in. Having to be observed 24 hours a day, shuffling around in socks while being behind locked doors marked "elopement risk" was very humbling.

I was observed twice daily for the next seven days for signs of alcohol withdrawals and was having to answer simple questions and was being instructed to hold my hand steady to be observed for shaking. Having to be watched by a private 1st class while shaving and eating with plastic utensils was humiliating. The only hope was the fresh-air breaks—having two quick cigarettes in succession while standing out in the cold German air, wearing socks and a hospital gown, under the constant supervision of one of the staff. These smoke breaks were the only event to look forward to.

I soon realized that the purpose of my being in a lockdown ward was for my own safety. I quickly became assimilated, and I have nothing but great respect and admiration for all of the personnel who work on Ward IX Charlie in Landstuhl.

As New Year's Day 2008 approached, I was told by one of the psychiatrists that he was recommending that I be medically retired and sent to Walter Reed to out-process the Army via the Warrior Transition Brigade. I was told that I would receive PTSD care after I was separated, at a Veterans Administration facility. I was heartbroken. I did not want to retire. I cried for the first time since returning from Iraq. I was able to have my wife and two sons come to say goodbye to me.

I flew to Walter Reed by Medevac flight on New Year's Day. I had never been to Walter Reed, but I had heard the stories. I was very apprehensive upon arriving. I was very apprehensive. Upon arriving by bus to Walter Reed after the Medevac flight landed at Andrew's Air Force Base, I was allowed a quick smoke before being escorted to the hospital.

I was then taken to Ward 54, the inpatient psychiatry ward at Walter Reed. Knowing the initial drill from having been at Landstuhl lessened my apprehension of in-processing the ward. I was soon back in the hospital again, and I received a new bracelet. I was now able to wear shoes without laces instead of socks. That was refreshing.

Ward 54 had many patients. I soon reacquainted myself with a few of the soldiers I had met at Landstuhl. They assured me that Ward 54 was cool. I felt much better then. I soon began talking with psychiatrists and psychologists. They were very kind and understanding. I immediately expressed my desire not to be medically retired. I was then advised that I would be my best advocate. I then made a decision to make the best of the situation. I participated in group therapy and followed orders. I made friends with my fellow patients. The staff was courteous and professional. The smoke breaks continued to be all that I looked forward to, those and the phone calls that I could make to my wife.

I was then made aware of the Specialized Care Program at Walter Reed that was specifically geared toward PTSD. Upon receiving this information, I made up my mind that getting into that pro-

gram was my goal for getting better and for staying in the Army. I had hope for the first time in weeks.

I continued the therapy on Ward 54. I quickly became disgruntled with the initial-entry soldiers that were also in Ward 54. These trainees were learning to be soldiers and were admitted to Ward 54 for various reasons. I soon became disenchanted with the group therapy after having to listen to people less than half my age complaining that they could not adapt to the Army, could not get along with their drill sergeants, et cetera. My disdain for this element on Ward 54 was shared with the other combat veterans who had PTSD issues. We soon branched off into our own groups and shared our stories. I felt relieved that I was not the only one experiencing the same problems with PTSD. I worked toward my next goal of being moved to Ward 53, the outpatient psychiatry ward at Walter Reed. My whole being was focused on continuing my care.

After almost 2 weeks on Ward 54, I was released to Ward 53 and moved to Abrams Hall. This time, I almost cried tears of joy. Ward 53 was a breath of fresh air. The staff was very friendly and accommodating. The atmosphere was very refreshing, hopeful and professional. I made my intentions very clear early on of wanting to be inducted into the Specialized Care Program specifically geared toward the treatment of PTSD. I then began a series of interviews with psychiatrists and psychologists as well as with social workers from the Deployment Health Clinical Center here at Walter Reed. Initially, I was discouraged because I felt that I did not make the cut during the final phase of the process, but I did, indeed, begin the program on February 4th of this year.

The Specialized Care Program was awesome. From the very first day, I knew I was in the right place. I looked at the other seven soldiers in the program, and I saw the same worn, haggard, distant look that I became accustomed to seeing in the mirror each morning. The three-week, intense PTSD program provided an overall health assessment as well as an understanding and recognition of symptoms of PTSD. I also learned how to normalize my reactions to combat experience. Learning coping skills such as breathing techniques and Yoga Nidra, coupled with one-on-one therapy with passionate mental health providers, helped to reduce my hyperarousal and vigilance. Group therapy with my fellow PTSD sufferers was what made the biggest difference by providing mutual support.

I can now manage my depression and grief associated with PTSD. I am now aware of self-care and available resources. I feel like a husband and a father again. The program saved me. I owe my Dr. my life.

I often contemplate my reintegration when I return to duty at my unit in Germany. I am not worried about my being stigmatized. I am worried about how my wife and sons will be treated once the small, close-knit community knows the truth about my mysterious three-month absence.

I describe the perception of PTSD not as a stigma but as akin to having leprosy. Lepers are avoided, looked down upon and ostracized. Lepers also live and die slowly together in their own community. Lepers only have each other. PTSD sufferers are lepers without lesions. We are like discarded pennies on the ground. No one

picks up pennies. Only shiny quarters are retrieved. Many of my fellow PTSD sufferers long for outward physical injuries, to be accepted here at Walter Reed. Looking normal or healthy on the outside is hard to explain in a hospital environment. There are no photo opportunities on the psych ward for politicians or celebrities. There is no prosthetic for a lost soul.

I am sorry for your loss, Major.

Some concepts that would improve the image of PTSD sufferers seem fairly simple. I do know the infrastructure of hospital psychiatry wards were designed for peacetime. No one expected this to be a long war, five years and counting.

Segregating soldiers who have PTSD and combat stress from patients who are hospitalized for noncombat-related issues is paramount. The mutual support that PTSD sufferers receive from each other is incredibly therapeutic. It is very difficult to discuss PTSD issues in an open forum containing patients who are not suffering from PTSD in a psychiatric environment.

I also feel that substance abuse and PTSD are not compatible. My abstinence from alcohol is a driving force in my accelerated recovery in coping with PTSD. It is very easy for PTSD sufferers to cope the wrong way by using illegal drugs, by huffing inhalants or by abusing alcohol. I feel that substance abuse counselors need to be incorporated into the PTSD recovery program, not isolated in a distant building away from the group therapy. They have to be part of the same program of recovery, not separate or in parallel programs. One feeds the other. I feel very strongly about this.

The Warrior Transition Brigade (WTB) is an outstanding success, in my opinion. My only recommendation would be to slowly replace the initial group of cadre with noncommissioned officers and junior officers who are still viable in the Army but who are offered or forced into medical retirement. Having these nondeployable experts who have navigated the environment here at Walter Reed would pay huge dividends. Simply keep them here. Make the offer. Let them continue to contribute. The present cadre is dedicated, but you can only truly learn about programs and assistance that are available here if you have walked the walk.

There are tremendous benefits available here that soldiers in the WTB discover on their own. Word of mouth soon spreads, enabling soldiers to enjoy sporting events, to learn to play the guitar and to kayak, to take advantage of airline miles donated, and to obtain items such as toiletries and clothing from the Red Cross. The benefits are endless.

Finally, many soldiers celebrate their second birthday, or their "life day," on the day that they survived being wounded in Iraq or Afghanistan. I do not celebrate that September day that I was shot by a sniper in the Anbar Province. I celebrate the day that I was enrolled in the Specialized Care Program for PTSD here at Walter Reed.

In the words of Colin Powell, "I will never not be a soldier." Thank you for this opportunity to tell my story.

[The prepared statement of Chief Gutteridge can be found in the Appendix on page 129.]

Mrs. DAVIS. Thank you very much. Thank you to all of you. This has been stirring, truly, to hear your stories.

Mr. Scheuerman, of course we regret your loss greatly, and I am so impressed that out of your tragic story you have looked to what could be done to help other families, and that is greatly appreciated.

We have a vote coming up. What I would like to do is to probably start with a question or two, but I am hoping that members can come back. As you know, we often give our witnesses about five minutes apiece, and you can tell that we did not want to stop you at all within your testimony because it is all so important to us to hear from you, and we greatly appreciate that.

Your story of renewal, Chief, gives great hope, I think, to many, many people who have suffered as you have.

We are always very, very happy to hear from all of you as to what has happened and the interaction of spouses as well. If there is one, I guess, message if people are not able to come back or are not able to go on with the hearing—you have all had a recommendation or two about partly how we make certain that there is an opportunity to have a second opinion, you know, to have somebody there who can speak up and say, "Hey, wait a minute. You know, I have seen something that you all are not seeing, and I need to be able to share that."

Chief, somebody could have just kind of written you off, and I think that you were about ready to write yourself off at one point, and we need to try and intervene.

Is there one particular recommendation that you feel that you just want to make certain that you have just hit home with us so hard? If you would like to—you know, I do not want you to have to repeat what you said but, rather, just make certain that we have heard it.

Mr. Scheuerman.

Mr. SCHEUERMAN. Yes, Chairwoman Davis.

All of the soldiers who are serving in Iraq, they do have the option to get a second opinion, and they sign the paperwork that their commander gives them, and it says at their own expense. It is impossible for them to do that, but they must be afforded that opportunity.

I had been in Army medicine for a long time prior to when I retired. You see a lot of patients. It takes a lot of time. You make mistakes. Mistakes are made. There has to be a check and balance. The only thing that I can think of that would cure that problem would be a hotline, a telephone number, that either the soldier could call or someone within the chain of command could call, or anyone with contact to that soldier who recognizes something that no one else sees. They can call that number, and then that soldier can get help. There has to be a safety net, and I do not believe that right now there is a safety net for the ones who fall through.

Mrs. DAVIS. Major Gannaway.

Major GANNAWAY. As a commander in Iraq, troopers are constantly surrounded by their peers, and it is leader business to make sure that your soldiers are taken care of physically and mentally.

Really, the system failed in your case, sir. I am very sorry about that.

Battle buddies, squad leaders, platoon sergeants, platoon leaders, commanders, chaplains, all have to be involved in the lives of our soldiers and make sure that they are taken care of.

On the rehabilitation side, some of these wounds are life-altering, and I understand how soldiers go into depression and abuse. I can see how they can go down the road of illegal drugs and alcohol and start down that downward spiral.

I believe if mental health were more involved in the daily life of the soldiers, it would remove some of the stigma. Instead of having to go to another part of the hospital and speak to somebody in a white coat, if they came down to Iraq with the soldiers during their therapy and talked to their therapist, I think they would have a better understanding of how the soldier is doing.

Mrs. DAVIS. Thank you. Mental health screening for everybody? Just routine?

Major GANNAWAY. During recovery, yes.

Mrs. DAVIS. Okay. Mrs. Gannaway. I guess, as a spouse, is there one thing that you would like us to particularly focus on either when leaving or returning from a deployment that is important?

Mrs. GANNAWAY. My recommendation would be to continue the efforts to increase availability of services. Second opinions or first opinions are sometimes very difficult to get because the providers are overwhelmed, and there is just not enough to go around. That is a challenge that is not exclusive to post-deployment units. It is a challenge that is universal across Army medicine.

So my recommendation would be to solve the problems related to staffing, because more staff who are better trained and who are less overburdened will be better able to meet the needs of Army families.

Mrs. DAVIS. Chief Gutteridge.

Chief GUTTERIDGE. Yes, ma'am.

You know, we can embed journalists in units. That is very popular. Why can't we embed more mental health providers?

You are right, Madam Shea-Porter. People do have a resistance to talk to somebody about combat stress or things that happen in combat when that person has not been there. When you are a soldier in Iraq and you come off a mission and you are told that, hey, there is a rotating team of mental folks who are here to talk to everybody, first of all, you are tired; you are hungry; you need to restock ammo; you need to preventive maintenance checks & services (PMCS) your vehicles; you need some sleep; and you are a member of a team. If you are taken out of that team even for 20 or 30 minutes to talk to somebody who is an outsider, number one, you are setting yourself up to be ostracized.

What I found that worked best in my unit, the 136th Infantry—we were in a remote area of the Anbar Province—was our battalion surgeon, Dr. Rumbaugh. Having a medical doctor who has a good rapport with soldiers and having those medics who have a good rapport with soldiers makes a huge difference. Once again, the only time you are going to be able to get well in a combat environment is to be taken out of that environment and to miss out on what is going on and to leave your buddies behind and to have a vacuum that has to be filled because you are not there.

If you had a professional mental health-type person at least the battalion level in units, people who are actually deployed with you, who eat the same food, who suffer the same mortar attacks, who cry when you lose soldiers—they are just a part of you, just like that surgeon is. Chaplains are capable of that, but they are not trained for it. Quite frankly, chaplains are hit and miss when it comes to traumatic events such as that.

That would be my recommendation, if we could embed mental health professionals at least at the battalion level who are down with the guys who are suffering. Thank you.

Mrs. DAVIS. Thank you very much.

We have about six minutes on that vote, Members. Then it is going to be about a half hour, I think, before we are going to be able to return.

Is everyone able to do that? Are you able to stay? Because I know members will be happy to come back. Okay. Thank you again very, very much for being here.

[Recess.]

Mrs. DAVIS. Thank you all for returning. We are here, we think at least, for quite a number of minutes, and we are going to go through and make certain that all of the members have a chance to at least ask a question, and then we will try and finalize the hearing after that.

Mr. McHugh.

Mr. MCHUGH. Thank you, Madam Chair.

I really do not have any questions. This is my 16th year in Congress, my 16th year on this full Armed Services Committee. I have heard a lot of testimony, but rarely have I heard a panel come with more well-thought-out, very straightforward suggestions. I want to thank you all for your service.

Mr. Scheuerman, you have my deepest sympathy on your loss. I will tell you, as you acknowledged, Bob Etheridge is concerned deeply about this. Hopefully, your efforts with him can get you some answers. I think that is the least this Nation owes you.

I can tell each and every one of you that the things you have said here today and your appearances here today will help another soldier, sailor, marine, airman, not have to face the challenges and difficulties and the heartbreak that you have. So thank you for being with us, and thank you for having the courage to step forward. I know it was probably not easy, but it is one of the bravest things that anybody could do, and we thank you so much for that.

So, with that, Madam Chair, I will be honored and pleased just to sit and listen and learn some more as we go through the rest of the panel.

Mrs. DAVIS. Thank you, Mr. McHugh.

Mr. Jones.

Mr. JONES. Madam Chairman, thank you very much.

I have had a chance to speak to several of the panelists, and I join Mr. McHugh. I do, in a way though, want to ask Mr. Scheuerman and, actually, each one of you.

Your son, Jason—and let me very quickly—I had a grandfather who was gassed at the Battle of the Argonne Forest and who took his own life when he was 31. I never knew him, and my daddy never talked much about him, but I did get his records. I know the

mental pain and alcohol and drug abuse that became part of his life and ended his life early.

I really do not understand—you know, I cannot help you. I wish I could help you and your wife and your family. I want to know how important—at least at some point you mentioned the chaplain; the major did; the warrant officer did. Did the chaplain see Jason's anguish? He was there to spiritually counsel him, but was he in a position where he could or did he reach up to the officers and say, "This young man has trouble"?

Mr. SCHEUERMAN. Sir, the chaplain did observe Jason, and saw that he was having troubles, and made a recommendation that Jason get a psychological evaluation.

Mr. JONES. Now, you might have said that in your testimony, and I just missed it.

Okay. From that point forward of the chaplain's making the recommendation, is that when you were saying that nothing seemed to move forward to help Jason?

Mr. SCHEUERMAN. At that point, there was a total breakdown in communication. Once Jason was sent to see the psychologist, the psychologist never called back to the unit. There was no communication between the psychologist, the chain of command or the chaplain. Had the psychologist called back to the unit, he would have heard the stories of Jason's laying in his bunk with the muzzle of his weapon in his hand, of Jason's sitting in the corner with his head bobbing up and down on his rifle, of Jason's sleeping at the command post in a fetal position. He would have heard those stories, and perhaps his assessment of Jason would have been much different than "feigning mental illness in order to manipulate his command."

Mr. JONES. Madam Chairman, I think this committee should ask for an investigation, quite frankly, of why when the chaplain made this request that it was dropped. I will tell you that I think truthfully that this—not just because of this family—but you just cannot not hear the cries of someone who is so anguished. If the chaplain went to his superior or to the ranking member of the military leadership and said "This young man needs help" and somebody did not do his job—I am going to tell you that I asked for an investigation when Chaplain Stertzbach was removed from his chapel in Iraq for praying over the body of a deceased soldier in the name of Jesus Christ, and they removed him. I think we need to ask for an investigation as to why this happened, so it will not happen again. I do not know if I can make that request, but I would like to make it.

Mrs. DAVIS. Thank you, Mr. Jones. There is an active investigation.

Is that correct, Mr. Scheuerman, as far as you know?

Mr. SCHEUERMAN. Right now, with the help of Congressman Etheridge, Congressman Etheridge asked Secretary Geren, the Inspector General of the Army, to conduct an investigation, and they are conducting that investigation at this time, sir.

Mr. ETHERIDGE. Madam Chair, if the gentleman would yield——

Mr. JONES. Yes, I yield to the gentleman.

Mr. ETHERIDGE [continuing]. Secretary Geren has initiated an Inspector General (IG) investigation that is ongoing.

What the committee might want to do, Madam Chair, is just follow up and take a special interest in that, because I know the Secretary has just been absolutely outstanding in this. He did not hesitate. He said we are going to do it and that it is going to be ongoing and that we are going to get to the bottom of it.

The committee might want to see the report when it is completed. He has expressed an interest, and I think that would be most appropriate at this time. We will go ahead and let that investigation move along because it is ongoing at this point.

Mr. JONES. Madam Chairman, since it is my time and I am about to lose it, I want to thank the gentleman from North Carolina for what you have already done. That is all I was trying to do is to make sure that we see the report so that we have a better understanding of what was not done so that it does not happen in the future.

To the major and to the warrant officer and to your lovely wife, thank you for being here. May this county never forget that you have earned this benefit, and I will continue, as long as I am here with my colleagues, to fight and to make sure that Americans—instead of sending money overseas to help other countries, how about let's take care of those who have served this Nation in the military.

I thank you. I yield back.

Mrs. DAVIS. Thank you, Mr. Jones. We certainly will follow up with the investigation. We want to check and see when that is going to be available.

I think many of the questions, of course, that you have raised in terms of communication are critical, and we need to be sure that we move forward and learn from them. Also, I think you mentioned an accountability piece, and I think that is an important one as well. Thank you.

Dr. Snyder.

Dr. SNYDER. Thank you.

Mr. Scheuerman, do you have other family members with you here today?

Mr. SCHEUERMAN. Yes. My wife, Anne, is here, sir.

Dr. SNYDER. I wanted to acknowledge your presence. We appreciate your being here today. I know this can be a difficult time to go through this, but it is very helpful to us and to other soldiers and soldiers' families. Thank you for being here also.

Mr. SCHEUERMAN. She has been my therapist, sir.

Dr. SNYDER. Mr. Scheuerman, you said one thing that I did not understand and that I have not heard before. When you talked about having to have some kind of written request for a second opinion, I did not understand that. Repeat that for me again, please.

