AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

S. HRG. 110–631

THE FINDINGS AND RECOMMENDATIONS OF THE DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH, THE ARMY'S MENTAL HEALTH ADVISORY TEAM REPORTS, AND DEPARTMENT OF DEFENSE AND SERVICE-WIDE IMPROVEMENTS IN MENTAL HEALTH RESOURCES, INCLUDING SUICIDE PREVENTION, FOR SERVICEMEMBERS AND THEIR FAMILIES

HEARING

BEFORE THE

SUBCOMMITTEE ON PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MARCH 5, 2008

Printed for the use of the Committee on Armed Services

U.S. GOVERNMENT PRINTING OFFICE

45–652 PDF WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON ARMED SERVICES

CARL LEVIN, Michigan, *Chairman*

EDWARD M. KENNEDY, Massachusetts
ROBERT C. BYRD, West Virginia
JOSEPH I. LIEBERMAN, Connecticut
JACK REED, Rhode Island
DANIEL K. AKAKA, Hawaii
BILL NELSON, Florida
E. BENJAMIN NELSON, Nebraska
EVAN BAYH, Indiana
HILLARY RODHAM CLINTON, New York
MARK L. PRYOR, Arkansas
JIM WEBB, Virginia
CLAIRE McCASKILL, Missouri

JOHN MCCAIN, Arizona
JOHN WARNER, Virginia,
JAMES M. INHOFE, Oklahoma
JEFF SESSIONS, Alabama
SUSAN M. COLLINS, Maine
SAXBY CHAMBLISS, Georgia
LINDSEY O. GRAHAM, South Carolina
ELIZABETH DOLE, North Carolina
JOHN CORNYN, Texas
JOHN THUNE, South Dakota
MEL MARTINEZ, Florida
ROGER F. WICKER, Mississippi

RICHARD D. DEBOBES, *Staff Director*
MICHAEL V. KOSTIW, *Republican Staff Director*

SUBCOMMITTEE ON PERSONNEL

E. BENJAMIN NELSON, Nebraska, *Chairman*

EDWARD M. KENNEDY, Massachusetts
JOSEPH I. LIEBERMAN, Connecticut
JIM WEBB, Virginia
CLAIRE McCASKILL, Missouri

LINDSEY O. GRAHAM, South Carolina
SUSAN M. COLLINS, Maine
SAXBY CHAMBLISS, Georgia
ELIZABETH DOLE, North Carolina

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

THE FINDINGS AND RECOMMENDATIONS OF THE DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH, THE ARMY'S MENTAL HEALTH ADVISORY TEAM REPORTS, AND DEPARTMENT OF DEFENSE AND SERVICE-WIDE IMPROVEMENTS IN MENTAL HEALTH RESOURCES, INCLUDING SUICIDE PREVENTION, FOR SERVICEMEMBERS AND THEIR FAMILIES

MARCH 5, 2008

	Page
Boxer, Hon. Barbara, U.S. Senator from the State of California	2
Arthur, VADM Donald C., USN (Ret.) Co-Chair, Department of Defense Task Force on Mental Health	19
MacDermid, Dr. Shelley M., Co-Chair, Department of Defense Task Force on Mental Health	19
Hoge, COL Charles W., USA, Director, Division of Psychiatry and Neuroscience, Walter Reed Army Institute of Research; Accompanied by COL Carl A. Castro, USA, Research Area Director, Military Operational Medicine Research Program	121
Schoomaker, LTG Eric B., USA, Surgeon General of the United States Army and Commanding General, United States Army Medical Command	129
Robinson, VADM Adam M., Jr., USN, Surgeon General of the United States Navy and Chief, Bureau of Medicine and Surgery	134
Roudebush, Lt. Gen. James G., USAF, Surgeon General of the United States Air Force	143
Sutton, COL Loree K., USA, Special Assistant to the Assistant Secretary of Defense (Health Affairs), Psychological Health and Traumatic Brain Injury	148

THE FINDINGS AND RECOMMENDATIONS OF THE DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH, THE ARMY'S MENTAL HEALTH ADVISORY TEAM REPORTS, AND DEPARTMENT OF DEFENSE AND SERVICE-WIDE IMPROVEMENTS IN MENTAL HEALTH RESOURCES, INCLUDING SUICIDE PREVENTION, FOR SERVICEMEMBERS AND THEIR FAMILIES

WEDNESDAY, MARCH 5, 2008

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:35 p.m. in room SR–232A, Russell Senate Office Building, Senator E. Benjamin Nelson (chairman of the subcommitee) presiding.

Committee members present: E. Benjamin Nelson, Lieberman, and Graham.

Committee staff member present: Leah C. Brewer, nominations and hearings clerk.

Majority staff members present: Gabriella Eisen, counsel; and Gerald J. Leeling, counsel.

Minority staff members present: Diana G. Tabler, professional staff member, and Richard F. Walsh, minority counsel.

Staff assistants present: Jessica L. Kingston and Ali Z. Pasha.

Committee members' assistants present: Frederick M. Downey, assistant to Senator Lieberman; Andrew R. Vanlandingham, assistant to Senator Ben Nelson; Jon Davey, assistant to Senator Bayh; Clyde A. Taylor IV, assistant to Senator Chambliss; and Andrew King, assistant to Senator Graham.

OPENING STATEMENT OF SENATOR E. BENJAMIN NELSON, CHAIRMAN

Senator BEN NELSON. Our ranking member, Senator Graham, is on his way. He'll be a little late, but he has suggested we go ahead and start the subcommittee hearing this afternoon, so we can give Senator Boxer an opportunity to address us on a series of very important issues.

Let me start by saying the Personnel Subcommittee hearing will come to order. I have a short initial statement which I'll read and then, Senator Boxer, it'll be our pleasure to have your testimony.

The subcommittee meets today to receive testimony on the findings and recommendations of the Department of Defense (DOD) Task Force on Mental Health, the Army's Mental Health Advisory Team (MHAT) reports, and DOD and Service-wide improvements in mental health resources, including suicide prevention, for servicemembers and their families.

This subcommittee is responsible for the most important aspect of the United States military system, our men and women and their families who volunteer to serve our great Nation. The repeated and extended deployments and the intensity of the conflicts in Iraq and Afghanistan are taking a toll on the mental health of our troops and their families. This hearing will help us to understand more clearly what help is currently available to them and, importantly, what more is needed.

It's been an honor to be able to work alongside my ranking member, Senator Graham. We've switched positions a time or two. We continue to work well together because there is nothing partisan about the mental health of our military.

Perhaps the most important piece of what we're about today in looking after the mental well-being of our Armed Forces and their greatest support, their families, is an opportunity to learn more about what is being done, but also what more should be done.

We're pleased here in the first panel to have Senator Boxer, who for years has been a tireless advocate for our servicemembers. She has taken the lead on this issue of mental health and offered the amendment to create the DOD Task Force on Mental Health, which was included in the National Defense Authorization Act for Fiscal Year 2006. She is here to discuss her efforts in this area. So we thank you for being with us today.

I'll talk one second about our second panel. We're honored to have several experts on the subject of mental health care and treatment in the military environment. They're here to share with us the findings and recommendations of the DOD Task Force on Mental Health, as well as the findings of the other reports. I'll introduce them when the second panel convenes.

The third panel will consist of the DOD official charged with implementing the recommendations of the task force and the surgeons general from each of the Services. They're here to discuss the programs, plans, and initiatives that the Services and DOD have in place already or plan to put in place to respond to the findings of the Army's MHAT reports and to implement the task force's recommendations. I'll introduce them when we begin the third panel.

So we look forward to the testimony today and we'll ask Senator Graham to make his statement when he is able to join us. In the mean time, Senator Boxer, thank you very much for being here.

STATEMENT OF HON. BARBARA BOXER, U.S. SENATOR FROM THE STATE OF CALIFORNIA

Senator BOXER. Senator Nelson and Senator Lieberman, I'm very honored to be before your subcommittee. If we remember back, with the gracious help of this committee, Senator Lieberman and

I working together, were able to include language establishing the Mental Health Task Force in the National Defense Authorization Act for Fiscal Year 2006.

At that time, we were roughly 2 years into the Iraq war and we were beginning to hear countless stories that showed we did not have an adequate mental health care system in place. I can't tell you how many phone calls I got from nameless families who said: We're just scared.

Over a 1-year period, the task force took a comprehensive and a very thoughtful look at the state of mental health care and services for our servicemembers and their families. Frankly, what they found, Mr. Chairman, was simply not good. In particular, the task force found that—and I'm quoting—"Significant gaps in the continuum of care for psychological health exist," and that "the military health system lacks the fiscal resources and the fully trained personnel to fulfill its mission to support psychological health."

In response to those findings, the task force developed a series of 95 comprehensive recommendations to dramatically improve the way that the DOD both views psychological health in general and provides treatment and care for those who need it.

I am tremendously proud of their work and I have told them so, and particularly I am proud of the outstanding leadership of the two co-chairs, who will testify next: Vice Admiral Donald Arthur and Dr. Shelley MacDermid.

It is my understanding that the DOD elected to adopt all but one of the task force recommendations. I am here today to both commend the work of the task force and to ask that you as the Senate committee charged with overseeing military health care, and particularly this subcommittee, provide the DOD with all of the resources and support necessary to implement these far-reaching changes. I am sure that you all agree, and from listening to the chairman's heartfelt opening, you all agree that we have a big problem on our hands that is only going to get worse if we don't do something big now, something that really fills the void.

According to a study published in the Journal of the American Medical Association on November 14, 2007, 20 percent or one in five of all Active Duty Army soldiers and 42 percent of all Reserve component soldiers, including Army Reserve and Army National Guard, who served in Iraq are reporting that they need mental health treatment for a range of problems—one in five. This means that tens of thousands of men and women need and deserve the best mental health care that we can provide.

I have to say, Mr. Chairman and Senator Lieberman, in all the years that I've been in Congress, and for a period of time in the 1980s I served on the Armed Services Committee, I saw that when the military decides to do something they do it right and they do it as a model for the rest of the Nation. I don't care whether it's child care or health care or whatever it is. So I am so optimistic that with the resources that we can make sure they can really not only solve the problems that we're facing in the military, but send a very clear signal to the civilian community of what the civilian community must do.

Too many servicemembers have been discharged for preexisting personality disorders when they actually had mental health prob-

lems from their combat experience. Imagine, they were discharged for preexisting conditions when they had mental health problems from their combat experience. That's wrong, because those people are not going to get the help they need.

Too many servicemembers have turned to drugs and alcohol, and the number of DUIs has risen at bases across this Nation. Too many servicemen and women have attempted or committed suicide. In 2007 alone, 121 soldiers committed suicide and another 2,100 attempted suicide, a six-fold increase since 2002. This is tragic. I know you agree with me because I've talked to you about these things.

If we don't act soon, we will see more devastating consequences of these wounds play out in the years to come on our streets with homeless and substance abuse. I still, when I talk to the homeless, find homeless vets from the Vietnam era.

Senators, we can't have this continue. We see homelessness. We see substance abuse. We see violence. We see divorce, and that's why we have to do more to confront these challenges today.

I am so proud of the work that we have done together, particularly with my colleague Senator Lieberman. We have successfully passed legislation to establish a center of excellence for military mental health and traumatic brain injury (TBI). We have helped to set standards for deployment for servicemembers with diagnosed mental health conditions and to examine issues involving women and combat stress.

But there is much more to be done. That is why I am continuing to work on legislation with Senator Lieberman to address mental health workforce shortages and to address the issue of suicide within the armed services.

We also must shatter the stigma associated with seeking mental health care that says a soldier, sailor, airman, or marine is weak if he or she wants to talk with a mental health professional about experiences in Iraq or Afghanistan. We must ensure that we have adequate numbers of uniformed mental health providers who can train and deploy with our troops and be there when they're needed. It doesn't help them if they can't find help quickly. We must give our servicemembers the tools they need to be able to cope with the stress upon them and the experiences that many of them face each and every day.

That is why it is so important that this subcommittee fully supports the recommendations of the DOD Mental Health Task Force.

Mr. Chairman, it's rare that Members of Congress look at a special committee that was set up to work within the DOD and say you're right on every count, you have done your work well. We are of one mind on this. Now, I know there are differences about the war in Iraq. There are bitter differences, difficult differences. But I know that all of us agree, regardless of how we feel about the war, we all feel the same way about the warriors. We honor them, we trust them, we want to stand by their side.

I think today, Mr. Chairman, with your leadership and that of Senator Graham and Senator Lieberman, who I'm so pleased is here, I really think we can take some bipartisan actions to ensure that our troops are treated.

In conclusion, let me say when we do this right it's going to help our military in the long run. It's going to enable us to attract more people when they know that if they do have this type of problem they'll be cared for, they'll be made whole, and it will help us recruit the best people and keep the best people.

Thank you so very much for this chance to speak to you.

[The prepared statement of Senator Boxer follows:]

PREPARED STATEMENT BY SENATOR BARBARA BOXER

Mr. Chairman, with the gracious help of this committee, I was able to include language establishing the Mental Health Task Force in the National Defense Authorization Act for Fiscal Year 2006.

At that time, we were roughly 2 years into the Iraq war and beginning to hear countless stories that showed we did not have an adequate mental health care system in place.

Over a 1 year period, the task force took a comprehensive and thoughtful look at the state of mental health care and services for our service men and women and their families. What they found was not good.

In particular, the task force found that "significant gaps in the continuum of care for psychological health" exist, and that the "Military Health System lacks the fiscal resources and the fully-trained personnel to fulfill its mission to support psychological health."

In response to their findings, the task force developed a series of 95 comprehensive recommendations to dramatically improve the way that the Department of Defense both views psychological health in general, and provides treatment and care for those who need it.

I am tremendously proud of their work, and particularly the outstanding leadership of the two co-chairs who will testify next, Vice Admiral Donald Arthur and Dr. Shelley MacDermid.

It is my understanding that the Department of Defense elected to adopt all but one of the task force recommendations.

I am here today to both commend the work of the task force and to ask that you—as the Senate committee charged with overseeing military health care—provide the Department of Defense with all of the resources and support necessary to implement these far-reaching changes.

I am sure that you all agree that we have a big problem on our hands that is only going to get worse if we don't do something big now.

According to a study published in the Journal of the American Medical Association on November 14, 2007, 20 percent (or 1 in 5) of all Active Duty Army soldiers and 42 percent of all Reserve component soldiers, including Army Reserve and Army National Guard, who served in Iraq are reporting that they need mental health treatment for a range of problems.

This means that tens of thousands of men and women need and deserve the best mental health care that we can provide. We can and must do better.

Too many servicemembers have been discharged for pre-existing personality disorders when they actually had mental health problems from their combat experience.

Too many servicemembers have turned to drugs and alcohol, and the number of DUIs has risen at bases across the Nation.

Too many service men and women have attempted or committed suicide. In 2007 alone, 121 soldiers committed suicide and another 2,100 attempted suicide, a sixfold increase since 2002. This is tragic.

If we don't act soon, we will see more devastating consequences of these wounds play out in the years to come—homelessness and substance abuse; violence and divorce. That is why we can and must do more to confront these challenges today.

I am proud of the work I have been able to do so far, much of it with my colleague Senator Lieberman. We have successfully passed legislation to establish a Center of Excellence for Military Mental Health and Traumatic Brain Injury. We have helped to set standards for deployment for servicemembers with diagnosed mental health conditions, and to examine issues involving women and combat stress.

But there is more to be done.

That is why I am continuing to work on legislation with Senator Lieberman to address mental health workforce shortages and to address the issue of suicide within the Armed Forces.

We also need to shatter the stigma associated with seeking mental health care that says a soldier, sailor, airman, or marine is weak if he or she wants to talk with a mental health professional about experiences in Iraq or Afghanistan.

We need to ensure that we have adequate numbers of uniformed mental health providers who can train and deploy with our troops and be there when they are needed.

We must give our servicemembers the tools they need to be able to cope with the stress of combat and the experiences that many of them face each and every day.

That is why it is so important that this subcommittee fully support the recommendations of the Department of Defense Mental Health Task Force.

I know that there are different views about the war in Iraq on this committee and in the Senate. But all of us agree that we should honor the service of the brave men and women of our military. We can and must come together to serve them as well as they have served us.

I look forward to continuing to work with you on this most important issue.

Senator BEN NELSON. Thank you, Senator.

Senator Lieberman, I understand you may have an opening statement you'd like to make. I didn't mean to pass over you so quickly.

Senator BOXER. I would love to hear it.

Senator LIEBERMAN. Just very briefly, I'm going to put my statement in the record.

Thank you for convening this hearing. Thanks, Senator Boxer. We've formed a partnership in shared concern, as you quite rightly said, about the warriors, even though we had differences of opinion about the war, and that's something that I think expresses the unity that the American people feel.

There's been a lot of work done on this. I'm very proud of the mental health care for our Wounded Warriors Act, which was in the National Defense Authorization Act for Fiscal Year 2008. I appreciate the work that is being done within the health services in the military.

I just want to focus for a moment on the two pieces of legislation you mentioned that we're working on, because the work is obviously not done. First, we've noted in all these Services a real shortage of uniformed behavioral health providers. That's why Senator Boxer and I are working on legislation that will increase and improve incentives for recruitment and training and retention of such providers. We're talking about psychologists, psychiatrists, social workers, and mental health nurses.

The need for uniformed providers cannot be overemphasized when one considers their dual missions to not only deploy to combat zones, but staff garrison military treatment facilities (MTFs) across the globe.

Incidentally, one of the things that Senator Boxer and I know you, Mr. Chairman and Senator Graham, understand is that a soldier, sailor, marine, or airman who is mentally fit is going to be a better fighter and is going to be a better team member with those in his or her unit.

One of the interesting things that we've learned in our work on this, Senator Boxer and I, is that uniformed mental health professionals are critical. You can buy civilian services on a contract basis, but in the work that we've done and our staffs have done it's very clear particularly those returning from combat strongly prefer receiving care from a fellow servicemember. That's what this piece of legislation that Senator Boxer and I are offering focuses on.

It's not going to be easy, particularly because of some very practical problems that some of our military installations are in places that are not, shall we say, in the middle of cosmopolitan metropolitan areas. Would those in uniform agree with that? Yes, and some of the mental health professionals prefer to be in such places.

So we have to figure out ways to attract people.

Second, suicide rates have become alarming. In the past year there have been a number of disturbing reports concerning suicide rates, particularly in the Army. In 2007—higher than at any other time since the statistic had been tracked by the military; higher also than the suicide rate in the civilian population.

So the legislation Senator Boxer and I are working on would in short create a new across-the-Services prevention program modeled on a highly successful aircraft incident prevention program, which is run by the Air Force. I hope that my colleagues will look at both of these pieces of legislation and ideally, as you were kind enough to include the previous legislation in the National Defense Authorization Act for Fiscal Year 2008, perhaps we could include these two in the National Defense Authorization Act for Fiscal Year 2009.

I thank you, Mr. Chairman, for your leadership, and again I thank Senator Boxer for her leadership here. Senator Graham, I don't want to leave you out. This is a real bipartisan concern, and you've been right at the leadership of those trying to do something about it.

Thank you very much.

[The prepared statement of Senator Lieberman follows:]

PREPARED STATEMENT BY SENATOR JOSEPH I. LIEBERMAN

Chairman Nelson, thank you for convening this important hearing on the status of the Department of Defense's mental health reforms.

Soon after the conflicts in Iraq and Afghanistan began, the "hidden injuries" resulting from the war began to surface. The statistics are not new to anyone here. An estimated one in six Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) servicemembers has a diagnosable condition of post-traumatic stress disorder and 1 in 10 has suffered a traumatic brain injury. Over one-third of OIF/OEF veterans treated by the Veterans Administration has been diagnosed with a mental health condition, including post-traumatic stress disorder, depression, and substance abuse, among others.

These realities have motivated this committee, and others including Senator Boxer, to work on a number of initiatives to improve our servicemembers' access to high quality behavioral health care. Numerous commissions and study groups have also contributed significantly to the effort and influenced our work on this committee. Specifically, I would like to applaud the seminal work of the Mental Health Task Force. The Task Force, led by Vice Admiral Arthur and Dr. MacDermid, has been critical in providing a blueprint for building a true continuum of care for psychological health, and I look forward to their testimony.

I would also like to thank the committee for working with Senator Boxer and myself to include our legislation, S. 1196, the Mental Health Care for Our Wounded Warriors Act, in the National Defense Authorization Act for Fiscal Year 2008, which authorizes the establishment of a Defense Center of Excellence on psychological and brain injuries. This center will provide critical leadership to the Department's efforts to conduct research, develop treatments, and disseminate best practices on psychological health and brain injuries. I look forward to supporting the new Defense Center of Excellence and applaud Colonel Sutton in her efforts to bring critical leadership to this issue. The task ahead will not be easy—to not only fulfill the mandates passed in the National Defense Authorization Act for Fiscal Year 2008, but to implement many of the recommendations of the Mental Health Task Force. We ask that you come to this committee when you require additional resources or authorities to accomplish these goals.

This hearing is very timely because we now have: a more comprehensive understanding of the psychological injuries affecting servicemembers, increasing research evidence to support the design of new interventions and models for delivering preventive and treatment services, and the political willpower to provide current and future servicemembers with the best behavioral health care. Therefore, we must now marshal our resources to implement long-term solutions that provide effective prevention and treatment services to those in uniform now and will promote resilience and early intervention and treatment for our future forces as well.

First, we will not be able to increase access to behavioral health services to those in need now, and to inoculate against, or provide early treatment for psychological injuries if we do not increase the number of uniformed behavioral health service providers in each of our Services. That is why Senator Boxer and I are introducing legislation to increase and improve incentives for the recruitment and retention of uniformed behavioral health providers, including psychologists, psychiatrists, social workers, and mental health nurses. The need for uniformed providers cannot be overemphasized in light of their dual missions to not only deploy to combat zones, but staff garrison military treatment facilities across the globe. We have also learned that uniformed mental health professionals are critical because many of those returning from combat strongly prefer to receive care from a fellow servicemember. As we learn more about the mental health conditions that arise from repealed tours of duty, we must have the uniformed workforce in place to meet the demands of our returning servicemembers and the long-term challenges facing the Department to improve both the access to and the quality of mental health care. I believe this is critical to not only addressing the Department's immediate behavioral health care needs, but also in strengthening the resilience of our forces in the future.

I will also be introducing a second piece of legislation focusing on suicide prevention. Our military's most valuable resource is the people who serve our country in uniform. In the past year, there have been a number of disturbing reports in the news concerning the Army's suicide rate, which was higher in 2007 than any other time this statistic has been tracked by the military, and significantly higher than in the civilian population. We must reverse the current trend. My legislation will create a new prevention program, modeled on the Air Force's highly successful aircraft accident prevention program, at the Department of Defense to investigate all suicides. An independent body, assembled by a four-star general, would produce a confidential report, including recommendations to address any recognized deficiencies. We must have the protocols in place to make sure we are able to determine when a servicemember needs help or immediate attention, and I believe my proposal will go a long way in preserving our most valuable resource—our men and women in uniform. Too much of our current debate on suicide has focused on whether or not there are statistically significant differences in suicides rates from 1 year to the next or when in comparison to those in the general population. Instead, I urge the Department to work with this committee and focus efforts on establishing protocols to investigate all suicides to determine causes and contributing factors, procedures to take immediate corrective action when necessary, and track the implementation of all Service-wide and force-wide recommendations emerging from such investigations.

We can all agree that providing the best behavioral health care to our servicemembers is a priority for the current and future health of our force. I look forward to working with my colleagues on both sides of the aisle this year to tackle the challenges before us. We have asked our servicemembers to accept near-impossible trials and tribulations on the battlefield. The least we can do is to provide them with the best possible care and the attention they deserve.

Senator BEN NELSON. Thank you.

Senator BOXER. Thank you, Senators.

Senator Graham, while you were gone I just said thank you so much for giving me this opportunity, because I think that this legislation is really needed and we would be so thrilled to have it included in the next DOD bill. Thank you very much.

Senator GRAHAM. Thank you, Senator. I agree with you.

Senator BEN NELSON. Thank you, Senator. Senator Graham, do you have an opening statement?

Senator GRAHAM. Very briefly. When Senators Lieberman, Boxer, Nelson, and hopefully Graham can come together, that's a big day

for the Senate. The topic brings us together, and I would just like to say to the witnesses, who are going to testify about the stress on the force, thank you for coming and telling us about what's going on out there. I think I have somewhat of an understanding how stressful it may be, but there have been so many acts of bravery and kindness of our troops in incredibly hostile circumstances and a lot of people have gone back more than twice, and it has to wear on them and their families.

The only thing I can tell you in the opening statement is that if I could be king of the world, bad people would not do bad things. We're in a world where bad people have a desire to disrupt life for the rest of us, and we can sit on the sidelines and hope they go away or we can go fight them. We're going to go fight them, and we're going to take care of those who are doing the fighting. But there's no other option as far as I see it. What happened in Afghanistan should be a wakeup call for all of us. The consequences of losing in Iraq are enormous, and so those who are willing to leave their families and go to far-away places with strange-sounding names to make us all safe, God bless. You're needed. What you're doing is noble and we're going to help you and your family the best we can. But I can't promise you an end to this, because the evil we're fighting will not be compromised with; it has to be defeated.

Senator BEN NELSON. Thank you, Senator Graham.

Before we ask the second panel to step up, I ask unanimous consent that the statements submitted by outside organizations that the staff has already compiled be included in the record.

Without objection, so ordered.

[The prepared statements of the National Military Family Association and Sam D. Toney, MD, follow:]

PREPARED STATEMENT BY THE NATIONAL MILITARY FAMILY ASSOCIATION

Chairman Nelson and distinguished members of this subcommittee, the National Military Family Association (NMFA) would like to thank you for the opportunity to present testimony today on the mental health services for the military and their families. We thank you for your focus on the many elements necessary to ensure quality mental health care for our servicemembers, veterans, and the families within the Department of Defense (DOD) health care system.

NMFA will discuss several issues of importance to servicemembers, veterans, and their families in the following subject areas:

Mental Health
Wounded Servicemembers Have Wounded Families
Who Are the Families of Wounded Servicemembers?
Caregivers

MENTAL HEALTH

As the war continues, families' needs for a full spectrum of mental health services—from preventative care and stress reduction techniques, to individual or family counseling, to medical mental health services—continue to grow. The military offers a variety of mental health services, both preventative and treatment, across many helping agencies and programs. However, as servicemembers and families experience numerous lengthy and dangerous deployments, NMFA believes the need for confidential, preventative mental health services will continue to rise.

Recent findings by the Army's Mental Health Advisory Team (MHAT) IV report stated current suicide prevention training was not designed for a combat/deployed environment. Other reports found a correlation between the increase in the number of suicides in the Army to tour lengths and relationship problems. "Armed Forces Suicide Prevention Act of 2008" is a bicameral proposal calling for a review of existing suicide prevention efforts and a requirement for suicide prevention training for all members of the Armed Forces, including the civilian sector and family support

professionals. NMFA is especially appreciative of the spouses and parents of returning servicemembers' provisions: providing readjustment information; education on identifying mental health, substance abuse, suicide, and traumatic brain injury (TBI); and encouraging them to seek assistance when having financial, relationship, legal, and occupational difficulties. NMFA supports this proposed legislation.

It is important to note if DOD has not been effective in the prevention and treatment of mental health issues, the residual will spill over into the Veterans Administration (VA) health care system. The need for mental health services will remain high for some time even after military operations scale down and servicemembers and their families' transition to veteran status. DOD and the VA must be ready. DOD must partner with the VA in order to address mental health issues early on in the process and provide transitional mental health programs. Partnering between the two agencies will also capture the National Guard and Reserve population who often straddle both agencies' health care systems.

The Army's MHAT IV report links the need to address family issues as a means for reducing stress on deployed servicemembers. The team found the top non-combat stressors were deployment length and family separation. They noted that soldiers serving a repeat deployment reported higher acute stress than those on their first deployment and the level of combat was the key ingredient for their mental health status upon return. The previous MHAT report acknowledged deployment length was causing higher rates of marital problems. Given all the focus on mental health prevention, the study found current suicide prevention training was not designed for a combat/deployed environment. Recent reports on the increased number of suicides in the Army also focused on tour lengths and relationship problems. These reports demonstrate the amount of stress being placed on our troops and their families. Are the DOD and VA ready? Do they have adequate mental health providers, programs, outreach, and funding? Better yet, where will the veteran's spouse and children go for help? Many will be left alone to care for their loved one's invisible wounds left behind from frequent and long combat deployments. Who will care for them now that they are no longer part of the DOD health care system? NMFA encourages this Subcommittee to talk with their VA committee counterparts on these important issues. We can no longer be content on focusing on each agency separately because this population moves too frequently between the two agencies, especially our wounded/ill/injured servicemembers and their families.

DOD's Task Force on Mental Health stated timely access to the proper mental health provider remains one of the greatest barriers to quality mental health services for servicemembers and their families. NMFA and the families it serves have noted with relief more providers are being deployed to theaters of combat operations to support servicemembers. The work of these mental health professionals with units and individuals close to the combat action they experience has proven very helpful and will reduce the stress that impedes servicemembers' performance of their mission and their successful reintegration with their families. However, while families are pleased more mental health providers are available in theater to assist their servicemembers, they are less happy with the resulting limited access to providers at home. DOD's Task Force on Mental Health found families are reporting an increased difficulty in obtaining appointments with social workers, psychologists, and psychiatrists at their military hospitals and clinics. The military fuels the shortage by deploying some of its child and adolescent psychology providers to the combat zones. Providers remaining at home stations report they are frequently overwhelmed treating active duty members who either have returned from deployment or are preparing to deploy. They are also finding it hard to fit family members into their schedules, which could lead to compassion fatigue, create burnout, and exacerbate the problem. NMFA hears from the senior officer and enlisted spouses who are so often called upon to be the strength for others. We hear from the health care providers, educators, rear detachment staff, chaplains, and counselors who are working long hours to assist servicemembers and their families. Unless these caregivers are also afforded respite care, given emotional support through their command, and effective family programs, they will be of little use to those who need their services most.

Access for mental health care, once servicemembers are wounded/ill/injured, further compounds the problem. Families want to be able to access care with a mental health provider who understands or is sympathetic to the issues they face. The VA has readily available services. The Vet Centers are an available resource for veterans' families providing adjustment, vocational, and family and marriage counseling. Vet Centers are located throughout the United States and in geographically dispersed areas, which provide a wonderful resource for our most challenged veterans and their families, the National Guard and Reserves. These Centers are often felt to remove the stigma attributed by other institutions. However, they are not

mandated to care for veteran or wounded/ill/injured military families. The VA health care facilities and the community-based outpatient clinics have a ready supply of mental health providers, yet regulations restrict their ability to provide mental health care to veterans' caregivers unless they meet strict standards. NMFA supports the Independent Budget Veterans Service Organizations recommendations to expand family counseling in all VA major care facilities; increase distribution of outreach materials to family members; improve reintegration of combat veterans who are returning from a deployment; and provide information on identifying warning signs of suicidal thoughts so veterans and their families can seek help with readjustment issues. However, NMFA believes this is just a starting point for mental health services the VA should offer families of severely wounded servicemembers and veterans. NMFA recommends DOD partner with the VA to allow military families access to these services. We also believe Congress should require Vet Centers and the VA to develop a holistic approach to care by including families in providing mental health counseling and programs.

NMFA has heard the main reason for the VA not providing health care and mental health care services is because they cannot be reimbursed for care rendered to a family member. However, the VA is a qualified TRICARE provider. This allows the VA to bill for services rendered in their facilities to a TRICARE beneficiary. There may be a way to bill other health insurance companies, as well. No one is advocating for care to be given for free when there is a method of collection. However, payment should not be the driving force on whether or not to provide health care or mental health services within the VA system. The VA just needs to look at the possibility for other payment options.

Thousands of servicemember parents have been away from their families and placed into harm's way for long periods of time. Military children, the treasure of many military families, have shouldered the burden of sacrifice with great pride and resiliency. We must not forget this vulnerable population as the servicemember transitions from active duty to veteran status. Many programs, both governmental and private, have been created with the goal of providing support and coping skills to our military children during this great time of need. Unfortunately, many support programs are based on vague and out of date information.

Given the concern with the war's impact on children, NMFA has partnered with the RAND Corporation to research the impact of war on military children. The report is due in April 2008. In addition, NMFA held its first ever Youth Initiatives Summit for Military Children, "Military Children in a Time of War" last October. All panelists agreed the current military environment is having an effect on military children. Multiple deployments are creating layers of stressors, which families are experiencing at different stages. Teens especially carry a burden of care they are reluctant to share with the non-deployed parent in order to not "rock the boat." They are often encumbered by the feeling of trying to keep the family going, along with anger over changes in their schedules, increased responsibility, and fear for their deployed parent. Children of the National Guard and Reserve face unique challenges since there are no military installations for them to utilize. They find themselves "suddenly military" without resources to support them. School systems are generally unaware of this change in focus within these family units and are ill prepared to look out for potential problems caused by these deployments or when an injury occurs. Also vulnerable, are children who have disabilities that are further complicated by deployment and subsequent injury. Their families find this added stress can be overwhelming, but are afraid of reaching out for assistance for fear of retribution on the servicemember. They often choose not to seek care for themselves or their families.

NMFA encourages the DOD to partner with and reach out to those private and non-governmental organizations who are experts in their field on children and adolescents to identify and incorporate best practices in the prevention and treatment of mental health issues affecting our military children. At some point, these children will become children of our Nation's veterans. We must remember to focus on preventative care upstream, while still in the active duty phase, in order to have a solid family unit as they head into the veteran phase of their lives.

Family readiness calls for access to quality health care and mental health services. Families need to know the various elements of their military health system are coordinated and working as a synergistic system. NMFA is concerned the DOD military health care system may not have all the resources it needs to meet both the military medical readiness mission and provide access to health care for all beneficiaries. It must be funded sufficiently so the direct care system of military treatment facilities (MTF) and the purchased care segment of civilian providers can work in tandem to meet the responsibilities given under the TRICARE contracts, meet readiness needs, and ensure access for all military beneficiaries.

National provider shortages in this field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates, TRICARE rules, or military-unique geographical challenges (large populations in rural or traditionally underserved areas). Many mental health providers are willing to see military beneficiaries in a voluntary status. However, these providers often tell us they will not participate in TRICARE because of what they believe are time-consuming requirements and low reimbursement rates. More must be done to persuade these providers to participate in TRICARE and become a resource for the entire system, even if that means DOD must raise reimbursement rates.

Many mental health experts state that some post-deployment problems may not surface for several months or years after the servicemember's return. We encourage Congress to request DOD to include families in its Psychological Health Support survey; perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for servicemembers as they deploy into theater); and sponsor a longitudinal study, similar to DOD's Millennium Cohort Study, in order to get a better understanding of the long-term effects of war on our military families.

NMFA is especially concerned at the lack of services available to the families of returning National Guard, Reserve members, and servicemembers who leave the military following the end of their enlistment. They are eligible for TRICARE Reserve Select, but as we know Guard and Reserve are often located in rural areas where there may be no mental health providers available. We ask you to address the distance issues families face in linking with military mental health resources and obtaining appropriate care. Isolated Guard and Reserve families do not have the benefit of the safety net of services provided by MTFs and installation family support programs. Families want to be able to access care with a provider who understands or is sympathetic to the issues they face. NMFA recommends the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographical practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture.

Mental health professionals must have a greater understanding of the effects of mild TBI in order to help accurately diagnose and treat the servicemember's condition. They must be able to deal with polytrauma—Post-Traumatic Stress Disorder (PTSD) in combination with multiple physical injuries. We need more education for civilian health care providers on how to identify signs and symptoms of mild TBI and PTSD. Military families also need education on TBI and PTSD during the entire cycle of deployment. NMFA appreciates Congress establishing a Center of Excellence for TBI and PTSD. For a long time, the Defense and Veterans Brain Injury Center (DVBIC) has been the lead agent on TBI. Now with the new Center, it is very important DVBIC become more integrated and partner with other Services in researching TBI.

Because the VA has as part of its charge "to care for the widow and the orphan," NMFA is concerned about reports that many Vet Centers may not have the qualified counseling services they needed to provide promised counseling to survivors, especially to children. DOD and the VA must work together to ensure surviving spouses and their children can receive the mental health services they need, through all of VA's venues. New legislative language governing the TRICARE behavioral health benefit may also be needed to allow TRICARE coverage of bereavement or grief counseling. While some widows and surviving children suffer from depression or some other medical condition for a time after their loss, many others simply need counseling to help in managing their grief and help them to focus on the future. Many have been frustrated when they have asked their TRICARE contractor or provider for "grief counseling" only to be told TRICARE does not cover "grief counseling." Available counselors at military hospitals can sometimes provide this service while certain providers have found a way within the reimbursement rules to provide needed care. However, many families who cannot access military hospitals are often left without care because they do not know what to ask for or their provider does not know how to help them obtain covered services. Targeted grief counseling when the survivor first identifies the need for help could prevent more serious issues from developing later. The goal is the right care at the right time for optimum treatment effect. The VA and DOD need to better coordinate their mental health services for survivors and their children.

The National Defense Authorization Act for Fiscal Year 2008 authorized an active-duty TRICARE benefit for severely wounded/ill/injured servicemembers once they are medically retired, but their family members were not mentioned in the bill's language. A method of payment to the VA for services rendered without finan-

cially impacting the family would be to include the medically retired servicemember's spouse and children. NMFA recommends an active duty benefit for 3 years for the family members of those who are medically retired. This will help with out-of-pocket medical expenses that can arise during this stressful transition time and provide continuity of care for spouses, especially for those families with special needs children who lose coverage under the Extended Care Health Option program once they are no longer considered active duty dependents.

WOUNDED SERVICEMEMBERS HAVE WOUNDED FAMILIES

Transitions can be especially problematic for wounded/ill/injured servicemembers, veterans, and their families. NMFA asserts that behind every wounded servicemember and veteran is a wounded family. Spouses, children, parents, and siblings of servicemembers injured defending our country experience many uncertainties. Fear of the unknown and what lies ahead in future weeks, months, and even years, weighs heavily on their minds. Other concerns include the wounded servicemember's return and reunion with their family, financial stresses, and navigating the transition process from active duty and the DOD health care system to veteran and the VA health care system.

The two agencies health care systems should alleviate, not heighten these concerns. They should provide for coordination of care, starting when the family is notified that the servicemember has been wounded and ending with the DOD and VA working together, creating a seamless transition as the wounded servicemember transfers between the two agencies' health care systems and eventually from active duty status to veteran status.

NMFA congratulates Congress on the National Defense Authorization Act for Fiscal Year 2008, especially the Wounded Warrior provisions, in which many issues affecting this population were addressed. We also appreciate the work DOD and the VA have done in establishing the Senior Oversight Committee (SOC) to address the many issues highlighted by the three Presidential Commissions. Many of the Line of Action items addressed by the SOC will help ease the transition for active duty servicemembers and their families to their life as veterans and civilians. However, more still needs to be done. Families are still being lost in the shuffle between the two agencies. Many are moms, dads, siblings who are unfamiliar with the military and its unique culture. There is certainly more work to be done by DOD and the VA. We urge Congress to establish an oversight committee to monitor DOD and VA's partnership initiatives, especially with the upcoming administration turnover and the disbandment of the SOC early this year.

WHO ARE THE FAMILIES OF WOUNDED SERVICEMEMBERS?

