

THE PROGRESS IN PREVENTING MILITARY SUICIDES AND CHALLENGES IN DETECTION AND CARE OF THE INVISIBLE WOUNDS OF WAR

HEARING

BEFORE THE

COMMITTEE ON ARMED SERVICES

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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JUNE 22, 2010
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**THE PROGRESS IN PREVENTING MILITARY
SUICIDES AND CHALLENGES IN DETECTION
AND CARE OF THE INVISIBLE WOUNDS OF
WAR**

TUESDAY, JUNE 22, 2010

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

The committee met, pursuant to notice, at 9:35 a.m. in room SD-G50, Dirksen Senate Office Building, Senator Carl Levin (chairman) presiding.

Committee members present: Senators Levin, Lieberman, Akaka, Webb, McCaskill, Udall, Hagan, Begich, Burris, McCain, Inhofe, Thune, and Collins.

Committee staff members present: Richard D. DeBobes, staff director; and Leah C. Brewer, nominations and hearings clerk.

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

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

Staff assistants present: Jennifer R. Knowles, Hannah I. Lloyd, and Breon N. Wells.

Committee members' assistants present: James Tuite, assistant to Senator Byrd; Nick Ikeda, assistant to Senator Akaka; Greta Lundeberg, assistant to Senator Bill Nelson; Gordon I. Peterson, assistant to Senator Webb; Tressa Guenov, assistant to Senator McCaskill; Roger Pena, assistant to Senator Hagan; Lindsay Kavanaugh, assistant to Senator Begich; Amanda Fox, assistant to Senator Burris; Anthony J. Lazarski, assistant to Senator Inhofe; T. Finch Fulton and Lenwood Landrum, assistants to Senator Sessions; Richard Perry, assistant to Senator Graham; and Ryan Kaldahl, assistant to Senator Collins.

OPENING STATEMENT OF SENATOR CARL LEVIN, CHAIRMAN

Chairman LEVIN. Good morning, everybody.

The committee meets today to receive testimony on the status of our efforts to prevent military suicides and the challenges in detection, treatment, and management of the so-called “invisible wounds of war,” which we consider to include traumatic brain injury (TBI), and concussive events, post-traumatic stress disorder (PTSD), and other combat-related psychological health concerns.

A hearing on military suicides was requested by Senator Inhofe several weeks ago, and we all appreciate that request. Due to our committee markup schedule, we were unable to schedule a hearing until this week. Originally, this hearing was meant to focus on Service suicide prevention policies and programs. But, given the recent disconcerting reports alleging poor diagnosis and treatment of servicemembers suffering from TBI and PTSD, I felt it important to broaden the scope of our discussion today to include those topics as well, especially given the fact that they can often occur concurrently, making diagnosis of any or all of these illnesses difficult.

The increase in suicides by military personnel in the last few years is alarming. In 2007, 115 Army soldiers committed suicide. In 2008, the number increased to 140, and to 162 in 2009. Similarly, 33 marines committed suicide in 2007, 42 in 2008, and 52 in 2009. I understand there are a number of additional cases where the Armed Forces medical examiner has not yet concluded whether the deaths are by suicide so, the 2009 numbers will likely be even higher.

These increases indicate that, despite the Services' efforts, there is still much work to be done. We must improve our suicide prevention efforts to reverse the number of servicemembers taking their own lives.

I am greatly concerned about the increasing number of troops returning from combat with PTSD and TBIs, and the number of those troops who may have experienced concussive injuries that were never diagnosed.

Studies indicate that mild TBI, or concussion, is associated with PTSD, depression, and anxiety. These conditions, in turn, may contribute to the increase in the number of suicides.

One key to suicide prevention is to make greater efforts to end the stigma that too many perceive attaches when they receive mental health care. Another key, of course, is the proper and timely diagnosis and treatment of TBI and PTSD, and increasing awareness of, and access to, mental healthcare resources, as well as leadership support for those seeking such care.

We hope to hear from our witnesses today the approach that each Service and the Department of Veterans' Affairs (VA) is taking to help detect, treat, and manage psychological health problems, to include PTSD and TBI.

The numbers of suicides have increased in every Service, but significantly more so in the Army and Marine Corps, the two Services most heavily engaged in ground combat in Iraq and Afghanistan. Congress has recognized the strain on these ground forces, and has, over the past several years, authorized significant increases in the Active Duty end strengths for the Army and Marine Corps. It is our intent that these increases will help to relieve the stress on those forces, but we also have to make sure that we provide all the assistance that our troops need to cope with the stress that they are experiencing.

The professionals tell us that common issues leading to suicide include relationship problems, financial problems, and legal problems, as well as mental health issues. I know that each of the Services, as well as the VA, have programs to address those as part of the suicide prevention efforts. Undoubtedly, deployments and lack

of dwell time have contributed to these underlying problems that are linked with suicides.

The Army is working with the National Institute of Mental Health (NIMH) on a 5-year longitudinal study to help identify and develop intervention and mitigation strategies to help decrease the number of suicides in the Army. While this is an important effort, we cannot wait for the full 5 years to occur for these results. We must identify actions, and take them now, to reduce suicides. General Chiarelli, we look forward to hearing about interim findings from the study, and how the Army might use those findings now to better target suicide prevention efforts.

We must learn more about TBI and concussive events, and their relationship to PTSD and suicide. Unfortunately, these brain injuries remain relatively unknown territory in both the military and civilian medical environments.

We look forward to learning more about the policies and programs each Service has in place to handle incidences of TBI and concussive events, both in theater and at home. We also look forward to learning what policies, programs, and initiatives each of the Services and the VA has implemented and identified to ensure that our servicemembers, in both the Active Duty and Reserve components, veterans, and their families, receive all of the support that we can provide, and that our All-Volunteer Force can continue to perform its mission with the health and other services that they need and deserve.

I'm pleased to welcome our witnesses. We have with us General Peter Chiarelli, Vice Chief of Staff of the U.S. Army; Admiral Jonathan Greenert, the Vice Chief of Naval Operations of the U.S. Navy; General James Amos, Assistant Commandant of the U.S. Marine Corps; General Carrol Chandler, Vice Chief of Staff of the U.S. Air Force; and Dr. Robert Jesse, the Acting Principal Deputy Under Secretary for Health for the Veterans Health Administration of the VA.

General Amos, since Secretary Gates has just announced his recommendation to the President to nominate you to be the next Commandant of the Marine Corps, I know we all offer our congratulations and great hopes for you in the future.

Senator McCain.

STATEMENT OF SENATOR JOHN McCAIN

Senator McCAIN. Thank you, Mr. Chairman.

Let me thank our witnesses for joining us today.

I'd like to also acknowledge Senator Inhofe, who initiated a request in April for a full committee hearing on the tragic and important issue of suicide in our military. Thank you for your initiative, Senator Inhofe. I'm pleased that we are having this hearing.

It's our privilege to serve the distinguished men and women of our Armed Forces, who, even after more than 9 years of war, love their country and risk everything to defend her. We have greatest admiration and appreciation for them and for their families, and we'll always honor their courage and sacrifice.

The burdens of our missions in Iraq and Afghanistan are tremendous, and so are the consequences for those who serve. Many of our servicemembers have answered their country's call, with multiple

deployments to combat and little time for rest and recovery at home.

The enemy's signature weapon, the improvised explosive device (IED), causes multiple injuries to parts of the body and brain. As is the case with every war, many of the deepest wounds are those that wrack the minds and souls of our citizen soldiers, wounds that continue to plague them long after they've returned home from the field of battle.

The Department of Defense (DOD) has documented nearly 2,000 suicides from 2001 to 2009. Today the Services report more than 140 during 2010.

Although the Air Force and Navy have previously experienced rates of suicide higher than those reported today, rates for the Army and Marine Corps are at historically high levels. These are casualties that our Nation cannot accept and that our armed services must work to prevent, both among troops who have deployed and those who have not. We must erase cultural barriers and attitudes from peers and leaders that may cause soldiers who need care to turn away from it. We must conquer any bureaucracy that stands in the way of compassionate care for a man or woman who seeks it.

Since the attacks of September 11, we have devoted billions of dollars to improving care for wounded and ill servicemembers and their families provided not just by DOD and the Veterans Administration alone, but by many agencies of government and the private sector.

One important example is the National Suicide Prevention Lifeline. Crisis counselors who respond to hundreds of calls from current and former serving members of the military every day. As a Nation, we can be proud of these efforts, but not yet content with their results. Teaching our servicemembers and their families to navigate complex pathways to care is necessary, but leading them there is essential. As in all military campaigns, the quality of leadership will determine our success or failure.

Several of our witnesses report that military servicemembers continue to distrust informing their chain of command that they have a brain injury or that they're experiencing stress or considering harm to themselves and others, for fear of bringing a sense of shame to themselves and their unit. This is unacceptable. There's no shame in admitting that you are struggling with the hidden wounds of war, for those wounds are every bit as real as those that are visible on the surface.

The Services must increase focus on transforming the culture of leadership, and must train more leaders to understand that emotional and physical health are critical factors in military readiness, and hold them accountable if they fail.

Americans expect that high quality health and mental health care, matched by compassionate involvement of military leaders, can and will make a difference that is capable of saving lives that would be lost to suicide. To meet this rightfully high expectation, leaders at every level must exercise their sacred obligation to take responsibility for their subordinates, know about their lives and families, have conversations with them, and listen to their concerns. These powerful human interactions, which are the essential

character of the core military values of trust and cohesion, can save lives. Our service men and women and their families deserve nothing less.

I thank you, and I look forward to hearing the testimony of our witnesses.

Chairman LEVIN. Thank you very much, Senator McCain.

We'll start with General Chiarelli, and we'll just go right down the table.

General Chiarelli.

**STATEMENT OF GEN PETER W. CHIARELLI, USA, VICE CHIEF
OF STAFF, U.S. ARMY**

General CHIARELLI. Chairman Levin, Senator McCain, distinguished members of the committee, I thank you for the opportunity to appear before you today to provide a status of the Army's ongoing efforts to reduce the number of suicides across our force, and also detect and care for soldiers suffering from PTSD, TBI, and other behavioral health issues.

I've submitted a statement for the record, and I look forward to answering your questions at the conclusion of our opening remarks.

As you are all aware, it remains a very busy time for our Nation's military. We're in the ninth year of war being fought in two separate theaters. The pace of operations is exceedingly high, and will likely remain so for the foreseeable future.

I'm proud to report that the men and women serving in our Army today are doing an absolutely outstanding job. They are well trained, highly motivated, and deeply patriotic. Our Nation has asked a great deal of them and of their families, and they've exceeded expectations by a long shot.

However, the prolonged demand continues to put a significant strain on our force. One of the symptoms of this, albeit the most severe, is the historically high number of suicides we've experienced in recent years. Fortunately, we've seen a fairly significant reduction in suicides among Active Duty soldiers this year, as compared to last year. However, we've seen an unexpected increase in suicides among our Reserve-component soldiers not on Active Duty, in particular, the Army National Guard.

Needless to say, the loss of any soldier, Army civilian, or family member to suicide is tragic and unacceptable. Each of these suicides represents an individual and a family that has suffered an irreparable loss. Over the past 12 months, we've learned a great deal about suicides. For example, we now know that soldiers with one or no deployments represent 79 percent of all suicides. First-termers represent 60 percent of all suicides.

I've worked closely with my colleagues from the Navy and Air Force, and particularly with my good friend Jim Amos. Our Army and Marine Corps ground forces share a similar mission, and we're working together on many of the same issues.

You have my word that we will continue to work diligently to learn even more, in an effort to further reduce suicides in our force.

In the meantime, we've learned a tremendous amount about the broader challenge of behavioral health issues affecting many of our soldiers, Army civilians, and family members. After 8-plus years of war and multiple deployments, many are suffering from depres-

sion, anxiety, TBI, and PTSD, often referred to as the “invisible wounds of war.” These and other highly complex injuries and conditions involving the brain pose unique challenges, especially as compared to easily detectable wounds, such as an amputation or a burn. In particular, the comorbidity of symptoms can make diagnosis especially difficult, in many cases, a fact not well understood or appreciated by many.

The reality is, the study of the brain is an emerging science, and there is still much to be learned. But, we’re making progress. Over the past 12 months, the Army’s commitment to health promotion, risk reduction, and suicide prevention has changed Army policy, structure, and processes. We have realigned garrison programs, increased care provider services, refocused deployment and redeployment integration, and enhanced treatment of PTSD and TBI, and promoted tele-behavioral medicine.

Our success notwithstanding, we still have much more to do. We face an Army-wide problem that can only be solved by the coordinated efforts of our commanders, leaders, soldiers, program managers, and health providers.

This is a holistic problem, with holistic solutions, and that is how we’re approaching it. We remain focused on investigating ways to promote resiliency, reduce stressors caused by a variety of factors, improve leaders’ and soldiers’ ability and willingness to identify when they or their buddies need help, and be able and willing to take advantage of the resources and support that are available to them.

I can assure the esteemed members of the committee there is no greater priority for me and the other senior leaders of the U.S. Army than the safety and well-being of our soldiers. The men and women who wear the uniform of our Nation are the best in the world. We owe them and their families a tremendous debt of gratitude for their service and many sacrifices.

Mr. Chairman, Senator McCain, members of the committee, I thank you for your continued and generous support and demonstrated commitment to the outstanding men and women of the U.S. Army and their families. I look forward to your questions.

[The prepared statement of General Chiarelli follows:]

PREPARED STATEMENT BY GEN PETER W. CHIARELLI, USA

Chairman Levin, Senator McCain, distinguished members of the Senate Armed Services Committee; I thank you for the opportunity to appear here today to provide a status on the U.S. Army’s ongoing efforts to reduce the number of suicides across our force; and, also detect and care for soldiers suffering from post-traumatic stress, traumatic brain injury and other behavioral health issues.

On behalf of our Secretary, the Honorable John McHugh and Chief of Staff, General George Casey, I would like to take this opportunity to thank you for your continued, strong support and demonstrated commitment to our soldiers, Army civilians, and family members.

As you are well aware, it continues to be a very busy time for our Nation’s military. We are in the ninth year of war, being fought in two separate theaters. The pace of operations is exceedingly high; and, will likely remain so for the foreseeable future.

I will tell you, the men and women serving in the Army today are doing an absolutely outstanding job on behalf of our Nation. They are well-trained, highly-motivated, and deeply patriotic. Our Nation has asked a lot of our soldiers and they have exceeded expectations by a long shot.

However, the prolonged demand on them—and on their families—continues to put a significant strain on our force. Many individuals have deployed multiple times.

They are tired. A significant number of them suffer physical injuries, such as musculo-skeletal damage, amputations, bullet or shrapnel wounds, or burns. Many more suffer from behavioral health issues, such as depression, anxiety, traumatic brain injury and post-traumatic stress—often referred to as the “invisible wounds of war.” The Army is continuing to work very, very hard to identify ways to address these behavioral health issues by alleviating some of the stress on our force while also improving our ability to detect, prevent, and treat these and other injuries.

Our overarching goals are to improve individuals’ resiliency; eliminate the long-standing, negative stigma associated with seeking and receiving help; and, ensure soldiers, Army civilians, and family members who may be struggling get the help that they need.

CALENDAR YEAR 2009 AND CALENDAR YEAR 2010 ARMY SUICIDE REPORTS

Suicides in the United States Army have been on the rise since 2004. In calendar year 2009, we had 162 active duty suicide deaths (including activated members of the National Guard and U.S. Army Reserves), with 244 across the total Army. During this same period, we had 1,679 known attempted suicides.

However, so far this year, we’ve seen a fairly significant reduction in suicides among active-duty soldiers. As of 10 June 2010, there have been 62 suicides (includes 3 activated USAR soldiers and 3 activated ARNG soldiers); for the same time period last year there were 89.

Unfortunately, we have seen an increase in suicides among Reserve component soldiers not on active duty [2010 total (as of 10 June)—53 (43 ARNG; 10 USAR); 2009 total—42 (same time period)].

The decrease in active duty suicides would seem to indicate the refocused efforts by our Army are beginning to work. Conversely, the increase in suicides among Reserve component soldiers not on active duty may reflect the Army’s more limited ability to influence these soldiers once they return home.

We also track suicides among Department of the Army civilians [2010 total (as of 10 June) for DA civilians—13; 2009 total—21] and family members [2010 total (as of 10 June) for family members—4; 2009 total—11].

The loss of any soldier, Army civilian or family member to suicide is tragic, incomprehensible, and unacceptable. Each of these suicides represents an individual and a family that has suffered an irreparable loss. Army leadership is working to better understand the causes of the disturbing rise in soldier suicides and we’ve instituted prevention measures that recognize everyone in the Army must be part of the solution. You have my word that we will continue to work diligently to further reduce suicides across our Force.

SOLDIERS ENGAGING IN HIGH-RISK BEHAVIOR

Equally alarming to the increase in Army suicides is the growing population of soldiers engaging in high-risk behavior. Illicit drug use, alcohol abuse, disciplinary infractions, misdemeanors and felony crimes are all on the rise. There is a known spike in these behaviors as soldiers return from deployments. A so-called “star burst” effect has been recognized at about the 90 day mark, where an increase in these and other high-risk behaviors has been noted. Meanwhile, there is a clear link between suicides and these and other high-risk behaviors.

Of the 160 active duty suicide deaths in fiscal year 2009, 146 were related to high-risk behavior (e.g., self-harm, illicit drug use, binge drinking and criminal activity); including 74 drug overdoses. Data collected since 2005 consistently show that approximately 33 percent of suicides included either drug or alcohol use. In addition 32 percent had some form of closed or pending misdemeanor or felony investigation.

PRESCRIPTION DRUG ABUSE

Meanwhile, recent estimates show that 14 percent—or approximately 106,000 soldiers—are prescribed some form of pain, depression or anxiety medication. This ranges from Percocet for a simple tooth extraction to powerful anti-psychotic medications prescribed to an individual experiencing a true psychiatric crisis. The potential for abuse (or misuse) is obvious. We are working with the legal and medical communities to improve transfer of information between commanders, medical professionals, and program and service providers, while ensuring we protect the privacy rights of patients.

The office of the Army Surgeon General is also drafting a new policy to provide guidance on the prevention and management of polypharmacy with psychotropic medications and central nervous system depressants. This new policy will assist in reducing adverse clinical outcomes among patients receiving care in the military medical system.

This is one of the major risks associated with suicide: polypharmacy, post-concussive syndrome and pain. I have mentioned the first two; to address pain management, our medical department recently led a task force consisting of subject matter experts from all Services and Department of Veterans Affairs (VA). This task force has developed a number of recommendations to improve pain management for our patients; and, we are currently developing a campaign plan to address this important issue. These efforts will improve care for all patients, both in and out of uniform.

The Army is also continuing to conduct and evaluate programs for substance abuse self-referral, pre-deployment and post-deployment behavioral health screening, and the use of virtual communication technology to provide more accessible behavioral health counseling.

The nationwide shortage of behavioral health care providers and substance abuse counselors continues to present a significant challenge. The Army is working hard to recruit more in order to meet the increased need for these services across our Force.

For example, one hundred more Medical Corps officers were recruited in fiscal year 2009 as compared to fiscal year 2007. One hundred and twenty more civilian Behavioral Healthcare personnel were hired in fiscal year 2008 compared to fiscal year 2007. Meanwhile, the Army has increased funding for use of "3R" bonuses (recruiting, relocation and retention) in order to hire more substance abuse and family advocacy program counselors. The Army has also expanded its civilian force structure to include supportive specialties such as Licensed Professional Counselors, Licensed Marriage and Family Therapists (LMFTs) and Military Family Life Counselors (MFLC).

ARMY SUICIDE PREVENTION TASK FORCE

After the all-time high of 20 suicides in a single month, January 2009, the Army mandated an unprecedented Army-wide stand-down followed by a deliberate chain teaching program focused on suicide prevention. The Secretary of the Army at that time the Honorable Pete Geren, and Chief of Staff of the Army, General George Casey appointed me to lead the effort to reduce the trend of suicides in the Army.

I ordered the immediate activation of the Army Suicide Prevention Task Force (ASPTF)—a group of multi-disciplinary representatives from across the Army staff—in March 2009 to dedicate focused energies and resources to tackle all aspects of suicide.

Over the past year, the ASPTF examined the complexity of suicide, taking into account national suicide trends, individual soldier risk factors and the Army's institutional approach to suicide prevention. The task force identified risk factors and indicators that help potentially illuminate correlations to high-risk and suicidal behavior in the Army. The task force continues to review over 70 existing Army-wide programs, identifying those that work, while strengthening the most effective programs and streamlining efforts where it makes sense.

The unique governance, policy, structure and process of the task force, together with the Army Suicide Prevention Council (an interim HQDA-level organization chartered under my authority and mandated to expedite solutions from HQDA through appropriate commands) greatly expedited implementation of many strategic changes over the past 12 months, including:

- June 2009, reduced accessions waivers for adult felony (major misconduct) convictions; and DAT (positive drug and alcohol tests at MEPS); misconduct (misdemeanor/major misconduct) for drug use; possession; or drug paraphernalia, to include marijuana. This translated to nearly 4,300 fewer applicants accepted into the Army as compared to 2008.
- Revised legacy protocols for investigating and reporting suicide.
- Rewrote DA PAM 600-24, Health Promotion, Risk Reduction, and Suicide Prevention (HP/RR/SP) for synchronization of HP/RR/SP Program Portfolio. This policy integrates HP/RR/SP programs and services at the installation level.

VCSA SUICIDE SENIOR REVIEW GROUP

In an effort to learn as much as possible from every suicide, in March 2009 I also established the monthly VCSA Suicide Senior Review Group (SRG). The SRG involves senior commanders from affected commands across the Army. We meet in person or via video tele-conference and review approximately 15 to 20 suicide cases each month. The cases are discussed to glean lessons learned and identify trends and themes in an effort to help prevent future suicides. The SRG is the most intense 2½ hours I spend each month.

Also, to aid in gaining as much information as possible from every suicide, the task force developed a suicide event collection report, comprised of data fields to be filled in by the Field Army. The report provides me and Army leadership with instant, actionable information on each individual Army suicide within approximately 72 hours of the Criminal Investigation Command's initial response.

ARMY CAMPAIGN PLAN FOR HP/RR/SP REPORT

The ASPTF is responsible for the development and publication of the Army Campaign Plan for HP/RR/SP, a comprehensive plan outlining unprecedented changes in Army doctrine, policy and resource allocation. This holistic approach accounts for the many challenges our soldiers, Army civilians, and families face. These challenges include, but are not limited to: substance abuse; financial and relationship problems; and, post-traumatic stress and traumatic brain injury.

The content of the Campaign Plan was informed and developed by three concurrent efforts: (1) the collection of suicide data and research; (2) the comprehensive review of existing policy, doctrine and all known HP/RR/SP related documents from HQDA and across DOD; and (3) the VCSA-led installation level assessment, which obtained input from commanders, soldiers and family members and reviewed programs and processes at the installation level.

I also chartered a multi-disciplinary team of experts led by a General Officer that is writing a comprehensive report on the Army's HP/RR/SP past and future efforts. The team is preparing to release its full report as soon as it is completed and reviewed.

The report represents over a year's worth of work at the direction of the Army's Senior Leadership to provide a "directed telescope" on the alarming rate of suicides in the Army. The report is based on the ASPTF's experience, ongoing research; and, presents new concepts and modeling for HP/RR/SP governance, policy, structure, and process. It represents the most comprehensive HQDA report of its kind, capturing both the initial findings of the ASPTF and informing the future of suicide prevention within the Army.

In an effort not to prematurely reveal out of context details on findings, I will mention very few in this statement. Prior to the formal roll-out, I and the Army's other senior leaders will come back and brief the members and their staffs on the full contents of the report.

Bottom line: this report indicates there is a confluence of stressors that cause suicides, but no single panacea to prevent them. As I have said many times over the past year, there is no one solution to this problem.

Last year, shortly after Secretary Geren and General Casey appointed me as lead of this ongoing effort, I visited six installations with a team for the sole purpose of looking at suicide prevention efforts in the Force. By the time we reached the third installation, it was readily apparent to all of us that this challenge was not limited specifically to suicides; but, to the overall health and well-being of the Force after 8-plus years of war. In other words, we quickly determined that suicide is merely a symptom—albeit the most severe—of a much larger problem. The focus on suicide prevention was too narrow and the aperture needed to widen to a more comprehensive review of all soldier and family risk reduction and wellness programs.

That initial eye-opening experience led to the holistic approach we have since adopted to achieve soldier wellness (promoting the physical, mental and spiritual health of the force). We remain focused on investigating ways to promote resiliency; reduce stressors caused by a variety of factors; improve leaders' and soldiers' ability and willingness to identify when they or their buddies need help; and be able and willing to take advantage of the resources and support that are available to them.

A TEAM APPROACH

As I emphasized previously, effectively addressing the challenge of soldier suicides will require a team effort across all Army components, jurisdictions, and commands, as well as continued cooperation with partners outside of our organization, to include VA (has joined the Army Suicide Prevention Council) and the National Institute of Mental Health (NIMH).

In October 2008, the Army entered into a 5-year, \$50 million joint study with NIMH, the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). This study represents the largest DOD longitudinal epidemiologic study of mental health, psychological resilience, suicide risk, suicide-related behaviors, and suicide deaths in the Army. The goal is to help identify those soldiers most at risk, as well as develop intervention and mitigation strategies that will help decrease the number of suicides across the Army.

This is the largest single study on the subject of suicide that NIMH has ever undertaken. It includes soldiers from every component of the force—Active Army, Army National Guard, and Army Reserve. The study will follow willing soldiers as they enter the training base and periodically thereafter for the next 5 years. The researchers will conduct a variety of interviews, surveys, psychological evaluations, etc.

Intermediate data and emerging results are reported quarterly to inform the Army's ongoing intervention strategies. Initial findings from preliminary analyses of suicide deaths include:

- Suicide risk is highest for currently deployed soldiers, next highest for previously deployed, and lowest (in relative terms) for never-deployed soldiers;
- Since 2004, suicide risk has been elevated among soldiers with <1 year of service;
- Most (about 53 percent) soldiers who die by suicide do not have a record of an encounter with a behavioral health diagnosis in the military healthcare system;
- Mental disorders, particularly depression, anxiety, and post-traumatic stress are among the most potent risk factors for suicidal behavior; and
- The average period between onset of PTS and an individual seeking help is 12 years; during that period, symptoms can manifest in a variety of ways, including spousal abuse, anger management issues, divorce, drug/alcohol abuse, loss of employment.

We are confident this study's findings will eventually lead to predictive algorithms. Ultimately, we are trying to develop a predictive model that accounts for the cumulative effect of transitions of all types (accession, PCS, death of family member, TCS, retirement, etc.) and stressors across a soldier's entire career. Ideally, this would lead to tailored interventions based on known or predictive levels of stress. The results will benefit the Army, the other military Services, as well as the U.S. population overall, and may lead to more effective interventions for both soldiers and civilians.

TRAUMATIC BRAIN INJURY AND POST-TRAUMATIC STRESS

One of the challenges in preventing suicide is recognizing that an individual—even someone as close as a family member or good friend—is considering taking his or her own life and may need help. Too often individuals will suffer in silence. They may be dealing with severe depression or anxiety and choose to hide their concerns from family members or friends.

Post-traumatic stress (PTS), traumatic brain injury (TBI), and other behavioral health issues can present similar significant challenges. I consider these “invisible injuries” to be among the most common result of the “signature weapon” of this war: blast. In fact, the majority (60 percent) of the soldiers enrolled in the Army's Wounded Warrior program have PTS (43 percent) and/or TBI (17 percent) as a primary service disqualifying injury of 30 percent or greater.

These injuries pose unique challenges, especially as compared to easily-detectable wounds such as amputations and burns. PTS and TBI are among the most difficult and debilitating in terms of accurate diagnosis, treatment, and recovery. The study of the human brain is an emerging science; and, there is still much to be learned about these and other highly-complex injuries involving the brain. This pertains not just within the military community, but throughout the entire medical community as a whole, worldwide.

We are making progress, both in theater and at medical facilities around the world. In a concerted effort to minimize the number and severity of injuries, the Army implemented a new TBI management strategy across the force aimed at prevention, early detection and effective treatment of injuries. Additionally, the Army is instituting a revised program of instruction for medics and other behavioral health providers that includes training specific to TBI and PTS injuries. We're also incorporating instruction on this important issue into training programs at the National Training Center, Joint Readiness Training Center and other locations.

The new TBI management strategy, “Educate, Train, Treat, and Track,” is also being successfully implemented downrange. Deploying soldiers receive training prior to their arrival in theater; in fact, I personally have briefed several units. Last week, I briefed a deploying Brigade Combat Team via VTC. This emphasizes to leaders and soldiers just how serious I, and the Army's other senior leaders, are when it comes to these very serious injuries.

The new TBI management strategy also includes strict “event-based” protocols that govern exactly what leaders and soldiers must do if involved in any type of con-

cussive event. At a minimum, every soldier must undergo a medical evaluation followed by a mandatory 24-hour downtime period and a second exam before returning to duty. We cannot permit the proud “Warrior Spirit” of our soldiers, which leads many of them to ignore their concussions and remain in the fight, to dominate the competing need to protect them against another injury during the vulnerable period of healing.

Meanwhile, back at home, since 2002, the Department of Defense has opened 52 TBI treatment centers across the country. These centers are staffed with multidisciplinary teams of medical providers capable of treating the full range of TBI, from mild to severe. The National Intrepid Center of Excellence, dedicated to research and treatment of military personnel and veterans suffering from TBI and other behavioral health issues will open this summer. It is built on the Bethesda, Maryland campus of what will become the new Walter Reed National Military Medical Center, the DOD’s largest and most advanced medical complex, and across from the National Institute of Health—a key partner in advancing the science and treatment of these injuries and illnesses.

We are making progress, but it remains an incredibly challenging endeavor. The reality is some of these neurological injuries or conditions cannot be fully healed or repaired even with the most advanced medical treatment available. Unlike an amputation, for example, there is no standard procedure or prognosis for care for moderate or severe TBI. This can understandably add to the frustration felt by affected soldiers and family members.

In the past, individuals suffering from TBI, PTS, or what was previously referred to as “battle fatigue,” were often told there was nothing further that could be done for them. They were discharged from the military and left to suffer in silence. This is absolutely unacceptable. Next to the prosecution of current and future conflicts, our highest priority remains caring for the brave men and women who serve and sacrifice on behalf of our Nation.

In 2007, the Army established Warrior Transition Units (WTU) to facilitate the treatment and rehabilitation of soldiers determined to require complex medical care for 6 months or longer. Today, there are 29 WTUs and 9 community-based WTUs located around the world. Approximately, 9,300 wounded or injured soldiers are receiving treatment at these facilities. Teams comprised of nurse case managers, health care providers, and cadre members assist them and their families through the full recovery process. The feedback has consistently been very positive. We are continually making improvements to the care and services provided at these facilities based on lessons learned.

The Army activated the Warrior Transition Command to oversee the WTUs and to guide the ongoing execution and development of the Warrior Care and Transition Program. This included accomplishing a paradigm shift from simply treating and discharging soldiers to a comprehensive program that includes holistically preparing Veterans for a successful and productive future in the Army or as a private citizen. The overarching goal is to help soldiers and veterans to heal physically and mentally while building bridges to positive opportunities that lie ahead for them in the future.

I, and the Army’s other senior leaders, are absolutely committed to doing anything and everything possible to help these soldiers at all stages of care, even after they leave military service.

CHANGING THE ARMY CULTURE

Today, there is a wide range of programs and services available to soldiers, veterans, Army civilians and family members who need assistance. However, individuals are frequently reluctant to seek help. We must change the culture of our Army. In the past, there has been a stigma associated with seeking help from any kind of mental health professional. Soldiers avoided seeking this type of assistance for fear that it might adversely affect their careers. However, that is not the case; and, we are taking the necessary steps to change this misperception across the Army.

WEB-BASED BEHAVIORAL HEALTH CARE SERVICES

Today, soldiers and family members can access behavioral health care services online through the TRICARE Assistance Program (TRIAP). The program is open to:

- Active duty servicemembers
- Members eligible for the Transition Assistance Management Program (TAMP) for 6 months after demobilization
- Members enrolled in TRICARE Reserve Select, as well as spouses and family members 18+ years

Soldiers and family members can access unlimited short-term, problem-solving counseling 24/7 with a licensed counselor from home or any location with a computer, Internet, required software download, and webcam. If more specialized medical care is deemed necessary, an immediate warm handoff can/will be made to a medical provider.

In conjunction with TRIAP, the Army is working to build a network of locations and online providers for telemental health services, using medically-supervised, secure audio-visual conferencing to link beneficiaries with offsite providers. Once in place, this Network will be able to provide the full-range of behavioral health care services, including psychotherapy and medication management. Our long-term goal is to create a network of counselors and certified mental health care providers that encompasses the entire United States. Then, when a Brigade redeploys, for example, a gymnasium full of stations/computers could be put in place allowing every leader and soldier to participate in a behavioral health evaluation online upon redeploying.

From 28 Oct 09 to 18 Nov 09, Tripler Army Medical Center (TAMC), Schofield Barracks, HI, conducted a Behavioral Health (BH) virtual pilot study with soldiers returning from combat duty to determine clinical efficiency of BH screening, comparing face-to-face versus webcam versus VTC. A total of 450 soldiers from 25th Infantry Division were screened. The results were very positive. Young soldiers indicated an overwhelming preference for online counseling versus face-to-face.

The pilot conducted at TAMC validated the use of virtual BH counseling for our returning/redeploying soldiers. In March 2010, we conducted a similar pilot for an entire returning Brigade Combat Team (4-25 IBCT) at Fort Richardson, AK. Similar satisfaction and increased BH referral rates were appreciated; and, we are now implementing this virtual BH technology at other locations anticipating returning units. These previous efforts will allow us to enhance collaboration with the DVA and hopefully expand this capability in the future to include TRICARE network BH providers.

BEHAVIORAL HEALTH CARE

The good news is that soldiers are seeking behavioral health care in record numbers with over 236,000 behavioral health contacts in fiscal year 2009, indicating that our efforts to emphasize the importance of behavioral health are working. In particular, recent mental health assessments conducted in theater have shown a marked increase in the percentage of soldiers willing to seek mental health care without undue concern that it will be perceived as a sign of weakness or negatively impact their careers. This is because soldiers recognize the importance of individual help-seeking behavior and commanders realize the importance of intervention.

That said, we recognize that we must do more. We must eliminate the long-standing, negative stigma associated with seeking and receiving help. There is absolutely no reason for an individual to suffer when help is available simply because he or she is afraid of how others will react.