Mr. SCHEUERMAN. When Jason received his command referral to go see the psychologist, it is a Department of Defense directive that they be read off their rights. One of their rights is to a second opinion at their own expense as a Department of Defense directive.

If I may, as far as the investigation, all of the information that we got through the FOIA requests—and there were multiple FOIA requests, and they all came in piecemeal. It was our family that had to go through the Criminal Investigation Division (CID) report, that had to go through the 15–6 investigation, that had to go

through the psychological medical records to put all of the pieces together to say, "This is wrong. There were mistakes made." The Army had already closed that case and had moved on.

Dr. SNYDER. As you may have picked up in some earlier discussion, I am a family doctor, and we should be a lot smarter than—those were big warning signs; 25 years ago, I look back at some of the things that we would have missed in some of our colleagues, but those were very glaring warning signs, and it is absolutely appropriate to try to figure out what happened because, if it happened to your son, it is happening to other people, not just in the military but out of the military.

Mrs. Gannaway, I appreciate the thoroughness of your discussion, but I am not sure—I thought that was a discussion just of someone who, you know, sat next to a hospital bed or went to counseling sessions with your husband, because you really had some much better systems analysis than most of us House Members. How did you get up to speed on a lot of these issues? Is there a group of folks you are working with or is this just something you have been poking around in on your own?

Mrs. GANNAWAY. I have a vested interest in this issue——

Dr. SNYDER. Sure.

Mrs. GANNAWAY [continuing]. Because of being an Army family member but also because of my experience professionally in the medical community——

Dr. SNYDER. As an occupational therapist.

Mrs. GANNAWAY [continuing]. As an occupational therapist.

I ask a lot of questions. I have been frustrated at times by some of the difficulty that I have had navigating the Army medical system. I did have a life prior to being in the Army, and had my own health insurance through a private company, and found it to be much more simple to use.

My health care at our most recent duty station was provided at a satellite clinic. Initially, I had a relationship with one physician whom I saw on a regular basis when I needed it. The Army renegotiated the contract with that group of physicians, and he chose to leave. At that time, I got into a cycle of seeing different physicians and different providers over and over and over again. When that happened, I really started to pay attention to some of the things that I saw that could benefit from improvement.

Dr. SNYDER. Your comments were really helpful.

Major Gannaway, in your statement, you talked about the culture of the young, which is that young folks do not like to acknowledge problems. It seems to me that we need to also be dealing with that culture before people get hurt or sick. I mean the fact that somebody goes out, you know, at age 22, never having been overseas, never having been exposed to the kinds of things that you all have been, and putting away five beers on a Friday night and joking about it on Saturday morning is a problem. I mean, we may think that is the culture of the young, but it is an unhealthy culture.

Is it your experience in the military that we are addressing those kinds of things outside of the experience of people's being hurt or injured?

Major GANNAWAY. I believe the military is getting better at addressing substance abuse problems and mental health issues and at reducing the stigma of acknowledging mental health with their servicemembers. It is not to a level where it is completely accepted to go see a mental health professional, and it may not be that way in civilian society yet either, but we are working toward it. A lot of that simply just comes down to leadership within a unit.

Dr. SNYDER. Chief, I am out of time, so you do not have to hear me ask the question if you are still smoking, so——

Chief GUTTERIDGE. But I am not under any type of performance-enhancing drugs at this time.

Mrs. DAVIS. Thank you. I want to turn to Congressman Etheridge.

Thank you very much for joining us. We appreciate that, particularly as you work through and help Mr. Scheuerman in this investigation. Thank you.

Mr. ETHERIDGE. I thank the gentlelady. Thank you for letting me join the panel, and thank you to all of you for letting me have the opportunity to make a comment, and to really ask a question.

I join all of my colleagues here this morning in saying that in the years I have served in this body—and I have not been on the Armed Services, I have served on a number of other committees, even though I represent Fort Bragg and Fort Pope. I have a deep and abiding interest in having served in the military in Vietnam. A lot of the situations that you have talked about this morning, a number of my fellow soldiers who came back from Vietnam suffered from, and we should never let that happen in America again.

I just want to make a couple of points and get a comment because it seems to me—before I came to Congress, I ran a pretty good-sized organization. I was a State superintendent of schools. It was a lot people. It is hard changing a big organization that has a culture that is just there, and it takes time to change it. It seems to me that we are living in a really different time in the world today than we were 20 years ago or even 15 years ago.

As we start this process in our leadership in the military, from the top all the way down to the company commander and to the last trooper, we are going to change our culture, and that culture has to change to be accountable for more than just the weapons and the equipment. We have got to be accountable for people's health and for their mental health.

It seems to me, Madam Chair, that that has to be something we encourage, that the mental health piece has to be a part of this process of keeping our soldiers safe and healthy. I believe that Mr. Scheuerman mentioned earlier that if that were a part of the requirement of leadership, that accountability piece, that it would be treated a whole lot differently. So I would encourage us to look at that.

Each one of you in one way or another has said that. You may have said it in different ways, but that is really what you are saying. I think we need to hear it, and those of us in Congress need to take the actions, and we need to take whatever action it takes to get the system changed.

I think one other thing was this whole issue of second opinions. I do hope we find out what that is, because it seems to me if I am

a PFC in Baghdad or wherever I might be, and I am asked to have a second opinion and I have got to pay for it, number one, it may not be available; number two, you sure cannot get it there; and third, there ought to be a hotline.

Chief, if you had not had your hotline, I shudder to think where you would be today. Thank you for being able to get to it and to call. We do need to make that available.

For a lot of these young folks, as has been indicated, this is their first time away from home in some cases. For many of them, it is the first time they have ever been overseas. I think, Major, you touched on it, on the whole mental health issue, but it is all a total health issue. When we are in the States, we worry about speeding and driving, et cetera, and drinking, but the same has to be true of the total mental health overseas.

Finally, I would be interested in your comments at least on two issues. One is this whole issue of the total accountability to include things like mental health and others. Second, what do we do to change the culture? Because that is an important part. It is a part of the training, but it is also a part of the continual retraining. I would be interested in any of your comments because you have been through it, each one of you, in one way or another. I hope that you would be instructive, to help us.

Chief GUTTERIDGE. Congressman Etheridge, one thing that I would recommend is, if you do have a mental health issue, you either go to a behavioral health clinic or you go to a mental health clinic. If you have the symptoms of, let's say, combat stress or of PTSD and where you are not quite yet diagnosed with PTSD, we could change the culture by simply changing the name. Instead of behavioral health—we could still keep that, but we could have a subset or a smaller compartment that is, perhaps, combat stress. You know, everybody loves the word "combat." You attach that to anything, it is acceptable; it is manly; it is okay.

So, if you have combat stress and someone else tells you that you have a mental illness, you are going to pick combat stress every time. So I think it is something as simple as changing the wording of the programs, of the buildings, even the sign on the door or the number in the phone book. It is just how it is called. Just relate it somehow to combat or to operational stress as opposed to behavioral health. That would be my recommendation.

Mr. ETHERIDGE. Language is important.

Chief GUTTERIDGE. Yes, sir.

Major GANNAWAY. Sir, you touched on the total system.

You know, a leader is responsible for his soldiers' actions. He is responsible for making sure that he is up to date on his dental, on his shots, and so that includes a mental health screening. I think a way to reduce the stigma of mental health would be to make it part of a soldier's normal routine. Normalize it. If they have more exposure to it on a routine basis—predeployment, during deployment, post-deployment, and during train-up—it will lose some of the stigma and become more acceptable.

Mr. SCHEUERMAN. The Army has dealt with a lot of cultural changes in the past, sir, from sexual discrimination, racial integration, drunk driving. The Army has gone through a lot of cultural change, and a key to the Army's dealing with those cultural

changes has been a near zero tolerance for anyone's not getting with the program.

There was a time when I was a young soldier when, if you were caught drunk driving in Fayetteville, your 1st sergeant would come pick you up, and you would be on extra duty for 14 days. That was it. They tolerated it. Once they stopped tolerating it, you did not see so many drunk drivers in Fayetteville. Sexual discrimination was almost rampant when I first joined the Army. The culture changed. The Army changed. They no longer tolerated it. It went away.

Stigma against mental health in the Army exists today because we allow it to. If we do not tolerate it, it will go away.

Chief GUTTERIDGE. Sir, may I add one thing? Those are great points.

What I would like to add is that one of the things that I am most proud of from being in the Army is that it is a value-based culture. If you look back in history, it is the military and it is the Army that were the tip of the spear in changing society—segregation, dealing with different types of discrimination. We can do it. The Army can do it. The Army can lead society down the correct path of taking away the stigma. I look forward to that, and I think it can happen.

Mr. ETHERIDGE. Thank you very much. You have been very powerful today. It has been very instructive and very helpful.

Madam Chair, thank you. Thank you for this hearing, and thank you for letting me join. I yield back.

Mrs. DAVIS. Thank you very much. I just have a few very quick questions.

I wanted to go to you, Chief Gutteridge, because you mentioned that we might want to capture those individuals who have gone through these experiences and who were not necessarily in the mental health fields to begin with, but who perhaps could be trained appropriately. If I recall, I think that even our first panel questioned whether or not there is, you know, a new group of counselors that we might look to who could add to or be part of this new cadre that you spoke of.

I wonder if you wanted to just comment briefly on that. Where do you see that coming from? How realistic, I guess, do you think that is?

Chief GUTTERIDGE. Well, ma'am, to be very simple, drunks help other drunks not be drunks anymore. Mutual support in PTSD is absolutely critical. If you are in a group with just a couple of folks—they could be Vietnam-era veterans, they could be World War II—it is that common bond. The only people who understand that are people who have been in that situation.

Now, I understand you have to have a master's degree in, let's say, social work in order to be a counselor at certain places. I understand that procedure, and that is very important. But if you could have some sort of informal PTSD support groups or combat stress support groups, much like you have with bereavement for lost soldiers—of course, there is nothing worse than losing a child, and I am not going to downplay that at all. It is mutual support, and where we could in some way create an environment where, "hey, you know, there is a lunchtime meeting over here for guys

who want to talk about combat stress and see how they are doing." Yes, it is doable.

Mrs. DAVIS. Thank you.

I think in many ways, I probably want to carry that a little bit further, in that it may be that some people are particularly talented, who may not have known that, to be able to work with other servicemembers, and that we may need to think about helping them develop that in an educational setting so that they could go back and even be at higher levels, whether it is social work or psychologists or psychiatrists, in the future.

I just wonder whether we want to look to—and have people looking out for those individuals who, in fact, may have thought about separating from the service but who might be able to even stay in, in a different way. It all takes money, of course, but I was interested in what you had to say.

Quickly, I wanted to just follow up about the safeguards that you all talked about and how critical it is to have them in place. One of the concerns that we have heard is whether we, in fact, have those safeguards; if a servicemember's chain of command tries to override a medical recommendation that a servicemember not be deployed, for example, or if there is a desire to keep people moving—constant deployments—and yet, that servicemember really is suffering, and that recommendation hasn't been adhered to that they not be deployed.

Is that something in your experiences that you have seen in any way? Are you aware of people who are continuing to be deployed who, even in your own estimation, should not be?

Chief GUTTERIDGE. I have not had that experience, ma'am.

Mrs. DAVIS. Major, is there anything you could just add to that in terms of what we ought to be looking for?

Major GANNAWAY. When I was a commander, dealing with a soldier's medical problems was very critical to combat readiness. You do not wait until the last day to make sure the soldier has his shots. You know, you start looking six months out and start identifying problems and go after them. If a soldier needs to go to the dentist, you get him there.

So, if there are problems and you pay attention to your soldiers and you get to know them and their families, you identify those problems and try to take care of them and deal with them before it is time to walk out the door and deploy.

Mrs. DAVIS. Mr. Scheuerman, did you want to comment? You have obviously spoken with families who, perhaps, have suffered as you have. Is there anything you would like to add to that?

Mr. SCHEUERMAN. It is the most difficult thing in the world to lose your child. It was the worst day of my life and Anne's also. The only thing that I really want to say to the panel is, this is a problem that we have to get grips with because, as our kids come home this is only going to get worse. As they leave the service and they are not under daily supervision, this is only going to get worse. So we have to find a way to make this better. I do not want another set of parents to have to experience what we have.

I think we, as a Nation, can do it.

Mrs. DAVIS. Thank you.

I know that we are all better off having heard from you today, and we know that we also have issues within our general culture around mental illness, and we are trying to deal with that as well. Mental health parity is just one example. Hopefully, the services in many ways may be able to lead the way, actually, for the country on this one, and that would be a very good thing.

Thank you all very much for joining us. We look forward to moving on with these issues, to addressing them critically and very seriously. Your presence, again, does make a difference. Thank you.

[Whereupon, at 12:35 p.m., the subcommittee was adjourned.]

A P P E N D I X

March 14, 2008

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MARCH 14, 2008

Statement of Chairwoman Susan A. Davis
Military Personnel Subcommittee hearing
Hearing on Mental Health
March 14, 2008

The purposes of today's hearing are many and diverse.

First, we will receive an update on how the Department of Defense has implemented the recommendations of the 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.

Second, we will have an opportunity to hear about the findings of the Army's Mental Health Advisory Team-5. The results of other MHATs have provided great insight into the mental health needs of our military because the teams conduct their research and interviews on the ground in Afghanistan and Iraq.

Finally, we will have the opportunity to hear about what individual mental health needs are and are not being met from service members and family members.

Today's hearing will have two panels. The first panel, before us now, includes Dr. S. Ward Casscells, the Assistant Secretary of Defense for Health Affairs, Lieutenant General Eric Schoomaker, Surgeon General of the Army, Vice Admiral Adam Robinson, Surgeon General of the Navy, Lieutenant General James Roudebush, Surgeon General of the Air Force, and Dr. Shelley MacDermid, the Director of the Center for Families at Purdue University, Co-Director of the Military Family Research Institute, and a Co-chair of the Department of Defense Task Force on Mental Health.

These senior medical leaders will tell us what has changed since our last hearing, what they are doing now, and what they have planned for the future. Dr. MacDermid will help frame these responses in relation to the findings and recommendations of the Task Force.

Welcome to you all.

The second panel will have two currently serving soldiers, Chief Warrant Officer Richard Gutteridge and Major Bruce Gannaway , who have been treated for mental health conditions and are willing to share their experiences. Thank you both for your courage in being willing to testify.

We are also very fortunate in that we will hear from a spouse of one of these soldiers, Mrs. Sarah Gannaway, so we can understand the experience from the family's point of view, as well as learn what mental health services our family members require.

Finally, Mr. Christopher Scheuerman will share with us the story of his son, Private First Class Jason Scheuerman , who committed suicide in Iraq in 2005. The story will be painful hear, but it is illustrative of how the system failed a soldier, and will provide some insights into just how comprehensive and integrated military mental health services need to be.

To all of the witnesses on the second panel, thank you for your willingness to share such intimate and painful experiences with us to help ensure that others do not have to suffer as much.

All of the members of this subcommittee remain 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. It weighs heavily upon the readiness of our force, our ability to retain combat veterans, and our obligation to care for those who volunteer to serve our nation.

At our last mental health hearing I made it clear that this was going to be a long process. It will take a sustained effort from all concerned 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. We will also face fiscal challenges. The structural and cultural changes needed will require significant and continuing financial outlays, but our service members and their families deserve no less.

Finally, I would like to make mention of the fact that all of the second panel witnesses and many of the topics for the first panel are in some way connected to the Army. This is not because we feel that the Army is the only

service that faces mental health challenges. Far from it: we feel that all of the services need to do better.

Why, then, does the Army figure so prominently in this hearing?

First, the Army has the largest number of personnel in both Afghanistan and Iraq. Second, the Army has undertaken a number of self-assessments on mental health issues, and has unselfishly shared them. Finally, when the subcommittee staff interviewed potential witnesses, there were those with experiences that stood out as excellent examples of what improvements have been made, and what still needs to be done. By random chance, those happened to have a connection to the Army.

It would be a disservice to the Army to assume that these coincidences single it out as having more problems than any other service. Instead, we should be grateful to the Army that so much information is available to us to help guide our discussions.

Mr. McHugh, . . .

Opening Statement of Congressman John M. McHugh
Military Personnel Subcommittee
Hearing on Mental Health

"Today's hearing continues our efforts to assist the Department of Defense (DOD) to improve mental health services that are available to our military personnel and their families. I want to preface my statement by recognizing the tremendous work the Department of Defense and in particular the leaders of the military health system who appear before us today have done to respond to the mental health needs of our service members and their families. I understand that this has not been an easy task and I want to thank you for your efforts in this regard. With that said, clearly there is more work to be done.

"Last year the DOD Mental Health Task Force published its findings that identified significant shortcomings in the Department's efforts to provide mental heath care. Of note, the task force found that the Department of Defense has not invested the resources and funding required to make the necessary services available when and where they are needed.

"Following the report, Secretary Gates publicly committed to fixing the psychological health system stating that he had 'no intention of waiting' the full six months allotted by Congress for the development of a corrective action plan. The Secretary tasked DOD to complete a plan to address problems with the military psychological health system within 60 to 90 days.

"While I commend Secretary Gates for sense of urgency in addressing the reported gaps in the system, unfortunately we continue to hear from service members and their families, particularly those who have returned from Iraq and Afghanistan about the difficulty of obtaining timely mental health services. We are told of active duty members having to wait several months between mental health appointments in military treatment facilities and in the TRICARE system. Clearly this calls into question whether the Department has invested the necessary funding and personnel resources. I am anxious to hear from the witnesses if this is the case.

"I also want to hear from our first panel today about how DOD and the military services have addressed the resource shortfalls along with other task force findings such as:

"A pervasive stigma among military personnel about seeking mental health care that keeps them from getting the help they need,

"Gaps in the continuity of psychological health care which is often disrupted during transition among providers, and

"The TRICARE network benefit for psychological health being hindered by fragmented rules and regulations, inadequate oversight and inadequate reimbursement.

"With that said, I would like to again recognize the Army and Lieutenant General Schoomaker for continuing the commitment to assess the mental health system in theater and ensure that it is meeting the needs of the troops. While the Mental Health Advisory Team V findings clearly show positive trends in areas such as increased unit morale and decreased stigma associated with seeking mental health care, there are also some very disturbing findings. Soldiers on their third or fourth tour in Iraq report twice as many mental health problems as first-time deployers. That coupled with the reported increasing difficulty in accessing mental health care again causes me to question whether the right resources in sufficient quantity are in place.

"The report from Afghanistan is equally disturbing, where rates of mental health problems are significantly higher than in 2005 and soldiers are experiencing significant barriers to care. I would like to know how the Army plans to fix these problems.

"In addition, I understand that the MHAT V included information obtained from Marines in theater as well as soldiers. I'm interested in Admiral Robinson's perspective on whether mental health services available to deployed Marines are meeting their needs.

"With that, I would like to welcome our witnesses and thank them for participating in the hearing today. I would particularly like to thank the members of the second panel for their willingness to share their personal stories with us and their service to our nation."