In the past, the VA and the DOD have generally focused their benefit packages for a servicemember's family on his/her spouse and children. Now, however, it is not unusual to see the parents and siblings of a single servicemember presented as part of the servicemember's family unit. In the active duty, National Guard, and Reserves almost 50 percent are single. Having a wounded servicemember is new territory for family units. Whether the servicemember is married or single, their families will be affected in some way by the injury. As more single servicemembers are wounded, more parents and siblings must take on the role of helping their son, daughter, sibling through the recovery process. Family members are an integral part of the health care team. Their presence has been shown to improve their quality of life and aid in a speedy recovery.

Spouses and parents of single servicemembers are included by their husband/wife or son/daughter's military command and their family support and readiness groups during deployment for the global war on terror. Moms and dads have been involved with their children from the day they were born. Many helped bake cookies for fundraisers, shuffled them to soccer and club sports, and helped them with their homework. When that servicemember is wounded, their involvement in their loved one's life does not change. Spouses and parent(s) take time away from their jobs in order travel to the receiving MTF (Walter Reed Army Medical Center or the National Naval Medical Center at Bethesda) and to the follow-on VA Polytrauma Centers to be by their loved one. They learn how to care for their loved one's wounds and navigate an often unfamiliar and complicated health care system.

It is NMFA's belief the government, especially the DOD and VA, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded servicemember must also consider the needs of the spouse, children, parents of single servicemembers and their siblings, and the caregivers. We appreciate the inclusion in the National Defense Authorization Act for Fiscal Year 2008 Wounded Warrior provision for health care services to be provided

by the DOD and VA for family members as deemed appropriate by each agency's Secretary. According to the Traumatic Brain Injury Task Force, family members are very involved with taking care of their loved one. As their expectations for a positive outcome ebbs and flows throughout the rehabilitation and recovery phases, many experience stress and frustration and become emotionally drained. The VA has also called for recognition of the impact on the veteran when the caregiver struggles because of their limitations. NMFA recommends DOD and VA include mental health services along with physical care when drafting the NDAA fiscal year 2008's regulations.

NMFA recently held a focus group composed of wounded servicemembers and their families to learn more about issues affecting them. They said following the injury, families find themselves having to redefine their roles. They must learn how to parent and become a spouse/lover with an injury. Each member needs to understand the unique aspects the injury brings to the family unit. Parenting from a wheelchair brings on a whole new challenge, especially when dealing with teenagers. Reintegration programs become a key ingredient in the family's success. NMFA believes we need to focus on treating the whole family with programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. DOD and VA need to provide family and individual counseling to address these unique issues. Opportunities for the entire family and for the couple to reconnect and bond as a family again, must also be provided.

The impact of the wounded/ill/injured on children is often overlooked and underestimated. Military children experience a metaphorical death of the parent they once knew and must make many adjustments as their parent recovers. Many families relocate to be near the treating MTF or the VA Polytrauma Center in order to make the rehabilitation process more successful. As the spouse focuses on the rehabilitation and recovery, older children take on new roles. They may become the caregivers for other siblings, as well as for the wounded parent. Many spouses send their children to stay with neighbors or extended family members, as they tend to their wounded/ill/injured spouse. Children get shuffled from place to place until they can be reunited with their parents. Once reunited, they must adapt to the parent's new injury and living with the "new normal." Brooke Army Medical Center has recognized a need to support these families and has allowed for the system to expand in terms of guesthouses co-located within the hospital grounds. The on-base school system is also sensitive to issues surrounding these children. A warm, welcoming family support center located in Guest Housing serves as a sanctuary for family members. Unfortunately, not all families enjoy this type of support. The DOD could benefit from looking at successful programs like Brooke Army Medical Center's which has found a way to embrace the family unit during this difficult time. NMFA is concerned the about the impact the injury is having on our most vulnerable population, children of our military and veterans.

CAREGIVERS

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality of life of the wounded servicemembers and veterans, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to DOD and VA health care providers because they tend to the needs of the servicemembers and the veterans on a regular basis. Their daily involvement saves VA health care dollars in the long run. According to the VA, "'informal' caregivers are people such as a spouse or significant other or partner, family member, neighbor or friend who generously give their time and energy to provide whatever assistance is needed to the veteran". The VA has made a strong effort in supporting veterans' caregivers. The DOD should follow suit and expand their definition.

So far, we have discussed the initial recovery and rehabilitation and the need for mental and health care services for family members. But, there is also the long-term care that must be addressed. Caregivers of the severely wounded, ill, and injured servicemembers who are now veterans, such as those with severe TBI, have a long road ahead of them. In order to perform their job well, they must be given the skills to be successful. This will require the VA to train them through a standardized, certified program, and appropriately compensate them for the care they provide. The time to implement these programs is while the servicemember is still on active duty status.

The VA currently has eight caregiver assistance pilot programs to expand and improve health care education and provide needed training and resources for care-

givers who assist disabled and aging veterans in their homes. These pilot programs are important, but there is a strong need for 24-hour in-home respite care, 24-hour supervision, emotional support for caregivers living in rural areas, and coping skills to manage both the veteran's and caregiver's stress. DOD should evaluate these pilot programs to determine whether to adopt them for themselves. Caregivers' responsibilities start while the servicemember is still on active duty. These pilot programs, if found successful, should be implemented as soon as possible and fully funded by Congress. However, one program missing from the pilot program is the need for adequate child care. Servicemembers can be single parents or the caregiver may have non-school aged children of their own. Each needs the availability of child care in order to attend their medical appointments, especially mental health appointments. NMFA encourages DOD and the VA to create a drop-in child care for medical appointments on their premises or partner with other organizations to provide this valuable service.

NMFA has heard from caregivers of the difficult decisions they have to make over their loved one's bedside following the injury. Many don't know how to proceed because they don't know what their loved one's wishes were. The time for this discussion needs to take place prior to deployment and potential injury, not after the injury had occurred. We support the recent released Traumatic Brain Injury Task Force recommendation for DOD to require each deploying servicemember to execute a Medical Power of Attorney and a Living Will. We encourage this subcommittee to address this issue.

NMFA strongly suggests research on military families, especially children of wounded/ill/injured Operation Iraqi Freedom/Operation Enduring Freedom veterans; standardized training, certification, and compensation for caregivers; individual and family counseling and support programs; a reintegration program that provides an rich environment for families to reconnect; and an oversight committee to monitor DOD's and VA's continued progress toward seamless transition.

DOD must balance the demand for mental health personnel in theater and at home to help servicemembers and families deal with unique emotional challenges and stresses related to the nature and duration of continued deployments. We ask you to continue to put pressure on DOD to step up the recruitment and training of uniformed mental health providers and the hiring of civilian mental providers to assist servicemembers in combat theaters and at home stations to care for the families of the deployed and servicemembers who have either returned from deployment or are preparing to deploy. Spouses and parents of returning servicemembers' need programs providing readjustment information, education on identifying mental health, substance abuse, suicide, and TBI.

DOD should increase reimbursement rates to attract more providers in areas where there is the greatest need. TRICARE contractors should be tasked with stepping up their efforts to attract mental health providers into the TRICARE networks and to identify and ease the barriers providers cite when asked to participate in TRICARE. Congress needs to address the long-term continued access to mental health services for this population.

NMFA would like to thank you again for the opportunity to present testimony today on the mental health needs for the military and their families. Military families support the Nation's military missions. The least their country can do is make sure servicemembers, veterans, and their families have consistent access to high quality mental health care in the DOD and VA health care systems. Wounded servicemembers and veterans have wounded families. DOD and VA must support the caregiver by providing standardized training, access to mental health services, and assistance in navigating the health care systems. The system should provide coordination of care and DOD and VA working together to create a seamless transition. We ask this subcommittee to assist in meeting that responsibility.

PREPARED STATEMENT BY SAM D. TONEY, M.D.

Chairman Nelson, Ranking Member Graham, and distinguished members of the subcommittee, thank you for the opportunity to present this written submission in lieu of a personal testimony, regarding the need for improved mental health access and treatment programs, including suicide prevention, for servicemembers and veterans within the VA and Military Health Systems.

Challenges with mental health management are well documented and include, among other issues, social stigma and access for patients who reside in rural locations. Additionally, the demand for mental health services has been on the rise, par-

ticularly over the last few years.[1] Studies suggestive of improvements in access as a result of an increased number of individuals with psychologic distress having contacted mental health professionals are misleading in that as recently as 2002 approximately two-thirds of adults with significant psychologic distress received no professional mental health care.[2] The extent of this issue is one of global proportions. Several European studies, for example, examine the diminished use of mental health care services and explore the determinants of help-seeking interventions for mental health problems along with the factors that potentially influence treatment options.[3] Here in the United States reports from the surgeon general and the President's New Freedom Commission on Mental Health have concluded that the mental health system is fragmented and that evidence-based treatments are insufficiently used with less than optimal results.[4] Additionally, many studies have focused on adherence to treatment plans including an examination of co-morbidities and elements that might be predictive of frequent hospitalization.[5] Mental health disorders such as depression, for example, have been shown to impact one's inability to adhere to disease management treatment protocols thus worsening the course of the co-morbid state.[6]

Much of the veteran centric research in mental health examines problems specific to combat with a general focus on Post Traumatic Stress Disorder (PTSD).[7] While, veterans have access to a health care system unavailable to most Americans, the Veterans Health Administration (VHA), research demonstrates that utilization patterns in this population are suboptimal as compared to the general population. In 2002, the VHA provided care to approximately 4.5 million veterans in a total veteran population estimated at that time to be 25.3 million (10 percent of the total population).[8] Furthermore, veteran centric data reports that rural-urban disparities across regional delivery networks exist in the veteran population.[9] Such disparities exist in terms of optimal, effective treatment and what individuals in general receive in actual practice settings.[10] This results in functional impairments that continue to drive medical costs upward.

We have found that undiagnosed/untreated or suboptimal treatment of mental health conditions adversely affect the volume and levels of utilization of health care services overall. There are a number of barriers relative to the effective management of mental health conditions, including social stigma and the availability of psychiatric/psychotherapeutic providers in rural communities. The use of state of the art, population based predictive modeling/risk stratification methodologies in addition to traditional telephonic screening will enhance proactive identification of high risk veterans. These approaches coupled with a specialized telephonic mental health care coaching and consultation liaison program will serve to benefit those veterans who would otherwise not seek or have access to mental health care.

The first step toward addressing and effectively managing these veterans with mental health needs is accurate identification and risk stratification. This is a step that goes beyond current efforts to screen the population for a variety of mental health conditions (such as depression and PTSD) for a number of reasons. First, screening efforts typically focus on a limited number of definitive behavioral conditions with an emphasis on identifying and addressing the mental health issues. This does not take subclinical conditions or psychosocial/personality traits into consideration. More importantly, these efforts do not typically evaluate the clinical status/utilization or risk of co-morbid medical conditions. Finally, predictive modeling and risk stratification methodologies utilizing data mined from electronic medical records can provide for an efficient evaluation of the entire population in the system and does not rely on the "participation" of the veteran during screening campaigns. We believe this predictive modeling/risk stratification approach can be an adjunct to current screening processes both from a volume and content perspective.

Telephonically delivered, education-based, disease management programs can facilitate the care patients receive from their physicians, particularly on the primary care level.[11] Furthermore, population-based disease management programs "provide education for a broad population, enabling contact with far more patients than

---

[1] Grembowski, 2002; Colton & Manderscheid, 2006; Maciejewski, et. al, 2007
[2] Mojtabai, 2005
[3] Hutschemaekers, Tiemens, & de Winter, 2007; Kovess-Masféty, et. al, 2007; Younes, 2005
[4] Satcher, 2000; Hogan, 2003
[5] Goldney, Phillips, Fisher, & Wilson, 2004
[6] Ciechanowski, Katon, & Russo, 2000; DiMatteo, Lepper, & Croghan, 2000
[7] Ismail, 2002; Milliken, Aucherlonie, & Hoge, 2007; Ijff et. al, 2007
[8] Liu, Maciejewski, & Sales, 2005
[9] Weeks, et. al, 2004
[10] Satcher, 2000; Rost, Nutting, Smith, Elliott, & Dickinson, 2002; Katon et. al, 2005
[11] Maizels, Saenz & Wirjo, 2003

would be feasible by other means and at a lower per-patient cost than more intensive programs."[12]

Providers may not fully comprehend why their patients do not respond to management of chronic conditions despite best efforts to follow standards of care in treatment protocols. Poor adherence to medication regimens is the most common example of this.[13] While it is acknowledged in the literature that physician practices and patient behaviors contribute to gaps in care, recognizing psychologic distress as the potential source of non-adherence to treatment plans is difficult without the benefit of adequate predictive profiling and risk stratification for a large segment of the population suffering from chronic conditions. Much of the veteran centric research in chronic conditions including mental health examines problems specific to combat with a general focus on PTSD.[14] The VHA research demonstrates that utilization patterns in this population are suboptimal as compared to the general population. As referenced above, this may be secondary to social stigma or geographic challenges, given the facilities based VA care delivery model. Furthermore, veteran centric data reports that rural-urban disparities across regional delivery networks exist in the veteran population.[15] Such disparities exist in terms of optimal, effective treatment and what individuals in general receive in actual practice settings.[16] This results in functional impairments that continue to drive all aspects of medical costs upward.

It is widely recognized that access to care by rural veterans is a significant issue. While the VA system continues to improve by streamlining the appointment verification process, the distances many of our veterans are being asked to travel does not always seem feasible. In rural settings such as some parts of Nebraska or South Carolina, asking veterans to travel hundreds of miles each way does not seem appropriate. The VA has done an admirable job trying to accommodate as many veterans as possible but perhaps it is time to think "outside the box" to implement innovative and creative options, that extend beyond the VA's facilities based delivery paradigm, to address these geographic issues.

Following the identification of a target population within the VA system through the use of predictive modeling and risk stratification, and telephonic screening, we believe that individual veterans within this group should be contacted proactively through a unique and tested telephonic outreach campaign, and managed in an integrated program as follows:

- Engage Members

An enrolled veteran is defined as an individual who has been identified as eligible and appropriate for the program as described above and has agreed to enroll in a care coaching program. Veterans should be contacted for program engagement and enrollment using specially developed, individualized communications tools and techniques. Based on communications sciences, the tools are designed to quickly convey the value of the program, address and remove barriers to enrollment and active participation and ease the veteran into the program.

- Assess and Create Personal Intervention Plan

We believe that behavioral health clinicians (RNs and masters level therapists, supported by MDs and PhDs) should be the primary care coaches for veterans who agree to participate in an integrated management program. These clinicians telephonically conduct a comprehensive veteran assessment (BioPsychoSocial (BPS)) that includes a number of behavioral health screens such as the PHQ–9 and PCL–17 as well as proprietary assessment criteria such as present conditions or health risks, depression history, condition knowledge, communications skills, health literacy, psychosocial barriers, motivation/readiness to change relative to depression and any other care gaps or barriers to treatment. The assessment criteria is used to develop a Personal Intervention Plan, specify the intervention level which defines the intensity and frequency of interventions, and to set care coaching goals focused on improving self-efficacy and sustaining behavior change. In addition, condition-specific modules (e.g. PTSD, depression) assess individual treatment plans against evidence-based guidelines, measure individual symptom severity, quality of life, productivity, treatment plan adherence rates and condition-specific knowledge. Specific mental health assessments also enable care coaches to identify risk factors for suicide and to effectively intervene with preventive measures which include psychoeducational techniques, reframing, clinical alerts, and medical director con-

[12] Feifer, et al., 2004, p.101
[13] Osterberg & Blaschke, 2005
[14] Ismail, 2002; Milliken, Aucherlonie, & Hoge, 2007; Ijff et. al, 2007
[15] Weeks, et. al, 2004
[16] (Satcher, 2000; Rost, Nutting, Smith, Elliott, & Dickinson, 2002; Katon et. al, 2005).

sultation. Medical directors (Board Certified Physicians with specific VA experience and training) review each case monthly for consistency in treatment plans as well as potential underlying psychopathology not yet identified or treated. Medical directors may engage in a collaborative telephonic consultation with the VA practitioner to assist in the diagnosis and further enhancement of the particular treatment plan.

• Follow Personal Intervention Plan

A Personal Intervention Plan is oriented towards "graduation" from the program when the veteran has reached their care coaching goals, achieving sustained behavior change, treatment adherence and desired levels of self-efficacy. The intervention plan strategy includes Care Coaching, which involves motivational interviewing, working with tools to sustain behavior change, and follow up to assess and achieve progress towards goals. The second element to graduation is ensuring that all treatment plan interventions are consistent with evidence-based guidelines. As veterans are enrolled into an integrated program their initial assessment and individual psychosocial issues are communicated to the VA practitioner in a standardized reporting format.

• Measure Relevant Outcomes

Because programs such as these are driven by outcomes, they are developed to measure and report key relevant metrics to demonstrate the impact of the program. For individual veterans, this includes behavior modification milestones and achievement of "graduation" criteria. Across the population, this provides reporting on the activity and progress for every aspect of the program.

Again, I would like to thank the subcommittee for this opportunity and welcome the opportunity to serve as a resource to the subcommittee in the future.

Senator BEN NELSON. With that, will the second panel please come forward as your name placard is being put forward. While that's happening, I did mention, Senator Graham, how we have worked together on this subcommittee for some time when you were chair and now that you're ranking member, and we've reversed our roles, but there's nothing partisan about mental health care for our troops.

On our second panel we are honored to have Admiral Don C. Arthur, United States Navy, Retired; Dr. Shelley M. MacDermid, who are the Co-Chairs of the DOD Task Force on Mental Health, which, as I stated earlier, was a congressionally-mandated task force referred to by both Senator Boxer and Senator Lieberman. The task force, as indicated, was charged with conducting an assessment of and making recommendations for improving the efficacy of mental health services provided to members of the Armed Forces by the DOD, to include access to mental health care providers, the reduction or elimination of stigma in regards to seeking mental health care, and coordination between the Department and civilian communities with respect to mental health services, among many other things.

We're also fortunate to have with us today Colonel Charles W. Hoge, United States Army, who is the Director of the Division of Psychiatry and Neuroscience at the Walter Reed Army Institute of Research. Colonel Hoge is well known in the medical community for his extensive work in the area of mental health care in the military.

Accompanying Colonel Hoge is Colonel Carl A. Castro, United States Army, who is the Research Area Director of the Military Operational Medicine Research Program. Both colonels have participated in elements of all five of the Army's MHAT reports, so they're quite familiar with those reports.

Let me say that I commend the Army for starting these MHAT studies on its own initiative.

We look forward to hearing from each of you, and we will start first with Admiral Arthur—would you like to begin?

STATEMENT OF VADM DONALD C. ARTHUR, USN (RET.) CO-CHAIR, DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH

Admiral ARTHUR. Senator Nelson, Senator Graham: Thank you very much for inviting us to this panel. It's a great honor. Indicative of the teamwork that went into the Mental Health Task Force report, I would actually like to turn it over to Shelley MacDermid for a moment, and we will tag team our presentations if that's okay.

STATEMENT OF DR. SHELLEY M. MACDERMID, CO-CHAIR, DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH

Dr. MACDERMID. Thank you. The full report of the Task Force on Mental Health is being submitted for the record and I thank you very much for inviting both of us to speak today. I'm honored to be here and I'm honored to be among the very distinguished speakers that you will hear from today.

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 of 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 servicemembers and their families. Because of specific gaps that were found during its investigations, 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.

I will now turn to Admiral Arthur.

Admiral ARTHUR. Thank you.

Sir, this is the report. It's titled "An Achievable Vision" and it's titled "An Achievable Vision" because we can get there.

I would like to talk about the three pillars of mental health as concentrated on by this report: prevention, mitigation, and treatment. In the prevention, we focused on establishing a culture in the military Services that looks at mental health as part of an overall health policy, looking at mental health fitness with the same degree of concern that we have for physical fitness. Today we measure mile runs and pushups and pullups, but we don't really measure how psychologically fit or resilient people are to the very difficult stresses of military service. We feel that vulnerability can and should be assessed in our military members and that we accept military members, officers and enlisted, who already have significant issues of stress in their lives, that we can measure and mitigate those stresses that they come to us with.

We can measure their vulnerability to stress, and we can do two things with those measures. One is if we know that someone is vulnerable we can hopefully design programs, which will increase their resilience. We know that some are more resilient than others, and the more resilient the leaders, the less post-traumatic stress they have, and the men and women who serve them have.

So first we can recognize vulnerability and try to mitigate it. Second, we can tell people who are extraordinarily vulnerable that, for example, it would be nice if you could be a jet mechanic, a perfectly good military occupational specialty, but not necessarily put them into the stressful situations that may permanently harm their psychological well-being, such as walking down the streets of Fallujah breaking in doors. Those things can be for the more resilient.

This can also apply to a national level. You can see from the earthquake in Oakland and Hurricane Katrina in New Orleans that those two areas of the country dealt very differently with the environmental trauma, and I think that there could be some lessons learned from those two catastrophes and others; what is it that makes a community resilient and another community not as resilient, and try for the next time to build them up.

My last point on prevention is that the families are very significantly affected by military service. Military service is tough during the best of times, but in combat it is very stressful for the spouses and especially the children. Congressman Walter Jones tells the story of going to Camp Lejeune to a grade school, talking with the kids there and saying: Is your mom or dad in the Marine Corps? One child said: "Well, yes, my daddy is in Iraq, but he is not dead yet." To think of the impact on the families by that innocent statement really speaks to the fact that we must do everything we can to build up the families of our veterans.

The second is mitigation. That is, to try to prevent the effects of combat, which is an absolutely abnormal state. Everyone who comes back from combat suffers post-traumatic stress because that is a normal reaction. We can mitigate this by embedding psychological professionals into our clinics, into our deploying medical support, so that when you have a psychological issue, a soldier, sailor, airman, or marine, does not have to go to someone else, to the hospital, and become labeled as going to seek psychiatric help. He or she can see someone in the battalion, in the company, who understands exactly what the mission of that company is and day-to-day is prepared to mitigate those effects.

We need to screen and train our military leaders that physical fitness—that tactics of battle—are no less important than the psychological fitness of the men and women who go into combat, and that taking care of that psychological fitness is just as important as the maintenance that we would do on high-priced aircraft, tanks, and Humvees.

The last point I would like to make on mitigation is that we have many "volunteers"—and I put that in quotes—organizations, such as the key volunteers of the Marine Corps, the ombudsmen of the Navy, and there are other organizations of spouses and other concerned people who support the families. These are volunteers. They're unfunded. I think that these programs ought to be in some

way formalized, funded, so that every family member has a uniform degree of support.

The last pillar is treatment. It requires a recognition and a destigmatization of mental health issues when people come back from combat or even from non-combat, but extraordinarily stressful deployments. Our military service is like no other service, not like working third shift at Kmart. There are stresses that people need to recognize as normal and celebrate it when we can put someone back into service.

I was in Operation Desert Storm and was with a medical unit who had a battalion commander who was diagnosed with combat stress and admitted to us as an inpatient in Saudi Arabia. In 2 weeks he was returned to his battalion, in time to engage in ground combat evolution. That was a battalion commander returned to function by not taking him out of the field, but addressing the issues and it was General Krulak who did this in the field. He said: "Everybody's stressed; take care of that battalion commander and put him back in place. We have recruited, trained, and equipped the right people; now support them." We did.

Again, the embedding of psychological professionals is important so that you don't have to go somewhere else to get care. You're getting care essentially from your military family.

Access to MTFs, the Veterans Administration (VA) community assets, and other ways of getting the treatment that you need when you need it and where you need it is very, very important. One of the recommendations in the task force report is to have recruit stations be access points for people who are reservists or people who get out of the military and just pass by a recruit station and say: I have a problem; I was in Operation Desert Storm, or I was in Iraq, and I've had these feelings, these paranoia, these thought streams; can you give me some help? Yes, they would have a book, they could make appointments; they could get you into the VA. I think that's a great access point.

Last on treatment is the continuum from the field to the clinic to the hospital, with the family-centered care, to the VA and beyond, is extraordinarily important.

Underscoring all of this, as Senator Boxer well said, is the funding issue. The funding must be risk-adjusted, population-based. That is, to know what type of funding, what type of personnel assets you have to have based on the requirement; and it must be sufficient and predictable.

With that, let me turn it back over to Shelley.

Dr. MACDERMID. Thank you.

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 in advance of its statutory deadline. I know that many dedicated individuals within DOD and the military Services have been working very hard to improve support for mental health and several of the recommendations already have been fully implemented. Many remaining recommendations are targeted for complete implementation by May 2008.

You have many experts here today who can tell you about what is being done and what 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'm aware of little progress, however, on some 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. 18 months ago the task force heard testimony from staff in the TRICARE Management Activity and representatives of the TRICARE contractors that cumbersome TRICARE rules resulted in intensive outpatient care not being covered under TRICARE. They asked for change. We made a recommendation to correct the deficiency.

Yet little progress appears to have been made. These services are offered and heavily used in VA, available at many MTFs, 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-on of services to military members and family members who require care. The task force made several recommendations aimed at increasing the number of such providers and I think several efforts are underway in this area. I'm especially eager to learn about progress in the area of 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 VA 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 individuals who do that work is being recognized by very strong efforts to recruit and retain them.

Also in the area of staffing, I'm 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; temporary staff already in place often could not be retained because it wasn't possible 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; crit-

ical 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 servicemembers and their families. I'm 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 nonrecurring 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. 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 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 servicemembers could easily get access to installations, care managers, and other services. Because they have no official status within the military system, parents sometimes face barriers which systematically disadvantage young unmarried servicemembers.

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'm eager to hear about progress in all of these areas.

In conclusion, Mr. 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 which we all feel pales before the daily struggles that confront families dealing with depression, substance abuse, children's disorders, or post-traumatic stress disorder (PTSD). I'm very much looking forward to the day the plan is fully implemented.

That concludes my remarks and I thank you for your attention and turn it back to Admiral Arthur.

Admiral ARTHUR. Sir, because a veteran is a complex organism and post-traumatic stress is not the only thing that affects them in combat—it is also TBI; they come home and add some alcohol to it, they have family strife—it's very difficult to tease apart what is a mental health issue and what are some of the other social issues. So I'd like to conclude our portion by talking about TBI, which I think is a very big issue in this combat arena.

I would like you to understand the fundamentals of how it differs from TBI that we see in the United States. First is the mechanism. In the United States, and all over the world, we have traffic accidents, we have football injuries, we have domestic violence, and

they are relatively low velocity injuries. Something strikes the person's head and the brain moves, the skull moves, and it causes a bouncing and you get an injury where the strike was and an injury on the other side, and it's a relatively low velocity injury.

That is not what is being seen in Iraq in blast injuries. This is not a tenth of a second, but a microsecond insult to the brain. The brain and the skull do not move as a unit. There tends to be a jiggle effect, in other words. The brain is not a solid piece of tissue that has uniform density. It has many different structures within it that are different densities, and at the density gradients you get a shear effect.

It's more global than just a single injury to one part of the brain, and that's why, because of that diffuse mechanism, you get many symptoms that are not well localized. They are not often predictable. They can be individual as each person is affected differently.

One of the things that we asked for in DOD when I was head of the TBI Task Force was for an omnidirectional blast indicator, something that you could wear into combat, and you could put on vehicles. Now we ask people, what was your blast exposure? They will say: "Well, I was 100 feet from a blast." We don't really know how far 100 feet is in combat. We don't know whether they were in a vehicle, outside of the vehicle, behind a wall, in front of the wall. We don't know what the insult was to the individual soldier, sailor, airman, or marine.

So we've asked the blast industry to construct an omnidirectional indicator that we can use, that will allow us to tell what the exposure has been, correlate that with the symptomatology and with treatment efficacy, and even give the VA an ability to base compensation on actual environmental exposure.

Senator GRAHAM. Where is that at?

Admiral ARTHUR. I don't know, sir. That would be something you would have to ask my Service colleagues now. Since I left 4 months ago, I have not kept pace with where that is.

We also would like a baseline cognitive test. Football players, soccer players, already have that. If we had a baseline cognitive test going into combat or even coming into the Service, we could in the field assess an individual's exposure and the resultant cognitive effect and have some idea on the extent of their injury.

When I had my TBI 2½ years ago, the psychologist gave me a whole battery of tests, and—in the air he drew a line—he said: "But you're normal; you are here on the battery of tests, you score very high." I said: "I know, but I did not start there; I started at some other level."

I think you know of General Manny and his struggles. I talked with him just this last week. A general officer, a judge in his local constituency down in Florida, did not start at a baseline average American intellect. So we have to have, I think, individual baseline testing.

Third, we have to have recognition and treatment with research, and the recognition won't come from people presenting and saying: "I have TBI." They will come with people saying: "You know, I can't remember things, I can't remember faces, I can't find my way out of Home Depot. My wife says that I forget her anniversary, and I'm blaming it on TBI." [Laughter.]

"I can't calculate how much to give on a tip at a restaurant. These are abnormal for me." So people will present with a myriad of symptoms that are not normal behavior for them and must be recognized and treated.

Senator Boxer brought up the incidence of behavioral issues, of people going to non-judicial punishment because they've acted out of the context of what they had, or they're discharged for psychological issues existing prior to entry, when really it may be our failure to recognize TBI.

Last is prevention. There are many things that we can do to prevent some of these TBIs. Let me give you one example of technology, and again I don't know where this one is either. But I was up in Massachusetts at Mass General in a collaboration between Harvard and MIT on these design issues of mitigation strategies. I talked to the head of the physics department at MIT and he said: We have this gel, which is very much like the gel you would use on a bicycle seat or something like that. You put your hand in it and it forms an impression. We can change the characteristic of that gel by adding electricity, and the amount of electricity we add to that gel will make it harder or softer. It will change the shape of the polymers, the molecules, and make it hard or soft. So it might be soft as a nice helmet liner when you have a motor vehicle accident and you're bouncing your head inside of a motor vehicle, but for a blast injury you may want it to have a different consistency, maybe a little harder, and the blast indicator could send a message to a microprocessor and provide an amount of electricity to that gel which would change its polymorphic configuration to be more blast-attenuating.

So there are many things we could do, and the solution to TBI isn't just in the treatment or recognition; it's in the technology to prevent and mitigate.

Senator Nelson, Senator Graham, thank you very much for this opportunity. It's a true honor to be able to come back and testify before you, and thank you for your attention that you're paying to this very important issue.

[The prepared statement of Dr. MacDermid follows:]

PREPARED STATEMENT BY SHELLEY M. MACDERMID, MBA, PH.D

Chairman Nelson, Senator Graham, 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. 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 with my co-chair Admiral Arthur today.

The full report of the Task Force on Mental Health is being submitted for the record. 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 servicemembers 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.

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 military treatment facilities (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 Activity 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, yet little progress appears to have been made. These services are offered and used heavily in VA, available at many MTFs, 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.

I am especially eager to learn about progress in the area of 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.

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 servicemembers and their families—I am eager to hear how they have been addressed.

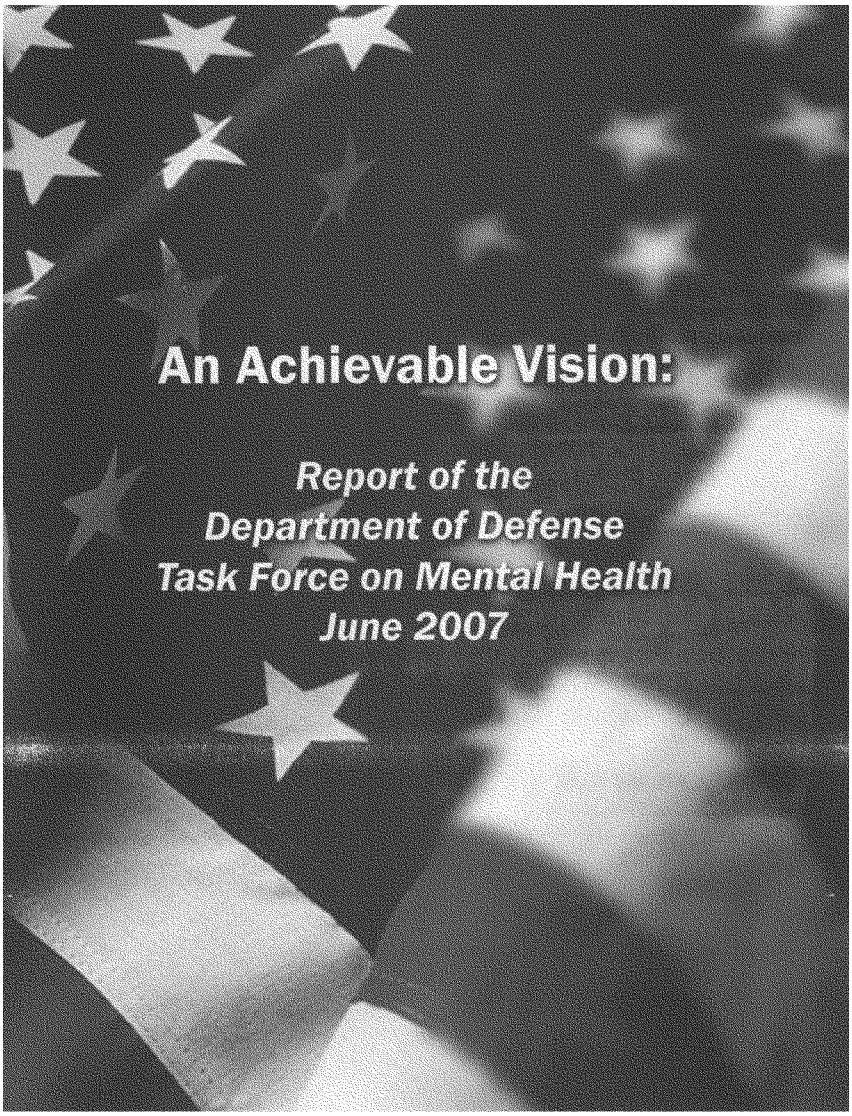
While Congress has been helpful in allocating funds, I am eager to hear whether the right mix has been provided. For example, substantial funds have been allocated on a non-recurring basis, which makes it difficult to address infrastructure issues, and makes it difficult to hire the best staff. The task 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 servicemembers 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 servicemembers. 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 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, Mr. 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 post-traumatic stress disorder. 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.

[The Report of the Department of Defense Task Force on Mental Health dated June 2007 follows:]


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

Defense Health Board
Task Force on Mental Health
5205 Leesburg Pike
Falls Church, Virginia 22041-3258

Co-Chairs

Vice Admiral Donald C. Arthur, MC, USN
(April 2007 – June 2007)

Shelley MacDermid, MBA, Ph.D.
(May 2006 – June 2007)

Lieutenant General Kevin C. Kiley, MC, USA
(May 2006 – March 2007)

Committee Members

Dan German Blazer, M.D., M.P.H., Ph.D.
Colonel Rick Campise, USAF, BSC
Lieutenant Colonel Jonathan Douglas, USMC
Deborah Fryar, RN, BSN
Captain Warren Klam, MC, USN
Richard McCormick, Ph.D.
Layton McCurdy, M.D.
Colonel David T. Orman, MC, USA (Retired)
Colonel Angela Pereira, MS, USA
A. Kathryn Power, M.Ed.
Lieutenant Commander Aaron Werbel, MSC, USN
Antonette Zeiss, Ph.D.
Captain Margaret McKeathern, MC, USN (alternate member)

Suggested citation: Department of Defense Task Force on Mental Health. (2007). *An achievable vision: Report of the Department of Defense Task Force on Mental Health.* Falls Church, VA: Defense Health Board.

TABLE OF CONTENTS

EXECUTIVE SUMMARY ES-1
1. BACKGROUND, ORGANIZATION & ACTIVITIES OF THE TASK FORCE 1
2. INTRODUCTION 5
3. A VISION FOR THE FUTURE 7
4. TODAY'S LANDSCAPE 11
5. FINDINGS AND RECOMMENDATIONS: AN ACHIEVABLE VISION 15
5.1 Building a Culture of Support for Psychological Health 15
5.1.1 Dispel Stigma 15
5.1.2 Make Mental Health Professionals Easily Accessible to Service Members 17
5.1.3 Embed Training about Psychological Health throughout Military Life 18
5.1.4 Revise DOD Policies to Reflect Up-to-Date Knowledge about Psychological Health 20
5.1.5 Make Psychological Assessment an Effective, Efficient, and Normal Part of Military Life 25
5.2 Ensuring Service Members and Their Families Receive a Full Continuum of Excellent Care 27
5.2.1 Make Prevention, Early Intervention, and Treatment Universally Available 27
5.2.2 Maintain Continuity of Care across Transitions 28
5.2.3 Ensure High-Quality Care 32
5.2.4 Provide Family Members with Excellent Access to Care 36
5.3 Providing Sufficient Resources and Allocating them According to Requirements 41
5.3.1 Provide Sufficient Resources for the Support of Psychological Health 41
5.3.2 Provide Sufficient Staff and Allocate Them Properly 42
5.3.3 Ensure an Adequate Supply of Uniformed Providers 45
5.3.4 Ensure TRICARE Networks Fulfill Beneficiaries' Psychological Health Needs 49
5.4 Empowering Leadership 53
5.4.1 Establish Visible Leadership and Advocacy for Psychological Health 53
5.5 Special Topics 57
5.5.1 Reserve Components: Special Considerations 57
5.5.2 Female Service Members and Veterans 58
5.5.3 Traumatic Brain Injury and Its Psychological Health Implications 60
6. THE WAY FORWARD 63

APPENDICES

Appendix A: Summary of Findings Related to Task Force Elements A-1
Appendix B: Members of the Task Force A-5
Appendix C: Sites Visited by Task Force Delegations, Sept 2006 – Feb 2007 ..... A-11
Appendix D: Task Force Meetings, July 2006 – April 2007 ..... A-13
Appendix E: Briefings Received at Task Force Meetings A-15
Appendix F: Glossary A-17
Appendix G: Acronyms A-21
Appendix H: References A-23
Appendix I: Acknowledgements A-28

EXECUTIVE SUMMARY

Background

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

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

Introduction

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

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

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

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

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

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

Vision

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

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

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

Findings

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

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

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

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

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

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

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

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

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

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

4) *Empowering leadership*

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

Recommendations

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

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

Conclusion

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

1. BACKGROUND, ORGANIZATION & ACTIVITIES OF THE TASK FORCE

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

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

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

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

Site Visits

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

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

Task Force Meetings

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

Working Groups

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

Task Force Support

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

Scope of the Task Force

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

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

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

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

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

Limitations of the Task Force and Report

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

[Next page intentionally left blank]

2. INTRODUCTION

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

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

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

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

DOD's mental health mission has fundamentally changed.

