[H.A.S.C. No. 111–155]

IMPLEMENTATION OF THE REQUIREMENT TO PROVIDE A MEDICAL EXAMINATION BEFORE SEPARATING MEMBERS DIAGNOSED WITH POST–TRAUMATIC STRESS DISORDER (PTSD) OR TRAUMATIC BRAIN INJURY (TBI) AND THE CAPACITY OF THE DEPARTMENT OF DEFENSE TO PROVIDE CARE TO PTSD CASES

HEARING

BEFORE THE

MILITARY PERSONNEL SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

HEARING HELD
APRIL 20, 2010

U.S. GOVERNMENT PRINTING OFFICE
58–290 WASHINGTON : 2010

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

MILITARY PERSONNEL SUBCOMMITTEE

SUSAN A. DAVIS, California, *Chairwoman*

VIC SNYDER, Arkansas
LORETTA SANCHEZ, California
MADELEINE Z. BORDALLO, Guam
PATRICK J. MURPHY, Pennsylvania
HANK JOHNSON, Georgia
CAROL SHEA-PORTER, New Hampshire
DAVID LOEBSACK, Iowa
NIKI TSONGAS, Massachusetts

JOE WILSON, South Carolina
WALTER B. JONES, North Carolina
JOHN KLINE, Minnesota
THOMAS J. ROONEY, Florida
MARY FALLIN, Oklahoma
JOHN C. FLEMING, Louisiana

MICHAEL HIGGINS, *Professional Staff Member*
JEANETTE JAMES, *Professional Staff Member*
JAMES WEISS, *Staff Assistant*

CONTENTS

CHRONOLOGICAL LIST OF HEARINGS

2010

TUESDAY, APRIL 20, 2010

IMPLEMENTATION OF THE REQUIREMENT TO PROVIDE A MEDICAL EXAMINATION BEFORE SEPARATING MEMBERS DIAGNOSED WITH POST–TRAUMATIC STRESS DISORDER (PTSD) OR TRAUMATIC BRAIN INJURY (TBI) AND THE CAPACITY OF THE DEPARTMENT OF DEFENSE TO PROVIDE CARE TO PTSD CASES

STATEMENTS PRESENTED BY MEMBERS OF CONGRESS

WITNESSES

APPENDIX

IMPLEMENTATION OF THE REQUIREMENT TO PROVIDE A MEDICAL EXAMINATION BEFORE SEPARATING MEMBERS DIAGNOSED WITH POST–TRAUMATIC STRESS DISORDER (PTSD) OR TRAUMATIC BRAIN INJURY (TBI) AND THE CAPACITY OF THE DEPARTMENT OF DEFENSE TO PROVIDE CARE TO PTSD CASES

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Tuesday, April 20, 2010.

The subcommittee met, pursuant to call, at 5:35 p.m., in room B–318, Cannon House Office Building, Hon. Susan A. Davis (chairwoman of the subcommittee) presiding.

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

Mrs. DAVIS. The hearing will come to order.

Today the subcommittee will hear testimony about the efforts of the Department of Defense (DOD) to implement Section 512 of the National Defense Authorization Act, Fiscal Year 2010.

The section requires the Secretaries of the military departments in certain cases to conduct a medical examination before administratively separating a member under less than honorable conditions if the member has been deployed overseas in support of a contingency operation.

The purpose of the examination is to evaluate a medical diagnosis or assertion by the member that Post-Traumatic Stress Disorder, PTSD, or traumatic brain injury, TBI, might have caused the behavior that resulted in the commander's decision to pursue separation. The subcommittee considered this legislation at the request of the gentleman from North Carolina, Mr. Jones, who, unfortunately, is not able to be here, and I want to commend Mr. Jones for bringing this issue before the attention of the subcommittee.

I agree with the gentleman that it is unacceptable that the military departments were separating service members because of misconduct that was caused by a PTSD or TBI injury that occurred during his or her combat tour. Now that we know so much more about the extent of those injuries in the force, we owe every returning service member the assurance that we will not punish them for an injury that resulted from combat service.

The unfortunate truth is that we have very likely already separated a number of service members where the commanders did not consider that the member was experiencing the consequences of

PTSD or TBI. That is why the provision we adopted last year also requires the Discharge Review Boards in the military departments to provide expedited review of cases that involve a diagnosis or assertion of the influence of PTSD or TBI.

We intend to learn about the status of DOD efforts to implement this law and improve the general access to mental health care. As always, if the Congress needs to do more, we would like to know what further action is needed.

I want to welcome our witnesses here today. We are very pleased that you are here joining us. Mr. Bill Carr, Deputy Under Secretary of Defense, Military Personnel Policy Officer of the Under Secretary of Defense for Personnel and Readiness; and Dr. Charles Rice, MD, Dr. Rice is performing the duties of the Assistant Secretary of Defense for Health Affairs and is president of the Uniformed Services University (USU) of Health Sciences.

Again, we are pleased that you are here and look forward to your discussion.

Mr. Wilson, do you have any comments you would like to make?

[The prepared statement of Mrs. Davis can be found in the Appendix on page 25.]

STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, RANKING MEMBER, MILITARY PERSONNEL SUBCOMMITTEE

Mr. WILSON. Thank you, Chairwoman Davis, for holding this hearing.

I believe Congress and this nation has no greater responsibility than to provide the care and support needed by members of our armed forces, who endure the horrors of war to protect our freedom.

I am aware of the challenges the Department of Defense and the Department of Veterans Affairs (VA) have in providing mental health care to the growing numbers of combat veterans returning with Post-Traumatic Stress Disorder and traumatic brain injury. I am also aware that the legislation Congress passed last year requiring medical examinations prior to administratively separating service members who may be experiencing Post-Traumatic Stress Disorder or traumatic brain injury may increase the burden on the two departments. But that does not mean we should allow one combat veteran to slip through the cracks and be discharged from the service without the proper recognition of and medical benefits for the mental health issues they may be facing.

As a former president of Mid-Carolina Mental Health Association, I especially appreciate mental health care. Thankfully, the mental health profession now understands that Post-Traumatic Stress Disorder and traumatic brain injury may cause behaviors that previously would only be considered reasons to administratively discharge service members.

Identifying the underlying mental health issues and brain injuries is often further compounded by a service member's reluctance to seek help. Too often they are self-medicating, which leads to behavior problems. Simply discharging these troops without the possibility of necessary medical care is not the answer. We owe it to our combat veterans and their families to proper diagnose combat-

related mental health and brain injury issues and to provide the care, regardless of cost, to facilitate their recovery.

I am interested in hearing from our witnesses today how the Department of Defense is providing the required medical exams before separating a service member. I am particularly interested in how you are accomplishing this, given the recognized shortage of mental health providers. I would also like to know how many previously discharged service members have been screened by the Discharge Review Board and how many have been identified with Post-Traumatic Stress Disorder or traumatic brain injury. Finally, I would like to know how we can help.

With that, I welcome our witnesses and thank them for participating in the hearing today. I look forward to your testimony.

[The prepared statement of Mr. Wilson can be found in the Appendix on page 27.]

Mrs. DAVIS. Thank you, Mr. Wilson.

I want to ask unanimous consent that Congressman Bill Pascrell be allowed to participate in the hearing.

Without objection, so ordered.

I know that you have a plan to present short opening statements, and without objection, your full statements will be entered into the record.

Mrs. DAVIS. Do I understand, Mr. Carr, you are going to start? Oh, Dr. Rice. Okay, please proceed.

STATEMENT OF CHARLES L. RICE, M.D., PRESIDENT, UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES, PERFORMING THE DUTIES OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, U.S. DEPARTMENT OF DEFENSE

Dr. RICE. Thank you, Madam Chair and distinguished members of the committee, it is a pleasure to join my colleague, Mr. Carr, the Deputy Under Secretary For Military Personnel Policy, and thank you for the opportunity to discuss with you today our efforts to both implement the requirements for pre-separation medical examinations for service members diagnosed with Post-Traumatic Stress Disorder or traumatic brain injury, and to ensure that we have the resources to meet the demand for behavioral health services.

DOD continues to apply the necessary resources to develop and improve policies and programs that address all behavioral health issues for our service members. Our clinical programs provide a continuum of care, whether through prevention, treatment, rehabilitation, reintegration, or transition.

DOD screens all service members returning from the operational theater for potential traumatic brain injury. Although positive screens are not necessarily diagnostic of traumatic brain injury, they do trigger the requirement for further evaluation by a clinician. TBI screening of service members can occur at several time points and locations. Our Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) patients who are medically evacuated from the combat theaters are screened at Landstuhl Medical Center in Germany. In addition, all service members will be screened

after any deployment and upon admission to a VA health care facility.

All service members identified as having sustained a traumatic brain injury, whether from deployed or non-deployed locations, are provided care following evidence-based clinical care guidelines to ensure maximum treatment benefits for any level of severity of their traumatic brain injury.

Similar guidelines also exist for Post-Traumatic Stress Disorder. DOD providers not only have very detailed treatment guidelines but receive ongoing training and education on the screening, diagnoses, common symptoms, and recognized treatments for TBI and PTSD.

Regarding DOD's policy on separation examinations, service members scheduled for separation from active duty must have had a physical examination within 12 months prior to separation and a termination evaluation for any occupational exposure in which they are enrolled. Waivers to this policy are granted only when both the service member consents and the unit commander concurs. Service members with work limitations related to TBI or PTSD must be referred for a medical board to determine fitness for retention and may receive a disability evaluation and separated appropriately.

The Joint Executive Council has recently directed establishment of a DOD VA work group to reexamine and make recommendations concerning our separation examination policies.

Regarding our ability to meet the demand for behavioral health services, we are addressing access issues with every tool available. Our active duty mental health professionals are largely focused on serving those in uniform. We have placed an unprecedented number of these professionals into the combat theaters. We have also increased our capacity to leverage a combination of contracted professionals in our medical facilities and on our managed care support contractor networks in the civilian community to serve the needs of our families.