STATEMENT ON

MENTAL HEALTH

BY 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

MARCH 14, 2008

NOT FOR PUBLIC RELEASE UNTIL

RELEASED BY COMMITTEE

Madam Chairwoman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System (MHS). Today, the Service surgeons general and I will provide an update on MHS improvements in psychological health and I will address implementation of the Mental Health Task Force recommendations. I will also discuss the Department of Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury (TBI), and information on suicide rates and risk factors. In addition, I will touch on programs provided by the Services. The Surgeons will provide more details on their program goals and outcomes.

The MHS serves more than 2.2 million members of the Active, Reserve, and National Guard components with more than 272,000 Service members deployed overseas. Nearly a year ago, the Secretary of Defense charged me with being the guarantor of quality health care for Service members and their families. In the past year, we have reexamined our mission, vision and core competencies.

With the improvised explosive device (IED)-driven war and the influx of Service members with complex wounds to some of the older hospitals and out-patient facilities – where caregivers were lost to the military treatment facilities (MTFs) through deployment – the MHS needed a new focus. We rewrote the MHS mission to: Sustain a medically ready military force and provide world-class health services for those injured and wounded in combat.

Competent medical care is comprehensive, conscientious, compassionate, coordinated, confidential, computable, communicated clearly, controlled by consumer choices, and cost effective. Getting there requires continuous commitment (and some courage). This is our duty at the bedside and in the field. Equally important goals are to protect (for example, against injury) and to prevent (for example, against disease), and to educate future clinicians and conduct the medical research that others cannot do.

To this end, we must better understand and diagnose conditions not yet fully understood – combat stress and traumatic brain injury (TBI). We understand that the seven-year war has put additional stress on military families. We are committed to working closely with the Under Secretary of Personnel and Readiness to reduce even further our low levels of binge drinking, smoking, accidents, illicit drug use, domestic abuse and divorce. Finally, we are closely monitoring suicide rates and seeking early identification and more effective interventions for Service members at risk.

DoD Psychological Health Programs

The psychological health programs in the Military Health System continuum of care encompass:

- Resilience, prevention, and community support services;
- Early intervention to reduce the incidence of potential health concerns;
- Deployment-related clinical care before, during and after deployment;

- Access to care coordination and transition within the Department of Defense (DoD)/Department of Veterans Affairs (VA) systems of care; and
- Robust epidemiological, clinical, and field research.

DoD Mental Health Task Force. The Department is grateful for the hard work and dedication of the members of the DoD Mental Health Task Force (MHTF). In September of 2007, DoD responded to the Task Force's report and accepted 94 of the 95 recommendations for implementation.

We have completed five of the recommendations offered by the MHTF. We have initiated actions on all other recommendations. Some will be completed by May of this year, and others will be completed at a later date due to long-term implementation requirements. We will conduct a broad evaluation of our progress in May 2008 to gauge our status and re-prioritize as needed to maintain our momentum.

The one recommendation DoD did not accept was for services currently provided under Military OneSource. We do not want to confuse our Warriors and their families or take them away from successful programs.

Defense Center of Excellence (DCoE). Our approach in developing a culture of leadership and advocacy began with the creation of the DCoE. I appointed Colonel (promotable) Loree Sutton, M.D., to be the DCoE director in September 2007. The DCoE opened its doors on November 30, 2007. The Center serves as the Department's "front door" for all issues pertaining to psychological health and TBI.

I selected Dr. Sutton for this crucial position because of her record as a leader (most recently in command of health services at Fort Hood) and because she knows:

- that mental health is not just the province of the psychiatrist but also the psychologist, nurse, social worker, medic, spouse, noncommissioned officer and company commander;
- that psychological health is not just about medications but has to do with genes, childhood, education, work and family;
- that prevention involves education, rest, nutrition, exercise and matching Service members with assignments where they are challenged but know they can succeed;
- that our Service members must understand that it takes strength to ask for help;
- that it is their duty to reach out to battle buddies who are struggling; and
- that doctors need to take a scientific look at the therapies people use on their own, such as alcohol and vitamins, and those which hold promise but are not yet well established, such as music, art, sunshine, biofeedback, medication and others.

This Center will lead clinical efforts toward developing excellence in practice standards, training, outreach and direct care for our military community with psychological health and TBI concerns. It will also provide research planning and monitoring in these important areas of knowledge.

The DCoE will provide intensive outpatient care for wounded warriors in the National Capital Region, and more important, it will instill that same quality of care across the country and around the world. We will accomplish this by establishing clinical standards; conducting clinical training; developing education and outreach resources for leaders, families and communities; and researching, refining and distributing lessons learned and best practices to our MTFs and to the TRICARE provider networks. We will work together with our colleagues at the Department of Veterans Affairs (VA), National Institutes of Health (NIH) and elsewhere to create these clinical standards.

The DCoE staff will build and orchestrate a national network of research, training, and clinical expertise. It will leverage existing expertise by integrating functions currently housed within the Defense Veterans Brain Injury Center (DVBIC), the Center for Deployment Psychology (CDP), and Deployment Health Clinical Center (DHCC).

To date, the DCoE is engaged in multiple projects that respond to the recommendations of the MHTF, including:

1) Enhancing the military's campaign to reduce the stigma of seeking help through partnerships with the Uniformed Services University of the Health Sciences, NIH, VA, Substance Abuse and Mental Health Services Agency, our coalition partners and others in the public and private sectors (examples include the Army's chain teaching day, Health Affairs' news, U.S. Army Center for Health Promotion and Preventive Medicine's posters, and especially line leaders and celebrities who have volunteered their own stories of overcoming depression or anxiety);

2) Establishing effective outreach and educational initiatives, including an Information Clearinghouse, a public website, a wide-reaching newsletter and a 24/7 call center for Service members, family members and clinicians;

3) Promulgating a telehealth network for clinical care, monitoring, support and follow-up;

4) Conducting an overarching program of research relevant to the needs of Service members in cooperation with other DoD organizations, VA, NIH, academic medical centers and other partners – both national and international;

5) Providing training programs for providers, line leaders, families and community leaders; and

6) Designing and planning for the National Intrepid Center of Excellence (anticipated completion in fall 2009), a building funded by the Intrepid Fallen

Heroes Fund that will be located in Bethesda adjacent to the future Walter Reed National Military Medical Center.

The Department has allocated more than $83 million dollars toward DCoE functions. That total includes amounts allocated specifically to the telehealth infrastructure, Automated Behavioral Health Clinic (ABHC), Defense Suicide Event Registry (DSER) and DVBIC functions. We allocated an additional $45 million to research and development projects (among these are 1. the critical need for agreement as to definitions and standards (agreed to by psychiatrists, psychologists and social works) and 2. evidence as to how best to improve screening, prevention, early detection and treatment.)

A vital responsibility of the DCoE is quality of care. The quality-of-care initiative relies on developing and disseminating clinical guidance and standards, as well as training clinicians in clinical practice guidelines (CPGs) and effective evidence-based methods of care.

DCoE is moving forward on these projects, as it continues the relentless momentum to reach full operational capability in October of 2009. Each of the Services has initiated quality-of-care functions, including essential clinician training. For mental health, each Service is training mental health providers in CPGs and evidence-based treatment for PTSD. The Services are training primary care providers in mental health CPGs. Regarding TBI, we sponsored a TBI training course attended by more than 800 providers, including VA providers from more than 30 disciplines. We will repeat this training in 2008 to provide a basic level of understanding of mild TBI to as many health care providers as possible. Over the coming months, the DCoE will consolidate and standardize these training efforts.

Severe TBI is readily diagnosed. Similar to other severe trauma conditions, severe TBI is treated using well-established procedures, though treatments are not yet advanced enough to permit full recovery in most instances. Usually, moderate TBI is clearly recognizable with an event-related period of loss of consciousness and observable neurocognitive, behavioral, or physical deficits. On the other hand, mild TBI, while more prevalent, is more difficult to identify and diagnose on the battlefield, just as it is in civilian scenarios. Our index of suspicion must be high to ensure that we appropriately evaluate, treat and protect those who have suffered mild TBI. Military medicine has established a strategy to improve the entire continuum of care for TBI and published a DoD policy on the definition and reporting of TBI. This policy guidance serves as a foundation for shaping a more mature TBI program across the continuum of care and sets the stage for the mild TBI CPG to follow.

The Army Quality Management Office – the DoD executive agent for Clinical Practice Guidelines – is creating a formal CPG for mild TBI. Guidelines generally require two years to develop; however, we have expedited that process and will have the CPG completed in one year. The Department will collaborate with VA on the development of this CPG to ensure a standard approach to identification and treatment of mild TBI.

Having standard guidelines and trained staff represent only part of the quality requirement. Equally important is proper equipment for the provision of care. Operations Iraqi Freedom and Enduring Freedom have placed our Service members at the highest risk for potential brain trauma. Therefore, DoD acquired equipment to enhance screening, diagnosis, and recovery support for these Warriors.

Access. Our ability to deliver quality care depends, in part, on timely access. Access, in turn, depends on the adequacy of staff to meet the demand. We also must provide the services in a location or manner in which the Service or family member can meet with the provider or interface with the system without undue hardship or long travel times and distances.

In October 2007, the Department issued a new policy that patients should have initial primary psychological evaluations scheduled within seven days of their request, with treatment to follow within normal access standards. Emergency evaluations are addressed right away.

In addition to this enhanced access, we have begun moving psychological health functions into primary care settings. The Services will hire psychological health personnel for both mental health clinics and primary care clinics. In the primary care setting, psychological health providers may consult with primary care providers to identify mental health conditions and to make appropriate referrals for treatment. Alternately, behavioral health providers may manage the patient's care in the primary care setting when appropriate. This arrangement also enables us to provide care for behavioral aspects of more traditionally physical health problems, such as pain and sleep problems that cause patients to seek care.

To ensure ready access to mental health and TBI care in our MTFs, we are increasing staff using a number of approaches.

- For TBI, we developed a standard capabilities model of multi-disciplinary staffing and management – capabilities we are now assessing for use across the military Services. This model offers the basis for a site-certification pilot program that the Army has undertaken to ensure soldiers with TBI receive care only at those facilities that have established capability to care for them.

- Deployment-related health care is most effective when integrated with total health care. The Institute of Medicine advocated this position and the Department codified it in the DoD/VA Post-Deployment Health Evaluation and Management Clinical Practice Guideline (PDH-CPG). Telehealth technology will help to integrate this care, particularly in the more remote locations. The DCoE will coordinate and integrate telehealth activities and capabilities across the Department; meanwhile, the Services have begun demonstration projects to assess how best to leverage telehealth technology to increase care for TBI patients in remote or underserved locations.

- For mental health, we developed a population-based, risk-adjusted staffing model to more clearly inform us of the required number of mental health providers. The Department contracted with the Center for Naval Analysis (CNA) to validate the model and expects results later this year. Using that validated model, the Department will adjust the requirements and disposition of mental health providers in the next fiscal year.

    - United States Public Health Service (USPHS). Mental health providers are in short supply across the country – complicated by hard-to-serve areas, such as remote rural locations. To increase providers in these areas, we have initiated a partnership with USPHS, which will provide uniformed mental health providers to the MHS. The USPHS has committed to sending us 200 mental health providers of all disciplines. The military services will place those providers in locations with the greatest need.

    - Civilian and contract. We will employ civilian and contract providers to increase our mental health staff by more than 750 providers and approximately 95 support personnel. Additionally, the MTF commanders have hiring authority and may increase their staffs to meet unique demands.

    - TRICARE network. In the past few months, our managed care support contractors have added more than 2,800 new mental health providers to our TRICARE network across the three regions. In addition, they have reached out to thousands of non-network providers to identify clinicians who would be available to take on new patients if a network provider could not be identified within the established access times.

    - Military. As always, we must recruit and retain military providers. These men and women serve critical missions as an integral part of our deploying force.

Resilience. Our vision for building resilience incorporates psychological, physical, and spiritual fitness. When health concerns surface, we must strive to break down the barriers so that those seeking care receive it at the earliest possible time and with least resistance, including non-medical settings, such as with chaplains, first sergeants and counselors.

I mentioned our anti-stigma campaign earlier. An important part of reducing stigma is education. The DCoE proposes a standardized curriculum for psychological health and TBI education for leaders, Service members, and family members. In the interim, each Service will implement training that adheres to our overarching principles and is adaptable to the culture of its own Service.

For families, we have implemented and expanded a number of education and outreach initiatives.

- The Mental Health Self-Assessment Program (MHSAP) is accessible at health fairs as well as in a web-based format. We expanded this program to include our school-aged family members. This program provides military families, including National Guard and Reserve families, web-based, phone-based and in-person screening for common mental health conditions and customized referrals to appropriate local treatment resources. The program includes screening tools for parents to assess depression and risk for self-injurious behavior in their children. The MHSAP also includes a suicide-prevention program that is available in DoD schools. Spanish versions of these screening tools are also available. This voluntary and anonymous program is designed to provide increased awareness education in the area of mental health conditions and concerns. It supplements the more formal assessment programs and extends the educational process to families. Our robust outreach program increased awareness for military and family members around the globe. More than 2,000 participants a month use the Web-based education and more than 160,000 participants each year use the in-person educational events. With this program, our goal is to reduce the stigma of suffering from mental health conditions and foster an environment that encourages self-referral and/or colleagues and battle buddies looking out for one another.

- The Signs of Suicide Program, an evidence-based prevention and mental health education program in our DoD Educational Activity (DoDEA) schools, will expand to public middle and high schools in areas with high concentrations of deployed forces.

- For our younger children, the producers of the proven-successful Sesame Street Workshop will expand the program to address the impact of having a deployed parent come home with an injury or illness. This program will be added to the original Workshop educational program and distributed widely across the Department. It is scheduled for completion and kickoff in April 2008 to coincide with the Month of the Military Child.

For our Service members we have taken a number of steps to prevent and identify early psychological issues.

- We will incorporate baseline neurocognitive assessments into our lifecycle health assessment procedures – from entering the service through retirement. As we progress in that objective, we will continue to provide pre-deployment baseline assessments.

- We added questions to both the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA) to facilitate TBI screening. We also support initial identification teams at high-density deployment locations to ensure consistent screening and to further evaluate and treat those who screen positive. We are even discussing where a Service member completes the PDHA – perhaps on the plane ride home to give the person a chance to think about the answers.

- When people come in for sick call, we should ask these questions up front: 1. Have your leaders told you it takes strength to ask for help? 2. Is anyone in your unit struggling? If so, have you urged them to seek help from a medical person or chaplain? If no, why not? 3. Do you have any suggestions for how we can do better?

- Screening and surveillance will promote the use of consistent and effective assessment practices along with accelerated development of electronic tracking, monitoring and management of psychological health and TBI conditions and concerns. We will incorporate screening and surveillance into the lifecycle of all Service members.

- We must remember that our health care and community support care givers may develop compassion fatigue. To help with that, the DCoE will develop a new curriculum of training or validate existing training to alleviate and mitigate compassion fatigue.

DoD-VA Transition. We must effectively establish a patient- and family-centered system that manages care and ensures a coordinated transition among phases of care and between health care systems. Transition and coordination of care programs help wounded warriors and their families make the transition between clinical and other support resources in a single location, as well as across different medical systems, across geographic locations and across functional support systems, which often can include non-medical systems.

In terms of transition, we seek better methods to ensure provider-to-provider referrals when patients move from one location to another or one health care system to another, such as between DoD and VA or the TRICARE network. This is most relevant for our Reserve Component members.

Care coordination is essential for TBI patients who may have multiple health concerns, multiple health providers and various other support providers. Frequently, they are unsure of where to turn for help. Proactively, the DCoE Clearinghouse, Library and Outreach staff will offer accurate and timely information on benefits and resources available. Meanwhile, the Army and Marines have established enhanced care coordination functions for their Warriors.

Newly hired care managers will support and improve transition activities. The Marine Corps created a comprehensive call center within its Wounded Warrior Regiment to follow up on Marines diagnosed with TBI and psychological health conditions to ensure they successfully maneuver the health care system until their full recovery or transition to the VA. The Navy is hiring psychological health coordinators to work with their returning reservists and the National Guard is hiring directors of psychological health for each state headquarters to help coordinate the care of guardsmen who have TBI or psychological health injuries or illnesses related to their mobilization. The other Reserve Components are looking closely at these programs to obtain lessons learned as they set up their own programs.

Information sharing is a critical part of care coordination. DoD and VA Information Management offices are working to ensure that information can be passed smoothly and quickly to facilitate effective transition and coordination of care.

Research. Research and development provide a foundation upon which other programs are built. Our intent is to rely on evidence-based programs, and we will develop a systematic program of research that will identify and remedy the gaps in psychological health and TBI knowledge. To that end, we have established integrated individual and multi-agency research efforts that will lead to improved prevention, detection, diagnosis, and treatment of deployment-related psychological health issues and TBI.

We will fund scientifically meritorious research to prevent, mitigate and treat the effects of traumatic stress and TBI on function, wellness and overall quality of life for Service members and their caregivers and families. Our program strives to establish, fund and integrate both individual and multi-agency research efforts that will lead to improved prevention, detection, diagnosis and treatment of deployment-related psychological health and TBI.

We are looking closely at recent advances in stem cell biology that may over the next 5–10 years permit a person's skin cells to function as stem cells capable of regenerating previously non-regenerating tissues, such as brain cells, spinal cord or retina. We are discussing creating a center dedicated to this research at the Uniformed Services University of the Health Sciences.

Suicides. Let me now offer you an update on our suicide rates and risk factors.

The DoD's confirmed and suspected suicide rates increased in 2006 and 2007. While the aggregate suicide rate for DoD was within expected statistical variation, the Army rate increased in 2006 and 2007. Risk factors for suicide remain unchanged:

- failing relationships;
- legal/occupational/financial problems; and
- alcohol abuse.

Early intervention and prevention programs include pre-deployment education and training, suicide prevention training, Military OneSource, the MHSAP, 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 partnership with the VA and other federal agencies, as well as professional advocacy groups.

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, among many other community programs.

Service Programs, Goals and Outcomes

Army. The following is a list with brief descriptions of the mental health programs in place in the Army:

- **Family Advocacy Program (FAP).** The purpose of this program is to effectively evaluate and treat child and spouse maltreatment. The Army implemented a new decision-tree algorithm to standardize the case-review-committee process.

- **Army Substance Abuse Program (ASAP).** This program provides policy, consultation, planning and funding management for all ASAP clinical and clinical-related functions (outpatient and inpatient treatment, education, training, staffing, certification and biosurety). The Army gave a predecision briefing to the G-1 to develop a plan for providing limited substance abuse services in theater.

- **Combat and Operational Stress Control Program (COSC).** The Army implemented its COSC program in accordance with DoD guidance, the Army transformation, and changing missions and military operations. The Army will continue the broad front development of its COSC policy doctrine, training, leader development, organization, materiel and employment as a component of Army Behavioral Health.

- **Marriage and Family Therapist Contract.** The Army expanded its licensed marriage and family therapists to CONUS installations identified as not having civilian providers in adequate numbers within a 50-mile radius of the installation. The Army expanded the contract to include 32 marriage and family therapists. Currently, there are 11 marriage and family therapists OCONUS and 24 marriage and family therapists CONUS.