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

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

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

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

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

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

3. A VISION FOR THE FUTURE

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

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

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

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

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

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

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

Goals of a World-Class System

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

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

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

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

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

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

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

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

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

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

An Unrealized Vision

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

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

[Next page intentionally left blank]

4. TODAY'S LANDSCAPE

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

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

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

TRICARE

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

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

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

The Military Health System

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

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

Source: DEERS Data, 7 March 2007

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

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

Substance Abuse Prevention and Treatment

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

Family Support Centers

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

Family Advocacy Programs

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

Military OneSource

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

Chaplains

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

Other Organizations

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

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

Departments of Defense and Veterans Affairs Joint Initiatives

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

5. FINDINGS AND RECOMMENDATIONS: AN ACHIEVABLE VISION

5.1 BUILDING A CULTURE OF SUPPORT FOR PSYCHOLOGICAL HEALTH

5.1.1 Dispel Stigma

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

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

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

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

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

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

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

Combating Public Stigma

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

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

Recommendation 5.1.1.1

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

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

Combating Self-Stigma

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

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

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

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

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

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

Combating Structural Stigma

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

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

5.1.2 Make Mental Health Professionals Easily Accessible to Service Members

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

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

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

Embed Mental Health Providers in Units

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

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

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

Recommendation 5.1.2.1

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

Integrate Mental Health Professionals into Primary Care

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

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

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

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

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

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

Recommendation 5.1.2.2

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

5.1.3 Embed Training about Psychological Health throughout Military Life

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

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

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

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

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

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

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

Training Leaders

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

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

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

Recommendation 5.1.3.1

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

Training Family Members

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

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

Recommendation 5.1.3.2

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

Training Medical Personnel

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

Recommendation 5.1.3.3

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

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

Recommendation 5.1.3.4

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

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

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

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

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

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

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

Revise Policies on Command Notification and Self-Disclosure

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

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

Recommendation 5.1.4.1

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

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

Recommendation 5.1.4.2

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

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

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

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

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

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

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

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

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

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

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

Recommendation 5.1.4.3

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

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

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

Recommendation 5.1.4.4

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

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

Revise DOD Directive 6490.1 and Instruction 6490.4

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

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

Recommendation 5.1.4.5

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

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

Redeployment of Military Personnel with Psychiatric Conditions Including PTSD

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

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

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

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

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

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

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

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

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

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

Challenges to Effective Assessment

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

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

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

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

Recommendation 5.1.5.1

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

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

Recommendation 5.1.5.2

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

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

Recommendation 5.1.5.3

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

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

5.2.1 MAKE PREVENTION, EARLY INTERVENTION, AND TREATMENT UNIVERSALLY AVAILABLE

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

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

Gaps in What Services are Offered

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

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

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

Gaps in Where Services are Offered

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

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

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

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

Gaps in to Whom Services are Offered

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

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

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

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

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

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

Recommendation 5.2.1.1

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

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

5.2.2 MAINTAIN CONTINUITY OF CARE ACROSS TRANSITIONS

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

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

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

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

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

Recommendation 5.2.2.1

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

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

Recommendation 5.2.2.2

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

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

Recommendation 5.2.2.3

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

Military-to-Civilian Health Care Transitions for Service Members

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

Recommendation 5.2.2.4

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

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

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

Recommendation 5.2.2.5

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

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

Recommendation 5.2.2.6

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

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

Recommendation 5.2.2.7

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

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

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

Recommendation 5.2.2.8

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

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

Recommendation 5.2.2.9

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

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

Recommendation 5.2.2.10

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

Consent Issues during Transitions

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

Recommendation 5.2.2.11

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

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

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

Recommendation 5.2.2.12

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

5.2.3 ENSURE HIGH-QUALITY CARE

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

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

Accessibility

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

Recommendation 5.2.3.1

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

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

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

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

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

Recommendation 5.2.3.2

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

Content of Care

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

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

Recommendation 5.2.3.3

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

Effectiveness of Care

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

Recommendation 5.2.3.4

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

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

Recommendation 5.2.3.5

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

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

Recommendation 5.2.3.6

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

Processes of Care

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

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

Recommendation 5.2.3.7

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

Developing Innovations in Care

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

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

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

Recommendation 5.2.3.8

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

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

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

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

Recommendation 5.2.3.9

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

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

Recommendation 5.2.3.10

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

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

Recommendation 5.2.3.11

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

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

Recommendation 5.2.3.12

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

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

Recommendation 5.2.3.13

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

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

5.2.4 PROVIDE FAMILY MEMBERS WITH EXCELLENT ACCESS TO CARE

Family Members

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

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

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

Expanding the Military Definition of 'Family'

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

Recommendation 5.2.4.1

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

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

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

Recommendation 5.2.4.2

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

Deployment Cycle Support

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

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

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

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

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

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

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

Recommendation 5.2.4.3

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

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

Recommendation 5.2.4.4

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

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

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

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

Recommendation 5.2.4.5

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

Barriers to Mental Health Services

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

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

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

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

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

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

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

Schools Serving Military Children

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

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

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

Recommendation 5.2.4.7

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

Care for Survivors and Families of Wounded Service Members

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

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

Recommendation 5.2.4.8

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

5.3 PROVIDING SUFFICIENT RESOURCES AND ALLOCATING THEM ACCORDING TO REQUIREMENTS

5.3.1 Provide Sufficient Resources for the Support of Psychological Health

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

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

Recommendation 5.3.1.1

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

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

Recommendation 5.3.1.2

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

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

Recommendation 5.3.1.3

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

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

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

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

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

Recommendation 5.3.1.4

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

5.3.2 Provide Sufficient Staff and Allocate Them Properly

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

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

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

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

Care Must be Provided by Professionals Familiar with Military Life

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

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

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

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

There is an Inadequate Number of Providers

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

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

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

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

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

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

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

Recommendation 5.3.2.1

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

Recommendation 5.3.2.2

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

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

The Current Allocation System is Problematic

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

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

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

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

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

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

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

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

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

Recommendation 5.3.2.3

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

5.3.3 Ensure an Adequate Supply of Uniformed Providers

Uniformed Mental Health Professionals Are Critical Resources

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

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

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

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

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

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

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

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

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

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

Recommendation 5.3.3.1

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

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

Recommendation 5.3.3.2

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

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

Recommendation 5.3.3.3

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

Maximize the Use of Uniformed Mental Health Technicians

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

Recommendation 5.3.3.4

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

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

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

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

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

Recommendation 5.3.3.5

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

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

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

Recommendation 5.3.3.6

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

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

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

Recommendation 5.3.3.7

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

5.3.4 Ensure TRICARE Networks Fulfill Beneficiaries' Psychological Health Needs

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

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

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

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

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

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

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

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

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

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

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

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

Recommendation 5.3.4.1

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

Recommendation 5.3.4.2

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

Recommendation 5.3.4.3

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

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

Recommendation 5.3.4.4

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

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

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

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

Recommendation 5.3.4.5

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

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

Recommendation 5.3.4.6

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

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

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

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

Recommendation 5.3.4.7

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

Recommendation 5.3.4.8

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

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

Recommendation 5.3.4.9

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

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

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

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

Recommendation 5.3.4.10

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

5.4 EMPOWERING LEADERSHIP

5.4.1 Establish Visible Leadership and Advocacy for Psychological Health

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

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

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

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

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

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

Recommendation 5.4.1.1

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

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

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

Recommendation 5.4.1.2

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

Recommendation 5.4.1.3

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

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

Recommendation 5.4.1.4

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

Recommendation 5.4.1.5

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

Recommendation 5.4.1.6

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

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

Recommendation 5.4.1.7

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

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

Recommendation 5.4.1.8

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

Recommendation 5.4.1.9

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

Psychological Health Leadership in the National Guard and Reserves

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

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

National Guard Leadership

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

Recommendation 5.4.1.10

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

Recommendation 5.4.1.11

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

Recommendation 5.4.1.12

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

Recommendation 5.4.1.13

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

Recommendation 5.4.1.14

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

Reserve Component Leadership

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

Recommendation 5.4.1.15

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

Recommendation 5.4.1.16

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

5.5 SPECIAL TOPICS

5.5.1 Reserve Components: Special Considerations

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

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

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

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

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

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

- Strengthen the mental health infrastructure within the National Guard and Reserves (see Sections 5.1.2, Make Mental Health Professionals Easily Accessible to Service Members, 5.1.4, Revise Military Policies to Reflect Up-To-Date Knowledge about Psychological Health, 5.1.5, Make Psychological Assessments an Effective, Efficient, and Normal Part of Military Life, and 5.4.1 Establish Visible Leadership and Advocacy for Psychological Health).
- Improve the training of TRICARE contractual providers on the military experience and its sequelae, and make access to such providers more user-friendly (see Section 5.3.4, Ensure TRICARE Networks Fulfill Beneficiaries' Psychological Health Needs).
- Improve the interface between DOD and DVA (see Section 5.2.2, Maintain Continuity of Care across Transitions).
- Improve education on the early identification and management of mental health issues provided to commanders and enhance the basic medical resources (e.g., corpsmen and medics) assigned to Reserve Component units (see Section 5.2.1, Make Prevention, Early Intervention and Treatment Universally Available).
- Assure that Reserve Component policies foster a supportive approach to service members returning from deployment (see Section 5.1.4, Revise Military Policies to Reflect Up-To-Date Knowledge about Psychological Health).

Even if these changes are implemented, however, we cannot be sure that they will sufficiently address the enormous challenge of assuring that every member of the National Guard and Reserves, and their family members and survivors, has ready access to the help needed to successfully readjust to life with their families in their home communities. Currently, no one has responsibility for the ongoing assessment of what is working well for and what is failing these service members and their families. As such, there is no feedback loop to continuously improve our efforts in the face of these daunting challenges.

Recommendation 5.5.1.1

The Department of Defense should earmark sufficient funds for and mandate that the National Guard Bureau and Reserve Component Commands conduct regular anonymous surveys of National Guard and Reserve members, their families, and survivors assessing the following (at a minimum):

- *Barriers (i.e., structural, financial, personal) to access to a full array of psychological health services, including marital and family counseling;*
- *Satisfaction with such services, including the perceived empathy of providers for the military experience;*
- *Stigma surrounding mental health issues;*
- *Knowledge and understanding of commanders about mental health issues; and*
- *Adequacy of training for unit-level medics in psychological health issues.*

Recommendation 5.5.1.2

The Department of Defense should ensure problems uncovered by the above surveys result in timely action plans to improve access to and the quality of psychological health services for Reservists, their families and survivors. The Director of Psychological Health for each Guard element or Reserve command should draft action plans addressing these needs and forward them and regular progress reports to the National Guard Bureau or Central Reserve Command Office.

5.5.2 Female Service Members and Veterans

Female service members in combatant areas have had to fight the enemy in the same manner as their male counterparts: engaging in firefights, taking prisoners and possibly becoming casualties.

Current Public Law (NDAA 1994, HR 2401, Sec. 543) excludes active duty women from certain job categories including, but not limited to, ground combat operations (e.g., infantry, armor, artillery units). Despite this restriction, female military members are an integral part of the large support force for these and other operations. The lack of frontlines and the insurgent nature of the current conflicts have made avoidance of many combat situations very difficult. Female service members in combatant areas have had to fight the enemy in the same manner as their male counterparts: engaging in firefights, taking prisoners, and occasionally becoming casualties. In June 2005, Sergeant Leigh Ann Hester, of the 617th Military Police Company from the Richmond, Kentucky National Guard Unit, became the first woman to be awarded the Silver Star (the nation's third-highest medal for valor) since World War II. Her citation noted actions against the enemy including the killing of at least three insurgents (see http://www.defenselink.mil/news/newsarticle.aspx?id=16391).

Women comprise approximately 15 percent or approximately 210,000 out of 1.4 million active duty service members (DMDC, 2006). Since 2001, female service members have served in the combat areas in both Afghanistan and Iraq. OEF and OIF are the first combat operations where a large number of female service personnel have had the potential for repeated exposures to combat situations. Repeat deployments have also added to the exposure potential. Like their male counterparts, incidents affecting women have included, but have not been limited to, firefights, ambushes, security operations, mortar and grenade attacks, improvised explosive devices, and witnessing and/or experiencing severe injury and/or death. Overall, of the 229,015 OIF/OEF veterans who sought VA care between 2002 and 2006, 12 percent were women. As a result, the DVA will be providing services to more female veterans than in the past. It is estimated that by 2010, 14 percent of all veterans will be women (see http://www1.va.gov/wvhp/page.cfm?pg=26). As with male service members, female veterans are at risk for exposure to combat-related incidents and trauma, which have the potential to result in PTSD or other stress reactions at a higher incidence than previously thought.

Studies of how women are affected psychologically by combat are relatively recent and results to date are mixed. Hoge et al. (2004) reported, "Women serving in combat have about the same risk as men of getting PTSD or other mental health conditions." Studies conducted after the Gulf War concluded that female service members were more likely than their male counterparts to develop PTSD (Perconte, Wilson, Pontius, Deitrick & Spiro, 1993). This is consistent with the 2 to 1 ratio of female to male PTSD sufferers in the general population (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). A comparison of male and female veterans form the Vietnam and Gulf Wars, however, suggests that when controlling for the level of combat exposure, males are three times more likely to be given a diagnosis of PTSD than females (Pereira, 2002). One explanation for this may be cultural expectations that make it difficult for society and mental health providers to recognize women as combatants. Additionally, there is a tendency in the mental health profession to diagnose women as having depression, anxiety and borderline personality disorder instead of combat-related PTSD (Becker, 1994).

Treatment of PTSD in women has also recently begun to be studied. In 2005, the DVA conducted a study of PTSD among female veterans, the first DVA study to focus exclusively on a large number of female veterans. The study was designed to determine whether treatment with "Prolonged Exposure Therapy (PE)" was more effective than "Present-Centered Therapy (PCT)". PE was found to be significantly more effective than PCT for treating PTSD in active duty personnel and female veterans. After treatment, the PE group was more likely to no longer meet the diagnostic criteria for PTSD than the PCT group (41% vs. 27.8%). The PE group was also more likely to achieve total remission (15.2% vs. 6.9%; Schnurr et al., 2007). Based on these results, the DVA created two national initiatives in evidence-based practice in PTSD. The first will train and support 600 therapists to conduct related Cognitive Processing Therapy (CPT). The second will support the use of PE therapy as an alternative means of treatment.

Making such effective therapies available for women veterans is an important goal. A potential barrier for women needing treatment for mental health issues related to combat trauma is their need to show the emotional strength expected of military members. The self-image of the woman veteran may serve as an additional obstacle in obtaining treatment for military-related PTSD. After their military service, many women no longer see themselves as veterans. Moreover, they may not associate symptoms of trauma exposure with their military service. Despite such conjectures, at the end of FY06, female veterans of OEF and OIF sought DVA care at a higher rate than male veterans (17% vs. 11%). Further, thirty-seven percent of female veterans OEF/OIF have used the DVA for some type of health care at least once between 2002 and 2006. As the DVA continues to expand its programs for women, it is expected that female veterans will increasingly seek care there.

The DVA has made significant steps in its programs for female veterans. A Women's Veterans Program Manager is now located at every DVA medical center in the country. The Program Manager also functions as an advocate to assist women in finding and accessing DVA services, programs, community resources, and state and federal benefits. Increasing numbers of DVA facilities have specialized inpatient and outpatient mental health services and clinics. There are also programs for women who are homeless and those who are at risk of becoming homeless.

Another area of concern for the DVA is military sexual trauma (MST), which refers to a variety of sexual offenses ranging from verbal sexual harassment to assault and rape. Public Law 102-585, the Veterans Health Care Act of 1992, authorized new and expanded services for women veterans including outreach and counseling services for sexual trauma incurred while serving on active duty. The law was later amended, authorizing the DVA to provide counseling to men (see http://www1.va.gov//wvhp/page.cfm?pg=25). Each DVA medical center has an MST coordinator and trained sexual trauma counselors. There is also a DVA MST support team to ensure that these programs are in compliance with legally-mandated monitoring of MST screening and treatment. This team also coordinates and disseminates the latest education, training and best practices related to MST throughout the DVA healthcare system.

Both female service members and veterans have an increasing number of mental health services available to them. Research is continuing to find better methods of prevention, early intervention, and treatment for psychological problems. Overcoming the fear and misunderstanding that surrounds psychological care should not be overlooked and requires continued attention. The following recommendations capture the highest current priorities for such efforts:

Recommendation 5.5.2.1

The needs of women service members and veterans should remain a focus of high-level planning groups in the Department of Defense (with all military Services represented) and the Department of Veterans' Affairs. The Department of Defense Psychological Health Strategic Plan should include specific attention to the

psychological health needs of women. The annual report on the Status of Female Members of the Armed Forces should include information about the adequacy of support for psychological health of women.

Recommendation 5.5.2.2

The Department of Defense should develop treatment programs specifically geared towards the psychological health needs of female service members.

Recommendation 5.5.2.3

The Department of Defense should continue to aggressively conduct prevention, early identification and treatment of military sexual trauma among service members of both sexes. DOD should continue to evaluate the effectiveness of restricted reporting for domestic violence and sexual assault.

5.5.3 Traumatic Brain Injury and Its Psychological Health Implications

TBI can be a consequence of exposure to blast injuries, automobile crashes, blunt object force to the head, or a number of other sources of injury during combat. TBI injuries fall along an extremely broad spectrum, from very mild injuries with minimal functional implications and likely spontaneous recovery to profound brain injuries that result in multiple impaired cognitive functions that are unlikely to fully resolve. TBI is not a mental health problem; it is a neurological problem. At the same time, there are psychological health implications of TBI that warrant mention in this report.

Before exploring psychological health implications, some problems facing the military system in regard to TBI should be noted:

- Documentation of injury is not always available, given that the nature of combat is such that an injury can occur at any time and there may be no observer or person in a position to keep a record of the event(s). Thus, criteria for determining possible TBI must depend on self-report and evidence of functional limitations.
- Researchers are working to develop a reliable, valid screening tool for TBI that would trigger a more thorough evaluation. At present, however, there is no well-validated screening tool, and any efforts to carry out such assessment must address the fact that there will be a large number of false positive and/or false negative results.
- Sustainment of a TBI may increase the likelihood of sustaining an additional TBI, due to impaired response time, judgment, problem-solving capacity, etc. Even a mild TBI may increase risk for further injury.

Psychological Health Implications

The differential diagnosis of TBI and PTSD may be difficult, given some overlap in symptoms (e.g., irritability, distractibility, memory lapses). Nonetheless, *differential* diagnosis may be less important than attention to *co-occurring* diagnoses. The likelihood of such co-occurring disorders is high:

- Most individuals who sustained a TBI also were exposed to a situation that would fit the definition of events described in Criterion A for a diagnosis of PTSD – a dangerous event in which the person felt in danger of his/her life, felt helpless and powerless to prevent negative events, etc. Many of these individuals will have other PTSD symptoms and can best be understood as having both a TBI and PTSD resulting from the same event(s).
- Some individuals with TBI may have had exposure to events leading to PTSD prior to or subsequent to the TBI.
- Other mental health problems, such as substance abuse problems, may be present.
- Mental health problems may result from the experience of living with the sequelae of TBI (e.g., functional losses, changed vocational prospects, changed family roles and aspirations).
- Treatment for co-occurring mental health disorders will be influenced by TBI. For example, psychosocial approaches are currently the most effective treatments for PTSD, and they require cognitive capabilities such as learning and problem-solving. When medications are appropriate treatment, ability to follow a medication regimen is crucial. Mental

health care providers need to be aware of the challenges posed by TBI and must develop processes to adapt their treatment approaches to make them accessible and useful to these patients.

- TBI has garnered considerable media interest and is widely described as extremely prevalent, despite the absence of definitive data and assessment procedures. It is possible that former service members who have not incurred a TBI, but who have other problems leading to emotional distress, may read about TBI and erroneously infer that their problems are a result of TBI. This misidentification of the cause of problems may be exacerbated by the fact that mental health problems are still more stigmatized than brain injury.
- Caregivers of individuals with TBI are also under considerable stress and may develop mental health problems that need attention for that individual to stay in the caregiving role.

There are currently work groups in both the DOD and DVA examining needs for TBI services and development of policy recommendations for effective handling of these needs (e.g., IRG, 2007).

Recommendation 5.5.3.1

We suggest acceptance of the Independent Review Group's traumatic brain injury recommendations and endorse close examination of recommendations proposed by the other Department of Defense and Department of Veterans' Affairs traumatic brain injury working groups when they are issued.

[Next page intentionally left blank]

6. THE WAY FORWARD

The psychological health needs of service members, their families and their survivors are daunting and growing. The evidence for this is substantial. Despite the suppressing effects of stigma, more than a third of active duty Soldiers and Marines self-report psychological health problems in the months following deployment, as do half of the members of the Reserve Component (DMSS, 2007). Rates of self-reported psychosocial and marital concerns are highest among service members exposed to the greatest degree of danger and who have repeatedly deployed. Further, the number of service members in these subgroups continues to grow (U. S. Army, 2006; Wheeler, 2007).

The time for action is now. The human and financial costs of un-addressed problems will rise dramatically over time. Our nation learned this lesson, at a tragic cost, in the years following the Vietnam War. Fully investing in prevention, early intervention, and effective treatment are responsibilities incumbent upon us as we endeavor to fulfill our obligation to our military service members.

The Task Force recognizes that some of the recommendations identified herein will require further planning and refinement. We do not have the luxury of time for protracted planning. We urge DOD and the military Services to adopt the proactive battlefield strategy of engaging the problem and adjusting plans while engaged. This strategy is equally imperative in addressing the needs highlighted throughout this report. The recommendations on adequately resourcing the system, which underpin many of the other recommendations, provide a crucial example of this point. The current complement of mental health professionals is woefully inadequate to provide the prevention, resilience building, unit-level command consultation, in-theater intervention services, and a full continuum of direct care services tailored to the needs of military members and their families. The process for recruiting additional trained mental health professionals, both uniformed and civilian, is time consuming and cumbersome. The number that could possibly be recruited within the next six months, for example, is well below the number required to ultimately address the need. The recruitment process should be initiated immediately, even as plans for an eventual staffing model and prioritizing of needs are underway.

We urge that as the Secretary of Defense approves a recommendation in principle, he also require the rapid drafting of an action plan that includes immediate steps, timelines, and firm deadlines to ensure its achievement.

While the current operational tempo has drawn attention to the need for services that build and maintain the resilience of our fighting forces, provide a full continuum of prevention, early intervention, and treatment for them and their families, and eliminate barriers such as stigma, the lessons learned will be equally applicable to the periods of time after we have recovered from the immediate effects of the current conflicts and prepare for the next. The solutions to the problems highlighted in this report are not short-term fixes that can be funded with the temporary allocation of resources. Rather, we must build and maintain a robust psychological health infrastructure that is capable of fulfilling the broad recovery and prevention mission outlined in this report.

While we recognize the work of this Task Force is necessarily incomplete and that our recommendations provide only the groundwork for a comprehensive strategic plan to support the psychological health of service members and their families, the immediacy of these needs imparts a sense of urgency to our report. We urge DOD to adopt a similar sense of urgency in rapidly developing and implementing a plan for action.

We urge that as the Secretary of Defense approves a recommendation in principle, he also require the rapid drafting of an action plan that includes immediate steps, timelines, and firm deadlines to ensure its achievement.

The true test of our nation's commitment to address the unseen needs highlighted in this report lies in how aggressively and expeditiously we act. Service members, their families and their survivors are bearing our burden. We owe them nothing less than to act immediately.

[Next page intentionally left blank]

Appendix A: Summary of Findings Related to Task Force Elements

In this appendix, we summarize specific information related to each of the elements mandated for consideration by the Task Force. The elements are grouped according to the working groups of the Task Force and listed by letter from the original legislation.

Elements Dealing with Active Duty Service Members

(A) The awareness of the potential for mental health conditions among members of the Armed Forces.

The Task Force is unaware of any large-scale data collection efforts that assess awareness of the potential for mental health conditions among members of the Armed Forces. There are ongoing data collection efforts that assess the prevalence of specific symptoms related to mental health conditions – most notably the Pre- and Post-Deployment Health Assessments, and the Post-Deployment Health Reassessment. Based on information gathered during site visits, there is widespread awareness of the possibility of combat stress or PTSD, and to a lesser extent, traumatic brain injury. Awareness of other mental health conditions is much more limited.

Section 5.1.1 (Dispel Stigma) and 5.1.3 (Embed Training about Psychological Health throughout Military Life) contain findings and recommendations to raise awareness of mental health conditions.

(B) The access to and efficacy of existing programs in primary care and mental health care to prevent, identify, and treat mental health conditions among members of the Armed Forces, including programs for and with respect to forward-deployed troops.

Goals 2 (Ensure Service Members and their Families Receive a Full Continuum of Care) and 3 (Provide Sufficient Resources and Allocate Them According to Requirements) of the Task Force's vision focus in detail on these issues, and the corresponding sections of this report makes specific recommendations.

(E) The reduction or elimination of barriers to care, including the stigma associated with seeking help for mental health-related conditions, and the enhancement of confidentiality for members of the Armed Forces seeking care for such conditions.

Section 5.1.1 (Dispel Stigma) focuses in detail on this issue.

(H) The early identification and treatment of mental health and substance abuse problems through the use of internal mass media communications (including radio and television) and other education tools to change attitudes within the Armed Forces regarding mental health and substance abuse treatment.

The Armed Forces Radio and Television service runs Public Service Announcements (PSAs) on up to 42 different topics at a time on a rotating basis. Currently, about half of the topics related to support for service members, including stress, financial counseling, Military OneSource, domestic and sexual abuse, suicide, and chaplain services. These 'support' PSAs have become more common since large deployments began. Radio stations average 10 to 20 PSAs per week; television statements average 5 to 10 announcements. Evaluation data are not systematically gathered regarding the effectiveness of PSAs.

Sections 5.1.1 (Dispel Stigma) and 5.1.3 (Embed Training about Psychological Health throughout Military Life) of this report provide findings and recommendations regarding the use of media and education to change attitudes.

Elements Dealing with Evaluation

(C) Identification and means to evaluate the effectiveness of pilot projects authorized by section 722 with the objective of improving early diagnosis and treatment of post traumatic stress disorder and other mental health conditions.

To the best of our knowledge, these projects have not yet been implemented.

(M) The scope and efficacy of curricula and training on mental health matters for commanders in the Armed Forces.

Section 5.1.3 (Embed Training about Psychological Health throughout Military Life) provides specific recommendations about training for commanders and service members.

(N) The efficiency of pre- and post-deployment mental health screening, including mental health screenings for members who have experienced multiple deployments.

Section 5.1.5 (Make Psychological Assessments an Effective, Efficient and Normal Part if Military Life) provides specific recommendations.

(O) The effectiveness of mental health programs provided in languages other than English.

We are not aware of any assessments of the effectiveness of such programs. Such programs do not appear to be widespread. Military OneSource offers document translation into over 150 languages, and simultaneous interpretation in over 160 languages. Each military installation also maintains a list of individuals who speak languages other than English. The TRICARE South Region reports that 1404 providers have proficiency in at least one language other than English, with the five most common languages being Spanish, Hindi, French, German, and American Sign Language (Lupo & Proctor, 2006).

Elements Dealing with Family

(D) The access to and programs for family members of members of the Armed Forces, including family members overseas.

Sections 5.2.4 (Provide Family Members with Excellent Access to Care) and 5.3.4 (Ensure TRICARE Networks Fulfill Beneficiaries Psychological Health Needs) provide findings and recommendations regarding this element.

(F) The <u>awareness of mental health services</u> available to dependents of members of the Armed Forces whose sponsors have been activated or deployed to a combat theater.

Section 5.2.4 (Provide Family Members with Excellent Access to Care) provides findings and recommendations regarding this element.

(G) The <u>adequacy of outreach, education, and support programs</u> on mental health matters for families of members of the Armed Forces.

Section 5.2.4 (Provide Family Members with Excellent Access to Care) provides findings and recommendations regarding this element.

Elements Dealing with Continuity of Care

(I) The <u>efficacy</u> of programs and mechanisms for ensuring a seamless transition from care of members of the Armed Forces on active duty for mental health conditions through the Department of Defense to care for such conditions through the Department of Veterans Affairs after such members are discharged or released from military, naval, or air service.

Section 5.2.2 (Maintain Continuity of Care across Transitions) provides findings and recommendations regarding this element.

(J) The availability of long-term follow-up and access to care for mental health conditions for members of the Individual Ready Reserve and the Selective Reserve and for discharged, separated, or retired members of the Armed Forces.

Sections 5.2.2 (Maintain Continuity of Care across Transitions) and 5.5.1 (Reserve Components: Special Considerations) contain findings and recommendations related to this element.

(K) Collaboration among organizations in the Department of Defense with responsibility for or jurisdiction over the provision of mental health services.

Section 5.4.1 (Establish Visible Leadership and Advocacy for Psychological Health) of this report provides findings and recommendations related to this element.

(L) Coordination between the Department of Defense and civilian communities, including local support organizations, with respect to mental health services.

Section 5.3.4 (Ensure TRICARE Networks Fulfill Beneficiaries' Psychological Health Needs) of this report provides findings and recommendations related to this element.

(P) Such other matters as the task force deems appropriate.

The Task Force spent considerable time considering members in the Reserve Components and their families. Relevant findings and recommendations appear throughout the report, in addition to special coverage within the "Special Topics" section.

Section 735. Additional Elements of Assessment of Department of Defense Task Force on Mental Health Relating to Mental Health Members who were deployed in Operations Iraqi Freedom and Operation Enduring Freedom.

Section 723c of the National Defense Authorization Act for Fiscal Year 2006 (Public Law 109-163; 119 Stat. 3348) is amended by adding at the end the following new paragraph:

Mental Health needs of members who were deployed in OIF or OEF. As part of the assessment required by paragraph (1) of the efficacy of mental health services provided to members of the Armed Forces by the Department of Defense, the task force shall consider the specific needs with respect to mental health of members who were deployed in Operation Iraqi Freedom or Operation Enduring Freedom upon their return from such deployment, including the following:

1) An identification of mental health conditions and disorders (including Post-Traumatic Stress Disorder, suicide attempts and suicide) occurring among members who have undergone multiple deployments in Operation Iraqi Freedom or Operation Enduring Freedom.

Data gathered by the MHATs indicate that multiple deployers were significantly more likely to report symptoms consistent with depression, anxiety, acute stress, and concerns about deployment length, and also significantly lower personal morale than first-time deployers.

2) An evaluation of the availability to members of assessments under the Mental Health Self-Assessment Program of the Department of Defense to ensure the long-term availability of the diagnostic mechanisms of the assessment to detect mental health conditions that may emerge in such members over time.

The Mental Health Self-Assessment Program (www.militarymentalhealth.org) offers anonymous self-administered assessments via Internet, telephone or in person for depression, bipolar disorder, alcohol use, post-traumatic stress disorder, and generalized anxiety disorder. To date, approximately 50,000 assessments have been completed. An evaluation project is planned.

3) **The availability of programs and services under the Mental Health Self-Assessment Program to address the mental health of dependent children of members who were deployed in Operation Iraqi Freedom or Operation Enduring Freedom.**

No assessments for children are currently available via the Mental Health Self-Assessment Program.

4) **Recommendations on mechanisms for improving the mental health services available to members who were deployed in Operation Iraqi Freedom or Operation Enduring Freedom, including members who have undergone multiple deployments.**

Goals 2 and 3 of the Task Force vision address quality of and access to care. The corresponding sections of this report provide findings and recommendations.

Appendix B: Members of the Task Force

VADM Donald C. Arthur, Medical Corps, U. S. Navy

VADM Arthur is the 35th Surgeon General of the Navy and Chief of the Navy's Bureau of Medicine and Surgery. Serving as the Chief Executive Officer for Navy Medicine, he is responsible for all aspects of medical and dental service delivery worldwide for the Navy, a workforce of 57,000 personnel, 30 military hospitals, 266 free standing clinics, and 6 major research centers with an annual budget of nearly $7 billion. VADM Arthur served as Deputy Surgeon General, Chief of the Navy Medical Corps and Chief Executive Officer of the National Naval Medical Center in Bethesda, Maryland and the Naval Hospital in Camp Lejeune, North Carolina. In 1991, Dr. Arthur served in combat operations with the Marine Corps in Desert Storm.

VADM Arthur obtained his B.A. from Northeastern University and his M.D. from the College of Medicine and Dentistry of New Jersey. He is residency-trained in emergency medicine and attained board certification in Emergency Medicine and Preventive Medicine (Aerospace). Dr. Arthur is a Fellow and Past President of the Aerospace Medical Association and was President of the Association of Military Surgeons of the U.S. Among VADM Arthur's numerous awards are the American College of Healthcare Executives', "Federal Excellence in Healthcare Leadership Award", the Federal Healthcare Executives Interagency Institute's "Distinguished Service Award", and the Association of Military Surgeons' "Outstanding Federal Healthcare Executive Award" as well as their "Founder's Award." VADM Arthur's military decorations include the Navy's Distinguished Service Medal, four Legions of Merit, and three Meritorious Service Medals.

Dan German Blazer, M.D., M.P.H., Ph.D.

Dr. Blazer is the J. P. Gibbons Professor of Psychiatry and Behavioral Sciences and Professor of Community and Family Medicine at Duke University Medical Center and past Dean of Medical Education, Duke University Medical Center. He is also the Head of the University Council on Aging and Human Development and serves as Adjunct Professor in the Department of Epidemiology, School of Public Health at the University of North Carolina.

Dr. Blazer received his B.A. from Vanderbilt University in 1965 (Biology), his M.D. from the University of Tennessee in 1959, his M.P.H. from the University of North Carolina – Chapel Hill in 1979 (Epidemiology), and his Ph.D. from UNC in 1980 (Epidemiology). Dr. Blazer was elected to the Institute of Medicine, National Academy of Sciences in 1995 and is a Diplomate of the American Board of Psychiatry and Neurology (with a Certificate of Added Qualifications in Geriatric Psychiatry), and a Fellow of numerous Associations and Societies including the American Psychiatric Association and the American College of Psychiatry. Among Dr. Blazer's numerous honors are the Research Career Development Award from the National Institute of Mental Health, the Honored Teaching Professor in the Dept. of Psychiatry, the Alex Haley National Award in 1985, the Distinguished Alumni Award at the School of Public Health, UNC in 1989, the Jack Weinberg Award from the American Psychiatric Association in 1992, the American Association of Geriatric Psychiatry Senior Investigator Award in 1994, the Milo Leavitt Award from the American Geriatrics Society for Life Contributors to education in geriatric medicine in 1997, the Pioneer Award in Geriatric Psychiatry in 2000, and the Rema LaPouse Award from the American Public Health Association in 2001.

Col Rick L. Campise, Ph.D., ABPP

Col Campise currently serves as the Chief of Air Force Deployment Behavioral Health and the Chief of Air Force Substance Abuse Prevention in the Air Force Medical Operations Agency within the Office of the Air Force Surgeon General. Col Campise also serves on the faculty of the USAF Clinical Psychology Internship at Andrews AFB and is a Clinical Assistant Professor of Medical and Clinical Psychology at the Uniformed Services University of the Health Sciences. Previously, Col Campise held a variety of appointments within the Air Force, serving as an Air Staff officer, deputy squadron commander, operations officer, program director, clinician, and researcher.

Col Campise completed a post-doctoral fellowship in Pediatric Psychology at Harvard University, received his Ph.D. in Counseling Psychology from the University of Kansas, and was awarded his B.A. in Psychology from Westmont College. He is board-certified in Counseling Psychology, a member of the American Psychological Association (Divisions 17, 19, and 54), and a member of the Air Force Society of Clinical Psychologists. Col Campise was a co-winner of the American Association of Suicidologists Presidential Citation for Outstanding Contributions to Suicide Prevention, was a finalist for the Joint Chiefs of Staff Award for excellence in Military Medicine, received the APA Division 19 Mid-Career Military Psychologist of the Year Award, and has been awarded four Meritorious Service Medals. Col Campise's AF/DOD Suicide Public Service Announcements were

finalists for a Freddie Award and the website he created for the Air Force Suicide Prevention Program received a Horizon Interactive Awards Silver Medal for Public Service.

LtCol Jonathan Douglas

LtCol Douglas currently serves as the Branch Head for Semper Fit Programs, HQMC M&RA, a position he has held since June 2005. Previously, LtCol Douglas served in the N8 as the Sea Strike and Sea basing requirements officer; as the assistant Operations Officer Marine Aircraft Group 36 Okinawa, Japan; and as the North East Asia Exercise Officer, III MEF Okinawa, Japan. At HMX-1 in Quantico, Virginia, LtCol Douglas served as a White House Liaison Officer and was designated a White House Aircraft Commander. Additionally, he served as Platoon Commander at Officer Candidate School. After attending The Basic School, LtCol Douglas was designated a Naval Aviator in December 1989, reporting to MCAS Tustin, California for training as a CH-53D Pilot. During his first fleet assignment, with HMH-362, LtCol Douglas held several billets including: Aviation Life Support Systems Officer, Ordnance Officer and Operations Training Officer. He deployed with the squadron in support of Operation Desert Shield/Desert Storm.

LtCol Douglas graduated from the University of Maryland and was commissioned as a Second Lieutenant in July 1987. LtCol Douglas was also selected to and attended the Marine Corps Command and Staff College, Amphibious Warfare School, and has an MBA from Touro University. LtCol Douglas' personal decorations include the Meritorious Service Medal with two gold stars, Air Medal with Strike/Flight Numeral "1", Joint Service Achievement Medal and Navy and Marine Corps Achievement Medal.

Deborah Kline Fryar

As a military family member, Ms. Fryar has worked to support families for many years. She has been involved with the National Military Family Association (NMFA) since 1996, and currently serves as an NMFA representative for Aberdeen Proving Ground, Maryland. In this position, she monitors issues relevant to the quality of life of families of the Uniformed Services and represents the Association at briefings and other meetings. Previously, Ms. Fryar served as Director of Government Relations for NMFA from March 2004 until June 2006, where she wrote and presented testimony concerning families before Congress. Ms. Fryar also currently serves on the DOD Beneficiary Advisory Panel for the Uniform Formulary. She has served on The Military Coalition's (TMC) Veterans and Health Care Committees and has represented military families on the Navy Force Management Oversight Committee (FMOC) Working Group of the Injured Marines and Sailors Program. She also works with the Joint Task Force for Family Readiness Education on Deployments (FRED).

Ms. Fryar earned a B.S. in Nursing from West Texas A&M University in Canyon, Texas and has spent the past seventeen years as a military spouse. She has been involved at all levels of family programs as a Core Instructor and Master Trainer for the Army Family Team Building Program. Ms. Fryar has also been involved in a myriad of other volunteer family programs, including Health Services Auxiliaries at various military hospitals, American Red Cross, Army Family Action Plan, Marines' Toys for Tots, Compassionate Ministries, Ladies Ministries and a Military and Uniformed Services Support Group at her church.

LTG (Ret) Kevin Kiley, M.D.

LTG Kiley served as the 41st Surgeon General of the Army and Commander, US Army Medical Command from September 2004 until his retirement in March 2007. Early in his career, LTG Kiley served as chief of OB/GYN services at the 121st Evacuation Hospital in Seoul and as Assigned Division Surgeon, 10th Mountain Division before returning to Beaumont as Assistant Chief, and later Chairman, of the Department of OB/GYN. In 1990, Kiley assumed command of the 15th Evacuation Hospital at Fort Polk and in 1991 deployed the hospital to Saudi Arabia in support of Operations Desert Shield/Storm. After graduating from the Army War College in 1994, LTG Kiley assumed command of the Landstuhl Regional Medical Center and the U.S. Army Europe Regional Medical Command in 1994, serving as the Command Surgeon, U.S. Army Europe and 7th Army. In 1998, LTG Kiley became Assistant Surgeon General for Force Protection, Deputy Chief of Staff for Operations, Health Policy and Services, U.S. Army Medical Command; and Chief, Medical Corps. In 2000, he became Commander of the U.S. Army Medical Department Center and School and Fort Sam Houston and continued as Chief of the Medical Corps. LTG Kiley assumed command of Walter Reed Army Medical Center and North Atlantic Regional Medical Command and Lead Agent for Region 1 in 2002, prior to his appointment as Surgeon General of the Army.