Our VA partners are part of the network, and within the medical treatment facilities (MTFs), the services have contracted for additional mental health specialists to augment existing staff, adding almost 2,000 additional mental health providers to our direct care system.

We have entered into a collaborative relationship with the United States Public Health Service (PHS) that has resulted in over 130 PHS officers either assigned or in the process of being assigned into DOD positions, and we are making significant progress in bringing those resources on board.

TRICARE management activity monitors the adequacy of the TRICARE civilian network, and we work with our TRICARE contractors to find remedies for service areas that are not meeting our standards for access. In 2009, we established a new program within TRICARE in which telephone mental health services may be offered to beneficiaries, providing the opportunity to address medically underserved populations by using resources that are available in other communities.

We have also established the TRICARE Assistance Program, called TRIAP, which permits beneficiaries to contact a counselor for

assessment and advice via the Internet. And finally, our managed care support contractors offer a health care finder capability for TRICARE prime beneficiaries to assist service members and their families in locating mental health providers who accept TRICARE.

VA medical facilities also provide services for post-traumatic stress and other mental health problems to our beneficiaries through both local and national resource sharing agreements. While we offer patients choice in facilities, they can use these facilities and resources when they are proximate and they can provide timely access to care.

Madam Chair and distinguished members of the committee, thank you again for inviting us here today. The Department is working constantly to improve and to monitor the content and performance of these examinations. We look forward to actively participating in the Joint Executive Committee Working Group focused on this important issue. We hope to gain valuable insight that will enhance the evidence-based guidelines we use in the process. We are intently focused on ensuring available behavioral health services to those we serve, to include when they are ready to separate and require examination.

We are both pleased to answer to any questions you have and to participate in a continuing dialogue to better serve our current and former service members.

[The joint prepared statement of Dr. Rice and Mr. Carr can be found in the Appendix on page 29.]

Mrs. DAVIS. Thank you very much, Dr. Rice.

And that would be your statement as well, Mr. Carr.

STATEMENT OF WILLIAM J. CARR, DEPUTY UNDER SECRETARY OF DEFENSE FOR MILITARY PERSONNEL POLICY, OFFICE OF THE UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS

Mr. CARR. It would be. I would just add one thing to put in historical context. The committee's actions on 512 were timely, and they are producing results.

To put it in historical context, if we went back to the time when I was a company commander in the 1970s, you had a different type of soldier than you would have today, and you could have a motivational problem, or you could have a distressed psychological condition. And so you would, perhaps, refer the soldier to a psychiatrist, and a diagnosis, if it came back a personality disorder, then the separation would be immediate. And, therefore, it was often used.

As we ran into 2008, the question arose, has that become a practice where we would look toward a personality disorder, which is an expedient separation of a problem, when it was masking, just as the committee did in 512, when it was masking PTSD? And we decided it could. And so the rule we established was that in the event that you ever separated someone who had been deployed in the past 24 months, then you had to rule out PTSD. And if you didn't want to do that, then you could have an exception but the exception had to be sent to the surgeon general of the service, so it was clearly administratively something a commander would never do because it was simply too much.

That had the same impulse that 512 did, and that was to guard against PTSD and the possibility that we could do harm administratively to someone who was doing the best they could and suffered and was separated for some reason other than their disability. So those actions have taken place, and we applaud 512 to this day.

[The joint prepared statement of Mr. Carr and Dr. Rice can be found in the Appendix on page 29.]

Mrs. DAVIS. Thank you. I appreciate your sharing that with us because we know this is a somewhat different time.

We are going to want to talk about the needs, the capacities, certainly, of the mental health community within the services and the general population as well, and being able to meet these requirements as well as having the numbers really to review a number of these cases.

But I wanted to focus initially on the commanders in the field and talk about how we are educating them and the role that you think they are actually playing in trying to assess the severity or the possibility that someone could be suffering with PTSD or TBI. One of the things we know is how difficult it is to diagnose and certainly in a subjective fashion to be able to get that information, but yet the commander plays a pretty significant role. What are we doing, and what is the status of that? How do you think we are doing in trying to move that area forward?

Mr. CARR. The first is for the commanders. We use the term PTSD, but what does it mean? How do you spot it? What does it mean in concrete terms? If you can express it in a way that they comprehend, then the likelihood of their uniting that circumstance with medical help is that much greater. The Army and the Marine Corps have active programs and training where they instruct the field in the terms.

For example, for PTSD, my point before this was that commanders have guides that allow them to take a situation that presents and make some more rational and informed judgment as to whether or not the symptoms they are seeing represent PTSD. And for example, some of the instruction presents to them that if the person reports disturbing memories and disturbing dreams, reliving and so forth, those are things we would all say, yes, I recognize that now as PTSD.

But unless we actively say it to the chain of command, then they will hear it, and they won't understand the medical significance of what they have just heard. So the education and training programs of the Army and the Marine Corps and making sure commanders know that.

Mrs. DAVIS. Can you be more specific in helping us understand? I think in the testimony there was some notion of how much time is spent, but what does that look like in terms of that training?

Mr. CARR. It would take the form of about one hour training, and I am going to have to, I am sorry, I will have to confirm back to you exactly how it would play out for a unit at let's say Fort Bragg, what specifically do they experience? I would be glad to provide that back. There are a number of references on the Web that are available to those who go look for them, and they are easily found. But I think the question from the Chair is, what do we present so

it is deliberately placed before the chain of command so that these terms are described? And I am sorry, I can't define that now, but I will provide that.

[The information referred to can be found in the Appendix on page 47.]

Mrs. DAVIS. Dr. Rice.

Dr. RICE. Yes, ma'am.

Madam Chair, I think it is important to emphasize that the emphasis on this comes from the very top. General Chiarelli, the Vice Chief of Staff of the Army; General Amos, the Assistant Commandant of the Marine Corps, have talked about this over and over and over again with their commanders. Once a month, for example, General Chiarelli has a video teleconference with all of his commanders where a suicide has occurred, and the general officer at that particular post or station is there to report on what were the specific circumstances that led up to the suicide.

Obviously, we don't want to be tumbling to this problem after a suicide has been completed, but I think it does bring to bear the fact that the emphasis from the Vice Chair, Vice Chief and from the Assistant Commandant is continuous; it is important, and they are very emphatic about making sure that it gets disseminated down the chain of command.

I think the other, in addition to the point that Mr. Carr made, the other place that it is really important is at the senior noncommissioned officer level, because those are the people who are really in day-to-day contact with the troops. Education in this area has been incorporated into the sergeant major course, for example. All of the senior noncommissioned officer (NCO) leaders are taught about how to recognize various aspects, and the details and content of those courses are something, like Mr. Carr, I would have to get back to you on.

[The information referred to can be found in the Appendix on page 47.]

Mrs. DAVIS. Thank you very much, because I think we all know how long it takes the medical professional to be able to describe and understand, and I think there is a great deal for our commanders to be doing, and certainly the officers. And it is difficult to even find some of the time for that. But I think that, while we had a great deal of emphasis early in the last few years and had to focus a great deal on suicide in the units, I think that we want to be sure that we are spending enough time doing that, because in many ways, they really are the critical factor in this.

Dr. RICE. Yes, ma'am, I think that is exactly right. I think the most important thing that the commander or the senior NCO does is to convey to a member of his unit it is okay to go ask for help. It takes a strong person to do that.

Mrs. DAVIS. Mr. Wilson.

Mr. WILSON. Thank you, again, for both of you being here.

Mr. Carr, how has DOD reached out to former military members who are administratively discharged, separated, to inform them of the opportunity to request a review of their separation through the Discharge Review Board (DRB)? And to date, how many individuals have requested such a review?

Mr. CARR. The outreach was through media principally to ensure that it reached cities and towns. And to date, the number is relatively low, 129 Army have applied to the Discharge Review Board. So it was a media effort.

Mr. WILSON. A media effort. And also, I am sure for persons discharged, you all send—I have seen them—periodic newsletters to the discharged personnel, and it would have been in that publication, too, wouldn't it?

Mr. CARR. I am almost sure it was in those publications as well.

Mr. WILSON. Inadvertently, one of my sons who served a year in Iraq, I kept getting his mail, and it was really very enlightening and very encouraging to me how helpful the information that was provided, and of course, I would get it to him right away. And then they got his correct address.

What is your plan for providing additional mental health assets required for the pre-separation exams and the Discharge Review Boards, how many additional personnel do you anticipate needing? Additionally, I am very grateful, I work with a volunteer organization called Hidden Wounds of Columbia, South Carolina, which is serving as a back-up for discharged personnel. They are actively promoting mental health assistance, and so it is DOD, VA, and then volunteer organizations, but how many more personnel do we need?

Mr. CARR. For the Discharge Review Board function, as long as the criteria are kept broad, for example, we don't stipulate a grade and whether active or reserve and are not overly restrictive in the academic disciplines, my understanding is that the manning requirements will be met for the DRBs, that that wouldn't impose the restraint on the flow of applications.

Mr. WILSON. And it is encouraging to me, I went to a pancake breakfast to raise money for Hidden Wounds, and the VA had a table set up there with personnel from the VA hospital. I could see it was a really positive interaction between volunteer organizations and DOD and personnel and VA personnel.

Mr. CARR. Yes, sir.

Mr. WILSON. It is my understanding the same neuro-cognitive assessment test used for pre-deployment assessment is not authorized for post-deployment assessment of our returning soldiers in the Army. Do you feel this is a violation of the law in the fiscal year 2008 National Defense Authorization Act aimed to create a comprehensive approach to address the mental health of our soldiers? If not, why not?