CLOSING

In my 38-year career in the Army, I have never dealt with a more difficult or critical mission than the current charge to reduce the number of soldier suicides and properly diagnose and treat individuals suffering from TBI, PTS, and other behavioral health issues.

Over the past year, our commitment to health promotion, risk reduction and suicide prevention has changed Army policy, structure and processes. We have realigned garrison programs, increased care provider services, refocused deployment and redeployment integration, enhanced treatment of PTS and TBI, and promoted tele-behavioral medicine. Our success notwithstanding, we still have much more to do. We face an Army-wide problem that can only be solved by the coordinated efforts of our commanders, leaders, program managers and service providers.

This is a holistic problem with holistic solutions, and that's how we are going to continue to approach it with this campaign.

Again, I can assure the esteemed members of this committee that there is no greater priority for me and the other senior leaders of the U.S. Army than the safety and well-being of our soldiers. The men and women who wear the uniform of our Nation are the best in the world, and we owe them and their families a tremendous debt of gratitude for their service and for their many sacrifices.

Chairman, members of the committee, I thank you again for your continued and generous support of the outstanding men and women of the U.S. Army and their families. I look forward to your questions.

Chairman LEVIN. Thank you very much, General.

Admiral Greenert.

**STATEMENT OF ADM JONATHAN W. GREENERT, USN, VICE
CHIEF OF NAVAL OPERATIONS, U.S. NAVY**

Admiral GREENERT. Thank you, sir.

Chairman Levin, Senator McCain, and distinguished members of this committee, thank you for the opportunity to testify about the ongoing efforts to prevent suicides in our Navy and to discuss what has been referred to as the “invisible wounds of war”—namely, PTSD and TBI.

Each suicide is a tragic loss that can destroy families, devastate a community, and impact unit cohesiveness and morale. While the contributing factors of suicide are unique to each person, a common thread is a personal perceived inability to cope with stress.

Our focus of effort is to better understand the stressors that sailors and their families face, and equip them with positive methods to cope with stress. We want to foster resilience in our sailors and their families, increase unit- and family-level vigilance, and encourage early intervention and care.

Our acronym, or our brand, in this, is ACT, A-C-T—to “Ask” about a shipmate, to “Care” for the shipmate, and to help that shipmate get “Treatment.” A first step in this is awareness and training of the providers, the sailors, and the families. To that end, in fiscal year 2010, training workshops for leaders, for first responders, and for suicide prevention coordinators, has been conducted at 20 locations in 5 countries, with 5 more being planned for the end of the fiscal year.

A new training video, called “Suicide Prevention: A Message from Survivors,” was distributed, just this April. Interactive training programs, such as front-line supervisor training and peer-to-peer training, have been distributed, aimed at strengthening a culture of support. We have trained about 120,000 people, so far, in operational stress control.

A key in all of this is taking control of stressors. Stress is a fact of life. We want to reframe the issue, in terms of operational stress control, a comprehensive approach to address the psychological health of sailors and their families amidst a period of high operational tempo, a dynamic work environment, and increased deployments. It’s a program designed to be implemented by leadership at all levels, providing them with practical decisionmaking tools for sailors, for leaders, and for families to build resilience and improve their awareness of stress response, and to take every action to mitigate the effects of stress as part of a healthy lifestyle.

Our sailors deployed to Iraq and Afghanistan face a dynamic environment with unique experiences and a preponderance of events that could manifest PTSD. Accordingly, we are focused on preventing PTSD, building resilience, and eliminating barriers or stigma associated with the treatment after deployment.

Prevention efforts include incorporating operational stress control continuum and stress first-aid principles for all our sailors, from basic training to flag officer development, Web-based information resources, and Navy career courses. Our Project FOCUS (Families Overcoming Under Stress) is an example of a selected intervention for families responding to the challenges of deployment and

related stresses. It has reaped tangible results, and it is being instituted DOD-wide.

The combat and operational stress first-aid training is designed to guide our sailors, our leaders, and caregivers to provide support in a manner designed to overcome the stigma of requesting help.

While there are several injury patterns in theater, an important area for all of us remains TBI. The diagnosis and treatment of TBI is a top priority. There is still much we do not know about the injuries and their long-term impacts on the lives of our service-members. But, through a collaborative effort with other Services, Defense Centers of Excellence, Defense and Veterans Brain Injury Centers, the VA, and academia, we are committed to a full assessment of blast injuries, immediate attention to injuries, and ensuring at every sailor affected subsequently receives the best medical treatment available.

Surveillance for injuries across the deployment continuum is essential to the early identification of TBI. Predeployment screening, which will establish a baseline, monitoring and treating, in situ, sailors involved in a blast event, and instituting tracking mechanisms for followup care are key elements.

I want to thank you for your attention and commitment to the critical issue of suicide prevention, and your interest in the best possible care for the silent injuries of war: PTSD and TBI. By teaching sailors to navigate stress, our Navy will make our force more resilient. By assisting in treating those with TBI and PTSD, we could eliminate a potential cause of depression and suicidal behavior.

Our Navy is committed to a culture that fosters individual, family, and command resilience and well-being. We honor the sacrifice and the service of our members and their families, and we will do everything possible to support our sailors so that they recognize that their lives are truly valued and truly worth living.

On behalf of the men and women of the U.S. Navy and their families, thank you for your attention and commitment to these issues. I look forward to your questions.

[The prepared statement of Admiral Greenert follows:]

PREPARED STATEMENT BY ADM JONATHAN W. GREENERT, USN

Chairman Levin, Senator McCain, and distinguished members of this committee, I would like to thank you for this opportunity to discuss our efforts to prevent suicides and the treatment of traumatic brain injury and post-traumatic stress.

Suicide loss destroys families, devastates communities, and unravels the cohesive social fabric and morale inside our commands. Navy has worked at multiple levels to understand and appreciate the unique factors that contribute to each loss, and at the same time recognize and foster the common factors of the organization and environment that help keep people on a path to life.

WHAT WE KNOW

In calendar year 2009, 46 Active Duty sailors and 6 Selected Reserve sailors took their lives. This translates to an annual suicide rate of 13.3 per 100,000. From January through May 2010, there have been 13 suspected Active Duty suicides, compared to 20 through May in 2009; there are 3 suspected Selected Reserve suicides, compared to 2 through May in 2009.

Since 1993, Navy suicide rates per 100,000 have ranged from 17.3 in 1995, to 9.7 in 2005, with an average of 11.6.

Numbers and rates alone do not describe the entire situation nor reveal all the lessons learned to save lives. Each suicide and each suicide attempt is investigated. Further a DOD Suicide Event Report, and other documents, provides the means to

gather case data for qualitative and quantitative analysis. Lessons learned are integrated into the education and training continuum, communications plans and policy changes. Demographic factors, such as age, time-in-service, pay grade, and ethnic background have thus far revealed little regarding suicide risk; Navy's demographic distribution of suicides largely mirrors population demographics. Analyses conducted on deployment cycle status, recent deployments, boots-on-ground deployment, and "individual augmentee" status are a relatively proportional to suicides among sailors who had deployed (Center for Naval Analysis May 2010, CNO Executive Panel (CEP) 2010). A deployment experience may influence the sequence of events to suicide in some individual cases. But, as a whole, deployment history does not appear to affect suicide risk.

Consistent with the last 10 years of analysis, sailors who commit suicide tend to have multiple stressors (DONSIR Technical Report, DODSER). Recent analysis suggests that as many as half of those who committed suicide had transition-related factors, such as: change of duty station, deployments, temporary duty or an upcoming separation from active duty or retirement (CEP Study: 2010). Periods of duty station transition introduce stress, may interrupt social support systems, and could result in leadership and organizational systems being less available to see some signs of change in a sailor. Coincident with their decision to act, many sailors who commit suicide had factors or were in situations that affected their judgment: including alcohol, anger, high emotion, and/or sleep disruption. We are working closely to analyze and understand how work load, operational tempo and organizational (unit) factors may contribute to sleep deficit and how sleep deficit may link to suicide.

The 2008 DOD Health Related Behaviors Survey reported that ~5 percent of sailors surveyed had seriously considered suicide in the past 12 months. Although that might be a generalization, using the force level at that time (340,000), this translates to as many as 17,000 sailors contemplating suicide in a year. Since the long-term annual average of sailors who have died of suicide is 40, it is clear that the vast majority of sailors who consider suicide ultimately chose a path to life. Factors such as resilience, leadership, peer engagement, family bonds, support services, and a sense of purpose can compel sailors to not choose suicide.

OUR APPROACH

Potential solutions to suicide must enhance our ability, as a community, to influence one to choose a path of life. That includes the ability to recover from traumatic change or misfortune and regain physical and emotional stamina. The center of gravity of our policy and practice is the combination of resilience of sailors and their families, the command's awareness and intervention. We consider it a core responsibility to educate, build a resilient force, and provide an environment in which sailors and families can thrive in the face of dynamic and demanding operations. It is incumbent on every leader to build trust and unit cohesion at the command level, and provide a clear sense of mission and meaning to what our sailors do. Additionally, leaders must identify and assist those faced with significant outside stressors, to include relationships, financial and legal matters, health and mental health issues, and depression. All of these are similar to issues that affect suicide rates in the general U.S. population.

WHAT WE'VE DONE

Navy's suicide prevention efforts focus on leadership, education, and awareness. Prevention efforts in the past year have provided policy guidance, training, tools, and communication to enable local command suicide prevention programs, and strengthen a network of command suicide prevention coordinators. Chief of Naval Operations instruction (OPNAVINST) 1720.4A, published 4 August 2009, provides updated policy for Navy suicide prevention programs centered on local command programs supported by a designated suicide prevention coordinator, responsible for support of training, intervention, reporting, and response. In fiscal year 2010, training workshops for leaders, first responders, and suicide prevention coordinators have been conducted at 20 locations in 5 countries, with 5 more planned by the end of the fiscal year. A new training video, "Suicide Prevention: A Message from Survivors" was distributed in April 2010. Interactive training options such as "Front Line Supervisor Training" and "Peer-to-Peer Training" which include skill-building exercises, based on scenarios and role play, have further enhanced the command toolkit. Community-specific outreach workshops and leadership briefs were provided, upon request, to Reserve, Recruiter, and Supply Corps audiences.

Navy continues a robust communications plan about suicide awareness, promoting the core message: "Life Counts!" A dedicated website (www.suicide.navy.mil), poster

series, brochures, videos, leadership messages and newsletters communicate Navy's message on suicide prevention. Expanded communications have included quarterly update messages, public service announcements, and efforts to engage sailors in creating innovative options such as our poster contest, in which sailors designed the entries and chose the winner with online voting. Providing families with information about risk factors, warning signs, and support resources has also been a top priority since families are the most likely the first to observe sailor distress.

Our program, "Operational Stress Control (OSC)", is an increasingly integrated structure of promoting health, family preparedness/resilience, and stress prevention. It is aimed at building resilience and proactively addressing chronic problems before they become acute. OSC¹ addresses the psychological health needs of sailors and their families; it is implemented by operational leadership and supported by the naval medical community. OSC provides practical decisionmaking tools for sailors, leaders, and families, developing their abilities to identify stress responses and mitigate tension. By addressing problems early, most individuals should be able to mitigate the effects of personal turmoil and acquire the necessary help when professional counseling or treatment warrants. The Stress Continuum² is an evidence-informed model that highlights the shared responsibility of sailors, families, leadership, and caregivers for maintaining optimum psychological health. This model has been integrated into our behavioral health communications to the Fleet. It includes suicide awareness, substance abuse, navigating stress, and leader skills. This past year has seen the introduction of a formal OSC curriculum for sailors "from boot camp through War College", as well as for their families. Within a few months, a 1-day, facilitated, skills-based course will be available.

Recognition of stress related behavior must be followed by effective action. We have developed a stress first-aid intervention to recognize when a shipmate is in trouble, called Combat and Operational Stress First Aid (COSFA). It is being taught to all sailors, to intervene and engage that shipmate, and to connect that shipmate to the next level of leader and caregiver support. The advantage of this integrated approach is that we are training our sailors to look beyond stereotypical warning signs, and to recognize changes in behavior and initiate helpful actions to save lives, preclude further injury, and promote personal growth.

The Chief of Naval Operations (CNO) directed the establishment of the Navy Preparedness Alliance (NPA), represented by Chief of Navy Personnel, Commander U.S. Fleet Forces, Surgeon General, Commander Navy Installations Command, and Chief of Navy Reserve, Chief of Chaplains, and Master Chief Petty Officer of the Navy to address a continuum of care covering all aspects of individual medical, physical, psychological, spiritual and family readiness across the Navy. The "alliance" has proven valuable in examining the tough readiness issues that cross stakeholder boundaries and making informed decisions on identified issues. For example, acting on the advice of the "alliance," Navy placed a limitation on tour lengths for personnel assigned to overseas detainee operations, based upon a review of the results of the Behavioral Health Needs Assessment Survey (BHNAS) (a battery of anonymous self-reports to evaluate psychological well-being). The Chief of Naval Personnel chairs the NPA and routinely reports its findings directly to the CNO. Navy's integrated approach continues to rely on leadership monitoring a variety of indicators of the "tone of the force," including a comprehensive quarterly review of personal and family readiness/preparedness metrics and trends, various family readiness polls, and focus groups.

Support structures and intervention mechanisms initiated in the last few years have become more integrated and effective. "Navy Safe Harbor"³ continues its mission to provide nonmedical support for all seriously wounded, ill, and injured sailors, and their families, with Recovery Care Coordinators and Nonmedical Care Managers covering 17 locations. The Navy Reserve Psychological Health Outreach (RPHO) Program, implemented in fiscal year 2008, provides two RPHO Coordinators and three Outreach team members (all licensed clinical social workers) to each Navy Reserve Region (five regions) for mental health support. The RPHO teams engage in active outreach, clinical assessment, referral to care, and follow-up services

¹NAVADMIN 332/08 dated 21 November 08 established the Navy's Operational Stress Control program.

² The Navy and Marine Corps utilize the Stress Continuum Model. Historically, Navy viewed those under stress as either fit or unfit whereas now we understand four distinct stages of stress responses: Ready (Green), Reacting (Yellow), Injured (Orange) or Ill (Red). This model is used to recognize and intervene when early indicators of stress reactions or injuries are present before an individual develops a stress illness, such as PTSD or depression.

³Safe Harbor is a Navy program, established in 2005, for the non-medical care management of severely wounded, ill, or injured sailors and their families. Safe Harbor sailors have had no suicides.

to ensure the mental health and well-being of Reserve sailors and have been actively involved in extending tracking and intervention for suicide related behaviors in our Reserve community.

WHAT IS WORKING

The 2009 Behavioral Health Quick Poll provided a baseline assessment of our suicide prevention and OSC awareness and attitudes. This annual poll will be repeated over the next few months to examine changes over time. The 2009 poll indicated that 83 percent of sailors polled reported receiving required annual training, and 86 percent of sailors polled expressed confidence that they know what to do if someone talks about suicide or shows warning signs. Over 84 percent of enlisted sailors polled and 94 percent of officers polled believed an at-risk sailor would get needed help. However, several perceived that pursuing treatment would result in some negative impact to their careers such as loss of security clearance, or that the individual would be treated differently by their peers in the unit. These polls have shaped our actions to foster new attitudes and habits, to encourage early use of support resources and to provide viable paths to unit reintegration and continued Navy service.

WHAT WE'VE LEARNED

There is no conclusive evidence that suicide awareness efforts alone reduce suicide rates. Evidence does support the effectiveness of comprehensive approaches that include stress reduction, suicide awareness, intervention skills, community building, leadership engagement, and access to quality treatment. Communities engaged in workshop training in 2008–2009 experienced relatively stable or declining suicide numbers during this period. A rise in Navy's suicide rate in 2009 was, in part, attributable to shore and training units that were not systematically included in or utilizing comprehensive training workshops, until 2010.

WHERE WE'RE GOING

Initiatives and areas of expanded focus for fiscal year 2011 include: providing one-day training workshops for Navy mental health providers to improve skills in assessing and managing suicide risk; articulation of policies and best-practices regarding communication between commands and medical providers related to suicide assessments and follow-up care; better communication processes for access to support services for civilian personnel; continuing to implement OSC; assessing tangible effectiveness of training efforts; expanding post-intervention support for those affected by suicide loss; and researching the means to measure organizational strain in terms of the ratio of mission demands to end-strength resources, and how to reduce or mitigate strain effects.

POST-TRAUMATIC STRESS (PTS)

What we know

Combat stress affects each sailor uniquely, falling along a physical and emotional stress continuum ranging from stress reactions to stress injuries and disorders, to include Acute Stress Disorder and Post-Traumatic Stress Disorder. Early identification of symptoms enables supervisors and unit leaders to aggressively intervene to preclude stress reactions and injuries from becoming stress disorders. Navy has channeled our psychological health-related efforts within the domains of: reducing stigma through culture change, psychological health promotion, surveillance, and clinical care.

What we've done

Culture Change:

Using a partnership of Navy line officers and clinicians/caregivers, Department of the Navy embarked on developing a Maritime Combat and Operational Stress Control doctrine that creates a new way of thinking and talking about the effects of psychological demands on our sailors, marines, and their families. This joint leader and caregiver effort created the stress continuum model that provides a color-coded paradigm for recognizing and communicating about stress injury behaviors. This model has been integrated into our behavioral health communications that include: suicide awareness, substance abuse, stress management, and leader skills.

Psychological Health Promotion:

Psychological health promotion efforts are based on the Institutes of Medicine three levels of prevention: universal, selected, and indicated. Selected prevention ef-

forts includes stress resilience training in operational training, suicide and substance use awareness training and leader after action reviews following critical events. Project FOCUS (Families Over-Coming Under Stress) is an example of a selected intervention for families responding to the challenges of deployment. Indicated prevention efforts are those that provide critical interventions for those who show stress injury behaviors. The combat and operational stress first aid training is designed to guide sailors, leaders, and caregivers to provide early non-stigmatizing support.

Surveillance:

Navy medicine implemented an aggressive in-theater surveillance program combining on-site mental health leadership consultation and care through the Mobile Care Teams (MCT)—a small team of industrial/organizational psychologists supported by a clinical mental health provider. In conjunction with the consultation and care services, the MCT executed the fourth installment of BHNAS. The BHNAS is the most comprehensive in-theater mental health assessment conducted by the U.S. Navy and provides data relative to critical mental health indices (PTS, Depression, Anxiety, Morale, Suicide-Risk, and TBI) as well as organizational variables (e.g., living conditions, leadership, unit cohesion, family relationships). Data collection for BHNAS IV recently concluded in Afghanistan and Kuwait and consisted of over 1,000 sailor surveys. Analysis is ongoing.

Post-Deployment Health Assessments (PDHA) and Post-Deployment Health Reassessments (PDHRA) are also utilized to assess the mental health of our sailors. Current efforts are underway to expand the Mental Health Assessment aspect of these tools to continue surveillance for 2 years after redeployment.

Clinical Care: Beginning in 2007, Navy Medicine established Deployment Health Centers (DHCs) as nonstigmatizing portals of care for servicemembers staffed with primary care and psychological health providers. We now have 17 DHCs operational. Our health care delivery model supports early recognition and treatment of deployment-related stress reactions and injuries within the primary care setting, enabling early and effective interventions to reduce occurrence of post-traumatic stress disorder and other mental health conditions.

Navy Medicine emphasizes the importance of evidence-based treatments when caring for our wounded sailors and marines with post-traumatic stress disorder. The Navy Center for Combat Operational Stress Control (NCCOSC) has developed the Psychological Health Pathways program and is currently pilot testing this program at Naval Medical Center San Diego, Naval Hospital Camp Pendleton, and Naval Hospital Twentynine Palms. The program is designed to track all patients diagnosed with PTSD to ensure that clinical practice guidelines are followed and evidence-based care is provided to each patient. It involves aggressive mental health case management, standardized measures, provider training and comprehensive data tracking.

What we've learned

Command and shipmate intervention can help prevent stress reactions and injuries from developing into stress disorders such as post-traumatic stress disorder, depression, and other mental health conditions that could potentially lead to suicidal behavior. Navy's broad array of prevention, early intervention, and treatment programs serves to empower shipmates, supervisors, and leaders to identify stress symptoms early in the reintegration process and get them the level of support they need.

Where we're going

Navy is constantly assessing the effectiveness of current programs, with a priority on increasing access to evidence-based programs with proven outcomes. Research efforts are underway to build on the rapidly growing body of knowledge regarding the innovative prevention and treatment of stress disorders in military populations.

Navy Medicine is actively engaged in ongoing efforts with the Department of Veterans Affairs (VA) and the other Services to implement the Integrated Strategy for Mental Health. The goal of this effort is to collaborate and coordinate across departments to develop a population based continuum of care.

TRAUMATIC BRAIN INJURY

What we know

While there are many significant injury patterns in theater, an important focus area remains Traumatic Brain Injury (TBI). Blast is the signature source of injury of Operation Enduring Freedom and Operation Iraqi Freedom, and blast injury often causes TBI. Sailors are deployed in support of operations in Iraq and Afghani-

stan and, accordingly, treatment of TBI is a priority for Navy. The majority of TBI injuries are categorized as mild—a concussion. There is much we do not know about these injuries and their long-term impacts on the lives of our service members.

What we've done

Education of sailors and medical personnel about the early identification and treatment of TBI is critical to the successful recovery. Navy medicine is addressing this issue by providing TBI training to health care providers from multiple disciplines throughout the fleet. This training is designed to educate personnel about TBI/concussion, ensure all medical personnel are familiar with tools used to assist in diagnosis of TBI, and to review guidelines for the treatment of TBI.

Navy Medicine, in partnership with the Center for Deployment Psychology at the Uniformed Services University, is providing hands-on training on TBI/Concussion management and the Military Acute Concussion Evaluation, an in-theater screening test for possible TBI. Initial training has been provided to 688 medical officers, physician assistants, and Hospital Corpsmen. Plans are underway to expand this training.

Surveillance for injuries across the pre and post deployment continuum is essential to early identification of TBI. Pre-deployment screening with the Automated Neurological Assessment Metrics (ANAM) establishes a baseline, and enables identification of individuals with conditions that should preclude deployment. Navy has implemented ANAM testing with targeted testing of the highest risk communities, including: Navy Military Construction Battalions, Explosive Ordnance Detachments, and Weapons Intelligence Units.

The Navy is standardizing a model for treatment of injured service members with Traumatic Brain Injury/Concussion and will implement it across the Navy Medicine enterprise. The multidisciplinary model will be primary care based with active case management to ensure coordination of care. Experts in treatment of TBI are available to all individuals with TBI that need care beyond what can be provided in Navy Primary Care.

We are employing a strategy that is both collaborative and integrative by actively partnering with the other Services, Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, Defense and Veterans Brain Injury Center (DVBIC), the VA, and leading academic medical and research centers to make the best care available to our wounded, ill and injured afflicted with TBI.

What we've learned

In order to detect TBI cases earlier, event-based reporting is required to ensure that all at risk individuals receive proper evaluation. Additionally, we have learned that there are other tools available to help diagnose TBI that may be more effective than the ANAM. Navy will continue to explore new ways to identify individuals with TBI so that they can receive the care they need.

Where we are going

Navy Medicine is working with the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and the DVBIC, as well as the other Services, to ensure we have a comprehensive TBI surveillance program in place for the identification and early management of TBI cases in theater. This process again emphasizes the importance of collaboration between line and medical leaders. The new in-theater TBI surveillance process will be based upon incident event tracking and will require that leaders send all service members with suspected concussions and those exposed within a set radius of an explosive blast to medical for evaluation. This process will cast a wider net to further ensure individuals with TBI are identified early.

Navy Medicine is also working to establish TBI Restoration Centers in theater, where servicemembers can receive assessment and short-term treatment from a team consisting of a psychologist, physical therapist, occupational therapist, and a sports medicine trained family physician.

CONCLUSION

On behalf of the men and women of the U.S. Navy, I thank you for your attention and commitment to the critical issue of suicide prevention and in your interest in the best possible care for the silent injuries of war: PTS and TBI. By teaching sailors to navigate stress, Navy will make our force more resilient. By assisting and treating those with TBI and PTS, we could eliminate a potential cause of depression and suicidal behavior. Navy is committed to a culture that fosters individual, family, and command resilience and well-being. We honor the service and sacrifice of our

members and their families, and we will do everything possible to support our sailors, so that they recognize that their lives are truly valued and truly worth living.

Chairman LEVIN. Thank you so much, Admiral.
General Amos.

**STATEMENT OF GEN. JAMES F. AMOS, USMC, ASSISTANT
COMMANDANT, U.S. MARINE CORPS**

General AMOS. Thank you, Chairman Levin and distinguished members of the committee, for inviting me here today to discuss the issues of suicide, TBI, and PTSD.

On behalf of the more than 240,000 Active and Reserve marines and their families, I'd like to extend my appreciation for the sustained support Congress has faithfully provided its Marine Corps.

As we begin this hearing, I would like to highlight a few points from my written statement:

You have rightfully focused on three of the most difficult challenges facing the Marine Corps today. Let me assure you that the leadership of the Marine Corps recognizes the seriousness of the challenges we face with TBI, PTSD, and suicide, and we are doing all that we can to prepare and to protect our young men and women.

We have learned much in the last several years about the effects of concussive events and combat stress on our marines that we just simply did not know several years earlier in this long war. With the knowledge we have gained, we have made progress in training to develop resiliency in diagnosing and treating TBI and PTS, and at educating our marines to prevent suicides.

We also realize that we have much more to do. With the benefit of research coordinated by organizations such as the Defense Centers of Excellence for Psychological Health and TBI, we will continue to improve our diagnostic tools and treatment for these injuries.

The tragic loss of a single marine to suicide is deeply felt by all of us who remain behind. We have experienced about the same number of suicides this year as we had last year at this same time. We recognize that our considerable efforts to prevent suicides must continue if we are to turn the trend of the last few years around.

We are building on the noncommissioned officer (NCO) training program that we launched, late last year, to reach the rest of our Marine Corps. We continue to examine each suicide carefully and forensically, and disseminate the lessons learned from that across all Marine Corps leadership.

I have personally been involved, along with General Chiarelli, USA, in the development of theater guidelines for the detection and treatment of mild TBI. The newly established concussive protocol and regulations we have in place for marines deployed in Afghanistan are squarely aimed at the leaders and medical personnel, all in an attempt to further care for our wounded marines and sailors. It will ensure that those exposed to concussive events will be properly diagnosed and receive immediate attention, and that this information will have been properly recorded for future reference. The long-term objective of this protocol is to reduce the chances that a marine or sailor will suffer the effects of a blast injury at some later date, perhaps even years later.

PTSD is a real injury that is often difficult to diagnose. Many marines are reluctant to recognize the fact that they are injured, and even more reluctant to come forward. Our efforts to reduce this injury begin early on in our training regimen, by training marines to be more resilient to the stresses of combat. We have embedded mental health professionals in our combat units to reduce the stigma and the barriers to seeking help. We are exploring new ways to ensure that marines have access to care, including the establishment of a new crisis hotline aimed at marines, for marines and their families.

Partnering with the medical community, we are committed, as a Corps, to making sure every marine struggling with stress gets the support and, if needed, the treatment they need. While there is no single answer that will solve the challenges of rising suicides, TBI, and PTSD, we are committed to exploring every potential solution and using every resource we have available. We will not rest until we have turned this around.

Thank you again for your concern on these very important issues. I thank each of you for your faithfulness to our Nation and your confidence in the leadership and commitment of your Marine Corps.

I request that my written testimony be accepted for the record. I look forward to your questions.

[The prepared statement of General Amos follows:]

PREPARED STATEMENT BY GEN. JAMES F. AMOS, USMC

Chairman Levin, Senator McCain, and distinguished members of the committee; on behalf of your Marine Corps, I would like to thank you for inviting me here today to discuss the issues of suicide, traumatic brain injury (TBI), and post-traumatic stress (PTS). We are grateful for your continued generous and faithful support and for your attention to these critical issues.

SUICIDE

With every suicide case there is a unique life to understand. As a matter of practice, I am fully briefed on each and every suicide and believe that suicide prevention is a leadership issue. We are certain of this: there is no single answer that will prevent suicides, and solutions must include initiatives that approach the problem from multiple angles and from multiple disciplines.

Central to our efforts, we are educating all marines to be focused on this fight. Whenever a Marine is in distress, whether due to a relationship problem, mental illness, financial crisis or combat experience, it is the responsibility of all marines to get that Marine to help. We are working hard to eliminate the stigma that deters some marines from seeking care.

Whether our total suicide numbers trend higher or lower, one suicide is still one too many. The Commandant and I, along with other Marine Corps leaders, remain actively engaged in this fight.

UNDERSTANDING THE STATISTICS

Between 2001 and 2007, the number of suicides in the Marine Corps fluctuated between 23 and 34, but in the past 2½ years we have seen a disturbing increase. From a recent low point of 25 suicides in 2006, the number increased to 33 in 2007, 42 in 2008, and 52 in 2009. This year, from January 1, 2010 through June 8, another 21 Marines have died by suicide, which the exact same number of suicides that we had last year through the 8th of June. Our suicide rate in 2009 was 24.0 suicides per 100,000 marines, which exceeded the national civilian rate of 20.0 per 100,000 when adjusted to match the demographics of the Marine Corps. Attempted suicides have also increased from 103 attempts in 2007, to 146 in 2008, and to 164 in 2009. Through June 8 of this year, 89 marines have attempted suicide. This is an increase from the same time last year.

Marines who attempt suicide resemble our institutional demographics: Caucasian male, 17–25 years old, and between the ranks of Private and Sergeant (E1–E5). As with suicides, reported risk factors and stressors for suicide attempts also center on mental health issues and relationship problems.

Based on our ongoing assessment, we are also concerned that our current surveillance and investigative procedures may be missing qualitative data from the final 72 hours prior to a marine's death. As a result, we are exploring a forensic psychological autopsy study to more fully understand the detailed processes that lead to a marine suicide, which we hope will further inform points at which intervention may prevent another tragedy from occurring.

Additional analysis is being conducted to assess the impact that operational deployments may have on suicide rates. To date, this data suggests that while the continuing stress resulting from overall operational tempo may be a factor in our increasing suicide rate, there does not appear to be a difference in suicide risk resulting from deployment history. Our analyses also suggest that there is no specific time period post deployment that is associated with increased risk of suicide for marines.

SUICIDE REPORTING

We review and investigate all non-hostile casualty reports daily to track both suicides and suicide attempts and we coordinate weekly with the Armed Forces Institute of Pathology, who is the final arbiter on the manner of death for the Marine Corps. When a suspected suicide or attempt is reported, our Suicide Prevention Program Office makes contact with the local command to verify the report and facilitate their completion of the Department of Defense Suicide Event Report (DODSER). This surveillance tool is standardized for use by all Services. Along with the other Services, we initiated use of the DODSER in January 2008 for suicides, and in December 2009, we began using it for all suicide attempts. We believe that the standard operating procedures put into place for reporting suicide attempts will facilitate a richer dialogue between medical personnel and marine leadership.

After each suicide, we do an extensive review of the factors leading up to the suicide. We seek information from leaders, co-workers, friends, and medical personnel. We do not require information from family members so as not to burden the family at a time of such tragic loss and grief, but include it when available in such a manner that will not compound their loss.

In November 2009, I directed all Commanding Generals to personally receive investigative information on all suicides under their command and to report those deaths directly to me. Lessons learned identified in these reviews are analyzed and selected for inclusion in a monthly report that is sent to all Marine Corps General Officers, Senior Executive Service civilians, and Sergeants Major across the Marine Corps.

SUICIDE PREVENTION EFFORTS

Training

We have learned that peer to peer leadership is essential and our gradually increasing understanding of this problem over the last 5 years led directly to the creation of the Non-Commissioned Officer (NCO) suicide prevention course, "Never Leave a Marine Behind." The course was developed with a targeted process approach to ensure it was reality-based, relevant for and about NCO marines. Despite NCOs and the marines they lead making up about 75 percent of the Marine Corps, that group of Marines has accounted for up to 93 percent of marine suicides. Since the implementation of the course, they now account for 81 percent of marine suicides. We have directed the development of similarly targeted courses for our youngest marines (private to lance corporal), staff-NCOs and officers.

In addition to targeted training approaches, prevention is incorporated into our formal education and training at all levels of professional development and throughout a Marine's career; from recruit training in boot camp and new officer training in The Basic School, to the Sergeants Major Symposium and the Commanders Course for senior leaders. Training is continuously evaluated and revised to reflect the best practice as science knows it today. It is also taught using warrior metaphors in the Marine Corps Martial Arts Program, in which every Marine participates.

Partnerships

The complex nature of suicide requires an important balance between immediate action and long-term thinking. We are fully engaged in research efforts with both Federal and civilian partners to fill in the gaps in our understanding and continue

to guide our prevention efforts. We continue to coordinate our suicide prevention efforts with other experts from across the Federal Government, civilian organizations, and with international military partners. Some specific examples include:

- The Secretary of the Navy authorized \$10 million to fund the Marine Corps' participation in the Army's ground breaking study with the National Institute for Mental Health (NIMH) called the "Study to Assess Risk and Resilience in Servicemembers" (STARRS). The Marine Corps and NIMH program managers are currently developing the procedures that will guide the study. The Army STARRS team is providing their full and complete support as we join this unprecedented 5-year longitudinal study on modifiable risk and protective factors related to mental health, suicide and resilience. The study has been specifically designed to return timely information to Marine Corps leadership to inform our evolving prevention strategies and is likely to inform our suicide prevention program this year and for many years to come.
- We actively participate as a member of the DOD Suicide Prevention and Risk Reduction Committee (SPARRC), meeting monthly with our DOD and Veterans Affairs (VA) partners to join efforts in reducing suicides.
- The Marine Corps also chairs the International Association of Suicide Prevention Task Force on Defense and Police Forces. This Task Force includes membership from 15 different countries working together to share best practices and develop effective suicide prevention programs, building on shared unique experiences in military culture that crosses national boundaries.

TRAUMATIC BRAIN INJURY AND POST-TRAUMATIC STRESS

Traumatic Brain Injury (TBI)

Naval medicine remains at the forefront of researching and implementing pioneering techniques to treat TBI. The Marine Corps is an active partner with the medical experts within and outside the Department of Defense in continuing to advocate for innovative research and best practice dissemination to improve the lives of our marines. We are complying fully with the DOD directive for each deploying marine to complete the Automated Neuropsychological Assessment Metrics test prior to deployment. Along with the Vice Chief of the Army, I have personally been involved in the development of theater guidelines for the detection and treatment of TBI. These departmental level guidelines are aimed at Leaders as well as medical personnel and will ensure that marines who are exposed to potentially concussive events will have this information recorded for future reference as well as removing the onus from the individual to self identify to receive a medical evaluation.