LTG Kiley graduated from the University of Scranton with a bachelor's in biology in 1972. He received his medical degree from Georgetown University School of Medicine in 1976, and completed a surgical internship and an obstetrics and gynecology residency at William Beaumont Army Medical Center in 1980. Among LTG Kiley's awards and decorations are the Distinguished

Service Medal, Legion of Merit (three Oak Leaf Clusters), Bronze Star Medal, Defense Meritorious Service Medal, Meritorious Service Medal (two Oak Leaf Clusters), Army Commendation Medal, the "A" designator, the Order of Military Medical Merit and the Expert Field Medical Badge.

CAPT Warren P. Klam, M.D., M.S.M.M.

Captain Warren Klam received his M.D. from Louisiana State University Medical School in 1971 before training in Pediatrics and in Adolescent Medicine. Upon completion of his training he entered the Navy and served as a Pediatrician and Adolescent Medicine specialist at the National Naval Medical Center. In 1981 he was released from Active Duty and entered into the private practice of Adolescent and Addiction Medicine in Northern Virginia. While in private practice he became one of the first physicians in Virginia to be certified in Addiction Medicine by the American Society for Addiction Medicine.

In 1993, CAPT Klam left private practice to reenter the United States Navy. He trained in General Psychiatry and in Child and Adolescent Psychiatry Following completion of his training CAPT Klam served at the Naval Hospital in Yokosuka Japan as Child Psychiatrist and as part of its senior leadership. Following his tour in Japan, CAPT Klam became the Force Medical Officer for the Seabees. In 2003 he transferred to Naval Medical Center San Diego where he now serves as the Director for Mental Health. Since 2004, he has also served as the Navy Psychiatry Specialty Leader. CAPT Klam is board certified in Pediatrics, General Psychiatry and Child and Adolescent Psychiatry.

Shelley M. MacDermid, M.B.A., Ph.D.

Shelley M. MacDermid is Associate Dean in the College of Consumer and Family Sciences, and Professor in the Department of Child Development and Family Studies at Purdue University. Since 1996, she has directed the Center for Families, and currently serves as director of the Military Family Research Institute (having served as co-director from 2000 to June 2007), also at Purdue. Dr. MacDermid earned an M.B.A. in Management in 1988 and a Ph.D. in Human Development and Family Studies in 1990 from The Pennsylvania State University. Her research focuses on relationships between job conditions and family life, with special interests in organizational size, adult development, and organizational policies, and has been published in scientific journals including the *Journal of Marriage and Family* and the *Academy of Management Journal*. Her research has been supported by the Alfred P. Sloan Foundation, the Henry A. Murray Center, the Department of Defense, and the state of Indiana; and has earned awards from the Groves Conference and Gamma Sigma Delta. She is a 2006 winner of the Work-Life Legacy Award from the Families and Work Institute. In 2005, Dr. MacDermid was named a fellow of the National Council on Family Relations. She serves on the editorial boards of the Journal of Family Issues, Family Relations, and Journal of Family and Economic Issues. Dr. MacDermid works extensively with corporations and serves as a faculty fellow to the Boston College Work-Family Roundtable.

CAPT Margaret A. McKeathern, M.D. (alternate member)

CAPT McKeathern currently serves as Director of Mental Health at National Naval Medical Center in Bethesda, having previously served as Associate Director of Behavioral Healthcare Service and Department Head of Child and Adolescent Behavioral Health Care at NNMC Bethesda. CAPT McKeathern also serves as Mental Health Representative to the Family Advocacy Headquarters Review Team and Child and Adolescent Psychiatry Consultant to the Armed Forces Center for Child Protection.

CAPT McKeathern received her M.D. from Virginia Commonwealth University in 1986, completing her internship in Internal Medicine at Eastern Virginia Graduate School of Medicine and her Psychiatry Residency at Portsmouth Naval Hospital. CAPT McKeathern also completed a fellowship in Child and Adolescent Psychiatry at Johns Hopkins Hospital. CAPT McKeathern also holds a B.S. in Chemistry, magna cum laude, from Hampton University (1982). CAPT McKeathern is a Diplomate of the American Board of Psychiatry and Neurology, and is board-certified in General Psychiatry and Child and Adolescent Psychiatry). CAPT McKeathern is also a member of the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, and the American Medical Association. CAPT McKeathern's military decorations include three Navy and Marine Corps Commendation Medals and two Navy and Marine Corps Achievement Medals.

Richard A. McCormick, Ph.D.

Dr. McCormick retired as the Director of the Mental Health Care Line for the DVA Healthcare System of Ohio. He was responsible for all DVA mental health services throughout most of Ohio and portions of surrounding states. While at DVA he was co-chair of the congressionally-mandated Committee on the Care of Severely Mentally Ill Veterans, a member of the DVA national task force charged with establishing evidence-based practice guidelines for a full range of conditions including substance abuse, depression and psychoses, chaired the oversight committee for the Serious Mental Illness Research and Treatment Center and was on the executive committee for the Mental Health Quality Enhancement Initiative. He was recently a Commissioner on the Department of Veterans Affairs CARES Commission, which set strategic clinical and capital asset-related goals for the Department for the next twenty years. He continues as a health services research consultant at Case Western Reserve University in the areas of substance use and PTSD. He has authored over 50 articles and book chapters focusing on pathological gambling, substance abuse, serious mental illness, suicide, PTSD and evidence-based care. Dr. McCormick is a clinical psychologist and continues to consult with health systems on mental health services.

Layton McCurdy, M.D.

Dr. McCurdy is Dean Emeritus and Distinguished University Professor at the Medical University of South Carolina. During his tenure at MUSC, Dr. McCurdy served as Vice President for Medical Affairs, Dean, Professor and Chairman of Psychiatry. Previously, Dr. McCurdy served as Psychiatrist-in-Chief at Pennsylvania Hospital and Professor at the University of Pennsylvania. Dr. McCurdy also worked at the National Institute of Mental Health (NIMH) and held a faculty appointment at Emory University Medical School in Atlanta. In 2005, Dr. McCurdy was appointed Chairman of the South Carolina Commission on Higher Education. A noted academician, Dr. McCurdy has made numerous contributions to the scientific literature in the areas of medical education, the social responsibility of physicians, addictions, and psychiatry.

Dr. McCurdy received his undergraduate education from the University of North Carolina – Chapel Hill, his M.D. from MUSC, and completed his psychiatric residency at UNC. Dr. McCurdy has served as President of the American Board of Psychiatry and Neurology (ABPN), the American College of Psychiatrists, the Association for Academic Psychiatry, the Association of Chairmen of Departments of Psychiatry, and as chair of the American Psychiatric Association's (APA) Committee on Diagnosis and Assessment. Dr. McCurdy has received numerous national and international recognitions including membership in Alpha Omega Alpha, the Distinguished Alumnus award for the Medical University of South Carolina (1988), appointment as a Fellow in the Royal College of Psychiatrists (United Kingdom), the Bowis Award for distinguished service to the American College of Psychiatrists, the Earl B. Higgins Award for Achievement in Diversity, the SELAM International Award in recognition of his support and dedication to the advancement of women in academic medicine, and La Societe Francaise Humanatati Award for life-long work to aid and better the human condition.

COL David T. Orman, M.D.

COL Orman currently travels and works full-time for the Army Surgeon General in support of the DOD Mental Health Task Force. He previously served as Director of Residency Training in Psychiatry at Tripler AMC, HI. Prior to that assignment, COL Orman served as Behavioral Health Policy Staff Officer at MEDCOM, Fort Sam Houston, as the Psychiatry Consultant to the US Army Surgeon General, and as Chief of the Department of Psychiatry at Darnall Army Community Hospital and Brooke Army Medical Center. Among his academic appointments, COL Orman has served as Assistant Director of Psychiatry Residency Training and Associate Professor of Psychiatry at Texas A&M Health Science Center College of Medicine, and as an Instructor in Psychiatry at the USUHS.

COL Orman received his MD from USUHS in 1982, completing his internship and residency in Psychiatry at Walter Reed AMC, serving as Chief Resident in 1985. COL Orman also holds a BS, summa cum laude, from Midwestern State University (1977). COL Orman is a diplomate of the National Board of Medical Examiners (1983) and is board certified in Psychiatry by the American Board of Psychiatry and Neurology (1988). COL Orman has authored numerous articles in peer-reviewed journals, and identified 13 peer-reviewed publications as representative of his body of work.

COL Angela Pereira, Ph.D.

COL Pereira is currently assigned to the Department of Behavioral Health at Dewitt Army Community Hospital, Fort Belvoir, VA. Previously, COL Pereira served as Chief of the Combat Stress Control/Mental Health Clinic of Task Force Medical 115/344 Prison Hospital at Abu Ghraib, Iraq; Chief of the Social Work/Family Advocacy Program at USAMEDDAC in Heidelberg, Germany; Chief of Education and Training at USACHPPM, Aberdeen Proving Ground, MD; and deployed as the Division Social Worker for the 3rd Armored Division during Operations Desert Shield/Storm. COL Pereira has also served in a broad range of Social Work Officer positions in Fort Jackson, SC; Frankfurt, Germany; and Fort Riley, KS.

COL Pereira received her Ph.D. in Social Work from the University of South Carolina in 1998. COL Pereira also holds an M.S.W. and a B.A. in Psychology from the University of California - Berkeley (1983 and 1978, respectively). COL Pereira is a Board Certified Diplomate in Clinical Social Work (2001) and certified as a licensed clinical social worker in Maryland (1998). COL Pereira is a member of the National Association of Social Workers and the International Society for Traumatic Stress Studies. COL Pereira has authored several articles in peer-reviewed journals and has given numerous presentations at national conferences. COL Pereira's many awards and decorations include the Bronze Star Medal, the Meritorious Service Medal, the Army Commendation Medal, the Meritorious Unit Citation, the Order of Military Medical Merit, the Combat Action Badge, and the Expert Field Medical Badge.

A. Kathryn Power, M.Ed.

A. Kathryn Power is Director of the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division of the US Department of Health and Human Services (DHHS). Prior to her appointment as Director of CMHS, Ms. Power served over 10 years as the Director of the Rhode Island Department of Mental Health, Retardation and Hospitals (DMHRH), a Cabinet position reporting to the Governor. Ms. Power previously directed the Rhode Island Office of Substance Abuse, the Governor's Drug Program, the Rhode Island Anti-Drug Coalition, and the Rhode Island Council of Community Mental Health Centers. Earlier professional experiences include teaching at elementary and secondary schools; providing counseling, leadership and advocacy for rape crisis and domestic violence agencies; and working as a computer systems analyst for the Department of Defense.

Director Power received her Bachelor's degree in education from St. Joseph's College in Emmitsburg, Maryland, and her Master's degree in education and counseling from Western Maryland College. She is a graduate of the Toll Fellowship program of the Council of State Governments, and completed programs in senior executive leadership development, mental health leadership, and substance abuse leadership at the Harvard University John F. Kennedy School of Government. In 2005, Director Power received the U.S. Department of Health and Human Services Secretary's Award for Distinguished Service for spearheading the Federal Mental Health Transformation Team, an unprecedented interdepartmental coalition that produced the first ever Federal Action Agenda for Mental Health Transformation. In 1997, Director Power served as President of the National Association of State Mental Health Program Directors (NASMHPD). Ms. Power has been recognized locally and nationally for her leadership and advocacy on behalf of individuals with disabilities and has served on the boards of directors of over 100 non-profit agencies, commissions, and task forces in both the public and private sectors. Ms. Power is currently a Captain serving in the U.S. Navy Reserve.

LCDR Aaron D. Werbel, Ph.D.

LCDR Werbel currently serves as Behavioral Health Affairs Officer and Suicide Prevention Program Manager at Headquarters, Marine Corps (Manpower and Reserve Affairs.) He is a member of the Department of Defense Suicide Prevention and Risk Reduction Committee. Previously, LCDR Werbel has served as Staff Psychologist in the Midshipman Counseling Center at the United States Naval Academy; Head of Behavioral Healthcare at the Branch Medical Clinic Capodichino in Naples, Italy; Head of the Substance Abuse Rehabilitation Program at the Naval Hospital in Naples, Italy; Head of HIV/AIDS Psychology Division and Staff Psychologist at the National Naval Medical Center in Bethesda, Maryland where he was a member of the training staff for the psychology internship program. LCDR Werbel is a highly sought-after speaker, having presented at national DVA conferences, national mental health association conferences, state sponsored suicide prevention conferences and numerous military conferences. He was the planning chair of the 2007 DOD Military Suicide Prevention Conference.

LCDR Werbel received his M.A. and Ph.D. in Clinical Psychology from Michigan State University in 1994 and 1998, respectively, and completed his APA-accredited internship at the National Naval Medical Center in Bethesda, Maryland. LCDR Werbel also received a B.S. with distinction in Psychology from the University of Michigan (1988). LCDR Werbel is a licensed Clinical

Psychologist and is a member of the American Association of Suicidology and the International Association of Suicide Prevention.

Antonette M. Zeiss, Ph.D.

Dr. Zeiss currently serves as Deputy Chief Consultant, Office of Mental Health Services at the Department of Veterans Affairs (DVA) Central Office. Prior to joining the DVA Central Office, Dr. Zeiss served as Assistant Chief and Director of Training at the DVA Palo Alto Health Care System. Among her academic appointments, Dr. Zeiss has served as Clinical Lecturer in the Stanford University Department of Medicine, Visiting Professor of Psychology at Stanford University, and Assistant Professor of Psychology at Arizona State University.

Dr. Zeiss received her M.A. and Ph.D. in Clinical Psychology from the University of Oregon in 1975 and 1977, respectively. Dr. Zeiss also holds a B.A. in Psychology from Stanford University (1966). Dr. Zeiss is currently licensed to practice psychology by the state of California. Dr. Zeiss' honors and awards include APA Division 12's Clinical Geropsychologist Distinguished Clinical Mentorship Award (2004), APA Division 18's Outstanding DVA Psychologist Training Director Award (2003), the Interdisciplinary Creativity in Practice and Education Award (2003), the APPIC Award for Excellence in Internship and Postdoctoral Training (2002), and the Arizona State University Psychology Department Faculty of the Year Award (1979).

Appendix C: Sites Visited by Task Force Delegations, Sept 2006 – Feb 2007

Date(s)	Installation(s)
6-7 SEP 06	Fort Drum, NY
18-19 SEP 06	Fort Hood, TX
27-28 SEP 06	Hawaii: • Hickam Air Force Base • Marine Corps Base Hawaii Kaneohe Bay • Tripler Army Medical Center • Naval Station Pearl Harbor • Schofield Army Barracks
2-3 OCT 06	Okinawa: • Marine Corps Base Camp Butler • Kadena Air Force Base • U.S. Naval Hospital Okinawa
5-6 OCT 06	Korea: • 121st General Hospital • Osan Air Base
16-17 OCT 06	Marine Corps Base Camp Pendleton, CA
20 OCT 06	Naval Base San Diego, CA
23 OCT 06	Marine Corps Air Station Miramar, CA
30-31 NOV 06	Fort Bragg, NC
1-2 OCT 06	Pope Air Force Base, NC
13-14 NOV 06	Nellis Air Force Base, NV
16-17 NOV 06	Travis Air Force Base, CA
20 NOV 06	National Center for PTSD, Palo Alto, CA
21 NOV 06	VA Hospital, San Francisco, CA
29-30 NOV 06	Maxwell Air Force Base, AL
4-5 DEC 06	Naval Construction Battalion Center Gulfport, MS
7-8 DEC 06	Naval Station Norfolk, VA
11 -12 DEC 06	Marine Corps Base Camp LeJeune, NC
15 DEC 06	Marine Corps Air Ground Combat Center Twentynine Palms, CA
14-15 DEC 06	Marine Corps Air Station Cherry Point, NC
5-6 JAN 07	Sheppard Air Force Base, TX
8-10 JAN 06	Lackland Air Force Base, TX
11-12 JAN 07	Fort Riley, KS
18-19 JAN 07	Fort Lewis, WA
25-26 JAN 07	Fort Carson, CO
31 JAN-8 FEB 07	Germany: • Landstuhl Regional Medical Center • Ramstein Air Base • U.S. Army Garrison Baumholder • Geilenkirchen NATO Air Base
20-21 FEB 07	Fort Stewart, GA
22-23 FEB 07	Warner-Robbins Air Force Base, GA
17 FEB 07	Ohio Marine Corps Reserve

[Next page intentionally left blank]

Appendix D: Task Force Meetings, July 2006 – April 2007

Date(s)	Location
15-16 JUL 06	Walter Reed Army Medical Center, Washington DC
20-21 SEP 06	Fort Hood, TX
19-20 OCT 06	San Diego, CA
20-21 NOV 06	San Francisco, CA
18-20 DEC 06	Crystal City, VA
22-23 JAN 07	Tacoma, WA
26-28 FEB 07	Arlington, VA
19-21 MAR 07	Arlington, VA
16-18 APR 07	San Antonio, TX

[Next page intentionally left blank]

Appendix E: Briefings Received at Task Force Meetings

Date(s)	Speaker(s)/Briefing Title
15-16 JUL 06	Elspeth Cameron Ritchie, MD, MPH, COL, MC – *Army Medical Department: Behavioral Health* Charles Hoge, MD, COL, MC – *Summary of Data on the Mental Health of the Force* Patricia Buss, CAPT, MC, USN – *TRICARE Mental Health Benefit* Terry Washam, COL – *VA Office of Seamless Transition: Leaning Forward in Serving Veterans* Col Schuyler K. Geller, MD, SFS & LtCol Rick L. Campise, PhD, ABPP – *United States Air Force Behavioral Health* Aaron D. Werbel, PhD, LCDR, MSC, USN – *Behavioral Health in the U.S. Marine Corps* Morgan T. Sammons, CAPT, MSC, USN – *Mental Health in the U.S. Navy: Key Trends and Initiatives*
20-21 SEP 06	Larry Applewhite, LtCol, PhD, LCSW – *Pre and Post Deployment Screening: Fort Hood* Division Behavioral Health, 1Cav – *Pre-Deployment Mental Health Issues*
19-20 OCT 06	Mark Russell, PhD, CDR, MSC, USN – *The future of Mental Health Care in the DOD: Carpe Diem* John Sparks, Kris Large, Sherilyn Curry, LTC, Marge Crowl, & Jim Chandler, MD – *TRICARE West: Behavioral Health*
20-21 NOV 06	Kerry Childress – *Traumatic Brain Injury* Steven Fetrow, PhD, MAJ – *Mental Health Programs, California National Guard*
18-20 DEC 06	Nancy Fortin, COL – *Programmatic Considerations of Mental Health in the Army National Guard* Barbara Thompson – *Military Community & Family Policy: Non-Medical Counseling Support, Military OneSource and Military & Family Life* Charles Engel, MD, COL – *Respect-Mil: The Army Surgeon General's Program to Improve the Mental Health Services for Soldiers Receiving Primary Care* Jody W. Donehoo, PhD – *Continuation of Health Coverage for Guard/Reserve Members and TRICARE Reserve Select* Jack Wagoner, MD, PhD & Lois W. Krysa, RN, MSN, CPHQ – *TRO North/Health Net Federal Services* Martha Lupo & Gary Proctor, MD – *TRICARE Region South* Michael O'Bar, Christine Coure & Stan Regensburg – *TRICARE Reimbursement* (conference call) Steven Robertson – Veterans For America Barbara Thompson – *Military OneSource* Robert Ireland, MD, Col – *DOD Mental Health Policy*

Date(s)	Speaker(s)/Briefing Title
	Kenneth Cox, USAF, MC, SFS – *DOD Health Surveillance: Across the Continuum of Care* Ana Smythe – *Military Officers Association of America*
22-23 JAN 07	Millard Brown, MD, MAJ, Joseph Etherage, PsyD, & Matthew Rein – *Automated Behavioral Health: A Technological Solution for Building a Quality Mental Health Care System* Mark Reger, PhD; Gregory Gahm, PhD, COL; Debi Harris & Kristin Onorati – *Improving Behavioral Health Surveillance: An Example from the Suicide Risk Management & Surveillance Office* Robert Ciuella, MD & Josef Ruzek, MD – *Post-Deployment On-line: PTSD Project* Gregory M. Reger, PhD, CPT & Albert Rizzo, MD– *Virtual Reality in Operational Psychology* Charles Marmar, MD – *Predicting PTSD: Prospective Studies off Risk and Resilience Factors*
26-28 FEB 07	Sumathy Reddy, COL, MC, FS & Clemens Presogna, MAJ, AN – *Mental Health in the Army Reserve* Jeff Thomas, MAJ – *Battlemind Training System* Mary Carstensen, COL – *Army Wounded Warrior Program* John A. Casciotti – *Confidentiality of Mental Health Records in the Military* Gerald Cross, MD – *Veterans Health Affairs (VHA): Overview* Ira Katz, MD – *VHA: Mental Health Programs* David W. Niebuhr, MD, MPH, MSc, LTC(P) – *Accession Medical Standards Analysis & Research Activity (AMSARA)* Tania Glenn, PsyD, LCSW, CTS – *Readiness-Resilience-Recovery: The 4th Marine Aircraft Wing Combat and Operational Stress Control Program*

Appendix F: Glossary

Activation – Order to active duty (other than for training).

Active Duty – Full time duty in the active service of a Uniformed Service including active duty training (full-time training duty, annual training duty and full-time attendance at a school designated as a military Service School, e.g., United States Military Academy).

AHLTA – DOD's electronic medical record/information system, formerly Armed Forces Health Longitudinal Technology Application.

Army Wounded Warrior Program – Formerly known as the Disabled Soldier Support Program (DS3), this program provides support and coordination of care to the soldier and his/her family through all phases of recovery and rehabilitation from injury.

Automated Behavioral Health Clinic – A computer application that uses software to automate the patient intake process and improve access to data relevant to patient care. It screens patients while they wait to see a mental health provider using a comprehensive questionnaire. It generates results to assist mental health providers and clinic managers.

Beneficiary – Individual eligible to receive medical care provided by military medical facilities and the TRICARE network, and can include Active Duty personnel, active duty dependents, military retirees and their dependents, and survivors of deceased service members.

Battlemind Training – Army program utilizing resiliency training that assists the soldiers transitioning from the combat-zone to the "home-zone". War-fighting skills and the "battle" frame of reference sustain the soldier in the operational setting. It is critical to transition successfully as effectiveness at home is as important as effectiveness in combat.

Billet – A personnel position or assignment that may be filled by one person.

Casualty Assistance Officer – Specially trained officer and enlisted personnel who are charged with personally notifying family members of the death of an active duty service member. They provide initial guidance and support in assisting families in dealing with the loss of a military member.

Chain of Command – The succession of commanding officers from a superior to a subordinate through which command is exercised.

Coordinating Authority – A commander or individual assigned responsibility for coordinating specific functions or activities involving forces of two or more military departments, two or more point force components or two or more forces of the same Service. The commander or individual has the authority to compel agreement. In the event that the essential agreement cannot be obtained, the matter shall be referred to the appointing authority. Coordinating authority is more applicable to planning and similar activities than to operations.

Dependent/Immediate Family – A service member's spouse, children who are unmarried and under 21 years of age or who, regardless of age, are physically or mentally incapable of self-support; dependent parents; including step and legally adoptive parents of the Service members spouse; and dependent brothers and sisters including step and legally adoptive brothers and sisters. See also Beneficiary.

Direct Care – Health care active duty and other classes of beneficiaries provided inside the MTF system, e.g. care received at National Naval Medical Center Bethesda, Landstuhl Regional Medical Center, health care provided to forces deployed to combatant sites and other locations overseas.

Family Member(s) – Relatives of Service members who may or may not be beneficiaries. This group can include, but is not limited to Service member parents, step-parents, grandparents, siblings, aunts, uncles, nieces, nephews, cousins, etc.

Family Support Centers (FSC) – FSCs are designed to offer family members of soldiers with a range of information including but not limited to provision of services provided by the installations, community resources and other necessary information unique to service members' families. Each Service has oversight of their respective FSCs. The Army is U.S. Army Community

and Family Support Center (CFSC), the Navy is the Fleet and Family Support Center, the Air Force is referred to as Airmen and Family Readiness Center, and the Marine Corps is the Marine and Family Services.

Health Care Provider – A broad term encompassing licensed clinical professionals (e.g., physicians, psychologists, advanced practice nurses, licensed clinical social workers). Commonly, health care providers have prescription writing privileges. Health care providers may also include trained and licensed professional including registered nurses

Individual Medical Readiness (IMR) – A means to assess an individual Service member's readiness level against established metrics to determine medical deployability in support of contingency operations.

Installation – A grouping of facilities located in the same vicinity, which support particular functions. Installations may be elements of a base.

Marine For Life (M4L) – Program provides transition assistance to Marines who honorably leave active service and return to civilian life and support to injured Marines and their families.

Marine Operational Stress & Surveillance Program (MOSSP) - an integrated progression of deployment cycle-specific educational briefs, health assessments and leadership tolls designed to prevent, identify early and effectively manage combat/operational stress injuries at all levels.

Medical Evaluation Board (MEB) – Physical and /or mental health problems that are expected to render a Service member unable to fully perform his/her duties exceeding 90 days require an MEB. A Limited Duty Board is a type of MEB that places a member in a less than full duty status for 6 months. If a Service member has a condition that is incompatible with military duty or that results in disqualification from world-wide deployment for more than 12 months, he/she will be referred to a Physical Evaluation Board (PEB).

Medical Holdover – Demobilized Reserve Component soldiers with medical conditions and/or injuries sustained in the line of duty that render them non-deployable but volunteer to remain on active duty as they are treated medically.

Medical Regulating – The actions and coordination necessary to arrange for the movement of patients through the levels of care. This process matches patients with a medical treatment facility that has the necessary health service support capabilities and available bed space.

Military Treatment Facility (MTF) – A military hospital or clinic on or near a military base.

Military Health System – A health system that supports the military mission by fostering, protecting, sustaining and restoring health.

Military One Source – A toll-free, 24/7 clearinghouse service that provides information and resources to active duty personnel and their beneficiaries.

Network – The health care services available through TRICARE outside the Direct (e.g. Medical Treatment Facility) Care System.

Operational Stress Control and Restoration Program (OSCAR) – Program where Navy behavioral health personnel are embedded with Marine Corps personnel involved in direct operational combat settings.

Palace Helping Airmen Recover Together (HART) – U.S. Air Force program that provides resources and support for severely injured active airmen and officers and their families.

Physical Evaluation Board (PEB) – This process provides a formal fitness-for-duty and disability determination that may return the service member to duty (with or without assignment limitations), place the member on the temporary disabled/retirement list, separate the Service member from active duty or medically retire the member. These recommendations are forwarded to a central medical board and can be appealed by the Service member, who is permitted to have legal counsel at these hearings.

Post-Deployment Health Assessment (PDHA) – A mandatory procedure for each service member redeploying from combatant operations. It is composed of two parts. Each returning service member must fill out form DD 2796, entitled the PDHA. In addition to the completion of the form, the Service member must also have a face-to-face interview with a trained health care provider. This is to be completed within five days before of after redeployment. If this is not possible, the member's commander should ensure that it is completed, processed and filed in the permanent medical record within thirty days of the member's return.

Post-Deployment Health Re-Assessment (PDHRA) – A mandatory program designed to identify and address health concerns with a specific emphasis on mental health issues that may have emerged over time since deployment and redeployment. The PDHRA form (DD 2900) which is also web-based and can be filled out online, provides a second health assessment for the three to six month period after redeployment. These forms must be reviewed by a health care provider and any follow-up with the service member must be undertaken.

Pre-Deployment Health Assessment – A required form (DD Form 2795) that allows military personnel to record information about their general health and share concerns they may have prior to deployment. It also assists health care providers identify issues and provide medical care before, during and after deployments It is mandatory for all deploying military personnel to fill out the form. It is to be completed and validated within 30 days prior to deployment. This is not to be confused with the Periodic Health Assessment.

Post-Traumatic Stress Disorder (PTSD) – An anxiety disorder that can occur following the experience or witnessing of a traumatic event. A traumatic event is a life-threatening event such as military combat, natural disasters, terrorist incidents, serious accidents or sexual assault in adult or childhood. Most survivors of trauma return to normal given a little time. However, some people will have stress reactions that do not go away on their own or may even get worse over time. These individuals may develop PTSD.

Purchased Care – Health services provided through a TRICARE contract that utilizes for civilian resources.

Redeployment – The withdrawal and redistribution of forces; to transfer to another place or job.

Reserve Component – The Army National Guard, Army Reserve, Naval Reserve, Marine Corps Reserve, Air National Guard, Air Force Reserve, Coast Guard Reserve and the Reserve Corps of the United States Public Health Service.

Service member – A person appointed, enlisted or inducted into a branch of the military Services including Reserve Components (includes National Guard), cadets, or midshipmen of the Military Service Academies.

Substance Abuse Prevention and Treatment – Programs designed to address the substance use, abuse and dependency needs of service members. Each Service has oversight over their substance abuse prevention and treatment programs. The Army's is referred to as Army Substance Abuse Program (ASAP). The Navy treatment program is referred to as Substance Abuse and Rehabilitation Program (SARP), while prevention activities are conducted by Navy Alcohol and Drug Abuse Prevention (NADAP). The Air Force program is titled Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program. In the Marine Corps, treatment programs are conducted by Substance Abuse Counseling Centers (SACC) and Drug Demand Reduction (DDR) is the prevention program.

Stigma – The shame or disgrace attached to something regarded as socially unacceptable.

Traumatic Brain Injury (TBI) – A blow or jolt to the head or a penetrating head injury. The injury may be caused by falls, motor vehicle accidents, assaults and/or other incidents. Blast and concussive events are a leading cause of TBI for active duty military personnel involved in war zones. TBI can temporarily or permanently impair a person's cognitive skills, interfere with emotional well- being and diminish physical abilities. Persons with TBI also remain at high risk for the development of delayed symptoms.

TRICARE – DOD's health care plan for active duty, active duty beneficiaries, retirees and their beneficiaries.

Veterans Health Information Systems and Technology Architecture (VistA) – The Veterans' Health Administration electronic medical information /record system.

[Next page intentionally left blank]

Appendix G: Acronyms

ABHC	Automated Behavioral Health Clinic
AC	Active Component
ADAPT	Alcohol and Drug Abuse Prevention and Treatment Program (Air Force)
ASAP	Army Substance Abuse Program
ASD(HA)	Assistant Secretary of Defense Health Affairs
CAO/CACO	Casualty Assistance Calls Officer
CARF	Commission on the Accreditation of Rehabilitation Facilities
CCHSA	Calgary Health Region Mental Health and Addictions Services Continuum
COSC	Combat Operational Stress Control
CPG	Clinical Practice Guidelines
CPT	Cognitive Processing Therapy
CSP	Community Support Program
C&P	Compensation and Pension
DACOWITS	Department of Defense Advisory Committee on Women in the Services
DDESS	Domestic Dependent Elementary Secondary School
DDR	Drug Demand Reduction
DEERS	Defense Enrollment and Eligibility Reporting System
DHB	Defense Health Board (formerly the Armed Forces Epidemiological Board)
DHP	Defense Health Program
DOD	Department of Defense
DODCDP	Department of Defense Center for Deployment Psychology
DODD	Department of the Defense Directive
DODDS	Department of Defense Dependent Schools
DODI	Department of the Defense Instruction
DSHRB	Defense Survey of Health Related Behaviors
DSM-IV	Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition
DVA	Department of Veterans' Affairs
FAP	Family Advocacy Program
FLC	Family Life Consultant
FM	Family Member
FRG	Family Readiness Group
FSC	Family Support Center
FY	Fiscal Year (e.g. FY 2006)
GAO	Government Accountability Office (formerly Government Accounting Office)
GME	Graduate Medical Education
GS	Government Service
GWOT	Global War on Terror
HA	Health Affairs
HART	Palace Helping Airmen Recover Together
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases, Ninth Edition
IG	Inspector General
IMR	Individual Medical Readiness
IOM	Institute of Medicine
IRG	Independent Review Group
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
LCSW	Licensed Clinical Social Worker
M4L	Marine For Life

MEB	Medical Evaluation Board
MHS	Military Health System
MHAT	Mental Health Advisory Team
MHSAP	Mental Health Self Assessment Program
MOA	Memorandum of Agreement
MOSST	Marine Operational Stress and Surveillance Program
MST	Military Sexual Trauma
MTF	Military Treatment Facility
NADAP	Navy Alcohol and Drug Abuse Prevention
NDAA	National Defense Authorization Act
NCO	Non-Commissioned Officer
NG	National Guard
NSPS	National Security Personnel System
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OMNF-I	Office of the Surgeon Multinational Force – Iraq
OSD	Office of the Secretary of Defense
OTSG	Office of the Surgeon General
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
PCP	Primary Care Provider
PDHA	Post-Deployment Health Assessment
PDHRA	Post-Deployment Health Re-Assessment
PHA	Periodic Health Assessment
PE	Prolonged Exposure Therapy
PEB	Physical Evaluation Board
PCM	Primary Care Manager
PCT	Present Centered Therapy
PEB	Physical Evaluation Board
PSA	Public Service Announcement
PTSD	Post-Traumatic Stress Disorder
RC	Reserve Component
RVU	Relative Value Unit
SACC	Substance Abuse Counseling Centers (Marine Corps)
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPRO	Sexual Assault Prevention and Response Office
SF	Standard Form
SLO	School Liaison Officer
SPRRC	Suicide Prevention and Risk Reduction Committee
TBI	Traumatic Brain Injury
TMA	TRICARE Management Activity
VHA	Veterans' Health Administration
VistA	Veterans' Health Information Systems and Technology Architecture
YA	'Professional/Analytical' Pay Scale
YH	'Professional' Pay Scale

Appendix H: References

American Psychiatric Association. (1994) *Diagnostic and statistical manual of mental disorders.* (4th ed.), Washington, DC: American Psychiatric Association.

American Psychological Association Task Force on Military Deployment Services for Youth, Families and Service Members (APATF). (2007). *The psychological needs of U.S. military service members and their families: A preliminary report.* Washington, DC: American Psychological Association.

Andrews, K., Bencio, K., Davis, S., Lee, M., Ng, J., Martin, E. S., & Schone, E. (2006). *Health care survey of DOD beneficiaries: 2005 annual report.* Washington, DC: Mathematica Policy Research.

Becker, D. (1994). Sex bias in the diagnosis of borderline personality disorder and posttraumatic stress disorder. *Professional Psychology Research and Practice, 25,* 55-61.

Beardsley, R., Gardocki, G., Larson, D. & Hidalgo, J. (1998). Prescribing of psychotropic medication by primary care PCMs and psychiatrists. *Archives of General Psychiatry, 45,* 1117-1119.

Bell, D. B., & Schumm, W. R. (1999). Family adaptation to deployments. In P. McClure (Ed.) *Pathways to the future: A review of military family research.* Scranton, PA: Military Family Institute, Marywood University.

Blount, A. (1998). Introduction to integrated primary care. In A. Blount (Ed.), *Integrated primary care: The future of medical and mental health collaboration.* New York: W.W. Norton.

Bray R. M., Hourani, L. L., Rae, K. L., Dever, J. A., Brown, J. M., Vincus, Pemberton, M., Marsden, M., Faulkner, D., & Vandermaas-Peeler, R. (2003). *2002 Department of Defense Survey of Health-Related Behaviors Among Military Personnel.* North Carolina: Research Triangle Institute.

Bray, R., Hourani, L., Olmstead, K., Witt, M., Brown, J., Pemberton, M., Marsden, M., Marriott, B., Scheffler, S., Vandermaas-Peeler, R., Weimer, B., Calvin, S., Bradshaw, M., Close, K., & Hayden, D. (2006). *2005 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel: A Component of the Defense Lifestyle Assessment Program (DLAP).* North Carolina: Research Triangle Institute.

Brown, M., Etherage, J & Rein, M. (2007, January). *Automated Behavioral Health Clinic" A technology solution for building a quality mental health care system.* Paper presented at the DOD Task Force on Mental Health meeting, Tacoma, WA.

Carpinello, S. E., Rosenberg L., Stone, J., Schwager, M., & Felton, C.J. (2002). Best Practices: New York State's campaign to implement evidence-based practices for people with serious mental disorders. *Psychiatry Services, 53*(2), 153-155.

Casciotti, J. A. (2007, February). *Confidentiality of mental health records in the military.* Presentation at the meeting of the DOD Task Force on Mental Health, Arlington, VA.

Castro, C. & Thomas, J. (2007, February). *The Battlemind training system.* Presentation at the meeting of the DOD Task Force on Mental Health, Arlington, VA.

Cigrang, J., Dobmeyer, A., Becknell, M., Roa-Navarrete, R., & Yerian, S. (2006). Evaluation of a collaborative mental health program in primary care: Effects on patient distress and health care utilization. *Primary Care and Community Psychiatry, 11*(3), 121-127.

Corrigan, P. & Gelb, B. (2006). Three programs that use mass approaches to challenge the stigma of mental illness. *Psychiatric Services, 57,* 393-398.

Coviello, D. M., Alterman, A. I., Rutherford, M.J., et al. (2001). The effectiveness of two intensities of psychosocial treatment for cocaine dependence. *Drug and Alcohol Dependence, 61,* 145-154.

Davis, N. J. (2002). The promotion of mental health and the prevention of mental and behavioral disorders: Surely the time is right. *International Journal of Emergency Mental Health, 4,* 3-29.

Defense Manpower Data Center (DMDC). (2006a). *Annual health manpower personnel data system report.* Monterey, CA. Defense Manpower Data Center.

Defense Manpower Data Center (DMDC). (2006b). *December 2005 Status of forces survey of active-duty members: Tabulations of responses.* Arlington, VA: Defense Manpower Data Center Survey and Program Evaluation Division.

Defense Manpower Data Canter. (2006c). *CTS Deployment File Baseline Report.* Monterey, CA. Defense Manpower Data Center.

Department of Defense. (2006). Policy guidance on deployment-limiting conditions. Retrieved from http://www.ha.osd.mil/policies/2006/061107_deployment- limiting_psych_conditions_meds.pdf.

Department of Veterans Affairs & Department of Defense. (2000). Major depressive disorder: Clinical practice guidelines. Washington, DC:(PublicationNo.10Q-CPG/MDD-00). Retrieved from www.oqp.med.va.gov/cpg/MDD/MDD_Base.htm.

Department of Veterans Affairs & Department of Defense. (2004). Clinical practice guideline for the management of post-traumatic stress. Washington, DC: Veterans Health Administration. Retrieved from www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm.

Dial,T. H., Bergsten, C., Haviland, M. G., & Pincus, H. A. (1998) Psychiatrist and nonphysician mental health provider staffing in health maintenance organizations. *American Journal of Psychiatry 155,* 405-408.

Donehoo, J. W. (2006, December). *Continuum of health coverage for Guard/Reserve members: TRICARE Reserve Select.* Presentation to DOD Task Force on Mental Health, Crystal City, VA.

Elisha, D., Levinson, D., & Grinshpoon, A. (2001). A need-based model for determining staffing needs for the public sector outpatient mental health service system. *Journal of Behavioral Health Services and Research, 31,* 324-333.

Faulkner L. R., & Goldman, C. R. (2007). Estimating psychiatric manpower requirements based on patients' needs. *Psychiatric Services, 48,* 666-670.