Dr. RICE. I think our understanding of what an appropriate instrument is for a pre-deployment screening for psychological condition and for post-deployment is evolving. And so the Army, I know, has been reevaluating the use of an instrument called the automated neurological assessment metric (ANAM) at the point of predeployment. There has been some professional disagreement within the community about whether or not the ANAM is an appropriate post-deployment instrument.

I think this is all evolving. I think the important point to make is that there is screening going on. Exactly how we are going to ultimately get to a point where we are satisfied that we have a comparable instrument that was used before deployment and post-de-

ployment, I don't think we are quite there yet, but certainly, we are working hard at it.

Mr. WILSON. Well, again, I appreciate your working with our troops. As a parent of two sons who have served in Iraq and another in Egypt and another one who may be on the way as an engineer, I appreciate, on behalf of my constituents and my family, what you are doing. Thank you.

Dr. RICE. I can't help but point out that one of your sons is a USU graduate.

Mr. WILSON. We have a USU graduate in the family, so Dr. Rice has been very helpful. I am very proud of his Navy service. But I see Army people in the back, and I want to verify that the other three are Army National Guard.

Mrs. DAVIS. Thank you.

Mr. Pascrell.

Mr. Loebsack, I am sorry, I was thinking of our joint——

Mr. LOEBSACK. Actually, I wouldn't mind, as long as I can have my five minutes, I wouldn't mind letting my colleague, Mr. Pascrell, go before me if that works for the committee.

Mrs. DAVIS. I would need to let Dr. Snyder go first, and then, since Mr. Pascrell is not on the committee, the rules say he would have to go last.

Mr. LOEBSACK. Thank you, Madam Chair.

I do want to thank both witnesses for being here today, and also thank the chairwoman and the ranking member for holding this hearing. This subcommittee has looked into some really critical issues this year, and I appreciate your leadership, Madam Chair and Ranking Member, in taking a critical look at some of the really tough issues facing our services, the troops and their families.

Mental health care of our armed forces is an issue that I know we all take extraordinarily seriously, and I have a personal interest in this as well. I have had a number of family members affected by mental illness, so this is kind of a personal concern of mine, I have to admit.

And given the shortage of civilian mental health professionals in the country, I think the challenges facing the Department in recruiting these specialists is understandably difficult, and that is mentioned in your testimony as well.

But I have an ongoing concern about access to mental health services for members of the reserve components, not unlike Mr. Wilson, and their families, those components and their families, especially those living in rural areas. I am from Iowa, and there are a number of us, obviously, in this Congress who represent rural areas.

In your testimony, on page 40, you mention a telehealth initiative that the Department has undertaken. Can you go into the status of that program, how you are making service members and their families aware of it, and how service members who are determined and need in-person care through a telehealth session are in fact receiving that treatment?

Dr. RICE. Yes, sir. Thank you.

The telehealth program was developed specifically to address those in more remote areas, especially among the guard and reserve, who frequently had difficulty accessing qualified behavioral

health specialists. Through a variety of media on post and in camps and stations, we make the web site known. People can access this over the Internet and communicate directly. There are educational materials provided on the web site, and there is the ability for someone to self-refer if they require further evaluation, or screening, or consultation.

The ability for someone, particularly in a rural area, to seek consultation with a qualified behavioral health provider who understands the context of the experience that that guard or reserve member has been through has been a challenge.

Mr. Young, several years ago, in collaboration with the American Psychological Association, asked us to develop a program, the Center for Deployment Psychology. This is based at the Uniformed Services University. This program offers a one- and two-week training course for civilian psychologists, usually not near a military base, but who are likely to see guardsmen or reservists returning from deployment, and educates them about the kinds of experiences these guardsmen and reservists have been through during their deployment.

So far, I think we have offered, and I forget the exact numbers, but approximately 50 courses of the two-week type and a similar number of the one-week type and have reached several hundred, if not a thousand, civilian practitioners.

Mr. LOEBSACK. I will keep following up with you folks on that particular issue as we move forward and as a member of this committee and someone who does represent, as I said, rural America in many ways, so I really appreciate that. I think this is going to be a huge issue, there is no doubt about it, especially as more and more of these folks—and in Iowa, I am talking about the guard in particular—as they continue to deploy and do multiple deployments and all of the problems that get presented. I will continue to follow up on that.

I do have one other question. Can you walk me through the steps that are taken if a member of the reserve components is determined to be suffering from PTSD or TBI due to a combat deployment after they have already been taken off title 10 active duty? What sort of treatment do they get? Who provides the treatment? And while undergoing treatment, are they put back on title 10?

Dr. RICE. Medical treatment for someone who is already separated, they would likely be referred to the VA. And they are, of course, eligible for care at the VA for anything, for any combat-related problem.

Mr. CARR. For the reservist, let's say national guard, I have been on active duty, I have been on deployment, I am now back in Iowa, and I have been there for eight months. And I believe I have PTSD. I am going to probably proceed with my physician on my own medical program to discuss it.

Or I could, as Dr. Rice said, take it up with the VA on the expectation that in short order, when I address this with the VA, they will administratively determine it to be a consequence of combat, therefore combat-related, therefore something that must be addressed by the VA.

So that is the exchange with the VA, where you have a logical talk about, I believe I have this, and if I do, it could, I believe, only

have come from there; the potential is so high that I will be rated by the VA, that I would like to pursue this conversation with you because I don't have health insurance. Then it would be the VA.

Mr. LOEBSACK. Sometimes those ratings are problematic, and that is why I raise the issue.

Thank you so much for your time.

Mrs. DAVIS. Thank you.

Dr. Snyder.

Dr. SNYDER. Thank you, Madam Chair.

Last week, Mrs. Davis held a hearing on the Centers of Excellence, which I thought was a good discussion of what has been described and was described by our witnesses last week as the signature issue of these wars, which is the blast injury. And this discussion today is a continuation of that discussion in many ways.

I have been having some discussion with our colleague Dr. Tim Murphy, a Ph.D. psychologist from Pennsylvania, about this issue of traumatic brain injury. The question I want to ask is this: We are aware that the unfortunate circumstance of war is every injury you can imagine has occurred in war or will occur. Some are minor, and some are absolutely devastating and lead to death. And then we have all the spectrum in between.

So when we think about traumatic brain injury, and that is what I want to ask about, TBI, pretty much isolated from the psychological aspects of it, so we are familiar with the devastating injuries in which our brave men and women end up as a total care individual. And then we have been talking a lot today about people who may have mild TBI, may have PTSD, but they are at home. They need some mental health counseling, but they are working and performing at home.

What I want to ask you about is the folks that have recovered from their wounds, I think this falls under, Dr. Rice, in your statement about the separation policy. You talk about the people that you conclude, the military concludes, are not fully capable of performing their tasks, so they are going to be released from the military. The segment of the population I want to ask about are those who, if you saw them walking down the street, you would not even notice anything different about them. But if you were a family member or their caretaker, you would realize in their own way this person is also going to need some kind of 24-hour care. Perhaps they can walk into town. Perhaps they can be dropped off in town. But they are going to need, in the olden days we called it a domiciliary, or some kind of a residential care facility. Tell me where that fits into the discussions you are having.

Clearly, this is probably going to be a veterans' health care part of things, but your separation policy, people need to get separated, not just released, but they need to end up immediately on the right perch. Would you discuss that segment of the population, and do you have any idea of what the numbers might be for the person I am describing?

Dr. RICE. No, sir, I don't have a sense of the numbers off the top of my head. We will certainly take it for the record.

[The information referred to can be found in the Appendix on page 48.]

Dr. SNYDER. Do you share my concern about those types of injuries?

Dr. RICE. Yes, sir, I do. And as you know very well, there is no gold standard diagnostic study for traumatic brain injury. We are working very hard on a program in collaboration with the National Institutes of Health to pursue that, to see whether there are either biomarkers or there are sophisticated neuro-imaging techniques that may shed some light on both a sensitive and a specific diagnostic test for traumatic brain injury.

With respect to the question of people who are not functional any more or are having challenges in functioning, if they are still on active duty, they would undoubtedly be referred to a Medical Evaluation Board to determine whether or not they are fit for duty. If they are found not fit for duty, they would go through the Disability Evaluation System.

Dr. SNYDER. And I assume that that process would occur at the point the medical team determined this person has probably recovered as much as they are going to recover?

Mr. CARR. If they have the potential of being unfit, and if that is the case, then it will go to the Medical Review Board to decide if we have that condition before us, or is this something easily remediable? But if it is long term and likely to be chronic unfit, then it would be evaluated for disability evaluation and either severance or retirement.

Dr. SNYDER. The people I am talking about would clearly fit into that category. But I am concerned about what happens to them afterwards. So, at the time of separation, how do we make sure they have the continuity of care so that they end up in the right place and not be lost, to their detriment, for maybe a matter of hours, days or weeks?

Dr. RICE. That is a discussion that we are having on a regular basis with the Department of Veterans Affairs to make sure that if somebody is medically retired with a disability rating of greater than 30 percent, they are medically retired from the armed services and are eligible for care, either in the military system or in the VA, if they are separated with less than that, then they are eligible for care in the VA.

The VA rating system is different. That is a whole other discussion. But they are eligible for care in the VA, and the VA is very sophisticated in providing that kind of continuing and long-term care for people with those injuries.

Mr. CARR. Another way we can go at this is just to follow on through that I was on active duty. I spotted this person in Roanoke, and they don't seem to be able to care for themselves. So, first, how did they get there? Were they recognized and disability processed?

However it works, if that which is the physical problem resulted from military service, then either the military, because we catch it while they are on active duty and we see these things and we classify them and we rate them as a disability; or we don't spot it, no one takes note of it, somehow it escaped undetected, and then it emerges later. In that latter case, they were not separated for medical disability, and in that instance, the most likely course of action

is they would come in contact with some veterans group and probably be advised to go to the board. There are various ways.