We have put into effect this new protocol for concussive events that will improve our ability to diagnose, track, and treat marines and sailors who may suffer mild TBI. This protocol requires all personnel in proximity to the blast event to be screened by medical personnel to better identify those that might have suffered a concussion. Those that show signs of a concussion are required to rest and are treated and evaluated prior to being returned to duty. The protocol takes into account the severity of the injury as well as whether this is the marine's first concussive event or if he has been subject to previous events. This new protocol will result in better diagnosis, recordkeeping, and treatment of marines and sailors at the time of the injury, which in turn will reduce the chances that the marine or sailor will suffer effects of the injury at some later date.

Post-Traumatic Stress (PTS)

We are attentive to the mental health of our warriors and we are dedicated to ensuring that all marines and family members who bear the invisible wounds caused by stress receive the best help possible. We developed the Combat Operational Stress Control (COSC) program to prevent, identify, and holistically treat mental injuries caused by combat or other operations. Again partnering with the medical community we are committed as a Corps to making sure every marine struggling with a stress issue gets the support and if needed, treatment, they need.

Resiliency Training

We have taken steps in our pre-deployment training to improve our marines' resiliency and give them the tools to deal with the stresses of combat. Realistic training prepares our deploying marines by simulating as closely as possible the sights, sounds, smells, and sensations of combat. Our Infantry Immersive Trainer at Camp Pendleton, CA, is a state-of-the-art facility that seeks to give the experience of com-

bat to our marines in training. We are expanding this capability by establishing other immersive trainers at locations such as Camp Lejeune, NC.

Combat and Operational Stress Control Program

The COSC program is a program through which Marines and leaders are trained to prevent, detect, and manage stress problems in marines as early as possible. COSC provides leaders with the resources to intervene and manage these stress problems in theater or at home. Collaboration between warfighters in the Marine Expeditionary Forces, Navy Medicine, and Navy Chaplains resulted in the Combat Stress Continuum Model. This tool facilitates the identification of distress in marines and offers a decision tree to guide leaders' responses.

To assist with prevention, rapid identification, and effective treatment of combat operational stress, we have expanded our program of embedding active duty Navy mental health professionals in operational units—the Operational Stress Control and Readiness (OSCAR) Program—to directly support all Active and Reserve ground combat elements in theater. We are extending OSCAR capabilities down to all of our infantry battalions and companies by providing additional training to doctors and corpsmen, chaplains, and selected leaders within each unit to make expertise more immediately available, and to decrease stigma through building relationships.

CONCLUSION

Suicides are a loss that we simply cannot accept. Leaders at all levels are personally involved in efforts to address and prevent future tragedies. Taking care of marines is fundamental to our ethos and serves as the foundation of our resolve to do whatever it takes to help those in need at every possible juncture whether it be suicide prevention, documenting and tracking concussive events, and assisting those with PTSD and combat operational stress. We are aggressively acting to increase our prevention activities and follow-on care in these areas. The further left of an incident is our best opportunity to save lives by connecting Marines to needed help and mentorship. Likewise, TBI and PTS are very real injuries that must be diagnosed, recorded, and treated. We have taken concrete steps to do just that and will continue our efforts to build resilience and reduce the stigma of seeking help for these wounds. Thank you again for your concern on these very important issues.

Chairman LEVIN. Thank you, General.

The testimony of all of our witnesses will be made part of the record, and we thank you for that.

General Chandler.

**STATEMENT OF GEN. CARROL H. CHANDLER, USAF, VICE
CHIEF OF STAFF, U.S. AIR FORCE**

General CHANDLER. Thank you, Mr. Chairman, distinguished members of the committee. Thank you for the opportunity to address suicides in the Air Force, as well as the detection and care of our airmen suffering from PTSD and TBI.

The Air Force is strongly committed to the physical, emotional, and mental health of our airmen. We appreciate the linkage between health of the force and mission readiness. The number of airmen taking their own lives has been rising, despite our commitment to prevention. Similarly, PTSD is an area of increasing concern. Finally, our ability to detect and treat TBI continues to be challenging.

The mental state of individuals contemplating suicide, and the actual condition suffering PTSD and TBI, are similar, in that they often do not manifest themselves in visible ways. The Air Force suicide rate recently reached slightly more than 14 suicides per 100,000 total-force airmen. Nearly two-thirds were not receiving assistance from mental health professional, despite concerted effort to reverse a long-held bias against seeking mental health assistance.

While no segment of the Air Force is immune to suicide, there are known high-risk populations and known common risk factors,

like relationship problems, legal issues, financial troubles, and the history of mental health diagnosis. The Air Force recognizes suicide as a public health concern that requires active and persistent involvement from commanders, supervisors, and peers, often referred to as "wingmen," at all levels of the organization. Their increased involvement is made easier and more effective through more available professional counseling service and focused training. All part of our improved resiliency program.

The Air Force initiated the Total Force Resiliency Program in February of this year to holistically address the root causes of suicide. The Air Force program reflects a broadbased approach to supporting airmen and their families, recognizing that physical, mental, and emotional health are critical to the quality of life and readiness of the force.

Airmen Resiliency Programs and the Air Force Suicide Prevention Program are complementary efforts that rely on leadership and engagement, immediate family involvement, and wingmen support are key components. In May, the Air Force Chief of Staff directed a servicewide Wingman Day to reinforce the significance and role of every airman as mutually-supportive critical components in suicide prevention and resilience. There is no substitute for airmen knowing their subordinates, and their coworkers well enough to recognize changes in attitude, behavior, and personality, and then intervening when something is not right.

Part and parcel of these programs is an effort to expand the availability of professional counseling. The Community Action Information Board, which provides a forum for cross-organizational review and resolution of individual, family, installation, and community issues, is now chaired by me, the Air Force Vice Chief of Staff, to provide adequate oversight, in light of our increasing suicide rates. Also, professional counseling is available, now more than ever, through primary care clinics, the Airmen Family Readiness Centers, and through DOD's Military OneSource Referrals for confidential no-cost counseling. Complementing this increased capacity are training programs to better prepare our individual airmen.

Resiliency training is delivered in a tiered fashion, based on risk factors. Those most at risk receive the greatest and most structured exposure to resiliency and suicide prevention training, while basic education and training is made available to low-risk audiences, via unit briefings, chaplain services, financial classes, and computer-based training. Additionally, the Air Force is identifying strategies to ensure all accessions are exposed to Total Force Resilience and Suicide Prevention Programs early on. Additionally, airmen will get additional training and assistance as they deploy from combat.

A Deployment Transition Center, at Ramstein Airbase in Germany, will open next month to provide 2 days of training to assist in the transition from deployment to home station for airmen regularly exposed to significant risks of combat-related death, like convoy operators, explosive ordinance disposal personnel, and security forces, and the Office of Special Investigations. The goals of the Center include providing reconstitution, wingman support, and fostering individual resiliency skills for our most vulnerable airmen,

those exposed to traumatic situations, situations that may lead to PTSD or TBI.

In 2003, more than 600 U.S. Air Force personnel were diagnosed with PTSD. In 2008, that number increased to over 1,500, with over 78 percent of the diagnosis stemming from deployment-related events.

Efforts to prevent, identify, and treat PTSD begin and end at home, with screening and education, the use of forums, like the Community Action Information Board, and the use of traumatic stress response teams at each installation. All aim to foster resiliency through focused education and psychological first-aid.

While deployed, combat operational stress control teams seek to prevent or minimize adverse effects of combat on our airmen. Of note, even nondeployed airmen, like those piloting remotely piloted aircraft and some of our intelligence personnel, must be monitored for PTSD symptoms as well. They too are actively engaged in combat operations.

Although, where it may not be possible to pinpoint the instant PTSD is onset in an individual, this is rarely the case with TBI. TBI is recognized in the Air Force as a physical condition that can cause lifelong symptoms.

From 2001 to 2009, 1,008 airmen were diagnosed with TBI, accounting for 4 percent of all DOD TBI cases. Baseline testing of deployers and education of commanders and medical personnel is increasing as we work to apply the best joint practices to prevent, identify, and treat TBI. Our goal is simply to provide the best possible treatment, minimize the impact on long-term health, and maximize rehabilitation, recovery, and reintegration.

In conclusion, airmen are our Air Force's greatest asset, the key component of our ability to partner with the joint and coalition team to win today's fight. There is a commonality among suicide, PTSD, and TBI, beyond their obvious impact on individuals and the mission. They all require heightened awareness and understanding if we're to identify, prevent, and treat them effectively.

Again, thank you for your continuing support for our airmen, and thank you for the opportunity to discuss these important issues today. I look forward to your questions.

[The prepared statement of General Chandler follows:]

PREPARED STATEMENT BY GEN. CARROL H. CHANDLER, USAF

INTRODUCTION

The Air Force is strongly committed to the physical, emotional, and mental health of our airmen, and appreciates the linkage between health of the force and mission readiness. The number of airmen taking their own lives has been rising, despite our commitment to prevention. Similarly, Post-Traumatic Stress Disorder (PTSD) is an area of increasing concern. Finally, detection and treatment of Traumatic Brain Injury continues to challenge us. All three are similar in that they are difficult to detect, and may have significant impact on health and mission readiness. We are taking action to reduce risk through measures to prevent, identify, and treat each. Efforts to bolster every airman's resilience must involve the entire chain of command, commanders, supervisors, co-workers, base support agencies, and especially our Air Force families throughout the Total Force.

SUICIDE IN THE U.S. AIR FORCE

In 2010, 45 airmen—27 Active Duty, 8 Guard, 3 Reserve, and 7 civilians—have taken their own lives, compared to 33 during the same period last year. Currently,

the Air Force suicide rate exceeds 14 suicides per 100,000 Total Force airmen. If these levels persist, the Air Force suicide rate by year's end will be a significant deviation from the 11.6 per 100,000 the Air Force averaged during the last 6 years.

Among our airmen who took their own lives, nearly two-thirds were not receiving assistance from a mental health professional. Despite concerted efforts to reverse a long-held bias against seeking mental health assistance, many airmen continue to resist seeking help when they most need it. Even among those who seek counseling, there is a marked bias against involving their chain of command in their treatment. Based on an anonymous review of more than 1,000 mental health records in 2006, approximately 89 percent did not inform their chain of command. Additionally, in the 2008 Health Related Behaviors Survey 1 out of every 8 airmen responded that they believe that a mental health appointment will "definitely" hurt their career.

While no segment of the Air Force is immune to suicide, there are known high-risk populations. The most common risk factors associated with Air Force suicides are relationship problems, legal issues, financial troubles, and history of mental health diagnosis. The Air Force seeks to identify these factors prior to enlistment and throughout an airman's service. While not directly linked to deployments or work-place stress, these factors can be exacerbated by demanding military lifestyles. Notably, only approximately 20 percent of Air Force suicide victims have deployment experience within the last year. Over the past 2 years, the Air Force has had four suicides in the U.S. Central Command area of responsibility—three in 2009 and one in 2010. In 2009, approximately 60 percent of all Air Force suicides were committed by airmen in age groups 17–24 and 25–34, accounting for 29 percent and 31 percent of total Air Force suicides respectively. Thus far in 2010, these age groups continue to be at the highest risk for suicide, combining for more than 61 percent of Air Force suicides. The security forces and intelligence career fields have the highest suicide rates; both averaged approximately 24 per 100,000 during the last several years. The Air Force recognizes suicide as a public health concern that requires active and persistent involvement from commanders, supervisors, and wingmen at all levels of the organization.

TOTAL FORCE RESILIENCY

In February of this year, the Air Force initiated Total Force Resiliency to holistically address the root causes of suicide. Because there is significant commonality between the Services, we have studied the Army and Navy resiliency programs and shared best practices to provide our airmen the skills they require to succeed during potential physical and psychological challenges. The Air Force program reflects a broad-based approach to supporting airmen and their families. It recognizes that physical, mental, and emotional health are critical to readiness and optimal performance, and is a comprehensive approach to enhance well-being, not merely a safety net. Our resiliency program focuses on the ability to withstand, recover and/or grow in the face of stressors and changing demands. Airman resiliency and the Air Force Suicide Prevention Program are complementary efforts. The key components of our suicide prevention program are leadership engagement and immediate family involvement. Both are helped by base support activities which deliver relevant programs and services.

To emphasize the imperative of leader and peer participation, the Chief of Staff directed a Service-wide "Wingman Day." During the month of May, every unit took time out to discuss suicide prevention, Total Force Resiliency, and reinforce the significance and role of every airman as supportive wingmen in prevention and resilience. This effort generated positive momentum and challenged every member of the Air Force to recognize his or her role in suicide prevention. There is no substitute for airmen knowing their subordinates and coworkers well enough to recognize changes in attitude, behavior, and personality—and then intervening when something is not right.

AVAILABILITY OF SERVICES

The Air Force Surgeon General, in collaboration with the Military Health System Strategic Communication Group, is working to ensure suicide prevention programs and messages receive sufficient breadth and depth of exposure. At Headquarters Air Force, Major Commands, and base level, the Community Action Information Board (CAIB) provides a forum for cross-organizational review and resolution of individual, family, installation, and community issues that impact the readiness of the force and the quality of life for Air Force members and their families. In a recent change, based on our concerns about the increased suicide rate, the Air Force Vice Chief of Staff now chairs the HQ USAF CAIB.

In addition, the Air Force has significantly expanded counseling services beyond those traditionally available through chaplains or the mental health clinic. Mental health providers are now based in primary care clinics across the Air Force. Airman and Family Readiness Centers sponsor Military Family Life Counselors that offer counseling to individuals or couples without generating documentation. Military OneSource, a Department of Defense program that provides resources and support to service members and their families, provides free access to off-base counselors for as many as six sessions.

TARGETED TRAINING PROGRAMS

Resiliency training is delivered based on a tiered model. The few career fields with the highest risk factors, including those departing or returning from deployments, receive the greatest and most structured exposure to resiliency training and suicide prevention programs in the Tier 1 category. Tier 1 training also ensures that members with acute risk of suicide receive clinical care by mental health professionals. Tier 2 training tailors and intensifies resiliency and suicide prevention messages based on risk factors. Tier 3 training provides basic education and training to the widest possible audience via unit briefings, chaplain services, financial classes, and computer-based training. Additionally, the Air Force is identifying strategies to ensure all accessions, beginning with Basic Military Training at Lackland AFB, TX, will incorporate resiliency training into their curriculum to provide initial exposure. Shortly thereafter, this training will be expanded to include commissioning programs and technical training. In order to improve the effectiveness of healthcare provider interventions, we are also focusing on advanced provider training.

DEPLOYMENT TRANSITION CENTER

A Deployment Transition Center (DTC) will begin initial operations in July 2010 at Ramstein AB, Germany. This organization will provide 2 days of training to assist in the transition from deployment to home station for airmen regularly exposed to significant risk of combat-related death, and will be initially focused on convoy operators, explosive ordinance disposal personnel, and security forces personnel, although these services may be extended to other at-risk Air Force members as the DTC matures. This overseas center will provide these airmen centralized training and facilitate a graduated transition home with positive family reintegration. The goals of the center include providing reconstitution, utilizing the support of fellow airmen returning from deployment, and fostering individual resiliency skills and coping mechanisms. The center is part of the overarching resiliency education and training program being developed with the goal of supporting broader Air Force populations, not merely those airmen considered most vulnerable due to high potential of exposure to traumatic situations.

INVISIBLE WOUNDS OF WAR: POST-TRAUMATIC STRESS DISORDER AND TRAUMATIC BRAIN INJURY

In 2003, more than 600 USAF personnel were diagnosed with PTSD, and in 2008, that number increased to over 1,500, with over 78 percent of the diagnoses stemming from deployment related events. Over the same period, there has been an increase in the number of medical visits for PTSD, from more than 3,800 in 2003, to more than 14,300 in 2008. The increase in medical care can be attributed not only to the increase in PTSD cases, but also our increased awareness and treatment efforts. The Air Force has taken numerous steps to address this threat to our airmen, beyond the standup of the DTC already discussed.

Efforts to prevent, identify and treat PTSD begin at home, during pre-deployment preparation. Prescreening and education at home bases now enhance resilience through education on risk factors, symptom recognition, benefits, and destigmatization of mental health care, and promotion of the wingman culture. Also, the Integrated Delivery System and the CAIB provide forums at each installation for cross-organizational review and resolution of individual, family, installation, and community issues associated with PTSD and other issues that impact mission readiness. Additionally, mental health providers are receiving training focused on prevention, identification, and treatment of PTSD. Finally, Traumatic Stress Response teams at each installation now foster resiliency through focused preparatory education and psychological first-aid for those exposed to potentially traumatic events.

Similarly, Combat Operational Stress Control teams seek to prevent or minimize adverse effects of combat on our airmen in theater. In addition to airmen deployed to the combat zone, nondeployed airmen, like our remotely piloted aircraft crews and intelligence personnel, must be monitored for post-traumatic stress symptoms—they too are actively engaged in combat operations. Although challenges remain for

the Air Force to prevent, identify, and treat PTSD, we, along with our joint partners, are actively engaged to improve our capability and capacity institutionally, for what is often a very individualized need. Recognizing PTSD is a challenge—as it often is for Traumatic Brain Injury (TBI).

TBI is recognized in the Air Force as a physical condition that can cause life-long symptoms. From 2001 to 2009, 1,008 airmen were diagnosed with TBI, accounting for 4 percent of all Department of Defense TBI cases reported. Effective early TBI detection is the cornerstone of TBI care, and baseline Automated Neuropsychological Assessment Metric is now collected on 56 percent of airmen deploying into theater. Also, the Air Force will begin educating commanders and medical personnel by the end of this calendar year, applying best joint practices in prevention, identification, and treatment of TBI. Through education that is focused on early detection and prevention, our goal is to identify TBI cases and ensure our airmen receive the best possible treatment, minimizing the impact on long-term health, and maximizing rehabilitation, recovery, and reintegration.

CONCLUSION

Airmen are our Air Force's greatest asset—the key component to our ability to partner with the Joint and coalition team to win today's fight. We ask for an extraordinary amount of selflessness and sacrifice from them and their families. In return, our obligation is to assist each of them according to their particular needs. There is commonality among suicide, PTSD, and TBI beyond their obvious impact on individuals and mission; they all require heightened awareness and understanding if we are to prevent, identify, and treat them effectively. Also, although it is possible to focus efforts on high-risk categories of people, every individual remains vulnerable, valuable, and must be considered. The needless loss of an airman and the resultant impact on their families and the Air Force is not acceptable.

Chairman LEVIN. Thank you so much, General Chandler.
Dr. Jesse.

STATEMENT OF ROBERT L. JESSE, ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Dr. JESSE. Good morning, Chairman Levin, Ranking Member McCain, and members of the committee. Thank you for inviting me here to discuss the VA efforts to respond to, treat, and minimize the impacts of TBI, PTSD, and veteran suicide.

My written testimony provides greater detail about our programs and about our cooperation with our partners at DOD and the Services, but, in the few minutes I do have now, I'd like to highlight a few key factors for the committee.

Before doing so, I would like to express our gratitude to the committee for their insight into the importance of these issues, and for their ongoing support of all of the initiatives that are intended to mitigate this.

The VA has developed and implemented a range of innovative programs to ensure that it provides world-class rehabilitation care for veterans and servicemembers with TBI. We offer services at 108 facilities across the country through an integrated network that brings together some of the best minds in medicine. We deliver comprehensive clinical rehabilitative services through interdisciplinary teams of specialists, while providing patient and family education and training, psychosocial support, and advanced rehabilitation and prosthetic technologies.

VA has placed nurse liaisons in military treatment facilities to support coordinated care, patient transfers, and shared patients. In terms of the population we treated between March 2003 and March 2010, the VA has seen, at our state-of-the-art Polytrauma Rehabili-

tation Centers, almost 1,800 patients, more than half of whom are Active Duty servicemembers.

Second, the Federal Recovery Coordination Program is a successful joint VA/DOD initiative that provides severely injured veterans and servicemembers with access to the benefits and care that they need to recover. Our 20 Federal Recovery Coordinators work with military liaisons, member of the Services' Wounded Warrior programs, Service Recovery Care coordinators, TRICARE coordinators, and various VA staff members, to bridge the transition from VA to DOD.

Each enrolled client has a specially tailored Federal Individual Recovery Plan based on the goals and needs of the veteran or servicemember, and based upon input from the client and his or her family. This plan serves as the basis for returning our wounded warriors to the highest level of functionality independence they can achieve.

Third, VA has implemented a robust screening protocols for PTSD, TBI, and suicidal tendencies. We screen every veteran from Afghanistan and Iraq for brain injuries, and we screen every veteran we see for PTSD, depression, and drinking problems. If the PTSD or depression screen is positive, we require an evaluation for suicidal tendencies. VA repeats the screening at consistent intervals, since problems can arise at any time. Any positive screen leads to further evaluation in the primary care setting, followed by specialty care services as needed.

The VA has established access standards for mental health that require prompt contact of new patients, within 24 hours of referral, by a clinician, to evaluate the urgency of the veteran's needs. If the veteran has an urgent care need, we require our staff to make appropriate arrangements, including an immediate admission to one of our facilities. If the need is not urgent, the patient must be seen for a full mental health and diagnostic evaluation and development initiation of an appropriate treatment plan within 14 days. Across the system, the VA is meeting the standard over 95 percent of the time.

Finally, VA's suicide prevention efforts are having a meaningful and positive impact on those veterans who come to us for care. A suicide by a servicemember or veteran is a tragedy for the individual, his or her friends and family, and to the Nation.

We have initiated several programs to put VA in the forefront of suicide prevention. Chief among these is establishing a national suicide prevention hotline, placing suicide prevention coordinators at VA Medical Centers, significantly expanding mental health services, and integrating primary and mental health care to alleviate the stigma of seeking mental health assistance.

The return on investment for these efforts is significant. Our suicide prevention hotline has saved the lives of more than 9,000 veterans and servicemembers since its inception. Other data demonstrate that younger veterans who come to the VA for healthcare services were 30 percent less likely to die from suicide than those who don't come to us for care. More broadly, the rate of suicide among veterans receiving healthcare from VA has declined steadily since 2001. From a public health perspective, this decline is signifi-

cant, corresponding to about 250 fewer lives lost as a result of suicide.

These are considerable accomplishments that both VA and Congress can be proud of. But, it is imperative that we reach more of our veterans and servicemembers, and deliver them the care that they need.

In conclusion, VA and DOD maintain a longstanding relationship that shares best practices, identifies joint solutions, operates centers of excellence, and works to support the brave men and women who wear the uniform.

Thank you again for the opportunity to discuss these important issues with you today. I'm prepared to answer your questions.

[The prepared statement of Dr. Jesse follows:]

PREPARED STATEMENT BY ROBERT JESSE, M.D., PH.D.

Good morning Chairman Levin, Ranking Member McCain, and members of the committee. Thank you for inviting me here to discuss the Department of Veterans Affairs (VA) efforts to respond to, treat, and minimize the impacts of traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and veteran suicide. My testimony will describe VA's programs and initiatives in the areas of TBI and mental health, with a specific emphasis on our suicide prevention programs, and highlight the close cooperation VA maintains with the Department of Defense (DOD) and the Services.

TRAUMATIC BRAIN INJURY

Care, Management, and Transition of Veterans and Servicemembers

Polytrauma is a new word in the medical lexicon that was termed by VA to describe the complex, multiple injuries to multiple body parts and organs occurring as a result of blast-related injuries seen from Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF). Polytrauma is defined as two or more injuries to physical regions or organ systems, one of which may be life threatening, resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability. TBI frequently occurs in polytrauma in combination with other disabling conditions such as amputation, auditory and visual impairments, spinal cord injury (SCI), post-traumatic stress disorder (PTSD), and other medical problems. Due to the severity and complexity of their injuries, servicemembers and veterans with polytrauma require an extraordinary level of coordination and integration of clinical and other support services.

VA has developed and implemented numerous programs to ensure it provides world-class rehabilitation services for veterans and active duty servicemembers with TBI. VA has enhanced its integrated nationwide Polytrauma/TBI System of Care. The VA Polytrauma/TBI System of Care consists of four levels of facilities, including 4 Polytrauma Rehabilitation Centers, 22 Polytrauma Network Sites, 82 Polytrauma Support Clinic Teams, and 48 Polytrauma Points of Contact. The system offers comprehensive clinical rehabilitative services including: treatment by interdisciplinary teams of rehabilitation specialists; specialty care management; patient and family education and training; psychosocial support; and advanced rehabilitation and prosthetic technologies. In 2005, VA expanded the scope of services at existing VA TBI Centers, and accordingly renamed them Polytrauma/TBI Rehabilitation Centers, to establish an integrated, tiered system of specialized, interdisciplinary care for polytrauma injuries and TBI.

PRCs provide the most intensive specialized care and comprehensive rehabilitation care for veterans and servicemembers with complex and severe polytrauma. PRCs maintain a full staff of dedicated rehabilitation professionals and consultants from other specialties to support these patients. Each PRC is accredited by the Commission on Accreditation of Rehabilitation Facilities, and each serves as a resource to develop educational programs and best practice models for other facilities across the system. The four regional centers are located in Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA. A fifth center is currently under construction in San Antonio, TX, and is expected to open in 2011.

Since 2007, VA has placed Polytrauma Nurse Liaisons at Walter Reed Army Medical Center and National Naval Medical Center (at Bethesda, MD) to support coordination of care, patient transfers, and shared patients between DOD and VA PRCs.

Whenever an injured veteran or servicemember requires specialized rehabilitative services and enters VA health care, the Polytrauma Nurse Liaison maintains close communication with the admissions nurse case manager at the VA PRC, providing current and updated medical records. Before transfer, the Center's interdisciplinary team meets with the DOD treatment team and family by teleconference as another way to ensure a smooth transition.

VA ACCOMPLISHMENTS

A total of 1,792 inpatients with severe injuries have been treated at the Polytrauma Rehabilitation Centers from March 2003 through March 2010; 907 of these patients have been active duty servicemembers, of which 754 were injured in OEF or OIF. VA continues following these patients after their discharge from a VA PRC to assess their long-term outcomes. Data available for 876 former PRC patients indicate:

- 781 (89 percent) are living in a private residence;
- 642 (73 percent) live alone or independently;
- 413 (47 percent) report they are retired due to age, disability or other reasons;
- 206 (24 percent) are employed;
- 90 (10 percent) are in school part-time or full-time; and
- 59 (7 percent) are looking for a job or performing volunteer work.

Throughout the Polytrauma/TBI System of Care, we have established a comprehensive process for coordinating support efforts and providing information for each patient and family member. Specialized rehabilitation initiatives at the PRCs include:

- In 2007, VA developed and implemented Transitional Rehabilitation Programs at each PRC. These 10-bed residential units provide rehabilitation in a home-like environment to facilitate community reintegration for veterans and their families, focus on developing standardized program measures, and investigate opportunities to collaborate with other entities providing community-based reintegration services. Through December 2009, 188 veterans and servicemembers have participated in this program spending, on average, about 3 months in transitional rehabilitation. Almost 90 percent of these individuals return to active duty, or transition to independent living.
- Beginning in 2007, VA implemented a specialized Emerging Consciousness care path at the four PRCs to serve those veterans with severe TBI who are slow to recover consciousness. Patients with disorders of consciousness (e.g., comatose) require high complexity and intensity of medical services and resources in order to improve their level of responsiveness and decrease medical complications. To meet the challenges of caring for these individuals, VA collaboratively developed this care path with subject matter experts from Defense and Veterans Brain Injury Center (DVBIC) and the private sector. VA and DVBIC continue to collaborate on research in this area, and incorporate improvements to the care path in response to advances in science. From January 2007 through December 2009, 87 veterans and servicemembers have been admitted in VA Emerging Consciousness care. Approximately 70 percent of these patients emerge to consciousness before leaving inpatient rehabilitation.
- In October 2008, all inpatients with TBI at VA PRCs began receiving special ocular health and visual function examinations based upon research conducted at our Palo Alto PRC. To date, 840 inpatients have received these examinations.
- In April 2009, VA began an advanced technology initiative to establish assistive technology laboratories at the four PRCs. These facilities will serve as a resource for VA health care, and provide the most advanced technologies to veterans and servicemembers with ongoing needs related to cognitive impairment, sensory impairment, computer access, communication deficits, wheeled mobility, self-care, and home telehealth.
- The PRCs have been renovated to optimize healing in an environment respectful of military service. Military liaisons located at the centers help to support active duty patients and to coordinate interdepartmental issues for patients and their families. Working with the Fisher House Foundation, we are also able to provide housing and other logistical support for family members staying with a veteran or servicemember during their recovery at one of our facilities.

- In fiscal year 2009, 22,324 unique outpatients had 83,794 total clinic visits across the Polytrauma Support Clinic Team sites; an increase of over 30 percent from fiscal year 2008.

In addition to improvements in the Polytrauma/TBI System of Care, VA developed and implemented the TBI Screening and Evaluation Program for all OEF/OIF veterans who receive care within VA. From April 2007 through March 2010:

- 408,474 OEF/OIF veterans have been screened for possible TBI;
- 56,161 who screened positive have been evaluated and received follow-up care and services appropriate for their diagnosis and their symptoms;
- 30,368 have been confirmed with a diagnosis of having incurred a mild TBI;
- Over 90 percent of all veterans who are screened are determined not to have TBI, but all who screen positive and complete a comprehensive evaluation are referred for appropriate treatment.

VA continues to increase collaborations with private sector facilities to successfully meet the individualized needs of veterans and complement care in cases when VA cannot readily provide the needed services, or cases where the required care is geographically inaccessible. VA medical facilities have identified private sector resources within their catchment area that have expertise in neurobehavioral rehabilitation and recovery programs for TBI. In fiscal year 2009, 3,708 enrolled veterans with TBI received inpatient and outpatient hospital care and medical services from public and private entities, with a total disbursement of over \$21 million.

VA and DOD Cooperation on Outreach, Transition and Complementary Care

VA and DOD have shared a longstanding integrated collaboration in the area of TBI through the DVBIC. Since 1992, DVBIC staff members have been integrated with VA Lead TBI Centers (now Polytrauma Rehabilitation Centers) to collect and coordinate surveillance of long-term treatment outcomes for patients with TBI. Other significant initiatives that have resulted from the ongoing collaboration between VA and DVBIC include: developing collaborative clinical research protocols; developing and implementing best clinical practices for TBI; developing materials for families and caregivers of veterans with TBI; developing integrated education and training curriculum on TBI, and joint training of VA and DOD health care providers; and coordinating the development of the best strategies and policies regarding TBI for implementation by VA and DOD.

In addition to the longstanding affiliation with DVBIC, since 2007, VA has collaborated with DOD to develop implementation plans for Defense Centers of Excellence (DCoE) and the associated injury registries, including Centers for Psychological Health and Traumatic Brain Injury, Extremity Injuries and Amputation, Hearing Loss and Auditory System Injuries, and Vision. VA has assigned personnel at the Center for Psychological Health and TBI, and at the Vision Center. VA continues to be involved in working groups with DOD representatives to assist in developing concepts of operations and plans for the Hearing Loss and Auditory System Injuries Center and the Center for Extremity Injuries and Amputation.

VA, in collaboration with DVBIC, developed a uniform training curriculum for family members in providing care and assistance to servicemembers and veterans with TBI: "Traumatic Brain Injury: A Guide for Caregivers of Servicemembers and Veterans." In 2009, VA and DOD collaboratively developed clinical practice guidelines for mild TBI and deployed this to health care providers, as well as recommendations in the areas of cognitive rehabilitation, drivers' training, and managing the co-occurrence of TBI, PTSD, and pain.

In 2009, the VA-led collaboration with DOD and the National Center for Health Statistics produced revisions to the International Classification of Diseases, Clinical Modification (ICD-9-CM) diagnostic codes for TBI, resulting in significant improvements in the identification, classification, tracking, and reporting of TBI and its associated symptoms.

The Federal Recovery Coordination Program

The Federal Recovery Coordination Program (FRCP) serves an important function in ensuring that severely injured veterans and servicemembers receive access to the benefits and care they need to recover. Beginning in 2008, FRCP has helped coordinate and access Federal, State, and local programs, benefits and services for severely wounded, ill, and injured servicemembers, veterans, and their families through recovery, rehabilitation, and reintegration into the community. The program is a joint program of DOD and VA, with VA serving as the administrative home.

The program has grown since enrolling the first client in February 2008. Not every individual referred to the program meets enrollment criteria or needs the full

services of FRCP. Some individuals are enrolled for a period of time and then determine that they no longer need the program's services. Currently, 538 clients are enrolled and another 26 individuals are being evaluated for enrollment; 478 have received assistance. Anyone can return for re-enrollment or additional assistance if the problems are not resolved or if new problems develop.

Recovering servicemembers and veterans are referred to FRCP from a variety of sources, including from the servicemember's command, members of the interdisciplinary treatment team, case managers, families, or clients already in the program, Veterans Service Organizations, and other nongovernmental organizations. Generally, those individuals whose recovery is likely to require a complex array of specialists, transfers to multiple facilities, and long periods of rehabilitation are referred.

FRCP outreach efforts include brochures, a presence on VA's OEF/OIF Web site, participation and presentations at local, State, and national events. Our toll-free number (1-877-732-4456), new in April 2009, provides another avenue for referral or assistance. When a referral is made, a Federal Recovery Coordinator (FRC) conducts an evaluation that serves as the basis for problem identification and determination of the appropriate level of service.

FRCs coordinate benefits and services for their clients through the various transitions associated with recovery and return to civilian life. FRCs work with military liaisons, members of the Services' Wounded Warrior Programs, Service recovery care coordinators, TRICARE beneficiary counseling and assistance coordinators, VA vocational and rehabilitation counselors, military and VA facility case managers, VA Liaisons, VA specialty care managers, Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) OEF/OIF case managers, VBA benefits counselors, and others.

Each enrolled client receives a Federal Individual Recovery Plan (FIRP). The FIRP, based on the goals and needs of the servicemember or veteran and upon input from their family or caregiver, is designed to efficiently and effectively move clients through transitions by identifying the appropriate services and benefits. The FRCs, with input and assistance from interdisciplinary team members and case managers, implement the FIRP by working with existing governmental and nongovernmental personnel and resources.

FRCP staffing has grown to meet the program's needs. Eight FRCs were initially hired in January 2008. We are adding 5 additional FRCs to the 20 current positions in order to meet the growth and success of the program. Most of these new hires will be placed at VA PRCs adding additional support for severely wounded, ill, and injured servicemembers and veterans. The table below shows the current locations, as well as the locations for the new FRCs.