- **Respect.Mil.** The Army designed this new program to decrease stigma and improve access to care by providing behavioral health care in primary care settings. The pilot test at Fort Bragg was successful, and the Respect.mil program is being implemented this year in fifteen other Army locations.

- **Battlemind.** The Army has numerous Battlemind products in the process of development and/or they have been implemented. The Army designed these training products to enhance recovery and resiliency. The Post-Deployment and Spouses Battlemind are available at www.battlemind.org. The Army also has new trainings and videos in development. The Army has invested $3.2 million to cover the cost of this product, including personnel and training aids and web-based products.

- **Warriors In Transition Unit (WTU) Social Worker.** The Army embedded social workers in all WTUs that provide, suicide screening, individual therapy,

group therapy, family therapy and referrals when warranted. The current ratio for social workers is 1:50 at both Brooke Army Medical Center and Walter Reed Army Medical Center; at all other military treatment facilities the ratio is 1:100.

Navy Medicine. Navy Medicine is developing, implementing, and collaborating with other Navy and Marine Corps agencies to provide a comprehensive integrated continuum of initiatives to address the psychological health and TBI for Service members and their families. Specifically:

- Navy Medicine has established 17 Deployment Health Centers (DHCs) to serve as non-stigmatizing portals of care for Post Deployment Health Re-Assessment (PDHRA) screening, treatment, referral and education.

- Navy Medicine has developed education and training for non-mental health providers for PTSD and TBI in the COSC. This program provides standardized PTSD and TBI information to Navy and Marine Corps Chaplains, primary care physicians, Navy corpsmen and fleet and family support center (FFSC) providers.

- Navy Medicine's Deployment Health and COSC program designed and distributed laminated pocket guides and brochures that describe signs and symptoms of PTSD and TBI for deployed sailors, Marines and family members. These brochures provide multiple resources for individuals to contact if they seek more information. In addition to brochures and guides, the Navy posts fact sheets on PTSD and TBI on multiple Navy/Marine Corps web sites and on private military servicing web sites, such as Military OneSource.

- Navy Medicine is implementing a comprehensive COSC primary prevention program for Service members and families in collaboration with Headquarters Marine Corps COSC and Navy Special Operations Command (SOC) Navy SEALS. Comprehensive programs will include education, intervention, and strategic structuring of mental health assets.

- Navy Medicine is executing more than $47 million in FY2007 GWOT supplemental appropriations for contract personnel in order to provide psychological health and TBI services. Additionally, the Navy has leveraged existing uniformed mental health assets, such as licensed clinical social workers and psychiatric nurse practitioners, to meet increasing in-theater support needs, such as the Expeditionary Combat Readiness Center's newly implemented Warrior Transition Program.

- The National Naval Medical Center (NNMC) has established the Traumatic Stress and Brain Injury Program (TSBIP), a dual-diagnosis program that services patients with traumatic stress, brain injury and both traumatic stress and brain injury. The TBSIP has served more than 1,082 blast-exposed Service members and provides PTSD/TBI education and training to family members. The TSBIP has expanded to Naval Hospital Camp Pendleton, Naval Hospital Camp Lejeune, and Naval Medical Center San Diego.

- In September 2007, the DVBIC sponsored the first major tri-service TBI educational conference at the University of Maryland, College Park, Maryland. The Navy will expand effectiveness-monitoring measures to encompass outreach and educational initiatives based upon professional consensus on standardized signs and symptoms of PTSD and TBI.

- The navy requires all new proposals submitted for addressing psychological health and TBI to have specific outcomes performance measurements that are tracked monthly in order to assess effectiveness of pilot programs and training initiatives.

- Additional Navy mental health assets include the following: outpatient mental health services for family members (adults and children) available in the private sector through TRICARE; professional and anonymous counseling services for active duty and family members in the civilian community available through Military One Source; and confidential counseling services for military and family members available through the Chaplain Corps.

Regarding treatment of PTSD and TBI, the Navy offers programs for long-term follow-up.

- In addition to the long-term aspects of programs/initiatives described above, Navy Medicine has funded a CNA initiative to develop a neurocognitive assessment tool to screen U.S. Marine Corps recruits at baseline and post-deployment.

- NNMC's TSBIP is partnering with the NNMC DHC to identify Service members who are at risk, have psychological health needs, or have incurred a blast exposure.

- Efforts to ensure the ongoing mental health needs of returning Service members include programs such as virtual reality treatment for PTSD at Naval Medical Center San Diego.

- Navy Medicine completed Phases I and II of the Navy Medicine Behavioral Health Needs Assessment (BHNAS) for personnel in-theater. This assessment will provide data to assist Navy Medicine in determining the appropriate use of limited mental health resources.

- CNA is currently launching a Navy-wide COSC Program Development Survey to study ongoing needs of sailors, Marines, and family members. In addition, the study will identify factors that contribute to promotion of resilience in families and Navy communities.

- The Center for Deployment Psychology (CDP) at the Uniformed Services University of the Health Sciences (USUHS) provides training for Navy mental health providers and non-mental health providers in deployment-related psychological health issues. Courses are currently available to both uniformed and civilian providers, providing training in the spectrum of treatment modalities

identified in the VA/DoD CPGs for the treatment of PTSD, with a primary emphasis on exposure therapy.

Air Force. The Services all have effective suicide-prevention programs. The Air Force Suicide Prevention Program (AFSPP) has reduced active duty air force suicides by 28% since 1996.

- The average annual rate dropped from 13.8 per 100,000 (in FY1987–FY1996) to 9.9 per 100,000 (in FY1997–FY2007).
- Air Force prevention focused on early identification/effective intervention with Airmen at risk.
- The AFSPP is one of 12 evidence-based suicide prevention programs on the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of evidence-based programs and practices.
- Air Force subject matter experts have spoken at the National Institute of Mental Health, SAMHSA, American Psychiatric Association, American Association of Suicidology, DoD Suicide Prevention Conference, Suicide Prevention Action Network, and Academy of Organizational and Occupational Psychiatry. The Air Force plays a crucial leadership role in suicide prevention in United States and across the world.

The Air Force also offers a half-day workshop for supervisors called Frontline Supervisors Training (FST). FST is an Air Force-led, DoD-wide collaborative initiative, with the motto "Good Leadership is Good Prevention." The initiative provides in-depth training on assisting personnel in distress, as well as suicide prevention. Users say the program effectively meets needs of supervisors in an affordable manner (saves time and money) and it emphasizes supervisory skills as much as helping skills. Course materials (curriculum and manual) are available on-line at http://afspp.afms.mil.

The FST curriculum covers the PRESS model of assisting Airmen in distress, which includes the following:

- Prepare: Connect with your people;
- Recognize: Identify personnel in distress;
- Engage: Intervene with distressed Airmen;
- Send: Refer personnel to appropriate helping agency; and
- Sustain: Follow-up regularly until problem resolved

Course materials (curriculum and manual) available on-line at http://afspp.afms.mil

The Air Force PTSD provider training ensures 100% of Air Force mental health providers are trained on evidence-based PTSD treatment. This year, the Air Force plans to hold seven prolonged exposure and three cognitive processing trainings and projects to train 300–400 providers.

The Air Force COSC programs provide the full spectrum of care to strengthen the military war fighter during deployment through prevention and intervention. In addition deployed mental health providers perform prevention/outreach services, outpatient behavioral health services, combat stress support services with 24-hour combat stress facility, as needed.

The Air Force convened a Traumatic Stress IPT to address screening, prevention and treatment of traumatic stress in deployers and identify profiles of risk/vulnerability. The Air Force also developed the "Landing Gear," standardized deployment re-deployment education program, which uses comprehensive risk-factor analysis to develop exposure-based profiles of deployer vulnerability to traumatic stress reactions.

The Air Force Family Advocacy Program (FAP) offers a comprehensive range of services to strengthen warfighters and families pre, during and post deployment through prevention interventions targeting domestic abuse and neglect. Programs include child development education; interactive playgroups; parenting education; communication skills training for couples; family violence prevention training for leaders; and Family Advocacy Strengths-Based Therapy (FAST) which offers professional intervention to families in crisis or at-risk.

TRICARE Program

We have worked diligently to ensure our TRICARE beneficiaries have timely access to mental health care in the private sector. Our efforts include the following:

- ensuring an adequate number of providers are available;
- assisting beneficiaries in making appointments;
- permitting beneficiaries to self-refer for eight mental health care visits each year and to obtain additional visits upon request from the attending provider;
- undertaking an expansion of the TRICARE permissible settings for obtaining substance use disability rehabilitation treatment; and
- designing an intensive outpatient program for addition to the TRICARE benefit upon completion of the required Code of Federal Regulations rule-making process.

Since May of 2007 we have added nearly 2,800 mental health providers to the TRICARE network, and each of our three TRICARE Regional Offices and its associated managed care support contractor have active projects to encourage providers outside the

network to see TRICARE Standard patients. In addition, we are proceeding through the rule-making process to adjust our partial hospitalization program certification requirements to bring them in line with Joint Commission accreditation standards. This will increase access to partial hospitalization programs for our beneficiaries by removing a barrier that has kept many of these programs from becoming authorized TRICARE providers.

This past December we modified the three managed care support contracts to provide active duty service personnel and their family members a telephone-based mental health appointment assistance service. Included in the service is an option for a beneficiary to request the contractor to establish a three-way call with a provider willing to give appointments to TRICARE beneficiaries. In the first two months of its operation, the service assisted more that 1,500 callers in obtaining appointments. We expect use of the service to increase in conjunction with our campaign to market it to beneficiaries.

At the direction of Congress, we executed new health benefits which extend TRICARE coverage to members of the National Guard and Reserve. We implemented an expanded TRICARE Reserve Select (TRS) health plan for Reserve Component personnel and their families, as mandated by the NDAA for fiscal year (FY) 2007. Today, more than 61,000 reservists and their families are paying premiums to receive TRS coverage. In addition, we made permanent their early access to TRICARE upon receipt of call-up orders and their continued access to TRICARE for six months following active duty service for both individuals and their families. Our FY 2009 budget request includes $407 million to cover the costs of this expanded benefit.

Health Assessments. We are also ensuring our Service members are medically evaluated before deployments (through the Periodic Health Assessment), upon return (through the Post-Deployment Health Assessment) and then again 90–180 days after deployment (through the Post-Deployment Health Reassessment). These health assessments provide a comprehensive picture of the fitness of our forces and highlight areas where we need to intervene. For example, we have learned that Service members do not always recognize or voice health concerns at the time they return from deployment.

For the period of June 1, 2005, to January 8, 2008, 495,526 Service members have completed a post-deployment health reassessment, with 147,638 (29.8%) of these individuals receiving at least one referral for additional evaluation. By reaching out to Service members three to six months post-deployment, we have found that the most prevalent concerns are physical concerns, e.g., back or joint pain and mental-health concerns. This additional evaluation gives medical staff an opportunity to provide education, reassurance, or additional clinical evaluation and treatment, as appropriate. Fortunately, as these clinical interactions occur, we have learned that only a fraction of those with concerns have diagnosed clinical conditions.

We published the new forms with the TBI screening questions and other improvements on September 11, 2007. Since then, the Services have worked hard to modify their respective electronic data collection systems. They finished this work in late

December. In addition, the Armed Forces Health Surveillance Center-Provisional (AFHSC-P), which is the repository for the electronic forms, has successfully tested data feeds from the Army, Air Force, and Navy systems. No problems were identified.

The Services will start using the new forms for health assessments, and dates will vary with each Service. To ensure a smooth and timely start, we issued a policy memorandum to establish a 60-day implementation phase during which AFHSC-P will accept both the old and new versions of the forms. We have encouraged the Services to start using the new versions of the forms immediately rather than waiting for the formal announcement. The Army plans to start selected pilot tests of the new forms between now and April 1, 2008. The Navy, Air Force, and Coast Guard all expect to start using the forms in March 2008.

The Department is working on a number of additional measures to evaluate and treat Service members affected or possibly affected by TBI. In August 2006, we developed a clinical-practice guideline for the Services for the management of mild TBI in-theater. We sent detailed guidance to Army and Marine Corps line medical personnel in the field to advise them on ways to look for signs and to treat TBI.

The "Clinical Guidance for Mild Traumatic Brain Injury (mTBI) in Non-Deployed Medical Activities," October 2007, included a standard Military Acute Concussion Evaluation (MACE) form for field personnel to assess and document TBI for the medical record. The tool guides the evaluator through a short series of standardized questions to obtain history, orientation (day, date, and time), immediate memory (repeat a list of words), neurological screening (altered level of consciousness, pupil asymmetry), concentration (repeat a list of numbers backwards), and delayed recall (repeat the list of words asked early in the evaluation). The evaluator calculates and documents a score, which guides the need for additional evaluation and follow-up. The MACE also may be repeated (different versions are available to preclude "learning the test"), and scores may be recorded to track changes in cognitive functioning.

U.S. Central Command (USCENTCOM) has mandated the use of clinical guidelines, which include use of the MACE screening tool, at all levels of care in theater, after a Service member has a possible TBI-inducing event. Furthermore, Landstuhl Regional Medical Center is using MACE to screen all patients evacuated from the USCENTCOM area of responsibility with polytrauma injuries for co-morbid TBI. In addition, MACE is used in MTFs throughout the MHS.

Communications. TRICARE launched a new website in 2007 with a new approach to delivering information to its beneficiaries that is based on extensive user research and analysis. The redesigned My Benefit portal at www.tricare.mil offers comprehensive information with a more user-friendly layout and an updated look, while providing up-to-date TRICARE benefit information in seconds. The My Benefit portal's simplified navigation system makes using the site easier than ever before. A key feature of the redesign is that users now receive personalized information about their health care benefits by answering a few simple questions about their location, beneficiary status and current TRICARE plan.

Recently, my staff launched a new website, www.health.mil. Its purpose is to inspire innovation, creativity and information sharing across the Military Health System in a way that complements the chain of command. Our website is transparent in that every feature includes a comment box. I invite everyone to use the website as a tool to break down barriers and share information between military medical personnel and other government agencies and organizations outside the government.

The site provides a way to create a partnership for health that brings Service members and their families, the military leaders and the medical providers-planners together with the objective of patient-focused health care. Visitors to the site can post comments, take surveys, watch web cams, subscribe to podcasts, and read unfiltered opinion from MHS leaders on our blog.

Conclusion

Madam Chairwoman, distinguished members, thank you for caring and for understanding the needs of our Warriors and their families. Thank you also for providing the resources and support to design and implement programs to meet these needs. I look forward to working with you as we continue to build the Center of Excellence and implement the MHTF recommendations for psychological health and TBI. I am honored to serve with you in support of our Warriors and their families.

- END -

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FINAL VERSION

STATEMENT BY

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COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

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COMMITTEE ON ARMED SERVICES

Chairwoman Davis, Congressman McHugh and distinguished members of the military personnel subcommittee: thank you for the opportunity to discuss the Army's efforts in improving the mental healthcare for our Soldiers and their Family members. We are committed to getting this right and providing a level of care and support to our Warriors and Families that is equal to the quality of their service. Secretary Geren, General Casey, General Cody, and the rest of the Army leadership actively support our efforts to improve the access to and quality of mental healthcare services. They are also aggressively engaged in changing the culture and eliminating the stigma associated with seeking mental healthcare that not only our Army, but our Nation, experiences.

We all recognize that the increased operational demand of our military force to fight the global war on terror has stressed our Army and our Families. The DoD and the Army have made a concerted effort to proactively research the effects of this conflict through the DOD's Mental Health Task Force as well as the Mental Health Advisory Team's annual assessments. We know from this research that repeated and extended deployments have led to increased distress, family difficulties, and other psychological effects of war, such as symptoms of post-traumatic stress as well as post-traumatic stress disorder (PTSD). The Army is absolutely committed to ensuring all Soldiers and their Families are healthy, both physically and psychologically. We have made a concerted effort to mitigate risks and enhance mental healthcare services through various programs and initiatives which directly align with the DoD's Mental Health Task Force Report's 4 major recommendations: 1) Build a culture of support for psychological health; 2) Ensure a full continuum of excellent care for service members and their families; 3) Provide sufficient resources and allocate them according to requirements; 4) Empower leadership.

Enhancing, protecting, and improving the mental health for our Soldiers and Families starts from the time a Soldier enters the Army, through various stages of their service, which includes getting ready for deployment, being deployed, and returning from deployment (often referred to as the Army Force Generation or ARFORGEN cycle) as well as departure from service.

From the moment they start Basic Combat Training and at every successive assignment, Soldiers and their Families have access to a wide range of support services – the Installation's Army Community Service program, the Chaplain's network, Leadership and Family Readiness Groups, and of course healthcare at either the military facilities on post or the extensive TRICARE network of providers in the civilian community.

During a Soldier's service it is very likely that he or she can be called to deploy to a remote location of the world away from their Families for various and sometimes extensive lengths of time. The Army has wisely recognized that building Soldier and Family resiliency is key to maintaining their health and welfare. We developed "Battlemind" training products to increase this resiliency and we have several different training programs available for pre, during and post-deployment. These programs are designed for Soldiers and their Families, including children as young as pre-school age, and they are distributed throughout the force. These programs are also available online at www.behavioralhealth.army.mil.

In a powerful effort to both raise awareness and reduce the stigma associated with seeking mental healthcare, the Secretary of the Army and Chief of Staff of the Army initiated a leader chain teaching program to educate all Soldiers and leaders about post-traumatic stress and signs and symptoms of concussive brain injury. This was intended to help us all recognize symptoms and encourage seeking treatment for these conditions. All Soldiers were mandated to receive this training between July and October 2007, during which time we trained over 800,000 Soldiers. We are now institutionalizing this training within our Army education and training systems to continue to share the information with our new Soldiers and Leaders and to continue to emphasize that these signs and symptoms are normal reactions to a stressful situation. I encourage Soldiers to seek assistance to cope with these issues.

During deployments, the Army found tremendous value in providing mental health treatment far forward in the operational areas. Our primary method of providing both preventive and required mental health treatment was through Combat Stress Control Teams. From the beginning of combat operations, there has been a robust Combat Stress Control presence in theater, with approximately 200 deployed behavioral

health providers to Iraq alone. These combat stress control assets are heavily used to monitor and mitigate the effects of multiple and extended deployments. This is now a joint effort, with the Air Force assisting us in Iraq and Afghanistan and the Navy in Kuwait. The Army has also done unprecedented work in surveillance of Soldiers, both in the combat theater and back home. The Mental Health Advisory Teams (MHATs) have gone to theater every fall since 2003 and surveyed Soldiers, care providers, chaplains and others. Their findings on epidemiology of symptoms, access to care, and stigma, have led to direct and immediate improvements in the way that we deliver care. I have included information specific to MHAT V as an appendix to this statement.

Upon redeployment, we continue to gather information about physical and psychological health symptoms on the Post-Deployment Health Assessment. Through our use of scientific studies to drive evidence-based practices, such as the work of the Mental Health Advisory Teams, we developed the Post Deployment Health Re-Assessment to screen Soldiers again during a later stage of the reintegration and post-redeployment period. Typically we find the signs and symptoms of post-traumatic stress are not fully apparent until after a 60 – 90 day readjustment period. In addition to these two event driven assessments, we have also implemented an annual screening tool, the Periodic Health Assessment, to further supplement our information.