The likely way, go to the Board For the Correction of Military Records and assert that I separated. I felt these things, but I never expressed them. I ended up in Roanoke, and I am even more confused, and these are the events which have progressed. I assert, therefore, that I had this condition while in the military, and my record should be reflected to show my current diagnosis, which by my symptoms is 50 percent disability.

Then, at that point, that adjustment would be made. If it were made and it were accepted, you would be a medically retired member of the military. Or it could be caught in a different way later, and you would be entirely managed by the VA.

But it would come down to, what is it that is your impairment? How would that rate as a disability? And when the rating is high, who is responsible? Somebody is, assuming it was led to their military service. Was it the military that was responsible for solving that and missed it? Even in good faith, it was never mentioned. Or was it instead something that was dormant and manifest years later and reasonably was not at the fault, if you will, of the military, in which case I would take that up with the VA?

So I trust that that person is going to come in touch with social network, and that social network is probably going to guide them to a veterans' support and that will lead them on the path. That is the scenario I would sort of see for the case we described to make it right under either of the two systems, as if it had been caught if it should have been caught.

Mrs. DAVIS. Mr. Pascrell.

Mr. PASCRELL. Thank you, Madam Chair and Ranking Member Wilson, for allowing me to sit on the committee today. I appreciate that.

As the co-chair of the Brain Injury Task Force in the Congress, I have been committed to bringing awareness of the prevalence of TBI since 2001. As everyone here knows, and I want to thank Dr. Rice and Mr. Carr for their service to our country, I take this very seriously. And I know you do, too.

This has been dubbed the major injury of the wars in Iraq and Afghanistan. It is estimated that 360,000 Iraq and Afghanistan veterans, or nearly 20 percent of those deployed, may have suffered brain injury. We are talking about over 70,000 of our bravest. The best way to determine the health of returning service members, because that is what this hearing is about, is to provide for a baseline neurological test.

And finally, in the fiscal year 2008 National Defense Authorization Act, and I want to refer to the exact words of the act: Public Law 110–181, the National Defense Authorization Act, Fiscal Year 2008, Title 16, Section 1618, the two sections, 6 and 9, one is assessment and one is managing and monitoring. The words are very clear. I won't read the whole thing. I won't suffer you through that. But it says, including a system of pre-deployment and post-deployment screenings of cognitive ability in members for the detection of cognitive impairment. It also says that at the end of the section on management, on managing and monitoring, including the monitoring and assessment of treatment and outcomes.

Why have a baseline if you are not going to follow it up with a comparative test in separating yourself from the service? You need a consistent test. You need a consistent metric. And, therefore, what we are using is absolutely inadequate.

I read through this several times. It didn't just happen the other day. This is not the baseline. It has nothing to do with the baseline, and no comparison can be made. No comparison can be made in terms of what tests are given to that brave soldier when he goes or she goes before the front line, before they go to the front line. So we are not doing neuropsychological testing afterwards, which is what the language says we must do.

I wrote a letter, on April 19, which several my colleagues have signed onto to Mr. Gates, the Secretary of Defense, and John McHugh, Secretary of the Army. And I said in the letter, in the second paragraph, We were reassured that the Department of Defense had implemented pre-deployment neurocognitive assessments across all services. Unfortunately, we recently learned that the use of the same neurocognitive assessment instrument is specifically not authorized for post-deployment assessment of our returning soldiers. Not only is this approach ineffective at identifying brain injuries, we believe that it violates the intent, if not the letter of the law certainly, and I believe it is the intent of the law, the spirit of that law.

One of these provisions here was the language that required—and the language is specific about this—that the Department of Defense provide pre- and post-deployment. And as I said, you cannot do this unless you have established a baseline and then follow it up with something where you can make a specific comparison. The only effective way to identify traumatic brain injury is to use the same neuropsychological testing, both pre- and post-incident, in order to produce a consistent metric.

In late March 2010, we learned that the Army has been using an automated neuropsychologic metric—I just raised it to you, I just showed you—for pre-deployment assessment. The U.S. Army Medical Command had also issued a memo stating that ANAM was specifically not authorized for post-deployment assessment for our service members. Instead, only concussion-related questions have been added to the post-deployment questionnaire. Read pre-deployment, you will see that questionnaire, but they also are giving the baseline test. Service members fill this out themselves. This post-deployment health assessment is filled out by the soldier himself or herself, and yet we are making the comparison to a test that is given, a baseline test, which is given. It does not make scientific sense.

So I don't believe that the DOD is conducting neurocognitive assessments in a uniform manner, and our troops are suffering because of that. Common sense would suggest that the same neurocognitive assessment tool should be used throughout the term of service to properly identify and manage long-term changes in cognitive ability. The DOD has failed, and I have worked closely with the DOD. I have worked closely with General Sutton and I have worked closely with Colonel Jaffee and I have worked closely with my brother who is no longer with us, Congressman Murtha.

We worked in the past four or five years; we have accomplished, all of us together, quite a bit.

Why has the Department of Defense selected two incompatible neurocognitive assessments for pre-deployment and post-deployment, specifically using a automated baseline neurocognitive assessment for pre-deployment and symptom survey for post deployment? Are you just trying to follow the letter of the law while ignoring the actual intent of it? Either one of you.

Dr. RICE. I think that, certainly, you are absolutely right that you cannot compare two different instruments before and after and expect to get consistent results.

I think the challenge has been validating the instrument to be used to make sure that it is both sensitive and specific for what we are trying to detect. And as I understand it—I am a trauma surgeon, not a neurologist or a psychiatrist—but as I understand it, there has been disagreement among the experts in the field about the extent to which the ANAM is an accurate representation of cognitive ability.

It is my understanding that that was the motivation behind looking for a test that was perceived to be more accurate, more sensitive and more specific. I would be happy to look further into that issue and get back to you.

[The information referred to can be found in the Appendix on page 49.]

Mr. PASCRELL. So you believe the instrument in the pretest is valid?

Dr. RICE. I am not certain. And again, this is not my area of expertise, but I am not certain that there is general agreement among the experts in the field that the ANAM is a valid test.

Mr. PASCRELL. So you don't—you can't state for the record that the baseline neurocognitive assessment is valid?

Dr. RICE. I believe there is disagreement among experts in the field about its validity.

Mr. PASCRELL. So are you telling us today that the test we are using before someone goes on the battlefield may not be valid; is that what you are saying?

Dr. RICE. I am not sure that it is. That is right.

Mr. PASCRELL. Well, that says something, doesn't it?

Mr. Carr, what would you say to that? What is your response?

Mr. CARR. I think this is more a matter of judgment on the medical validity, the scientific validity of this baseline against that later measurement, and that is, unfortunately, not my policy province or my area of expertise.

Mr. PASCRELL. Madam Chair, if I may, in conclusion, the law, the words right in front of me are very, very specific. I would contend that they are not being followed, that we are breaking the law, and we are not doing service to our bravest.

I don't think the gentlemen on that side of the table want that, and certainly I know the people on the panel who are sensitive to this issue don't want that. I would suspect that there needs to be a sense of urgency on this issue, otherwise we are not doing justice, and we are just doing empty words. And we have had enough of that.

Thank you, Madam Chair.

Mrs. DAVIS. Thank you for joining us today and raising that. I know it was raised earlier.

And I think, Dr. Rice, if I am not mistaken, you basically said that they were working on it, in terms of a post-deployment assessment and an instrument that is working. But I think we have had some other concerns that there is no way to align that if in fact the earlier instrument is not giving us the kind of information that is really important to be able to do that.

What do you think the next step should be? We are in a quandary, then, in terms of how we really can represent to anyone who is in a situation of having been—this hearing, of course, is about separation and the appeals and how we move forward, but clearly that is something that we need to do. Where do you think we should be?

Dr. RICE. Well, I think, I believe I am correct in saying this, that the Army, that all three of the services, actually, have engaged their experts in a very intense discussion of what the right psychometric evaluation should be and what the best available tools to deploy are, remembering that we are administering this to a very large number of people and therefore to make sure that we capture, in the most effective and efficient——

Mrs. DAVIS. What I am trying to determine is, are the tools out there to do that? Is it that we still have research to do to determine that? I know that a lot of money, even through the Centers of Excellence, have been focusing on some of these issues. Is there a problem just administratively to get this together and to focus appropriately?

Dr. RICE. No ma'am, I don't think it is an administrative problem, I think it is a conceptual problem of, what do we measure? If we take a screening test, what do we measure it against that we accept as a yardstick that is valid? I think that is where the disagreement among the experts has been.

Mrs. DAVIS. How do we move that forward then?

Dr. RICE. We are pushing on that very hard. There is a keen sense that, as Mr. Pascrell indicated, that this is an important need. We are concerned about people who have repetitive exposure to mild blast injuries, and we are not sure what the cumulative effect of that repeated exposure is. So determining what somebody's baseline cognitive functioning is so we can compare it to what we assess after such an exposure is very important.

Mrs. DAVIS. It seems, though, that there are a lot of reasons to have good instruments, and the one that we are focusing on today, it seems somewhat simple, in terms of being able to determine the extent to which someone's behavior, that the contributions to that have been as a result of a blast injury in some way and that that would be demonstrated. It seems to me there is some clarity there. There may not be for some other purposes, but there may be some clarity there. Am I missing something in terms of how we, the whole appeal process?

Mr. CARR. It gets linkage to the appeal process.

Mrs. DAVIS. Sure, whether of not—the purpose that we are looking at right now is the appeal process and the extent to which a person has been rightly or wrongly separated and that they can

continue with either their military career or at least have the honor of being separated——

Mr. CARR. I would say, no, and the reason I would say it is because comparing the condition that presents against something independent of this at the moment, the standard we would look at for any bodily function is, what represents a disability in my elbow or in my PTSD? I compare the condition to that. For example, usually PTSD is, I can't do my occupation. And depending on how severely I can't do my occupation, the percentage of disability would rise. So that judgment is made in contrast to me against doing my work quite independent of this.