Floyd D. Spence National Authorization Act of 2002, 5408 H.R, 1071 et seg. (GPO, 2002).

Greene-Shortridge, T. M., Britt, T. W., & Castro, C. A. (2007). The stigma of mental health problems in the military. *Military Medicine, 172,* 157-162.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care. *The New England Journal of Medicine, 351*(1), 13-22.

Hoge, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *The Journal of American Medical Association, 295* (9), 1023-132.

Hosek, J. Kavanagh, J. & Miller, L. (2006). *How deployments affect service members.* Santa Monica, CA: Rand Corporation.

Huebner, A. & Mancini, J. (2005). *Adjustments among adolescents in military families when a parent is deployed.* Military Family Research Institute: West Lafayette, IN.

Independent Review Group (IRG). (2007). *Rebuilding the trust: Report on rehabilitative care and administrative processes at Walter Reed Army Medical Center and National Naval Medical Center.* Alexandria, VA: Defense Health Board.

Institute of Medicine (IOM). (2005). Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Board on Health Care Services. *Improving the quality of health care for mental and substance-use conditions.* National Academies Press: Washington DC.

Jaffa, T., Lelliott, P., O'Herlihy, A., Worrall, A., Hill, P., & Banerjee, S. (2004). The staffing of inpatient child and adolescent mental health services. *Child and Adolescent Mental Health, 9,* 84-87.

Jumper, C., Evers, S. Cole, D., Raezer, J. W., Edger, K., Joyner, M., & Pike, H. (2006). *Cycles of deployment: An analysis of survey responses from April through September 2005.* Alexandria, VA: National Military Family Association. Retrieved from http://www.nmfa.org/site/DocServer/NMFACyclesofDeployment9.pdf?docID=5401

Katon, W., Robinson, P., Von Korff, M., Lin, E., Bush, T., Ludman, E., Simon, G. & Walker, E. (1996). A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry, 53*(10), 924-932.

Katon, W., Von Korff, M., Lin, E., Walker, E., Simon G., Bush, T., Robinson, R., & Russo, J. (1995). Collaborative management to achieve treatment guidelines: Impact on depression in primary care. *Journal of the American Medical Association, 273,* 1026-1031.

Kessler, R.C., Sonnega, Al, Bromet, E. J., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52,* 1048-1060.

Lupo, M. & Proctor, G. (2006, December). *TRICARE Region: South.* Presentation to the DOD Task Force of Mental Health, Crystal City, VA.

MacDermid, S. M. (2006, June). *Multiple transitions of deployment and reunion.* Presentation to Military Community and Family Policy (Office of the Secretary of Defense) Research Committee, Alexandria, VA.

McClure, G. (2007, January). *Soldier wellness assessment pilot program (SWAPP).* Presentation to the DOD Task Force on Mental Health, Fort Lewis, WA.

Novier, F. (2007). *Final report: Army behavioral health system assessment.* San Antonio, TX: BearingPoint, Inc.

Office of the Assistant Secretary of Defense for Health Affairs, Force Health Protection and Readiness (ASD(HA)). (February, 2007). *Sustaining the mental health and well being of the military community.* United States Department of Defense: Falls Church, VA.

Office of the Surgeon Multinational Force – Iraq and Office of the Surgeon General, U.S. Army Medical Command. (2005). *Mental Health Advisory Team (MHAT-III). Operation Iraqi Freedom 04-06.* Retrieved from http://www.armymedicine.army.mil/news/mhat/mhat.html.

Office of the Surgeon Multinational Force – Iraq and Office of the Surgeon General, U.S. Army Medical Command. (2006). *Mental Health Advisory Team (MHAT-IV). Operation Iraqi Freedom 04-06.* Retrieved from http://www.armymedicine.army.mil/news/mhat/mhat.html.

Ostroff, S. M. & Gibson, R. L. (2005). *Mental health support activities and programs for military service members – AFEB 2005-02.* Department of Defense Armed Forces Epidemiological Board: Falls Church, VA.

Pereira, A, (2002). Combat stress and the diagnosis of PTSD in women and men veterans. *Military Medicine, 167*(1).

Perconte, S. T., Wilson, A. T., Pontius, E. B., Deitrick, A. L., & Spiro, K. J. (1993). Psychological and war stress symptoms among deployed and non-deployed reservists following the Persian Gulf War. *Military Medicine,* 158 (8), 516-521.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America.* Rockville, MD: The President's New Freedom Commission on Mental Health. Retrieved from http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf.

Prochaska J.O., Diclemente C.C., & Norcross J.C. (1992) In search of how people change: Applications to addictive behaviors. *American Psychologist, 47,* 1102-1114.

Rentz, E. D., Marshal, S. W., Loomis, D., Casteel, C., Martin, S. L., & Gibbs, D. A. (2007). Effect of deployment on the occurrence of child maltreatment in military and nonmilitary families. *American Journal of Epidemiology, 15,* 1199-1206.

Robinson, S. L. (2004). Hidden toll of the war in Iraq: Mental health and the military. Center for American Progress. Washington, DC:

Roeder, T. & Vogrin, C. (2007, March 26). Post faces fourth straight PTSD increase. Retrieved from http://www.airforcetimes.com/news/2007/03/ap_ptsd_070326/.

Rowan, A. & Campise, R. (2006). A multi-site study of Air Force outpatient behavioral health treatment-seeking patterns and career impacts. *Military Medicine, 171,* 1123-1127.

Rusch, R., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20,* 529-539.

Russell, M. C. (2006a). An informal training survey of 133 Department of Defense mental health providers and treatment of combat-related Post-Traumatic Stress Disorder. Unpublished manuscript.

Russell, M. C. (2006b, October). *The future of mental health care in DOD: Carpe Diem.* Presentation to the DOD Task Force on Mental Health, San Diego, CA.

Sammons, M. T. (2005). Psychology in the public sector: Addressing the psychological effects of combat in the U.S. Navy. *American Psychologist, 60*(8), 899-909.

Scheffler, R., & Ivey S.I. (1998). Mental health staffing in managed care organizations: A case study. Psychiatric Services, 49, 1303-1308.

Schnurr, P., Friedman, M., Engel, C., Foa, E., Shea, T., Shaw, B., & Resick, P. (2007). Cognitive-behavioral therapy for post traumatic stress disorder in women: A randomized controlled trial. *Journal of the American Medical Association, 297,* 820-830.

Seal, K., Bertenthal, D., Miner, C., Sen, S., & Marmar, C. (2007). Bringing the war back home. *Journal of Internal Medicine, 167,* 476-482.

Smit, F., Willemse, G., Koopmanschap, M., Onrust, S., Cuijpers, P. & Beekman, A. (2006). Cost effectiveness of preventing depression in primary care patients. *British Journal of Psychiatry, 188 (4),* 330-336.

Taube, C. A., Goldman H. H., & Burns, B. J. (1998). High users of outpatient mental health services. *American Journal of Psychiatry, 145,* 19-24.

Timko, C., Lesar, M., Calvi, N. J., & Moos, R. H. (2003). Trends in Acute Mental Health Care: Comparing psychiatric and substance abuse treatment programs. *Journal of Behavioral Health Services and Research 30,* 145-160.

Timko, C., Sempel, J. M., & Moos, R. H. (2003). Models of standard and intensive outpatient care in substance abuse and psychiatric treatment. *Administration and Policy in Mental Health, 30,* 417-436.

TRICARE Behavioral Health Care Services. (2004). Retrieved from www.tricare.mil.

TRICARE Management Activity. (2007). Monthly Mental Health Facilities Listing Report. Falls Church, VA.

U.S. Air Force. (2004). *Guide for managing suicidal behavior.* Air Force Medical Operations Agency, Population Health Support Division: Washington DC.

U.S. Air Force. (2007). DOD Task Force on Mental Health Data Call. Unpublished raw data.

U.S. Air Force Medical Operations Agency, Office of the Air Force Surgeon General. (2002). Primary behavioral health services: Practice manual. Washington D.C.

U.S. Air Force Management Operations Agency, Office of the Air Force Surgeon General. (2005). DOD Public Service Suicide Prevention Vignettes CD. Washington DC.

U.S. Army. (2007). DOD Task Force on Mental Health Data Call. Unpublished raw data.

U.S. Army (Office of the Surgeon General). (2006). Battlemind Training. Walter Reed Army Research Institute: Washington D.C.

U. S. Army (Office of the Surgeon General) and Commanding General, Medical Research and Materiel Command. (2006). *Behavioral health strategy for the way ahead: AMEDD general officer behavioral health summit.* Forest Glen, MD: U.S. Army.

U.S. Army (Office of the Surgeon General). (2003). *Operation Iraqi Freedom (OIF) Mental Health Advisory Team (MHAT) Report.* Retrieved from http://www.pbs.org/wgbh/pages/frontline/shows/heart/readings/mhat.pdf

U.S. Army. (2005). *Operation Iraqi Freedom (OIF) Mental Health Advisory Team (MHAT-II) Report.* Retrieved from http://www.medicine.army.mil/news/mhat/mhat_ii/OIF-II_REPORT.pdf

U.S. Army Community and Family Support Center (2005). *Survey of Army Families V: Your children.* Retrieved from http://www.army.mil/cfsc/documents/research/safv/7.ppt#264,1,Slide 1.

U.S. Department of Defense. Office of the Deputy Under Secretary of Defense. (2004). *Demographics Profile of Military Community.* Washington, DC: Author.

U.S. Department of Defense. (2001). 2001 Department of Defense Survey of Health Related Behaviors Among Military Personnel. (May 2004). Washington, DC: Author.

U.S. Department of Defense. (2006, July). Combat and Operational Stress Control (Filed Manual N.4-02.51 (8-51). Washington, DC: Department of the Army.

U. S. Department of Defense. (2006). *Policy guidance on deployment-limiting conditions.* Retrieved from http://www.ha.osd.mil/policies/2006/061107_deployment- limiting_psych_conditions_meds.pdf

U.S. Department of Defense Advisory Committee on Women in the Services (DACOWITS). (2003) DACOWITS Report. Arlington, VA.

U.S. Department of Defense Office of the Deputy Under Secretary of Defense. (2004). *Demographics Profile of Military Community.* Washington, DC.

U.S. Department of Health and Human Services. (2000). *Healthy People 2010* (2nd ed.). With Understanding and Improving Health and Objectives for Improving Health. 2 Vols. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (2003). *Achieving the Promise: Transforming Mental Health Care in America. (Publication No. SMA-03-3831).* Rockville, MD: New Freedom Commission on Mental Health.

U.S. Department of Health and Human Services. (2005). Substance Abuse and Mental Health Services (SAMHSA). Transforming mental health care in America. The Federal action agenda: First steps. Rockville, MD: SAMHSA.

U.S. Department of Veteran Affairs. (2005) The National Center for PTSD 16th Annual Report "Resilience and Recovery". Washington, DC: U.S. Department of Veteran Affairs.

U.S. General Accounting Office. (2003). *Report to Congressional Committees: Military personnel: DOD needs more data to address financial and health care issues affecting reservists (Publication No. GAO-03-1004).* Washington, DC: U.S. General Accounting Office.

U.S. General Accounting Office. (2003). *Defense Health Care: Oversight of the TRICARE Civilian Provider Network Should Be Improved (Publication No. GAO 03-928).* Washington, DC: U.S. Government Accountability Office.

U.S. Government Accountability Office. (2004). Highlights of GAO-04-1069, a report to the Ranking Democratic Member, Committee on Veterans' Affairs, House of Representatives. VA and Defense Health Care: More Information Needed to Determine If VA Can Meet an Increase in Demand for Post-Traumatic Stress Disorder Services (GAO-04-1069) Washington, D.C.: U.S. Government Accountability Office.

U.S. Government Accountability Office. (2006). *Defense Health Care: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option (GAO-07-48).* Washington, DC: U.S. Government Accountability Office.

U.S. Government Accountability Office. (2006). *Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Service members (Publication No. GAO-06-397).* Washington, DC: U.S. Government Accountability Office.

U.S. Government Accountability Office. (2007). *Military Health: Increased TRICARE eligibility for Reservists presents educational challenges (Report No. GAO -07-195).* Washington, DC: U.S. Government Accountability Office.

U.S. Navy. (20027). DOD Task Force on Mental Health Data Call. Unpublished raw data.

U.S. Public Health Service Office of the Surgeon General. (1999). *Mental Health: A report of the Surgeon General.* Rockville, MD: Depart of Health and Human Services, U.S. Public Health Service.

U.S. Public Health Service Office of the Surgeon General. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: Depart of Health and Human Services, U.S. Public Health Service.

Veterans Health Affairs Office of Public Health and Environment Hazards. (2006). *Analysis of VA healthcare utilization among US Southwest Asian war veterans: Operation Iraqi Freedom, Operation Enduring Freedom.* Unpublished data.

Weisner, C., Mertens. J., Pathasanrathy, S., et al. (2000). The outcomes and cost of alcohol and drug treatment in an HMO: Day hospital versus traditional outpatient regimens. *Health Services Research, 35,* 791-812.

Wheeler, E. (2007). Self-reported mental health status and needs of Iraq veterans in the Marine National Guard. Manuscript submitted for publication.

Appendix I: Acknowledgements

The Task Force owes thanks for assistance received from many quarters during the preparation of this report. First and foremost, we express our gratitude to the members and families who serve in the U.S. military. Their dedication and patriotism is inspiring, and their well-being is the single over-riding priority of the Task Force.

The members of the Task Force greatly appreciate the time, energy and commitment demonstrated by all of the individuals and groups who provided information during its deliberations. We learned a great deal from both the military members and civilians who provided briefings, the advocates who spoke during public sessions, and individuals who sent or submitted information in other ways.

We also are very grateful to the commanders, points of contact, and participants who made it possible for us to complete thirty-eight visits to military installations around the world. The wide range of information candidly shared during those meetings had a powerful impact on the conclusions of the Task Force. We especially appreciate the care and concern demonstrated by the many mental health providers, counselors, therapist and chaplains with whom we met.

The work of the Task Force proceeded only with support from a large number of professionals. We especially appreciate the efforts of Roger Gibson, Executive Secretary of the Defense Health Board, Cynthia Vaughan, Mike Heimall, Morgan Sammons, and Marianne Coates. Dr. Thomas Burke acted as the Task Force's Executive Secretary. Contract support staff included: Kate Surman, Deirdre Farrell, Severine Bennett, Chey Bosley, Carolyn Reyes, Meredith Richards, Abigail Wilson and Karen Triplett.

The service of each Task Force member was made possible by the military Services, employers, coworkers, and family members, who graciously sacrificed time taken for travel to meetings or site visits, conference calls, and study. We thank them all.

Last but not least, we wish to gratefully acknowledge the energetic and enthusiastic leadership demonstrated by Lieutenant General C. Kiley during his tenure as co-chair of the Task Force. In every way, the service of LTG Kiley and his staff members, Colonel Jeffrey Davies and Major Anthony Cooper was exemplary.

Senator BEN NELSON. Thank you, Admiral. Thank you, Dr. MacDermid.

Colonel Hoge?

STATEMENT OF COL CHARLES W. HOGE, USA, DIRECTOR, DIVISION OF PSYCHIATRY AND NEUROSCIENCE, WALTER REED ARMY INSTITUTE OF RESEARCH; ACCOMPANIED BY COL CARL A. CASTRO, USA, RESEARCH AREA DIRECTOR, MILITARY OPERATIONAL MEDICINE RESEARCH PROGRAM

Colonel HOGE. Senator Nelson, Senator Graham: I have a very brief statement for both Colonel Castro and myself regarding the MHAT assessments that we've conducted annually in Iraq, also called MHATs. So I may use that acronym.

The MHAT missions were established by the Army Surgeon General at the request of the Commanding General, Multinational Force-Iraq and U.S. Central Command. They've been conducted annually in Iraq since the start of Operation Iraqi Freedom, and we've also conducted two assessments in Afghanistan in 2005 and 2007. The MHATs are part of an ongoing scientific effort to understand the mental health impact of deployment to Iraq and Afghanistan and then utilize this knowledge to improve the care that we deliver to the servicemembers in the deployed environment and post-deployment.

This effort is unparalleled compared with previous wars, where mental health issues really weren't addressed until years and sometimes decades after servicemembers came home.

The MHATs have maintained a consistent focus on soldiers and brigade combat teams or, in the case of Marine units, regimental combat teams. We've looked at both Active and National Guard units and units that have directly supported those brigade combat teams. The in-theater MHAT assessments have utilized the same methodology that we've utilized in some of our studies post-deployment that we published in the New England Journal of Medicine and other top-tier journals.

The results of these investigations have shown that 15 to 20 percent of combat troops deployed to Iraq experience significant symptoms of acute stress, PTSD, or depression, and 15 to 20 percent of married servicemembers experience serious marital concerns. The MHATs have shown that longer deployments, multiple deployments, greater time away from the base camps, and combat frequency and intensity all contributed to higher rates of mental health problems.

The most recent MHAT V report is in the process of being released, but one of the key findings concerns the cumulative effects of deployment, because this was the first time we were able to look at servicemembers who were on their third rotation to Iraq, compared with two rotations or their first rotation. What we found was that mental health problems rose with each cumulative deployment, reaching nearly 30 percent among those soldiers on their third deployment to Iraq.

The MHAT V effort also showed that soldiers deployed to Afghanistan are now experiencing levels of combat exposure and mental health rates equivalent to levels in Iraq and substantially

higher than they were experiencing in 2005 during our last assessment.

The data from the MHAT missions have led to a number of important policy changes. Most importantly, the findings have led to revised doctrine and combat stress control procedures that we use in the theater, an improved training and distribution of behavioral health personnel. They've assured that there's sufficient mental health personnel deployed in theater and are providing support to soldiers at remote locations.

The MHATs have demonstrated the critical role of strong leadership in maintaining the mental health of combat units, and it's led to the development and testing of new interventions, such as the training program called Battlemind, which is now being implemented Army-wide.

Thank you very much for your continued interest in our research and your support for our servicemembers. We look forward to answering your questions.

[The prepared statement of Colonel Hoge follows:]

PREPARED STATEMENT BY COL CHARLES W. HOGE, USA

Chairman Nelson and distinguished members of the committee, thank you for the opportunity to discuss the Army's Mental Health Advisory Team (MHAT) assessments. I am Colonel Charles W. Hoge, M.D., Director of Psychiatric Research at Walter Reed Army Institute of Research. Accompanying me today is Colonel Carl A. Castro, who is Director of the Military Operational Medicine Research Program, Medical Research and Materiel Command. We have both participated in and supervised elements of all five of the MHATs.

The MHAT missions were established by the Army Surgeon General at the request of the Commanding General, Multinational Force-Iraq, and U.S. Central Command. The MHATs have been conducted annually in Iraq since the start of Operation Iraqi Freedom and twice in Afghanistan in 2005 and 2007. The mission of the MHATs has been to assess the mental health and well-being of deployed forces, examine the delivery of behavioral health care in theater, and provide recommendations for sustained and improved mental health services to theater commanders. Some of the MHATs have also included assessments of morale, the effect of multiple deployments, the status of training in behavioral health, and battlefield ethics.

The MHATs are not representative of all soldiers deployed throughout Iraq or Afghanistan, but have maintained a consistent focus on soldiers in brigade combat teams (BCTs), to include Active and National Guard BCTs, as well as units that directly support these BCTs. Marine Regimental Combat Teams were studied 2 years ago. The assessment methods have included surveys of soldiers, focus group interviews, and surveys of behavioral health providers, unit chaplains, and primary care professionals.

The results of these investigations have shown that rates of mental health have remained consistent from year to year among soldiers in Iraq; 15–20 percent of combat troops deployed to Iraq experience significant symptoms of acute stress, posttraumatic stress disorder (PTSD), or depression, and 15–20 percent of married servicemembers experience serious marital concerns. The MHATs have shown that longer deployments, multiple deployments, greater time away from the base camps, and combat frequency and intensity all contribute to higher rates of PTSD, depression, and marital problems. The full report on the findings of MHAT V will be released soon. However the initial review shows that rates of mental health problems rose significantly with each deployment, reaching nearly 30 percent among soldiers on their third deployment to Iraq. The 2007 effort also showed that soldiers in brigade combat teams deployed to Afghanistan are now experiencing levels of combat exposure equivalent to levels in Iraq, and that mental health rates are now comparable between Iraq and Afghanistan. Suicide rates have increased compared with baseline rates prior to Operation Iraqi Freedom. The data collected from the MHAT missions have also been compared with data obtained in the post-deployment period. These studies have shown that 12 months is insufficient to reset the mental health of soldiers, and that rates of mental health, particularly PTSD, remain elevated and even increase somewhat during the first 12 months after return from deployment.

The last two MHAT missions have shown that combat experiences, such as losing a team member, and mental health problems are associated with approximately a two-fold elevated risk of reporting ethical mistreatment of non-combatants, such as damaging Iraqi property when it was not necessary or hitting or kicking an Iraqi non-combatant when it was not necessary. All of the MHATs have shown that good unit leadership is vital in sustaining mental health and well-being among combat troops, as well as reducing the likelihood of ethical mistreatment of non-combatants.

The data from all the MHAT missions have led to a number of important policy changes. The data have been used to improve the training and distribution of behavioral health personnel in theater. They have assured that sufficient mental health personnel (credentialed providers and mental health technicians) are deployed in theater and are providing support to soldiers at remote locations. The MHAT findings were the impetus for revising the Combat and Operational Stress Control doctrine and training that behavioral health personnel receive. All behavioral health professionals deploying to theater are now mandated to take the new Army Medical Department Combat and Operational Stress Control Course. The MHAT assessments have also led to the implementation of new Army-wide mental health training, called Battlemind, for all soldiers and leaders, as well as improved training in battlefield ethics and suicide prevention. When the findings of the most recent MHAT are released, we will further refine our policies to meet the mental health needs of soldiers.

Thank you very much for your continued interest in our research and your continued support for our servicemembers. We look forward to answering your questions.

Senator BEN NELSON. Colonel Castro, do you have anything to add?

Colonel CASTO. No, I do not, sir.

Senator BEN NELSON. Thank you very much for your testimony here today.

I'm going to ask a question about what we can do for mental health care in the rural areas that are not in close proximity to a base or may not even have a large city within a certain distance. Dr. MacDermid, did you find any protocols in place or that could be put in place to ensure that you could still have adequate mental health services? I'm thinking primarily of national guardsmen and reservists, who are by comparison stranded in other areas, not necessarily close to a base or other location for an operation.

Dr. MACDERMID. Thank you for your question. We made a number of recommendations about ways to reach National Guard and Reserve folks, one of which was to simply increase the infrastructure within those organizations, because, for example, in each State there's not necessarily someone who has the responsibility to oversee and monitor and take action about psychological health issues.

I think it is also the case that the TRICARE system has to be functional for Guard and Reserve members, and the VA has also been increasing resources in that area. I think it doesn't make sense in my mind to try to create something new when there are services already out there, but it's not clear that those services are working effectively. We recognized, for example, that we were told on many installations that even in those areas the TRICARE network records did not appear to be very accurate, and that is likely to be similar and even more problematic in areas where there is not an installation.

Senator BEN NELSON. Did you encounter anything having to do with confidentiality, or were you able to look at all of the records?

Dr. MACDERMID. We did not look at medical records, sir. That was not something that we had the authority to do. Our conversations were with leaders of health care facilities, with patients, and with community providers.

Admiral ARTHUR. Senator, may I add. There's an even more vulnerable population. That's the people who come back and are no longer affiliated with the Active, Reserve, or Guard component, those people who've gotten out of the Service. They go back to work and back in their community, where people really don't understand what they have been through and don't have any context for some of their mental health issues.

One of the programs that I think is very successful is the Marine for Life program, where the marines have people all over the country who are retired or who have just done one or two tours in the Marine Corps and feel it is their obligation, their responsibility, to take care of marines who have gotten out. I think that population really is the unseen population for us.

Senator BEN NELSON. In terms of the family that would be experiencing this vicariously, what have your thoughts been about how we might deal with the family members, particularly if they're in a stranded location far away from a base or another provider?

Dr. MACDERMID. There are substantial shortages in the civilian community for a variety of medical specialties, and it is a problem. That's true for Active folks as well. When they have to go to communities to find specialists, they have trouble, too, which is one of the reasons why we put as much emphasis as we did on uniformed providers.

I think in many cases the solutions for families are the same as the solutions for reaching National Guard and Reserve members, because it's families that are out there in communities and that is where they have to get most of their care, and there's a lot we could still do to try to make sure those communities are well prepared to receive them.

These policy issues we identify that have the effect of impeding access to care I think might be low-hanging fruit. There probably are things I don't understand. I'm sure that there are. But on their face, when it's a matter of changing a policy that looks to be a good target for something that might open up quite a bit of access fairly quickly; I'm happy to be told that I'm wrong about that, but I think it's certainly worth a look.

Admiral ARTHUR. We also need to provide access for the families where they can receive the assistance, the social assistance, not just where it's convenient for us. One of the things we talked about in the report is even going down to school counselors and teachers to educate school counselors and teachers about the particular stresses of the military and allow them to assist the children right in their schools.

So there are a lot of things that we can do, but we shouldn't make the families necessarily come to us when they have a problem. We should be accessible to them before they have a problem.

Senator BEN NELSON. If you were to identify as a percentage of shortage, percentage shortage of the providers, the care providers that would be available to help, do you think we're 50 percent below where we should be, or are we more than that, or do you have an opinion?

Dr. MACDERMID. This is Admiral Arthur's favorite question, sir.

Admiral ARTHUR. I mentioned the population-based risk-adjusted model, and that speaks to assessing what the risks are. The risk

for a deploying combat battalion might be more than for a non-deploying motor transportation battalion, for example. So I think we have to assess what the risks are, the number of people, and then provide an appropriate number of resources and the appropriate kinds of personnel. It is not just psychiatrists. We tend to focus on the physician issues, but it's really the sociologists, the social workers, the psychologist, the mental health practice nurses—anyone who can be involved, at the lowest level possible.

Senator BEN NELSON. So do you have an opinion about how adequate we are in terms of numbers? Is it say 50 percent, 40 percent? Any estimate of that sort?

Admiral ARTHUR. I would like to leave that up to my Service colleagues, because I think they've done a lot more assessments recently, and I actually don't know where we are in the full contracting and the supplying of people for battalion support, particularly in the field. So if I may I would leave that for my Active Duty colleagues.

Senator BEN NELSON. There have been a lot of questions raised about the length of deployment and then how much time should lapse between deployment number one and deployment number two; in other words, how much time back home should there be. I think we're looking at trying to make the number the same or something similar to that. I think the longer the time at home that a soldier has or an airman or a marine probably the better. But I don't know that statistically I can prove that.

It seems self-evident that that time back would be very helpful and be required. But is that an assumption on our part that is founded on anything that you've been able to determine in your studies?

Admiral ARTHUR. I think that's a very valid conclusion. It also matters greatly where you are in the combat arena. If you're right up front in combat operations day after day, or you're in convoys day after day with the threat of adverse combat action, then you're much more stressed and need more time back at home.

If you're in a rear echelon or a headquarters element in some place like Bahrain or other rear locations, then you may not need as much rest.

The greatest concern I have are for the Special Forces people in the Army, the SEALS in the Navy, and the recon people in the Marine Corps, who have an incredibly high operational tempo and a very high degree of mental health issues in themselves and their families when they return.

Colonel HOGE. Sir, if I may answer that question as well. We have good data that after a 12-month deployment, 12 months back home is not sufficient to reset. We actually see rates of mental health concerns rise slightly during that 12-month period. They certainly don't go down.

Senator BEN NELSON. Would it be fair to say, though, that the shorter the time in between, it wouldn't be better; it would be worse? In other words, is there an optimum time, or is each case an individual case? Or have you been able to establish what would be an optimal timeframe in between?

Colonel CASTRO. Sir, it is important to also keep in mind the length of deployment. For example, the Army deploys much longer

and probably then it would require much longer in-between deployments. For the Marine Corps, which deploys the shorter amount of time, 7 months, then their recovery time probably doesn't need to be as long. But as Admiral Arthur points out, it's very critical to look at what exactly is happening to the servicemember, the warrior, while they're over there.

One of the key findings from the MHAT IV is that those soldiers and marines who are in day-to-day combat operations day-in and day-out, their mental health rates were two to three times higher than the overall force. So it's very important to look at all of the variables that we know are related to and impacting on the psychological health of the servicemember. But we certainly know, as Colonel Hoge points out, a year is not long enough if you're deployed for a year or longer. But perhaps if you deployed shorter, it's not as long.

But the bottom line is we don't know because our soldiers deploy so frequently we have never been able to give you an exact time.

Senator BEN NELSON. That raises some obvious questions about the dwell time, as you say, depending upon whether you were forward deployed or where you were in the deployment. It's hard enough to try to get something that is uniform across the board for each branch the way it is. I imagine it gets a little byzantine if you try to make it a pattern or tailor it to each individual case.

So 15 months may not be long enough. Do you have a recommendation just overall, a one-size-fits-all type of dwell-time recommendation?

Colonel CASTO. One of the recommendations we made in the MHAT IV report was 18 to 24 months dwell time. But that was quite a controversial recommendation.

Senator BEN NELSON. I imagine it was, yes.

Senator Graham?

Senator GRAHAM. Thank you, sir. Mr. Chairman, thanks for having the hearing. This has been fascinating. When it seems on the money front you expand TRICARE to include mental health services available in the civilian community, that would be a great start. It seems we're going down that road.

The investment in technology to understand the brain injury situation better—I am fascinated by some of the ideas out there and we will follow up and see where this monitoring device is at. I know I just want America to know we do spend a lot of money trying to find out what is the best equipment, what's the best way to prepare our folks for war, and it's always an ongoing endeavor.

You said about 30 percent, I think, Colonel Hoge, of people who have gone back for the second or third time are having some mental health-related problems, is that right?

Colonel HOGE. Yes, sir.

Senator GRAHAM. Is it affecting retention rates?

Colonel HOGE. I can't answer that. I don't have access to that. I haven't looked at that particular outcome.

Senator GRAHAM. Is it affecting the ability to go back to duty? Are these incapacitating problems?

Colonel HOGE. They aren't necessarily incapacitating to the point of not being able to do their duty. But that 30 percent rate is based on self-report survey data, where we ask a series of questions about

what types of mental health problems the soldier is experiencing, and they have to report a substantial number of symptoms to meet that threshold. So it is not just a few symptoms. They have to report a fair number of symptoms.

Senator GRAHAM. I guess what I'm asking is what kind of impact does it have on retention? What kind of impact does it have on being able to go back to duty? If you could maybe explore that a little bit and get back with us.

Colonel HOGE. Yes, sir, I'd be happy to do that.

[The information referred to follows:]

The Army's retention database does not include any data that may indicate if a soldier has a mental health issue. Consequently, we do not have retention data that can be used to assess the impact of mental health problems. However, the Walter Reed Army Institute of Research (WRAIR) proactively approached this issue by looking at Post-Deployment Health Assessments (PDHA). Researchers from WRAIR conducted population-based analyses of over 300,000 Army soldiers and marines who completed a PDHA between May 2003 and April 2004. Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) deployers with a mental health problem who self-identified on the PDHA were over 30 percent more likely to leave military service within 1 year than OIF and OEF veterans who did not report a mental health problem on the PDHA. These findings have been published in the March 2006 edition of the Journal of the American Medical Association.

Senator GRAHAM. Civilian contractors—we have 130,000 folks over there. Has anybody looked at the civilian contracting force? I see some heads nod. To be asked later, I guess, in the next panel.

We will do what money can do. We will try to grow the Army. I think that's one of the goals, is to grow the Army to make sure the rotation schedules are not so onerous.

Admiral, you had something?

Admiral ARTHUR. Sir, I'd like to make a comment about the money. We've talked about money and TRICARE and modifying the TRICARE benefit. I'd just like to put a plug in that the reason we have such a wonderful save rate or resuscitation rate of combat injuries and so much attention that can be paid to our veterans in the field is because we have maintained an Army, Navy, and Air Force medical system that has not only taken care of our servicemembers and their families, but has maintained a state of readiness over so many decades and is ready to do whatever the Nation calls on it, and that requires that the Services and their medical functions be properly funded to train and equip for their combat role as well as their normal health care role.

Senator GRAHAM. That's well said. I think some of the unsung heroes of this war are the men and women in the medical services. If you could make it through the door of a hospital in Iraq, they say you have about a 90 percent survival rate, which is phenomenal. But these injuries are solid. They have to be detected, having your buddies understand what to look for, having commanders be sensitive.

What you're doing is good work for the country. War is a terrible thing. Just listening to this—my dad went off to World War II before I was born, but a lot of people went away for 4 years, never saw their family.

Admiral ARTHUR. For the duration.

Senator GRAHAM. For the duration. So America's been through these tough times before. But this war is unique and we need to make sure that we're stepping up to the plate and providing all of

the services possible, and retention and recruitment are amazingly good to me. The one thing I hear from these beds in hospitals when I go visit, like Senator Nelson, is the number one comment I get is: "I want to go back to be with my buddies," which just astonishes me.

So I think our force needs to be protected and nurtured. But we're blessed to have them. So thank you.

Senator BEN NELSON. We certainly don't have to work that much harder on creating a team concept in the military, because that is the reaction that you pick up from a wounded warrior, a feeling of guilt that they're no longer able to be there with their comrades. If we can establish stronger mental health care and recognition of challenges at the time for prevention or intervention, it seems to me that we'll be doing what needs to be done.

The suicide rate, is there any comment that any of you would like to make about what is an alarming suicide rate for our military personnel today?

We can take that up with the next panel. But I'm also thinking perhaps from your standpoint you may have some thoughts about it from the reports that you've been involved with.

Colonel HOGE. Yes, sir. We've looked at suicide rates in theater with every one of the MHATs and we have seen consistently for the last couple of years a higher rate than the expected baseline rate of suicides. I think the factors that generally drive suicides, there's an element of impulsivity. The soldier may, in an impulsive moment, make a decision that he wouldn't make when he's back home.

Then a lot of times these things are precipitated by relationship problems that the soldier is having, that type of thing.

Senator BEN NELSON. Any connection that you could draw between the length of deployment or the number of deployments or the short timeframe for dwell-time tied to suicide?

Colonel HOGE. Sir, we haven't been able to make a direct link because suicides are still quite rare events. We can make that kind of link for overall mental health concerns, mental health problems. We know there's a relationship between mental health problems and suicide, and so we could make the link in that way. But we haven't been able to make it in a direct way.

Senator BEN NELSON. Thank you very much. We appreciate what you're doing and thanks for being here today. [Pause.]

Last, but certainly not least, on our third panel we welcome: Lieutenant General Eric Schoomaker, United States Army, Surgeon General of the Army and Commanding General, United States Army Medical Command; Vice Admiral Adam M. Robinson, Jr., United States Navy, Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery; Lieutenant General James G. Roudebush, United States Air Force, Surgeon General of the Air Force, and a resident of Gearing, NE. We appreciate that connection, General. Also with her is Colonel Loree K. Sutton, United States Army, Special Assistant to the Assistant Secretary of Defense for Health Affairs on Psychological Health and TBI.

Colonel Sutton, we congratulate you on your recent selection for promotion to brigadier general. Colonel Sutton is responsible for, among other things, implementation of the DOD Centers of Excel-

lence for PTSD and TBI, which were mandated by the Wounded Warrior Act in the National Defense Authorization Act for Fiscal Year 2008.

General Roudebush, I understand you received both your bachelor of medicine and doctor of medicine degrees from the University of Nebraska, another fine institution. So we have high expectations for you as a result of your stellar education.

I know that, General Schoomaker, you have a brother living in Omaha, NE. As your brother, the other general, has told me on so many occasions, he's had more than one good steak in Omaha.

So we look forward to hearing your assessments today of Service and DOD-wide plans to implement all of the findings and recommendations we've just heard about in great detail. So with that, General Schoomaker, the platform is yours.

STATEMENT OF LTG ERIC B. SCHOOMAKER, USA, SURGEON GENERAL OF THE UNITED STATES ARMY AND COMMANDING GENERAL, UNITED STATES ARMY MEDICAL COMMAND

General SCHOOMAKER. Chairman Nelson, Senator Graham, distinguished members of the Personnel Subcommittee: Thank you for this opportunity to discuss the Army's efforts to improve mental health care for soldiers and family members. Our Army Secretary, Pete Geren, our Chief of Staff of the Army, General George Casey, and the rest of Army leadership strongly support our efforts to improve the quality and access to mental health services and are also actively leading and remain engaged in our efforts to eliminate the stigma associated with seeking mental health care.

The stigma is not just found in the military community. It is a national concern and should really be addressed in all communities.

Our soldiers and our Army are doing amazing work in an Army that is demanding and has an extremely high operational tempo that you have heard spoken about by our previous two panels. But our soldiers and families are stressed. The global war on terror has placed increased operational demands on our military force. We know that repeated and extended deployments, as you've heard from the group that has performed our MHAT surveys, are experiencing increased stress, family difficulties, other psychological effects of war, such as depression, anxiety, withdrawal, and social isolation, and symptoms of post-traumatic stress, which, if not identified and treated promptly, may evolve into a more resistant psychological injury known as PTSD.

The Army is absolutely committed to ensuring all soldiers and families are healthy both physically and psychologically. We have embraced the recommendations of the DOD Task Force on Mental Health and commend its authors. We are striving to provide the best mental health care for our soldiers and families. From the time a soldier enters the Army to the time that they depart, they are assessed, trained, and offered treatment for mental health care should they need it. This includes their families as well.

Much of our efforts are concentrated on the activities associated with deployments, whether that's building resiliency through training and awareness prior to deployment or assessing, training, and treating while being deployed. We then follow soldiers very closely

upon redeployment and several months after redeployment to ensure that the mental health needs are assessed and are being met.

I'll only touch on a few of the many programs that we have that address the recommendations of the Task Force on Mental Health. I hope it shows that we are taking significant action in line with each of these six key objectives that are described in the task force report and in their testimony. Let me just expand on a few.

As described by Colonels Hoge and Castro just a moment ago, the MHATs are a groundbreaking achievement. Never before has a military force studied the psychological strains of combat as intensely during the conflict. This work of our best and brightest minds is published year after year in the world's leading medical journals, like the New England Journal of Medicine and the Journal of the American Medical Association.

I was pleased to hear Senator Boxer in her comments actually refer to one of those published studies. The authors of that study were sitting here in front of you a moment ago.

Based on these assessments, we make changes, some immediately, to make our work and things work better. Sometimes it is not pleasant to hear what they found. Self-assessment is often not pleasant, but it is important we hear their unvarnished feedback so we can take the necessary steps to improve.

The Army's unprecedented Leader Chain Teach was a powerful initiative started at the top of the Army by the Secretary and by the Chief, that simultaneously and powerfully addressed leadership culture and advocacy. The program has now trained over 800,000 soldiers in a massive education effort in the summer and fall of last year, and has now been incorporated into various soldier and leader training programs throughout the Army.

Our Battlemind training program, which is the brand that we essentially call all of our resiliency and recognition and prevention programs in the Army, is an outgrowth directly of the MHAT assessments. It focuses on building fitness and resilience, which Admiral Arthur talked about. MHAT V findings indicate that Battlemind training is hitting the target and making soldiers less susceptible to combat stress.