Facility Name and Location	Total FRCs
Walter Reed Army Medical Center, DC	3
National Naval Medical Center, Bethesda, MD	3
Brooke Army Medical Center, San Antonio TX	4
Naval Medical Center, San Diego, CA	3
Camp Pendleton, CA	1
Eisenhower Army Medical Center, Augusta, GA	2
James A. Haley VAMC, Tampa, FL	1
Providence VAMC, Providence, RI	1
Michael E DeBakey VAMC, Houston, TX	1
USSOCOM Care Coalition, Tampa, FL	1
Richmond VAMC Polytrauma, VA	2 (new hire)
Palo Alto VAMC Polytrauma, CA	2 (new hire)
Navy Safe Harbor, DC	1 (new hire)
Total (FRC) FTE	25

Administrative staff includes an executive director, two deputies (one for benefits and one for health), an executive assistant, an administrative officer, and two staff assistants.

The FRCP is VA's lead for the National Resource Directory (NRD), an online partnership of the U.S. Departments of Defense, Labor and Veterans Affairs for wounded, ill, or injured servicemembers, veterans, their families, caregivers, and supporting providers. The NRD is a comprehensive online tool available worldwide with over 11,000 Federal, State, and local resources organized into 9 easily searchable topic areas including: benefits and compensation, families and caregivers, employment, education and training, health care, housing, transportation and travel, and

homeless assistance. The NRD has an average of 1,200 visitors a day where they access approximately 5,000 page views.

FRCP's success rests in its extraordinary and well-trained problemsolving professional staff. We have learned a great deal over the past 2 years and have been able to respond quickly to developing needs or problems. We are looking forward to the results from a current Government Accountability Office program evaluation and those from our satisfaction survey. This input will guide the Program's future development and adaptation.

MENTAL HEALTH CARE AND SUICIDE PREVENTION

VA has responded aggressively to address previously identified gaps in mental health care by expanding our mental health budgets significantly. In fiscal year 2010, VA's budget for mental health services reached \$4.8 billion, while the amount included in the President's budget for fiscal year 2011 is \$5.2 billion. Both of these figures represent dramatic increases from the \$2.0 billion obligated in fiscal year 2001. VA also has increased the number of mental health staff in its system by more than 6,000, since 2005 when VHA began implementing its Mental Health Strategic Plan. During the past 3 years, VA trained over 3,000 staff members to provide psychotherapies with the strongest evidence for successful outcomes for PTSD, depression, and other conditions. Furthermore, we require that all facilities make these therapies available to any eligible veteran who may benefit. In fiscal year 2010 and fiscal year 2011, we will continue to expand inpatient, residential, and outpatient mental health programs and continue our emphasis on integrating mental health services with primary and specialty care. We thank Congress for its strong support over the past several years, as without its help, none of this would be possible.

VA is working closely with our colleagues at DOD to improve the quality of care for veterans and servicemembers alike. Since October 2009, VA and DOD have held two major conferences related to the mental health needs of veterans and servicemembers.

VA offers mental health services to veterans through medical facilities and Community-Based Outpatient Clinics (CBOC), and in addition, VA's Vet Centers offer another important component of mental health care focused on readjustment counseling. Vet Centers embrace a veteran-centric program model that goes beyond formal procedures in making a personal and empathic connection that helps combat veterans overcome stigma and other barriers to care. Approximately 80 percent of all Vet Center staff members are veterans, and 60 percent are combat veterans. In addition to 100 Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veteran Outreach Specialists, more than one-third of all staff now serving in Vet Centers are OEF/OIF veterans. Early access to readjustment counseling in a safe and confidential setting can help reduce the risk of suicide and promote recovery among servicemembers returning from a combat theater. Through the end of December 31, 2009, Vet Centers have made contact with 424,398 (39 percent) of all separated OEF/OIF veterans, and 317,309 were provided outreach services, primarily at demobilization sites, while 107,089 received substantive readjustment counseling in a VA Vet Center.

VA has been making significant enhancements to its mental health services since 2005, through the VA Comprehensive Mental Health Strategic Plan and special purpose funds available through the Mental Health Enhancement Initiative from fiscal year 2005 to fiscal year 2009. In 2007, VA approved the Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics to define what mental health services should be available to all enrolled veterans who need them, no matter where they receive care, and to sustain the enhancements made in recent years.

VA's enhanced mental health activities include outreach to help those in need to access services, a comprehensive program of treatment and rehabilitation for those with mental health conditions, and programs established specifically to care for those at high risk of suicide. To reduce the stigma of seeking care and to improve access, VA has integrated mental health into primary care settings to provide much of the care that is needed for those with the most common mental health conditions. In parallel with the implementation of these programs, VA has been modifying its specialty mental health care services to emphasize psychosocial as well as pharmacological treatments and to focus on principles of rehabilitation and recovery. VA is ensuring that treatment of mental health conditions includes attention to the benefits as well as the risks of the full range of effective interventions. Making these treatments available responds to the principle that when there is evidence for the effectiveness of a number of different treatment strategies, the choice of treatment

should be based on the veteran's values and preferences, as well as the clinical judgment of the provider.

Screening, Treatment, and Access

Crucial to initiating such care, VA requires that all new patients to primary care be screened for PTSD, depression, and problem drinking. If the PTSD or depression screen is positive, an evaluation for suicidality also is required. VA repeats this screening at consistent intervals, since problems can arise at any time, not just on initial access to VA care. Any positive screen leads to further evaluation in the primary care setting, followed by initiation of mental health services, if needed, in the primary care setting or through referral to mental health specialty care.

For patients identified through these screens, or in any other way, VA has established access standards that require prompt evaluation of new patients (those who have not been seen in a mental health clinic in the last 24 months) with mental health concerns. New patients are contacted within 24 hours of the referral by a clinician competent to evaluate the urgency of the veteran's mental health needs. If it is determined that the veteran has an urgent care need, appropriate arrangements (e.g., an immediate admission) are required. If the need is not urgent, the patient must be seen for a full mental health diagnostic evaluation and development and initiation of an appropriate treatment plan within 14 days. Across the system, VA is meeting this standard 95 percent of the time.

Screening usually occurs in the primary care setting where most veterans initially seek care for mental health as well as physical health problems. VA has expanded integrated mental health services in primary care throughout the system. To ensure veterans are monitored appropriately while they are receiving mental health services, including treatment with psychotherapeutic medications, VA requires that these integrated care programs include evidence-based care management and co-located, collaborative care by a mental health professional.

In addition, research has shown the value of having co-located, collaborative mental health staff that can complement the medication-focused care management programs with psychosocial interventions to address depression and other mental health problems. The mental health providers co-located in primary care also can engage with family members when appropriate to listen to their concerns, ensure they understand the care the veteran is receiving, and describe how they can contribute to ongoing treatment for the veteran.

One important set of requirements in the handbook was to ensure that evidence-based psychotherapies are available for veterans who could benefit from them and that meaningful choices between effective alternative treatments are available. VA implemented the broad use of evidence-based psychotherapies in response to evidence that for many patients, specific forms of psychotherapy are the most effective and evidence-based of all treatments. Specifically, the Institute of Medicine report on treatment for PTSD emphasized findings that exposure-based psychotherapies, including Prolonged Exposure Therapy and Cognitive Processing Therapy, were the best-established of all treatments for PTSD. Other specific psychotherapies included in VA's programs include Cognitive Behavioral Therapy and Acceptance and Commitment Therapy for depression; Skills Training, Social Skills Training for Veterans with serious mental illness, such as schizophrenia; and Family Psycho-Education for schizophrenia. VA is adding other treatments such as Problemsolving for Depression, Cognitive Behavioral Therapy and Contingency Management for Substance Use Disorder, and behavioral strategies for managing both pain and insomnia.

For several years, VA has provided training to clinical mental health staff to ensure that there are therapists in each facility able to provide evidence-based psychotherapies for the treatment of depression and PTSD as alternatives to pharmacological treatment or as a course of combined treatment. More recently, VA has begun training Vet Center mental health professionals in Cognitive Processing Therapy (CPT). To date, 120 Vet Center staff members have participated in training courses to develop full competency in this treatment approach. Vet Center staff training will also be enhanced this year through national training in May commemorating the Vet Center program's 30th year in existence. VA is initiating a training academy for all Vet Center team leaders.

VA has expanded care for veterans with Substance Use Disorders (SUD), for example, greatly expanding Intensive Outpatient Centers for Veterans with Substance Use Disorders. These Centers have the strongest evidence base for effective treatment; they provide a team of mental health professionals in a comprehensive program format that offers care at least 3 days each week for at least 3 hours each day. In addition, SUD care also has been integrated in PTSD Clinical Teams by including a SUD provider to work with these Teams at each VA facility.

A central concept for all services is a recovery orientation. For those with serious mental illness, the focus on recovery reflects major scientific advances in treatment and rehabilitation. Although it is still not possible to offer definitive cures for all patients with serious mental illness, it is realistic to offer the expectation of recovery. Veterans, often with their families, should collaborate with their providers in planning treatments based on the goals that will help the veteran live the kind of life he or she chooses, in spite of any residual signs or symptoms of mental illness. To achieve this vision, VA has hired a Local Psychosocial Recovery Coordinator at every facility and has hired staff members to provide peer support, trained clinicians in evidence-based strategies for treatment and rehabilitation, enhanced the care in residential treatment settings, developed Psychosocial Rehabilitation and Recovery Centers and strengthened programs that involve families.

Suicide Prevention

Preventing suicides is a top priority for VA. A suicide by a servicemember or veteran is a tragedy for the individual, his or her friends and family, and the Nation. Data indicate that while civilian suicide rates have remained fairly static over the past 30 years, there has been a deeply concerning increase in the suicide rate among members of the Armed Forces over the last 5 years. Eighteen deaths per day among the veteran population are attributable to suicide. More than 60 percent of suicides among VA health care users are among patients with a known mental health diagnosis. We have initiated several programs that put VA in the forefront of suicide prevention for the Nation. Chief among these are:

- Establishment of a National Suicide Prevention Hotline, including a major advertising campaign to provide this phone number to all veterans and their families;
- Placement of suicide prevention coordinators at all VA medical centers;
- Significant expansion of mental health services; and
- Integration of primary care and mental health services to help alleviate the stigma of seeking mental health assistance.

In 2007, VA developed its signature program, the Suicide Prevention Hotline (1-800-273-TALK (8255)), in partnership with the existing Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Prevention Hotline. At the same time, VA provided specific funding and training for each facility to have a designated Suicide Prevention Coordinator; it also held the first Annual Suicide Awareness and Prevention Day. The same year, VA initiated system-wide screening for suicide in primary care patients, instituted training for Operation S.A.V.E. (which trains non-clinicians to recognize the signs of suicidal thinking, to ask veterans questions about suicidal thoughts, to validate the veteran's experience, and to encourage the veteran to seek treatment), and required Suicide Prevention Coordinators to begin tracking and reporting suicidal behavior. In addition, VA added more suicide prevention coordinators and suicide prevention case managers in our larger medical centers and community-based outpatient clinics, doubling the number of dedicated suicide prevention staff in the field. By 2008, VA had re-established a monitor for mental health follow-up after patients were discharged from inpatient mental health units and held a fourth regional conference on evidence-based interventions for suicide. In 2009, VA launched the Veterans Chat Program to create an online presence for the Suicide Prevention Hotline. Veterans Chat and the Hotline are intended to reach out to all veterans, whether they are enrolled in VA health care or not. VA also added a flag to patient records to notify physicians of patients at risk for suicide. This year, VA has already held a Suicide Prevention Coordinator conference and co-hosted a conference with DOD to discuss ways VA and DOD can reduce the prevalence of suicide among veterans and servicemembers.

VA has adopted a broad strategy to reduce the incidence of suicide among veterans. This strategy is focused on providing ready access to high quality mental health and other health care services to veterans in need. This effort is complemented by helping individuals and families engage in care and addressing suicide prevention in high risk patients. VA cannot accomplish this mission alone; instead, it works in close collaboration with other local and Federal partners and brings together the diverse resources within VA, including individual facilities, a Center of Excellence in Canandaigua, New York, a Mental Illness Research and Education Clinical Center in Veterans Integrated Service Network (VISN) 19, VA's Office of Research and Development, and clinicians.

This evidence clearly demonstrates that once a person has manifested suicidal behavior, he or she is more likely to try it again. As a result, VA has adopted a comprehensive treatment approach for high risk patients. This includes a flag in a patient's chart, necessary modifications to the patient's treatment plan, involvement

of family and friends, close follow up for missed appointments, and a written safety plan included in the veteran's medical record. This plan is shared with the veteran and includes six steps: (1) a description of warning signs; (2) an explanation of internal coping strategies; (3) a list of social contacts who may distract the veteran from the crisis; (4) a list of family members or friends; (5) a list of professionals and agencies to contact for help; and (6) a plan for making the physical environment safe for the veteran.

During 2009, the VA Call Center for the Suicide Prevention Hotline (1-800-273-TALK) received approximately 10,000 calls per month, approximately 20 percent of all calls to the National Suicide Prevention Lifeline. Approximately a third of these calls are from non-veterans. These calls led to 3,364 rescues of those determined to be at imminent risk for suicide and 12,403 referrals to VA Suicide Prevention Coordinators at local facilities. In 2009, the VA Call Center received calls from 1,429 active duty servicemembers, a little more than 1 percent of all calls. To address the needs of the active duty population, VA worked with SAMHSA to modify the introductory message for Lifeline, developed memoranda of understanding with DOD, and established processes for facilitating rescues, including collaborations with the Armed Services in Iraq. Also during 2009, the Hotline services were supplemented with Veterans Chat, which has been receiving more than 20 contacts a day.

The online version of the Hotline, Veterans Chat, enables veterans, family members, and friends to chat anonymously with a trained VA counselor. If the counselor determines there is an emergent need, the counselor can take immediate steps to transfer the visitor to the Hotline, where further counseling and referral services can be provided and crisis intervention steps can be taken. Since July 2009, when Veterans Chat was established, VA has learned many valuable lessons. First, it is clear that conversations are powerful and capable of saving lives. As a result, opening more avenues for communications by offering both an online and phone service is essential to further success. Second, training and constant monitoring is very important, and VA will continue pursuing both of these efforts aggressively.

The Lifeline and VA Call Center may be the most visible components of VA's suicide prevention programs, but the Suicide Prevention Coordinators are equally important. Both the VA Call Center and providers at their own facilities notify the Suicide Prevention Coordinators about veterans at risk for suicide. The Coordinators then work to ensure the identified veterans receive appropriate care, coordinate services designed specifically to respond to the needs of veterans at high risk, provide education and training about suicide prevention to staff at their facilities, and conduct outreach and training in their communities. Other components of VA's programs include a panel to coordinate messaging to the public, as well as two Centers of Excellence charged with conducting research on suicide prevention: one, in Canandaigua, focused on public health strategies, and one in Denver, focused on clinical approaches. VA also has a Mental Health Center of Excellence in Little Rock, AR, focused on health care services and systems research.

Data also support the conclusion that high quality mental health care can prevent suicide. The suicide rate for all veterans who used VA health care declined significantly from fiscal year 2001 to fiscal year 2007. Fully understanding these data require some background on VA's efforts to track suicide rates for veterans. First, it is important to consider who accesses VA health care. For this, it is useful to refer to findings on those veterans returning from Afghanistan and Iraq who participated in the Post-Deployment Health Re-Assessment (PDHRA) program administered by DOD. Between February 2008 and September 2009, approximately 119,000 returning veterans completed PDHRA assessments using the most recent version of DOD's form. Of the more than 101,000 who screened negative for PTSD, 43,681 came to VA for health care services (43 percent). Among 17,853 who screened positive for PTSD, 12,674 came to VA for health care services (71 percent). These findings demonstrate that veterans screening positive for PTSD were substantially more likely to come to VA for care. Findings about depression were similar. Both sets of findings support earlier evidence that those veterans who come to VA are those who are more likely to need care and to be at higher risk for suicide. The increased risk factors for suicide among those who came to VA is often referred to as a case mix difference.

Working with the Centers for Disease Control and Prevention's National Violent Death Reporting System, VA recently calculated rates of suicide for all veterans, including those using VA health care services and those who do not. This analysis included data from 16 states for individuals aged 18-29, 30-64, and 65 and older for the years 2005, 2006, and 2007 (during the period of VA's mental health enhancement process). The year 2005 marked the beginning of enhancement, while the year 2007 is the most recent one for which data are available.

Suicide rates for veterans using VA health care services aged 30–64, and those 65 and above were higher than rates for non-users, and they remained higher from 2005 to 2007, probably a reflection of the case mix discussed above. However, findings for those aged 18–29 were quite different. In 2005, younger veterans who came to VA for health care services were 16 percent more likely to die from suicide than those who did not. However, by 2006, those younger veterans who came to VA were 27 percent less likely to die from suicide, and by 2007, they were 30 percent less likely. This difference appears to reflect a benefit of VA's enhancement of its mental health programs, specifically for those young veterans who are most likely to have returned from deployment and to be new to the system.

Because the number of veterans from the 16 States in this group is relatively low, the rates are, for statistical reasons, variable. Nevertheless, they demonstrate important effects. In 2005, 2006, and 2007, respectively, those who came to VA were 56, 73, and 67 percent less likely to die from suicide. Those who utilized VA services were, to some extent, protected from suicide with an effect that appeared to increase during the time of VA's mental health enhancements. More broadly, the rate of suicide among veterans receiving health care from VA has declined steadily since fiscal year 2001; specifically, the rate declined more than 12 percent during this time. From a public health perspective, the decline in rates is significant, corresponding to about 250 fewer lives lost as a result of suicide.

CONCLUSION

In conclusion, thank you again for the opportunity to speak about VA's efforts to treat and reduce TBI, PTSD, and suicide among servicemembers and veterans.

Chairman LEVIN. Thank you very much, Dr. Jesse.

Thanks to the VA also for the important work that they do in this area, and the joint work that is being done between the VA and DOD.

We are lucky that the chairman of the Senate Veterans' Affairs Committee, Senator Akaka, is also on the Armed Services Committee, which has allowed us to do a lot better with coordination on these matters. It's a real break for us, and more importantly, for our troops and our veterans, that Senator Akaka is a member of this committee.

Let's try a 7-minute first round for questions.

General Chiarelli, let me start with you. A couple of weeks ago, National Public Radio reported that the military is failing to diagnose brain injuries in troops who served in Iraq and Afghanistan, that the injuries were not documented on the battlefield, and that soldiers with TBI don't always get the best medical treatment. Interviews of soldiers at Fort Bliss revealed that some soldiers with TBI, who were crying out for help, still had to wait more than a month to see a neurologist. Also, they reported that many military doctors have failed to accurately diagnose TBI. Can you give us your response to those reports?

General CHIARELLI. Mr. Chairman, I provided a complete response to National Public Radio in which I detailed my problems with the report. I have three basic problems with the report:

Number one, it criticized the leadership for not caring or not doing anything about it. I think that's far from the truth.

I took great exception with the report stating that our doctors don't seem to care, and are not properly diagnosing these injuries, without explaining the real issue here. You cannot isolate TBI without talking about PTSD.

As I mentioned in my opening statement, the comorbidity of symptoms between these two make it very, very difficult for doctors to make that diagnosis. Of my Army wounded warrior population—the most severely wounded population I have, with a single dis-

qualifying injury of 30 percent or greater—60 percent have either TBI or PTSD—43 percent PTSD, 17 percent TBI. I really believe that when you fail to talk about both PTSD and TBI in this issue of comorbidity, you're doing a great disservice, because, to state it flatly, our science on the brain is just not as great as it is in other parts of our body. Researchers are struggling today to find the linkages and to learn everything they can about the brain, and because of this, we're going to see some misdiagnosis.

I can tell you, of the folks that the National Public Radio talked about, they had over 200 appointments apiece. There's no doubt, you could go to any one of our posts and find soldiers who are struggling because of our inability to nail down and to diagnose exactly what treatment they need for these behavioral health issues. But, I promise you, it is not for a lack of trying or real care on the part of our doctors. Our leadership is totally committed to working these issues.

Chairman LEVIN. In terms of the wait one of the soldiers claimed it took a month or more to see a neurologist?

General CHIARELLI. I will tell you that a neurologist is not the answer, necessarily, to these soldiers' issues. I have a total of 52 neurologists in the U.S. Army; 40 of them are currently practicing. Forty, and that's when I include my child neurologists. The team that will work with somebody on any behavioral health issue is a team of a neurologist, possibly a psychiatrist, nurse case manager, who will look at the entire file or medical record of care given to that soldier, and work to provide them the best that they can.

One of the problems we have here—I get this from talking to doctors—is, the medications for PTSD and TBI are totally different. So, if we misdiagnose, at the beginning, and provide a diagnosis of PTSD, when in reality it's TBI, the medications we're going to put that soldier on are going to be different than what the real problem is, and may be different from another behavioral health issue that that soldier may have, because it's not all TBI and PTSD. There's anxiety issues, depression issues, other issues that are the product of these wars, that are causing us so much difficulty in this area.

I have 79 percent of the psychiatrists currently assigned to the U.S. Army, based on my authorization prior to 2001. I know that that authorization is lacking, but I only have 79 percent. It's not just an Army problem. This, I think you will all agree, is a national problem, a shortage of behavioral health specialists.

Chairman LEVIN. So, there are some areas of professional need where we are short. Is this a matter of funding? Is this a matter of finding people? Or, what is it?

General CHIARELLI. No, I don't believe it's a matter of funding at all. I think it's a matter of finding folks, getting them to move to some of the places where the Army is stationed. I think a psychiatrist might prefer to be in Nashville than in Clarksville, TN. So, we have to rely on the TRICARE network, many times, to provide some of the behavioral health specialists that we need.

Chairman LEVIN. In terms of the delay issue, is the delay the result of a lack of resources, in the cases that were talked about on National Public Radio, or is that a matter of the complexity which you just described?

General CHIARELLI. I would argue it's the case of the complexity, I really would. I'm not saying that, in every instance, that we're getting soldiers in exactly when we want them to be, but when soldiers are assigned to our Wounded Warrior Transition Units (WTU), they have a primary care manager, at the rate of 1 per 200, a primary care manager, where you or I would have a primary care manager at a ratio of 1 to 1,200 to 1,500. They have a nurse case manager at a ratio 1 to 20, and they have a squad leader at a ratio to 1 to 10 or less.

So, we've done everything we can to focus our resources, our limited resources, in this area. But, I will tell you, we are short behavioral health specialists.

Chairman LEVIN. But, again, that's not a funding issue?

General CHIARELLI. It is not a funding issue.

Chairman LEVIN. All right.

Dr. Jesse, the VA, as you, I think, testified, screens all of our Iraq and Afghan veterans who receive care from the VA for TBI. Does that screening for TBI indicate that there is a routine failure in the military to properly diagnose TBI before you see that veteran, when they're still on Active Duty?

Dr. JESSE. No, sir. I don't think we can say that. The problem with TBI is that there's no hard, fast diagnostic test. There's not a lab test that you can send off and get a solid answer back. The other one is that of temporal issues—often it takes time for it to manifest some of the effects that show up.

So, I don't think that it's a failure, on DOD side, to find these people. I think, it may just be the complexity of disease, as you've heard, takes time to manifest in ways that we can then identify it.

Chairman LEVIN. Thank you.

My time's up.

Senator Inhofe.

Senator INHOFE. Thank you, Mr. Chairman.

Chairman LEVIN. Again, thank you, Senator, for your initiative in this area.

Senator INHOFE. Yes, sir.

Oddly enough, of all of the subcommittees of the Armed Services Committee, the one I've never served on is Personnel. I don't know a lot about these issues. But, when it was called to my attention, the propensity of these suicides, and we started looking into it, I made the request, Mr. Chairman—and, also the request, which I think you may be doing in another hearing, actually bringing in some of the medical experts and soldiers, with their experiences.

General Chiarelli, I know that you have really made a study of this thing. It was in your written testimony that on Active Duty, you've actually had a reduction in suicides, but an increase in the Reserve component. Is this correct?

General CHIARELLI. That's correct, Senator.

Senator INHOFE. I can remember back during the 1990s, when we were downsizing the military. Then, of course, when September 11 happened, we have all these deployments—everybody up on this side of the table hears from our people back home, our Guard and Reserve, the OPTEMPO is just not livable. That goes all the way across Services. I would think that, since you made that statement, that perhaps the OPTEMPO might be some leading cause of these,

in that the OPTEMPO for the Reserve and the Guard is much higher. Do you see that relationship?

General CHIARELLI. I see that as one of the factors, Senator. We've had a decrease of 15 Active component suicides this year, compared to last year. When I talk Active, I'm talking about the 547,400 we have in the Active component force, plus about 200,000 that are mobilized at any one time out of the Reserve and National Guard. It's about a 700,000-person force.

Once a Reserve soldier is made an Active Duty soldier, he is counted in my Active component numbers. We are down 15. We are down two with our Reserve component soldiers not on Active Duty. We are up 21 in our National Guard soldiers who are not on Active Duty, and that concerns me greatly.

It's three things. I think its multiple deployments for them. I don't think we're getting enough time with them at the DEMOB station to give them the kind of behavioral health checkouts that they need. Third, I think—Senator McCain said it in his opening statement—this lack of human interaction, at least with other soldiers, that they have when they leave the Service within 5 to 7 days after a 12-month deployment, I think, is a real issue here.

Senator INHOFE. OPTEMPO, that's what we're talking about. There is an article—and perhaps you had implied that—on the public radio thing, that that was not totally accurate. I agree with you.

There's another article, from June 14, in USA Today. It was pretty critical because it talked about the law that was passed in 2008, and one of the main persons was this Representative Bill Pascrell, of New Jersey—which said, there have to be both “pre” and “post”—and apparently we're short on the “post” end of it. Can you elaborate on that a little bit?

General CHIARELLI. Senator, we followed the law when it was passed. The law stated that we were to use the Automated Neuropsychological Assessment Metrics (ANAM) as a screening tool in pre- and post-deployment. We still use the ANAM in predeployment to get a baseline on cognitive skills of our soldiers. But, what we found when we used the ANAM in post, was that we were getting a number of false positives, a high number of false positives, way too high. We were tying up our limited behavioral health specialists in working their way through these false positives from the ANAM.

Now, we still use the ANAM in post if a soldier demonstrates any of the symptoms of TBI or any cognitive issues. So, we are still using it. We're just not making it mandatory for every soldier, so we don't take our short behavioral health specialists and wade through a whole bunch of false positives, which the test tended to produce.

We have other things that we're using. Virtual behavioral health is something I'm very excited about, where we can give every soldier a 30- to 40-minute triage session with a behavioral health specialist, using the Internet putting together a virtual net of providers who can take an entire brigade and put everybody, from brigade commander to the youngest private in that unit, through a 30- to 40-minute screen. I mean, this is the kind of thing I would

like to be able to provide to Reserve component soldiers when they get back, but I don't necessarily have the time necessary to do that.

Senator INHOFE. I really appreciate the attention you've given to this issue.

Do any of the rest of you want to comment on that, in terms of how it relates to the provision that was passed in 2008 in our authorization bill?

General CHANDLER. Senator, if I could, I would say that we still use the ANAM, pre and post. We're fortunate, in a way, based on the numbers that we're dealing with, that we can do that, even with the false positives. Like the Army, we also have other tools that we use. We had a fair amount of success with a Post-Deployment Health Assessment, which takes place in theater, face to face, or shortly after return. One of the things that I think is very important is, 6 months later, there's a post-deployment health reassessment. That assessment has yielded 16 percent of those airmen that we're treating for post-deployment stress syndrome. We think that 6-month follow up is extremely important, as well.

Senator INHOFE. All right.

General AMOS. Senator, we're in agreement with the Army and the other Services here. We test, using the ANAM test, 100 percent of our marines, prior to deployment. We are not doing that when they come back. It is used occasionally by our mental health professionals, if they don't have anything better. But, the issue of false positives, and the lack of reliability in the ANAM on the post-TBI incident, especially when you come home, leads our Navy doctors, our mental health professionals, to seek other ways to take a look at our marines. We're doing that.

Much like General Chandler talked about, we screen both 100 percent of the marines as they're coming out of theater, and then, within 90 to 180 days later, we do it again. Just to give you some numbers, for PTS, 15 percent of those that are screened coming out theater answer some questions positively, which would lead you to further screening. Of that further screening, 7 percent see mental health professionals. Then, by the time you dwindle this thing down, it's about 2 percent of the marines actually need mental health care when they come out.

Senator INHOFE. Right.

General AMOS. So, it's just not that reliable on the back side, sir.

Senator INHOFE. That's very helpful. I appreciate that.

My time has expired, but I wanted to ask you a question that could be answered for the record, if that's all right, Mr. Chairman.

Chairman LEVIN. Yes.

Senator INHOFE. A January 14 article said, "When Soldiers Deploy, Family Deploys." It's talking about tying in the OPTEMPO with the families, with the deployments. The New England Journal of Medicine did a study. I read this article and then did a little bit more research on some of the findings that they're having, in terms of the families—the wives, the kids—and nothing was really said during the opening statements about that.

So, I'd like to have the four of you address what we might be doing, in terms of the wives, the children, that might be having the same problem in the same ratio that the troops themselves, or the Active and the Reserve components are having.

Thank you, Mr. Chairman.
[The information referred to follows:]

General CHIARELLI. The Army provides a wide array of services, training and support to soldiers, wives, and families in the early detection and treatment of psychological problems. The Comprehensive Behavioral Health System of Care mitigates the effects that the stress of deployment can have on the mental well-being Army families. Inpatient and outpatient behavioral health care is available to family members through medical treatment facilities at every Army installation that hosts families. The Army leverages local healthcare providers in the surrounding installation communities through the TRICARE network system. TRICARE covers medically and psychologically necessary behavioral health care services for family members to include individual, family, and group therapies, collateral visits, psychoanalysis, psychological testing, inpatient hospitalization, partial hospitalization and residential treatment.

Other programs that provide training and behavioral health services to Army families include Army Community Service; Battlemind; Child, Adolescent and Family Behavioral Health; Family Assistance for Maintaining Excellence; Military OneSource; Psychological Health in Schools Programs; and the Warrior Resiliency Program. Through these services and programs, family members receive help to deal with depression, anxiety, behavioral health symptoms, and reintegration. These services also provide crisis intervention, classroom intervention, individual therapy, and resilience training.

Admiral GREENERT. Operational Stress Control (OSC) is the Navy's comprehensive prevention and awareness initiative to address the psychological health needs of sailors and their families and reduce the stigma associated with seeking assistance. The initiative is led by operational leadership and supported by Navy Medicine. OSC provides practical decisionmaking tools for sailors, leaders, and families to identify stress responses and mitigate problematic tension. The Stress Continuum is an evidence-informed model that highlights shared responsibility by sailors, family members, and Navy leadership for maintaining optimum psychological health. The model is used to recognize and intervene early, when indicators of stress reactions or injuries are present, before an individual develops a serious stress illness, such as Post-Traumatic Stress Disorder or depression.

Working in collaboration with Navy Medicine, Fleet and Family Support Programs (FFSP) have launched an OSC awareness effort focusing on family members. OSC concepts are being incorporated into existing, regularly scheduled family support services such as predeployment and stress management workshops, Family Readiness Groups, Ombudsmen training, transition assistance workshops, parenting classes, and clinical counseling sessions, to familiarize family members with the concepts and stress continuum language. This information provides family members a framework from which they can identify behaviors/symptoms early and speak to someone about obtaining help for themselves, their children, or their military loved one.

Brief, solution-focused clinical counseling provided in Fleet and Family Support Centers (FFSC) is another avenue where military and family members can seek consultation and assistance from licensed mental health professionals for commonly occurring situations and adjustment issues before more significant problems develop that require medical or psychiatric intervention. Placement of clinical counselors for children in FFSCs and Behavioral Health Consultants in Child Development Centers help identify and provide assistance to children who are adversely impacted by their parent's deployment.

General AMOS. The Marine Corps does not maintain surveillance of the rates of mental illness among Marine dependents. There is no evidence to indicate that rates of mental illness are higher among the Marine dependent population than in a similar civilian population. However, the leadership of the Marine Corps is acutely aware of the stresses borne by Marine families as a result of deployments in support of military operations overseas and is constantly making improvements in the support provided to the physical and psychological health of Marine families.

A full spectrum of mental health care is provided to Marine dependents through TRICARE. Direct care, where available, is provided by the Navy military treatment facilities which support the Marines. Where care is not available through the direct care system, it is provided through the TRICARE network.

Additional resources are available to support military dependents. Marine Corps Community Services provides counseling and referral services and conducts activities to facilitate return and reintegration of families following deployment. Navy chaplains supporting Marine Corps can provide spiritual counseling and informal referral to the mental health care system. Military OneSource is available to provide

confidential life skills advice and up to six sessions with a mental health counselor. The Exceptional Family Member Program provides a spectrum of services and referral to Marine families with members who have ongoing physical, psychological and emotional challenges. Educational and Developmental Intervention Services are provided by BUMED to children with physical or psychological needs related to their education. Families Over-Coming Under Stress (FOCUS) is a very successful program which provides developmentally appropriate education, family-centered skill building and social support for families of deployed servicemembers, particularly focused on children with deployed, injured, or deceased parents.

General CHANDLER. The mental health of families is of significant concern to the Air Force (AF) as family support is essential for effective functioning of our servicemembers. The AF has had an increase in utilization of mental health services over the past 5 years at military treatment facilities and the TRICARE network. AF health care records show that approximately 16,000 active duty family member beneficiaries (approximately 3 percent of all beneficiaries) have a primary diagnosis of some form of depression. This compares to an estimated national prevalence of depression of approximately 10 percent.

AF Airman and Family Readiness Centers (A&FRC) champion the resilience of AF families by offering proactive services and programs to assist in identifying and resolving concerns brought about by personal and familial stress. Those programs include support across the entire cycle of deployment; contracted non-medical counseling by licensed mental health professionals; emergency financial assistance through the AF Aid Society; advocacy for military child education and families with special needs; consultations on personal financial readiness, spouse employment, relocation and transition assistance; and information and referral to other appropriate agencies.

In addition to the services available through the A&FRC, more formal mental health care is also available.

Mental health visits: Beneficiaries have access to mental health treatment in both outpatient and inpatient settings. In the AF, due to the primacy of the mission to active duty airmen, most care to family members is arranged through the TRICARE network.

Behavioral Health in primary care: Studies show that half of all medical visits for mental health concerns occur in primary care clinics. Often this is enough, but over 60 percent of AF medical treatment facilities have behavioral health providers embedded within them. Seeing a mental health provider in primary care is a lower-stigma alternative and typically involves a few visits for a focused intervention. No separate mental health charting is necessary.