So, no, it wouldn't affect the capacity to correctly and properly dispose of the disability, to rate it, and to pay it. I think, instead, it was a matter of classifying the change, but that change, even if it were classified, hadn't made its way into the disability rating system. So that, this is—it is important for all of the reasons the congressman pointed out. But as far as a direct deleterious effect on an incapacitated soldier, that judgment is made against the circumstances that present, against the description of, in this case, being able to do my occupation.

Mrs. DAVIS. I know Mr. Wilson earlier asked a question about the number of individuals and the appeals, and I think you said 128. Is that correct?

Mr. CARR. 129, yes, ma'am, in the Discharge Review Board. But I would like to distinguish, the Discharge Review Board is, I got a discharge that was not an honorable; I would like another look. That has been for decades.

The more recent items have been the Physical Disability Review Board established by the Defense Authorization in 2008, on which the committee played a key part. And that board said if you went out for less than 30 percent, because 30 percent is military retirement, it is valuable to the member, as opposed to 20 or 10 percent, if you went out for less than 30 percent and you think you were wronged, you may apply to the Physical Disability Review Board. It started in 2008, and it really got moving, its first full year was 2009, and 690 applications came in. Most, about 58 percent, were Army, and about 61 percent of them were upheld. By that I mean, I now have an assertion from Bill Carr that you got it wrong. I am comparing the evidence that existed on me at the time of my separation, not new stuff, against the standard in making a determination. And in 61 percent of the cases, it is being adjusted upward for those 690 that are through so far. There are more to come, to be sure.

I also should mention that, of those that come in, it is not PTSD or TBI or what we might have suspected going in. It is 80 percent orthopedic, so it is arthritis and joints and back; and 22 percent is PTSD. So there certainly are some where we missed, according to the Board's recent conclusions, its newest conclusions, it looked at this, and it said that there was more than half in error. But the vast majority had to do with orthopedic as opposed to PTSD, and that is a little understood fact.

Mrs. DAVIS. Thank you.

My conclusion from this is some folks may say, in some ways, it is a premature hearing to try to get at these issues because there

are some things that I understand are definitely in progress. On the other hand, I think, it may be too late.

So what I would like to do is to have some time and to come back in a few months and really take a look at this again, because it may be that we may want to strengthen some language in the authorization bill. We want to take a look at where we were. And whether we can put additional urgency on this I am not certain with the language, but it is clear that we have a problem, and we need to be addressing it. I know there is a lot of seriousness about it, but we need to put some real focus and try to understand better where we are. So if we can do that in a few months, that would be very helpful. Do you think that there is—what would be your timeline? What would you suggest that would be a good time to come back and really be sure that we are moving ahead with the instruments that are needed to align them properly?

Dr. RICE. A couple of things occur to me. Obviously, as someone here who is not an expert in the cognitive evaluation of large numbers of people, either before or after deployment, so it is entirely possible that there is a great deal more sophistication that could be brought to bear immediately on that to better answer your question.

Absent that, however, I would think that an opportunity for us to see what the current state of thinking among our experts is about the various tools that are available to assess cognitive ability is something that we could do within a relatively short period of time and be able to get back to you within six weeks, six to eight weeks.

Mrs. DAVIS. Okay.

Mr. Carr, did you have anything to add.

Mr. CARR. Only that as we—section 512, which was an important section that we are implementing, the committee directed, the Congress directed that 240 days afterwards there be a report, and that will be the 25th of June. And our report will lay out how it is we are going to do that which 512 directs, which essentially means publishing a policy that integrates health, disability, and Board For Correction of Records all in one. Much of it is already completed in draft. But what we will deliver to the committee at the deadline is the report. In other words, at that point, the system will exist. People will not have been through it. A couple of months later, as people go through it, call that implementation, then we will provide another update to the committee.

So June 25, we will meet, and that is, how are we going to do that which was directed by 512 exactly? Are there any shortages? What are the qualifications of the people, the physicians that will be involved, and the earlier question? Provide that report on June 25, and then implement shortly thereafter and update the committee on how the numbers are working. Are there any bottlenecks, and are the skill sets proper and so forth?

Mrs. DAVIS. So you are saying that the committee would have that report by the 25th?

Mr. CARR. Yes, the 25th of June.

Mrs. DAVIS. Okay.

Again, you have seen some of that report. Do you think it answers the kinds of questions that we are after?

Mr. CARR. I think it does. It addresses the concern, which was, be certain that we haven't disadvantaged someone who can't take care of themselves by misclassifying or rushing to judgment that which could be a subtle injury or disease. In that case, yes, we will have reported how exactly it is that we will allow for success against that standard, exactly what the protocol, the procedure, and the flow will be, and what the manning of it will be to make for a successful implementation.

Mrs. DAVIS. Wouldn't that be dependent on having instruments that can properly make those assessments?

Mr. CARR. No. Because, for now, we are operating on whether or not there is a disabling condition quite apart from—so there is a standard that says if you can't perform your occupation and so forth. Now quite apart from that, for these signature diseases, can science tell us in more cogent terms an expression that is better than he can't do his occupation? For example, if it can show a shift of a certain quantity, and that is a cogent correlation to not being able to do my occupation, that makes it more empirically reliable.

But the fact that you don't have that empirically reliable document at the moment doesn't stop you from doing what we have done for decades, and that is to take the standard as it is written and apply it fairly to the patient and reach a determination as to what the disability percent should be.

Mr. PASCRELL. Madam Chair?

Mrs. DAVIS. Yes, Mr. Pascrell.

Mr. PASCRELL. I think that is preposterous, and I will tell you why.

To a layman, and I am a layman, how can you prescribe care unless you have something to go on? We have taken the protocol and moved it into the area of sports, and I don't want to compare sports to what these brave men and women have endured on the battlefield, but we are now using protocol to protect our children in middle school, high school, and college, in terms of prevention, in terms of what happens when there is a concussion on the field in gals basketball or guys football; it doesn't matter. In fact, there is more injury in women's sports than male sports. How do you prevent this from happening? And then, if there is a concussion, what do you do? So now they are testing them before they go on the field, aren't they, Mr. Carr?

Mr. CARR. They are.

Mr. PASCRELL. In order to do that and the reason why they do that is to have a baseline. And then they are testing them after they get a concussion in order to make the comparison.

Mr. CARR. Yes, sir.

Mr. PASCRELL. You are not going to be able to prescribe care unless there is a comparative baseline, unless you use the same kind of test, whatever those tests are.

Mr. CARR. You are right.

Madam Chair's question was, are we blocked from proceeding with the business of handling a disability absent that? And the answer is, no, we are not. We will continue to dispose of cases with the tools at hand.

The congressman is entirely correct, that our empirical base, so that we can reach—so that we can quickly and decisively and accurately and cogently know that this shift has occurred.

Mrs. DAVIS. Mr. Carr, I am afraid we are going to have to stop. But I can assure you that we will continue to discuss these issues and perhaps bring in additional individuals who will be helpful in the discussion. I think it is a very important one, as you know and appreciate, and Dr. Rice, I know as well, to our troops and to their families and to their futures. And so we will want to continue to try and understand it better.

I appreciate my colleague being here and Mr. Wilson, and we will continue. Thank you very much.

[Whereupon, at 6:44 p.m., the subcommittee was adjourned.]

A P P E N D I X

APRIL 20, 2010

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

APRIL 20, 2010

Opening Statement
Chairwoman Susan Davis
PTSD/TBI Separation Medical Examinations
April 20, 2010

Today, the Subcommittee will hear testimony about the efforts of the Department of Defense to implement section 512 of the National Defense Authorization Act for Fiscal Year 2010. The section requires the secretaries of the military departments in certain cases to conduct a medical examination before administratively separating a member under less than honorable conditions if the member has been deployed overseas in support of a contingency operation. The purpose of the examination is to evaluate a medical diagnosis or assertion by the member that post-traumatic stress disorder—PTSD or traumatic brain injury—TBI might have caused the behavior that resulted in the commanders decision to pursue separation.

The Subcommittee considered this legislation at the request of the Gentleman from North Carolina, Mr. Jones, and I want to commend Mr. Jones for bringing this issue to the attention of the Subcommittee. I

agree with the Gentleman that it is unacceptable that the military departments were separating service members because of misconduct that was caused by a PTSD or TBI injury that occurred during his or her combat tour. Now that we know so much more about the extent of those injuries in the force, we owe every returning service member the assurance that we will not punish them for an injury that resulted from combat service.

The unfortunate truth is that we have very likely already separated a number of service members where the commanders did not consider that the member was experiencing the consequences of PTSD or TBI. That is why the provision we adopted last year also requires the Discharge Review Boards in the military departments to provide expedited review of cases that involve a diagnosis or assertion of the influence of PTSD or TBI.

We intend to learn about the status of DOD efforts to implement this law and improve the general access to mental health care. As always, if the Congress needs to do more, we would like to know what further action is needed.

Opening Remarks – Congressman Wilson

Military Personnel Subcommittee Hearing on
Implementation of Requirement to Provide Medical Examination Before Separating Members Diagnosed with Post-Traumatic Stress Disorder or Traumatic Brain Injury and Capacity of DOD to Provide Care to PTSD Cases

April 20, 2010

Thank you Chairwoman Davis, and thank you for holding this hearing. I believe Congress and this nation has no greater responsibility than to provide the care and support needed by members of our Armed Forces who endure the horrors of war to protect our freedom.