The Chief of Staff of the Army and Secretary of the Army have challenged us to incorporate all of this training and prevention and early recognition of the psychological consequences of deployment and family separation and combat. We're doing so throughout the career of every soldier and every leader. Excellent quality care is being addressed throughout through improved and expanded training courses, like the new combat operational stress control course which is now mandatory for all deployed behavioral mental health providers.

Under my predecessor, Major General Gale Pollock, we have launched an initiative to hire over 300 behavioral health providers, of which we have now hired 149 in the United States. These will have direct and lasting impact on access.

Finally, we've taken the recommendation of the task force to heart and have incorporated access and enhancing skills through primary care providers through a program called RESPECT–MIL. This program had a pilot at Fort Bragg and was so successful we have now expanded this to 15 other installations.

I enumerate these initiatives, not to assert that we are 100 percent or that we have a 100 percent solution here, but to make the point that the Army takes reasoned, focused action everywhere we see the opportunity to make a difference.

I applaud Senator Boxer and Congress for standing up the Task Force on Mental Health in 2006. I applaud Congress in 2007 for directing the establishment of the Centers for Excellence for Psychological Health and TBI being directed by my colleague, Dr. Loree Sutton. She is absolutely the right person, as I think you will see, to lead that organization and generate the kind of results that you, Congress, are seeking.

This committee, along with the leaders of the DOD and the Army, is troubled by some of the negative trends that are related to the psychological health of our force. I'm very conscious of these reports. I know we will address some of these issues in these hearings. But I'm also heartened to see the terrific effort and the energy being applied to reverse these trends, and I am confident that with continued strong support from this committee and from Congress, we will provide the care and support that our warriors and their families deserve.

Thank you again for holding this hearing. Thank you for the privilege of being here and responding to your questions.

[The prepared statement of General Schoomaker follows:]

PREPARED STATEMENT BY LTG ERIC B. SCHOOMAKER, M.D., PH.D., USA

Chairman Nelson, Senator Graham, and distinguished members of the Personnel Subcommittee: thank you for the opportunity to discuss the Army's efforts in improving the mental health care 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 in improving the access to and quality of mental health care services. They are also actively engaged in changing the culture and eliminating the stigma associated with seeking mental health care 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 Department of Defense (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 health care services through various programs and initiatives which directly align with the DOD's Mental Health Task Force Report's four major recommendations: 1) Build a culture of support for psychological health; 2) Ensure a full continuum of excellent care for servicemembers 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 (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 health care 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 to this stressor is key to maintaining their health and welfare. We developed "Battlemind" products to increase this resiliency and 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 aged to teens, and they are distributed throughout the force. These programs are also available online anytime at www.behavioralhealth.army.mil.

In a parallel effort to both raise awareness and reduce the stigma associated with mental health care, 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 a normal reaction to a stressful situation and it is absolutely acceptable 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 utilized 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. The fifth MHAT report is due to be released soon.

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 MHATs, we developed the Post-Deployment Health Reassessment 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, to include mental health, of our soldiers, the need for behavioral health care is increasing. We do have gaps at some locations in meeting behavioral health care 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 138 providers of about 340 identified requirements in a very competitive hiring environment. 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 (WTUs). 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.

This committee is familiar with RESPECT–MIL, a program designed to decrease stigma and improve access to care by providing behavioral health care 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, we've developed a program for our warriors in transition called the Comprehensive Care Plan which is implemented across our 35 WTUs. 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. They are vocationally enabled and a life-care plan is established for each of them. This program sets the conditions for a successful transition to the VA or society.

As the Army Surgeon General, I am compelled to remain extremely cognizant of the toll that this demand has placed on my health care providers. 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 for not only 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, there are also 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 in fact they may actually have PTSD or mild traumatic brain injury (TBI).

Unfortunately, Active Army suicide rates have increased over the last 7 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 2 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 risk mitigation strategies to 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. A new policy was implemented in August 2007, requiring a review by the installation's behavioral health chief of all personality disorder discharge recommendations. We are implementing an update to this policy mandating PTSD and mild TBI screenings for any soldier being discharged for misconduct. This change in policy will mitigate the risk of discharging soldiers with a health condition that was 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 health care to our soldiers and families. We appreciate your support as you interact with service men and women and their families in your states in communicating our strategic successes in this area. We also appreciate your help in influencing the mental health care providers in your areas to accept TRICARE patients which will expand our behavioral health care 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 servicemembers and families as DOD 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.

Senator BEN NELSON. We thank you, General.

Admiral Robinson?

STATEMENT OF VADM ADAM M. ROBINSON, JR., USN, SURGEON GENERAL OF THE UNITED STATES NAVY AND CHIEF, BUREAU OF MEDICINE AND SURGERY

Admiral ROBINSON. Good afternoon, Chairman Nelson. Thank you very much. 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, 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. Navy medicine is continuously adapting to meet the short- and long-term psychological health needs of servicemembers 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 servicemembers, as well as the well-being of their families. The Navy and Marine Corps operational tempo in support of the global war on terror is unprecedented. We need to 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.

To accomplish this, Navy medicine engages at several levels along the continuum of care, from commanding officers to small unit leaders to individual servicemembers, and of course with their families. Our goal is for psychological health services to be available to all who need them, when they need them.

The same way physical conditioning prepares sailors and marines for the rigors and challenges of high tempo operational deployments, we are psychologically preparing servicemembers and their leaders to build resiliency, which will help manage the physical and psychological stresses of battle. We do this by preventive education programs introduced at every career training point, which help educate servicemembers on the importance of psychological health, in an effort to decrease the stigma often associated with being given a mental health diagnosis and receiving mental health services.

Command involvement, together with dedicated and embedded stress management teams comprised of mental health providers and other professionals, are critical in helping sailors and marines

become comfortable with the concept of building resiliency and decreasing stigma.

Our experiences in previous conflicts, most notably Vietnam, suggest that delays in seeking mental health services increase the risk of developing mental illness and may exacerbate physiological symptoms.

We are attacking the stigma in a variety of ways to ensure servicemembers receive full and timely treatment. This also 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 mental health conditions is as important as preparing servicemembers 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 front-line supervisors, including junior leaders, are able to identify when others in their unit may need help. The Marine Corps' Marine Operational Stress Surveillance and Training (MOSST) program 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.

Navy medicine, in coordination with the 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. Our goal is for members dealing with combat stress to be as comfortable in dealing with it as any other medical issue.

For the servicemember, the predeployment health assessment is one way to become aware of potential psychological health needs and the health care services available. The symptoms of a mental health condition may not necessarily make an individual nondeployable, but this assessment helps emphasize the importance of psychological health as part of physical health and may decrease any delay in seeking treatment.

Since the late 1990s, Navy medicine has embedded mental health professionals with operational components of the Navy and 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 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 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 cost.

For the Marines, Navy medicine division psychiatrists stationed with the Marines developed Operational Stress Control and Readiness (OSCAR) teams 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 units, 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, and currently there is strong support for making these programs permanent and ensuring they are resourced with the right staff and funding.

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 after returning home.

The post-deployment health assessment measures the health status of returning servicemembers and must be completed within 30 days before or after redeployment. Navy and Marine Corps post-deployment health assessments are being accomplished in theater, 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 the sailor's redeployment process home. Recognizing the hardest part of going to war is reconciling the experience inclusive of one's losses, mental health professionals and chaplains assist servicemembers to reflect, recall, and reconcile the enormity of their deployment before returning home. Warrior transition is now mandatory for all seabees, individual augmentees, and soon our SEALs.

Since 2005 Navy medicine has been administering the post-deployment health reassessment (PDHRA), as directed by Health Affairs. Implementing this program was a joint effort between the Navy 's Bureau of Medicine and Surgery, the Bureau of Navy Personnel, Headquarters Marine Corps, and the Deputy Commandant of the Marine Corps for Manpower and Reserve Affairs.

The PDHRA extends the continuum of care, targeting servicemembers for screening at 3 to 6 months post-deployment. 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 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 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 and their communities by deploying Special Psychiatric Rapid Intervention Response Teams (SPRIRT). These teams have been in existence over 15 years and provide short-term mental health and emotional sup-

port 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 solutions. Never before has the mental health and well-being of sailors and marines deployed to a war zone been as intensely studied. In order to establish comprehensive psychological health services throughout Navy and Marine Corps and to evaluate and provide recommendations on the needs of deployed sailors and marines, Navy medicine has developed the Behavioral Health Needs Assessment Survey (BHNAS).

The BHNAS was adapted from the Army's series of MHAT surveys. Recently, Navy received funding for creation of a Navy-Marine Corps Center for the Study of Combat Stress, to be located at the Naval Medical Center in San Diego. This center is strategically located to work closely with our new comprehensive combat casualty center, our C–5, to better understand the impact upon Navy and Marine Corps families.

I have commissioned the Center for Naval Analyses to conduct a wide-ranging 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 the global war on terror.

Reinforcing a culture which values psychological health will require an enduring commitment to the mental health needs of servicemembers, 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 stresses 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.

Chairman Nelson, Navy medicine continues to rise to the challenge of meeting the psychological needs of our brave sailors and marines and their families. I thank you very much for your support to Navy medicine and look forward to answering your questions.

[The prepared statement of Admiral Robinson follows:]

PREPARED STATEMENT BY VADM ADAM M. ROBINSON, JR., MC, USN

Chairman Nelson, Ranking Member Graham, 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 servicemembers 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 servicemembers 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 servicemembers, as well as the well-being of their families. The Navy and Marine Corps operational tempo in support of the global war on terror 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 servicemembers 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 servicemembers, 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 servicemembers 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 servicemembers 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 servicemember, jeopardize a servicemember'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 servicemembers 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 servicemembers 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 available in various formats 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 and Training (MOSST) Program, 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.

For the servicemember, the Pre-Deployment Health Assessment is one way to become aware of potential psychological health needs and the health care services available. The symptoms of a mental health condition may not necessarily make an individual nondeployable, 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 IA Family Readiness Program has been a step in the right direction in reaching out to these servicemembers 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 demobilize 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, hundreds of thousands of dollars in operational costs.

For the marines, Navy Medicine division psychiatrists stationed with marines developed Operational Stress Control and Readiness (OSCAR) Teams 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 debriefings address the topic of combat and operational stress and provide units and individual servicemembers 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.

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 (PDHAs) to measure the health status of returning servicemembers. This global screening must be completed within 30 days before or after redeployment. The criteria for a PDHA vary and depend on where an individual deployed and for how long. Current guidance states that a PDHA is required if the servicemember 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 PDHAs 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 servicemembers to reflect, recall and reconcile the enormity of their deployment before returning home. Warrior Transition accomplishes this by providing 3 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 PDHAs 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 servicemembers for screening at 3 to 6 months post-deployment.

Currently, BUMED provides PDHRA program management and oversight and management of global war on terrorism 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 servicemembers 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, 6 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 7 percent referral rate for mental health (AC 6 percent, RC 9 percent).

Since February 2007, Command Navy Reserve Forces 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 servicemember 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 servicemembers 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 cam 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 surveys, which started in 2003, of land warfighters.

Preliminary results of the BHNAS show that Navy's contributions to the global war on terrorism 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 which focuses exclusively on our IAs, a study now which now has evaluated more than two thousand Sailors, 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 Medical Center San Diego. 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 Combat and Operational Stress Consultants (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. 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 global war on terrorism. 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 COSC. These two individuals 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 assigned to Navy Medicine serves as the Director of Deployment Health, and he and his staff oversee Pre- and Post-Deployment Health Assessments, as well as the PDHRA. In addition, this position 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 fiscal years 2008 and 2009. These programs will provide outreach to Reserve servicemembers and their families for psychological health, including high risk concerns such as PTSD and TBI, as well as post-deployment reintegration issues. Psychological Outreach Coordinators will work directly with Reserve servicemembers 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 Families Overcoming and Coping Under Stress (FOCUS). Project FOCUS is a prevention/very early intervention program consisting of 10 to 12 sessions with a team of specially trained counselors. In the initial pilot, this service—which can be arranged by direct contact from the family at risk—will positively impact 1,200 families.

Reinforcing a culture that values psychological health will require an enduring commitment to the mental health needs of servicemembers, 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 need to underscore a culture that recognizes and embraces the value of enhancing our resilience to deal with the increasing stressors of military life, and a culture that understands that in the end, it may be less a question for medical science than a challenge for every leader to accept.

Chairman Nelson, Ranking Member Graham, 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 any of your questions.

Senator BEN NELSON. Thank you, Admiral.

General Roudebush?

STATEMENT OF LT. GEN. JAMES G. ROUDEBUSH, USAF, SURGEON GENERAL OF THE UNITED STATES AIR FORCE

General ROUDEBUSH. Yes, sir. First, Chairman Nelson, thank you. I know you are the driving force that brings us here today to discuss this and the information that has been shared already, that will be shared, and the questions that have been asked. The concerns raised I think underscore the importance of this. So thank you for giving us the opportunity to come at this in a way that I think is very meaningful for us all within the Air Force.

I would first like to lay out the challenge and the opportunity, and then I will talk a bit about how we in the Air Force are approaching this. We clearly have airmen in harm's way, as do our sister Services, perhaps not in the magnitude, but certainly within the intensity. We have airmen serving in the battlefield that are out there in the joint warfight, doing that mission every day, and we must take care of them.

In addition to that, we have an incredibly high operational tempo. As I believe you would agree, we've been at war 18 years. We did not come home after the Gulf War. We continued operations, and that has caused stress, strain, and wear on our forces and our equipment that we simply must attend to.

Now, we in the Air Force come at this in a way that is very coherent and resonant with our Air Force culture of accountability, caring for each other, a wingman culture, if you will. You always take care of your wingman. You protect their six. You make sure that nothing is below or behind that could be injurious, and that's how we succeed. We succeed as a team very much the same in the way that we approach the challenges for our airmen. We medics support our line directly in doing this.

We are accountable for a fit, healthy force that's able to do the mission in some very demanding circumstances, both at home station and deployed, because every Air Force base is an operational platform whether we're providing global deterrence from F.E. Warren in Cheyenne, WY, or global strike from Knob Noster, MO, or global mobility from Charleston. Every base is an operational platform, and we medics support our line in doing that, first by providing a healthy, fit force, but also by taking care of families, providing resilience and families that are able to support these warriors as they go in harm's way and take on these intense and very demanding missions.

In addition to that, we provide constant surveillance, understanding, and attending to the health of our forces, so that rotationally and repeatedly and heroically we can deploy and do the mission, wherever that mission is found. When illness or injury occurs, we are there with the right care, to take care of those injuries and illnesses and, in support of our joint warfighters, to take care of those injuries and illnesses forward, stabilize them, and bring them home safely for definitive care here in the States.

The best care that we can provide, though, we believe is often preventive. If there is not an injury or an illness, that is the best outcome. That's economy of force. That's preserving health, and we think that is the best outcome right up front. But again, if illness or injury occurs, we're there to take care of it.

Now, we support the line in doing this. Within our Air Force culture, the line is very much accountable and responsible for the health and well-being of the forces. I mentioned the wingman culture. The wingman program, if you will, wherein we take care of each other and we work to reduce the stigma—there is no stigma in needing help or asking for help. Certainly it can be uncomfortable, but sometimes that very uncomfortable conversation is the one that needs to happen: I need help or you need help. That's the best place for it to begin.

In addition to that, we have a suicide prevention program which is very much a line program. This was initiated in 1996 and serves as a model both for the military and for the Nation. During that time we've reduced our suicide—the incident of suicides, 28 percent. Any suicide is too many. However, to the full extent that we can prevent suicide we believe that that's very important to do. That's a community-based program, but it requires attention every day. It requires training, and it requires buy-in that in fact we do take care of each other and there is no stigma in seeking or needing help.

Lastly, for those who are significantly wounded we have the Air Force Wounded Warrior Program, wherein a family liaison officer is assigned to every severely injured airman to administratively assist the family, and to assure that all medical issues are attended to as well, and that injured or ill individual is properly taken care of.

So through this constellation of programs, both the medical and line, we are every day attending to our airmen to assure that we can repeatedly, heroically be there to support the mission, accomplish the mission, to dominate the domains, air space and cyber space, in support of our sovereign options, and do it without fail.

Sir, I appreciate this opportunity to talk to you about Air Force medicine and I look forward to your questions.

[The prepared statement of General Roudebush follows:]

PREPARED STATEMENT BY LT. GEN. (DR.) JAMES G. ROUDEBUSH, USAF

Mr. Chairman 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 (AFMS). The AFMS 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 AFMS 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 3 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 National Defense Authorization Act (NDAA) for Fiscal Year 2008 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 (PHAs). We begin with the annual PHA of all personnel to identify and manage overall personnel readiness and health, including assessment for post-traumatic stress disorder (PTSD) and traumatic brain injury (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 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 Department of Defense (DOD) and Veterans Affairs (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

The incidence of PTSD is low in the Air Force, 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 TBI may be the "signature injury" of the Iraq war and is becoming more prevalent among servicemembers. 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 servicemembers stateside, and again at stateside hospitals as indicated. The Military Acute Concussive Evaluation tool is administered in accordance with the Joint Theater Trauma System TBI Clinical Practice Guideline. U.S. Transportation Command policy dictates that all servicemembers 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 U.S. military treatment facilities and/or DVBICs. The 59th Medical Group, Lackland Air Force Base, TX, is one of three DOD DVBIC Regional Centers that cares for TBI patients.

The Air Force 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.

TBI 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 Air Force 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 Air Force 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 Air Force 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 Air Force 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 Air Force 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 Air Force Suicide Prevention Program was added to the National Registry of Evidence-based Programs and Practices (NREPP) in 2007, and is currently 1 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 fiscal year 2009 deployment of our Tele-mental Health Project, which will provide video teleconference 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 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 servicemembers and their families.

In the months ahead, we will continue to implement enhanced AFMS psychological health and TBI programs made possible by fiscal year 2007 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 Congress for your support.

We will continue to work closely with the Office of the Secretary of Defense and our sister Services to implement the recommendations of the DOD Mental Health Task Force and the wounded, ill, and injured provisions of the NDAA for Fiscal Year 2008.

CONCLUSION

In closing, Mr. Chairman, I am intensely proud of the daily accomplishments of the men and women of the United States AFMS. 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 AFMS will continue to improve the health of our servicemembers and their families. We will win today's fight, and be ready for tomorrow's challenges. Thank you for your enduring support.

Senator BEN NELSON. Thank you very much, General.

Colonel, General-to-be?

STATEMENT OF COL LOREE K. SUTTON, USA, SPECIAL ASSISTANT TO THE ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS), PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY

Colonel SUTTON. Good afternoon, Chairman Nelson. Thank you so much for inviting me. We thank you also for your kind remarks in your introduction.

Let me just say for the record, sir, that my grandmother, Volga Bell Ward, graduated from Union College in Lincoln, NE. I just wanted to establish that. [Laughter.]

Senator BEN NELSON. Great connection.

Colonel SUTTON. Today, Mr. Chairman, I'm here to provide an update on the military health system improvements in psychological health and TBI, with a particular emphasis on what is happening with the Defense Center of Excellence for Psychological Health and TBI. Let me start out by saying I'm heartened by the optimism expressed by Senator Boxer and certainly shared by yourself and members of your committee, and Admiral Arthur and Dr. MacDermid.

I'm deeply indebted to the Mental Health Task Force and to their emphasis on culture, on leadership, on the continuum of care, as well as the resources needed, particularly to reach those very tough populations that are particularly at risk, such as our Reserve components.

I would also like to share with you some of my excitement, sir, in terms of what's going on with the Defense Center of Excellence. We are becoming the front door for the Department for all matters of concern related to psychological health and TBI. I am pleased to report to you, sir, that we are on the verge of requiring a name change already, because Secretary Peake at my first meeting with him in January, he said: "Loree, what you really need is you need a deputy for your center from the VA." I assured him that such an addition would be welcome, at which point we'll need to change our name from the "Defense Center of Excellence" to, I would propose, the "National Centers of Excellence."

We opened our doors for initial operations on November 30, 2007, which meant that on December 1, we had a phone number, we had a receptionist, and we had a dugout in Rosslyn with a part-time chief of staff, a couple of contractors, and, fortunately, we are harnessing also the power, the momentum, and the achievements of a number of centers.

So I would think of the Center of Excellence at this point, sir, as a center of centers. We are so pleased to be able to bring in the efforts and the track record, the achievements, of the Defense and Veterans Brain Injury Center with their 16 years of research, education, and treatment. They were named in fact as the number one treatment and research network for TBI in the country in 2005.

We're also bringing in, led by David Riggs, the Center for Deployment Psychology, which will really help boost our efforts, not just to reach out to psychologists, but to mental health professionals, health professionals within our direct care system, as well as throughout the country, because we realize those 800,000 soldiers, sailors, airmen, and marines who've already served are out there as veterans in various areas of the country.

We're bringing in the efforts of the Deployment Health Clinical Center, led by Colonel Chuck Engel, as well as working very closely with the Center for the Study of Traumatic Stress at the Uniformed Services University, led by Dr. Bob Ursano.

Sir, we are also so blessed to be working with Mr. Arnold Fisher and the Intrepid Fallen Heroes Fund. Mr. Fisher has pledged to do for psychological health and TBI what he and his fund have already done for the care of amputees with the Center for the Intrepid.

We just recently convened our first strategic planning conference last week, sir. We had 160 folks that came together, a combination of military, VA, and advocacy groups. We had folks such as Meredith Beck from the Wounded Warrior Project, Ted and Sarah Wade, Barbara Cohoon from the National Military Family Association. It was just a tremendous effort coming together to really get our first initial traction. This will be a quarterly conference and I'll look forward to reporting to you our ongoing results.

We are in the process of launching a national awareness campaign, building upon the efforts that the National Institute for Mental Health had several years ago: Real Men, Real Depression. We are now looking to harness the power of stories that come from real warriors, real battles, and real strength.

Sir, having said all of that, yes, we have done a lot. We are working on the issues of concern that were earlier addressed. I can certainly provide more details on that, and we have much more work ahead of us. We must continue to fully implement the Mental Health Task Force recommendations, redouble our efforts for suicide prevention, build that global network that will include not only DOD and the Services, but also the VA, our civilian colleagues. Yes, we've already been contacted and are in collaboration with folks in Israel, Great Britain, Australia, Canada, and we seek to add to that global network.

We're opening a clearinghouse and a call center which will really facilitate that communication between us and those that we serve. We want it to be two-way. The 18th of March this month we will initiate what will become a monthly video teleconference that will reach out to not only our folks within the Services, but to anyone who wants to join our regular communication, followed by a newsletter coming out in April. We're also looking for ways to harness the power of not just 800 numbers and websites and newsletters, but YouTube and MySpace and podcasting and all of the ways that our generation of warriors and their families communicate.

Sir, we are also very, very interested in working on what really was emphasized first and foremost by the task force and has been mentioned by so many others this afternoon. That is the importance of culture. We can work the implementing of all of the task force recommendations. We can come up with the best strategy, plans, programs, and policies. But unless and until we transform the culture that undergirds our efforts, we will fall flat.

So that is a particular area of focus coming out the gate. We are partnering with the National Institutes of Health. We have the CDC, the Institutes of Medicine, the Substance Abuse and Mental Health Services Administration. We are working with a group of founding Federal partners, working with the Federal Steering

Group to initiate a priority working group to address the reintegration needs of our veterans, servicemembers, and families that will be co-chaired by Toni Zeiss who is also on the task force. So clearly it's time for us to do a little less talking and a whole lot more action here, sir, and we're after it.

We thank you so much for your support. We thank you for your sustained collaboration. We have a lot of work ahead, but I assure you, sir, we'll keep after it.

[The prepared statement of Colonel Sutton follows:]

PREPARED STATEMENT BY COL LOREE K. SUTTON, USA

Mr. Chairman, distinguished members of the committee, thank you for inviting me. Today, I will provide an update on the Military Health System (MHS) improvements in Psychological Health and Traumatic Brain Injury (TBI). You asked that I address implementation of the Mental Health Task Force recommendations, implementation of the Department of Defense Center of Excellence (DCoE) for Psychological Health and TBI, and information on suicide rates and risk factors.

The Psychological Health programs in the MHS 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 2007, DOD responded to the Task Force's report accepting 94 of the 95 recommendations for implementation.

As of today 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 longer term implementation requirements. Finally, some will continue, based on the requirement of the recommendation. We will conduct a broad evaluation of our progress in May to gauge our status and reprioritize as needed to maintain our momentum.

The one recommendation that DOD did not accept recommended actions that are taking place through programs that are currently operating, such as Military OneSource. Further initiatives could serve to confuse our warriors and their families as well as duplicate successful programs.

DEFENSE CENTER OF EXCELLENCE

Our approach in developing a culture of leadership and advocacy began with the creation of the DCoE. The Assistant Secretary of Defense for Health Affairs appointed me as the DCoE Director in September 2007 and 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.

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 importantly, 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, along with researching, refining and distributing lessons learned and best practices to our military treatment facilities (MTFs) and to the TRICARE provider networks. We will work together with our colleagues at the 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) Mounting an anti-stigma campaign projected to begin this spring using input from the Uniformed Services University of the Health Sciences, NIH, VA, the Substance Abuse and Mental Health Services Administration, our coalition partners, and others in the public and private sectors;

(2) Establishing effective outreach and educational initiatives, including an Information Clearinghouse, a public Web site, a wide-reaching newsletter, and a 24/7 call center for servicemembers, family members, and also for 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 servicemembers 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 toward DCoE functions. That total includes amounts allocated specifically to telehealth infrastructure, Automated Behavioral Health Clinic, Defense Suicide Event Registry and DVBIC functions. An additional $45 million was allocated to research and development projects.

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 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 Post Traumatic Stress Disorder (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 over 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 easily observed. Similar to other severe trauma conditions, severe TBI is treated using well-established procedures. 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 2 years to develop; however, we have expedited that process and will have the CPG completed in 1 year. The Department will collaborate with VA on the development of this CPG to assure 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 servicemembers at 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 in line with acceptable standards for appointment wait times. 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 stating that patients should have initial primary psychological evaluations scheduled within 7 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 can consult with primary care providers to identify mental health conditions and to make appropriate referrals for treatment. Alternately, behavioral health providers can 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 that soldiers with TBI receive care only at those facilities with established capability to care for them.
- Deployment-related health care has proven 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. 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 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 needs.
    - 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 3,000 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 present, we must strive to break down the bar-

riers so that those seeking care receive it at the earliest possible time and in the least restrictive setting, including nonmedical settings, such as 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, servicemembers, and family members. In the interim, each Service will implement training across its leadership spectrum 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 is accessible at health fairs as well as in a Web-based format. We expanded this program to include our school-aged family members.
- The Signs of Suicide Program, an evidence-based prevention and mental health education program in our DOD Educational Activity schools, will expand to public middle and high schools in areas with high concentrations of deployed forces.
- For our younger children, the proven-successful Sesame Street Workshop will expand with our cooperation 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 servicemembers, 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 and Post-Deployment Health Reassessment 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.
- 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 servicemembers.
- We must remember that our health care and community support caregivers 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 nonmedical 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 relevant most especially 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, Army and the 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; our assessment identifies the need to 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 servicemembers 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.

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. Even with these increases, the aggregate suicide rates for DOD remain comparable to the demographically-adjusted civilian population rates. Risk factors for suicide remain unchanged:

- Failing relationships
- Legal/occupational/financial problems
- Alcohol abuse

Early intervention and prevention programs include pre-deployment education and training, suicide prevention training, Military OneSource, the Mental Health Self Assessment Program, National Depression and Alcohol Day Screening, and health fairs. To increase the awareness of DOD's outreach and prevention programs available to the Reserve component members, DOD formed a 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.

CONCLUSION

Mr. Chairman, 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 families. There simply is no greater privilege!

Senator BEN NELSON. Thank you very much, and I believe you will.

I'm concerned about how you transform the culture and how you identify the condition in such a way that it doesn't have stigma associated with it. Now, General Schoomaker, we were talking the other day. You made it clear, and I think most everybody would recognize this, that the stress associated with the warriors is not something brand new; from the beginning of time stress has been associated with conflict. Perhaps our knowledge of it is more re-

fined today, and we're working to refine it even more as we move forward.

As we do that, is there really an expectation that we can somehow move from what is a macho attitude toward a recognition that we're really trying to build people's resiliency? Are there softer ways to talk about the situation, or does that even help?

General SCHOOMAKER. Sir, I think it goes without saying that the U.S. military is a microcosm—a subset of the American society as a whole, and reflects the attitudes of society as a whole. The problems that we encounter in stigma within the uniformed Services is reflected in society at large. As I said in my opening comments, I think that this is an issue that needs to be addressed by all communities.

Having said that, I think that this is done not by medics, it's not done by people sitting at this table, but, as I think all my colleagues have emphasized, this is a problem for line leadership right down to the smallest unit leader and fellow soldiers, sailors, airmen, marine, coast-guardsmen, who in a sense give license to the view that the human dimension of combat and the human dimension of deployment and separation from families involves stressors that are going to be manifesting symptoms that may make them—as you said in your opening comments and as Senator Graham said—less than completely engaged warriors.

That's how we have to look at this. I think that our leadership has taken a very assertive role in doing exactly what you describe.

Senator BEN NELSON. Colonel, maybe I can ask you in terms of that, the cultural change in the way we think of this. In the training, basic training, building people into warriors requires building up self-confidence, teamwork, everything that we want to have somebody be combat prepared. How far can we go at the beginning to build up that resiliency to, if not eliminate the possibility, which is unlikely, but reduce the impact of the stress?

Is there some tie to that where people would be less stressed with more training, more specific training, more directed training toward that, so that maybe we can get ahead of it rather than have to treat it after the fact?

Colonel SUTTON. I couldn't agree more with you, Mr. Chairman. In fact, I would say that the process of building resiliency for soldiers, sailors, airmen, marines, coasties, and their families has to start at day one. It starts not only with the tough training that challenges our young folks to go beyond that which they believe or know about themselves. Of course, it's always fun to go to a basic training graduation where, after 12 weeks, when the buses come in it looks like they've scooped up folks from the shopping malls of America, with purple hair and rings and all of the rest. Twelve weeks later, the parents walk right by them and don't even know who they're seeing.

It's a transformation, and it starts with day one. I think we also need to look toward baseline cognitive screening when folks come in at accession, as well as perhaps imaging. We're looking at that right now because, although we're currently focused on the deployment cycle, we know that we need to prolong that. We need to extend that over the life cycle of a young troop and her family member being with us.

It also has to do with the tough training that you mentioned. I would take issue with your comment earlier as to whether we need a softer approach. In fact, I would go back to a couple of weeks ago in the Washington Post newspaper; there was an article with a young female, as it turns out, Cobra pilot. When she was asked at the end, how do you cope with the stress of doing your job and engaging in combat, and she says: "Don't ask me, how do I cope. That makes it sound like I have to get over something. Because when somebody's shooting at my marines, this is my job; this is what I'm trained to do and I'm proud to do it."

I think it's that kind of pride, buttressed by the confidence that can only come from tough training, as well as the framework of education to help folks understand what are the normal consequences of exposure to trauma, to killing, to losing one's buddy, and what are the support systems; what are the tools.

This generation wants tools. They don't see themselves as disabled or weak or needing help. They want tools to be able to keep themselves going and performing. So I think that's part of it.

Two other examples I would point to, sir, as already positive signs of this transformation in culture that we're aiming for. Several weeks ago in Tom Rick's Inbox in the Washington Post once again, he gave the story of a young marine staff sergeant; and Staff Sergeant Travis Twigg, who came back from his third deployment and had a tough time, lost several of his men, and was not readjusting well.

His sergeant major brought him in and said: "Sit down, Twigg; do you know why you're here?" No, Sergeant Major. "You're here because you have PTSD. Do you know why I know? Because I have it, and you're going to get help."

He got Staff Sergeant Twigg to Bethesda, where he was hospitalized. He had a tough course of treatment, but did very well. He's back in the Corps today, and in the article Staff Sergeant Twigg says: "Listen, here's my phone number, here's my email; I want to help anyone else who has these problems." I'm going to be contacting young Staff Sergeant Twigg here and bringing him on our team.

But think of what that says. The chain of command saw a problem, and didn't say: "Ah, Twigg's weak; he's messed up; he can't hang." No. They recognized that this young staff sergeant needs help, and said I'm going to get it to him, and he's going to be back in the force. That expectation of recovery, of performance, of resilience, whether it's in the classroom or the battlefield, it's paramount for our leaders to understand that we must prepare our troops; we must give them the tools that will allow them to gain the confidence and the expectation of recovery.

Lastly, sir, I would point to as another sign of this transformation in culture that is just really getting started, has to do with Secretary of Defense Gates, his leadership in saying that, question 21 on the security clearance questionnaire, we need to change that. I'm proud to say that there's been a lot of interagency work on that, but that is nearing fruition, and I think that's going to be a real improvement that will help our troops understand that the Department's stance toward seeking help, whether it be for mental or for physical health issues, is absolutely a sign of strength

and we want folks to feel like they can go forward without fear for their careers.

Senator BEN NELSON. Now, we as a society at large have stigmatized seeking help by the very question about have you ever had this. People get over appendicitis, I guess, when the appendix is removed and other conditions, but there isn't necessarily an indication that that condition has been removed with or without treatment. So we've probably done society as a whole a great disservice. We have to move beyond that.

General Roudebush, maybe you can give us your perspective from the Air Force.

General ROUDEBUSH. Yes, sir, and I think it does go that form follows function. We train individually. We select people for their capabilities and we train them in a particular area of expertise, and we expect them to execute in that particular area. But in reality we execute as a team. We very seldom ever execute individually. You're always reliant on a team member for some portion. We execute as a team, but quite literally, we take care of each other as a family. Now, we have the family that the good Lord gave us, but we have the family that we're issued, and they're both really good families. I think that is at the essence of taking care of each other.

Stigma is both self-perceived and outwardly or externally perceived. The individual may feel some reticence to say, "I need help," and may suspect or assume that the others in the unit will think less of them because they did in fact need some assistance. But if you break down those barriers and say, yes, we execute and we succeed as a team and we take care of each other as a family, those barriers become less noticeable and less onerous.

Now, I will tell you, it is far from perfect. I think the recommendations that the task force made are right on target, both in terms of assisting us in positioning the right resources and in prioritizing the right activities, policies, and issues. So I think we must do it better.

But at the end of the day it's going to be that accountability to each other and the willingness not to inflict stigma or assume stigma that I think will allow us to get to the other side. Once we get by that, and if you can get to a problem sooner, when it's this big, as opposed to later when it's this big, the whole process is enhanced. A better result, less time out; and frankly, it helps us deal with some very trying and demanding circumstances.

In our theater of operations, everyone has PTS. There is nothing normal about that circumstance. It's preventing that from becoming PTSD that we need to concentrate on.

Senator BEN NELSON. We don't have to establish the disorder associated with every PTS. It's the extent of the PTS, I assume, that then establishes whether it's a disorder or not.

General ROUDEBUSH. Yes, sir, and getting to it sooner, in a proactive fashion, mitigating it early, is clearly the preferred way to do this. But it does take a team to do that.

Senator BEN NELSON. In the case of Active Duty, when following the deployment the unit comes back and it stays pretty much intact. When you get to Guard and Reserve in stranded situations, where a reservist comes back from a deployment and goes back

into society, which probably does not have him or her associated with the team that they were with during the deployment, is there a greater risk of PTS becoming a disorder as time goes by if they don't get some care for that up front? Is there a greater risk with that group, and is the probability higher that they will have a greater problem than somebody that will stay with the unit?

General ROUDEBUSH. Sir, I can give you the Air Force statistics. Our statistics as we have gathered them, and they are far from as complete as we would rather or they need to be, but we continue to make progress in that regard. Our findings for our Guard and Reserve members are not significantly different than our Active Duty.

Now, the challenges for us is getting to those folks in a way in terms of both surveilling and screening to assure that that happens. To that end, certainly their line and their unit counterparts are instrumental in assuring that we don't lose track of them, as are their families; and sensitizing the families that if something does not seem right, if something is amiss, to ask the question much sooner than later, as both an ally and a resource, is helpful in that regard.

But it is more challenging with the Guard and Reserve, there is no doubt about that.

Now, when we find it we very aggressively go after it and treat it, either using uniformed capabilities or using our TRICARE networks if that's more appropriate, because keeping these folks close to their home of record and at home with their families we believe is an important part of reintegrating them and successfully taking care of these folks.

But yes, sir, it is a challenge.

General SCHOOMAKER. Sir, this is a great question and it's one that all of us are very concerned about, and I'm going to lean on what we've learned from the MHAT studies. I think I could say without fear of contradiction that we know there are several factors that contribute to raising the risk of post-traumatic stress symptoms and other stress-related symptoms, like isolation and depression.

First is intensity of combat. The variability of combat teams, marine and soldier teams, the variability in their self-reported symptoms is a function of the intensity of combat.

Second is the coexistence of concussive or mild TBI or severe injury. We think there is now some work done by Dr. Hoge that was recently published that suggested it might be the context in which that concussive injury occurred. In contrast to the sport field, when it's in combat concussive injury is often associated with a life-threatening event, maybe associated with the loss of friends and the like.

The third is deployment length and frequency of deployment. These are all associated with a higher risk of stress.

Let me say one other thing that I think is very important that you've touched on in your last series of questions, and that has to do with stigma. I think one of the very positive effects of reexamining and rescreening soldiers, sailors, airmen, and marines, anyone who's been deployed, not just at reintegration, because we've learned through the MHAT studies that the excitement of re-

integration, the desire to get home and to be fully incorporated into home and family and job if you're a reservist or a national guardsman overwhelms what may be symptoms.

The MHAT studies have very closely shown us that you need to go back and reexamine at the 90- to 180-day period, and that is a challenge for the distributed Reserve and National Guard.

Finally, I'd say in regard to stigma, and this is Eric Schoomaker's opinion, the assumption of a stigma to oneself I think is attributed in part to fear. Part of that fear is that I am self-identifying a serious illness, a mysterious illness, one that may never end. One of the things that can be reassuring about our studies is that, with screening and identification of the early symptoms of post-traumatic stress, we can do things symptomatically that improve the individual soldier or marine's state and eliminate, as you said, their emergence into or maturation into a disorder, especially if we can keep them away from alcohol and drugs and family discord and violence and all the other things that may characterize the establishment of a well-established PTSD.

So I think one of the clues and one of the keys to removing stigma for that individual is improved education about the fact that your having these symptoms does not label you with a permanent disability, that in fact we can treat these and we can prevent a much more long-lasting disability.

Admiral ROBINSON. Mr. Chairman, I would also like to add, just to the stigma question, I agree with what General Schoomaker said and also what General Roudebush said. Stigma is going to be a factor because it's a factor in our country. The keys to success that I think the Navy and Marine Corps have shown are leadership, number one, education number two, education from boot camp all the way through War College. It's a continuous process and there has to be education amongst the buddies that are caring for one another, the shipmates that are there, the leaders that are there, the small units that are there.

Additionally—and this is very important, and I think this may be one of the keys—to embed mental health resources in the units means that when you go see the chaplain, who could be part of that, but when you go see the psychologist, the psychiatrist, or the social worker who is a part of your unit and who has been living with you day-in and day-out, it becomes less of an issue of stigma; it becomes more an issue of, that's one of my shipmates, that's one of my buddies, I have to go see him, I have some issues.