As expected, through our efforts to reduce stigma, raise awareness, and assess the health of our Soldiers, the need for behavioral healthcare is increasing. We do have gaps at some locations in meeting behavioral healthcare demand, but we are diligently working on solutions. The Army developed a program titled the Army Family Covenant, which formally commits us to improving access to high quality behavioral health for Soldiers and Families. Through Congressional Supplemental Funding targeted at caring for psychological health, we have been able to focus resources on hiring behavioral health providers. So far, we have been able to hire and put in place 147 providers in a very competitive hiring environment. We are striving to hire almost 200 more behavioral health providers. We are also pursuing the hire of an additional 40 substance abuse counselors and over 50 marriage and family therapists and have added about 90 social workers to our Warrior Transition Units. My medical treatment facility commanders tell me that these hires are making a difference. We also have

numerous long-term efforts to enhance recruitment and retention of uniformed behavioral health providers.

We are also trying to address behavioral health care through increased education and training of our primary care providers. This committee is familiar with RESPECT-MIL, a program designed to decrease stigma and improve access to care by providing behavioral healthcare in primary care settings. Because of the success of this program, we have initiated further efforts to train primary care providers and integrate behavioral health with primary care. The combination of ongoing education and improved access to care through numerous portals should again help encourage Soldiers to seek care early.

As part of the Army Medical Action Plan (AMAP), we've developed a program for our Warriors in Transition called the Comprehensive Care Plan which is implemented across our 35 Warrior Transition Units (WTU). The continuum of care that a Soldier receives while in the WTU culminates in a care plan which integrates the more conventional medical and surgical interventions we administer to our wounded, ill and injured Warriors with efforts to optimize the Soldiers' return to uniformed service or transition into successful life as a veteran. These insights were derived from our experiences over the last year and have now been institutionalized under the direction of my Assistant Surgeon General for Warrior Care and Transition, Brigadier General Mike Tucker. Soldiers in the WTUs are expected to be physically, mentally, socially, and spiritually strengthened. This program sets the conditions for a successful transition to the Department of Veterans Affairs or society.

As the Army Surgeon General, I am aware of the toll that increased demand has placed on my health care team. The Army's uniformed behavioral health providers are among the most highly deployed of any of our specialties. We use numerous recruitment and retention initiatives to encourage them to join and stay in the Army, including increased bonuses for psychologists and increased educational opportunities for social workers. As part of our detailed force management review being led by Major General Gale Pollock, we are assessing our manpower requirements and will recommend changes to the force structure as needed. We also developed Provider Resiliency Training to mitigate burn-out not only for our medical providers, but also for

Army Chaplains and other specialists who are in the business of serving our Soldiers and Families.

Although we have had many successes, I have some areas of concern. These include the increasing suicide rate, accidental deaths due to overdose, and public perceptions that Soldiers are being inappropriately discharged from the Army for personality disorder when they may have underlying medical conditions.

Unfortunately, active Army suicide rates have increased over the last seven years. Although the Active Army suicide rate is comparable to the demographically-adjusted civilian population rate, it is at an all-time Army high and we are taking action to address it. Over the last two years, there has been a concerted effort to improve suicide prevention. The Army G-1 is leading this effort with support from the medical and chaplain communities. The Army Medical Department's Army Suicide Event Report continues to offer surveillance and perform analysis. Recent analyses of suicides have resulted in concrete recommendations, which are currently being implemented, both in theater and on our installations.

We have also chartered a General Officer Steering Committee to address suicide prevention. We will develop an action plan focused on five areas of emphasis: 1) develop life-coping skills; 2) maintain constant vigilance; 3) encourage help-seeking behaviors and reduce stigma; 4) maintain constant surveillance of behavioral health data, and 5) integrate and synchronize unit and community programs. We must develop actionable intelligence that provides our leaders an analysis of each suicide or attempted suicide that includes lessons learned, trend data, and potential factors to monitor. The intent is to modify leader behavior towards Soldiers who are impacted by stressors and are at risk of harming themselves.

On the issue of accidental overdoses, I recently chartered a multi-disciplinary team of 17 dedicated professionals (psychologists, psychiatrists, physicians, nurses, unit commanders, First Sergeants and Sergeants Major) to analyze and develop risk mitigation strategies to reduce the number of accidental deaths and accidental drug overdoses within our WTUs. This team recommended 71 strategies that focus on improving identification, training, and monitoring systems. We have already adopted 26 of those recommendations. The Army will improve its capability to identify high-risk

soldiers. We will also improve the training of our clinical staff, leaders and Soldiers on risk reduction measures. We have changed policies and procedures to facilitate these risk-reduction measures and we will improve our capability to monitor and track accidental deaths and accidental drug overdoses.

Finally, there has been a perception that Soldiers are being inappropriately discharged for personality disorder. All Soldiers discharged for personality disorder are required to receive a mental status evaluation as per Army Regulation 635-200. MEDCOM implemented a new policy in August 2007 that requires the installation's behavioral health chief to review all personality disorder discharge recommendations. We will also require Soldiers being discharged for misconduct to receive mandatory screenings for PTSD and mild TBI. This change in policy will mitigate the risk of discharging Soldiers with health conditions that were acquired while serving their country.

I greatly appreciate the privilege to command the United States Army Medical Command and the opportunity to report on the progress we have been making on providing quality mental healthcare to our Soldiers and Families. We appreciate your support as you interact with servicemen and women and their families in your districts in communicating our strategic successes in this area. We also appreciate your help in influencing the mental healthcare providers in your areas to accept TRICARE patients which will expand our behavioral healthcare capacity.

In closing, I'd like to share with you a quote from the DoD Mental Health Task Force Report: "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." Thank you for holding this hearing and giving us the opportunity to share our accomplishments and to reaffirm our unyielding commitment to provide the best care to all our Soldiers and their Families.

APPENDIX

INFORMATION PAPER

SUBJECT Army's Fifth Mental Health Advisory Team (MHAT) Assessment

On March 6, 2008 the Department of the Army announced the results of the Army's fifth Mental Health Advisory Team (MHAT) report: MHAT V. This assessment examined the morale and mental health of Soldiers deployed to Iraq and Afghanistan in the fall of 2007. MHAT V continued the precedent of deploying advisory teams to Iraq and Afghanistan to assess behavioral healthcare requirements of Soldiers.

MHAT assessments are established by the Army Surgeon General, and have deployed to Iraq every year since 2003 at the request of the Commanding General, Multi-National Force-Iraq. The Army uses the results of these studies to shape programs, policies and procedures and to allocate resources to better meet the Mental Health needs of our Soldiers. Since the first MHAT, the Army has conducted chain teaching, implemented Battlemind training, expanded training for health care providers, redistributed mental health assets in theater, and hired additional mental health providers.

In 2007, MHAT V also deployed to Afghanistan at the request of the Service Chief, Army Central Command (ARCENT). Army leaders in Iraq, Afghanistan and at home began implementing MHAT recommendations upon completion of the assessment.

In Iraq, the MHAT collected 2,279 anonymous surveys from Soldiers, and 350 anonymous surveys from behavioral health, primary care and unit ministry team members. In Afghanistan, 889 Soldiers completed the anonymous Soldier survey, and 87 anonymous surveys were completed by behavioral health, primary care and unit ministry team members.

Soldiers in Iraq reported an increase in unit morale in 2007 relative to 2006. The percent of Soldiers screening positive for mental health problems was similar to previous years, although the report found that Soldiers on their third or fourth deployment reported higher mental health and work-related problems than Soldiers on their first or second deployment. Soldiers who received pre-deployment Battlemind training reported fewer mental health problems. The Army-wide implementation of Battlemind training was an MHAT IV recommendation made in 2006 (http://www.battlemind.org).

Overall, Soldiers in Afghanistan reported rates of mental health problems similar to rates observed among Soldiers in Iraq. The one exception was that reports of depression were higher in Afghanistan in 2007 than in Iraq during the same timeframe. Rates of mental health problems in Afghanistan in 2007 were higher than rates of mental health problems reported in the last Afghanistan assessment in 2005.

In Iraq, an increase in the number of months deployed was directly related to a variety of outcomes. Reports of work-related problems and plans for Soldiers to pursue divorces or separations increased with each subsequent month deployed. Reports of mental health problems increased over time, but showed an improvement in the months immediately before returning home; this is most likely due to redeployment optimism.

In Iraq, overall levels of combat exposure in 2007 declined relative to 2006 although levels of combat exposure varied significantly among units. Soldiers in Afghanistan reported significant increases in combat exposure relative to the Afghanistan assessment in 2005. The sub-sample of 282 Soldiers in Brigade Combat Teams (BCTs) in Afghanistan reported levels of combat exposure similar to or higher than levels reported by BCT Soldiers in Iraq.

Soldiers deployed to Iraq in 2007 reported lower rates of stigma associated with accessing behavioral health care, but more difficulty accessing health care than in 2006. Access to care was impacted by the increase in smaller outposts in Iraq in 2007. Behavioral health personnel reported conducting more command consultations than in 2006 indicating that commanders are increasingly relying on behavioral health personnel for a variety of behavioral health support missions. Behavioral health personnel also indicated a need for more personnel.

In Afghanistan, Soldiers reported significant barriers to mental health care, and behavioral health personnel reported difficulties getting to Soldiers.

For the first time, MHAT personnel examined sleep patterns in theater. Sleep problems are a strong predictor of work-related performance and are associated with other mental health problems such as depression and post-traumatic stress. Soldiers in OIF reported an average of 5.6 hours of sleep, too few to maintain optimal performance; however, self reports of sleep are not always objective. Therefore, a need to look at sleep patterns more objectively was indicated.

MHAT IV and MHAT V showed that Soldiers who screen positive for mental health problems and anger are significantly more likely to report engaging in unethical behaviors. In OIF, reports of unethical behaviors were largely unchanged from 2006.

Annual suicide rates for Soldiers in both Iraq and Afghanistan were elevated relative to historic Army rates. The OIF MHAT found that self reports of suicidal thoughts peaked around mid-deployment then dropped off, and there was also some evidence suggesting that suicides increased after being deployed 6 months or more. As for frequency of deployments, the MHAT found no evidence to suggest that multiple deployments were associated with increased suicidal thoughts.

In Iraq and Afghanistan, the teams made a number of recommendations that Army leaders began reviewing or implementing as soon as the assessment was completed.

These include:

Non-Theater Specific

- Allow government civilian or contracted behavioral health personnel to fill select positions in theater to augment military personnel.
- Create and fill behavioral health officer and enlisted positions in aviation brigades as these personnel are not organic to the units.
- Ensure that all combat medics receive Battlemind Warrior Resiliency training before deploying in support of OEF or OIF so that they can augment behavioral health personnel.
- Move division psychiatrists from sustainment brigades to a division surgeon cell, and move brigade mental health officers from brigade support battalions to brigade surgeon cells. These moves will allow mental health officers to serve as special staff to Commanders on mental health issues.
- Update the Combat Operational Stress Course (COSC) to ensure it stays relevant to division and brigade combat team behavioral health assets.
- Increase number of Family-life providers to work with spouses and Family members.
- Enhance training for Non-Commissioned Officers on their role in maintaining Soldier resiliency through counseling & mentorship training.
- Develop and implement senior leader Battlemind training.

Theater Specific to Iraq

- Modifying the position of the theater mental health consultant and senior mental health Non-Commissioned Officer in Charge (NCOIC) to allow broader overview of the theater.
- Hold quarterly behavioral health conferences to enhance networking, communication, coordination and to increase personnel morale and well-being.
- Ensure use of COSC Workload and Activity Reporting System throughout the theater of operations.
- Develop suicide prevention action plan at the operational and tactical levels.
- Develop consistent policies for evaluation after a concussive event and standards for return to duty.

Theater-Specific to Afghanistan

- Appoint a Behavioral Health Consultant to the Command Surgeon who understands the mental health needs within theater, and can advise the Commander on optimal allocation of mental health resources.
- Redistribute behavioral health assets and conduct an aggressive outreach program.

**Not for Publication until released by
the House Armed Services Committee**

Statement of

Vice Admiral Adam M. Robinson, MC, USN

Surgeon General of the Navy

Before the

House Armed Services Committee

Subcommittee on Military Personnel

Subject:

Psychological Health Programs for Sailors and Marines

14 March 2008

**Not for Publication until released by
the House Armed Services Committee**

Chairwoman Davis, Representative McHugh, distinguished members of the committee, I appreciate the opportunity to share with you Navy Medicine's efforts in preventing, diagnosing, and treating psychological health issues affecting our active duty and Reserve Sailors and Marines, and their families.

As the provider of medical services for both the Navy and the Marine Corps, we have to be prepared to meet the needs of these similar, and yet unique military populations. Sailors and Marines often serve side-by-side, and they also serve under very different conditions – aboard ships, as boots on the ground, or as individual augmentees (IAs). As a result, these service members face different physical and mental stressors and challenges during deployments. At the same time, their families may be also impacted by the unique stresses and demands of military life in slightly different ways. Navy Medicine is continuously adapting to meet the short and long term psychological health needs of service members and their families before, during and after deployments.

We are well aware of the fact that the number and length of deployments have the potential to impact the mental health of service members, as well as the well-being of their families. The Navy and Marine Corps operational tempo in support of the Global War on Terror (GWOT) is unprecedented. At the same time, Navy Medicine is playing an increasing role in Humanitarian Assistance and Disaster Relief missions. We need to remain vigilant of the potential long term impact our mission requirements – past, present and future -- will have on the physical and mental health of our Sailors and Marines.

Continuum of Care

Navy Medicine ensures a continuum of psychological health care is available to service members throughout the deployment cycle -- pre-deployment, during deployment, and post-

deployment. We are also making more mental health services available to eligible family members who may be affected by the psychological consequences of combat and deployment.

To accomplish this continuum of care, Navy Medicine engages at several levels -- from Commanding Officers, to small unit leaders, to individual service members, and of course, with their families. Our goal is that necessary psychological health services will be available to all who need them -- when they need them.

Prevention and Stigma Reduction

The same way physical conditioning prepares Sailors and Marines for the rigors and challenges of high tempo operational deployments, we are working to psychologically prepare service members and their leaders to build resiliency, which will help Sailors and Marines manage the physical and psychological stresses of battle and deployments. Preventive education programs introduced at each career training point help educate service members on the importance of psychological health in an effort to decrease the stigma often associated with being given a mental health diagnosis and receiving psychiatric care.

Command involvement, together with dedicated stress management teams comprised of health care providers and other professionals, are critical in helping Sailors and Marines become comfortable with the concept of building resiliency and seeking mental health support and care when necessary. Our experiences in previous conflicts, most notably Vietnam, suggest that delays in seeking mental health services increase the risks of developing mental illness and may exacerbate physiological symptoms. These delays can have a negative effect on the health of the service member, jeopardize a service member's career and permanently alter their family situation. That is why we are attacking the stigma associated with getting help for mental health

and stress-related conditions in a variety of ways to ensure service members receive full and timely treatment – before deployment, in theater or after returning from deployment.

The reduction of stigma to seeking mental health services is a critical component in our efforts to decrease the number of suicides among Sailors and Marines. Although suicide rates in the Navy and Marine Corps have not significantly fluctuated in recent years, our efforts to improve leadership's understanding and acceptance of the importance of treating psychiatric conditions is as important as preparing service members to deal with the stresses of military life. Both the Navy and the Marine Corps have published Leaders Guides for Managing Marines/Sailors in Distress. These products are available in various formats and are part of a greater effort to ensure frontline supervisors, including junior leaders, are able to identify when others in their unit may need help.

The Marine Corps created the Marine Operational Stress Surveillance & Training Program (MOSST), which includes briefings, health assessments, and tools to deal with combat and operational stress. The MOSST program includes warrior preparation, warrior sustainment, warrior transition (which happens immediately before Marines return home), and warrior resetting. Warrior resetting, the final phase of the program includes medical screenings and briefings about the prevention of drug and alcohol abuse, anger management, and handling financial difficulties.

Before Deployment

Navy Medicine, in coordination with line leaders in the Navy and the Marine Corps, is building on current training programs for leaders and our own caregivers. The curriculum focuses on combat stress identification and developing coping skills. From the Navy's "A" Schools, to the Marine Corps Sergeant's course, and in officer indoctrination programs, we are

ensuring that dealing with combat stress becomes as comfortable as dealing with any other medical issue.

Before a unit deploys, there are several opportunities for Sailors, Marines and their families to become acquainted with the types of resources available to help them cope with the stresses of deployment. Pre-deployment briefs include information about everything from legal services, pay fluctuations, chaplain services, as well as family support assets available in the military community organizations, and the medical facilities at the base. Representatives from each of these organizations detail when and how to access these services. Pre-deployment training for Marines also increasingly includes skills for stress first aid – both self- and buddy-aid, recognizing that fellow Marines may identify the signs of stress injury first.

For the service member, the Pre Deployment Health Assessment is one way to become aware of potential psychological health needs and the healthcare services available. The symptoms of a mental health condition may not necessarily make an individual non-deployable, but this assessment helps emphasize the importance of psychological health as part of physical health and may decrease any delay in seeking treatment.

Because IAs do not deploy as part of a larger unit, providing them with information presents unique challenges for Navy Medicine. There is an increasing number of Sailors who are serving as IAs and the Navy Expeditionary Combat Readiness Center's (ECRC) IA Family Readiness Program has been a step in the right direction in reaching out to these service members and their families. These centers have proven to be a critical asset in assessing the health of returning IAs, as well as in coordinating their transition for additional care at the Department of Veterans Affairs (VA), or out into the community. Reserve Component and IAs

also receive debriefings, medical assessments, and information on access to care as they mobilize and de-mobilize through the Navy Mobilization Processing Sites.

During Deployment -- Aboard ships and In-Theater

In 1999, the Department of Defense directed the establishment of Combat Stress Operational Control programs within the services and the combatant commands to ensure appropriate management of combat and operational stress and to preserve mission effectiveness and war fighting capabilities.

Before 1999, the Marines relied upon Chaplains and a very small organic mental health footprint for prevention and early intervention of operational stress with more definitive care provided by the nearest Navy Medical Treatment Facilities. Hospital medical services were not always well coordinated with commands and during large-scale deployments medical battalions relied upon the use of mental health augmentees who had limited orientation and connections to the units they were called upon to support.

Since the late 1990s Navy Medicine has embedded mental health professionals with operational components of the Navy and the Marine Corps. Since 1998, clinical psychologists have been regularly embarked aboard all of our aircraft carriers and have become a valuable member of ship's company. Not only have mental health assets helped crews deal with the stresses associated with living in isolated and unique conditions, but medevacs and administrative discharges for conditions typically managed by mental health personnel (e.g., Personality Disorders), fell precipitously. Tight quarters, long work hours, and the fact that many of the staff may be away from home for the first time, present a situation where the stresses of "daily" Navy life aboard ship may prove detrimental to a Sailor's ability to cope. Having a mental health professional who is easily accessible and going through many of the

same challenges has increased operational and battle readiness aboard these floating platforms, saving lives as well as hundreds of thousands of dollars in operational costs.