I am aware of the challenges the Department of Defense and the Department of Veteran's Affairs have in providing mental health care to the growing numbers of combat veterans returning with post-traumatic stress disorder and traumatic brain injury. I am also aware that the legislation Congress passed last year requiring medical examinations prior to administratively separating service members who may be experiencing post-traumatic stress disorder or traumatic brain injury may increase the burden on the two departments. But that does not mean we should allow one combat veteran to slip through the cracks and be discharged from the service without the proper recognition of and medical benefits for the mental health issues they may be facing.

Thankfully the mental health profession now understands that post-traumatic stress disorder and traumatic brain injury may cause behaviors that previously would only be considered reasons to administratively discharge service members. Identifying the underlying mental health issues and brain injuries is often further compounded by a service member's reluctance to seek help. Too often they are self medicating, which leads to behavior problems. Simply discharging these troops without the possibility of necessary medical care is not the answer. We owe

it to our combat veterans and their families to properly diagnose combat related mental health and brain injury issues and to provide the care, regardless of cost, to facilitate their recovery.

I am interested in hearing from our witnesses today how the Department of Defense is providing the required medical exams before separating a service member. I am particularly interested in how you are accomplishing this given the recognized shortage of mental health providers. I would also like to know how many previously discharged service members have been screened by the discharge review board and how many have been identified with post-traumatic stress disorder or traumatic brain injury. Finally, I would like to know how we can help.

With that, I welcome our witnesses and thank them for participating in the hearing today. I look forward to your testimony.

HOLD UNTIL RELEASED
BY THE COMMITTEE

STATEMENT BY

CHARLES L. RICE, M.D.

PRESIDENT, UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES, PERFORMING THE DUTIES OF THE ASSISTANT SECRETARY OF DEFENSE, HEALTH AFFAIRS REGARDING

AND

WILLIAM J. CARR

DEPUTY UNDER SECRETARY OF DEFENSE FOR MILITARY PERSONNEL POLICY

MEDICAL EXAMS FOR SEPARATING MEMBERS DIAGNOSED WITH PTSD OR TBI

BEFORE THE
HOUSE COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

April 20, 2010

Madam Chairwoman, Members of the Committee, thank you for the opportunity to come before you today to discuss the implementation within the Department of Defense (DoD) of the statutory requirement for pre-separation medical examinations for Service members diagnosed with posttraumatic stress disorder (PTSD) or traumatic brain injury (TBI). In addition, I will address the resources available to the Department for the long-term for addressing PTSD issues.

DoD has dedicated considerable resources to develop comprehensive policies and programs to address behavioral health and related clinical issues for our Service members. With significant support from the Congress, we have introduced a variety of programs – from research to treatment to transition to the Department of Veterans Affairs (VA) – for our Service members and their families. Our programs span the continuum of care.

Scope of Behavioral Health Research, Prevention, Treatment and Transition Programs

Research – We have awarded more than $500 million to fund research studies in traumatic brain injury and psychological health, including PTSD at Department of Defense, Veterans Affairs, and academic organizations across the country.

Prevention – We have invested in resiliency training programs to better prepare our Service members for the undeniable stressors of deployment and combat.

Evaluation and Treatment – We have incorporated the Military Acute Concussion Evaluation (MACE) for Service members who sustain head or neck injuries. This evaluation is performed in-theater, at Landstuhl Regional Medical Center in Germany for all Operation Enduring Freedom / Operation Iraqi Freedom patients evacuated from the combat theaters, at the post-deployment phase, and upon entry into VA.

Our pre- and post- deployment health assessments are repeatedly reviewed and updated. Currently, we are revamping both the pre- and post-deployment health re-assessment to introduce a more comprehensive person-to-person assessment. These planned changes will also likely impact the pre-deployment health assessment.

Following deployment and / or separation, Service members and their families continue to have access to self-help resources, community forums, podcasts, and libraries to assist them at www.afterdeployment.org.

When care is required, we have made great efforts, with encouraging signs of success, to reduce the stigma associated with seeking behavioral health support.

One element of our new approaches is the Re-Engineering Systems for the Primary Care and Treatment of Depression and PTSD (RESPECT-MIL). This program is designed to help providers recognize warning signs early while eliminating Service Members' fears

about the stigma of psychological illness. RESPECT-MIL takes advantage of any visit Service Members make to their primary care physician for any reason, turning those visits into opportunities to detect symptoms that could indicate the soldier is struggling with PTSD. Originally piloted by the Army, early efforts from Ft. Bragg showed a significant increase in the successful diagnosing and treatment of Soldiers with PTSD and depression, and 60-90 percent of PTSD patients showed improvement. The program is being proliferated throughout the Military Health System (MHS).

We have also introduced an array of care venues for our Service members. These include traditional forms of behavioral health services delivery, as well as new approaches using telehealth technologies (to include coverage for this service under our TRICARE program). The telehealth initiatives are particularly helpful to our Service members who reside in rural areas or other communities where there are insufficient numbers of behavioral health providers.

Transition – Finally, we work closely with VA to ensure Service members can transition through the continuum of care. Throughout all of these programs, we work to understand the best, evidence-based clinical practices, supported by independent subject matter experts in academia, the private sector and in other federal health agencies, to include national experts in VA, the National Institutes of Health and other prominent agencies. Our clinical approaches to screening and medical examination are thereby informed by the collective wisdom of these experts.

This summary of program initiatives across the continuum of care highlights the comprehensive nature of the services we offer – health care is documented throughout a Service member's career and provides our clinical teams who perform separation physicals with a rich source of information upon which to tailor their examinations. As our policy states – "how well the Military Health System services its members is more than just a measure of the care they received while on Active Duty. It is also the fulfillment of our obligation to ensure they are returned to civilian life in the best health possible, compensated for any disability, and any care received or injury incurred is documented."

Separation Medical Examinations

DoD policy (*Policy Guidance for Separation Physical Exams*, October 23, 2005) directs the Services to ensure Service members who are scheduled for separation from Active Duty undergo a physical examination within 12 months prior to separation. Waivers to this policy are only granted when *both* the Service member consents and the unit commander concurs.

At a minimum, these examinations include: a face-to-face interview with a provider and a comprehensive review of the medical record; focused, age- and gender-specific exams aligned with the recommendations of the U.S. Preventive Services Task Force and the

Defense Health Board; and any indicated specialty consultations or diagnostic procedures.

Each Service has explicit instructions provided to its military treatment facility (MTF) commanders that outline the policies and requirements for conducting medical examinations for Service members prior to separation. As mentioned earlier, we also collaborate closely on best practices with our colleagues at the Department of Veterans Affairs. The tools we offer our providers highlight the VA-developed screening questions as the consensus best approach. All Service members who are determined to have mild TBI or PTSD are mandatorily directed for further examination and testing.

We have worked with VA on several innovative approaches to make this process easier for our Service members and less costly to the taxpayer. The Benefits Delivery at Discharge program is a cooperative process by which VA benefit decisions can be accelerated through use of a single exam and form. The DoD/VA Disability Evaluation System (DES) pilot project allows DoD and VA to conduct a single exam that meets the minimum VA disability exam evaluation criteria.

Mental Health Provider – System Capacity

There has been a considerable growth in demand for mental health services from many of our Active Duty Service members and their families. DoD carefully monitors access to

behavioral health services, whether in our direct care system, or within our network of civilian providers in the TRICARE program.

Our Active Duty mental health professionals are largely focused on serving those in uniform, and we have placed an unprecedented number of these professionals into the combat theaters. Consequently, we rely to a greater degree on a combination of contracted professionals in our medical facilities, and on community capacity to serve our families.

Within MTFs, the Services have contracted for additional mental health specialists to augment existing staff, adding almost 2,000 additional mental health providers as of January 1, 2010. We have developed a number of innovative solutions to address our needs. For example, using a DoD-established Memorandum of Agreement with the U.S. Public Health Service (PHS) to provide mental health officers to MTFs, we have added 105 PHS officers with approximately 32 more candidates who are in the process of applying to the PHS and being matched to DoD positions. In some cases, the recruitment and hiring process has moved more slowly than desired, but we are making significant progress in bringing resources on board.

For the longer term, DoD is implementing the Psychological Health Risk Adjusted Model for Staffing to enable the Services to determine appropriate mental health staffing needs at MTFs.

In the summer of 2009, we established a new program within TRICARE in which telepsychiatry services may be offered to beneficiaries. This program has the potential to address medically underserved populations by using resources that are available in other communities.

We have established access to care standards for timeliness into our TRICARE network for both primary care and specialty services. We closely monitor access to care across all specialties in our network, to include mental health, and we work with our TRICARE contractors to remedy any service area that is not meeting our standards for access.

We have also established a healthcare finder capability through our managed care support contractors to assist Active Duty Service member and Active Duty family member TRICARE Prime beneficiaries in making timely routine and urgent appointments with mental health providers.

Since 2001, TRICARE has witnessed an 18 percent annual growth rate in mental health services, and our network support has adapted to this increased demand.
Over 50,000 behavioral health providers are in the network, with more than 10,000 added in the past three years to ensure TRICARE can continue meeting access to care standards.

VA medical facilities often provide PTSD counseling services to our beneficiaries through both local and national resource sharing agreements. While we offer patients choice in facilities, we use these facilities when they are proximate and when they can provide timely access to care.

DoD is ensuring all of these programs and initiatives have proper subject matter leadership oversight. We are establishing Directors of Psychological Health in the Services and military units to oversee coordination and management of a continuum of mental health care services. The National Guard Bureau has established positions for Directors of Psychological Health at each of the 54 Joint Force Headquarters, and Army National Guard and Air National Guard Headquarters act as the focal point for coordinating the psychological support for National Guard members and their families.

In 2006, the Center for Deployment Psychology (CDP) was established at the Uniformed Services University of the Health Sciences in response to a nationally-recognized need for behavioral health providers with experience in deployment-related issues. The CDP

is a DoD training consortium that supports a network of deployment behavioral health psychologists at 10 military medical centers throughout the country that offer American Psychological Association-accredited psychology internship programs. The CDP offers several training programs, including a two-week comprehensive course for military providers, a one-week comprehensive course for civilian providers, 2-3 day courses focusing on treatments of PTSD, sleep problems and depression, and online courses that address topics including military cultural competence, PTSD and military families.

