STATEMENT ON

MENTAL HEALTH

BY THE HONORABLE S. WARD CASSCELLS, MD

ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

ARMED SERVICES COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 14, 2008

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

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

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

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

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

DoD Psychological Health Programs

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

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

- Access to care coordination and transition within the Department of Defense (DoD)/Department of Veterans Affairs (VA) systems of care; and

- Robust epidemiological, clinical, and field research.

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

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

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

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

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

- that mental health is not just the province of the psychiatrist but also the psychologist, nurse, social worker, medic, spouse, noncommissioned officer and company commander;

- that psychological health is not just about medications but has to do with genes, childhood, education, work and family;

- that prevention involves education, rest, nutrition, exercise and matching Service members with assignments where they are challenged but know they can succeed;

- that our Service members must understand that it takes strength to ask for help;

- that it is their duty to reach out to battle buddies who are struggling; and

- that doctors need to take a scientific look at the therapies people use on their own, such as alcohol and vitamins, and those which hold promise but are not yet well established, such as music, art, sunshine, biofeedback, medication and others.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DoD also provides a broad array of support systems and services to the military community. Services available at military installations include health and wellness programs, stress management, family readiness and community support centers, family

readiness groups, ombudsmen, volunteer programs, legal and educational programs and chaplains, among many other community programs.

Service Programs, Goals and Outcomes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TRICARE Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

- END -