For the Marines, Navy Medicine division psychiatrists stationed with Marines developed OSCAR Teams (Operational Stress Control and Readiness) which embed mental health professional teams as organic assets in operational units. OSCAR teams provide early intervention and prevention support through all of the phases of deployment. The same team providing care in garrison also deploys with the units, which improves cohesion and helps to minimize stigma. These teams provide education and consultation to commanders, entire units and individual Marines. Battlefield briefings address the topic of combat and operational stress and provide units and individual service members with the skills to recognize and cope with the unique stressors of combat. Types of stress-related injuries are discussed, as well as how these injuries may manifest physically and mentally. The briefings also provide an opportunity to prevent combat stress situations from deteriorating into disabling conditions. Since the beginning of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF), mental health related medical evacuations for Marines have been significantly lower among units supported by OSCAR and currently, there is strong support for making these programs permanent and ensuring they are resourced with the right staff and funding.

In urgent or extraordinary situations, Navy Medicine meets the psychological needs of Sailors, Marines and their communities by deploying Special Psychiatric Rapid Response Teams (SPRINT). These expeditionary teams, which have been in existence for over 15 years, provide short-term mental health and emotional support immediately after a disaster with the goal of preventing long-term psychiatric dysfunction or disability. The teams, which are organized much like OSCAR Teams, may provide educational and consultative services to local supporting

agencies for long-term problem resolution. They are staffed with psychiatrists, psychologists, chaplains and enlisted personnel. SPRINTs are located throughout CONUS and OCONUS and are ready to respond to both GWOT and HA/DR missions. SPRINTs have been deployed to East Africa after the bombings on U.S. Embassies; to Yemen following the attack on the USS Cole; and to the Southern U.S. after Hurricane Katrina in 2005.

After Deployment

Before returning from the operational theater, Sailors and Marines are typically provided a series of briefings that familiarize them with issues related to combat stress, as well as how to manage their expectations about returning home. The presentations focus on whatever experiences the Sailors and Marines have encountered while in theater and how these may affect their daily lives post deployment. In addition, since 2001, Navy Medicine has been providing Post Deployment Health Assessments to measure the health status of returning service members. This global screening must be completed within 30 days before or after redeployment. The criteria for a Post Deployment Health Assessment vary and depend on where an individual deployed and for how long. Current guidance states that a Post Deployment Health Assessment is required if the service member was involved in land based operations for 30 continuous days to overseas locations without a fixed Military Treatment Facility (MTF) or by Command decision based on health risk. Navy and Marine Corps Post Deployment Health Assessments are being accomplished in theatre, during Warrior Transition, and at Navy Mobilization Processing Sites. Warrior Transition, initiated during OIF and expanded each year, has now become an inherent part of a Sailor's redeployment process home. Recognizing that truly the hardest part of going to war is reconciling the experience—inclusive of one's losses—mental health professionals and chaplains located in Kuwait assist service members to reflect, recall and

reconcile the enormity of their deployment before returning home. Warrior Transition accomplishes this by providing three days of facilitated decompressing; This preparation being the psychological equivalent of the "long boat ride home". Warrior Transition is now mandatory for all Seabees, IAs, and soon SEALs.

Of the Post Deployment Health Assessments completed in the Navy, there is an overall referral rate for additional health care services of 10 percent, with a 2 percent referral rate for mental health issues. The rate is currently the same for Active or Reserve Component (AC/RC) Sailors. For the Marines, the overall referral rate following the assessment is 16 percent, with a mental health referral rate of 3 percent. This rate is also the same among Active and Reserve Component Marines.

Since 2005, Navy Medicine has been administering the Post Deployment Health Reassessment (PDHRA) as directed by the Office of the Assistant Secretary of Defense for Health Affairs (ASD(HA)). Implementing this program was a joint effort between the Navy's Bureau of Medicine and Surgery (BUMED), the Bureau of Naval Personnel (BUPERS), Headquarters Marine Corps (Health Services), and the Deputy Commandant of the Marine Corps for Manpower and Reserve Affairs (USMC (M&RA)). The PDHRA extends the continuum of care, targeting service members for screening at three to six months post-deployment.

Currently, BUMED provides PDHRA program management and oversight and management of GWOT funds. In addition, in consultation with ASD(HA), BUMED develops directives, procedures and protocols for supporting program implementation. Navy Medicine also serves as the liaison with the Navy and Marine Corps Public Health Center to provide technology and training for the electronic completion, storing and reporting of PDHRA data.

Navy Medicine played a critical role from the program's inception to sustainment and coordinated implementation in line units.

Beginning in 2006, Navy Medicine established Deployment Health Centers (DHCs) to serve as non-stigmatizing portals of entry in high fleet and Marine Corps concentration areas and to augment primary care services offered at the MTFs or in garrison. Staffed by primary care providers and mental health teams, the centers are designed to provide care for Marines and Sailors who self-identify mental health concerns on the Post Deployment Health Assessment and Reassessment. The centers provide treatment for other service members as well. We now have 17 such clinics, up from 14 since last year. From 2006 through January 2008, DHCs had over 46,400 visits, 28 percent of which were for mental health issues.

The Navy and Marine Corps are working to improve their PDHRA completion rates. To date, for Sailors who have completed their PDHRAs, the follow-on medical care referral rate is 26 percent (AC 21 percent, RC 34 percent). Of the 26 percent of referrals, six percent are for mental health issues. For the Marines, of the PDHRAs completed, the overall Marine Corps referral rate is 28 percent (AC 24 percent, RC 48 percent) with a seven percent referral rate for mental health (AC 6 percent, RC 9 percent).

Since February 2007, Command Navy Reserve Forces (COMNAVRESFOR) assumed responsibility for overseeing implementation of the PDHRA program in the Navy Reserve Component. With strong leadership support they are actively engaged in program execution, as reflected in their high compliance rate. For the AC, BUMED is still working with line leadership on the transition of program oversight and execution to the appropriate line organizations. In addition, we are advocating on behalf of a single integrated database and reporting system for identification, notification and documentation of compliance by eligible members.

Since April 2007, USMC, M&RA assumed management oversight for program execution for the Marines. With BUMED support, USMC M&RA developed and implemented an aggressive plan to contract $4.5 million for mobile surge teams to complete 50,000 PDHRAs.

Accessing Mental Health Services

Whether a service member is identified as needing mental health services through a health assessment tool or through self-referral, our personnel at Navy MTFs are prepared to provide high quality mental health services. In addition, Sailors, Marines and eligible beneficiaries seeking services can access a wider range of providers to meet their needs through various organizations such as Military OneSource, Navy's Family Support Centers, Marines' Corps Community Services, and the Navy's Chaplains Corps. All of these of entry points allow beneficiaries to select the type of mental health services they feel most comfortable to help them deal with their situation.

While Navy Medicine is making a concerted effort to ensure psychological health care for active duty members is available in the direct care system whenever possible, personnel shortages in psychological specialties make that a challenge. TRICARE network resources may be available; however, there is some concern that those providers may be less familiar with the unique demands placed upon active duty members.

There are 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 90 percent manning, our clinical psychology community is at only 77.5 percent manning. The roles of the Navy social work community are being expanded and increases in the Psychiatric Nurse Practitioner community are also being explored to meet the growing needs for mental health services, both in theater and in garrison. Uniformed mental

health providers are critical in our efforts to provide preventive and clinical services to Marines and Sailors. We must continue to develop mechanisms, including changes to accession and retention bonuses and special pays, to ensure an adequate complement of uniformed mental health providers.

Providing services to Reserve Sailors and Marines is a continuous challenge as mental health problems may not emerge until the end of their benefit period. Furthermore, other problems, such as substance abuse, family discord or vocational dysfunction, may not present until after their benefits expire. Another challenge in meeting the needs of Reservists is that many of them, unlike the active duty forces, do not reside in large fleet or military concentration areas and return from deployments to sites where they lack access to medical services or support networks. We will continue to strengthen our partnership with the Department of Veterans Affairs so that these service members will be able to access psychological health services as close to their homes and families as possible.

Coordination of care is being provided by a myriad of agencies and our commitment to ensure quality health care for reservists and their families remain in the forefront. The demands of providing services to these veterans, particularly in high fleet and Marine Corps concentration areas, is closely monitored to ensure sufficient capacity is available in our system. Our goal is to establish comprehensive and effective psychological health services throughout the Navy and Marine Corps. This effort requires seamless programmatic coordination across the existing line functions (e.g., Wounded Warrior Regiment, Safe Harbor), and we are working to achieve long-term solutions to provide the necessary care.

Navy Medicine is also paying particular attention to de-stigmatizing psychological health services, the continuity of care between episodes and the hand-off between the direct care system

and the private sector. We are developing a process to continuously assess our patient and their families perspectives so that we can make improvements when and where necessary.

Continuing Efforts to Meet the Mental Health Needs of Sailors and Marines

In order to evaluate and provide recommendations on the needs of deployed Sailors and Marines, Navy Medicine has developed the Behavioral Health Needs Assessment Survey (BHNAS). BHNAS was adopted from the Army's series of Mental Health Advisory Team (MHAT) surveys, which started in 2003, of land warfighters.

Preliminary results of the BHNAS show Navy's contributions to the GWOT are diverse and substantial. The impact of OIF-related deployments appears to vary according to type of assignment and degree of exposure to direct combat. Sailors who had seen the most combat were more likely to screen for a mental health problem. As a matter of fact, Navy Corpsmen showed the highest incidence of mental health problems among Navy personnel surveyed. Sailors reporting a strong sense of unit cohesion and leadership were half as likely to report mental health issues as those in less-stable command environments. These findings highlight an additional burden on the IA population because IAs do not enjoy the same level of command integrity, ethos and camaraderie. Phase II analysis of our BHNAS data, which includes IAs, is near completion.

Recently Navy Medicine received funding for creation of a Navy/Marine Corps Center for the Study of Combat Stress to be located at the Naval Medical Center San Diego (NMCSD). This Center is strategically located to work closely with our new Comprehensive Combat Casualty Care Center (C5). The concept of operations for this first-of-its-kind capability is underway, as is the selection of an executive staff to lead the Center. The primary role of this Center is to identify best COSC practices; develop combat stress training and resiliency

programs specifically geared to the broad and diverse power projection platforms and Naval Type Commands; establish provider "Caring for the Caregiver" initiatives; and coordinate collaboration with other academic, clinical, and research activities. As the concept for a DOD Center of Excellence develops, we will integrate, as appropriate, the work of this center. The program also hopes to reflect recent advancements in the prevention and treatment of stress reactions, injuries, and disorders.

Never before has the mental health and well-being of Sailors and Marines deployed to a war zone been as intensely studied. The Navy and Marine Corps' partnership with the Department of Veterans Affairs' National Center for Post Traumatic Stress Disorder, and civilian academic experts in psychological health are collaborating on developing evidence-based tools for combat and operational stress first aid. Our work with the University of California-Los Angeles and the National Child Traumatic Stress Network to pilot a program of resilience training for children and families affected by operational stress shows great promise. In addition, in collaboration with the Veterans Affairs Medical Centers in San Diego and Boston we will be developing an unprecedented prospective, longitudinal study of the factors that predict risk and resilience of ground combat Marines. We expect to begin this study in April 2008.

To better understand the impact upon Navy and Marine Corps families, I have commissioned the Center for Naval Analysis to conduct a sweeping study of Combat and Operational Stress Control impact and attitudes. This survey, unlike the anonymous BHNAS, will target over 15,000 randomly selected families and provide the most comprehensive determination as to the cumulative effect of GWOT. Navy Medicine will continue to build upon and expand our efforts of assessing their mental health needs as a result of their service. Among the recommendations by the first BHNAS are to: continue developing stress resiliency programs;

adopt a consistent "Caring for the Caregiver" program; fully implement the Psychological First Aid (self-aid and buddy-aid); and assess differential COSC burden on RC and IAs and their families.

Implementing the recommendations of the BHNAS is the responsibility of Navy Medicine's Combat and Operational Stress Consultants (COSC), who are 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. The COSC serves as the Director of Deployment Health, and he and his staff oversee Pre and Post Deployment Health Assessments, as well as the Post Deployment Health Reassessment. The COSC also oversees Substance Abuse Prevention and Treatment, Traumatic Brain Injury diagnosis and treatment, and a newly created position for Psychological Health Outreach for Reserve Component Sailors. Navy Medicine is also establishing psychological outreach programs at the Navy Operational Support Centers (NOSC) throughout FY08 and FY09. These programs will provide outreach to reserve service members and their families for psychological health, including high risk concerns such as PTSD and TBI, as well as post deployment re-integration issues. Psychological Outreach Coordinators will work directly with reserve service members and their families as a liaison to the NOSCs and Military Treatment Facilities, the Department of Veterans Affairs, and other service organizations.

As Navy Medicine champions multi-disciplinary efforts in preventing, identifying, and managing stress, we continue to expand and strengthen our collaboration with a variety of community resources such as Navy Chaplains, the Navy Fleet and Family Support Centers and Marine Corps Community Services. Another example of strategy to create solutions for pressing problems is the implementation of Project FOCUS (Families Overcoming and Coping

Under Stress). Project FOCUS is a prevention / very early intervention program consisting of 10 to 12 sessions with a team of specially trained counselors. This service—which can be arranged by direct contact from the family at risk--will positively impact 1200 families and is expected to launch Spring 2008.

Reinforcing a culture which values psychological health will require an enduring commitment to the mental health needs of service members, their families, and those who provide their care. It requires a commitment to: ensuring psychological health services are available and accessible in the operational environment; expanding surveillance and detection capabilities; equipping our providers with the best possible training, and minimizing the stigma associated with seeking treatment. We will underscore a culture that recognizes and embraces the value of enhancing our resilience to deal with the increasing stressors of military life, and understands that in the end, it may be less a question for medical science than a challenge for every leader to accept.

Chairwoman Davis, Representative McHugh, distinguished members of the committee, Navy Medicine continues to rise to the challenge of meeting the psychological health needs or our brave Sailors and Marines, and their families. I thank you for your support to Navy Medicine and look forward to answering your questions.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON ARMED SERVICES

SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: Mental Health

STATEMENT OF: Lieutenant General (Dr.) James G. Roudebush
Air Force Surgeon General

March 14, 2008

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) JAMES G. ROUDEBUSH

Lt. Gen. (Dr.) James G. Roudebush is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Roudebush serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Roudebush has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of more than 43,131 people assigned to 75 medical facilities worldwide.

The general entered the Air Force in 1975 after receiving a Bachelor of Medicine degree from the University of Nebraska at Lincoln, and a Doctor of Medicine degree from the University of Nebraska College of Medicine. He completed residency training in family practice at the Wright-Patterson Air Force Medical Center, Ohio, in 1978, and aerospace medicine at Brooks Air Force Base, Texas, in 1984. The general commanded a wing clinic and wing hospital before becoming Deputy Commander of the Air Force Materiel Command Human Systems Center. He has served as Command Surgeon for U.S. Central Command, Pacific Air Forces, U.S. Transportation Command and Headquarters Air Mobility Command. Prior to his selection as the 19th Surgeon General, he served as the Deputy Surgeon General of the U.S. Air Force.

EDUCATION

1971 Bachelor of Medicine degree, University of Nebraska at Lincoln
1975 Doctor of Medicine degree, University of Nebraska College of Medicine
1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar

1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar
1989 Institute for Federal Health Care Executives, George Washington University, Washington, D.C.
1992 National War College, Fort Lesley J. McNair, Washington, D.C.
1993 Executive Management Course, Defense Systems Management College, Fort Belvoir, Va.

ASSIGNMENTS
1. July 1975 - July 1978, resident in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
2. July 1978 - September 1982, physician in family practice and flight surgeon, USAF Hospital, Francis E. Warren AFB, Wyo.
3. October 1982 - July 1984, resident in aerospace medicine, USAF School of Aerospace Medicine, Brooks AFB, Texas
4. August 1984 - September 1986, Chief of Aerospace Medicine, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
5. September 1986 - July 1988, Commander, USAF Clinic, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
6. August 1988 - June 1991, Commander, 36th Tactical Fighter Wing Hospital, Bitburg Air Base, Germany
7. August 1991 - July 1992, student, National War College, Fort Lesley J. McNair, Washington, D.C.
8. August 1992 - March 1994, Vice Commander, Human Systems Center, Brooks AFB, Texas
9. March 1994 - January 1997, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
10. February 1997 - June 1998, Command Surgeon, Pacific Air Forces, Hickam AFB, Hawaii
11. July 1998 - July 2000, Commander, 89th Medical Group, Andrews AFB, Md.
12. July 2000 - June 2001, Command Surgeon, U.S. Transportation Command and Headquarters Air Mobility Command, Scott AFB, Ill.
13. July 2001 - July 2006, Deputy Surgeon General, Headquarters U.S. Air Force, Bolling AFB, Washington, D.C.
14. August 2006 - present, Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION
Rating: Chief flight surgeon
Flight hours: More than 1,100
Aircraft flown: C-5, C-9, C-21, C-130, EC-135, F-15, F-16, H-53, KC-135, KC-10, T-37, T-38, UH-1 and UH-60

BADGES
Chief Physician Badge
Chief Flight Surgeon Badge

MAJOR AWARDS AND DECORATIONS
Defense Superior Service Medal with oak leaf cluster
Legion of Merit with oak leaf cluster
Meritorious Service Medal with two oak leaf clusters
Air Force Commendation Medal
Joint Meritorious Unit Award
Air Force Outstanding Unit Award with oak leaf cluster
National Defense Service Medal with bronze star
Southwest Asia Service Medal with bronze star
Air Force Overseas Long Tour Ribbon with oak leaf cluster
Air Force Longevity Service Award with silver oak leaf cluster

Small Arms Expert Marksmanship Ribbon
Air Force Training Ribbon

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS
Society of USAF Flight Surgeons
Aerospace Medical Association
International Association of Military Flight Surgeon Pilots
Association of Military Surgeons of the United States
Air Force Association
American College of Preventive Medicine
American College of Physician Executives
American Medical Association

EFFECTIVE DATES OF PROMOTION
Second Lieutenant May 15, 1972
First Lieutenant May 15, 1974
Captain May 15, 1975
Major Dec. 8, 1979
Lieutenant Colonel Dec. 8, 1985
Colonel Jan. 31, 1991
Brigadier General July 1, 1998
Major General May 24, 2001
Lieutenant General Aug. 4, 2006

(Current as of January 2008)

Madam Chairwoman and esteemed members of the Committee, it is my honor and privilege to be here today to talk with you about the Air Force Medical Service. The Air Force Medical Service exists and operates within the Air Force culture of accountability wherein medics work directly for the line of the Air Force. Within this framework we support the expeditionary Air Force both at home and deployed. We align with the Air Force's top priorities: Win Today's Fight, Take Care of our People, and Prepare for Tomorrow's Challenges. We are the Nation's Guardian—America's force of first and last resort. We get there quickly and we bring everyone home. That's our pledge to our military and their families.