The TRICARE Assistance Program (TRIAP): TRIAP offers web-based counseling for adult beneficiaries.

Chairman LEVIN. Thank you, Senator Inhofe.

Now, Senator Inhofe, made reference to a bill that has been introduced by Congressman Bill Pascrell, who was the cofounder and cochair of the Congressional Brain Injury Task Force. We have received a statement from him, which we will make part of the record.

[The information referred to follows:]

PREPARED STATEMENT BY CONGRESSMAN BILL PASCRELL, JR.

Mr. Chairman, in 2001, I cofounded the Congressional Brain Injury Task Force with former Congressman Jim Greenwood of Pennsylvania. At that time, there was little awareness and understanding of traumatic brain injury and the issue was generally seen as problem in the civilian realm. In contrast, today this issue has become most pressing as roughly 1 of out 5 veterans of Operation Enduring Freedom and Operation Iraqi Freedom are estimated to experience a possible traumatic brain injury and as traumatic brain injury has been recognized as the "signature injury of the war."

This month, the media extensively covered the military's failure to identify, diagnose, record, and treat brain injuries. NPR and ProPublica found that while millions of dollars have been pumped in the system since 2007, there have been few results. Furthermore, USA Today found that the Pentagon "failed to comply with a congressional directive to give all troops tests before and after" combat.

To give some background, in 2007, through the fiscal year 2007 supplemental appropriations bill, Public Law 110-28, Congress gave the Department of Defense \$900 million to increase access, treatment, and research for traumatic brain injury

and post-traumatic stress disorder. In 2008, my colleagues and I put in place protections for the troops in the National Defense Authorization Act for Fiscal Year 2008, Public Law 110-181, requiring cognitive screenings of soldiers pre-deployment and post-deployment. Two years later, the law has yet to be fulfilled as less than 1 percent of approximately 560,000 members of the Armed Forces have been given a post-deployment cognitive screening in order to identify any possible brain injury.

We have let too many soldiers fall through the cracks and we cannot continue to wait as our soldiers continue to come home from the battlefield, without the proper diagnoses. The Department today uses two different tests on soldiers pre-deployment and post-deployment. These tests are not comparable and cannot detect changes to a soldier's brain. To correct this, I included language in the 2011 Defense Authorization bill, H.R. 5136, to require the same cognitive screening tool be used pre-deployment and post-deployment to detect any cognitive change in our soldiers and also to require the Department of Defense to complete the studies necessary to find the best cognitive assessment tools for our troops.

Over the last few years, Congress has continued to emphasize the importance of this issue and has made funds available for the identification and treatment of brain injuries in our soldiers. I am disappointed that after so many Members of Congress weighed in on this matter, that we must again push to have this problem addressed. I hope that this hearing will help the Department to better understand our goals and that they will be willing to demonstrate their desire to put strong policies in place to identify, diagnose, record, and treat brain injury for not only our troops who are currently still deployed, but also for the soldiers that we have missed since the beginning of these wars. I thank the Chairman for holding this hearing and look forward to working with members as well as the Department of Defense to help our soldiers in this area of need.

Chairman LEVIN. Senator Akaka.

Senator AKAKA. Thank you very much, Mr. Chairman, for scheduling this hearing on these vitally important topics.

I want to thank my brother and friend Senator Inhofe for helping to bring this about.

I want to welcome our distinguished group of witnesses, and thank each of you for your dedicated service to our country. I also want to thank the men and women that you lead, and thank them for their outstanding service.

Like you, the topics at hand today are ones that I care deeply about. Continuing to work with you and my colleagues, we can refine efforts to prevent military suicides and to look for better ways to detect, treat, and care for those suffering from invisible wounds of war.

General Chiarelli and General Amos, suicide prevention is difficult and challenging. For all of you on our panel, this has come about, of course, because of what we call "combat stress." As was mentioned, this includes PTSD, TBI, and behavioral health issues that we are facing here.

As was previously stated, the Services have experienced a rise in the number of suicides since the wars in Afghanistan and Iraq started. There is a need to understand suicide, look at the causes, and get a point where we can prevent it.

Generals Chiarelli and Amos, and also Dr. Jesse, how can the DOD and VA better collaborate in the area of suicide research and prevention? This has been mentioned, by General Chiarelli, as a great need here. I'd like to have the three of you give your perspectives on this.

General Chiarelli?

General CHIARELLI. I will argue, the cooperation between the VA and the Services, I believe, has never been better. I think the disability evaluation system (DES) pilot that we're running at different installations is proving to be a great success for the U.S.

Army. The wonderful thing about this is, is that when a soldier goes through the DES, we ensure, that, if they are leaving the Service, that they're in the VA system. This is something that has never happened before, as far as I know it. It is a wonderful benefit of this system, that when a soldier makes the decision to leave the Service, he or she is in that VA system. Before, we would, in fact, have soldiers separate, and it would be their responsibility to work their way through the process to get in to receive both their medical benefits and other benefits through the VA system.

I think that you've hit upon a key piece here, and that is stressors. But, it's not only combat stress, it's individual soldier stress and family stress. When we look at those across a continuum, what we're seeing in the Army, with the high OPTEMPO that we're on today, that a soldier, in the first 6 years he or she spends in the U.S. Army, has the cumulative stressors of an average American throughout their entire life. That's when you combine high OPTEMPO, individual soldier stressors, and family stressors.

This is an area we're looking at very, very hard. When you realize that 79 percent of our suicides last year were soldiers, 60 percent in their first term, 79 percent one deployment or no deployments, I think, it points to doing everything we possibly can to mitigate those stressors, whenever possible, and as we're working so hard to do in the Army, work to increase the resiliency of our soldiers, particularly in their younger years.

Senator AKAKA. Thank you.

General Amos?

General AMOS. Senator, I'll be happy to talk about, not only the relationship, but the handoff between the military and, in my backyard, the Marine Corps and the Veterans Administration. Like General Chiarelli, I have never seen it better. The entire organization is well led, from the top down, from VA. They are compassionate. They are passionate about the care of our young men and women that enter their system. I've never seen it better. I'm fortunate to get to travel around and visit a lot of our VA hospitals and our wounded, and I come away just completely wowed by what I see.

There is a systematic handoff. In the Marine Corps, this is done through what we call our Recovery Care Coordinators. We have them around the Nation, and they are not part of the Federal Recovery, but they are linked to it—but, they are U.S. marines whose job and life is to know everything they can about the VA system. So, when a marine transitions—especially one of our wounded marines—out heading into VA-land after a disability board, and he's moving on to the next half of his life, that Recovery Care Coordinator contacts a Federal Recovery Care Coordinator, the District Injured Support Marine we have out there, our network of Marine for Life, to put our arms around this guy.

I've seen it firsthand, where the actual handoff for a needy marine, in some cases 2 years after the initial injury—I just saw this about last month, down in Corpus Christi, TX. A young marine, TBI, 2 years ago, his life is unraveled right now. Through the Federal Recovery Coordinator and the VA in San Antonio, and our

Care Coordinator, we were able to plug this marine, get him back into a hospital right now for further care.

So, I've never seen it better, Senator.

Senator AKAKA. Yes.

Let me ask, Admiral Greenert, for your comments, as well as General Chandler, after you.

Admiral GREENERT. Thank you, Senator. I think General Chiarelli and General Amos hit the nail on the head. The cooperation is very good. In fact, we meet monthly with the leadership of the VA and leadership of DOD to streamline the DES.

I would say that what we are finding in our study of suicides, the transitional period seems to be a spike in stressors. This is an area we need to watch very closely, this transition period, and be sure that our sailors have the social support network that they've had as they've moved through their career in the Navy, as long as it is. It's also a focus area, to watch out for those stressors.

Thank you.

Senator AKAKA. General Chandler?

General CHANDLER. Senator, we have approximately 700 airmen in our Wounded Warrior Program. These are young men and women whose lives have been changed forever, and that we are dedicated to taking care of, from the time they've been wounded until they no longer need our services in the Air Force, and we make the transition to the Federal system, if, in fact, that's required and we're not able to bring them back to the Air Force.

We use much of the same system that General Amos described, with Care Recovery Coordinators that allow us to do that around the Nation, to service the young men and women that require that kind of treatment and that kind of handling. We're very comfortable with our relationship with the VA and the way that's working.

Senator AKAKA. I'm glad that we've been working on what we call "seamless transition." It appears that we are moving along on that.

Dr. Jesse?

Dr. JESSE. Thank you, sir. So, as not to reiterate things that have already been said, I'd just like to point out a couple areas where this level of integration has really become manifest. The first is in the post-deployment and health reassessment exercises. The VA generally has a presence at those exercises, not to administer the exams, but to be present to make sure that those servicemembers are aware of all of their benefits that the VA can provide. But, also, if there are immediate health, and particularly mental health, issues that arise, that they are there and can literally make an appointment on the spot. They can get them enrolled in the VA, make an appointment. If we need to take them into our care at that point, we can do that, so that we participate in that.

The second is the polytrauma networks, which really are—while the VA has four, and going on five now, Polytrauma Centers of Care, are very tightly integrated into the Wounded Warrior Programs at Walter Reed and Bethesda. In fact, I had the real honor to accompany Deputy Secretary Gould and Dr. Stanley on a tour of Walter Reed, and then come directly down to Richmond and look

at the seamless way that both patients and their information move back and forth through those networks, including the fact that there are VA representatives stationed in the DOD facilities, and DOD clinicians in the VA Polytrauma Centers, so that we ensure that any movement of patient is a warm handoff and not just being sent to another place.

Finally, in the mental health area, I think there's just been an extraordinary collaboration going on for some time now. There was a joint conference, in the fall of 2009, that led to an integrated VA/DOD strategic plan. The real goal was to make sure that when, for instance there are evidence-based therapies for treatment of PTSD, that the VA and the Services agree on how we treat those patients so that as treatment begins in the Services, and then transitions in the VA, we're not abruptly stopping one form of therapy and entering into another. I think this is a hugely important point of collaboration, that we've gotten that far.

Senator AKAKA. Thank you for your responses.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator Akaka.

The testimony of our witnesses, saying that the integration of planning and diagnosis and treatment of our troops that are veterans is going along at a good pace, is important news to both of our committees. It's something we put a great focus on, both Veterans Affairs and Armed Services. Our wounded warrior legislation was aimed at accomplishing that. So, this is important testimony, and good to hear.

Senator COLLINS.

Senator COLLINS. Thank you, Mr. Chairman.

General Chiarelli, I want to follow up on a question that Senator Inhofe asked you.

Senator Inhofe, I want to thank you for suggesting this hearing, as well as the chairman, for holding this important hearing.

In the past year, I have met with a retired general in my State, with returning members of the National Guard, and with a whole variety of healthcare professionals, to discuss the mental health needs of our troops and the troubling rise in suicides. To a person, each of them has told me that it's insufficient dwell time between deployments that they believe is the biggest factor, that there's not sufficient recovery time before deployments occur again. How important do you think that factor is to the increase in problems with mental health and the suicide rates?

General CHIARELLI. I think, for the National Guard soldiers, it may be higher than we're seeing with the Active component soldiers. As I indicated, 79 percent of our suicides last year were soldiers who had never deployed or only deployed one time. So, that would argue that, in that group of 700,000, there's a bit of resilience that grows with repeated deployments. I'm just giving you the numbers we're seeing out of NIMH, and as we start to pull the early results.

I really believe, though, the real issue here for our National Guard soldiers is that, when they come back off of multiple deployments, that second or third deployment, that we have sufficient time at the DEMOB station to do the kind of medical tests, such as a virtual behavioral health counseling or other things, to ensure

that, number one, we get a good read on how they're doing; and, number two, that they fully understand the medical benefits that they're going to have when they return to their State.

One of the hardest things for any of us is that the benefits for a National Guard soldier differ from State to State. We've made great progress with TRICARE Reserve Plus. You add that to the Transitional Assistance Management Program, which gives you 6 months of care when you come back home. If we can get the soldier to enroll in TRICARE Reserve Plus, we can provide them continuous medical care to the next deployment. I think this is critical.

I think we have to look at this population a little bit differently, and, again, as Senator McCain said, I am able to wrap leaders around returning Active component soldiers for the entire time that they're back. We take a Reserve component soldier today and, within 5 to 7 days, he's back in his community, on his own.

Senator COLLINS. A related problem, at least in a rural State like mine, is an absence of mental health professionals in those rural communities. Even though the VA will provide the assistance, or the National Guard will provide the assistance, it's often many hours away. That's a problem that's in our society as a whole, and you've mentioned the shortages that you're facing, and that it's difficult to match the mental health professionals where bases may be located. But, that's an even worse problem when you're talking about National Guard members or reservists who are going back to their home communities, their regular jobs in small communities that may not have any mental health professionals at all.

General CHIARELLI. If I could just quickly comment.

Senator COLLINS. Yes.

General CHIARELLI. We started a program, last August, which gives counseling, 24-7, without a TRICARE referral, to anyone who's authorized for TRICARE. It is done online. It falls short of psychotherapy or prescription pain management, so we can't do that online. But, where I really see us making up for this shortage is to really explore what we can do with tele-behavioral health.

Senator COLLINS. I agree.

General CHIARELLI. Because this gets at the stigma issues, it gets at the kind of shortages you're talking about in rural areas, Senator. I really think that this is something that will fix us now, rather than wait until we grow the necessary providers that we need over time. I really think we should be exploring this as hard as we possibly can.

Senator COLLINS. I completely agree. There's great potential, particularly since so many of these young troops have access to computers in their own homes, because the stigma still is there. Despite all of our efforts, it's still there. So, I'm delighted to hear you put an emphasis on that.

General Amos, even though we've given a lot of attention to the Army's rising suicide problem, I was struck to see, in 2009, that the branch with the highest rate of suicides among Active Duty personnel was actually the Marine Corps. The Army's clearly done a great deal, is the Marine Corps matching that effort, in stepping up your programs and trying to tailor them to the culture of the marines?

General AMOS. Senator, that's a great question. The short answer is: absolutely, yes. We are joined at the hip with our programs that we mutually share cross-boundary. We are aware of all that each of the other Services do. We collaborate. We share best practices. We steal good ideas from one another. So, the answer is yes.

In 2009, we led the Department of the Defense in suicides, percentage-wise. We had 52. That's double what we had in 2005, when we had 25. So, you ask yourself, "What is it that's caused this?" We don't have all the answers on this thing, and you wouldn't expect me to, but you would expect me to be trying to find out and do something about it.

Interestingly, the Marine Corps is the youngest Service, age-wise, of all the other Services; for instance, 67 percent of all of our 202,000 marines, between the ages of 17 and 25. If you compare that to the other Services, we are woefully more—when I say "immature," I'm just talking about years—as a whole-cloth force. So, that, in and of itself, causes some issues. Our population, where our marines are killing themselves, are between 17 and about 23/24; it's male; it's about half married, half single; white. The deployment—for instance, this year alone, we've had nine young marines take their lives that had never seen their deployment. We have had marines come right out of boot camp, and, after having spent 12 weeks in what is arguably a "legendary boot camp," which calls out an awful lot of folks who just can't handle the stress, they kill themselves. They go home on leave, and every now and then they'll take their life. They've never seen deployment one, and they've just completed the most rigorous, probably, physical and mental examination that they've ever had in their life. So, what causes that?

We had a young lance corporal just check into his unit, who were deployed in Afghanistan 2 weeks ago, his very first day, he goes on duty, walks outside the perimeter, and shoots himself. He did this—as you, kind of, do the forensics on this thing—his girlfriend left him just before he left. He has issues with his family at home, his mother and father, and so, these are the kind of things that we're seeing.

So, what are we doing about it? First and foremost, in our organization we're focusing on the leadership of the Marine Corps. I know that sounds trite, but we're an organization that's based on leadership, everything we do. So, we start with the very top. The Commandant of the Marine Corps, the Sergeant Major of the Marine Corps, are adamant about this, and it's flowed all the way down through our senior leadership, that we have to absolutely pay attention to this. This is not something to be taken lightly, and it is an issue. So, that's the first thing, the senior leaders' focus.

It took us about 6 months to develop—we pioneered it about last July, a NCO suicide prevention half-day course. It's film, it's in the vernacular of the NCOs, because looking at that population of our young marines that are taking their lives, it's that 17-to-22/23. That's where the NCOs—they own those marines. They know them better than anybody. So, we focused this effort on them. High reviews, just great reviews from the NCOs. One-hundred percent of our NCOs have gone through this thing, and they're taking that training down to the young marines below them.

Interestingly, we've seen a drop in suicides this year, even though right now we are on the same plateau as we were last year. That's probably not very encouraging, but if you consider this vector we've been on since 2005, which has been very steeply vertical, the fact that we are even where we were last year is an encouraging sign.

The further piece of news that's encouraging is, this NCO course, it is too soon to tell, but last year, 92 percent of our suicides were in this age group that I just described, about 23 to 17, and a lot of them were NCOs. We've seen a drop this year down to 84 percent, as of today. We've said, "Okay. Let's take a look at those real young marines, the privates through lance corporals; let's take a look at the staff NCOs; and let's take a look at our young officers, lieutenants to captains, and let's build a very similar program." We're in the throes of that right now. It should be published within the next 2 to 3 months. We're going to do that whole thing for the entire Marine Corps.

So, we think it's going to work. We think it has worked. Too soon to tell. But, ma'am, we have increased our resiliency training by—immersion training for our young marines, all that predeployment stuff, trying to make our marines more resilient.

I have a list of things down here that I could go through. But, I just want you to know this has our attention. This is job one with the Marine Corps.

Senator COLLINS. Thank you.

Chairman LEVIN. Thank you, Senator Collins.

Senator Udall is next.

Senator UDALL. Thank you, Mr. Chairman.

Good morning, to the panel.

General Chiarelli, I want to, in particular, note the attention you've paid to these important issues. I had an opportunity to travel with you to Fort Carson earlier this year. I know you've immersed yourself in these difficult discussions. I know we don't have all the answers yet, and that's why we're holding the hearing, in part. I trust my questions will be received in that spirit, as well.

I wasn't here earlier, during the questioning about the ANAM test. I think you said that, while the Army uses it, predeployment, for a baseline, you don't use it post-deployment, not usually, because of the false positives that often result, or result, to some extent of the time. Here's my question. By definition, a baseline is supposed to give us something to look back at, in the aftermath, a way to compare. So, if we're not using, what is it, close to 600,000 pre-deployment assessments to compare to the post-deployment assessments, what are we doing with them? Why use ANAM at all if it's not being used in that post-deployment situation?

General CHIARELLI. Senator, I will tell you, we are using the ANAM on post-deployment, but only if the soldier demonstrates some kind of a symptom of having cognitive issues. That may be cognitive issues that could be caused by TBI or some other behavioral health issue.

So, the baseline is very, very important, because it gives the doctor an additional tool that, when symptoms are demonstrated, or in a post-deployment screening we have reason to believe we should have that soldier go through the ANAM, we go ahead and

use it. What we're just not doing is doing a post-deployment ANAM for every soldier irregardless—or regardless of—my English teacher would have just been—thank you very much.

Senator UDALL. Mine too, General. [Laughter.]

General CHIARELLI. Regardless of whether they show those symptoms, because we were getting so many false positives. We just don't have the behavioral health specialist folks, to work through all those false positives and give the care we need to, to the rest of those who need care.

Senator UDALL. That's helpful, and we'll continue that conversation. My next question will follow on that. I want to talk about the post-deployment health assessment (PDHA). It's supposed to catch things that weren't caught in theater, as I understand it. A soon-to-be-published study has shown that the standard screen on the PDHA fails to catch 40 percent of those who sustained a TBI in theater. This comes from research at Fort Carson, in my home State of Colorado.

I've been there, as I've mentioned, on a number of occasions, to get briefings on how they're handling TBI patients. I think they're doing it right. By using a more thorough exam, with clinical interviews to augment the PDHA. There's a concern, as I understand it, that individualized approach would take too much time, and require scarce personnel to administer, and that such an approach can't be replicated across the force. But, I'm told that at Fort Carson it only takes about 15 to 20 minutes of additional time to do this. Could you speak to Fort Carson's approach and whether the Army's looking at maybe applying this elsewhere?

General CHIARELLI. I'll tell you, I disagree with Fort Carson. I want them to institute the virtual behavioral health screening, so that we can ensure that we get everyone. I don't want to use any form. I don't want to use any series of questions that automatically says that a soldier does not have those issues. I think that what we really need to do is to get to a standard that says we're going to give everyone a post-deployment screen; follow that up, 90 days later and 180 days later.

Here's my problem with the Fort Carson approach. The Fort Carson approach focuses on soldiers with doctors that they have assigned when they come back. They may get through a 15- to 20-minute screening of a select population who's demonstrated, based on a questionnaire, that they may have issues, they may be medium to high risk. But, when you do that, you take away the doctors that are providing care to those folks that we have already found, because you're focusing on this group. That's why this virtual network is so important, that you can do an actual triage and get the number down to those that you can treat with those people you have on base. I've had discussions with Fort Carson about this.

I have to tell you, until I get doctors to use the virtual method, many of them push back, and they push back because they have never done this before. But what we're finding is that those who go through it, the doctors—those doctors are the biggest supporters of it, because we find that this generation, in many times, opens up much greater using either Skype technology or some kind of high-definition video teleconference (VTC), even more so than sit-

ting across a room, like you and I are right here. They really feel they're able to get at some of these issues and do a good evaluation.

Senator UDALL. I respect the passion in your response. Let's continue the conversation. Again, it points out General, how involved you are, and how much you've paid attention to details and soldiers.

Let me turn to another—perhaps a bit of a difficult conversation that's tied to the National Public Radio story. They report a term that's used by researchers, “the miserable minority,” to refer to those who suffer from mild TBI, who have long-term repercussions. It's true, from what I learned, that most soldiers recover from mild TBI, but some who seem to have symptoms persist for months or even years, and if you get a repeat of a TBI incident, you can aggravate that mild TBI.

The National Public Radio story intercepted an email from one of General Schoomaker's advisors, Dr. Hogue, who questioned the importance of even identifying mild TBI accurately, asking, quote, “What's the harm in missing the diagnosis of mild TBI?” Can you help me understand whether finding ways to diagnose and treat mild TBI is important to the Army?

General CHIARELLI. It is extremely important to the Army. Dr. Hogue represents a population of psychiatrists and psychologists, quite frankly, you can find one who will support just about any different way of attacking this. It is not this well-developed science that we have in other areas, such as heart surgery. I think the dialogue is good. I didn't necessarily agree with Dr. Hogue when he wrote in the *New England Journal of Medicine*. But, he did do a peer-reviewed study where he talked about this.

I think the great disservice that National Public Radio did to everyone was to try to isolate TBI from PTSD. That is just not possible. As I indicated before, the comorbidity of these two is what's giving us the difficulty today. I also think that they did a disservice when they indicated that PTSD is a psychological problem. It is not just a psychological problem. It is a physical injury that occurs. If anything, I think could be best described as a chemical injury, because that frontal cortex doesn't turn on and stop the flow of those things that keep a person at this altered state for 4 to 6 hours. So, I think we have to look at these two together and realize the real difficulty that doctors are having trying to separate and understand the symptoms 100 percent in every single case.

Senator UDALL. General, thanks. Let's continue this spirit of discussion.

I want to thank all the members of the panel, as well, and I thank you for your service.

Thank you.

Chairman LEVIN. Thank you, Senator Udall.

Senator McCaskill.

Senator MCCASKILL. Thank you, Mr. Chairman.

I thank all of you for being here.

There are basically three areas I'd like to try to cover, quickly, that I think are important. An overarching concern is that of confidentiality. So many of the issues surrounding mental health, whether it is brought on by a brain injury or whether it's brought on by substance abuse, alcohol abuse, or prescription drug abuse,

so much of the problem we have in the military is the stigma associated with getting help, particularly for Active military, Reserves, and National Guard.

I'm sure you all are aware of the pilot program that is ongoing—I know General Chiarelli and I have talked about it—for the confidentiality of alcohol and substance abuse treatment at three different facilities, where these soldiers are not being referred to their chain of command after they have sought treatment.

General Chiarelli, could you address how that program is going, and whether you think this pilot program shows real potential for allowing folks to get help without the negative impact to their careers that so many of them fear right now?

General CHIARELLI. Tremendous potential. We've done it at three installations. We started in Fort Carson in August 2009. We're expanding it to two others. The only thing that's not—and the secretary of the Army approved this, a month ago—the only problem that we're having is trying to recruit the number of drug and alcohol counselors that we need in order to ensure that, when someone self-refers themselves for this problem, that, in fact, they can be seen immediately and not be told, "Well, come back 6 weeks from now and we'll take care of you." But, we're seeing great results from the three installations that we have started the pilot at.

Senator MCCASKILL. That leads to one of the other areas that I wanted to cover today, and that is the availability of counselors. In 2009 I was successful at getting a provision that required the Institute of Medicine to assess whether licensed mental health counselors should be allowed to practice without supervision within the military for purposes of this kind of counseling. That study was released in January, and supported the conclusion that they should be able to practice without that extra layer of supervisory personnel. I'm curious now, with that, Do you see the ability for us to staff up at more appropriate levels to get at this problem that we see, in terms of availability of mental health professionals for our men and women who need help?

General CHIARELLI. Yes. This is a wonderful provision, and we've come to about 92 percent of our pre-2001 authorization. We've done an exhaustive study. Just as we reach, or are getting close to reaching our goal, because of the increased amount of drug and alcohol issues that we have in the Army—and I'm not going to paper that over—we need about 225 more. So, we have authorization to hire an additional 225, and this is going to be a great help to us.

Senator MCCASKILL. I think it's so important that we look at this as being just as important as so many of the other tools we give to our fighting men and women. Our heroes need, not just the protective armor of the battlefield, they need the availability of help when they need it. I know that you've made this a huge priority, I know all of you on this panel have.

I want to make sure that if there's anything that we can do, as members of this committee, to continue to reinforce this at the highest levels of leadership in our armed services, that you let us know. The idea that we would stand between more help for our men and women who are struggling, that we need to get more people on board, is very frustrating. I want to make sure that you

know that there are many of us that want to go to battle over this, if necessary.

That brings me to the final thing. Unfortunately, Missouri has had one of the highest rates of suicide in our National Guard. That is this notion of embedding, particularly for our National Guard and our Reserves—embedding mental health counselors within units. As you probably know, this has been done in California, at a surprisingly low pricetag, because the availability of the embed is for the weekends and for the 2-week training, as opposed to 365 days, around the clock. That help, during those weekends and during those weeks of training, I think, it could be a huge assistance to our National Guard members, and would want your reaction to that.

I know that we don't have a member of the Reserves on the panel, or National Guard, but if—

General CHIARELLI. No, I look for any way that I can get behavioral health specialists down to National Guard units, and I think embedding is an outstanding idea. I will work with the surgeon generals but they have not brought that program to me. We've been trying to expand at the telehealth capabilities to our National Guard armories. But, I promise you, Senator, I'll look into that and talk to the National Guard surgeon general about just that.

Senator McCASKILL. This is really important, because in California, which has the largest Guard component in the country, it has 40 different Guard units—the cost for 1 year of mental health embeds was 820,000. That's a bargain, particularly when we see this kind of increase.

We've lost five members of the National Guard in Missouri already this year to suicide. That is something that is unacceptable, and something we clearly—and I know the surgeon general of the Missouri National Guard, General Danner, is very concerned, and wants to move toward some kind of embed program. I think the support of the people at this panel this morning would be crucial for that to move forward. I think we could also, obviously, do it for the Reserve units.

General CHIARELLI. We need to look across the National Guard, because as I indicated before, we've had an increase of 21 suicides across the National Guard, at the same time we're down in all other categories. So, this really has my attention and, I know, the attention of Ray Carpenter.

Senator McCASKILL. Okay. I'll continue to follow up on that.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator McCaskill.

Senator Begich.

Senator BEGICH. Thank you very much, Mr. Chairman.

I want to follow up, if I can, on just a few of the comments and responses to some of the questions that were given earlier.

First, General Chiarelli, I want to, one, thank you for the work you're doing. You are definitely passionate about trying to resolve this issue, or at least move forward in a positive way, and I really appreciate that.

I appreciated your comments on telemedicine. I know, Dr. Jesse, you've been subjected to my conversation before on this issue, through the VA, for the Veterans Committee. I do believe this is

a huge opportunity that both the DOD and the VA can really exploit in a positive way. With the new generation of young people who—you think, 10 years back, where we were with PDAs, telephones, cell phones, and computers, to where we are today, is unbelievable. So, I'm curious, because I hear your comment about some doctors push back on this new technology. How are you getting them to see the value?

I say this in as polite way as I can. You're the military. One thing I've learned about the military is, when you want to do something, you just do it and get moving. I understand that doctors have to grow into some of these things. But, time is of the essence. What are you using to get these doctors to get on step with telemedicine? Because that is the future, when it comes to mental health services, especially in a State like mine, where these folks come back from serving, and they're sent back home, to a village—and I'll use the Guard as an example—back to a village of 200 people. No medical services that they can tap into, from a veteran's perspective. But, what are you doing to get those doctors to get on step and get on with the program, here?

General CHIARELLI. We're doing exactly what you would expect us to do now. We published an overall comprehensive behavioral health plan. We're standardizing how we're going to treat soldiers when they come back. Part of this time, I believe we've seen a thousand flowers blooming, and I think it's time—[Laughter.]

—to move away from that, ensuring that we look for innovation and new kinds of treatments, but, at the same time, we have standard program for returning soldiers, that not only takes them from the day they return home, but at the 90-, 180-daymark, when so many of us, I think, would agree, we start to see many of these problems pop up.

Senator BEGICH. Right.

General CHIARELLI. So, we're doing it exactly in the military way that you allude to, Senator.

Senator BEGICH. Okay.

General CHIARELLI. We're going to make sure that it's standardized across our force.

Senator BEGICH. I think that's great.

Dr. Jesse, I know we've talked, but I'd love you to put on here—I actually just saw some technology development, done by an Alaska native corporation, on utilization of BlackBerrys, PDAs, and others, on alcohol screening and alcohol abuse—kind of, follow-up for those that decide to move forward. I saw that technology, and it was impressive to me, because what it shows is, it's reaching into how to get to these young men and women in their world of technology, versus what we think is the right way, bringing them into the office, sit them down. We're touching them in a different way. So, that technology is very unique, and I know the VA is starting to look at some of that.

Can you just put on the record a little bit of what you're doing around electronic telemedicine?

Dr. JESSE. Sure. We have quite a long history in telehealth, actually dating back even to the 1980s, with home monitoring of pacemakers using TTM technology. We've invested heavily in home telehealth by putting, if you will, "boxes" in patients' home. I think

we have 43,000 of them deployed. But, as you mention, the new technology is using smart phones, where you don't even have to invest in something that ties somebody to their home. Anybody who has a kid in their 20s now knows you don't even bother to call them, you just text them.

Senator BEGICH. That's right.

Dr. JESSE. They don't answer their phone, but they'll text you back.

Senator BEGICH. Right.

Dr. JESSE. Interestingly, as an example, you're all aware of the VA's suicide hotline, which people can call in to, but, about a year ago, they started a chat line for the younger folks are much more used to chat lines on the Web than they are to having phone conversations. That's been, I think, an important emerging way to contact, for the younger people. So, as we deploy that mental health technology, along with all of other medical capabilities, using new technologies that the people who need it understand and prefer to use, I think, is going to be vital.

General CHIARELLI. Could I mention one other thing?

Senator BEGICH. Please.

General CHIARELLI. We just signed an MOU with the VA on credentialing and privileging, which is a key and critical piece, here. We can do that with the VA so their doctors can be part of our virtual behavioral health—

Senator BEGICH. Excellent. Yes.

General CHIARELLI. But, that is a real issue when you're trying to provide the same kind of care across State lines, and even within State lines. In the area of behavioral health, I think we really need to look at some of those rules, and think about, do they need to be the same for this branch of medicine as they do, say, for a heart surgeon or someone else?

Senator BEGICH. You just got to my next question, so I'm going to start with you and then come down the row here. I'll leave my friend, Howie Chandler to last.

My next question is kind of the question that hasn't been asked; I think Senator McCaskill started to get to it. What do we need to do, here in Congress, to help make it easier for you to deliver the services that you know, instinctively and as well as data has shown you, to the young men and women? What you just made a comment about, delivering these services over State lines, or maybe you could elaborate. What are those one or two things, each one of you, if you could just expand—because part of what we should be doing here, honestly, is—what do we need to do to support you? It's great to have a hearing, but what's the next step?

General CHIARELLI. I would mention credentialing and privileging. Give you just a quick example. I can go ahead and provide a TRICARE referral for a soldier at Fort Campbell, Kentucky, to drive 100 miles to Nashville to see a psychiatrist. I cannot hook him up over the Internet if he is not at military installation, and privileged and credentialed from that location. So, I can't hook into his office in Nashville, yet I can put a soldier in a car and send him 100 miles to go see that doctor, as a TRICARE referral.

Senator BEGICH. Good example. My time is up, but if each one of you can just give a quick one, and then I'll close out.

Thank you, Mr. Chairman.
Go ahead.

Admiral GREENERT. Senator, for the Navy, if we could look at the age of healthcare professional appointments and mandatory retirements, there are a lot of people want to help, out there, that may be over the age of 42. That, I think, if I understand it right, is the limit for a lot of our healthcare providers, particularly mental. That could be helpful.

Senator BEGICH. Very good.

General AMOS. For the Marine Corps, your continued support for our deployment cycles and in sustainment of our Marine Corps while we are in between those deployment cycles, with programs like the Yellow Ribbon Program, our Returning Warrior Programs, those kinds of things that help our families—that is a modest investment that has paid rich dividends. So, your continued support on that would be great.

Senator BEGICH. General Chandler?

General CHANDLER. Senator, I would echo what my counterparts have said, and also add to that, thanks for your support for the bonuses and special pays. That has allowed us to recruit, frankly, almost the numbers we need, in most areas. We're suffering, as the Nation is, in a shortage of mental health nurses. But, that's really the only shortage that's dramatic at this point, and we appreciate your support for that.

We've had some promising research at Lackland Air Force Base, in San Antonio, with TBI and hyperbaric treatment. Any support that we could receive in that area would also be very helpful.

Thank you.

Senator BEGICH. Very good. Thank you very much.

Dr. Jesse, we've already had our conversation. I'll leave that, if I can, because my time is expired. I'll be tapping you, don't worry. [Laughter.]

Mr. Chairman.

Chairman LEVIN. Thank you, Senator Begich.

What kind of support do you need for that hyperbaric treatment?