To date, more than 500 providers have completed one of 16 iterations of the two-week course, and approximately 1,000 have completed one of 12 one-week courses. The CDP has trained more than 3,000 in evidence-based treatments for PTSD. Going forward, the CDP plans to expand and modify the current curricula, develop new workshops to address other audiences such as university counseling center providers who work with veterans, develop online support and consultation programs for those trained by the CDP, and forge new partnerships with other universities, foundations and state agencies.

Separation Policy

Separation policy promotes readiness of the Services. It leads to an orderly transition of those who honorably complete their service to the nation, and it helps manage targeted losses among those whose continued service is not merited. Included in the latter group are Service members not fully capable of continuing their careers.

Medical fitness is an area of particular concern, and the Services must carefully reach such a determination. In that regard, the nature of the signature injuries sustained in Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) has challenged the Department to better understand and treat those disabilities, including Traumatic Brain Injuries (TBI) and Post Traumatic Stress Disorder (PTSD). As the body of knowledge of PTSD and TBI has matured, personnel policies have also evolved to ensure Service members are thoroughly evaluated prior to consideration of discharge from military service. The Department's separation policies offer many levels of oversight to protect against inappropriate discharge. These levels of oversight are especially important in caring for wounded warriors, including PTSD and TBI are sustained, as these could directly lead to physical disability discharges which are compensable.

Leadership awareness and understanding of PTSD and TBI are Department priorities. One example of this is the new discharge policy (August 28, 2008) on personality disorders, which adds far greater rigor and increased confidence in the Department's ability to accurately diagnose personality disorders, which by themselves are not compensable. Such rigor also improves the identification of any co-morbidity of PTSD or TBI, which are compensable discharges. The new policy authorizes personality disorder separations only if diagnosed by a psychiatrist or PhD-level psychologist.

In addition, members who have served or are currently serving in imminent danger pay areas must have their diagnosis corroborated by a peer -- psychiatrist, PhD-level

psychologist, or higher level mental health professional -- and endorsed by the Surgeon General of the Service concerned. While there is little evidence Service members would be routinely misdiagnosed, there were concerns early in the conflicts that members suffering PTSD or TBI might be separated under the non-compensable, exclusive diagnosis of a personality disorder.

Such concerns were reasonable, given our nascent understanding of these signature injuries. To ensure the requisite safeguards were put in place, the Department implemented oversight mechanisms to include an annual personality disorder report and periodic reviews of personality disorder separation data by the Department's medical and personnel council.

The number of personality disorder discharges of Service members who have deployed in support of a contingency operation has decreased from 81 per month in September 2008, just after the new policy was promulgated, to an average of 16 per month in 2009; this data makes evident the positive effect of increased rigor and oversight. In addition, a greater percentage of PTSD diagnosed veterans discharged under the Disability Evaluation System are being compensated for their disability, which could indicate that the Department is doing a better job of screening, diagnosing, and compensating veterans with PTSD.

For administrative separations, to include those for misconduct not related to personality disorders, there are equally rigorous processes to ensure Service members receive the appropriate discharge characterization. Much of the rigor in the discharge process occurs before the case is presented to the separation authority. The initiating commander, who often is a lower level commander, must consult legal counsel to provide advice on the case. This commander also has medical professionals available to assess the Service member to ascertain if the behavior/misconduct is a departure from the individual's norm. If there are intermediate commanders between the initiating commander and the separation authority, those commanders will also review the adequacy of the case. The separation authority also has the counsel of his senior judge advocate who can provide the appropriate legal guidance and suggest mitigating or extenuating concerns. The separation authority for misconduct is not a "lower level commander," but rather a special court-martial convening authority or higher. This senior officer, typically at or above the grade of Colonel or Navy Captain, is tasked to determine if there is sufficient evidence to verify the allegations set forth in the notification to the Service member. The Service member is also provided counsel who can argue to the separation authority that such misconduct is out of the norm and a result of PTSD or TBI, if it is an extenuating circumstance.

To further ensure the Department identifies Service members with PTSD or TBI, title 10, United States Code, section 1145 and DoD policy, require the Secretary concerned to ensure a physical examination of Service members immediately before any discharge

with the intent existing conditions are documented and to rule out PTSD or TBI diagnosis or other problematic or extenuating medical condition(s). If PTSD or TBI is identified by a medical professional or alleged by the Service member during this process, DoD policy mandates the separation authority consider a PTSD or TBI diagnosis as an extenuating circumstance, and if this new evidence outweighs the conduct or cause for separation, consider denying or modifying the separation and /or separation characterization.

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

Looking ahead, and in response to Section 512 of the National Defense Authorization Act for FY 2010, the Department is developing policies to ensure medical examinations are conducted with the participation of mental health professionals experienced in diagnosing PTSD and TBI for those Service members who have deployed to a contingency operation

within the past two years, have been experiencing or reasonably assert PTSD or TBI, and are being considered for discharge under conditions other than honorable. These emerging policies will also ensure the assessment of the effects of PTSD or TBI relating to the basis for a separation under conditions other than honorable. An integrated effort across the Department, these new policies will necessitate changes to DoD separations, medical exam, and discharge review board legal policies as well as cascading changes to Military Department Instructions and Regulations. The Department is working hard to implement the statute in policies, regulations and in practice and is looking forward to reporting the status and accomplishment by June 2010.

The Department is more confident Service members who experience or assert PTSD or TBI are being diagnosed and those diagnoses are being considered in administrative discharge proceedings prior to adjudication. Oversight of policies is crucial and the Department continues to conduct reviews of discharge data.

Conclusion

We want to thank you for the opportunity to talk with you about the status of our implementation of the requirement for medical examinations and separation policy for all personnel, and in particular for those Service members diagnosed with PTSD or TBI. The Defense Department is complying with both the letter and, we believe, the spirit of the law, and is working to improve the means by which we perform these examinations, and to enhance the evidence-based guidelines we use in the process.

The focus on behavioral health service support has increased the demand on our MTFs, and we continue to work closely with our TRICARE contractors to augment them. We are introducing new programs to address any shortfall in behavioral health resources.

We would be pleased to respond to any questions you may have.

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

APRIL 20, 2010

RESPONSES TO QUESTIONS SUBMITTED BY MRS. DAVIS

Dr. RICE. The Army implemented Mild TBI (mTBI) Chain Teaching in the Fall of 2007, for all Soldiers in the Active and Reserve Components, to address symptoms of mTBI, Soldier and leader actions, and resources for assistance. The chain teaching, with video illustrations, is taught by a facilitator and takes about 30 minutes. Newly assigned Soldiers receive this training within 30 days of assignment. In fall 2009, an "Educate, Train, Treat & Track" campaign plan was implemented to facilitate line and clinical collaboration for acute concussion identification and management in conjunction with the new mTBI/concussive injury management strategy. This protocol directs that any Soldier who sustains a direct blow to the head or witnessed loss of consciousness; is within 50 meters of a blast (inside or outside); is in a vehicle damaged by a blast event, collision or rollover; or is command directed, must undergo a medical evaluation. Appropriate treatment includes assessment, a mandatory 24-hour downtime, followed by medical clearance before returning to duty. Comprehensive medical evaluations are mandatory for anyone sustaining three concussions within 12 months. The Vice Chief of Staff of the Army (VCSA) has addressed deploying units at Ft Campbell, JRTC, NTC, and Ft Stewart about the TBI protocol "Educate, Train, Treat & Track" via VTC since Dec 2009. The VCSA spent up to 90 minutes at each session. These training sessions are ongoing.

The Marine Corps provides training on Operational Stress Control to leaders and Marines at all levels. This training focuses on developing the observational skills to detect when a Marine is "not acting quite right." The Marine leader's responsibility is to notice a change and engage appropriate help and resources. The curriculum includes six hours of training for approx 50 Marines per battalion or equivalent command.

All Air Force Airmen receive basic instruction on Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD), and suicide awareness. Commanders and Supervisors are provided approximately 60 minutes of additional training on recognition and mitigation of these problems in their subordinates. Instruction is a combination of didactic lectures, on-line instruction, publications, and interactive classes. It is incorporated into pre-deployment training for all deployers, including commanders and Senior Non Commissioned Officers.

The Navy is planning a programmed release of the formal Operational Stress Control (OSC) curriculum in all accession and leadership schools—recruit training and "A" school, petty officer and chief petty officer indoctrination and officer candidate school, to name a few—in the very near future. In addition, specific pre- and post-deployment OSC training is being delivered at all Navy Mobilization Processing sites and Returning Warrior Weekends. The extensive OSC training continuum, while not specific to PTSD, provides training to commanders and the chain-of-command, along with Sailors and families, to help them recognize and address the symptoms of many different stress reactions and injuries. [See page 7.]

Mr. CARR. The Army implemented Mild TBI (mTBI) Chain Teaching in the Fall of 2007, for all Soldiers in the Active and Reserve Components, to address symptoms of mTBI, Soldier and leader actions, and resources for assistance. In fall 2009, an "Educate, Train, Treat & Track" campaign plan was implemented to facilitate line and clinical collaboration for acute concussion identification and management in conjunction with the new mTBI/concussive injury management strategy. The Army's Proponency Office for Rehabilitation & Reintegration (PR&R) developed the following courses, which are being uploaded to Military Health System (MHS) Learn for training for health care providers. The TBI 101 module will also be available on Army Knowledge Online (AKO) for viewing by all Soldiers.