Win Today's Fight

It is important to understand that every Air Force Base is an operational platform and Air Force medicine supports the war fighting capabilities at each one of our bases. Our home station military treatment facilities form the foundation from which the Air Force provides combatant commanders a fit and healthy force, capable of withstanding the physical and mental rigors associated with combat and other military missions. Our emphasis on fitness, disease prevention and surveillance has led to the **lowest disease and non-battle injury rate in history.**

Unmistakably, it is the daily delivery of health care which allows us to maintain critical skills that guarantee our readiness capability and success. The superior care delivered daily by Air Force medics builds the competency and currency necessary to fulfill our deployed mission. Our care is the product of preeminent medical training programs, groundbreaking research, and a culture of personal and professional accountability fostered by the Air Force's core values.

The Air Force Medical Service is central to the most effective joint casualty care and management system in military history. The effectiveness of forward stabilization followed by

rapid Air Force aeromedical evacuation has been repeatedly proven. We have safely and rapidly transferred more than 48,000 patients from overseas theaters to stateside hospitals during Operations ENDURING FREEDOM and IRAQI FREEDOM. Today, the average patient arrives from the battlefield to stateside care in three days. This is remarkable given the severity and complexity of the wounds our forces are sustaining. It certainly contributes to the **lowest died of wounds rate in history**.

Take Care of Our People

We are in the midst of a long war and continually assess and improve health services we provide to Airmen, their families, and our joint brothers and sisters. We ensure high standards are met and sustained. Our Air Force chain of command fully understands their accountability for the health and welfare of our Airmen and their families. When our warfighters are ill or injured, we provide a wrap-around system of medical care and support for them and their families – always with an eye towards rehabilitation and continued service.

The Air Force is in lock-step with our sister services and federal agencies to implement the recommendations from the President's Commission on the Care for America's Returning Wounded Warriors. The AFMS will deliver on all provisions set forth in the 2008 National Defense Authorization Act (NDAA) and provide our warfighters and their families help in getting through the challenges they face. As we will discuss today, the AFMS is committed to meeting the mental health needs of all our Airmen, whether deployed or at home, and we are very grateful for your support in these areas.

Psychological Health

Psychological health means much more than just the delivery of traditional mental health care. It is a broad concept that covers the entire spectrum of well-being, prevention, treatment, health maintenance and resilience training. To that end, I have made it a priority to ensure that the AFMS focus on the psychological needs of our Airmen and identify the effects of operational stress.

Prevention

The Air Force has enhanced mental health assessment programs and services for Airmen. We identify mental health effects of operational stress and other mental health conditions, before, during and following deployments through periodic health assessments. We begin with the annual Periodic Health Assessment (PHA) of all personnel to identify and manage overall personnel readiness and health, including assessment for PTSD and TBI.

Before deployment, our Airmen receive a pre-deployment health assessment. This survey includes questions to determine whether individuals sought assistance or received care for mental health problems in the last year. It also documents any current questions or concerns about their health as they prepare to deploy. The responses to these questions are combined with a review of military medical records to identify individuals who may not be medically appropriate to deploy.

The Post-deployment Health Assessment (PDHA) and Post-deployment Health Reassessment (PDHRA) contain questions to identify symptoms of possible mental health conditions, including depression, PTSD, or alcohol abuse. Each individual is asked if he or she would like to speak with a health care provider, counselor, or chaplain to discuss stress,

emotional, alcohol, or relationship issues and concerns. New questions were added to the PDHA and PDHRA to screen for traumatic brain injury (TBI). Quality assurance and programs evaluations are conducted to assess implementation effectiveness and program success. Treatment and follow-up are arranged to ensure continuity of care by building on DoD and VA partnerships.

The Air Force integrates these prevention services through the Integrated Delivery System (IDS). The IDS is a multidisciplinary team that identifies and corrects gaps in the community safety net. Leaders from the chapel programs, mental health services, family support centers, child and youth programs, family advocacy and health and wellness center are involved at each installation. They promote spiritual growth, mental, and physical health, and strong individuals, families, and communities.

Post Traumatic Stress Disorder (PTSD)

The incidence of Post Traumatic Stress Disorder is low in the AF, diagnosed in less than 1 percent of our deployers (at 6 month post-deployment). For every Airman affected, we provide the most current, effective, and empirically validated treatment for PTSD. We have trained our behavioral health personnel to recognize and treat PTSD in accordance with the VA/DoD PTSD Clinical Practice Guidelines. Using nationally recognized civilian and military experts, we trained more than 200 psychiatrists, psychologists, and social workers to equip every behavioral health provider with the latest research, assessment modalities, and treatment techniques. We hired an additional 32 mental health professionals for the locations with the highest operational tempo to ensure we had the personnel in place to care for our Airmen and their families.

Traumatic Brain Injury

We recognize that Traumatic Brain Injury (TBI) may be the "signature injury" of the Iraq war and is becoming more prevalent among service members. Research in TBI prevention, assessment, and treatment is ongoing and the AF is an active partner with the Defense and Veterans Brain Injury Center (DVBIC), the VA, the CDC, industry and universities. The AF has very low positive screening for TBI —approximately 1 percent from OPERATION IRAQI FREEDOM and OPERATION ENDURING FREEDOM.

Screening for TBI occurs locally in theater, before transport of wounded service members stateside, and again at stateside hospitals as indicated. The Military Acute Concussive Evaluation (MACE) tool is administered in accordance with the Joint Theater Trauma System (JTTS) TBI Clinical Practice Guideline. U.S. Transportation Command (USTRANSCOM) policy dictates that all service members be screened for the signs and symptoms of TBI prior to transportation out of theater at either Landstuhl Regional Medical Center or at U.S. Air Forces Europe Aeromedical Staging Facilities. Follow up care for those with positive screens is conducted at US military treatment facilities and/or DVBIC's. The 59th Medical Group, Lackland AFB, Texas, is one of three DoD DVBIC Regional Centers that cares for TBI patients.

The AF is involved in several cutting edge research initiatives involving TBI. One in particular is the collaboration between the Air Force Research Laboratory and the University of Florida's Brain Institute. This research is focusing on the presence of biochemical markers in spinal fluid that is associated with TBI. Another is the Brain Acoustic Monitor, which detects mild TBI injuries and replaces invasive pressure monitors used to measure brain pressure for severe TBI cases.

Traumatic brain injury is an expanding area of study requiring close cooperation among the Services, the Department of Veterans Affairs, academic institutions and industry. It is vital that we better understand this disorder and clarify the long-term implications for our Airmen, Soldiers, Sailors, and Marines.

Suicide Prevention

The AF suicide prevention program is a commander's program. It has received a great deal of national acclaim and has achieved a 28 percent decrease in AF suicides since the program's inception in 1996. We continue to aggressively work our 11 suicide prevention initiatives using a community approach, and this year released Frontline Supervisor's Course. The course further educates those with the most contact and greatest opportunity to intervene when Airmen are under stress. We conducted suicide risk assessment training for mental health providers at 45 Air Force installations throughout 2007 to ensure Air Force mental health providers are highly proficient in evaluating and managing suicide risk.

Air Force prevention efforts are centered on effective detection and treatment. Recurring suicide prevention training for all Airmen is a central component of this risk recognition. As part of our Chief of Staff's and Secretary's new Total Force Awareness Training initiative, we recently released revamped computer-based training. This effort incorporates suicide prevention education into the CSAF's core training priorities, ensuring suicide prevention will continue to receive the appropriate priority and attention.

In 2008, the AF Suicide Prevention Program will monitor the Frontline Supervisors Training and the new computer-based suicide prevention training to ensure these initiatives effectively meet the training needs of Airmen. Every Air Force suicide will be studied for

lessons learned to prevent future suicides. These lessons will be shared in the annual Air Force Suicide Lessons Learned Report that is distributed Air Force-wide.

The best approach to preventing Air Force suicides is continued emphasis on the data-proven AF Suicide Prevention Program. Each of the 11 initiatives in the Air Force Suicide Prevention Program represents an important tool for commanders. These initiatives focus on leadership involvement; suicide prevention in professional military education; community preventive services; community education and training; Critical Incident Stress Management and others. Since September 2006, every base commander must ensure all 11 initiatives are fully implemented on their installation using the annual AF Suicide Prevention Program Assessment Process and Checklist. There is no single, easy solution to preventing suicide. It requires a total community effort using the full range of tools.

The AF Suicide Prevention Program was added to the National Registry of Evidence-based Programs and Practices (NREPP) in 2007, and is currently one of only 10 suicide prevention programs listed on the registry. NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders. Operated by the Substance Abuse and Mental Health Services Administration, NREPP was developed to help people, agencies, and organizations implement effective mental health programs and practices in their communities. This listing demonstrates the military's ongoing pivotal leadership role in suicide prevention within the United States and around the world.

Prepare for Tomorrow's Challenges

We're looking forward to the FY 09 deployment of our Tele-mental Health Project, which will provide video teleconference (VTC) units at every Mental Health clinic for live

patient consultation. This will allow increased access to, and use of, mental health treatment to our beneficiary population. Virtual Reality (VR) equipment will also be installed at six Air Force sites as a pilot project to help treat patients with post traumatic stress disorder. Using this equipment will facilitate desensitization therapy by recreating sight, sound and smell in a controlled environment. We are excited about these initiatives, not only for our returning deployers, but for all of our service members and their families.

In the months ahead, we will continue to implement enhanced AFMS psychological health and TBI programs made possible by FY 07 supplemental funding. These programs promote greater focus on access to care, quality of care, resilience, and surveillance. The funding will allow us to hire 97 additional mental health specialists over the next several months. We are indebted to the Congress for your support.

We will continue to work closely with OSD and our sister services to implement the recommendations of the DoD Mental Health Task Force and the Wounded, Ill and Injured provisions of the FY 08 NDAA.

Conclusion

In closing, Madam Chairwoman, I am intensely proud of the daily accomplishments of the men and women of the United States Air Force Medical Service. Our future strategic environment is extremely complex, dynamic and uncertain, and therefore we will not rest on our success. We are committed to staying on the leading edge and anticipating the future. With your help and the help of the committee, the Air Force Medical Service will continue to improve the health of our service members and their families. We will win today's fight, and be ready for tomorrow's challenges. Thank you for your enduring support.

STATEMENT

BY

SHELLEY M. MacDERMID, MBA, PHD

ASSOCIATE DEAN

COLLEGE OF CONSUMER AND FAMILY SCIENCES

AND

PROFESSOR

DEPARTMENT OF CHILD DEVELOPMENT AND FAMILY

STUDIES

PURDUE UNIVERSITY

BEFORE THE

SUBCOMMITTEE ON PERSONNEL

COMMITTEE ON ARMED SERVICES

UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 14, 2008

Chairman Davis, Representative McHugh, Distinguished Members of the Subcommittee, other Distinguished Members of Congress, ladies and gentlemen, good morning. I am honored to be in the company of the distinguished speakers who are here to discuss with you today the mental health resources available to military members and their families. As you know, I completed service several months ago as the co-chair of the Department of Defense Task Force on Mental Health, and I am very pleased to be here today.

The full report of the Task Force on Mental Health has been submitted for the record. As you know, the report presented an achievable vision for supporting the psychological health of military members and their families. The task force recommended building a culture of support for psychological health throughout DoD in order to combat stigma, shortages in staff and training, and procedural and policy barriers that were interfering with access to quality care. The task force also made recommendations aimed at ensuring a full continuum of excellent care for service members and their families, because of significant gaps that were found during its investigations. Third, the task force recommended increases in resources and staff, and changes in staff allocations in order to address shortages that were impeding adequate care. Finally, the task force recommended that leadership be created and empowered to ensure consistent attention to and advocacy for the psychological health of military members and their families.

As you know, the task force made 95 recommendations, almost all of which were endorsed by the Secretary of Defense, who submitted a detailed implementation plan to Congress in September 2007, several months ahead of its statutory deadline. I know that many dedicated individuals within DoD and the military services have been working very hard to improve supports for mental health, and several of the recommendations already have been fully implemented. Many remaining recommendations are targeted for complete implementation by

May 2008, a few short weeks from now. You have many experts here today who can tell you about what is being and has been done, so all that I will do in my remaining remarks is to identify three areas where I am eager to hear about positive progress.

The first issue I would like to address is TRICARE. The task force recommended several specific changes needed to ensure that the TRICARE system could provide adequate care for the psychological health of military members and their families who cannot receive their care at MTFs. Some of these changes have been made. For example, TRICARE Reserve Select has been simplified to be more accessible, and efforts have been made to make it easier to find mental health providers. I am aware of little progress, however, on many of the other recommended changes.

Let me give you one example, which pertains to intensive outpatient services, a highly utilized benefit in most health plans, and a cost-effective treatment of choice for many patients with substance abuse or other serious psychological problems. Eighteen months ago the Task Force heard public testimony from staff in the TRICARE Management Authority and representatives of the TRICARE contractors that cumbersome TRICARE rules resulted in intensive outpatient care NOT being covered under TRICARE. They asked us for change. We made a recommendation to immediately correct this deficiency, and the Secretary of Defense endorsed the recommendation. Yet little progress appears to have been made. These services are offered and used heavily in VA, available at many MTF's, and are a frequently utilized service in Medicaid and Medicare. Thus, military members and their families whose primary source of health care is the TRICARE system have no access to care that IS available to the poor, the elderly, veterans, and their military brothers and sisters who are fortunate enough to receive care at MTFs. On its face, this seems quite inequitable.

The second issue I would like to address is the supply of professionals who are well-prepared to provide the prevention, assessment, treatment and follow-up services to military members and family members who require care. The task force made several recommendations aimed at increasing the number of such providers within the military, and I think several efforts are underway in this area.

A question Admiral Arthur and I have often been asked is how many more professionals are needed to meet the need. The task force did not answer this question because it required the development of a new model for allocating the staff who support psychological health – specifically, a risk-adjusted population-based system. The existing staff allocation system is based on 'relative value units' that undercount prevention activities and unmet demand. The task force recommended that staff instead be allocated according to the size of the population in a given area, adjusted according to the presence of risks such as combat deployments and other challenging conditions. According to the workplan released in September, the new model has been designed, which should make it possible to identify quite precisely where sufficient staff are in place to meet the estimated need, where the numbers are insufficient, and by how much.

I am also eager to learn about successes in recruiting and retaining mental health professionals. The task force received numerous indications that it is difficult to get and keep highly qualified mental health professionals, especially when there are already shortages in the civilian community and DoD must compete with the Department of Veterans' Affairs and others for staff. But as the cumulative load of deployments on the force mounts, there is no question that the need to support psychological health is only becoming more urgent. I hope that the importance of the individuals who do that work is being recognized by very strong efforts to recruit and retain them, including incentives and opportunities for career development.

Also in the area of staffing, I am eager to here about changes in contracting procedures. The task force made site visits to 38 installations, where we heard over and over again that contracting mechanisms were cumbersome. Temporary staff already in place often could not be retained because it was impossible to give them timely information about whether their contract would be extended. Hiring and processing procedures for new temporary staff took so long that the funds were gone before the person could begin work. Critical GS positions lay empty for long periods even when a qualified and willing person had already been identified. These procedural problems were significant hurdles in the race to meet the needs of service members and their families -- I am eager to hear how they have been addressed.

While Congress has been helpful in allocating funds, I am eager to hear whether the right mix has been provided. For example, substantial funds have been allocated on a non-recurring basis, which makes it difficult to address infrastructure issues, and makes it difficult to hire the best staff. The Task Force report emphasized that the shortcomings we observed in the military mental health system were not caused by the protracted conflicts in which the United States is now engaged, and are unlikely to disappear when the conflicts end. Non-recurring funds, while helpful, do not allow the fundamental challenges to be addressed.

Finally, as someone who has devoted her life to studying and advocating for families, I will close by saying that I am especially eager to learn how services for family members have been improved since the Task Force submitted its report. We made several specific recommendations in this area. For example, we wanted to be sure that parents or others caring for wounded or injured service members could easily get access to installations, care managers, and other services. Because they have no official status as family members within military systems, parents sometimes faced barriers which systematically disadvantaged young unmarried

service members. We also recommended that the substantial delays many children were experiencing in accessing care be addressed. And we recommended that inequities between families who were nearby and could receive treatment at MTFs and families who were far away and had to rely on TRICARE be eliminated. I am eager to hear about progress in all of these areas.

In conclusion, Madam Chairman and Distinguished Members, I appreciate your sustained attention to these issues. I also very much appreciated the prompt and detailed plan submitted by the Secretary of Defense. But many weeks have elapsed and I know the strong sense of urgency we all feel pales before the daily struggles that confront families dealing with depression, substance abuse, children's disorders, or PTSD. I am very much looking forward to the day the plan is fully implemented. That concludes my remarks, and I thank you for your attention.

STATEMENT BY

MR CHRISTOPHER M. SCHEUERMAN PA-C

MSG (RET) USA

COMMITTEE ON ARMED SERVICES

SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 110TH CONGRESS

MENTAL HEALTH OVERVIEW

14 MARCH 2008

I would like to thank Chairwoman Davis, and the distinguished members of the Subcommittee for allowing me to testify today on an issue that has been tragically personalized in my life. Additionally, I would like to thank Congressman Etherege and his staff for their steadfast support and dedication.

In July of 2005, my son Jason, who was fighting the war on Terrorism in Iraq, lost his battle with depression and took his life while in theater. PFC Jason Scheuerman was twenty.

I address you today not only as a father of a soldier who took his own life but also as a combat veteran with over 20 years of service as both an enlisted man and commissioned officer in Army medicine. Though it is difficult to discuss the events preceding my son's death, I believe it can serve as a catalyst to help us better understand and treat soldiers battling depression or mental illness. Not all, but most depression related suicides are preventable.

In an article dated Jan. 2008, Col. Richie, the Consultant for Psychiatry to the Army Surgeon General states, "We've got multiple portals to care through chaplains, through primary care, through behavioral health, through leadership. We also need to make sure that family members know how to call if they are worried about their soldier."

Three weeks prior to Jason's death, we called his unit after receiving a suicidal email and pleaded for help not knowing if our son was still alive.

Jason was seen by his chaplain who had earlier witnessed him sitting alone with his head bobbing up and down on his rifle. He later said in a sworn statement, that he believed Jason to be possessed by demons and obsessed with suicide, he did nothing.

Jason was ignored by his primary care provider. It was common knowledge throughout the unit leadership, that Jason was experiencing problems; he was never seen by his battalion medical officer, he did nothing.

After being on suicide watch, Jason was sent to an Army Psychologist, who never contacted Jason's unit to hear of prior suicidal gestures. He relied solely on standardized test scores, misdiagnosed and dismissed Jason back to his unit with recommendations that caused more harm than good. He made the situation worse.

All of the access to care portals that Col. Richie speaks of in 2008, existed in 2005 and failed miserably.

The first step in reversing the growing trend in soldier suicides is accountability. If a soldier has an environmental injury such as frostbite, and a subsequent investigation shows that event to be preventable, leaders are relieved. The same standard of accountability should exist for suicide, if it is shown to be preventable. People need to be held accountable, leaders need to be relieved. Then we will see a significant statistical decrease in soldier suicides. Any program is only as good as the people executing it, without accountability we are doomed to failure.