General CHANDLER. Sir, we're actually in our infancy, quite honestly. If I can take that for the record and get back—

Chairman LEVIN. Is it a—

General CHANDLER.—in terms of costing.

But, as most things go, it becomes a personnel and dollar issue. But, we've had some fairly promising results with hyperbaric chamber treatment.

Chairman LEVIN. If you can just give us any example—and this goes for all of you—where there is a funding shortfall on the appropriations side, we would more than welcome it. We're determined we're going to get you whatever funding you need to address this issue.

[The information referred to follows:]

Congressional support for current Air Force (AF) hyperbaric oxygen treatment (HBOT) for Traumatic Brain Injury (TBI) research is sufficient and greatly appreciated. Department of Defense (DOD) research on HBOT for TBI is in its infancy and is centered on chronic mild and moderate TBI. It remains an unproven therapy and is not accepted as a standard of care because only anecdotal case reports and a small series of trial reports indicate some potential benefit for TBI. Several prospective randomized clinical trials are underway within DOD and civilian institu-

tions to provide more conclusive evidence regarding HBOT's use for TBI. Definitive phase 3 trials, which will take 2–3 years and include randomized, multi-center (DOD facilities only), double blind, definitive studies under the auspices of the Food and Drug Administration with an investigational new drug registration, are projected to start in fall 2010. If this research validates the efficacy of HBOT for TBI, we will request additional congressional support for the sustainment and possible expansion of hyperbaric chambers and personnel in addition to presenting the evidence to the Undersea and Hyperbaric Medical Society for consideration as an accepted indication for use.

Chairman LEVIN. Senator Lieberman.

Senator LIEBERMAN. Thanks, Mr. Chairman.

Thanks, to all of you. I apologize that I was drawn out to another meeting in between.

I appreciate, very much, the work that all the Services are doing on these problems, particularly, obviously, suicide prevention programs. I know, for each of you, this is a deeply personal issue, and I thank you for the time that you're putting into it.

In my own work on this, I have become familiar with some statistics that surprised me. I want to offer them, not to diminish the problem that you and we are facing among servicemembers, because every suicide is a tragedy, and we want to prevent them all. But, what's interesting to me is that—and obviously the most significant factor for all of us is the extent to which the suicide rate among Active Duty U.S. military personnel has increased, over the last decade, from 9.1 per 100,000 in 2001, to 15.6 per 100,000 in 2009. The increase is in comparison to a rate among the civilian population of 11.11 per 100,000 population. But, what's really striking to me, and shows, really, a broader societal problem—if you take out the young male population in the country—and the military is still disproportionately composed of young males, as compared to the overall population—the rate of suicide among 18- to 24-year-old males is 17.8 percent.

This suggests a broader societal problem, which was a total surprise to me as I went over the numbers. It doesn't diminish, in any way, the importance of the efforts you are making, and that we're trying to support you in making. But, what it says is that rate of suicide among young males in military was actually significantly lower than the general civilian population. Certainly, a decade ago, now has come up, but still is lower. Obviously, we'd like it to be zero.

But, I want to suggest, in these statements, no attempt to minimize the problem, but to say that this cries out for some larger societal response that deals with young males in our society.

I don't know whether any of you want a chance to respond to that.

General CHIARELLI. If I could, real quick.

Senator LIEBERMAN. Yes, General Chiarelli.

General CHIARELLI. Sir, we've run across something that's very, very interesting. As I indicated—I threw out some numbers—but, when we look at the number of soldiers who are first-termers—

Senator LIEBERMAN. Right.

General CHIARELLI.—who join the Army between the ages of 28 and 29, they account for three times their expected rate of suicide. In other words, they're only 5 percent of the first-term populations, but they account for 15 percent of the first-term suicides, which

would indicate that not only is it youth, but it is also this combination of additional stressors.

Senator LIEBERMAN. Interesting. Well, those are compelling numbers.

Let me go on to another question. I apologize, I gather, from staff, this hasn't been dealt with in depth, so I'll run the risk of asking it again. This is the question of how the Services diminish the understandable human fear, that anxiety in a member of the Service, that going for help will be detrimental to that service-person's career and advancement. I know that the Air Force actually quantified that in their study. But, my own sense, from conversations with members of other Services, is that this is a pervasive problem. You all, obviously, are deeply concerned about this and focused on how to make it better. In some sense, my question is, how do you transfer that concern down the chain of command so that individual members of your Services feel that they can go for help for a mental problem, just like you go for help if your leg is bothering you?

General CHANDLER. Senator, I wouldn't minimize that problem for the Air Force, quite frankly. I think it still exists, and I think there is a stigma attached to that. I think the basic answer to your question is, it becomes a leadership issue, directly down to the senior NCOs and officers that look the young men and women in the eye every day, that can recognize whether or not they have an issue, and then act accordingly.

We have the same demographic issues that you described earlier, in terms of young male airmen that are taking their lives. We diverge a little bit from the other Services, in that our biggest issue, in terms of suicide, are relationships; about 70 percent of Air Force suicides involve relationship issues of some kind.

Senator LIEBERMAN. You mean within the military—

General CHANDLER. These are typically personal relationships.

Senator LIEBERMAN. Personal. Yes.

General CHANDLER. Second would be legal issues that a member might have. Then, third, financial. Only 20 percent of our suicide victims have been deployed in the last year. So, we deviate, again, a little bit from the Army and the Marine Corps, as we do that. But, if you look at the elements of the Air Force where that occurs—those specific career fields—those, in fact, are young male members, primarily in terms of security forces, EOD—explosive ordnance disposal—and those kinds of duties. But, at the same time, those career fields are also under a fair amount of high OPTEMPO. Security forces are at 1-to-1, in terms of dwell time.

So, I wouldn't minimize the way we get at this in the Air Force, but we have moved our mental health care providers into our primary care clinics, to try to keep people from having to necessarily go someplace else, behind a curtain, to see a mental health provider. Our airman family and readiness centers also provide military health counselors, where you can actually go get help with your family members or for yourself. Of course, the Military OneSource provides, at no cost—I believe the number is six visits that you can arrange for yourself to do that. Again, all of these are confidential kinds of ways to do this.

There are ways to get at it, including our Chaplain Corps, which are all trained in suicide intervention, as well. We approach this from a number of different directions. But, I think the stigma issue is one that's going to be very, very difficult to overcome.

Senator LIEBERMAN. Thanks.

My time's up, but I wonder if any of the others of you want to briefly comment on that. Essentially, what you're doing to try to remove this—what General Chandler called—I think, appropriately called, a stigma.

General AMOS. Senator, you're absolutely right. I think this is evolutionary. Just 5 years ago, we wouldn't have even been talking about this in a battalion or a squadron or some type of deployed unit. We would be sloughing this off. Now, my sense in the Marine Corps is, we have the senior leadership of the Marine Corps, both the enlisted and the officer side, that are believers. They understand that this stigma is real and that we have to set the conditions to get around it. I'm not convinced that our middle-grade staff NCOs and our young officers have the same sense of appreciation. I think it's probably because they're younger, there's less—

Senator LIEBERMAN. Right.

General AMOS.—they've been exposed to it less. But, this is a leadership issue that we're working on. To get around this and to try to mitigate this, we've put mental health—we call them OSCAR teams—we put them in the deploying battalions that are forward-deployed. We have gone through—and that has mental health providers, corpsmen; we brought our chaplains involved in these things. Now we have embedded these units with every single forward-deployed unit in Afghanistan right now. So, we're trying to get away from that.

There's just a host of things we're trying to do to deviate around this, or sneak around behind the backdoor of this stigma thing—but, the last thing is, is that, on the suggestion of our young marines, we are establishing, right now, with TRICARE West, everything west of the Mississippi, a Marine Distress Hotline. It's manned by marines, plugged into the TRICARE West Region, 21,000 healthcare—mental health care providers. The whole idea behind that, it's completely nonattribution. Family members can use it 24 hours a day. You can call and say, "I'm having serious issues with PTSD," "I'm having issues with whatever." It's all anonymous.

Senator LIEBERMAN. Right.

General AMOS. So, we're working around it, Senator.

Senator LIEBERMAN. Mr. Chairman, I know my time's up. I leave it to you. I don't want to intrude on Senator Hagan's time.

Chairman LEVIN. Admiral, that's fine. You can go ahead.

Admiral GREENERT. Real quick, Senator, if I may. We have a, kind of, statistically different situation. Our demographics for those that committed suicide is sort of spread across the age spectrum, and location and rating and seniority. The last three suicides—we had a 40-year-old senior enlisted individual, right before deployment; a 50-year-old captain entering retirement; and an 18-year-old sailor, just out of boot camp.

So, looking across that, our focus has been, no one's immune to the stressors, and, if you can't deal with the stressors, to a bad choice.

Senator LIEBERMAN. Right.

Admiral GREENERT. So, to us, as a leadership issue. We focus on operational stress control and management. For those that still have a stigma—and it does exist—we have what we call Deployment Health Centers—there are 17 of them, they're spread around where our fleet concentration area is—where folks can go and see a clinician or a counselor, without the stigma being attached. It's not attached to the hospital, it's not attached to the fleet family support center; it's located away, where our sailors feel more comfortable. We find that, once they go there, then they'll see there's nothing wrong seeking treatment, and they tend to migrate to the clinic.

Thank you.

Senator LIEBERMAN. Good. Thank you.

Chairman LEVIN. Before I call on Senator Hagan, let me mention this. I'm going to have to leave. There's a question, that I'm going to ask you to answer for the record, about the status of our Centers of Excellence for Traumatic Brain Injury.

[The information referred to follows:]

General Chiarelli, Admiral Greenert, General Amos, and General Chandler, in the Wounded Warrior Act of 2008 (Public Law 110-417), Congress mandated the establishment of Centers of Excellence to help focus research projects, eliminate duplication of efforts, and to learn and share best practices through collaboration with other Federal agencies, academia, and the private sector. What is the current relationship between each of the Services and the Centers of Excellence?

General CHIARELLI. The Suicide Prevention Program Managers from each of the Services are represented in the Suicide Prevention and Risk Reduction Committee (SPARRC), which is part of the Defense Centers of Excellence (DCoE). To support Army family members, we promote and utilize DCoE's resources, such as the DCoE Outreach Center, Real Warriors Campaign, and Afterdeployment.org.

Admiral GREENERT. Navy Medicine works collaboratively with the DCoE for Psychological Health and Traumatic Brain Injury (TBI) and its component centers: Defense and Veterans Brain Injury Center (DVBIC); Center for the Study of Traumatic Stress (CSTS); Center for Deployment Psychology (CDP); Deployment Health Clinical Center (DHCC); and the National Center for Telehealth and Technology.

Navy Medicine also provides staff in support of the DCoE and is working to ensure that professionals throughout Navy Medicine—clinicians, researchers, educators and program managers—are working with the DCoE to enhance research, education and outreach efforts.

Additionally, the Services support the other Centers of Excellence by providing lead operational support as assigned by Assistant Secretary of Defense for Health Affairs. Navy has the lead of the Vision Center of Excellence which is focused on research and treatment for improved vision care and restorative innovations for servicemembers.

General AMOS. The Marine Corps works collaboratively with the DCoE for Psychological Health and TBI and its component centers: DVBIC; CSTS; CDP; DHCC; and the National Center for Telehealth and Technology (T2) on an ongoing basis. The interface for these interactions is through various Headquarters level work centers, but principally Health Services and Manpower and Reserve Affairs.

General CHANDLER. There is a Quad Services Meeting every week between the DCoE, DVBIC, National Intrepid Center of Excellence, the TRICARE Management Activity, and the four Services to discuss TBI issues. This has been a great collaborative group.

Chairman LEVIN. If Senator Lieberman is not able to stay, then I would ask Senator Hagan to adjourn the committee after she is done.

Thank you.

Senator Hagan.

Senator HAGAN. So, that means we might be here a while. No. [Laughter.]

I think this is a very important hearing. I think anytime we have one suicide, that's one too many, and certainly, the numbers that we've been seeing are certainly unacceptable. So, I really appreciate the time that the Services are putting into helping address this issue.

General Chiarelli and General Amos, you have underscored the importance of mental resiliency programs, proper and timely diagnosis, transferring the culture of leadership with regards to the invisible wounds, the strain of our forces, limited dwell time; and personal problems, such as financial and relationships, are certainly among the many challenges that we have to overcome. However, we do have a responsibility to effectively institute mental resiliency programs to prepare our servicemembers for the combat stresses that they will ultimately face. What are the Services doing to institutionalize resiliency training at the predeployment and the post-deployment stage?

General CHIARELLI. Our program is comprehensive soldier fitness. Senator, we've been working with the University of Pennsylvania. We have trained over 1,200 master resilience trainers, through a very intensive course. Our goal is to get them down to every battalion in the U.S. Army. We are focusing those trainers, right now, at the basic entry levels of our soldiers, because we know we have to build their resiliency early on in their career. It is absolutely critical.

In addition to that, we have the Global Assessment Tool (GAT) that is a requirement for every soldier to fill out, to understand where they stand when it comes to resiliency. We've had, now, over 780,000 folks fill out the GAT. Plus, online instruction, based on the results you get on the GAT, that is available for a soldier to take, to work resiliency.

This is something that finally starts to get us to the left, and not waiting until we see soldiers with problems, but try to attack resiliency as far to the left as we possibly can.

Senator HAGAN. Thank you.

General Amos.

General AMOS. Senator, we, in the Marine Corps, believe it's two-part. Resiliency is both physical and mental. The beginning stages of a marines recruit training at Parris Island or San Diego begins to build that physical strength. We attribute a lot of our ability to be able to do the things the Marine Corps does for this Nation as a result of its physical strength training. So, it begins there.

Values-based training was instituted about a year ago in the Marine Corp, at boot camp and at schools of infantry—at North Carolina, at Camp Geiger, and out in San Diego, at Camp Pendleton—which teaches some of these things, along with suicide prevention, sexual assault prevention, those behavioral health issues. So, that's where it begins.

When the marine enters his first unit and is preparing to deploy, we believe the best thing we can do for them is to not only get them physically fit, conditioning-wise, which we have a combat fitness regimen we put them through, but the second piece is what

we call immersion training. In other words, we want the marine to experience, back home, before he or she leaves, most of what—the fear, the anxiety, the confusion, the fog of war. We started on the west coast, we're now migrating to Camp Lejeune, going out to Hawaii, and and we'll do the same thing in Okinawa. But, an immersion trainer, inside a building—it's a huge building—and we have transitioned from an Iraqi village to an Afghan village. We have role players, we have amputees in there, we have RPGs that fire, we have music, well, we have everything in there. You couple that, and you rerun the scenario over and over again, so the young marines become accustomed to fear, and they become accustomed to the uncertainty of warfare. You take that, you put them in an IED lane that's as—2½ miles long, walking through villages, IEDs are going off, RPGs, more role players. So, you get the idea that our last attempt to build this resiliency is to immerse them, as much as we can, and help them know that their training is adequate and they will be okay.

We find that, if we do that, that when they are—when they hit their first firefight, their chances of them surviving are greatly enhanced. We believe, intuitively, that they'll probably have less cases of PTS, down the road.

So, that's what we're doing to build that resiliency. We follow along when they come home.

Senator HAGAN. Thank you.

Admiral Greenert, you mentioned, in response to Senator Begich's question, the last question that he asked, something about the age of 42. I didn't quite get that. Could you elaborate on that?

Admiral GREENERT. Yes, ma'am. Healthcare providers who desire to enter service, there's a maximum age of 42. That allows them for a 20-year career, age-of-62 mandatory retirement. That was the point. If we could raise that age—because there are a lot of folks older than 42 that want to help.

Senator HAGAN. Okay. That's what I thought. Thank you.

Many of the burdens associated with the wars in Iraq and Afghanistan have been shouldered by the Reserve and the National Guard members. When these citizen soldiers redeploy, they are almost immediately demobilized and returned to their civilian lives. Unfortunately, for many, the lives and the jobs that they left are not what they return to, which is compounded by the isolation of not having a support structure that's comparable to what is available to those on Active Duty.

One of the questions is, what efforts are being made to ensure that our members of the Guard and Reserve have a soft landing when they return home?

General CHANDLER. Senator, if I could?

Senator HAGAN. Great.

General CHANDLER. I would tell you that, in your reintegration and redeployment process, you need to go all the way back to the beginning, obviously, before you start your deployments, to make it successful. Our Guard and Reserve total force, if you will, in the Air Force, and that includes Air Force civilians, all have access to the same things that our Active Duty people do, as well.

Your point is well taken, in terms of how we reintegrate those people once they come home. I would tell you that the Yellow Rib-

bon Reintegration Program, that's been a very good part of our Guard and Reserve, has been very successful at, not only preparing members and families for deployment, but caring for families during deployment, and then giving us the opportunity to reintegrate those Guard and Reserve members when they return.

In my discussions with the commander of the Reserve and the director of the Guard, they seemed to be very happy. We're happy, at this point, with the results that we're getting. We're getting the resources to do that, and for that, we appreciate your support.

General AMOS. Senator, for the Marine Corps, we will deploy almost two types of—we don't have Guard, and two types of Reserves. We'll deploy what we call a Selective Marine Corps Reserve Unit, which is a whole-cloth unit, a squadron, a battalion. It's some type of unit. They actually activate 4 months or so before they deploy. They go through the entire training program, the resiliency training, the immersion, all that stuff. When they come back, they do a unit reintegration. They have access to the exact same capabilities and helps that a regular unit does.

Where we struggle, and where we have been working hard the last year and a half, are what we call "individual augments." In other words, that's that young marine, out of the middle of North Carolina or Oklahoma or someplace, that is pulled out of what we call Individual Ready Reserve. He or she has volunteered, perhaps, and come forward and said, "I'll go to Afghanistan. I'll join the staff of General McChrystal." That individual then comes on Active Duty individually, doesn't have access to all these great programs. We do our best, we have a training program for them to get them set; but, when they come home is where I worry the most about. That's where, just as General Chandler talked about, the whole idea of the Returning Warrior, or the Yellow Ribbon Program, has been such a huge hit, because we reach out, harvest them in, and then plug them into that program, along with their spouse, and it gets rave reviews. So, that's how we are trying to accommodate those onesy-twosies.

Senator HAGAN. All right.

Thank you. My time is up.

Senator Lieberman.

Senator LIEBERMAN [presiding]. Thank you.

I have no further questions. I thank all the witnesses for what you're doing, and also for your responses to our questions.

I know, from Chairman Levin and Senator McCain, for all of us, this will be a continuing focus of concern for members of the committee. We are so grateful to our military personnel. They serve with such honor and capability and sacrifice. It's a part of why, of all the great institutions in our country, I think the military today remains one that still enjoys broad public respect and trust. But, it takes its toll, that service and sacrifice, and I think we're getting much more in touch with the toll it takes on the minds and spirits of people who serve. Therefore, we want to do everything we can to make sure that we, one, prevent the most serious problems, such as suicide; and, two, we treat problems much before we get to that point.

So, I hope you will understand that you should feel free to advocate to us what you think you need from Congress to fulfill the

goals that you have in this regard, which are the goals that we have as well.

I thank you very much. The hearing is adjourned.

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR CARL LEVIN

DEFENSE CENTERS OF EXCELLENCE FOR TRAUMATIC BRAIN INJURY AND
PSYCHOLOGICAL HEALTH

1. Senator LEVIN. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, in the Wounded Warrior Act of 2008 (Public Law 110–417), Congress mandated the establishment of Centers of Excellence to help focus research projects, eliminate duplication of efforts, and to learn and share best practices through collaboration with other Federal agencies, academia, and the private sector. What is the current relationship between each of the Services and the Centers of Excellence?

General CHIARELLI. The Suicide Prevention Program Managers from each of the Services are represented in the Suicide Prevention and Risk Reduction Committee (SPARRC), which is part of the Defense Centers of Excellence (DCoE). To support Army family members, we promote and utilize DCoE's resources, such as the DCoE Outreach Center, Real Warriors Campaign, and Afterdeployment.org.

Admiral GREENERT. Navy Medicine works collaboratively with the DCoE for Psychological Health and Traumatic Brain Injury (TBI) and its component centers: Defense and Veterans Brain Injury Center (DVBIC); Center for the Study of Traumatic Stress (CSTS); Center for Deployment Psychology (CDP); Deployment Health Clinical Center (DHCC); and the National Center for Telehealth and Technology.

Navy Medicine also provides staff in support of the DCoE and is working to ensure that professionals throughout Navy Medicine—clinicians, researchers, educators and program managers—are working with the DCoE to enhance research, education and outreach efforts.

Additionally, the Services support the other Centers of Excellence by providing lead operational support as assigned by Assistant Secretary of Defense for Health Affairs. Navy has the lead of the Vision Center of Excellence which is focused on research and treatment for improved vision care and restorative innovations for servicemembers.

General AMOS. The Marine Corps works collaboratively with the DCoE for Psychological Health and TBI and its component centers: DVBIC; CSTS; CDP; DHCC; and the National Center for Telehealth and Technology (T2) on an ongoing basis. The interface for these interactions is through various Headquarters level work centers, but principally Health Services and Manpower and Reserve Affairs.

General CHANDLER. There is a Quad Services Meeting every week between the DCoE, DVBIC, National Intrepid Center of Excellence (NICoE), the TRICARE Management Activity, and the four Services to discuss TBI issues. This has been a great collaborative group.

2. Senator LEVIN. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, have you found the Centers of Excellence to be a valuable resource for the military Services?

General CHIARELLI. DCoE is a valuable resource for the Army, particularly the Real Warriors Campaign, which promotes the processes of building resilience, facilitating recovery and reintegration of returning servicemembers and reducing stigma associated with seeking help. As previously noted, due to the participation of all the Services, the SPARRC facilitates sharing initiatives and best practices.

Admiral GREENERT. The Centers of Excellence have been a valuable resource in a number of ways:

- The DCoE has served a role in facilitating and increasing collaboration among the Services. This is best demonstrated through the development of the Department of Defense (DOD)/Department of Veterans' Affairs (VA) Integrated Mental Health Strategy and the Directive Type Memorandum (DTM) developed by all of the Services to require event reporting and tracking of individuals exposed to blast and, therefore, at risk for TBI.
- Education and Stigma Reduction as demonstrated by the Real Warrior Campaign.
- Since their establishment they have directed over \$50 million in funding to further research on psychological health and TBI.

General AMOS. The Centers of Excellence have been valuable in a number of ways:

1. The DCoE has served a role in facilitating collaboration among the services. This is best demonstrated through the development of the DOD/VA Integrated Mental Health Strategy and the DTM developed by all of the Services to require event reporting and tracking of individuals exposed to blast and therefore at risk for TBI.
2. Education and Stigma Reduction as demonstrated by the Real Warrior Campaign and DCoE educational conferences and monthly webinars.
3. Coordination of Research, directing over \$50 million in funding to further research on psychological health and TBI.

General CHANDLER. The Quad Services Meeting every week between the DCoE, DVBIC, NICoE, the TRICARE Management Agency and the four Services is valuable for the discussion of TBI issues. This has been a great collaborative group. Some initiatives from the group include:

1. Developed the DTM "Policy Guidance for Management of Concussion/Mild TBI in the Deployed Setting."
2. Educated medical providers on mild to severe TBI (more than 800 DOD/VA clinicians attended the 2009 DVBIC 3rd Annual Military Training Conference).
3. Conducted a media roundtable to increase awareness of DOD initiatives during TBI awareness month in March 2010.
4. Developed education materials for servicemembers on TBI to implement the DTM.
5. Developed a TBI pocket guide highlighting TBI clinical practice guidelines.
6. Developed TBI Program Guidance for the Services to standardize the treatment of our servicemembers across the DOD.
7. Identified Medical Treatment Facilities (MTFs) to participate in the DOD Cognitive Rehabilitation Program.

3. Senator LEVIN. Dr. Jesse, the Centers of Excellence were intended to be joint DOD-VA ventures. What role does the VA currently play in the Centers of Excellence?

Dr. JESSE. Since 2007, VA has collaborated with DOD to establish the DCoE and the associated injury registries, including the Centers for Psychological Health and Traumatic Brain Injury (TBI), Extremity Injuries and Amputation, Hearing Loss and Auditory Injuries, and Vision. VA has assigned personnel to the Centers for Psychological Health and TBI, including a deputy director for the Centers, and two subject matter experts—one for TBI, and one for psychological health-related disorders. VA has also assigned personnel at the Defense Vision Center of Excellence, including: a deputy director, chief of staff, and a vision rehabilitation specialist. VA is completing selections for three additional staff positions (research optometrist, administrative assistant, and a biostatistician) to be posted at the Vision Center of Excellence.

VA continues to work with DOD representatives to finalize the implementation plan to jointly establish the Center for Extremity Injuries and Amputation. VA also continues to assist DOD representatives with developing the concept of operation and implementation plan for the Center for Hearing Loss and Auditory Injuries. After the implementation plans for these two centers are finalized by DOD and forwarded for review, VA will determine its level of support for both of these centers.

QUESTIONS SUBMITTED BY SENATOR JACK REED

LATER DEVELOPMENT OF WOUNDS

4. Senator REED. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, acknowledging the imminent need to treat invisible wounds today, we also have to prepare to care for the conditions that may not manifest for 5, 10, or 15 years after a deployment. How are the Services working to address the long-term effects of invisible wounds on our Active Duty and Reserve component servicemembers?

General CHIARELLI. Timely detection and identification of a soldier's behavioral health issues or TBI is the goal of the Army's Comprehensive Behavioral Health System of Care. Long-term support of our troops is a continuous process. Soldiers undergo screening for behavioral health issues as they enter the Army, during periodic health assessments (PHAs) mandated for soldiers throughout their military service, and upon discharge from the Service. During pre-deployment readiness processing, soldiers undergo extensive screening for medical and behavioral health issues, including family problems, in order to document baseline soldier well-being, and to detect/treat conditions that may interfere with meaningful military service.

Upon redeployment, soldiers are promptly screened in Post-Deployment Health Assessment (PDHA) for Post-Traumatic Stress, major depression, and TBI, as well as for concerns about family issues and drug and alcohol abuse. Soldiers who screen positive undergo further clinical assessment as needed, and are provided definitive treatment as clinically indicated.

All medical encounters and care are recorded in the soldier's electronic health record. This information is available to healthcare providers throughout the Military Health System. It is also available to providers in the VA health system through the Bidirectional Health Information Exchange (BHIE). The BHIE allows providers at DOD Military Treatment Facilities and VA health facilities to view clinical data when a shared patient presents for care. The capture of a soldier's health information electronically and the ability to share a soldier's health information with the VA ensures continuity of care even if the soldier presents for behavioral health care in future years in either the Military Health System or the VA.

Admiral GREENERT. Tracking sailors with increased risk for the invisible wounds of this conflict will help us to follow them into the future to learn about the long term effects and to offer treatment as new discoveries occur. This tracking currently is accomplished in a number of ways:

- The Combat Trauma Registry, located at the Naval Health Research Center, tracks all combat injuries which allows for inquiries into injury patterns and casualty management that are helpful in guiding prevention and treatment efforts both now and in the future.
- Additionally, the new requirement, established by the Directives Type Memorandum, for tracking individuals exposed to blast, regardless of symptoms, will allow for enhanced follow up care and evaluation.
- The Centers of Excellence are also developing registries that will track individuals with various conditions specific to their mission. As an example, the Vision Center of Excellence, led by Navy, is developing a registry that will allow all individuals with eye injuries to be tracked and followed.

Research also continues help to redefine how we care for wounded warriors today and in the future. Navy Medicine is coordinating with organizations such as the DVBIC, the NICoE, and the Center for Neuroregenerative Medicine at the Uniformed Services University of the Health Sciences to complete and publish clinical research about the clinical outcomes of individuals diagnosed with TBI as a result of combat. We hope these efforts allow us to be better able to detect the long-term effects of concussions/mild TBI resulting from combat deployment or blast exposure.

General AMOS. Tracking patients with increased risk for the invisible wounds will help us to follow them into the future to learn about the long term effects and to offer treatment as new discoveries occur. This tracking currently is accomplished in a number of ways:

1. The Combat Trauma Registry, located at the Naval Health Research Center, allows for tracking of all combat injuries which allows for inquiries into injury patterns and casualty management that is helpful in guiding prevention and treatment efforts both now and in the future.
2. Additionally, The new requirement for tracking individuals exposed to blast, regardless of symptoms will allow for enhanced follow up care and evaluation.
3. The Centers of Excellence are developing registries that will track individuals with various conditions specific to their mission.

Research will also help to define how we care for wounded warriors in the future. Navy Medicine is coordinating with organizations such as the DVBIC, the NICoE, and the Center for Neuroregenerative Medicine at the Uniformed Services University of the Health Services to complete and publish clinical research regarding the clinical outcomes of individuals diagnosed with TBI from combat. In this manner we hope to be better able to detect the long-term cognitive sequelae of concussions/mTBI resulting from combat deployment or blast exposure.

General CHANDLER. While airmen are offered pre- and post-deployment education that encourages them to get help for problems early, surveillance for mild TBI or post-traumatic symptoms is primarily through periodic mandatory assessments.

Airmen undergo a PDHA upon return from deployment, which is a face-to-face assessment that asks specifically about symptoms related to Post-Traumatic Stress Disorder (PTSD) and TBI. Positive responses are assessed and treatment is offered. Later, between 90 to 180 days post-deployment, the airman completes a Post-Deployment Health Reassessment (PDHRA) questionnaire, again screening for PTSD and TBI symptoms in addition to other physical/psychological symptoms. If airmen respond positively to critical items, they are contacted by a provider and an appointment is arranged for further assessment. In addition to the PDHRA, members undergo an annual PHA that assesses physical and psychological symptoms. The air-

man sees their Primary Care Manager (PCM) for further evaluation if they report symptoms related to TBI/PTSD. In the event that there are still undisclosed symptoms at the end of an airman's career, these can be identified during the separation physical examination occurring upon discharge from the Air Force.

TIMING OF TREATMENT RECEIVED

5. Senator REED. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, how long, on average, does it take for a servicemember to begin receiving mental health treatment once a need is identified?

General CHIARELLI. A soldier may begin receiving mental health treatment at the time the need is identified if the medical situation dictates. The Army is committed to meeting the mental health needs of our soldiers by providing quality care, at the appropriate level, and in a timely manner. Timely treatment is of particular importance since mental health diagnoses are treatable, and treatment delay has been shown to be an important factor associated with response to functional outcomes. The Army offers an extensive array of mental health referral and program options that promote early detection and treatment.

Admiral GREENERT. In-theater services are typically provided by embedded medical and mental health providers. This allows for immediate evaluation, treatment and medical evacuation for emergent conditions is available as required.

In response to the recommendations by the DOD Mental Health Task Force, the Assistant Secretary of Defense for Health Affairs (9 Oct 07) issued a memorandum making the initial, non-urgent/emergent mental health assessments be booked similar to routine primary care appointments for which the TRICARE access standard is 7 days. Since 15 Jan 08, Navy Medicine military treatment facilities have been directed to operate under this new access standard. Data, provided via the TRICARE Operations Center (Health Affairs/TRICARE Management Activity), allows Navy Medicine to monitor our ability to meet this standard. Current data indicates that across Navy Medicine: (1) acute mental health care appointments occur within the 24-hour standard 89 percent of the time; and (2) routine mental health appointments occur within the 7-day standard 85 percent of the time.

General AMOS. In-theater services are typically provided by embedded medical and mental health providers. This allows for immediate evaluation, treatment and emergent medical evacuation available as required.

In response to the recommendations of the DOD Mental Health Task Force, ASD (HA) (9 Oct 07) issued a memorandum requiring initial, non-urgent/emergent MH assessments be booked similar to routine primary care appointments for which the TRICARE access standard is 7 days.

The Marine Corps works closely with Navy Medicine on issues concerning in-garrison medical care. As of 15 Jan 08, Navy Medicine MTFs have been directed to operate under this new access standard. Data, provided via the TRICARE Operations Center (Health Affairs/TRICARE Management Activity), has been available since September 2009 allowing Navy Medicine to monitor the percentage of time the mental health access to care standards are being met. Current data indicates that across Navy Medicine: (1) acute mental health care appointments occur within the 24-hour standard 89 percent of the time; and (2) routine mental health appointments occur within the 7 day standard 85 percent of the time.

General CHANDLER. Mental health issues identified by servicemembers as emergent or urgent in nature are addressed on an immediate or same day walk-in basis with access to care in the military treatment facilities or through civilian network partnerships. Routine or non-urgent mental health concerns identified by servicemembers are addressed by referral to either behavioral health optimization program mental health providers embedded in primary care or by referral to mental health providers in specialty mental health clinics. Over 76 percent of beneficiaries seeking mental health treatment for routine, non-urgent concerns are seen in the military treatment facilities within the routine access to care standard of 7 days of identifying their need. An additional small percentage of servicemembers that identify a mental health concern either decline the option for mental health services or decline offered evaluation within the access to care timeframe, opting for a later appointment at their discretion. Additionally, many servicemembers are opting to utilize the available mental health resources offered through TRICARE and Military OneSource to address stress and other psychological health concerns.

GUARD AND RESERVE

6. Senator REED. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, in what ways do you coordinate with your Reserve component counterparts to ensure that our guardsmen and reservists are receiving the mental health treatment they may need following their demobilization?

General CHIARELLI. The Army is implementing improvements in letting demobilizing guardsmen and reservists know what services are available and how they can receive them before they leave the mobilization platform. These services include use of the Department of Veterans Affairs (VA) medical system, TRICARE resources and the Yellow Ribbon Reintegration Program (YRRP).

The Army coordinates healthcare delivery for Reserve component soldiers coming off active duty with the VA. The VA routinely provides direct care for Reserve and other remote or geographically dispersed soldiers. An Army and VA partnership embeds VA Liaison Case Managers in 14 prioritized Army MTFs under an initiative called VA Liaison and Care Management Program, which ensures soldiers receive seamless continuity of care as they migrate from active duty to veteran status in the VA Healthcare System.

TRICARE also has programs that assist Guard and Reserve soldiers and families. A National Guard or Reserve member separating from a period of active duty that was more than 30 consecutive days in support of a contingency operation is eligible for Transitional Assistance Management Program (TAMP). The TAMP provides 180 days of transitional health care benefits to help certain uniformed services members and their families transition to civilian life.

Additionally, Guard and Reserve members who are experiencing common psychological health concerns like combat stress and family separation may use a new initiative called TRICARE Assistance Program (TRIAP), which provides video chat and instant messaging to give quick and easy access to counseling services. This program is also available to spouses, and other family members 18 years or older.

Further post-demobilization support is provided through the YRRP. The YRRP provides deployment support, reintegration programs, services and training for National Guard and Reserve members throughout all phases of deployment to include demobilization. It provides soldiers with transition information on available resources and connects them with providers who can assist in overcoming the challenges of reintegration.