So that together helps from the culture point of view. If at the same time families are given the opportunity to have deployment counseling, to have ombudsmen, to have different people who are available and units who are available to provide that mental health or that support that they need, so that they can in fact understand what their loved one's going through while away on the deployment and they can also build up their resiliency and psychological health, it becomes a synergistic effect and it becomes very effective in terms of not only reducing the stigma, but also realizing that mental health and mental illnesses are as real as physical illnesses.

You said it yourself: If I break my leg, no one cares that I come in with a cane and have a limp. But if I've had some sort of mental

issue, then everyone looks at me as if I'm not capable of ever functioning again, which is completely untrue.

Senator BEN NELSON. General?

General ROUDEBUSH. Chairman Nelson, if I might add one thing. We've been focusing a great deal on mental health capabilities, psychiatrists, psychologists, social workers, and all the technical support that surrounds that. But as a family physician I can tell you that I was trained to anticipate and expect that upwards of two-thirds to perhaps even more of the issues that I would face as a family physician will have an emotional aspect to it or a psychological aspect to it.

So I think it's important, while we focus on the pure mental health resources or the more specifically focused, that we also pay very close attention to the whole constellation of care capabilities that we have, both primary care as well as specialty and subspecialty, to provide them training, as in fact we all have, to focus on getting the right kinds of diagnostic training and sensitization, if you will, to look for TBI, to look for PTSD, while you may be treating something that is a very visible issue relative to an injury or an illness, to look for those things that may not be quite so visible.

So we can really leverage the entire care capability that we have to further focus on this and assure that we're not overlooking those injuries that we ought to be paying attention to.

General SCHOOMAKER. General Roudebush is right on target. In fact, I think that that is the main thrust of the military's respect-military effort. It's to further arm primary care providers of all kinds—nurse practitioners, physician assistants, general internists, family medicine doctors, whoever that primary care provider is—with the tools and skills necessary to screen and do first-line treatment.

Admiral ROBINSON. That's the plan for the deployment health centers that the Navy now has, so agreed.

Senator BEN NELSON. The screening that you do I suppose prior to somebody's joining one of the branches is important in trying to ferret out existing conditions of some sort of mental condition or perhaps identifying people that might have a greater potential for stress, as I think was indicated, put somebody as a mechanic as opposed to out in the front line if there's something that could be identified that might be predisposed to stress.

Then before they're sent to theater there's another screening. Do the screenings take it up to where you can really catch the people, somebody that might be more predisposed than someone else? Or can the person being screened hide it from the screening process? Colonel Sutton, do you have a thought?

Colonel SUTTON. Sir, this is an important area. I think screening does play a role both at accession and certainly predeployment and ongoing during deployment and after they return, as well as the post-deployment reassessment of health. I would say, though, that rather than thinking of, for example, at accession this being a process designed to screen out, I would argue that this ought to be a process designed to screen in, that is to identify strengths as well as areas of potential vulnerability, and then to customize our lead-

ership and our approach to help that troop really reach his or her potential.

When 3 out of 10 of our 18- to 25-year-olds qualify for military service, I would argue that we already have an elite force, and so I would argue to screen at the beginning and then as we go through the process—and this, by the way, is something that in light of Colonel Hoge's recent article and other emerging reports in the last year that have come out, we are relooking our screening process right now. We want to make sure that we are absolutely asking the right questions to elicit the information that we're after.

To do that, we're bringing in not only experts from DOD and the VA, but we're also going to bring in civilian experts from around the country, in fact around the world. We will be coming forward with recommendations to the senior leadership within the next 6 to 8 weeks. But the screening process, the one that we had in place now, is a good one. I think that, armed with our latest knowledge, we can improve it even further.

General SCHOOMAKER. But sir, with respect, I would say that the present state of what we have still centers around self-identification.

General ROUDEBUSH. Exactly.

General SCHOOMAKER. This dovetails very clearly with your earlier line of questioning around stigma, that in a society that stigmatizes a mental health or behavioral health problem, it is the tendency for some of our soldiers to obscure or to withhold information that is sensitive.

I failed to mention one other stressor, one other factor that predisposes to post-traumatic stress, and I defer to my colleague the psychiatrist at the other end of the table to validate this. That is preexisting experiences prior to coming into the Service. Severe trauma prior to coming into the Service represents another predisposing element to development of symptoms while in service. If that's obscured or withheld, then it does become a challenge to us.

Senator BEN NELSON. Thank you for what you're doing. It seems just even gratuitous for me to say how important it is, but I think we all recognize the mental well-being of our men and women in uniform is critical, not only to performance, but to quality of life and to our society. So I really do appreciate what you're doing and I hope that we'll continue to learn more about what will help us in not only identifying but treating these different areas.

I'm encouraged by the fact that there's not just one category that everything falls into. The more that we're able to distinguish between various different degrees of post-traumatic stress is, I think, critically important to being able to do the job right and get the best result for our servicemembers and their families. So I commend you for what you're doing.

Colonel, thank you for taking the leap into a new area. We wish you the very best. Of course, we want to be responsive to the needs in terms of what financial resources and other resources will be necessary for us to be able to do this.

Working to have the VA together with DOD, with a new name, in your area and in so many other situations, such as retirement, and disability determination, is extremely important to our mem-

bers as well. So I hope that we'll be able to cross the lines to VA and DOD generously and not get blocked in that process.

Of course, General Schoomaker, we all appreciate your stepping into the breach with the Walter Reed situation and your willingness to take that, make that an opportunity and give us more confidence that, as you have, that the military really does care from the top down about the people who have the need for care of any kind. Our wounded warriors deserve no less than the best, and we thank you for providing it.

The hearing is adjourned.

[The following appendices will be retained in committee files:]

Appendix A: Mental Health Advisory Team (MHAT–I) Report, Operation Iraqi Freedom, 16 December 2003

Appendix B: Mental Health Advisory Team (MHAT–II) Report, Operation Iraqi Freedom, 30 January 2005

Appendix C: Mental Health Advisory Team (MHAT–III) Report, Operation Iraqi Freedom, 29 May 2006

Appendix D: Mental Health Advisory Team (MHAT–IV) Report, Operation Iraqi Freedom, 17 November 2006

Appendix E: Mental Health Advisory Team (MHAT–V) Report, Operation Iraqi Freedom/Operation Enduring Freedom, 14 February 2008

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR JOSEPH I. LIEBERMAN

MENTAL HEALTH TASK FORCE REPORT

1. Senator LIEBERMAN. Vice Admiral Arthur and Dr. MacDermid, I thank you both again for your work on the Mental Health Task Force. Your report issued critical findings and recommendations that provide a blueprint for the Department to build a true continuum of care for psychological health (PH). In fact, your report issued over 90 findings, many of which can be accomplished administratively and others which will require statutory changes. If you can, please provide specific recommendations you regard as priorities that you feel our committee should act on in the National Defense Authorization Act (NDAA) for Fiscal Year 2009.

Vice Admiral ARTHUR and Dr. MACDERMID. The Task Force made 95 recommendations, 94 of which were endorsed by the Secretary of Defense. The testimony by the other panelists made it clear that many actions are being undertaken to respond to the recommendations. I am not a legislative expert, so there may have been progress of which I am unaware, but my impression is that there may be action yet required related to the recommendations of the Task Force regarding TRICARE. I list four specific recommendations below. The background and justification for each of these recommendations is provided in the task force report, which was submitted for the record.

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

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

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

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

As I indicated in my testimony, the shortcomings in the PH system identified in the task force report were revealed but not caused by the current war. A long period of relatively constrained conflicts (though their frequency was increasing rapidly) led to the development of a system that been streamlined, downsized, and civilianized to the point that it has been very difficult during this large sustained conflict to adequately serve the needs of Active and Reserve, deployed and at-home, members and their families. While substantial funds have been allocated, my im-

pression is that most of these funds are non-recurring, and not permitted to be used to increase the infrastructure of positions to support PH. Without recurring funds, we are at risk of coming out of this war with an infrastructure no better prepared for the next war than it was prior to September 11. Thus, I suggest that the following recommendation may deserve further legislative attention.

5.3.1.1 ..... Congress should provide, and the military Services should allocate, sufficient and continuing funding to fully implement and properly staff an effective system supporting the PH of servicemembers and their families.

I know that Members of Congress are deeply concerned about the PH of servicemembers and their families, and deeply committed to making long-lasting change. For that reason, I suggest that the following recommendation be considered for legislative action.

5.4.1.5 ..... Each Service Surgeon General's annual report to Congress should include data about the PH of servicemembers and their families, and on the efforts to improve PH.

UNIFORMED BEHAVIORAL HEALTH PROVIDERS

2. Senator LIEBERMAN. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, I hope that we all agree that Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and other mental health issues are significant health challenges facing the Department and our servicemembers in this conflict. I believe that now we must move beyond simply recognizing that PTSD, TBI, and other mental health issues are a problem and find long-term solutions. In order for the immediate mental health needs of servicemembers to be met, and to build the continuum of care for PH called for by the Department of Defense (DOD) Mental Health Task Force, we must have significantly more uniformed behavioral health providers. Growing our uniformed behavioral health workforce is critical to a long-term solution to our mental health crisis and also to inoculate our forces against such injuries in the future. What plans do each of the Services have to increase the number of uniformed behavioral health providers?

Lieutenant General SCHOOMAKER. The Army offers several programs to increase and train mental health professionals in uniform. The Clinical Psychology Internship Program is a postdoctoral program which trains up to 30 interns per year. Participants are on Active Duty during this program and incur an additional Active Duty service obligation. The Health Professions Scholarship Program is available for students pursuing a doctorate in Clinical Psychology in exchange for an Active Duty service obligation. The newly-established Masters in Social Work program at the U.S. Army Medical Department Center and School will send up to 25 students per year to Fayetteville State University starting in Academic Year 2008. The Uniformed Services University of the Health Sciences offers a Clinical Psychology Training Program, and has introduced a new Adult Psychiatric Mental Health Nurse Practitioner (PMH–NP) program. The PMH–NP program is a 24-month, full-time program, that will begin in Academic Year 2008.

Vice Admiral ROBINSON. The Navy will increase authorized endstrength by 14 Psychiatrists, 4 Clinical Psychologists, and 3 Mental Health Nurse Practitioners. In addition there will be increased uniformed mental health assets bought by the Marine Corps to support the Combat Stress Control and Readiness Program (OSCAR). The numbers have not been finalized by the Marine Corps but the Navy has already taken steps to increase the accession and retention of our mental health practitioners.

The Psychiatry multi-year special pay has increased $8,000 each of the past 2 fiscal years and will be evaluated again for fiscal year 2009 by OSD/HA. NDAA for Fiscal Year 2007 authorized a Critical Wartime Skills Accession Bonus (CWSAB). As a result, the DOD initiated a $175,000 CWSAB for Psychiatrists for a 4-year commitment in fiscal year 2008. This rate will be revaluated for fiscal year 2009 by OSD/HA. The CWSAB has been fully funded for 50 physician direct accessions in fiscal year 2009.

Clinical Psychologists with 3 to 8 years of service are now eligible for $60,000 Critical Skills Retention Bonus (CSRB) for a 4-year commitment. Navy and OSD are also reviewing an accession bonus for Clinical Psychologists and the OSD/HA and the three Services are evaluating the NDAA for Fiscal Year 2008 Special Pay authority to pay Clinical Psychologists a multi-year retention bonus.

The Navy has also established six new Mental Health Nurse Practitioner billets in fiscal year 2008 with plans to grow this community in the near future.

Lieutenant General ROUDEBUSH. We agree that meeting the mental health needs of our airmen is a priority that requires a comprehensive integrated mental health structure. The Air Force has taken a two-pronged approach to growing mental health providers. In the short-term, we have hired 32 mental health professionals at the locations with the highest operational tempo and are hiring 75 contract personnel to provide direct patient care and support the establishment of Active Duty Directors of Psychological Health at every Air Force installation worldwide. We have also assigned an Air Force Active Duty mental health clinician to my staff as a consultant on PH.

In the long-term, Active Duty authorizations for mental health providers require an AFMS-wide evaluation of our medical services and potential offsets to live within our budgetary constraints. The Air Force plans to recruit an additional 71 psychologists (68 AD/3 GS), 44 social workers (25 AD/19 GS), 6 psychiatrists (6 AD), and 6 mental health nurses (6 GS) in fiscal year 2008.

Our goal is to improve the continuity of mental health care by collaborating with the Department of Veterans Affairs (VA) and Public Health Service, and by shoring up our access to the civilian network of medical providers. The directors of PH will help facilitate these relationships.

3. Senator LIEBERMAN. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, would additional authorizations for bonus and special pays assist in recruiting and retaining uniformed behavioral health providers?

Lieutenant General SCHOOMAKER. Yes, the Army competes within a market that suffers from shortages of qualified mental health professionals. Additional incentives specific to mental health are needed to recruit and retain these professionals in the Army. Current bonuses and special pays include the following:

1. Psychiatrists who execute a multi-year special pay contract that extends their Active Duty service obligation are paid $17,000 per year for a 2-year contract, $25,000 per year for a 3-year contract, and $33,000 per year for a 4-year contract.
2. Licensed Clinical Psychologists are offered the Critical Skills Retention Bonus (CSRB) at a rate of $13,000 per year for 2 years or $25,000 per year for 3 years. In addition, the Health Professions Loan Repayment Program (HPLRP) is available for the accession of 5 Clinical Psychologists and the retention of 20 Clinical Psychologists per year at the rate of $38,000 per year. Finally, the Health Professions Scholarship Program is available to students pursuing a doctorate in Clinical Psychology in exchange for an Active Duty service obligation.
3. Social Workers in the grade of Captain are offered the CSRB at the rate of $25,000 for a 3-year Active Duty service obligation. The HPLRP is also available for the accession of 5 Social Workers and the retention of 20 Clinical Psychologists per year at the rate of $38,437 per year. Finally, a Masters of Social Work program has been established at the U.S. Army Medical Department Center and School to send up to 25 students per year to Fayetteville State University starting in Academic Year 2008.
4. Psychiatric Nurses and Psychiatric Nurse Practitioners are authorized to receive Registered Nurse Incentive Special Pay at a rate of $5,000 per year for 1 year, $10,000 per year for 2 years, $15,000 per year for 3 years, and $20,000 per year for 4 years. The Uniformed Services University of the Health Sciences has also introduced a new Adult Psychiatric Mental Health Nurse Practitioner (PMH–NP) program. The PMH–NP program is a 24-month, full-time program beginning in Academic Year 2008, with Army allocations to be determined.

Vice Admiral ROBINSON. The recruiting and retention tools provided by the NDAAs for Fiscal Year 2007 and Fiscal Year 2008 have been very helpful. These, coupled with proposals for fiscal year 2009, should go a long way to help us meet our goals. However, we constantly review the efficiency of our tools and if it is deemed that these tools are insufficient, then more will be requested.

The military-civilian pay differential and current OPTEMPO to support the global war on terrorism has affected the retention of many of our health care providers, especially our mental health providers.

Navy continues to work with the Tri-service Health Professions Incentive Working Group (HPIWG) to address Special and Incentive pays based on inventory needs by specialty including behavioral health providers. In the proposed NDAA for Fiscal Year 2009, there is an accession bonus for fully trained clinical psychologists to address recruiting challenges.

The following describes the current incentives to attract and retain behavioral health specialists. Some have been recently enacted from the 2007 and 2008 NDAAs and we are monitoring the effects on recruiting and retention.

1. Psychiatry (Medical Corps)

a. Eligible for the following entitlements: Variable Special Pay, Additional Special Pay, and Board Certified Pay.

b. Eligible for the following discretionary special pays: Incentive Special Pay (ISP) $15,000/year and Multiyear Special Pay (MSP) 2 year-$17,000/year, 3 year-$25,000/year, and 4 year-$33,000/year. The 4 year MSP for Psychiatrist has increased from $17,000/year in fiscal year 2006 to $25,000/year in fiscal year 2007 to $33,000 in fiscal year 2008.

The NDAA 2008 allows up to $400,000 CWSAB for board certified direct accessions. DOD/HA has authorized $175,000 accession bonus for psychiatrists who accept a 4-year commitment. During the discharge of this Active Duty Service Obligation, individuals are not be eligible for the Multi-year Incentive Special Pay or Multi-year Special Pay. The number of psychiatrists Navy medicine can directly access is limited by our accession goal in fiscal year 2008. The proposed fiscal year 2009 goal has been increased to support this bonus and an increase in accessing psychiatrists.

c. Psychiatrists are eligible for the Health Profession Loan Repayment Program (HPLRP) if they meet eligibility requirements. HPLRP can be used as an accession incentive and as a retention incentive. This program provides up to $38,300 per year to repay qualified school loans. HPLRP obligation runs consecutively with other obligations.

2. Clinical Psychologists (Medical Service Corps)

a. The Navy recently implimemented a Critical Skills Retention Bonus for Clinical Psychologists. The incentive pays $60,000 ($15,000/year) for 4-year contract at MSR. Clinical Psychology Officers with 3–8 years of commissioned service are eligible.

b. Psychologists are eligible for the HPLRP if they meet eligibility requirements. HPLRP can be used as an accession incentive and as a retention incentive. This program provides up to $38,300 per year to repay qualified school loans. HPLRP obligation runs consecutively with other obligations.

c. Clinical Psychologists are eligible for Board Certified Pay.

d. A fiscal year 2009 ULB for a $70,000 Clinical Psychology Accession Bonus of was submitted and forwarded by DOD. This is in the proposed 2009 NDAA.

3. Social Workers

a. Social Workers are also eligible for HPLRP as an accession and retention tool.

b. Social Workers are eligible for Board Certified Pay.

4. Mental Health Nurse Practitioners

a. Nurse Corps recently recognized Registered Nurse Mental Health Nurse Practitioners with subspecialty code.

b. Once approved by Assistant Secretary of Health Affairs Mental Health Nurse Practitioners will be eligible for board certified pay.

Lieutenant General ROUDEBUSH. Increases to current authorizations and implementation of new bonuses and special pays among uniformed behavioral health providers may have an impact on some aspects of recruiting. Larger bonuses and special pays might encourage more psychiatry residents and newly graduated providers to consider the military as a viable place to start their careers. However, it may be difficult to offer a large enough accession bonus to entice an established behavioral health professional in civilian practice to leave and enter the military. Fully trained and qualified providers who come onto Active Duty service usually do so for reasons other than monetary gain.

Increases to current authorizations and implementation of new bonuses and special pays would likely benefit retention. Uniformed behavioral health providers who are ambivalent about staying in the military because of increased demands and stresses might be persuaded to remain if their pay was closer to or slightly above the pay of their civilian counterparts.

4. Senator LIEBERMAN. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, what has the impact of military to civilian conversions over the last several years been on the ability to provide behavioral health services in a time of war?

Lieutenant General SCHOOMAKER. Within the Army, we programmed 107 military behavioral health specialties for civilian conversion in fiscal year 2006 and fiscal year 2007 combined. We found, however, that in some local markets we were unable to replace military providers with civilians in a timely manner and so only executed 51 conversions and restored the military requirement to 56 of those billets. The conversion of those 51 billets decreased the depth of the pool we can draw from to support deployment needs.

Our increasing understanding of the scope of this challenge has led us to significantly increase the number of uniformed providers as we reshape our behavioral health structure. MEDCOM has the full support of Army leadership in this restructuring. We have been allowed complete flexibility to change the grade and skill of military positions as we see fit to best meet our growing behavioral health needs. Among the increases in fiscal year 2008 and fiscal year 2009 are 100 enlisted mental health specialists, 18 psychiatrists, 6 child psychiatrists, 8 psychiatric nurses, 19 social workers, and 12 clinical psychologists.

Vice Admiral ROBINSON. Military-to-civilian conversions have not impacted Navy's ability to provide behavioral health services. Although some billets were targeted for conversion in the early years, those were quickly restored. There has been no reduction in mental health capability associated with military to civilian conversions.

Lieutenant General ROUDEBUSH. The impact of military to civilian conversions has been minimal for the Air Force Medical Service. A total of 3 psychologist positions and 19 social worker positions have been converted in the past 3 years. Two of the psychologist positions have been filled, and 10 social workers have been hired. The social worker positions converted are Family Advocacy Officers (FAO), who work outside of the medical treatment facilities, rather than in clinical behavioral health care.

5. Senator LIEBERMAN. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, what models are the Services using in determining current and future uniformed provider staffing requirements, especially in light of new initiatives such as the Navy/Marine Corps Combat Stress Control and Readiness Program (OSCAR)?

Lieutenant General SCHOOMAKER. The Army uses MEDCOM's Automated Staffing Assessment Model (ASAM) to determine current and projected uniformed provider and ancillary support staffing requirements within Army fixed medical treatment facilities. Additionally, MEDCOM recently concluded an in-depth study of behavioral health staffing that will be used in concert with the ASAM to increase requirements for psychiatrists, social workers, clinical psychologists, mental health nurse practitioners, and behavioral health specialists. Finally, the Army Medical Department has adjusted its basis for allocating mental health support to the warfighter. In 2006, we assigned 1 behavioral health professional to support every 1,000 warfighters. Currently, our target is 1 behavioral health provider for every 700 soldiers.

Vice Admiral ROBINSON. Operational medical requirements for the Marine Corps, to include the OSCAR teams, are set by Headquarters Marine Corps. As a new requirement, additional "Blue in Support of Green" (BISOG) billets for the OSCAR program are to be established in a phased manner starting in fiscal year 2010. Beginning with the Active divisions and Marine Forces Reserve, the Marine Corps will eventually staff enough OSCAR teams to support all of the Marine Corps operational forces, to include air and logistics units, down to the regimental level or equivalent.

Navy Medicine will support the BISOG requirements through accession and retention initiatives and increased BSO 18 staffing to support the rotation base of the OSCAR billets. Navy Medicine determines the mental health staffing at their Medical Treatment Facilities using workload models and the rotation requirements needed to support operational staffing requirements.

Lieutenant General ROUDEBUSH. The Air Force has historically used a patient population-based product line medical manpower standard to formulate requirements for specific health care product lines, to include mental health. This population-based product line medical manpower standard methodology is what is used to formulate future requirements during programmatic/execution processes.

In addition to the established mental health standards, the Air Force added a Director, PH, at each of its Air Force Bases and has enhanced the Behavioral Health Outpatient Program (BHOP) at 20–25 bases that did not have a dedicated BHOP provider. The BHOP integrates behavioral health consultants (BHCs) into the primary care setting to help provide early recognition and intervention for those patients with psychosocial issues or behavioral health issues that may require more intensive specialty mental health care.

SUICIDE PREVENTION

6. Senator LIEBERMAN. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, our greatest resources in the Armed Forces are our personnel and we must implement measures that prevent suicides and assure those in uniform and their families that even one life lost is one too many. Too much of our current debate on suicide has focused on whether or not there are statistically significant differences in suicides rates from 1 year to the next or when in comparison to those in the general population. Instead, I urge the DOD and the committee to focus efforts on establishing protocols to investigate all suicides to determine causes and contributing factors, procedures to take immediate corrective action when necessary, and track the implementation of all Service-wide and force-wide recommendations emerging from such investigations. I believe that suicide prevention is critical to the health and future of our forces. What measures have the Services taken to date to prevent any increases in suicide rates given the physical and mental strain many servicemembers and their families are experiencing?

Lieutenant General SCHOOMAKER. On March 20, 2008, the Deputy Chief of Staff, G–1 and the Surgeon General hosted a Suicide Prevention General Officer Steering Committee (GOSC). The GOSC's efforts will be ongoing, with a focus on targeting the root causes of suicide, while engaging all levels of the chain-of-command. The GOSC approved the following: (1) conducting suicide prevention chain teaching for the entire force between June 1, 2008, and August 31, 2008; (2) establishing a suicide prevention analysis and reporting cell that has epidemiological consultation-like capabilities; and (3) developing the GOSC charter and expanding its membership. The GOSC also reaffirmed the Army Suicide Prevention overarching strategies and expanded them. They include: (1) raising soldier and leader awareness of the signs and symptoms of suicide and improving intervention skills; (2) providing actionable intelligence to leaders regarding suicides and attempted suicides; (3) improving soldiers' access to comprehensive care; (4) reducing the stigma associated with seeking mental health care; and (5) improving soldiers' and their families' life skills.

Vice Admiral ROBINSON. Navy's suicide prevention program goes beyond statistical baselines to focus on root causes that may lead to suicidal thinking. Navy programs and leadership training are designed to facilitate early recognition of sailors and marines who may be experiencing stress reactions for any reason, and to intervene with an appropriate level of support. Navy maintains an active suicide prevention program at each command, which include:

- Mandatory annual training on suicide awareness, including risk factors, protective factors, warning signs and how to obtain assistance for self and shipmate.
- Life-skills/health promotions training (on such topics as alcohol abuse avoidance, skills for managing finances, stress, conflict, and relationships) to enhance coping skills and reduce incidence of problems that increase suicide risk.
- Crisis intervention plans that outline the process for identification, referral, access to treatment, and follow-up for personnel who indicate a heightened risk of suicide.
- Support for those who seek help with personal problems including access to prevention, counseling, and treatment programs and services supporting the early resolution of mental health, family and personal problems that underlie suicidal behavior.
- Reporting of suicides and collection of data to inform prevention efforts and policy decisions.
- Providing supportive response to sailors and family members affected by suicide loss.
- All sailors have a duty to take care of each other and seek help for another sailor in distress.

The Manual of the Judge Advocate General (JAG Instruction 5800.7E) requires a command investigation to be conducted with deaths of military personnel apparently caused by suicide or under other unusual circumstances. Also, the Article 1770–030 of the Naval Military Personnel Manual (NAVPERS 15560D), directs completion of a Personnel Casualty Report (PCR), which provides visibility throughout Navy senior leadership, including the Bureau of Medicine and Surgery. Beginning in January 2008, PCR submission initiates the DOD Suicide Event Report (DODSER) reporting process by which gathering of standardized information occurs across DOD. The DODSER collects information on the decedent's demographics, circumstances of death, medical and performance history, recent stressors and behaviors, deployment history, combat experiences, substance use/abuse, and other information, to enable informed assessment of the causes of suicide to better develop

mitigation and prevention strategies. Navy reports are individually reviewed by a licensed mental health provider and collective data are analyzed for trends. While Navy suicide rates have remained relatively steady given increasing demands and stress on our sailors, even the loss of just one sailor or family member to suicide is one too many. We are continuously working to improve mental health initiatives and intervention focused on reducing the number of suicides in the Navy, as well as initiatives to enhance leadership's ability to recognize and understand depression and stress injuries, and the impact they have on sailor and family resilience.

Lieutenant General ROUDEBUSH. The loss of any airman to suicide is a tragedy of great concern to Air Force senior leaders. The Air Force has taken a multi-faceted, commander-driven and community wide approach to suicide prevention. Prevention of such events requires a culture of mutual responsibility, devotion and commitment. Our suicide data tracking systems are in place to monitor the effectiveness of these concerted prevention efforts.

I would like to ensure the committee those discussions related to the reduction of suicides from year to year, and the metrics to demonstrate change, are not reflective of our attempt to dehumanize the tragedy, but represent our pursuit of programs and initiatives that are successful at guiding our efforts to reach those in need of help and support.

Every Air Force suicide is investigated by the Air Force Office of Special Investigations and reviewed in detail by installation and Major Command leadership to identify lessons learned that might inform our efforts to identify and intervene with those at risk. Additionally, when there has been recent involvement of medical or mental health services, a Medical Incident Investigation (MII) is commissioned to review the chain of events leading up the death in terms of the standard of care provided and potential missed opportunities or systems failures that were contributory. This MII is briefed to the major command commander and up to the Office of the Air Force Surgeon General. The lessons learned from these various investigations are briefed to our most senior Air Force leaders and aggregated into an annual report which is disseminated to commanders throughout the Air Force.

Background:

The Air Force has achieved a 28 percent decrease in Air Force suicide rates since the program's inception in 1996. The Air Force Suicide Prevention Program was added to the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP) in 2007, and is currently 1 of 10 suicide prevention programs listed on the registry. This listing is not about chest thumping, it is about a successful program that makes a difference.

Air Force prevention efforts are centered on effective detection and treatment. A central component of this risk recognition and referral process is the recurring suicide prevention training for all airmen. To better standardize Air Force suicide prevention training, a revamped computer-based training was released on 15 Oct 07 as part of the Chief of Staff, U.S. Air Force's (CSAF) new Total Force Awareness Training initiative. This effort incorporates suicide prevention education into the CSAF's core training priorities, ensuring suicide prevention will continue to receive prioritized focus and attention.

Air Force Suicide Prevention Program (AFSPP) introduced the Frontline Supervisors Training in 2008. This interactive training provides a powerful vehicle for educating those with the most contact and greatest opportunity to intervene with airmen under stress. Lastly, suicide risk assessment training for mental health providers was conducted at 45 installations throughout 2007 to ensure Air Force mental health providers are highly proficient in evaluating and managing suicide risk. Throughout the next year, the Air Force Suicide Prevention Program will monitor the Frontline Supervisors Training and the new computer-based suicide prevention training to ensure these initiatives are effectively meeting the training needs of airmen.

7. Senator LIEBERMAN. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, would the Services support measures to initiate investigations on all suicides and establish Department-wide standards and protocols for taking necessary corrective actions?

Lieutenant General SCHOOMAKER. The Army supports measures to initiate investigations on all suicides and to establish Department-wide standards and protocols. The Army currently investigates all suicides through the Criminal Investigation Command. Additionally, units are required to conduct a Commander's Inquiry (known as a 15–6 investigation) on all suspected suicides. The Army currently uses a standardized instrument for reporting suicides and attempted suicides, the Army Suicide Event Report. Army behavioral health providers compile this report. This

instrument has been adopted recently by the other Services and is now known as the DODSER. Finally, the Army is planning to develop a multi-disciplinary suicide prevention analysis and reporting cell that has epidemiological consultation-like capabilities. This cell will integrate all of the above data.

Vice Admiral ROBINSON. The Navy fully supports the standardization for data collection/investigation into every suicide, which commenced at the beginning of CY 2008 with the implementation of the DODSER. The DODSER provides detailed insight into the circumstances, both personal and professional, surrounding the decedent at the time of the suicide. As the data is compiled we now have the ability to perform trend analysis and use the results to revise suicide prevention policy as needed. However, standardizing protocols for taking necessary corrective actions would likely be counterproductive. Every suicide presents unique circumstances and a standard protocol may not address the prevention efforts that would be the best course of action in that specific incident. Commanders in the field should be able to draw on multiple resources to take the most appropriate course of action when a suicide occurs. Standardizing protocols would tie leader's hands in making the right decisions for their command.

Lieutenant General ROUDEBUSH. The Air Force would support such proposals. In fact, the Air Force and DOD have already taken steps to implement similar activities. The Air Force tracks and analyzes suicide and suicide attempt data using the Air Force Suicide Event Surveillance System. In early 2008, the DOD Suicide Prevention and Risk Reduction Committee (composed of the Suicide Prevention Program Managers from each Service) launched the DOD Suicide Event Reporting System to track data on suicides and suicide attempts across all the Services.

Every Air Force suicide is investigated by the Air Force Office of Special Investigations and reviewed in detail by installation and Major Command leadership to identify lessons learned that might inform our efforts to identify and intervene with those at risk. Additionally, when there has been recent involvement of medical or mental health services, a Medical Incident Investigation (MII) is commissioned to review the chain of events leading up the death in terms of the standard of care provided and potential missed opportunities or systems failures that were contributory. This MII is briefed to the major command commander and up to the Office of the Air Force Surgeon General. Suicides related to domestic or child abuse are examined in the DOD-mandated Annual Fatality Review. The lessons learned from these various investigations are briefed to our most senior Air Force leaders and aggregated into an annual report which is disseminated to commanders throughout the Air Force.

DEFENSE CENTER OF EXCELLENCE

8. Senator LIEBERMAN. Colonel Sutton, last year, Senator Boxer and I introduced S.1196, the Mental Health Care for Our Wounded Warriors Act, which was incorporated, into the NDAA for Fiscal Year 2008. In addition to the mandates laid out in those provisions, the Defense Center of Excellence (DCoE) has also been charged with implementing many of the recommendations of the Mental Health Task Force Report. I believe that adequate resourcing of the Center is critical for its early and long-term utility and success. What resources do you need at this time to carry out the directives for the DCoE outlined in the NDAA for Fiscal Year 2008 and to implement the numerous recommendations of the Mental Health Task Force Report?

Colonel SUTTON. Congress has generously provided funding for the Department and the Center for fiscal year 2008 and fiscal year 2009. Our greatest challenge at present is the ability to use that funding effectively and efficiently to immediately staff the Center and to begin the programs necessary to fulfill the recommendations of the MHTF. Within the military health system, our clinical staffs are busy on the front lines both at home and in deployed status. The Department has initiated several actions to increase the numbers of mental health professionals to support our wounded warriors and their family members.

STRAINS OF MILITARY FAMILIES

9. Senator LIEBERMAN. Lieutenant General Schoomaker, we have been reading an increasing number of reports on the strain that military families are experiencing. Last summer, an article published in the Journal of the American Medical Association cited rising rates of child maltreatment in military families, primarily attributed to spouses alone during deployments. My staff has also been visiting a number of military bases across the country and they have heard reports at bases of increasing reports of domestic violence, substance abuse in families, and mental health

issues in spouses and children. What initiatives is the Army undertaking to assess the needs of military families and to direct resources to meet those needs?

Lieutenant General SCHOOMAKER. In July 2007, the Army Surgeon General's Office informed all Army Medical Department providers of the observed increases in child neglect rates during deployments and directed them to increase the screening of the spouses of deployed soldiers for depression and any signs of poor coping capacity. Additionally, 16 hours of free child care at child development centers has been made available for each child of deployed soldiers and wounded warriors. In November 2007, the Secretary of the Army teamed with the Gallup organization to initiate quarterly surveys of Army families as a part of the Army Family Covenant. The intent is to assess Army family health through satisfaction surveys of all Army families, including those who live away from Army installations. The survey includes questions that will help us evaluate services provided to families during deployments.

The article published last August in the Journal of the American Medical Association, "Child Maltreatment in Enlisted Soldiers' Families During Combat-Related Deployments," did not cite rising rates of child abuse overall. However, it did demonstrate that children were at 4 times greater risk of neglect by the civilian spouse during deployments. The rate of physical abuse was actually less during deployments. Similarly, the observed rates of domestic violence have not increased overall since the deployments began—rates have gone down. We have found that rates decrease during deployments and rise again after reunion, but rates do not rise above pre-deployment levels.

10. Senator LIEBERMAN. Lieutenant General Schoomaker, what additional resources or authorities does the DOD require to accomplish these objectives?

Lieutenant General SCHOOMAKER. The Army plans to more than double the number of marriage and family therapists that will be available to our soldiers and families this summer. We are using funding appropriated in the fiscal year 2007 Supplemental Appropriations Act to hire an additional 35 marriage and family therapists, bringing our total across the Army to 60. Based on our experience from the past few years, we determined that the ratio of one therapist for each brigade size element would best support our families. We have had 25 marriage and family therapists at select locations since 2003 and have observed more positive outcomes of family maltreatment cases when such services have been available. After the staffing increases this summer, we will continue to monitor outcomes to see if further adjustments are necessary.

REALLOCATION OF FUNDS

11. Senator LIEBERMAN. Lieutenant General Schoomaker, the Base Realignment and Closure process will lead to a greater concentration of military families at a smaller number of bases across the United States. How will funding be reallocated to ensure that resources will be available for families as they relocate?

Lieutenant General SCHOOMAKER. We are performing detailed planning to align health care capability with demand for services across time. Resources will be realigned to support both soldiers and their families using a resourcing model based on population timelines to ensure adequate health care continues at all of our medical treatment facilities. In areas where there is a potential for a lapse in care due to the difficulty in hiring providers or the timing of new construction or the expansion of existing health care facilities, we are developing mitigation strategies, such as the increased use of the TRICARE network.

SUBSTANCE ABUSE

12. Senator LIEBERMAN. Colonel Castro, substance abuse appears to be on the rise on military bases. Many of these individuals abusing substances also have PTSD, TBI, depression, or another mental health condition. I am growing increasingly concerned that we must not only focus on the psychological and brain injuries, but also on understanding how better to assess and treat substance abuse. Is substance abuse on the rise on our military bases and among those that have deployed to Iraq and Afghanistan?

Colonel CASTRO. The most recent data from the fifth Mental Health Advisory Team (MHAT V) conducted in 2007 found that 8 percent of soldiers deployed to Iraq reported using alcohol in theater and 1.4 percent reported using illegal drugs/substances. These reports of alcohol and substance abuse do not differ statistically from rates in 2006 (6.8 percent and 1.6 percent). The Army maintains a formal drug test-

ing program in theater, and the drug positive results have remained significantly lower than 1 percent for the last 3 years. Our drug positive rates across the Army have also remained relatively stable since the beginning of global war on terrorism. We have seen an increase in positive tests for pain killers, but the vast majority of those positives are found to be legitimate use. We have seen an increase in self-reports of alcohol abuse from 28 percent pre-global war on terrorism to 32 percent for those soldiers returning from deployment. We have also seen an increase in the numbers of soldiers being diagnosed with alcohol abuse or dependence. We have initiated use of more early intervention programs that are used with soldiers at the first sign of trouble. We are in the process of developing mediated versions of our best prevention/intervention programs to expand our reach and we have accelerated the hiring of substance abuse treatment professionals. We understand the importance of meeting soldiers' needs regarding substance abuse and we are responding accordingly.

13. Senator LIEBERMAN. Colonel Castro, how integrated are substance abuse programs with behavioral health services in military treatment facilities? Is the level of integration sufficient? If not, what integrated models of care is DOD examining and are there plans to export those models to military treatment facilities?

Colonel CASTRO. The level of integration is sufficient, because we are able to maintain the necessary communication and coordination to take care of soldiers while adhering to Federal law concerning privacy. We are looking at the feasibility of integrating records. The Army Substance Abuse Program (ASAP) is a command program in which the commanders and providers collaborate in our prevention efforts and assist soldiers who abuse alcohol or drugs. If soldiers have a substance abuse problem, they are referred to ASAP substance abuse counselors who are part of the behavioral health network, but are located in separate clinics. The regulation requires the soldier be mandated into treatment and that the commander be a part of the treatment planning; commanders are required to attend rehabilitation meetings with the servicemember and provider. The program also outlines commander's requirements if soldiers test positive for drugs or fail at attempts for rehabilitation. Specific laws (42 U.S.C., Sec 290dd–2) govern the privacy of soldiers who are in substance abuse treatment. This law is more stringent than those applied to other behavioral health programs or records. That being said, there is continuous cooperation and collaboration between the substance abuse clinics and other behavioral health providers. An example is dealing with or treating PTSD. Behavioral health and substance abuse clinics cross-check with each other to ensure that soldiers presenting with PTSD symptoms or substance abuse are also evaluated for the other since many patients suffering from PTSD self-medicate with alcohol.

MENTAL HEALTH NEEDS OF FEMALE SERVICEMEMBERS

14. Senator LIEBERMAN. Colonel Sutton, last year, Senator Boxer and I had included a provision in the NDAA for Fiscal Year 2008 for DOD to conduct a study on the potentially unique mental health needs of female servicemembers. Determining whether or not psychological injuries and brain injuries manifest differently in men and women will be important, especially when developing long-term research and treatment infrastructures across DOD. Will the DCoE be involved in this study?