Jason desperately needed a second opinion after his encounter with the psychologist. The Army did offer him that option, at his own expense. How is a PFC in the middle of Iraq supposed to access a civilian mental health care practitioner at his own expense? How alone my son must have felt, he had nowhere to go. I believe that soldiers should be afforded the opportunity for a second opinion via teleconference with a civilian mental health care provider of their own choice. Any standardized test scores could be faxed or sent by secured email to the provider, and then the soldier and the licensed mental health care provider could talk via web-cam or other technology available. The civilian providers do not have to be in theatre, they can provide a checks and balances element from home. I know that if this were available on the day Jason was seen, he would still be with us today.

There was great disparity between the observations made by Jason's unit Chaplain and the Psychologist. Jason's Chaplain clearly believed him to be extremely trouble and told Jason's mother in a conversation after his death that they had been watching Jason for some time. Jason's psychologist stated that he was capable of feigning mental illness in order to manipulate his command.

There must be a mechanism put into place when there is such a discrepancy of opinion. A Hotline should be established where a concerned member of the total care team, (Leadership, Chaplaincy, and Mental Health) can call when there is such disagreement and a board convened to review the specifics of the case to ensure soldier safety and that no mistakes are made. Additionally, when a provider is examining a potentially suicidal soldier, it should be mandatory for them to contact the family to gather pertinent background data. Who knows them better, who better to recognize a change than a spouse or parent? I believe these two simple steps will save lives.

The last two years has been an ongoing struggle to gather documents and information, to finally realize all the missed opportunities to save him. If we as a family were not willing to investigate the circumstances of Jason's death, we would have never known how bad it had become. I propose an independent panel made up of professionals from outside the DOD (both medical and psychological forensic experts and trained investigators), to do a retrospective analysis of all theater suicides to find other mistakes, or commonalities so we can learn and improve our understanding.

Opportunities to learn from mistakes have been lost. Our family's loss could have been a powerful training tool for all our soldiers and their leaders to recognize both the obvious and subtle signs of mental illness and suicidality. We always learn more from our failures than our successes.

My Story. CW4 Richard G. Gutteridge, United States Army. 14 March 2008

I returned from my latest Iraqi Freedom tour in February of 2007. I was very happy to return to my wife and two sons in Germany. The homecoming was very sweet.

I was required to complete a Post Deployment Health Assessment during the post deployment phase after returning. At that point, I did not have problems that needed immediate attention. Completing the needed forms was a ticket to begin leave. I did not want to be delayed in starting my leave; I had plans.

I began to clear my unit in Friedberg, Germany- the 1st Brigade of the 1st Armored Division was casing its colors and returning to the States. Friedberg was closing. Wanting to stay in Germany, I executed a Consecutive Overseas Tour (COT) and moved to Ansbach, Germany. While I was in-processing my new unit, I was informed that I failed to complete the 90 day Post Deployment Health Reassessment. At this point, I was required to complete the survey.

I had now been back from Iraq about four months. I had started to have nightmares and I was constantly reminded of being back in Iraq. I had intrusive horrible thoughts about what happened in Iraq. I was finding myself easily becoming angry at little things. I was also having trouble sleeping and I began to withdraw from my family. I answered the PDHRA more "honestly". A medical doctor in Ansbach then reviewed this assessment. As a result of reviewing this document with me, the doctor told me that I had chronic PTSD and combat stress. I was then referred to Behavioral Health in Ansbach.

I then called and made an appointment. I began therapy sessions with a Nurse- Practitioner Psychiatrist August 2, 2007. I was pleased with the one-on-one therapy I was receiving. As a result of one of my earliest sessions, the Nurse Practitioner recommended that I adjust my Cytalopram (Celexa) medication. I was told to call the clinic if needed after this adjustment.

My condition worsened- I continued to have nightmares and I felt as though I was losing control. I called the clinic in Ansbach a week later (August 8th) to see the Nurse again. The Nurse was on leave, and her next appointment was not for twenty (20) days. I then inquired about seeing a doctor, and I was told that the next available appointment was twenty-one (21) days from then. I then told the receptionist that I would drive to Landstuhl Hospital to see a doctor (two and a half hours away). I was told that was not possible, and she then told me that she would place a telephonic referral for me to speak to a doctor who is "deploying soon" from Vilseck, Germany and that he has 72 hours to contact me. I was then asked if I was "suicidal"- the only way to get immediate help was to be suicidal. I was not suicidal, and told her so. At this point I was very frustrated and angry. I then e-mailed the Wounded Warrior Hotline and stated that I need help now. I expressed the fact that I was a senior warrant officer with 24 years of active duty and that I had served in Iraq during Desert Storm and that I had two extended Iraqi Freedom tours. If this is how I was being treated, I asked how a young Infantry Soldier would be treated.

Shortly thereafter, I received a phone call from the Wounded Warrior Hotline. I then received a phone call that evening from the doctor that had my telephonic referral. We discussed my condition, and he made recommendations concerning my medication. I began to feel better. Weeks later, I continued my one-on-one care with the Nurse Practitioner.

As time went on, anniversaries of traumatic events that occurred in Iraq began to come around. October and November were particularly disturbing. Reliving the horrors of evacuating Fallen Soldiers and Marines remains as well as searching through body bags for dog tags and watching Soldiers die was too much. I became more withdrawn and distant from my family. I was having what I was later told to be "suicidal ideations". I also began to increase my use of alcohol to cope. I am not proud of this, and it is difficult to admit.

My life almost ended Christmas Day. I no longer had a desire to continue. I felt as though my condition would never change. I just wanted to be "like before" but I could not fathom this.

Late Christmas evening I phoned my Nurse Practitioner at home and told her what was going on. I felt relieved calling her- but I knew that as soon as I placed the call my career would be over. After I assured her that I was "safe", she told me to come see her the following morning in her office. I drove to her office alone, and we met. She then told me that I needed help that she could not give. I was then advised that I could go to Landstuhl on my own, or else I would be forced to. Seeing no way out, I gave in. I then opened her office door to see my wife with one of my suitcases. She was accompanied by my brigade commander and a chaplain. Reality kicked in. I was on my way to Landstuhl in a van with my brigade commander and the chaplain. I was very sad to leave my wife in the parking lot on such short notice. I never felt more alone in my life.

Upon arriving at Landstuhl, I was admitted to the In-patient Psychiatry Ward, Ward 9C. I was issued a hospital gown and socks that had tread woven into the soles. My entire belongings were inventoried. Once I snapped on the hospital bracelet, reality really set in.

Having to be observed 24 hours a day, shuffling around in socks behind locked doors marked "elopement risk" was very humbling. I was observed twice daily for the next seven days for signs of alcohol withdrawals, having to answer simple questions and being instructed to hold my hands steady to be observed for shaking. Having to be watched by a Private First Class while shaving and eating with plastic utensils was humiliating. The only hope was the "fresh air" breaks- having two quick cigarettes in succession while standing out in the cold German air wearing socks and a hospital gown under the constant supervision of one of the staff. These smoke breaks were the only event to look forward to. I soon realized that the purpose of me being in a lock-down ward was for my own safety. I quickly became assimilated, and I have nothing but great respect and admiration for all the personnel that work on Ward 9C in Landstuhl.

As New Year's Day 2008 approached, I was told by one of the Psychiatrists that he was recommending that I be medically retired and sent to Walter Reed to out-process the Army via the Warrior Transition Brigade. I was told that I would receive PTSD care after I was separated at a Veteran's Administration facility. I

was heartbroken- I did not want to retire. I cried for the first time since returning from Iraq. I was able to have my wife and two sons come to say goodbye to me.

I flew to Walter Reed by a MEDEVAC flight on New Year's Day. I had never been to Walter Reed, but I had heard the stories. I was very apprehensive. Upon arriving by bus to Walter Reed after the MEDEVAC flight landed at Andrews Air Force Base, I was allowed a quick smoke before being escorted into the hospital. I was then taken to Ward 54, the In-patient Psychiatry Ward at Walter Reed. Knowing the initial "drill" from having been at Landstuhl lessoned my apprehension of in-processing the ward. I was soon back in a hospital gown and I received a "new" bracelet. I was now able to wear shoes without laces instead of socks. That was refreshing.

Ward 54 had many patients. I soon reacquainted myself with a few of the Soldiers that I had met at Landstuhl. They assured me that Ward 54 was "cool". I felt much better then. I soon began talking with psychiatrists and psychologists. They were very kind and understanding. I immediately expressed my desire to not be medically retired. I was then advised that I would be my best advocate. I then made the decision to make the best of the situation. I participated in group therapy and followed orders. I made friends with my fellow patients. The staff was courteous and professional. The smoke breaks continued to be all that I looked forward to- that and the phone calls that I could make to my wife.

I was then made aware of a Specialized Care Program at Walter Reed that was specifically geared toward PTSD. Upon receiving this information, I made up my mind that getting into that program was my goal to getting better and staying in the Army. I had hope for the first time in weeks.

I continued the therapy on Ward 54. I quickly became disgruntled with the Initial Entry Soldiers that were also on Ward 54. These trainees were learning to be "Soldiers", and were admitted to Ward 54 for various reasons. I soon became disenchanted with the group therapy after having to listen to people less than half my age complaining that they could not adapt to the Army, could not get along with their Drill Sergeants, etc. My disdain for this element on Ward 54 was shared with the other combat veterans that had PTSD issues. We soon branched off into our own groups and shared our stories. I felt relieved that I was not the only one experiencing the same problems with PTSD.

I worked toward my next goal of being moved to Ward 53- the Outpatient Psychiatry Ward. My whole being was focused on continuing my care. After almost two weeks on Ward 54, I was released to Ward 53 and moved into Abrams Hall. This time I almost cried tears of joy.

Ward 53 was a breath of fresh air. The staff was very friendly and accommodating. The atmosphere was very refreshing, hopeful and professional. I made my intentions very clear early on wanting to be inducted into the Specialized Care Program specifically geared toward the treatment of PTSD. I then began a series of interviews with Psychiatrists and Psychologists as well as social workers from the Deployment Health Clinical Center here at Walter Reed. Initially I was discouraged because I felt that I did not make the cut during the final phase of the process, but I did indeed begin the program on February 4th of this year.

The Specialized Care Program was awesome. From the very first day, I knew I was in the right place. I looked at the other seven Soldiers in the program and I saw the same worn, haggard, distant look that I became accustomed to seeing in the mirror each morning. The three-week, intense PTSD program provided an overall health care assessment as well as an understanding and recognition of symptoms of PTSD. I also learned to normalize my reactions to combat experiences. Learning coping skills such as breathing techniques and yoga nidra coupled with one-on-one therapy with passionate mental health providers helped to reduce my hyper-arousal and vigilance. Group therapy with my fellow PTSD sufferers was what made the biggest difference by providing mutual support. I can now manage my depression and grief associated with PTSD. I am now aware of self-care and available resources. I feel like a husband and a father again. The program saved me. I owe Doctor Roy Clymer my life.

I often contemplate my reintegration when I return to duty at my unit in Germany. I am not worried about me being stigmatized- I am worried about how my wife and sons will be treated once my small, close-knit community knows the truth about my mysterious three-month absence.

I describe the perception of PTSD not as a stigma, but akin to having Leprosy. Lepers are avoided, looked down upon, and ostracized. Lepers also live and die slowly together in their own community. Lepers only have each other. PTSD sufferers are Lepers without the lesions. We are like discarded pennies on the ground- no one picks up pennies. Only shiny quarters are retrieved. Many of my fellow PTSD sufferers long for outward physical injuries to be accepted here at Walter Reed. Looking "normal" or healthy on the outside is hard to explain in a hospital environment. There are no photo opportunities on a Psych Ward for politicians or celebrities.

Some concepts that would improve the image of PTSD sufferers seem fairly simple. I do know that the infrastructures of hospital Psychiatry Wards were designed for peacetime. No one expected this to be a "long" war. Segregating Soldiers that have PTSD and combat stress from patients that are hospitalized for non-combat related issues is paramount. The mutual support that PTSD sufferers receive from each other is incredibly therapeutic. It is very difficult to discuss PTSD issues in an open forum containing patients that are not suffering from PTSD in a Psychiatric environment.

I also feel that substance abuse and PTSD are not compatible. My abstinence from alcohol is the driving force in my accelerated recovery coping with PTSD. It is very easy for PTSD sufferers to cope the wrong way by using illegal drugs, huffing inhalants or abusing alcohol. I feel that substance abuse counselors need to be incorporated in the PTSD recovery program, not isolated in a distant building away from the group therapy. They have to be part of the same program of recovery, not separate or parallel programs. One feeds the other. I feel very strongly about this.

The Warrior Transition Brigade is an outstanding success in my opinion. My only recommendation would be to slowly replace the initial group of cadre with Non-commissioned Officers and junior Officers that are still viable to the Army, but are offered or forced into medical retirement. Having these non-deployable

experts who have navigated the environment here at Walter Reed would pay huge dividends. Simply keep them here- make the offer- let them continue to contribute. The present cadre is dedicated, but you can only truly learn about programs and assistance that are available here if you have walked-the-walk. There are tremendous benefits available here that Soldiers of the WTB discover on their own. Word of mouth soon spreads enabling Soldiers to enjoy sporting events, learning to play the guitar and to kayak, taking advantage of airline miles donated, and obtaining items such as toiletries and clothing from the Red Cross. The benefits are endless.

Finally, many Soldiers celebrate their "second" birthday on the day that they survived being wounded in Iraq or Afghanistan. I do not celebrate that September day that I was shot by a sniper in the Anbar Province- I celebrate the day that I was enrolled in the Specialized Care Program for PTSD here at Walter Reed. In the words of Colin Powell "I will never not be a Soldier". Thank you for this opportunity to tell my story.

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

MARCH 14, 2008

RESPONSE TO QUESTION SUBMITTED BY MR. MCHUGH

Dr. CASSCELLS. By law, title 10, United States Code (U.S.C.), section 1079(h)(1), as implemented by title 32, Code of Federal Regulations (CFR), Part 199.14(j), TRICARE's reimbursement rates for all medical services from individual health care providers are tied to Medicare reimbursement rates for such services through the CHAMPUS Maximum Allowable Charge (CMAC) system, a nationally determined allowable charge level that is adjusted by locality indices and is equal to or greater than the Medicare Fee Schedule amount.

TRICARE adjusts its reimbursement rates, as necessary, to maintain the statutorily required relationship with Medicare's reimbursement rates. Often, network providers have committed in their independent agreements with our Managed Care Support Contractors (MCSCs) to accept reimbursement rates lower than CMAC. That is a business decision each provider makes independently.

Non-network providers may, under the same statutory requirements, charge the same percentage as the Medicare limiting percentage for non-participating Medicare providers, which is currently 15 percent above the CMAC rate. In the case of individual providers or particular Common Procedural Terminology codes, there are statutory provisions permitting TRICARE to raise its reimbursement rates up to 15 percent above the CMAC level upon official determination of the existence of network inadequacy (10 U.S.C. 1097b(a), as implemented by 32 CFR 199.14(j)) or to increase them without any specified limitation in cases of severe access to care deficiencies (10 U.S.C. 1079(h)(5), as implemented by 32 CFR 199.14(j)). In those areas where severe access problems are demonstrated, TRICARE has the authority to waive, on a case-by-case basis, the CMAC levels for providers beyond the 15 percent for network providers.

To date, TRICARE Management Activity has received one request for a locality based waiver for mental health services. The request was for all psychiatric services in the code range of 90800–90899 for patients age 18 and under in zip code 33040 in Key West, Florida. The amount of increase requested was 50 percent and was approved on January 7, 2008. In early 2008, a comprehensive review was conducted of our reimbursement rates compared to commercial and Medicaid rates as well as a review of access to mental health care. Access to care in all three regions was found to be adequate. [See page 15.]

RESPONSES TO QUESTIONS SUBMITTED BY MRS. BOYDA

General SCHOOMAKER. The suicide rates (per 100,000) for the U.S. Marine Corps from calendar year 1999 through calendar year 2007 are as follows:

1999–15.0
2000–13.9
2001–16.7
2002–12.5
2003–13.4
2004–17.5
2005–14.4
2006–12.9
2007–16.5

A comparison of the four years prior to Operation Iraqi Freedom (OIF) and four years after the commencement of OIF follows. Calendar year 2003 is excluded because it was a partial year as OIF commenced in March 2003.

Average Annual Suicide Rate

1999–2002—14.525
2004–2007—15.325

The difference between the average annual suicide rate from 1999–2002 is not statistically significant from the average annual suicide rate from 2004–2007 (t-test=0.289.) [See page 18.]

General SCHOOMAKER. Army and United States Marine Corps (USMC) Suicide Rates before and after onset of Operation Iraqi Freedom:

Year	ARMY	USMC
2001	9.0	16.7
2002	11.5	12.5
2003	11.4	13.4
2004	9.6	17.5
2005	12.7	14.4
2006	15.3	12.9
2007	16.8	16.5

* Suicide rates reported as number of suicides per 100,000 per year

** USMC rates are typically higher due to greater percentage of young males, and more variable due to being a smaller population. [See page 18.]

RESPONSE TO QUESTION SUBMITTED BY MR. JONES

Dr. CASSCELLS. We have data for military active duty physicians. Psychiatrists are a subset of that group. The majority of Physicians are accessed through the Uniformed Services University of the Health Sciences (USUHS) and the Health Professions Scholarship program (HPSP). Approximately 14% of accessions are from USUHS, 82% from HPSP and 4% are direct accessions. In terms of medical schools that produce active duty military physicians, the number one school is USUHS. The following table is a list of the top 25 (two-way tie for 25) civilian medical schools, ranked by the number of HPSP scholarships:

Medical Schools	Location	# HPSP
Lake Erie College of Osteopathic Medicine	Erie, PA	68
Philadelphia College of Osteopathic Medicine	Philadelphia, PA	67
Edward Via Virginia College of Osteopathic Medicine	Blacksburg, VA	63
Kansas City Univ of Medicine and Bio Sciences	Kansas City, MO	57
A.T. Still University of Health Sciences	Kirksville, MO	49
Nova Southeastern Univ of Osteopathic Medicine	Fort Lauderdale, FL	48
Des Moines University-Osteopathic Medical Center	Des Moines, IA	44
Midwestern University at Glendale	Glendale, AZ	43
Touro University of Osteopathic Medicine SF	San Francisco, CA	42
West Virginia School of Osteopathic Medicine	Lewisburg, WV	31
New York University	New York, NY	23
Midwestern University in Illinois	Downers Grove, IL	20
Georgetown University	Washington, DC	18
Boston University	Boston, MA	16
University of Illinois at Chicago	Chicago, IL	14
Philadelphia College of Osteopathic Med @ GA	Atlanta, GA	14

Medical Schools	Location	# HPSP
Howard University	Washington, DC	14
Western University of Health Sciences	Pomona, CA	14
Eastern VA Medical College of Hampton Roads	Norfolk, VA	13
University of Texas—All Campuses Combined	TX	11
Temple University	Philadelphia, PA	11
Creighton University	Omaha, NE	11
Wright State University	Dayton, OH	6
Ohio State University	Columbus, OH	6
University of North Texas HSC	Fort Worth, TX	5
Meharry Medical College	Nashville, TN	5

[See page 29.]