Admiral GREENERT. Commander, Navy Reserve Forces Command has assumed responsibility for overseeing implementation of the PDHRA program for the Navy Reserve. With strong leadership support they are actively engaged in program execution and because of this increased focus, Servicemember compliance rates have improved.

Providing mental health support to Reserve sailors is an integral component of Navy mental health care. To meet this need, the Navy implemented the Navy Reserve Psychological Health Outreach (NRPHO) program in fiscal year 2008. The NRPHO program has a team of 25 social workers who provide initial mental health clinical assessment of Reserve component servicemembers and provide appropriate health care referral if needed. They are also making visits to two to three Navy Operational Support Centers (NOSC) per month in each of the five Navy Reserve Regions where they provide psychological health education including the Operational Stress Control (OSC) Awareness brief to NOSC staff and Reserve unit members.

As June 2010, the NRPHO Teams have clinically assessed and referred almost 2400 reservists to appropriate sources of mental health care; have made outreach calls to an additional 1860 reservists; and have made 281 visits to the NOSCs, providing the OSC Awareness brief to over 29,400 RC members and NOSC staff. In addition, Navy Medicine has hired a full-time Director of Psychological Health (DPH) for Navy Reserve to oversee and expand Reserve Navy Reserve psychological health programs.

General AMOS. A primary tool to discover unmet needs of Reserve marines, like all marines who deploy, is the PDHRA instrument. reservists should be completing these surveys post-deployment just like their active duty counterparts. reservists have access to TRICARE health care benefits for 180 days following their separation from Active Duty.

While I defer to my military medicine colleagues on the actual delivery of care, our Wounded Warrior Regiment (WWR) and battalions stay connected to marines in need of services even after they leave active duty. I believe that our Wounded Warrior construct is a superb model and we will continue to leverage its successes moving forward.

General CHANDLER. In-theater services are typically provided by embedded medical and mental health providers. This allows for immediate evaluation, treatment and medical evacuation for emergent conditions is available as required.

In response to the recommendations by the DOD Mental Health Task Force, the Assistant Secretary of Defense for Health Affairs (9 Oct 07) issued a memorandum making the initial, non-urgent/emergent mental health assessments be booked similar to routine primary care appointments for which the TRICARE access standard is 7 days. Since 15 Jan 08, Navy Medicine military treatment facilities have been directed to operate under this new access standard. Data, provided via the TRICARE Operations Center (Health Affairs/TRICARE Management Activity), allows Navy Medicine to monitor our ability to meet this standard. Current data indicates that across Navy Medicine: (1) acute mental health care appointments occur within the 24-hour standard 89 percent of the time; and (2) routine mental health appointments occur within the seven day standard 85 percent of the time.

QUESTIONS SUBMITTED BY SENATOR E. BENJAMIN NELSON

CENTERS OF EXCELLENCE'S SUICIDE PREVENTION AND RISK REDUCTION COMMITTEE ANNUAL REPORT

7. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, a vital and significant component of our force is the operational Reserve. Last year, as Chairman of the Personnel Subcommittee of the Senate Armed Services Committee, I held a hearing on DOD suicide prevention programs and raised a concern that Services were not collecting information on Guard and Reserve members who commit suicide, while not on active status. Statistics show that servicemembers are more likely to commit suicide while not deployed, when they are removed from their support structure. I expressed that concern to Secretary Gates, and following 7 months of engagement with the Department, DOD established a policy to begin reporting suicides of Guard and Reserves in civilian status. The policy letter went into effect October 22, 2009, and was a critical step in understanding how the whole-of-Reserve Forces are being affected by suicides. If we don't collect data on our Reserve and Guard forces, we have no ability to know whether we are providing appropriate support and programs for our Guard and Reserve Forces. Those statistics were to be reported in the DCoE's SPARRC Calendar Year 2009 Annual Report—has this report been completed?

General CHIARELLI. The Army Suicide Prevention Task Force (ASPTF) provides the Armed Forces Medical Examiner (AFME) with quarterly suicide statistics for Active Duty, Reserve component on active duty, and Reserve component not on active duty. AFME provides this data to DCoE, which then provides service-wide statistics that are shared among DOD officials. DCoE prepared the 2009 DODSER annual report, which included data on active duty suicides, including Guard and Reserve soldiers in an active-duty status. The report has been completed and is with the Office of the Assistant Secretary of Defense for Health Affairs for review/approval. A release date has not been established at this time.

Admiral GREENERT. Navy provided Selected Reserve (SELRES) sailor suicide information to the DOD SPARRC Calendar Year 2009 Annual Report which has not yet been published. Navy began collecting DOD Suicide Event Reports (DODSERs) for suspected suicides and suicide attempts of SELRES sailors beginning in April 2009 to better understand the factors affecting this population and identify needs and prevention opportunities. Suicide numbers based on death certificates for SELRES sailors were available before that date. In 2008, there were nine suicides of Navy SELRES personnel not on drill or duty status at the time of death; there were six in 2009; and, there have been four to date in 2010.

General AMOS. The DOD Task Force on the Prevention of Suicide by Members of the Armed Forces has completed its study, with delivery of the report to the Secretary of Defense (SecDef) expected in early August. The Marine Corps is in full compliance with the Reserve tracking policy. We collect data using the DODSER on all Select Marine Corps Reserve members and report those numbers throughout the Marine Corps leadership in an attempt to identify lessons learned. We also submit the numbers quarterly to DOD leadership in accord with policy, through the DCoE on Psychological Health and TBI, SPARRC.

General CHANDLER. The 2009 DOD SPARRC 2009 annual report is currently being reviewed within the Defense Center of Excellence prior to release to Congress. The Air Force is very concerned with suicides throughout our total force. The Air Force has collected and monitored Guard and Reserve suicide events that occur while not on active status and reporting this to the SPARRC since 2009. The suicide

prevention program manager has provided Air Force senior leaders weekly reports on total force suicides since December of 2009.

8. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, two reporting periods have passed since the Under Secretary for Personnel and Readiness established this new reporting requirement. I would like to know how the numbers compare for that population and what we are doing to understand and assess the new information. Can anyone speak to this change in reporting and what we are finding?

General CHIARELLI. For calendar year 2010, suicides for the Reserve component not on Active Duty year-to-date exceeds last year's number for the same timeframe. The ARNG suicide cases also exceed the number of suicides for the same timeframe last year; USAR suicide cases are the same as this timeframe last year.

A Senior Review Group (SRG) briefing is conducted on a monthly basis by the Vice Chief of Staff of the Army (VCSA). A designated general officer from each reporting unit/command briefs the VCSA on circumstances related to the specific suicide cases that are presented. The ultimate goal of the SRG briefing is to develop solutions that the Army can implement to prevent or mitigate future suicides. These solutions are captured through lessons learned and themes and trends, which are then published for distribution to Army senior leaders.

Admiral GREENERT. Navy provided SELRES suicide information to the DOD SPARRC Calendar Year 2009 Annual Report, which has not yet been published. The Navy began collecting DODSERS for suspected suicides and suicide attempts of Selective Reserve sailors beginning in April 2009 to better understand the factors affecting this population and identify needs and prevention opportunities. Suicide numbers based on death certificates for SELRES sailors were available before that date. In 2008, there were nine suicides of Navy Selective Reserve personnel not on drill or duty status at the time of death; there were six in 2009; and, there have been four to date in 2010.

Population denominators for Selective Reserve not on active duty have not been standardized for exact rate calculation and rates tend to have considerable variance with relatively small numerator numbers; but, approximate suicide rates for Navy SELRES are very comparable to the active component suicide rate.

The Navy Reserve Psychological Health Outreach (NRPHO) Program has made significant strides in extending the suicide prevention training, surveillance, outreach, and follow-up provided to our Reserve population and, based on success of the approach, has served as the model that the U.S. Marine Corps is now implementing.

General AMOS. Suicides and attempts while a reservist is on active duty are captured within the Marine Corps Total Force System and reported in our annual active duty statistics. We also track inactive Select Marine Corps Reserve suicides and attempts, and report those numbers separately. We have not found any risk factors or characteristics unique to inactive reservists in our data, but continue to analyze for any actionable information to prevent suicides and get help to all marines.

Suicide data for Active Duty reservist and Inactive Select Marine Corps reservists:

Active Duty Reservists

Year	Suicides	Attempts
2005	3	
2006	0	
2007	0	
2008	2	
2009	1	4
2010 (through 19 July)	0	3

- USMC began tracking in 2009.
- Calendar Year 2009 data through 19 July, for comparison, were zero suicides and four attempts.

Inactive Select Marine Corps Reservists

Year	Suicides	Attempts
2009	12	
2010 (through 19 July)	4	0

- USMC began tracking in 2009.

- Inactive SMCR Suicide Reporting required effective 1 January 2009.
- Calendar Year 2009 data through 19 July, for comparison, were five suicides and four attempts.

General CHANDLER. The Air Force Guard and Reserve have established processes to identify suicides by not-in-status members and the Air Force is tracking this data as part of our Total Force Suicide Prevention efforts. These numbers are reported weekly to Air Force senior leaders. The smaller populations of these groups result in greater year-to-year variability in their overall rates. Over the past several years, the rates of suicide in the Air Force Guard and Reserve have been comparable to that of our active duty servicemembers.

2007

AD: 34 suicides (10.3 per 100,000)
 ANG: 17 suicides (16.9 per 100,000); 15 not-in-status/2 AGR
 AFR: 10 suicides (14.1 per 100,000) 9 not-in-status, 1 active

2008

AD: 40 suicides (12.1 per 100,000)
 ANG: 9 suicides (8.4 per 100,000); 7 not-in-status/2 AGR
 AFR: 5 suicides (7.4 per 100,000); 4 not-in-status, 1 active

2009

AD: 41 suicides (12.4 per 100,000)
 ANG: 15 suicides (13.9 per 100,000); 13 not-in-status/2 AGR
 AFR: 8 suicides (11.8 per 100,000); 5 not-in-status, 3 active

On average, the age of both Air Force Guard and Reserve suicides is higher than the average age of active duty suicides, and this demographic difference is consistent with the higher average age of Air Force Reserve component personnel compared with active duty personnel. We continue to analyze the data developed by these efforts to better focus our suicide prevention efforts.

9. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, I am interested in how the Guard and Reserve population is being supported and if the report has highlighted any challenges or concerns that the Reserve components face. How are our prevention programs working for them and what else must be done?

General CHIARELLI. The Army National Guard and the Army Reserve have implemented the Army's Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention. This multi-level, holistic approach takes into account the many challenges our Army National Guard and Army Reserve soldiers, Department of the Army civilians and family members are confronted with. The Centers of Excellence's SPARRC Annual Report further highlighted the issues faced by this same population. These concerns include substance abuse; financial and relationship problems; post-traumatic stress and TBI. The Army National Guard and Army Reserve have revised their internal policies, programs and support in order to leverage enhanced health promotion and suicide prevention support for soldiers, civilians, and family members who are located far away from our installations and garrisons. Despite significant efforts to address these challenges in the last year, it is too early to tell whether they will have the desired outcome in reducing the rate of suicide across the Force. The Army National Guard and the Army Reserve prevention program efforts are constant, evolving efforts to provide our Army family with the resources they need. Challenges remain with access to medical and behavioral health services for non-active duty soldiers who do not qualify for VA benefits, along with the lack of case managers to support medical issues within the same community.

Admiral GREENERT. The Navy Reserve has been completely integrated in Navy Suicide Prevention activities. The Chief of Navy Reserve attends weekly updates provided to the Chief of Naval Operations on suicide trends and prevention activities. Reserve commands have suicide prevention coordinators, leaders participate in program informational briefings, and Reserve component sailors receive the same spectrum of training in OSC and suicide prevention as their Active component counterparts. Additionally, the Navy Reserve PHOP conducts consultations, referrals, and support and follow-up for commands, sailors, and family members.

General AMOS. The Calendar Year 2009 DCoE on Psychological Health and TBI report has not been released. All Marine Corps suicide prevention policies apply equally to our Active and Reserve marines. In addition to our regular suicide prevention initiatives, the Marine Corps has a number of programs designated specifically to meet the needs of our Reserve marines. One such program is the PHOP. There are 30 Marine Corps Reserve Psychological Health Outreach staff members available to assist all returning units. We have also called upon the Military Family

Life Consultants (MFLCs), a program sponsored by the DOD, that is available to support returning units, whenever need is identified by the command. In addition, the Marine Corps Mobilization Command has a Family Readiness Team that helps track those in the Inactive Ready Reserve (IRR) in need of support. There are several initiatives already underway within Navy Medicine to provide support to the IRRs to include family readiness days.

Further, we support many reservists and Veterans through our WWR with liaison officers at the VA polytrauma centers and headquarters. The WWR's Call Center regularly coordinates with the VA by referring Veteran wounded, ill, and injured marines to appropriate VA divisions for assistance. The WWR participates in the VA's Return Integration Location process whereby demobilizing reservists at various post-deployment reassessment sites receive information on VA entitlements. To support remote and isolated reservists, the WWR has District Injured Support Cells (DISCs), who are geographically dispersed mobilized marine reservists who conduct face-to-face visits and telephonic outreach to Reserve and veteran marines and families located throughout the country. The WWR's DISCs and the marines from the Reserve Training Centers have immediate access to the WWR's Medical Cell and Clinical Services Staff for psychological health and TBI issues.

General CHANDLER. The data suggests the Air Force suicide prevention program results in the Guard and Reserve are roughly comparable to those in the Active-Duty Force. Data on suicides by Reserve and Guard members not in active status is drawn from local medical examiner determinations and may not be as consistent as death determinations made by the Armed Forces Medical Examiner for our active duty personnel. It is more challenging to collect accurate data on all Guard and Reserve members as much of their medical care is provided in the civilian system. There is also less visibility regarding the details of day-to-day activities and potential risk factors or stressors leading up to suicide events for these personnel.

Air Reserve Component (ARC) members participated in the recent Air Force Chief of Staff directed Wingman Day stand-down and have the same suicide prevention training requirements as active duty members. Current and future efforts are focused on clear communication and coordination between active duty component personnel and their ARC counterparts throughout the entire process from working on projects, initiatives and working groups, through the final coordination process.

DEPARTMENT OF DEFENSE OVERSIGHT OF SERVICES

10. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, what is DOD doing to understand what programs related to suicide the Services are undertaking and what works?

General CHIARELLI. The DOD Task Force, formed in August 2009, was directed to address trends and causal factors, methods to update prevention and education programs, suicide assessment by occupation, suicide incident investigations, and protective measures for confidential information derived from investigations for all the Services. Their findings are due to be released in the third quarter, calendar year 2010.

In addition, DOD contracted with RAND Corporation to evaluate suicide prevention efforts within DOD. The report assessed programs within each of the Services to identify strengths and weaknesses in our suicide prevention efforts. The information collected will be used to improve development of future suicide prevention programs.

Admiral GREENERT. Navy supports the efforts of the Defense Center of Excellence, the DOD SPARRC, and the DOD Task Force on Prevention of Suicide by Members of the Armed Forces in understanding Navy's suicide prevention initiatives and assessing effectiveness.

Navy efforts to assess effectiveness of programs have included an annual Behavioral Health Quick Poll (to assess perceived stress, attitudes, and suicide prevention knowledge and confidence) and an upcoming study, in conjunction with the Uniformed Services University of the Health Sciences (USUHS), on the effectiveness of the latest suicide prevention training. Navy OSC includes assessment and analysis as a centerpiece of the program. OSC has used various polls and questionnaires, focus groups, and studies to establish baseline measures of stress, knowledge, and the use of stress navigation strategies. This feedback helps to develop and assess leadership tools, communication efforts, and program goals, and is integral to continual process and program improvement.

General AMOS. The Marine Corps shares all of our programs, both implemented and under development, with our sister Services and DOD through our active membership in the SPARRC, chaired by DCoE on Psychological Health and TBI, in the

Office of the Assistant Secretary of Defense (Health Affairs). However, the Marine Corps has contracted with both the Uniformed Services University of the Health Sciences and the American Association of Suicidology to ensure best practices are applied and that our efforts are studied for effectiveness.

General CHANDLER. DOD has established the SPARRC, which provides oversight of the annual DOD suicide prevention conference. This conference provides a forum for sharing of best practices across the Services, the Department of Veteran Affairs and civilian agencies. The SPARRC has been instrumental in establishing consistent data collection processes across the Services, as well as standardizing the reporting of suicides. The SPARRC meets on a monthly basis to facilitate communication across DOD agencies and the Services regarding efforts underway in suicide prevention programs. The DOD recently took part in a Congressional Task Force on Suicide Prevention. This task force will provide a comprehensive review of suicide prevention efforts in DOD. The Air Force suicide prevention program and the SPARRC stand ready to respond to findings and recommendations from this task force.

11. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, is DOD overseeing a best practices model, taking into account the differences of the Services and incorporating those things and treatments that could work Service-wide?

General CHIARELLI. Through the Services' collaborative efforts, the SPARRC evaluates policy and best practices among the Services in order to provide input to DCoE for policy/procedural changes at the DOD level. Specifically, the DCoE, with input from the Services through the SPARRC, is working on formalizing these changes through a new DOD Instruction.

Admiral GREENERT. Navy supports the efforts of the Defense Center of Excellence, the DOD SPARRC, and the DOD Task Force on Prevention of Suicide by Members of the Armed Forces to understand Navy's suicide prevention initiatives and best practices. The annual DOD/VA Suicide Prevention Conference is a forum that brings together researchers, treatment providers, and policy makers for understanding and sharing of the latest information as applied to various populations and circumstances.

General AMOS. The Marine Corps shares all of our resources, plans and findings with our sister Services through the SPARRC, chaired by DCoE on Psychological Health and TBI, in the Office of the Assistant Secretary of Defense (Health Affairs). We regularly compare our initiatives to the best practices registry sponsored by the Department of Health and Human Services through the federally funded Suicide Prevention Resource Center.

General CHANDLER. DOD is overseeing the collection of best practice models through the DCoE. The DOD has established the SPARRC, which provides a forum for sharing of practices across the Services. The SPARRC has been instrumental in establishing consistent data collection processes across the Services through use of the DODSER, as well as standardizing the reporting of suicides across the Services, which allows a better comparison of suicide rates across DOD. The SPAARC provides oversight of the annual DOD suicide prevention conference. This conference provides a forum for sharing of best practices across the Services, the Department of Veteran Affairs and civilian agencies.

12. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, if we are not doing this, how can we do this and who should oversee the overall mental health and wellness of our armed services?

General CHIARELLI. We are doing this through the efforts of the SPARRC.

Admiral GREENERT. Responsibility for administering chapter 55 (Medical and Dental Care) of title 10, U.S.C., is vested in the Secretary of Defense. The purpose of the chapter is to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents.

Navy Medicine is an active participant in the VA and DOD Integrated Mental Health Strategy which aims to improve access, quality, effectiveness, and efficiency of mental health services for all active duty and Reserve sailors and their families.

Navy Medicine works collaboratively with the DCoE for Psychological Health and TBI and its component centers: DVBIC; CSTS; CDP; DHCC; and the National Center for Telehealth and Technology.

General AMOS. The Marine Corps is responsible for the overall mental health and wellness of your marines and it is a responsibility that is our foremost priority. Along with our partners in Navy Medicine and Chaplaincy, we strive to improve our understanding of mental health and wellness, stressors, barriers to care, and breaking stigma.

General CHANDLER. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) has oversight of health and wellness of our armed services as administrator of the Military Health System. While each Service's surgeon general tailors the delivery of care to the specific mission under the direction of the respective service chief, there is also extensive coordination both between the VA and the Services and between each of the Services. This coordination and integration has been on a course of steady improvement over the last 15 years.

Assistant Secretary of Defense (Health Affairs)

Since 1994, the ASD(HA) has been the principal advisor to the Secretary of Defense on DOD health policies, programs and activities and is responsible for a number of the organizations that directly affect the health care of servicemembers and their dependents including the TRICARE Management Activity.

The DOD/VA Joint Executive Council

The DOD/VA Joint Executive Council (JEC) was established in 2003 to oversee and guide the joint health and benefits activities of the Departments. The JEC links three supporting councils: the Health Executive Council (HEC); the Benefits Executive Council (BEC); and the Interagency Program Office (IPO). Under this structure, the DOD and VA work closely with one another across departmental lines to improve access, quality and efficiency.

The Wounded, Ill, and Injured Senior Oversight Committee

In May 2007, the Wounded, Ill, and Injured Senior Oversight Committee (SOC) was created by VA and DOD, and co-chaired by their Deputy Secretaries. The SOC was established as a means to bring high-level Department attention to addressing the recommendations and issues associated with the care and services for returning servicemembers.

YELLOW RIBBON REINTEGRATION PROGRAM

13. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, the goal of the YRRP is to prepare members of the National Guard and Reserves and their families for mobilization, sustain their families during mobilization, and reintegrate the servicemembers with their families, employers, and communities after deployment. How is the YRRP working for your Service?

General CHIARELLI. The YRRP works extremely well for the Army National Guard. Through May 2009, the National Guard had conducted 619 events involving 47,182 servicemembers and 58,350 family members. Attendees were provided information on available services to help prepare soldiers and their family members for mobilization, sustain families during mobilization and reintegrate soldiers with their families after mobilization. The YRRP is a proactive outreach to servicemembers, families, and employers throughout deployment cycle.

Admiral GREENERT. The Navy Reserve provides three specific activities that have been designated as YRRP events: Pre-Deployment Family Readiness Conferences (PDFRCs), the Returning Warrior Workshop (RWW), and the PDHRA.

PDFRCs are conducted every 12 to 18 months at 128 NOSCs across the country and are the Navy Reserve's largest pre-deployment event. Designed to build resilience, the PDFRC provides education, resources, and the opportunity for sailors and families to resolve a broad spectrum of issues prior to the rigors of a deployment and the challenges of family separation.

The RWW is a reintegration program sailors and their guests normally attend between 30 and 60 days following demobilization. This 2-day weekend retreat provides a safe, relaxed atmosphere to help sailors and families with post-deployment reintegration. In 2009, more than 1,800 servicemembers and 1,400 family members attended one of 27 RWWs held in every region of the country. In 2010, 13 workshops were attended by 832 servicemembers and 699 family members with an additional 38 workshops scheduled through July 2012.

The PDHRA is the 90-day YRRP event and occurs between 90 and 180 days after demobilization. The Navy Reserve has sustained a 98 percent rate for PDHRA compliance. Sailors complete the PDHRA online and a qualified health care provider follows up with each sailor by phone. Further follow-up in person is conducted if and when warranted. The PDHRA process is also used to provide information about VA health benefits, Military OneSource, etc.

Since program inception, the response from our Navy reservists and their families has been overwhelmingly positive in regards to all three aspects of the Yellow Ribbon Program. It has proven to be a Navy force multiplier and a vital part of preparedness, sustainment and reintegration.

General AMOS. The YRRP is working well for Marine Forces Reserve, our mobilizing units, small detachments, and individual augmentee servicemembers and their families. We are aggressively implementing the YRRP program to ensure servicemembers and their families are properly informed of and have access to myriad programs, resources, and services to minimize stress before, during, and after deployments. The Office of the Secretary of Defense is engaging on our behalf on logistical challenges, such as a proposed change to the Joint Federal Travel Regulations to permit non-dependent family members—or any designated representative chosen by the servicemember—funded travel and per diem to YRRP events. Language to address this issue is also included in the proposed National Defense Authorization Act (NDAA) for Fiscal Year 2011.

General CHANDLER. The YRRP for members and families has proven to be highly successful for the Air Force Reserves and Air National Guard. Deployment support and reintegration programs are provided in all phases of deployment, including, but not limited to, pre-deployment, deployment, demobilization, and post-deployment and reconstitution phases. Reconstitution activities are held at approximately 30, 60, and 90-day intervals following deployment or demobilization. These activities focus on reconnecting servicemembers and their families with providers to ensure they understand their benefits and entitlements as well as the resources available to help overcome the challenges of reintegration. Best practices from the most successful programs are collected and shared. Positive survey input from servicemembers and families have validated this program.

14. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, is the YRRP available to all members of your component when they deploy?

General CHIARELLI. Yes, the YRRP is made available to all members of the Army National Guard when they deploy. Additionally, the National Guard makes every attempt to ensure that all Service branches within our States, Territories and the District are included, whenever possible, in our YRRP process throughout all phases of the deployment cycle.

Admiral GREENERT. Although YRRP legislation addresses only the Reserve components, similar programs are available to all members of the Navy. Predeployment assistance is provided to Active component sailors through their local commands, and PDFRC are available to all reservists and their family members. RWWs are available to all redeploying Navy sailors, Active and Reserve component, and their families.

General AMOS. The YRRP is available to all members of the Marine Corps Reserve component.

General CHANDLER. Yes, the YRRP is made available to all members of the Army and Air National Guard when they deploy. Additionally, the National Guard makes every attempt to ensure that all Service branches within our States, territories, and the district are included, whenever possible, in our YRRP process throughout all phases of the deployment cycle.

15. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, could the YRRP be modified to help further extend support services to members and families to help address suicide prevention?

General CHIARELLI. Section 595 of NDAA for Fiscal Year 2010 has already expanded the YRRP to include a more enhanced suicide prevention, community healing and response training provision. In complying with this expansion, the National Guard ensures that suicide prevention, education and training are provided throughout all phases of deployment. However, the National Guard is moving towards placing this critical area within our Behavioral Health programs and has already started a Warrior Care Initiative that encompasses programs like Buddy-to-Buddy, Flash Forward, and Peer-to-Peer.

Admiral GREENERT. Suicide prevention education is provided annually to all Navy reservists as part of the Navy's Total Force policy and program.

The RWW provides the ideal opportunity to reinforce this important issue with redeploying sailors and their families. Considered a YRRP event, sailors and their guests normally attend a workshop between 30 and 60 days following demobilization. Mental health screening and suicide prevention education are provided as part of the workshop.

In addition Navy Medicine has funded the Navy Reserve PHOP (further discussed in the answer to question 18), which also provides outreach and education services to reservists and their family members to help address suicide prevention in addition to other stressors.

General AMOS. The NDAA for Fiscal Year 2010 directed DOD to develop suicide prevention awareness and training in the Reserve community. As such, the Marine Corps is an active member of the Yellow Ribbon Suicide Prevention Working Group. Training includes describing the warning signs for suicide teaching effective strategies for prevention and intervention; examining the influence of military culture on risk and protective factors for suicide; and engaging in interactive case scenarios and role plays to practice effective intervention and strategies. Additionally, the program provides the families and communities of National Guard and Reserve members with training that promotes individual and community healing in response to a suicide. We are happy with the YRRP authorities that exist today. As we fine-tune our efforts and gather data and lessons learned, we can recommend changes or extension of the YRRP program Office of the Secretary of Defense, Office of Reintegration Programs.

General CHANDLER. Section 595 of the 2010 NDAA has already expanded the YRRP legislation to include a more enhanced suicide prevention and community healing and response training provision. In complying with this expansion, the National Guard (NG) ensures that suicide prevention education and training are provided throughout all the phases of deployment. However, the NG is moving towards placing this critical area within our Behavioral Health programs and has begun a Warrior Care Initiative that encompasses programs like Buddy-to-Buddy, Flash Forward, and Peer-to-Peer, all of which embrace more of the Behavioral Health aspect of suicide prevention.

16. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, have you found that the YRRP varies significantly among States?

General CHIARELLI. The YRRP implementation requirements are standardized throughout the States. However, while we provide policy and guidance on what needs to be accomplished/presented during an event or activity throughout the deployment cycle, we do not tell our States, Territories, or the District how this information should be presented. For example, if you attend a National Guard YRRP post deployment event, Veterans Administration, Employer Support of the Guard and Reserve, and financial briefs will be presented, but how they are being presented is entirely up to the State.

Admiral GREENERT. YRRP events have been standardized throughout all Navy regions. In particular, the Navy has developed policy and execution guidance governing its three Yellow Ribbon events: PDFRCs, the RWW, and the PDHRA. Every effort is made to ensure the agenda, content, and messages delivered via PDFRCs and RWWs are consistent in every Navy region. The Bureau of Medicine and Surgery has developed standard procedures for conducting the PDHRA nationwide.

General AMOS. No. The Marine Forces Reserve executes the program consistently throughout the Nation.

General CHANDLER. The YRRP implementation requirements within the National Guard (NG) are standardized throughout our States. However, while we provide policy and guidance on what needs to be accomplished/presented during an event or activity throughout the deployment cycle, the States/territories and district determine how the information is presented. For example, if you attend a NG YRRP post-deployment event, you will receive information on VA, Employee Support to Guard and Reserves (ESGR), and a financial brief, but the presentations may vary based on need.

17. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, is there an effort to standardize the approach to provide guidance of what works to Guard and Reserve units across the country?

General CHIARELLI. Yes, and it's going very well. The Army Reserve shares after-action reports and best practices with the DOD's Center for Excellence. In evaluating the YRRP, the Army Reserve is working to provide sequential, progressive, and interactive approaches for all topics, to include suicide prevention. Pre-deployment suicide prevention training focuses on coping with the difficulties of extended separation and deployment. It then shifts to ensuring that family members get connected and remain connected with their unit's rear detachment and family programs staff during the soldier's deployment. The initial post-deployment focus is on reuniting, reconnecting, and reintegrating the soldier with their family members. Finally, the Army Reserve attends to each soldier's physical, behavioral, and mental health concerns through the PDHRA and other discussions approximately 90 days following the soldier's release from active duty.

Every 2 weeks the Army Reserve uses feedback to provide informal guidance to the field through teleconferences for all Yellow Ribbon points of contact in the Re-

gional Support Commands and Operational and Functional Commands. Each quarter, the program managers provide informational meetings and workshops where issues are discussed and disseminated to all for incorporation into local/regional events. The Army Reserve is projected to publish new guidance for program implementation at the start of fiscal year 2011 based on the first 2 years of feedback from commanders, Yellow Ribbon points of contact, and event participants.

For the National Guard, there is policy and implementation guidance published on what topics and issues that should be covered during a particular YRRP event. Additionally, in coordination with the Army and Air Guard, we are also developing a "Best Practices Toolkit," which will be available on our Joint Services Support website that all of our State event coordinators, as well as the other Reserve components, can access. As we continue to work with our Services within our States, the toolkit will be updated to ensure that the guidance being provided is relevant and up to date.

Admiral GREENERT. Following each Yellow Ribbon event, the responsible command, either a regional Reserve Component Command or NOSC, provides a detailed after-action report to Commander Navy Reserve Forces Command (CNRFC) to document attendance, money spent, and identify lessons learned, best practices, and potential improvements. CNRFC then evaluates this after-action report and forwards it to the Office of the Secretary of Defense for Reserve Affairs' Yellow Ribbon office. The most significant lessons learned, best practices, and program modifications and improvements are provided to the NOSCs so they can be shared with Reserve unit leaders and sailors, induce greater participation in Yellow Ribbon events, and convince sailors of the enduring value of these programs. In addition, the Yellow Ribbon Center for Excellence has established an online tool to capture best practices, termed "Golden Nuggets," for Yellow Ribbon events.

General AMOS. Promising practices identified in Marine Forces Reserve are shared with the Office of the Secretary of Defense (OSD) Office of Reintegration Programs to be offered to all Services for their edification. All of the Service Program Managers converse with the OSD Office and each other at least monthly to share challenges and solutions. In addition, regional and State partnerships between Service representatives ensure solutions to common challenges are shared and benefit all.

General CHANDLER. The Air Force Reserve YRRP is not managed by State, but rather by Air Force Reserve Command, which extends to all Air Force Reserve units. When planning a joint event (between Air Force components or between Services) a standardized agenda is used which includes presentations from the VA and TRICARE. The Office of the Secretary of Defense YRRP Working Group is developing a standardized curriculum for all YRRP events. The National Guard (NG) has made an effort to standardize the guidance for the program. The NG's Policy and Implementation Guidance provides guidance on topics and issues that should be presented/covered during a particular YRRP event. Additionally, in coordination with the Army and Air Guard, we are developing a "Best Practices Toolkit" that will be available on our Joint Services support website and is available to all State YRRP event coordinators and Reserve components. This information will be updated periodically to ensure the guidance is accurate and relevant.

18. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, Guard and Reserve members who do not live in close proximity to a military installation, or who live in very remote locations, can experience their own set of issues when it comes to access to health care and family support programs that may be needed following a deployment. Are there any specific programs, including Yellow Ribbon, in place in each of the Services to address the unique needs of Guard and Reserve members and their families, to ensure that there are no gaps in access to help and support for the Guard and Reserve when it comes to suicide prevention?

General CHIARELLI. In addition to the Yellow Ribbon program, which provides support both before and after a soldier deploys, many States and Territories have developed local programs to promote soldier health in the National Guard, such as Michigan's Buddy-to-Buddy peer program, California's embedded psychologist program, and Kansas' resiliency program. The Army National Guard's resilience, risk reduction, and suicide prevention efforts would be greatly improved with additional funding to sustain Army Family Covenant type services, provide behavioral health/emergent care/substance abuse treatment for soldiers and families regardless of status, and additional behavioral health providers for clinical and administrative case management.

Admiral GREENERT. The Navy Reserve has been completely integrated in Navy Suicide Prevention policy, programs, and activities. The Chief of Navy Reserve at-

tends weekly updates provided to the Chief of Naval Operations on suicide trends and activities. Reserve commands have suicide prevention coordinators, leaders participate in program informational briefings, and sailors receive the same spectrum of training in OSC and suicide prevention as their active duty counterparts.

While lack of day to day observation and contact can be a challenge to supporting SELRES between monthly drill periods, the Navy PHOP has provided a very helpful resource in extending the reach for consultation and referral, support, and follow-up for commands, sailors, and family members in the area of psychological health. As of 30 June, the PHOP teams had reached out to more than 1,860 Navy Reserve members, clinically assessed and referred 2,376 reservists to appropriate sources of mental health care, and conducted 281 visits to NOSC's nationwide, providing the OSC awareness and suicide prevention briefs to 29,400 SELRES and full-time support staff.

The Navy began collecting DODSERS for suspected suicides and suicide attempts of SELRES sailors beginning in April 2009 to better understand the factors affecting this population and identify needs and prevention opportunities.