(1) TBI 101: TBI Foundation: (All Audiences) This course describes TBI in non-clinical terms: core TBI message of early detection and recognition of symptoms; correlation between sports concussion and (mTBI); the magnitude of how TBI affects the military; and discusses the military's plan to address TBI from in-theater to home.

(2) TBI 201: TBI Overview for Healthcare Personnel (All healthcare personnel (Stateside and Deployed)) This course addresses TBI definition and discussion on

levels of severity; mechanisms of Injury/Pathophysiology, and identification, assessment, and management of common symptoms.

(3) TBI 301: First Responder Training: Battlefield Management for mTBI (Deployed Healthcare Personnel) This course addresses Field management guidelines; MACE: Military Acute Concussion Evaluation tool—test administration process; emergency care techniques; pre-hospital treatment; triage and transport; and documentation and coding.

(4) TBI 401: mTBI Symptom Management Guideline. This course addresses Primary Care Providers and TBI healthcare team (Non-deployed) Section 1: Assessment techniques, clinical algorithms, medication awareness, duty restrictions, and DOD/VA Clinical Practice Guidelines; Section 2: Clinical interviewing, evaluation techniques with patient and Families, TBI management including profile writing, and documentation and coding; Section 3: Principles of TBI identification, TBI screening process, resources, and tools for diagnosis.

The Marine Corps provides training on Operational Stress Control to leaders and Marines at all levels. The Marine leader's responsibility is to notice a change and engage appropriate help and resources. The curriculum includes six hours of training for approximately 50 Marines per battalion or equivalent command. Trains XOs, senior enlisted, junior leaders, medical and religious ministry personnel to provide, prevent and manage many stress problems tools, strategies, and resources (Causes of Stress Continuum [COSC], Five Core Leader Functions, COSC Decision Flowchart, listening skills and referrals) for preventing and managing stress problems. Senior Marines discuss advanced COSC issues and tools, COSC risk management, training for resiliency, stress mitigation strategies, psychological fitness to deploy, health assessments & confidentiality. Junior Marines role play scenarios to apply new skills and tools.

All Air Force Airmen receive basic instruction on Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD), and suicide awareness. Commanders and supervisors are provided approximately 60 minutes of additional training on recognition and mitigation of these problems in their subordinates. It is incorporated into pre-deployment training for all deployers, including commanders and Senior Non Commissioned Officers. All Airmen now receive TBI and Post Traumatic Stress (PTS) computer based training (CBT), which takes about 30 minutes to complete, when they complete the Self Aid and Buddy Care (SABC) CBT housed on the Advanced Distributed Learning System. A *Leaders Guide to Managing Personnel in Distress* is published guidance on how to handle PTSD and other "distress" conditions. Frontline Supervisor Training, *Assisting Airmen in Distress,* is targeted at lower-level supervisors who work side-by-side with their Airmen. This in-depth training course enhances supervisors' abilities to recognize and effectively intervene with personnel suffering from emotional distress due to a variety of life problems, build on skills first learned during annual suicide prevention training and various professional military education (PME) activities.

The Navy is planning a programmed release of the formal Operational Stress Control (OSC) curriculum in all accession and leadership schools—recruit training and "A" school, petty officer and chief petty officer indoctrination and officer candidate school, to name a few—in the very near future. In addition, specific pre- and post-deployment OSC training is being delivered at all Navy Mobilization Processing sites and Returning Warrior Weekends. The extensive OSC training continuum, while not specific to PTSD, provides training to commanders and the chain-of-command, along with Sailors and families, to help them recognize and address the symptoms of many different stress reactions and injuries. [See page 7.]

RESPONSE TO QUESTION SUBMITTED BY DR. SNYDER

Dr. RICE. There is a continuum of TBI severity ranging from mild TBI (otherwise known as concussion) to severe and penetrating. For mild TBI, assisting living programs are rarely required. Most concussed patients do not require a caregiver nor are they unable to take care of themselves from a supervision and assistance standpoint. These individuals can usually be managed with outpatient care and services. For more severe TBI patients, the assisted living pilot program is available for Service members who are unable to function independently without supervision or assistance. The numbers of patients who require these services appear to be low at this time.

Currently, there are seven Service members enrolled in the Veterans Health Administration (VHA) assisted living pilot program with two more anticipated by July 1, 2010. The VHA anticipates that by the end of Fiscal Year 2010, there will be 12–

15 patients enrolled. Should more information be needed, the Department of Veterans Affairs could provide more details. [See page 11.]

RESPONSE TO QUESTION SUBMITTED BY MR. PASCRELL

Dr. RICE. For clarity, there are three programs, each with different intent and purpose. These include the

1) Pre-Deployment Health Assessment Program, 2) Neuro-Cognitive Assessment Tool, and 3) Post-Deployment Health Assessment Program.

The Pre-Deployment Health Assessment Program serves to identify conditions that may impair performance during an upcoming deployment and to get a Service member to care if these conditions warrant. In addition to the Pre-Deployment Health Assessment, the Department implemented a Pre-Deployment Neurocognitive Assessment tool, using the Automated Neuropsychological Assessment Metrics (ANAM), to serve as a baseline for comparison if a Service member is injured while deployed. In this case, retaking the ANAM test will help inform a return-to-duty determination in theater following concussion. It also is used for post-deployment concussion management to help further elucidate cognitive symptoms and complaints. The third program, the Post-Deployment Health Assessment, enables health care providers to identify and refer for treatment those Service members who have physical or mental symptoms from their deployments due to a variety of conditions, one of which may be concussion.

The Department has based its neurocognitive testing programs on injury platforms, that is, the primary purpose of pre deployment neurocognitive baselining is to better inform a return to duty determination. We understand Congress wants the Department to base the neurocognitive programs on evaluating cognitive function before a Service member goes into war and when they come out of war to see if there are any differences. If there are differences, then theoretically, the clinical teams can evaluate these Service members and treat them, thus not allowing any Service member to "fall through the cracks."

While the Department understands the Congressional intent, the inherent problem with this wider based platform (all Service member vice injured Service member) is that the evidence does not support this concept for two reasons: 1) we have completed two studies with military populations, one at Ft Bragg and one at Ft Campbell that both showed that population based cognitive testing was not effective for screening or diagnosing concussion and 2) we do not know what "new cognitive normal" is after a theater experience. We have no normative data that would suggest what retesting these cognitive domains should look like after war. Therefore, any difference between pre-deployment and post deployment assessment cannot be attributed to any specific factors. [See page 15.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

APRIL 20, 2010

QUESTIONS SUBMITTED BY MS. FALLIN

Ms. FALLIN. The FY2008 NDAA included language mandating pre- and post-deployment neurocognitive assessments. The idea behind this being that a pre-deployment assessment would provide a baseline, to which a post-deployment assessment could be compared to. This was well understood by OSD Health Affairs at the time. Recent copies of orders that I've received from Army Medical Command have prohibited post-deployment neurocognitive assessments. Additionally, it's been brought to my attention that DOD considers itself to be complying with the law if paper and pencil evaluation is administered overseas before deployment back to the home station. Is it true that pre- and post-deployment neurocognitive assessments are not administered using the same test? What is the purpose of a pre-deployment baseline, if different methods of testing are used post-deployment? It is my understanding that DOD maintains a database of all data regarding pre-deployment assessments. Is this database accessible by the VA? Are the results in this database linked to each soldier, sailor, airman's health care file? May an individual serviceman or woman access the information related to their pre-deployment assessment? Finally, how does what DOD considers to be the post deployment assessment permit "differential diagnosis of traumatic brain injury in members returning from deployment in a combat zone"?

Dr. RICE and Mr. CARR. 1 & 2) No, DOD currently uses the same pre-deployment cognitive assessment tool (Automated Neuropsychological Assessment Metrics (ANAM)) to perform post-deployment cognitive assessments for returning Service members who have sustained a concussion. The Department does maintain a database of pre-deployment assessments as part of the Pre-Deployment Neurocognitive Program to serve as a baseline for comparison if a Service member is injured while deployed and to help better inform an injured Service member's return-to-duty determinations.

3) DOD maintains a database with pre deployment neurocognitive baselines of deploying Service members. These baselines will be available to the VA by December 2010. Milestone 4.2.A.3 in the VA/DOD Joint Executive Committee (JEC) Strategic Plan for FY 2010–2012 states "VA will begin implementing technical solution to enable VA providers to view DOD neuropsychological assessment data by June 30, 2011."

4) The results from the pre deployment neurocognitive baseline tests are not currently linked to a Service member's electronic health record.

5) The results are housed in a centralized repository so they may be retrieved if necessary post injury for comparison. Service members may access these results, when requested.

6) The population-based Traumatic Brain Injury assessment (versus cognitive screen) that occurs is the Post-Deployment Health Assessment (PDHA), is done by a health care provider. This assessment evaluates the entire spectrum of symptoms that may be associated with concussion. These include physical symptoms, i.e. headache; behavioral symptoms, i.e. irritability and cognitive symptoms, i.e. memory problems. Multiple diagnoses may result from these symptoms, to include but not limited to, posttraumatic stress disorder, high blood pressure, obstructive sleep apnea, or toxic chemical exposure. Thus, the presence of these symptoms does not diagnose a concussion or any other disorder, but they indicate the need for further clinical evaluation by a trained provider.

The TBI screening questions that have been on the Post-deployment Health Assessment form (DD 2796) since January 2008, are survey-type questions that ask about an injury event, alteration in consciousness while sustaining that injury event, symptoms reported immediately after the injury event, as well as current symptoms experienced. These questions have been endorsed by the Institute of Medicine and have gone through validation studies as the questions to ask to ascertain whether a Service member may have sustained a concussion. However, diagnosis is not made until a clinician evaluates and examines the Service member to determine whether a concussion has occurred. The assessment process is the first tier ap-

proach to cast a wide net for those who possibly have sustained a concussion. It is not expected to be a process that has high specificity but rather high sensitivity.

○