Colonel SUTTON. The DCoE recognizes and supports the unique needs of women servicemembers and veterans. One of the eight directorates of the DCoE, Research, Program Evaluation, Quality and Surveillance, has identified women's health issues as a priority research area. To emphasize the importance of this focus, the Research Directorate now actively includes statements encouraging examination of gender-specific issues in its request for proposals and broad agency announcements.

The DCoE encourages meritorious research on the mental health needs of female servicemembers. Basic, translational, behavioral and clinical research in women servicemembers' health, especially applied to sex/gender differences, are of particular interest. Studies considering the health disparities/differences and diversity are also important.

15. Senator LIEBERMAN. Colonel Sutton, what other initiatives will the Center be undertaking to examine the possibility that female servicemembers may process stress, trauma, and TBI differently than male counterparts?

Colonel SUTTON. The DCoE is collaborating with the scientific, health professionals and advocacy communities to fully address the unique gender-specific needs of recovering servicemembers and veterans with PH and TBI concerns/needs. In early March, the DCoE will hold an interagency initial planning meeting on wom-

en's issues related to PH and TBI by inviting its prospective collaborative partners from the VA, the Defense Health Board, and the National Institute of Health Office of Research on Women's Health. Ongoing research is examining the short- and long-term effects and outcomes of PH issues and TBI in women. These findings will be used to inform best practices. The DCoE will take the lead in creating best practices workshops in addressing the PH and TBI needs and concerns of servicemembers.

QUESTIONS SUBMITTED BY SENATOR CLAIRE MCCASKILL

PERSONALITY DISORDER DISCHARGES

16. Senator MCCASKILL. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, I am concerned with the continuing use of administrative personality disorder discharges in the Services, especially in instances involving combat veterans. A personality disorder discharge results in a servicemember being dismissed from service without medical or personnel benefits because his or her behavioral issues are determined to be pre-existing. I am concerned with the frequency that these highly prejudicial discharges are occurring—particularly in cases involving combat veterans. I am also especially concerned because these discharges are processed by unit commanders in concert with the personnel commands, not by medical professionals and the medical command, although I understand that it is a diagnosis from a medical professional that enables the discharge. Are you concerned that administrative personality disorder discharges are being misused in the DOD/your Service?

Lieutenant General SCHOOMAKER. No, we do not believe personality disorder discharges are being or have been misused. We recently completed a project to gather available data regarding the personality disorder separations of Army soldiers who have been deployed and were separated between 2001 and 2006. The data is currently being reviewed by Army leadership; however, initial assessments did not reveal evidence of systematic misuse in the Army. While gathering the data, however, issues were identified with the manner in which diagnoses are documented. Therefore, we took immediate steps to improve the level of medical review for personality disorder discharges to address this issue. The Army Medical Department implemented a new policy in August 2007, requiring all recommendations for personality disorder separations be reviewed by the installation's Chief of Behavioral Health. This will add an additional layer of experienced medical review to the separation process.

Vice Admiral ROBINSON. I believe that administrative personality disorder discharges are being properly used by the Navy. We have a valid process for determining if a personality disorder discharge is warranted with significant safeguards. A convenience of the Government separation as detailed in the Navy's Military Personnel Manual (MPM) 1910–122, clearly states the requirements for personality disorder separation as:

- Clinical diagnosis required, i.e., psychiatrist or clinical psychologist (Ph.D.-level)
- Disorder must be so severe that the member's ability to function in the Navy environment is significantly impaired
- Impairment interferes with the member's performance of duty, or poses a threat to the safety or well-being of the member or others

Furthermore, MPM 1910–122 requires various safeguards to protect an individual being separated by reason of convenience of the government. It specifically requires written notification to an individual requesting a mental health evaluation and clearly states the right of an individual to a second, independent mental health professional opinion. Additionally, an individual is reminded of their right to an Inspector General investigation if they feel their referral is a reprisal from the command.

Lieutenant General ROUDEBUSH. Air Force policy is clear that airmen will not be discharged for personality disorders when other psychiatric disorders that warrant medical disability processing are present. Units and personnel offices cannot discharge airmen for personality disorders without the recommendation of an Air Force mental health provider. Air Force mental health providers are trained in the careful assessment and diagnosis of airmen with mental health problems, and render a diagnosis of a personality disorder only when a lifelong pattern of maladaptive behavior is clearly present. If other psychiatric disorders are present, including combat-related conditions, Air Force mental health providers refer those individuals for a Medical Evaluation Board.

I have full confidence that our medical and mental health providers maintain high standards of competence and adhere to their ethical obligation to provide the best

possible care to every patient, and have not seen anything that has suggested that administrative personality disorder discharges are being misused in the Air Force.

17. Senator MCCASKILL. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, do you believe these discharges should continue to be handled as administrative discharges or should there be a more extensive medical process, like a Medical Evaluation Board?

Lieutenant General SCHOOMAKER. I do not believe personality disorder discharges should require a Medical Evaluation Board. In the Army, the diagnosis of a personality disorder is made by a psychiatrist or a doctoral-level clinical psychologist with necessary and appropriate professional credentials who is privileged to conduct mental health evaluations for the DOD. In addition, all recommended separations for personality disorder are now reviewed by the installation's Chief of Behavioral Health. Finally, all soldiers recommended for a personality disorder separation receive a mental status evaluation. Based on the findings of the evaluation, a soldier may be referred for a Medical Evaluation Board. With these procedures in place, a more extensive medical process is not required.

Vice Admiral ROBINSON. I believe that these discharges should continue to be handled as administrative discharges. The process for identifying and evaluating a personality disorder is fair to the individual and a reasonable method to separate someone, honorably and without undo delay or expense to the government. It is important to note that personality disorder is not a mental illness but, rather, a disorder and in this case simply a disorder which makes one incompatible for military service. The Navy uses the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., (DSM IV), which requires that all other mental illnesses and disorders must be eliminated before a valid diagnosis of personality disorder can be made. DSM IV is the basic reference followed by Navy Medical professionals in examining for mental illness and disorders. If during the evaluation the mental health professional (psychiatrist or Ph.D. clinical psychologist) recommends a Medical Evaluation Board, that process is initiated.

Lieutenant General ROUDEBUSH. Currently, both the administrative separation of airmen for conditions unsuited to service and the medical discharge of personnel unfit for service require thorough medical evaluations.

It is appropriate for psychological conditions as outlined in the American Psychiatric Association's Diagnostic and Statistical Manual for Psychiatric Conditions, 4th Edition, and defined by regulations as unsuitable for service to be processed for administrative separation after the thorough evaluation by an Air Force mental health provider. This group of conditions includes personality disorders, a diagnosis that reflects a lifelong pattern of maladaptive behavior. Other examples include sleepwalking, dyslexia, airsickness, flying phobia, claustrophobia, and adjustment disorders.

All psychiatric disorders not explicitly defined as unsuited to service are processed through the medical evaluation board system. Medical evaluation boards are initiated when an Air Force mental health provider identifies concerns about an airman's fitness for continued service. Disorders warranting a medical evaluation board are explicitly excluded from the administrative separation process.

18. Senator MCCASKILL. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, would you support a moratorium on the personality disorder discharges?

Lieutenant General SCHOOMAKER. I do not support a moratorium on all personality disorder discharges. Based on the review of data that is underway, we anticipate a need to tighten the criteria under which this separation may be applied, and improve enforcement of procedures already in place.

Vice Admiral ROBINSON. I believe that a moratorium on personality disorder discharges would put an undue burden on our already stressed forces and potentially add to the number of considerable hazards associated with military service. A servicemember is only separated for a personality disorder if a mental health professional determines the disorder is so severe that the member's ability to function effectively in the Navy environment is significantly impaired to the point where it interferes with the performance of their duties or poses a threat to the safety or well being of the member or others.

Lieutenant General ROUDEBUSH. Air Force mental health personnel exhibit high standards of professional and ethical conduct, and when an airmen displays a lifelong pattern of maladaptive behavior the diagnosis of a personality disorder is appropriate. In these cases, the successful adaptation to the military environment is unlikely. When an airman is failing to adapt because of a personality disorder, administrative separation is in the best interests of the airman and the Air Force. A

moratorium on personality discharges will force commanders to address these airmen through other measures, such as punitive discharges. This would be unfair to airmen with personality disorders, because the failure to adapt is secondary to the disorder and not misconduct.

We must also appreciate that further restriction on a Commander's ability to separate personnel who are not a good fit to our force, is a drain on leaders, stresses our health care system, and may well impact spill over to other areas of culture (i.e. like suicide rates, AWOL).

19. Senator MCCASKILL. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, do you believe the 1982 DOD directive on personality disorder discharges needs to be updated?

Lieutenant General SCHOOMAKER. I believe all of our policies and directives should be routinely reviewed and updated to reflect the realities of a Nation at war in a persistent conflict.

Vice Admiral ROBINSON. DOD Directive 1332.14, Enlisted Administrative Separations, outlines policy for personality disorder discharges. This directive was originally issued in January, 1982 and updated in December, 1993 and March, 1994 and presently meets our needs. Navy policies regarding enlisted separations are in accordance with this directive and I do not believe it needs updating at this time.

Lieutenant General ROUDEBUSH. It is reasonable that a document last published in 1982 be reviewed for currency and updated as appropriate.

20. Senator MCCASKILL. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, do you believe new safeguards should be applied to personality disorder discharges, especially in light of the heavy combat activity of most of today's servicemembers?

Lieutenant General SCHOOMAKER. Yes, some additional safeguards should be applied to personality disorder discharges. For example, the Army implemented a new policy in August 2007, where all recommendations for separation for a personality disorder require review by the installation's Chief of Behavioral Health. The Army Staff is currently reviewing additional safeguards for soldiers based on length of service and combat experience.

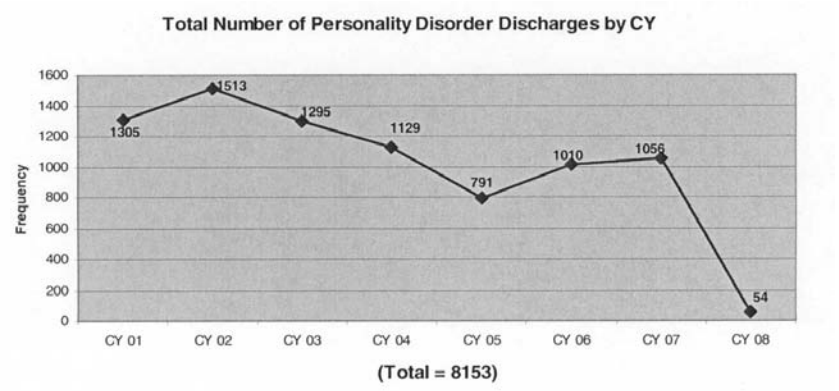
Vice Admiral ROBINSON. I believe that the current DOD and Navy policies regarding personality disorder discharges are sufficient to meet the needs of our servicemembers. I certainly recognize that the global war on terrorism has placed our sailors in harm's way and some may suffer from anxiety disorders like PTSD or other problems like TBI. In order for an individual to be discharged for a personality disorder they must receive a mental health evaluation by a psychiatrist or Navy clinical psychologist (Ph.D.). Our mental health professionals are sensitized to the special needs of our sailors returning from a combat zone and are able to distinguish between PTSD and a personality disorder. Additionally, the Navy will add a requirement to the Military Personnel Manual 1910–122 to include the statement in all personality disorder diagnoses that the examination included survey for symptoms of PTSD and TBI, and that none were found.

Lieutenant General ROUDEBUSH. I agree that existing safeguards must be strictly adhered to, and by and large, we do. These safeguards include the following: 1) involvement of Air Force mental health providers; 2) the use of diagnostic criteria for personality disorders as published in the American Psychiatric Association's Diagnostic and Statistical Manual for Psychiatric Conditions, 4th Edition; and 3) the requirement in DOD Directive 6490.1 that a member with a personality disorder must have an impairment "so severe so as to preclude satisfactory performance of duty" before administrative separation can be considered. A key feature of personality disorders involves persistent and pervasive patterns of behavior which are distinguishable by professionals from transient or emergent psychological issues, such as post-traumatic stress, insomnia, and adjustment disorders.

If the implication is that we are missing diagnoses and there is evidence to support that, it would make sense to ensure our mental health experts have current training on developing conditions and the literature related to it.

We must also appreciate that further restriction on a commander's ability to separate personnel who are not a good fit to our force may have other impacts, such as negatively affecting unit morale and stressing health care resources, and may well spill over to other areas (e.g. suicide rates, AWOL).

The table below shows Air Force data for personality disorder discharges; the number of airmen administratively separated for this reason has not gone up during Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF).



21. Senator MCCASKILL. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, do you believe a review board should be established to review past personality disorder discharges of combat veterans, as I have joined Senator Bond and others in calling for?

Lieutenant General SCHOOMAKER. Soldiers and veterans currently have the right to appeal their discharges to the Army Board for Correction of Military Records, as created by Congress. I do not believe a separate review board is needed.

Vice Admiral ROBINSON. To date, there is no evidence there is a problem in the Navy with personality disorder discharges and combat veterans. However, the NDAA for Fiscal Year 2008 requires DOD to report to Congress by 1 Apr 08 on all cases of administrative separation of any servicemember who had served in Iraq or Afghanistan since October 2001 for personality disorder. Before the establishment of a review board, I believe it would be prudent to await the results of this report.

Lieutenant General ROUDEBUSH. I do not believe an across-the-board review is necessary. I am confident in the professional and ethical conduct of Air Force mental health providers in these cases, and this contention is supported by recent data from the Air Force Personnel Center. Trends indicate no increase in personality disorder discharges since the start of the war. Of those separated for a personality disorder, more than 60 percent are discharged during their first 6 months on Active Duty and less than 5 percent have deployed. These data suggest that the Air Force uses administrative discharges to appropriately discharge airmen with longstanding personality issues that render them unsuitable for military service.

FEMALE WOUNDED WARRIORS

22. Senator MCCASKILL. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, I am interested in the physical and mental health needs of our female wounded warriors. Many studies have shown that women have particularly unique needs when it comes to mental health and that PTSD and TBI can sometimes be more difficult to diagnose in women. I was pleased that the NDAA for Fiscal Year 2008 included language that addressed potential unique needs of female wounded warriors. Are you confident that we are doing enough to recognize where there are differing needs for treatment of female wounded warriors?

Lieutenant General SCHOOMAKER. No, but we are using a variety of treatment interventions to address the unique needs of our female soldiers. When clinically appropriate, we will have female-only groups. We are attempting to hire 330 more civilian contract mental health providers (266 in the United States and 64 at our overseas locations), who will treat all soldiers. Our educational products, such as the Battlemind training programs and suicide prevention products, consider women as part of their target audience. More research is needed to assess the gender difference in the military population, specifically as related to global war on terrorism operations.

Vice Admiral ROBINSON. Navy has long recognized the importance of women's health issues and established a women's health program office in the Bureau of Medicine and Surgery many years before the onset of the global war on terrorism. I am confident that Navy health care providers are intimately familiar with the

varying needs of our heterogeneous beneficiary population, including those of our female wounded warriors. Through supplemental appropriations recently enacted to address PH and TBI diagnosis and treatment requirements among servicemembers, we have expanded access to care for all wounded warriors, which, in turn, allows us to more effectively address the unique needs of uniformed servicemembers, whether female or male.

Lieutenant General ROUDEBUSH. Since OEF/OIF are the first U.S. engagements where women have been exposed to combat stress in large numbers, we clearly have lessons to learn.

Trauma theory and treatment models fortunately have been developed through the study of responses to combat, disasters, motor vehicle accidents, sexual assault, and abuse trauma. Our current evidence-based trauma treatments have been used effectively with both men and women across the spectrum of exposures and trauma types. We are confident that our models of trauma adequately account for female trauma in terms of both assessment and treatment.

Nonetheless, the study of combat-related trauma and mild TBI in women remains in its infancy, and our Air Force and joint Service subject matter experts, in conjunction with experts from the Centers of Excellence and from academia, are now beginning to establish a body of literature that will help to improve our understanding in these areas.

23. Senator MCCASKILL. Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, are we doing enough to train our mental health and medical professionals to recognize differing symptom patterns? For example, do you have separate group counseling session for women when treating PTSD?

Lieutenant General SCHOOMAKER. We consider the uniqueness of every patient and provide the best possible treatment available, based on the individual patient's symptoms. In some of our facilities, however, we do offer separate counseling groups for women diagnosed with PTSD, when clinically appropriate. There is no centralized data base that allows us to track which facilities offer female only groups. We examine the specific needs of our female soldiers and strive to use treatment approaches that best meet their needs. We also partner with the VA and make use of their specialized programs for women experiencing PTSD. We will further review our training curriculum to ensure that we are offering adequate training to recognize differing symptom patterns in our women patients.

Vice Admiral ROBINSON. Using the congressional TBI and PH supplemental funds the Navy is implementing enhanced training to facilitate early recognition of stress injuries and appropriate initiation of clinical intervention at initial point of service. To achieve this goal we are using a two-tiered training approach. First, we are teaching the early recognition of stress injuries to a broad range of Navy caregivers; for example, physicians, nurses, corpsmen, chaplains, fleet and family service personnel. The stress injury continuum training that was started in September 2007 teaches awareness and intervention skills for stress reactions and those with stress injuries. Sailors and marines who show potential stress illness behaviors are referred to mental health for assessment. The second tier consists of enhanced training for the assessment and treatment of PTSD and mild TBI to primary care physicians and nurse practitioners. The goal is to initiate appropriate therapy for mild-PTSD and mild-TBI where sailors and marines receive their routine health care. The goals of this training are to enhance early recognition of problems that interfere with daily life, begin appropriate treatment in a non-stigmatizing care environment, and facilitate better use of limited mental health clinician services for more complex patients.

The treatment of PTSD uses a combination of cognitive behavioral therapy strategies, medications, individual, and group therapies based on a comprehensive assessment of individual symptoms and treatment goals. Specific decisions about what type of PTSD group therapy is most appropriate are dependent more on trauma exposure rather than gender. Decisions about participation in group therapy are made by the patient and their primary care provider. The trauma experiences of both women and men who have been sexually assaulted tend to have common issues around violation, powerlessness, and vulnerability and both genders can relate to those issues. Similarly, those exposed to violent crime and motor vehicle accidents have different trauma themes than those with combat stress injuries. It is also important to note that mixed trauma group therapy can be very effective for all participants regardless of gender or trauma if the individual is ready for group therapy and the clinicians address the diversity of trauma, commonality of post-trauma symptoms, and the effectiveness of recovery strategies.

Lieutenant General ROUDEBUSH. We know from the scientific literature on PTSD that women are at higher risk to develop PTSD than men and that they report twice

the lifetime prevalence of the disorder in the U.S. population. In the Air Force, female deployers are offered a comprehensive range of medical and mental health services to meet their needs as identified through our screening procedures. The Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA) employ the Primary Care PTSD Screen (PC–PTSD). The PDHRA also employs the PTSD Checklist-Military Version (PCL–M) for assessment of both male and female respondents who screen positive on the PC–PTSD. The choice of therapeutic modalities including individual, marital, or group therapy are generally determined collaboratively by the mental health provider and the patient to accommodate the needs of the patient. We are taking the mental health of our female deployers extremely seriously and are eager to incorporate the lessons learned from the Air Force, other Services, and the growing body of research in this area.

TRICARE AND MENTAL HEALTH ISSUES

24. Senator MCCASKILL. Vice Admiral Arthur, Dr. MacDermid, Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, should we expand TRICARE coverage to nonclinical mental health counseling? Isn't routine counseling a great way to prevent mental health issues from elevating and becoming more urgent and clinical in nature?

Vice Admiral ARTHUR and Dr. MACDERMID. The task force strongly supported access to routine counseling for servicemembers and their families. In recommendation 5.3.4.10, we recommended that TRICARE services be expanded to include treatment for 'V-codes,' such as partner relational problems, physical/sexual abuse, bereavement, parent-child relational problems, and other appropriate services. This was the single task force recommendation not endorsed by the Secretary of Defense. I believe the reason is that Military OneSource provides access to short-term non-medical counseling at no charge for all military members and their families.

Lieutenant General SCHOOMAKER. The Senior Army Leadership has identified a vital need to address nonclinical mental health counseling for soldiers and their families challenged by frequent and long overseas deployments. Ensuring the availability of comprehensive and sufficient nonclinical counseling services is a top Army priority. In partnership with the TRICARE Management Activity, we are seeking ways to deliver better and more comprehensive nonclinical mental health counseling for soldiers and their families. Army leadership is addressing this priority with the Assistant Secretary of Defense for Health Affairs.

Vice Admiral ROBINSON. Implementing guidelines of 32 CFR § 199.6, reflected in the TRICARE Policy Manual, already provide the necessary flexibility and support to leverage non-clinical mental health counseling and support to beneficiaries while supporting access to a higher level of care if symptoms worsen.

The issue of promoting mental health versus waiting to treat mental illness is crucial. The Navy and Marine Corps Operational Stress Control program teaches a form of stress first-aid that increases shipmate awareness of stress reactions, appropriate responses and helping those experience such stress reactions to seek further help. Providing, peers, family members, and unit leaders with the tools to help others deal with the stresses associated with daily life and crisis stressors will strengthen the most important factors for ensuring good mental health-social support and group cohesion. The next level of resources are the life-skills counseling services to help build enhanced coping options. If good social support and enhanced coping skills do not help to improve a servicemember's quality of life, clinical counseling and augmented social supports should be used.

Lieutenant General ROUDEBUSH. Non-clinical mental health counseling is widely available to Air Force members and their families, through Military OneSource and Military Family Life Consultants in our Airmen and Family Readiness Centers.

However, I do not support expanding TRICARE coverage to include non-clinical services. Maintaining a high degree of confidence in the Air Force Medical Service and TRICARE is best accomplished by covering the delivery of evidence-based mental health services by licensed mental health professionals. To maintain the highest standards of professional medical care, we must resist the temptation to consider the full range of needs and services that might benefit military members and families to be clinical in nature. We cannot maintain appropriate standards of care and practice fiscal responsibility if we expand our medical services in this manner. I submit that there are appropriate mechanisms to meet these needs as previously discussed and I support their continued availability as services distinct from medical care.

25. Senator MCCASKILL. Vice Admiral Arthur, Dr. MacDermid, Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, have you looked at the mental health professions and determined if we have professionals out there who could be providing care to our servicemembers that are currently being left out of the TRICARE system? Please discuss both clinical and non-clinical mental health professionals.

Vice Admiral ARTHUR and Dr. MACDERMID. In recommendation 5.3.3.3, the task force recommended that a full spectrum of mental health professions be used to support the PH of servicemembers and their families. A companion recommendation is 5.2.3.3., which recommends that mental health professionals apply evidence-based clinical practice guidelines.

The task force received testimony from several practitioner organizations seeking greater inclusion in the TRICARE system. We believe that TRICARE should constantly be monitoring the development of mental health professions, and when a profession has matured to the point that its training and certification procedures are such that there can be adequate confidence in the quality of care the members of that profession are likely to provide, then that profession should be included in TRICARE spectrum.

Lieutenant General SCHOOMAKER. Currently, we are making extensive use of clinical and non-clinical mental health providers. Clinical personnel include psychiatrists, psychologists, social workers and psychiatric social workers. Our clinical personnel need to be licensed and credentialed, so that we can be assured we have the best quality providers. We also provide nonclinical mental health support through the Military and Family Life Consultant (MFLC) Program which provides short-term, nonmedical counseling services to military families. MFLCs can help people who are having trouble coping with concerns and issues of daily life. Counselors and other nonclinical mental health professionals often provide support and counseling at our schools. In addition, Military OneSource (MOS) is staffed by both clinical and nonclinical mental health professionals. Military OneSource supplements existing family programs by providing a website and a worldwide, 24-hour, 7-day-a-week information and referral telephone service to all Active, Guard, and Reserve soldiers, deployed civilians and their families. Military OneSource services are provided at no-cost to the soldier.

There are many clinicians who have not signed up to be TRICARE providers. Anecdotally, providers claim difficulties with paperwork, reimbursement, and interference in medical decisions. The TRICARE Management Activity (TMA) is working to resolve these issues and urging more providers to sign up. Since May 2007, an additional 2,800 behavioral health providers have joined the TRICARE network. In addition, TMA recently required the Managed Care Support Contractor (MCSC) to establish toll-free Behavioral Health Provider Locators and Appointment Assistance Services. This service allows soldiers and their families to call the MCSC to receive assistance with locating a network mental health provider.

Vice Admiral ROBINSON. The MCSCs have developed and continue to refine comprehensive provider networks supporting the MHS including nonclinical mental health professionals (Counselors, Pastoral Counselors, and Licensed Clinical Social Workers). Although there is variability with the reporting format from three contractors, it appears that the majority of the networks include nonclinical mental health professionals. Although the capacity exists in the majority of the networks, the overall use of nonclinical mental health care support may be impacted due to referral patterns and the level of knowledge required of the health plan by network providers (primary care managers (PCMs)). The PCMs may not be leveraging the support from nonclinical mental health professionals in their efforts to provide care. This presents an education and marketing opportunity for TMA to ensure that existing capabilities within the health care plan are clearly articulated to network PCMs.

Lieutenant General ROUDEBUSH. There will always be a certain percentage of providers who make a choice not to participate in the TRICARE program, just as they make that same choice for other health plans. The real issue is not whether all providers accept TRICARE but if there are adequate numbers of providers accepting it in the areas where our servicemembers and families live. The provider's choice to participate in TRICARE is contingent upon a whole list of variables. There are undoubtedly methods by which TRICARE could increase its attractiveness to potential providers, including simplicity of claims filing, increased responsiveness to questions, and reimbursement rates. As the TRICARE program is not a Service program but in fact a DOD program, none of these changes are within the Services' ability to implement. We work closely with the TMA to identify locations that appear to have issues with access to medical care. They in turn work through the Managed Care Support contractor to contact providers in that area to encourage them to participate in the TRICARE program.

26. Senator MCCASKILL. Vice Admiral Arthur, Dr. MacDermid, Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, how are reimbursement rates in TRICARE affecting access to mental health care for our servicemembers?

Vice Admiral ARTHUR and Dr. MACDERMID. The task force was repeatedly told during its site visits that low TRICARE reimbursement rates are a disincentive to participation in the system. Of course, many practitioners would say the same about reimbursement rates for other government programs, so TRICARE is not unique. Military families are unique, however, in their service to the country in times of war and thus may merit special treatment. According to what we were told, slow reimbursement and cumbersome application processes are additional barriers.

Lieutenant General SCHOOMAKER. The Supplemental Health Care Program (SHCP) is the process for providing soldiers health care services from civilian providers. TRICARE reimbursement under SHCP uses the same reimbursement rate system as the rest of the TRICARE program. There is also a reimbursement waiver system in place to pay higher reimbursement amounts to ensure appropriate access to care for soldiers. This system allows the Managed Care Support Contractors (MCSCs) to increase rates up to 115 percent of the maximum allowable charge. If this increase does not improve access, the MCSC will determine the lowest rate the provider will accept. The MCSC will request approval of this higher reimbursement amount from the TMA.

Additionally, TMA continues to assess civilian provider acceptance of TRICARE patients. The results of TMA's 2007 survey of civilian providers show that only 55 percent of psychiatrists accepting new patients will accept TRICARE new patients. Approximately 25 percent of providers noted reimbursement rates as the main reason they will not accept TRICARE patients. Fortunately, title 10 provides the DOD the flexibility to approve higher reimbursement amounts in order to obtain adequate access to health care services. TMA is currently performing a nationwide analysis of access to mental health services. This analysis will evaluate the impact of reimbursement rates on mental health access. Where appropriate, TMA will have the ability to increase rates to improve access.

Vice Admiral ROBINSON. The Managed Care Support Contractors (MCSCs) monitor network adequacy and provide monthly Network Status/Inadequacy Reports—Network Management Activities. Reports are forwarded to the Regional TMA with copies provided by the Regions for Service review and comment.

Recent reports provide the following information related specifically to mental health:

- Shortage of Psychiatrists in Brunswick, ME—Naval Air Station [Require four Psychiatrists and we have two]
- Shortage of Psychiatrists and Psychologists in the area around Naval Hospital Cherry Point
- Shortage of Psychiatrist in the area around Naval Air Station Springfield, Missouri [require one more Psychiatrist]
- The contractors have not indicated that the above shortages are attributed to low reimbursement rates
- Shortage of Psychologists in the area around Yuma USMC/El Centro area [four Psychologist refusing to contract because they do not need additional business]
    - Two factors may attribute to the above shortage:
        - Anecdotally, this may be attributed to low reimbursement rates: the reimbursement rate may not be enough for the local psychologists to increase their availability
        - Or, it may be attributed to the fact that there are limited qualified behavioral health providers within this area and the demand is beyond the local capacity.

We have and continue to experience shortages of ENT, Anesthesiology, and Plastic Surgery in the area around Twentynine Palms. The MCSC (TriWest) continues to pursue these specialties despite the reluctance of providers to contract due to low reimbursement rates.

Although we have seen other surgical and medical specialties refuse to join the TRICARE network due to low reimbursement rates, we are not attributing shortages with mental health providers to reimbursement rates; other than the anecdotal information on the providers in Yuma USMC/El Centro. Standard reimbursement rates in areas that have high demand and low mental health resources may not be sufficient to entice or reward providers to offer preferred access to TRICARE beneficiaries.

Lieutenant General ROUDEBUSH. According to the DOD/HA survey, Civilian Physician Acceptance of New Patients Under TRICARE Standard, conducted from fiscal years 2004–2007, of those physicians not accepting new patients, the number one reason was reimbursement. This ranged, as the number one reason, from 23.6 percent to 28 percent for the 4 years of the survey. The second highest reason for not taking new TRICARE Standard patients was the physician was not available or was too busy.

The specialty least likely to accept any new patients, regardless of whether they were TRICARE, was psychiatry with only 89.4 percent accepting any new patients. Psychiatry is also the least likely specialty to accept new TRICARE Standard patients, with only 48.8 percent stating they would take new TRICARE Standard patients.

Taking those two survey results into consideration, it could be deduced that reimbursement rates are in fact affecting the decision of providers to accept new TRICARE patients.

27. Senator MCCASKILL. Vice Admiral Arthur, Dr. MacDermid, Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, do we have a problem getting mental health professions to enroll in and participate in the TRICARE network?

Vice Admiral ARTHUR and Dr. MACDERMID. During site visits, the task force was not told of difficulties getting professions to accept TRICARE, but was told that professionals are sometimes reluctant, for the reasons outlined above. Or professionals might accept TRICARE but severely limit the number of TRICARE patients that will be seen, in order to minimize negative financial impact on their practice.

Lieutenant General SCHOOMAKER. Participation in the TRICARE network by mental health providers varies from market to market. The 2007 TMA nationwide survey shows that psychiatrists have the lowest acceptance of TRICARE patients when compared to all other provider types. The Managed Care Support Contractors are aware of the increased demand for mental health services and are actively engaged in the recruitment of mental health providers.

Vice Admiral ROBINSON. The TRICARE Program is managed by OSD(HA). While some Navy Medicine beneficiaries utilize TRICARE, we do not have any direct oversight over the mental health manning issues that TRICARE may have. We do however, monitor network adequacy reports provided by the Managed Care Support Contractors.

Lieutenant General ROUDEBUSH. Getting mental health professionals to enroll in and participate in the TRICARE network is challenging. Currently there is a nationwide shortage of mental health professionals. Several task forces, including the recent Mental Health Task Force, identified several critical shortfalls within this specialty area. As we generate additional requirements in an environment where there is no unused capacity, Alaska for example, we will find these shortages increasing.

28. Senator MCCASKILL. Vice Admiral Arthur, Dr. MacDermid, Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, what do you think we need to do to get more mental health professionals accepting TRICARE?

Vice Admiral ARTHUR and Dr. MACDERMID. According to what we were told on site visits, raise reimbursement rates, speed processing of claims, and reduce administrative burden.

Lieutenant General SCHOOMAKER. The DOD has the authority to adjust TRICARE reimbursement rates in specific markets for specific specialties. The TMA is currently performing a nationwide analysis of access to mental health services. The nationwide review by TMA will indicate which areas are having problems with mental health access and which area may be candidates for an increase in reimbursement rates.

Vice Admiral ROBINSON. The TRICARE Program is managed by OSD(HA). While some Navy Medicine beneficiaries utilize TRICARE, we do not control general contract terms and other conditions that are set by OSD(HA).

Lieutenant General ROUDEBUSH. The DOD/HA survey, Civilian Physician Acceptance of New Patients Under TRICARE Standard, conducted from fiscal years 2004–2007, indicated that the number one reason physicians were not accepting new patients was reimbursement. This answer ranged from 23.6 percent to 28 percent for the 4 years of the survey. The second highest reason for not taking new TRICARE Standard patients was their practices were full. This answer ranged from 3 percent to 18 percent for the 4 years of the survey. A few other reasons were listed but were significantly less likely to result in a physician not taking new TRICARE patients.

Based on this data, it appears the area that would most likely result in increased provider acceptance of TRICARE would be in the reimbursement arena.

29. Senator MCCASKILL. Vice Admiral Arthur, Dr. MacDermid, Lieutenant General Schoomaker, Vice Admiral Robinson, and Lieutenant General Roudebush, what are we doing or should we be doing, in particular, to ensure mental health care access to servicemembers living in rural and remote areas, such as Guard members who demobilize in rural parts of Missouri?

Vice Admiral ARTHUR and Dr. MACDERMID. Like their civilian counterparts, military families living in rural areas face several problems in accessing care for PH. There is a well-known shortage of providers, such as psychologists and psychiatrists, in such areas. There are now fewer military installations than in the past. Another problem is that the civilian providers who are present in these areas may be whom they come in contact.

Many advocacy, professional and government organizations are working on the problem of reaching rural families, and it seems clear that a multi-pronged strategy is required. Elements of such a strategy likely include: a) increasing the number of military professionals who can be assigned to military installations as needed; b) creating incentives for civilian professionals to locate in underserved areas; c) increasing the number of DOD family assistance centers and VA vet centers; and d) increasing use of technology, such as web-based self-assessment and education, telephone-based counseling, telemedicine, and other emerging strategies.

Lieutenant General SCHOOMAKER. Military OneSource now offers six telephonic mental health counseling sessions which U.S. Army Reserve and National Guard soldiers can use in remote areas. Additionally, in December 2007, the TMA required the Managed Care Support Contractors (MCSC) to establish toll-free Behavioral Health Provider Locators and Appointment Assistance Services. This service allows soldiers and their families to call the MCSC and receive assistance locating a network mental health provider. The provider locator and assistance staff have assisted more than 1,500 beneficiaries successfully locate and make mental health appointments. This often requires the locator staff to conference call with the beneficiary and provider to ensure a satisfactory appointment.

Since October 2006, the Army Wounded Warrior Program has placed approximately 35 staff at VA Medical Centers around the country to assist wounded warriors, veterans, and their families access needed health care and social support services. Additionally, Warrior Transition Unit Forward Teams, formerly called AMEDD VA Liaisons, are assigned to VA Polytrauma Rehabilitation Centers. These uniformed personnel are strengthening the links between Army Medical Treatment Facilities, Warrior Transition Units, VA medical facilities, and civilian facilities. Some of their outreach efforts are directed at Army National Guard and U.S. Army Reserve soldiers.

Family support is also part of the Army Family Covenant Initiative and the Army Campaign Plan. The Army Family Covenant Initiative is an approach to standardize and fully fund family programs and services to support an expeditionary Army. The Army Integrated Family Support Network (AIFSN) is a service delivery system that is part of this initiative and will integrate all the programs and services currently operational in a State or region, like the Beyond the Yellow Ribbon Program, which is a program built specifically for National Guard soldiers and their families. The purpose of the Beyond the Yellow Ribbon Program is to provide concise, coordinated, and unified support to our citizen-soldier and their families to ensure a safe, healthy, and successful reintegration following deployments. Connecting programs, like Beyond the Yellow Ribbon, to AIFSN will provide a conduit for the Army to better prepare and care for all of its soldiers.

Vice Admiral ROBINSON. We have implemented several programs and initiatives to ensure that sailors and marines are provided mental health support during and after demobilization. Each of the Uniformed Services promote and participate in "Military OneSource"—a DOD web-based program providing comprehensive information and assistance (including guidance for obtaining counseling) for servicemembers. It also offers 24-hour/7-day-per-week toll free telephone access for assistance and support. During demobilization, sailors and marines receive briefings on post-deployment medical and dental benefits including those available through the Transitional Assistance Management Program (TAMP), TRICARE Reserve Select (TRS), as well as information and resources available at Navy and Marine Corps Reserve Centers.

TAMP offers transitional TRICARE coverage for up to 180 days following separation for eligible members and their families. National Guard and Reserve members separated from Active Duty after having been ordered to Active Duty for more than

30 days in support of a contingency operation are eligible for this coverage. Eligible members and family members include those who are:

- Involuntarily separated from Active Duty
- Separated from Active Duty after being involuntarily retained in support of a contingency operation.
- Separated from Active Duty following a voluntary agreement to stay on Active Duty for less than 1 year in support of a contingency mission.

To retain coverage, members must reenroll in TRICARE Prime during their transition period. This enables servicemembers and their families to access support through the Behavioral Health Provider Locater and Appointment Assistance Program, provided by all three Management Care Support Contractors. This program offers 24-hour/7-day-per-week assistance in locating and obtaining behavioral health care.

In addition to service described above, Navy Medicine ensures that Post-Deployment Health Centers actively support completion of PDHAs, for Active and Reserve component members, to monitor the needs of servicemembers.

Navy medicine has used a portion of the TBI and PH Supplemental to fund additional support for Naval Reserve personnel. The Navy Reserve has received $2.64 million worth of support to establish the Navy Reserve Psychological Health Outreach Program. The goals for this pilot program are to:

- Create a PH "safety net" for Navy reservists and their families, who are at risk for not having their stress injuries identified and treated in an expeditious manner;
- Improve the overall PH of Navy reservists and their families; and
- Identify long-term strategies to improve PH support services for reservists and their families.

Outreach Coordinators will also be responsible for:

- Coordinating "Returning Warrior Workshop" presentations in conjunction with Navy Reserve Component Command Family Readiness Coordinators and members of the Chaplain Corps;
- Working with the Navy Reserve PDHRA program manager to ensure reservists follow through with recommended or requested referrals to mental health care providers; and
- Facilitating access to PH support resources for Navy Reserve family members.

With respect to specific concerns you expressed regarding rural Missouri, I would offer that, while there have been some difficulties in maintaining a robust network at Naval Air Station Springfield, and the surrounding area, the Managed Care Support Contractor (TriWest) is proactively addressing the shortage (one provider) with psychiatrists. TriWest has contracted 11 Mental Health Counselors to improve mental health access within this area. We are also exploring partnering with the University of Missouri in using their curriculum for the Training Enhancement in Rural Mental Health program to expand the capabilities of our primary care providers, both Active and Reserve component, to care for patients with higher level behavioral health problems.

Lieutenant General ROUDEBUSH. The Military Medical Support Office (MMSO) serves as the centralized Tri-Service point of contact to coordinate health care outside the cognizance of a Military Treatment Facility for TRICARE Prime Remote-eligible Active Duty military and Reserve component servicemembers within the 50 United States and District of Columbia. The MMSO assists the member in finding providers and ensuring smooth claims processing. The Air Force has three full-time military members at the MMSO ensuring these members receive timely assistance.

[Whereupon, at 4:46 p.m., the subcommittee adjourned.]