General AMOS. As an active member of the Yellow Ribbon Suicide Prevention Working Group, the Marine Corps is working with its sister Services to identify and remove gaps which may limit access to help and support for its Reserve component. The Marine Corps Reserves' efforts mirror those of the total force and include non-commissioned officer peer-to-peer training along with annual suicide prevention training. We are expanding efforts to reach family members as key partners in the effort to prevent suicides. In addition to our regular suicide prevention initiatives, the Marine Corps has a number of programs designated specifically to meet the needs of our Reserve marines. One such program is the PHOP. There are 30 Marine Corps Reserve Psychological Health Outreach staff members available to assist all returning units. We have also called upon the MFLCs, a program sponsored by DOD, that is available to support returning units whenever need is identified by the command. In addition, the Marine Corps Mobilization Command has a Family Readiness Team that helps track those in the IRR in need of support, and Navy Medicine has several initiatives underway to provide support to the IRRs to include family readiness days.

General CHANDLER. For the Air Force Reserves (AFR), the Office of the Secretary of Defense recently authorized one adult MFLC, one child and youth MFLC and one Military OneSource coordinator to work at Headquarters, Air Force Reserve Command (AFRC). Some of their roles and responsibilities will be to coordinate with State-level Joint Family Assistance Program offices and assist in ensuring reservists and their families are aware of benefits to which they are entitled. AFR and Air National Guard (ANG) airmen and Family Readiness offices assist commanders and first sergeants with their responsibility of contacting families of deployed personnel to keep them abreast of their benefits and direct them to support services such as Military OneSource, which has been a tremendous asset for geographically dispersed families. When it comes to suicide prevention, the YRRP provides needed resources and support by means of a Chaplain presence and State Directors of Psychological Health at Yellow Ribbon events. We work with the servicemembers and their families, as well as commanders that may need guidance. We also realize that monitoring and providing support doesn't end after completed Yellow Ribbon events. We must train and educate the servicemember, families, and commanders and units on suicide prevention.

19. Senator BEN NELSON. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, how are these programs reviewed and managed to ensure that Reserve and Guard soldiers in Nebraska have the same benefits and support as those in other States?

General CHIARELLI. The Yellow Ribbon program is a standardized and funded program and each State individually requests the funding it needs to meet its annual requirements. The ARNG has developed a synchronization matrix to set overall standards while providing States the flexibility to meet their Yellow Ribbon goals.

Admiral GREENERT. DOD has an instruction which establishes a core curriculum for the Services' YRRP events.

Additionally, YRRP events have been standardized throughout the Navy Reserve. In particular, the Navy has developed policy and execution guidance governing its three Yellow Ribbon events: PDFRC, the RWW, and the PDHRA. Every effort is made to ensure the agenda, content, and messages delivered via PDFRCs and RWWs are consistent in every Navy region. The Bureau of Medicine and Surgery has developed standard procedures for conducting the PDHRA nationwide.

General AMOS. There is one Reserve company based in Nebraska. Marine Forces Reserve executes the YRRP consistently across the country regardless of where they

reside. Each battalion and squadron-level unit and above has a full-time, non-deploying Family Readiness Officer (FRO), whose responsibility it is to educate that unit's marines and family members on methods and resources to employ for attaining and maintaining a continual state of readiness for any exigency of the military lifestyle, including mobilization and deployment. FROs encourage socialization of the unit families through hosting of periodic family day and recreational events. They also schedule educational sessions to support the resiliency needs of families associated with welcome aboard; indoctrination into the Marine Corps lifestyle; pre-, during, and post-deployments; and life skills that cover a broad array of support to build knowledge, skills, and critical identification abilities in the areas of combat and operational stress, suicides, casualty assistance, elder care, and deployment impacts on children.

General CHANDLER. The Air Force Reserve YRRP is not managed by State but rather by Air Force Reserve Command (AFRC), which extends to all Air Force Reserve (AFR) units. As such, all AFR members receive the same benefits and support regardless of the State in which they reside. For the Air National Guard (ANG), the guidance set by the Office of the Secretary of Defense (OSD) as well as the policy memorandum (dated 20 July 2009) signed by General McKinley, Chief, National Guard Bureau (NGB), gives specific instruction as to what topics should be covered during each phase of the YRRP. In addition, the NGB Joint Staff Yellow Ribbon Office and the ANG Yellow Ribbon program managers work collaboratively to collect best practices, attend events and review policy and guidance to ensure each member eligible for the YRRP receives the necessary resources and information. Each State may orchestrate the events differently, but standards and guidelines are set by OSD as well as the Chief of the National Guard Bureau.

QUESTIONS SUBMITTED BY SENATOR JIM WEBB

PRESCRIPTION DRUGS

20. Senator WEBB. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, in response to a question for the record for the military departments' surgeons general following a March 10, 2010, Personnel Subcommittee hearing on the military health system, DOD responded that the Services do not have the capability to track prescription medication use in theater, and that "the Military Health System Pharmacy Data Transaction Service (PDTS) has no visibility of pharmacy data for prescriptions dispensed in forward operating areas." It is my understanding that the PDTS serves to track the administration of medications to enhance patient safety and avoid medication contradictions. However, in-theater doctors and medics are not linked to the PDTS; therefore, not only are prescriptions themselves not being tracked, but doctors and medics in-theater are required to treat patients without complete medical case histories. What policies and processes are the military departments instituting to ensure proper data collection and record keeping for the prescription of psychotropic and other drugs administered to forward-deployed servicemembers?

General CHIARELLI. Providers document theater-generated outpatient prescriptions in the Armed Forces Health Longitudinal Technology Application-Theater (AHLTA-T). This is the deployed version of the Military Health System's electronic medical record. Currently U.S. Army Medical Command (MEDCOM) is working with U.S. Central Command (CENTCOM) to develop a policy to ensure theater systems training requires entering all medications within the Medications Orders menu in AHLTA-T. This will improve standardization of documentation and ease in reviewing medications by the deployed provider. All prescriptions appear in the consolidated medications list within the Theater Medical Data Store (TMDS), which will comply with the current policy of electronic health record reach back capability via AHLTA-Warrior and TMDS.

Additionally, MEDCOM is developing training for providers on their responsibility to advise Commanders, as appropriate, about medications prescribed to a soldier if the medication affects mission readiness or fitness for duty.

Admiral GREENERT. It is not a completely accurate assumption that the Services do not have the capability to track prescription medication use in theater. Theater generated prescriptions are documented and viewable through TMDS and this information can be accessed by garrison providers via a web interface. Deployed health care providers have full reach back capability to the servicemember's garrison prescription history via TMDS, Armed Forces Health Longitudinal Technology Application (AHLTA-Warrior, or by Enterprise Remote Access (ERA) web based AHLTA virtualized access.

PDTS is a pharmacy claims service used to prevent drug-drug interactions, duplications, fraud, and assist with billing in the military MTF, retail pharmacy and mail order points of service and while the data forms a fairly solid picture of outpatient pharmacy use in DOD in the 3 points of service, it is not designed to answer questions about medications being prescribed in theater.

PDTS is currently not available in a deployed setting, however there are two electronic health records in theater: AHLTA-T (theater) (outpatient) and TC2 (inpatient). Each is a stand-alone system with the information entered into it uploaded to TMDS. This can be accessed via the web by other locations although internet connectivity in theater is a limiting factor. TMDS is currently the most comprehensive and best organized application to view theater health history (individual patient issues). TMDS is also available via AHLTA.

TMDS is not ideal for viewing medication history and does not perform drug checks against the greater enterprise. Drug interactions can also be checked utilizing Lexi-Comp medication resource electronic clinical reference that is available through the Navy Medicine Online telelibrary and downloadable.

The ASD/HA memo Policy on Worldwide Use of Theater Medical Information Program-Joint 03 November 2008, signed by Assistant Secretary of Defense for Health Affairs addressed the collection and storage of theater health related data on servicemembers. Navy Medicine is in compliance with this memorandum, with all outpatient care in theater being documented in AHLTA-T and inpatient care documented in TC2. Both systems feed data into TMDS. The provider notes are also visible to any provider anywhere in the world via TMDS or viewable as previous encounters in AHLTA.

General AMOS. PDTS is a pharmacy claims service used to prevent drug-drug interactions, duplications, fraud, and assist with billing in the military MTF, retail pharmacy and mail order points of service. The system was not designed for individual patient medication management and is a poor tool to accomplish this task. PDTS is useful in providing data to answer population based inquiries.

While leaders in Washington, DC may not have direct view of theater-generated prescriptions, patient encounters are documented and viewable through TMDS and this information can be accessed by garrison providers via a web interface to TMDS. Deployed health care providers have full reach back capability to SM's garrison prescription history via TMDS, AHLTA-Warrior, or by Enterprise Remote Access (ERA) web based AHLTA virtualized access.

The ASD/HA memo Policy on Worldwide Use of Theater Medical Information Program-Joint 03 November 2008, signed by Assistant Secretary of Defense for Health Affairs, S. Ward Casscells, M.D., addresses the collection and storage of theater health related data on SMs.

General CHANDLER. There are two electronic health records in theater: Armed Forces Health Longitudinal Technology Application-Tactical (AHLTA-T) for outpatient and emergency room records and Theater Medical Information Program Composite Health Care System Cache (TC2) for in-patient records. Each is a stand-alone system with the capability to upload information to the TMDS. This can be accessed via the internet; however, connectivity is often a limiting factor. Medication data is not transferred from AHLTA-T to PDTS, so reports cannot be run to evaluate medication usage. In the near term, DOD is testing the ability to run ad hoc reports through TMDS and is considering options for passing medication data from TMDS to PDTS for use in running reports. To address this in the long-term, TRICARE Management Activity's Defense Health Information Management System (DHIMS) personnel are working to identify data requirements for PDTS to be able to fully interface with theater systems (TMDS, AHLTA-T, and TC2). This information could be used for clinical decision support (e.g., screening for drug-drug interactions) and for analysis and reporting purposes. Requirements are being built into the next PDTS contract to transfer theater data to PDTS; however, the estimated completion date is unknown.

21. Senator WEBB. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, when will comprehensive data be available from the Services for prescription drug use for the Active-Duty, Guard, and Reserve components?

General CHIARELLI. Providers can view all medications prescribed to deployed soldiers.

Providers document and view all medications prescribed in garrison through the Armed Forces Health Longitudinal Technology Application (AHLTA), the Military Health System's electronic medical record. The system includes both inpatient and outpatient prescribed medications. This provides ready visibility of these medications without requiring additional information systems. Deployed healthcare providers have full reach back capability to a soldier's garrison prescription history via

AHLTA-Warrior, a web-based AHLTA view only interface, or by Enterprise Remote Access, a web-based AHLTA virtualized access.

Providers document theater-generated outpatient prescriptions in AHLTA-Theater. These prescriptions are then viewable through the TMDS, which is the data repository and a web-based program to access theater-generated electronic medical records. Garrison providers can access Theater outpatient information via a web interface to TMDS and via AHLTA. The Assistant Secretary of Defense (Health Affairs)/DHIMS is currently working to simplify the process of reviewing all prescribed medications within AHLTA with an implementation timeline of approximately September 2010.

Admiral GREENERT. CENTCOM submitted a requirement requesting a new capability to: track patients deployed in theater who are being prescribed medications that by themselves may require follow-up; track patients who are being prescribed medications in theater that may disqualify them from being in a deployed status; and identification of patients who may be going to multiple providers and/or clinics in the pursuit of multiple prescriptions for drugs that are prone to patient abuse. This capability is targeted for release, by the Office of Assistant Secretary of Defense for Health Affairs, in late September or early October 2010. DOD is testing the ability to run adhoc reports for medication data through TMDS.

Also, the TRICARE Management Activity has developed requirements that would allow PDTS to receive medication information from in theater. This information could be used as clinical decision support (screening for drug-drug interactions) and reporting purposes. The Office of Assistant Secretary of Defense for Health Affairs anticipates that software development work should begin in early fiscal year 2011.

General AMOS. CENTCOM submitted a requirement requesting a new capability to: track patients deployed in theater who are being prescribed medications that by themselves may require follow-up; track patients who are being prescribed medications in theater that may disqualify them from being in a deployed status; and identification of patients who may be going to multiple providers and/or clinics in the pursuit of multiple prescriptions for drugs that are prone to patient abuse. This capability is targeted for release in late September or early October 2010.

DOD is testing the ability to run ADHOC reports for medication data through TMDS. DHIMS is working to improve the reporting capabilities.

TRICARE Management Activity has developed requirements that would allow PDTS to receive medications from theater systems. This information could be used as clinical decision support (screening for drug-drug interactions) and reporting purposes. It is anticipated work should begin in early fiscal year 2011.

General CHANDLER. DHIMS personnel are currently working to identify data requirements for the PDTS to be able to fully interface with theater systems. These theater systems include the TMDS, Armed Forces Health Longitudinal Technology Application-Theater (AHLTA-T) and Theater Medical Information Program Composite Health Care System Cache (TC2). The estimated completion date of this interface is unknown.

22. Senator WEBB. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, what is being done to review the policies governing the prescription of psychotropic medications in general, including their prescription in combination with other drugs (polypharmacy)?

General CHIARELLI. In June 2009, Office of the Surgeon General/U.S. Army MEDCOM issued guidance to providers caring for patients who receive treatment with multiple medications. This policy was revised in September 2009, and is currently being updated further to fully address the problem of polypharmacy among soldiers receiving treatment, especially when psychotropic agents or central nervous system depressants are involved. The purpose of this policy is to provide guidance on the prevention and management of polypharmacy with psychotropic medications and central nervous system depressants to reduce adverse events and optimize clinical outcomes among soldiers receiving care in the military medical system. This policy mandates that care providers carefully monitor soldiers with complex or multiple medical and/or behavioral health problems to reduce the risk of serious drug interactions and polypharmacy. Providers will review the medication profile at each visit, assess for ongoing clinical indications for medication treatment, screen for the potential side effects, including the effects of drug-drug interactions, and refer to a clinical pharmacist for further review and reconciliation if the number and nature of the patient's medications triggers a pharmacy referral.

Risk has been greatly reduced for Warrior Transition Unit (WTU) soldiers, who are at the highest risk among our troops, by implementing intensive monitoring by primary care physicians in close collaboration with pharmacists assigned to the WTUs. Consequently, soldiers' medications are reviewed within 24 hours of arrival

in the WTU, reviewed thereafter at least weekly, and more often if changes in dosage or medication are made in the course of treatment. High risk soldiers are assigned to only one health care provider to access controlled medications that may put them at greater risk. Soldiers who have demonstrated difficulties in complying with treatment on opioid analgesics and other controlled medications are enrolled in the Sole Provider Program for more intense monitoring and control.

Admiral GREENERT. Medication reconciliation, a National Patient Safety Goal of the Joint Commission accreditation agency, is a complete review of all patient medications and any potential interactions with other drugs. Today, medication reconciliation is performed by the medical provider at each patient encounter, both in and out of theater.

The WTU Pharmacy Prescription Medication Analysis and Reporting Tool is a DOD-consolidated medication screening tool containing medication from all points of service (MTF, retail and mail order). This tool also provides reports on four targeted categories (sedative hypnotics, narcotics, antidepressants, and antipsychotics) and can be used to identify at-risk patients prior to deployment.

Current pre-deployment screening procedures address all medication usage including psychotropics as documented on the NAVMED 1300/4, which was revised April 2010.

General AMOS. While I defer to the military medicine professionals regarding appropriate management of all medical conditions, the Marine Corps adheres to all current directives regarding medications usage and deployment. Specifically, the Marine Corps is well aware of and adherent to the guidance contained in the CENTCOM "Individual Protection and Individual/Unit Deployment Policy" Mod 10 released 05 March 2010 and DOD DTM dated November 7, 2006 "Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications."

General CHANDLER. Several processes, programs, and directives are in place at Air Force MTFs to closely monitor and manage medication therapy, including the prescribing of psychotropics and the monitoring of polypharmacy:

Medication Reconciliation

This is a National Patient Safety Goal of the Joint Commission on Accreditation of Healthcare Organizations. The objective is for providers to review and evaluate all medications with each patient at each encounter. The patient leaves each encounter with a list of current medications from all providers, all pharmacies and any over the counter medications or vitamins.

Composite Health Care System (CHCS) Profile Review

All prescriptions filled through CHCS are screened for drug interactions, overlaps, duplications, and early fills. Prescriptions filled at network pharmacies are also screened through the Prescription Data Transaction Service. When potential problems are identified (e.g., duplications/overlaps, drug-drug interactions, etc.), pharmacy personnel follow-up with the patient and, when appropriate, with the patient's provider.

Prescription Restriction Program

This is a program available through the Pharmacy Operations Center that can be used to limit patients to one pharmacy and one provider. It is usually used for controlled substances, but can also be used as a patient safety tool to prevent patients from receiving prescriptions from multiple providers or pharmacies for the same or similar medications.

Pre-Deployment Screening

Pre-deployment screening addresses all medications including psychotropics. It is directed in Air Force Instruction (AFI) 48-120 (in coordination), which will implement DOD Directive (DODD) 6490.02E, Comprehensive Health Surveillance; DOD Instruction (DODI) 6490.03, Deployment Health, Joint Chiefs of Staff (JCS) Memorandum, 2 Nov 07, Procedures for Deployment Health Surveillance; and, Headquarters United States Air Force (HQ USAF)/Assistant Vice Chief of Staff (CVA) Memorandum, 23 Feb 06, PDHRA. The AFI provides guidance for all Air Force and Air Reserve component (ARC) installations in meeting the requirements of the deployment health and medical surveillance program. When published, it will supersede Air Force Surgeon General's Memorandum, dated 22 May 03, "Medical Procedures for Deployment Health Surveillance." Additionally, a tool available to assist in the pre-deployment screening process is the Prescription Medication Analysis and Reporting Tool (P-MART), which is a consolidated medication screening tool that displays medications from all points of service (MTF, retail, and mail order). This tool provides reports on four targeted categories (sedative hypnotics, narcotics, antidepressants, and anti-psychotics), and can identify at-risk patients.

QUESTION SUBMITTED BY SENATOR MARK UDALL

NPR AND PROPUBLICA INVESTIGATION INTERVIEW

23. Senator UDALL. General Chiarelli, you mentioned in your testimony that you provided to National Public Radio a complete response to its recent report on brain injuries in the Army, in which you detailed your problems with the report. Would you please provide me your complete response for the record?

General CHIARELLI. A copy of my letter to NPR is attached.



DEPARTMENT OF THE ARMY
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JUN 14 2010

Ms. Vivian Schiller
President & CEO
National Public Radio
635 Massachusetts Avenue, NW
Washington, DC 20001

Dear Ms Schiller:

I am compelled to respond to the recent articles by NPR reporter, Dan Zwerdling regarding care of our Wounded Warriors suffering from Traumatic Brain Injury (TBI). I do believe we agree on one important issue: our Soldiers deserve the very best medical treatment and support available.

That said, while I acknowledge Mr. Zwerdling's right to express his opinions, I strongly disagree with his depiction of efforts by Army senior leaders and medical professionals related to the care and treatment of Soldiers suffering from TBI. In particular, his assertion that Army leaders and medical professionals are minimizing – or worse – deliberately neglecting these injuries is simply not true. Certainly the abundance of evidence readily available today to Members of Congress, the general public and journalists alike clearly contradicts such assertions. Your audience was not afforded an opportunity to see a far more current balanced view of the efforts being made along the continuum of care from prevention to mitigation, early management healing and rehabilitation.

NPR's disparaging commentary is particularly disappointing as I personally invited Mr. Zwerdling to accompany me on a recent trip to Fort Carson, Colorado to visit the Warrior Transition Unit (WTU). Throughout the duration of the one-day trip he was provided access to facilities and medical personnel caring for Soldiers and family members. My goal was to ensure he gained a full, accurate appreciation for the programs and efforts in place specific to TBI and also post-traumatic stress (PTS). Yet, very little of the information relayed or gathered during that visit is reflected in Mr. Zwerdling's articles.

I consider PTS and TBI to be very difficult invisible injuries of the 'signature weapon' of this war: blast. In fact, the majority (60%) of the Soldiers enrolled in the Army's Wounded Warrior program have PTS (43%) and/or TBI (17%) as a primary diagnosis. I, and the Army's other senior leaders, are absolutely committed to doing anything and everything possible to help these Soldiers at all stages of care, even after they leave military service.

We readily acknowledge these injuries pose unique challenges, especially as compared to easily-detectable wounds such as amputations and burns. In fact, PTS and TBI are among the most difficult and debilitating in terms of accurate diagnosis,

care and recovery. The study of the human brain is an emerging science, and there is still much to be learned about these and other highly-complex injuries involving the brain. This pertains not just within the military medical community, but throughout the entire medical community as a whole, worldwide.

We are making progress, both in theater and at medical facilities around the world. In a concerted effort to minimize the number and severity of injuries, the Army implemented a new TBI management strategy across the force aimed at prevention, early detection and effective treatment of injuries. Education is key; we must teach our Leaders, Soldiers and family members about these injuries, the possible symptoms and what is required for full recovery. Additionally, the Army is instituting a revised program of instruction for medics and other behavioral health providers that includes training specific to TBI and PTS injuries. The new TBI management strategy also includes strict 'event-based' protocols that govern exactly what Leaders and Soldiers must do if involved in any type of concussive event. At a minimum, every Soldier must undergo a medical evaluation followed by a mandatory 24-hour downtime period and a second exam before returning to duty. We cannot permit the Warrior spirit of our Soldiers, which leads them to ignore their concussions and remain in the fight to dominate the competing need to protect themselves against another injury during the vulnerable period of healing.

Meanwhile, back at home, since 2002 the Department of Defense has opened 52 TBI treatment centers across the country. These centers are staffed with multidisciplinary teams of medical providers capable of treating the full range of TBI, from mild to severe. The National Intrepid Center of Excellence, dedicated to research and the treatment of military personnel and veterans suffering from TBI and other behavioral health issues will open this summer. It is built on the Bethesda, Maryland campus of what will become the new Walter Reed National Military Medical Center, the DoD's largest and most advanced medical complex and across from the National Institutes of Health—a key partner in advancing the science and treatment of these injuries and illnesses.

The reality is today some of these neurological injuries or conditions cannot be fully repaired or healed even with the most advanced medical treatment available. Unlike an amputation, for example, there is no standard procedure or prognosis for care of severe TBI. This can understandably add to the frustration felt by affected Soldiers and family members. While they are entitled to speak freely about their injuries to members of the media, HIPPA regulations and medical ethics restrict others, to include U.S. Army officials and medical personnel from doing so.

In the past, individuals suffering from TBI, PTS or what was previously referred to as "battle fatigue" were often told there was nothing more that could be done for them. They were discharged from the military and left to suffer in silence. This is absolutely unacceptable. Next to the prosecution of current and future conflicts, our highest priority remains caring for the men and women who serve and sacrifice on behalf of our Nation.

In 2007, the Army established Warrior Transition Units (WTU) to facilitate the treatment and rehabilitation of Soldiers determined to require complex medical care for six months or longer. Today, there are 29 installation-based WTUs and nine community-based WTUs located around the world. Approximately 9,300 wounded or injured Soldiers are receiving treatment at these facilities. Teams comprised of nurse case managers, health care providers and cadre members assist them and their families through the full recovery process. The feedback has consistently been very positive. And, we are continually making improvements to the care and services provided at these facilities based on lessons learned.

The Army activated the Warrior Transition Command to oversee the WTUs and to guide the ongoing execution and development of the Warrior Care and Transition Program. The overarching goal is to help Soldiers and Veterans to heal physically and mentally while building bridges to positive opportunities that lie ahead for them in the future.

These are just a few of the many collaborative efforts currently underway relevant to the very real and complex challenges of TBI and PTS injuries. As the Army's Vice Chief of Staff, I remain dedicated to ensuring our Soldiers suffering from TBI and PTS receive the proper care and treatment required. We owe the men and women who serve our Nation a tremendous debt of gratitude, especially those who sacrificed so greatly. The United States Army's Warrior Ethos states: "I will never leave a fallen comrade." I assure you and others that we remain fully committed to keeping that promise to our Soldiers every day of their lives. I would welcome any invitation to discuss this issue further at your convenience.

Sincerely,



Peter W. Chiarelli
General, U.S. Army
Vice Chief of Staff

THIS LETTER FALLS
SHORT OF CONVEY-
ING THE DEPTH OF
MY CONCERN ABOUT
THIS "INVESTIGATIVE"
REPORTING.

QUESTIONS SUBMITTED BY SENATOR ROLAND W. BURRIS

FAMILIES OF SERVICEMEMBERS

24. Senator BURRIS. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, as you know, war wounds and mental trauma do not only affect the injured veteran, dealing with these conditions is also very hard on the family members. Are there any statistics available about the incidence of suicide and depression of the families of servicemembers?

General CHIARELLI. The ASPTF has tracked family member suicides since calendar year 2009. Army Criminal Investigation Division (CID) investigates the death of all Army family members that occur on post. When the death of a family member occurs off-post, CID coordinates with the local law enforcement agency on the investigation. If the death appears to be the result of a suicide, CID notifies the ASPTF liaison officer. ASPTF does not track the incidence of depression in family members. However, this data may be obtained from medical channels if the family member was seen at one of the Army's medical facilities, or a TRICARE provider. Tracking Reserve component (not on Active Duty) family member suicides has proven to be problematic.

Admiral GREENERT. It is difficult to accurately quantify because dependents often access mental health services outside of the Military Health System. Additionally, psychiatric disorders are diagnosed by a cluster of symptoms rather than the presence of measurable physical findings. This leads to a disparity in the reported incidence rates and other epidemiologic statistics for the majority of psychiatric disorders calling into question their reliability.

We are however, able to infer a change in the psychological health status of our servicemembers' family members by their utilization of mental health services. For example, between 2007 and 2009 there was an increase of more than 14 percent in the number of family members under the age of 18 who received mental health treatment; 95 percent of this increase was in the diagnoses of conduct, adjustment and anxiety disorders as well as developmental disorders from increased learning problems in school. This supports the fact that children, when stressed, typically become anxious or act out their stress through behavioral problems rather than complain of sadness or depression. From these findings we can conclude that family members are also having difficulties with managing the impact of the war on the family unit of our veterans' and servicemembers.

Programs are in place to support the family; assist in building on the baseline resilience that family members bring with them; and treat mental health conditions once they are identified.

General AMOS. The Marine Corps tracks family member suicides that are reported through the personnel casualty reporting system. Over the last 5 years, there have been 0 to 2 Marine dependent suicides per year. We do not have detailed information on these deaths as they have occurred in the civilian area of responsibility with minimal military opportunity to investigate. This is below the National civilian suicide rate. The Marine Corps do not track statistics on the incidence of depression in families of servicemembers.

General CHANDLER. The mental health of families is of significant concern to the Air Force as family support is essential for effective functioning of our servicemembers. Air Force health care records show that approximately 16,000 active duty family member beneficiaries (approximately 3 percent of all beneficiaries) have a primary diagnosis of some type of depression. This compares to estimated national prevalence of depression of approximately 10 percent. The Air Force has had an increase in utilization of mental health services over the past 5 years both at military treatment facilities and through the TRICARE network.

There is currently no requirement for local authorities to report family members' cause of death to the Air Force. The Air Force suicide prevention program is working with Air Force Manpower and Personnel to develop a process for collecting this data and tracking Air Force family member suicides by obtaining data on Servicemembers Group Life Insurance claims. We will share this process with our Sister Services to ensure future tracking of this important issue across DOD.

25. Senator BURRIS. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, what types of mental health services are available to family members and caregivers?

General CHIARELLI. Inpatient and outpatient behavioral health care is available to family members through MTFs at every Army installation hosting families. The Army additionally leverages local healthcare providers in the surrounding installation communities through the TRICARE Network system. TRICARE covers medically and psychologically necessary behavioral health care services for family members to include individual, family, and group therapies, collateral visits, psychoanalysis, psychological testing, inpatient hospitalization, partial hospitalization and residential treatment.

There are also numerous programs that provide training and assistance for families experiencing stressors related to military service and deployments. These programs include an extensive array of behavioral health services that address symptoms of depression, anxiety, and other psychological health issues, and specifically provide training to assist families with identification of symptoms that may indicate depression, anxiety and other psychological health issues. These support programs for soldiers and their families include the following:

- Army Community Service. Army Community Service programs offer real-world solutions to problems commonly encountered by soldiers and their families. The program equips people with the skills and education that they need to face the challenges of military life today and tomorrow.
- Battlemind. Numerous Battlemind products have been developed and implemented to train soldiers and families to cope with the rigors of deployment and redeployment. These training products are designed to enhance the recovery and resiliency of soldiers before, during, and after deployment. Battlemind resources include training programs and videos focusing on post-deployment recovery, marital relationships, and supporting children from pre-school to teen.
- Child and Adolescent Center of Excellence. This COE works to characterize the effects of belonging to a military family; focuses on the impact of being a child with a parent who deploys, is wounded or killed in action;

follows them over time; focuses on interventions, programs, and policies to assist families in relation to these unique stressors; and provides targeted healthcare solutions, support products, and services to military dependent children and adolescents and exports them DOD-wide.

- Family Assistance for Maintaining Excellence. Formerly known as Families Adapting to Military Experience, Family Assistance for Maintaining Excellence provides standardized, evidence-based behavioral health assessments; services include education, prevention, screening, and/or treatment for Spouses.
- Military OneSource. A free 24-hour, 7-days-a-week information center and website where soldiers can seek assistance. Counseling is provided by phone or in person by Masters-level consultants on issues such as family support, emotional stress, debt management, and legal concerns at no cost to the soldier or family member for up to twelve sessions.
- Psychological Health School Programs. A preventive approach intended to strengthen individual servicemembers, their families, their units, and communities, enhancing their ability to cope with stress. Resilience promotion involves a continuum of care from non-clinical to clinical settings.
- Warrior Resiliency Program. Focuses on the prevention and treatment of combat and deployment stressors impacting on warriors and their families. This is a preventive approach intended to strengthen individual soldiers, their families, their units, and communities, enhancing their ability to cope with stress. Resilience promotion involves a continuum of care from non-clinical to clinical settings.

Caregivers who are not eligible beneficiaries can receive education counseling, research and referrals through Military OneSource (www.MilitaryOneSource.com) when the mental health concern is related to or on behalf of a servicemember. For mental health issues unrelated to the servicemember, Military OneSource will work with the non-dependent or parent to refer them to the appropriate behavioral health resource in the community. While there are no costs associated with using Military OneSource, the non-dependent is responsible for any resource other than the assistance provided by Military OneSource.

Admiral GREENERT.

For Families—

Project FOCUS (Families Over-Come Under Stress) addresses difficulties that children and families face during the challenges of multiple deployments and parental operational stress. FOCUS works in coordination with Navy's Fleet and Family Support Centers as well as the Marine Corps Community Service's programs to provide a thorough continuum of care to servicemembers and their families.

Navy Fleet and Family Support Centers (FFSCs) offer a wide-range of services to families to include pre- and post-deployment programs, including counseling services. They have incorporated the OSC concepts into their programs as appropriate.

Medical Care for Dependents—

Eligible beneficiaries can access a wide range of mental health services in the Military Health Service. TRICARE covers medically and psychologically necessary behavioral health care services including outpatient psychotherapy, psychological testing and medication management; acute inpatient psychiatric care, psychiatric partial hospitalization program, residential treatment center care (limited to beneficiaries under age 21), and substance use disorder services. The web-based TRIAP provides online access (chat, web-based video) to counseling for short-term, non-clinical issues. The Telemental Health Program is available at participating TRICARE facilities where beneficiaries can use secure audio-visual conferencing to connect with offsite TRICARE network providers for clinical counseling.

Respite care services are available to injured servicemembers and are provided by a home health agency authorized by TRICARE and approved by the servicemember's case manager. Respite care provides rest and change for the primary caregiver who has been caring for the patient at home and assisting with activities of daily living.

For Caregivers—

The Caregiver Occupational Stress Control (COSC) Project provides training and materials to educate caregivers on compassion fatigue and secondary trauma. COSC enhances the resilience of caregivers to the psychological demands of exposure to trauma, wear and tear, loss, and inner conflict associated with providing care.

General AMOS.

For Families—

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Marine Corps Community Services (MCCS) offer a wide-range of services to families to include pre- and post-deployment programs. They have incorporated the OSC concepts into their programs as appropriate.

For Caregivers—

The COSC project provides training and materials to educate caregivers on compassion fatigue and secondary trauma. Caregiver OSC enhances the resilience of caregivers to the psychological demands of exposure to trauma, wear and tear, loss, and inner conflict associated with the therapeutic use of self.

Respite care services are available to injured servicemembers and are provided by a Home Health Agency authorized by TRICARE and approved by the servicemember's case manager. Respite care provides rest and change for the primary caregiver who has been caring for the patient at home and assisting with activities of daily living.

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The web-based TRIAP provides online access to counseling for short-term, non-medical issues.

The Telemental Health Program is available at participating TRICARE facilities where beneficiaries can use secure audio-visual conferencing to connect with offsite TRICARE network providers.

General CHANDLER. There is a comprehensive spectrum of mental health care and support available to family members and beneficiaries who may also be care-givers of the wounded, ill, and injured.

The following types of treatments are available to family members:

Formal mental health visits:

In the Air Force, due to the primacy of the mission to active duty airmen, most care to family members is arranged through the TRICARE network.

Behavioral Health in primary care:

Studies show half of all medical visits for mental health concerns occur in primary care clinics. More than 60 percent of Air Force MTFs have behavioral health providers embedded within them. Seeing a mental health provider in primary care is a lower-stigma alternative and typically involves a few visits for a focused intervention.

The TRICARE Assistance Program:

TRIAP offers web-based counseling for adult beneficiaries.

Nonmedical counseling

Military OneSource offers nonmedical counseling with licensed providers for family members and is easily accessed through a toll-free telephone number by self-referral. MFLCs and licensed mental health providers offer confidential support to military members and family members through base Airman and Family Readiness Centers.

Support and referral

Recovery Care Coordinators (RCCs) and Family Liaison Officers working with wounded, ill, and injured airmen also help support family members and caretakers and refer them to any needed services. Additionally, our chaplains are active in supporting family members and caretakers and are trained in suicide prevention strategies.

In summary, there is a broad spectrum of mental health services available to beneficiaries who need mental health services.

26. Senator BURRIS. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, is it only military dependents that qualify for these services, or are there resources available to affected non-dependents such as parents?

General CHIARELLI. Army Behavioral Health services are not available to non-dependents such as parents. However, parents and non-dependents are eligible to receive education counseling, research and referrals through Military OneSource (www.MilitaryOneSource.com) when the mental health concern is related to or on behalf of a servicemember.

For mental health issues unrelated to the servicemember, Military OneSource will work with the non-dependent or parent to refer them to the appropriate behavioral health resource in the civilian sector. While there are no costs associated with using Military OneSource, the non-dependent is responsible for any resource other than the assistance provided by Military OneSource.

Admiral GREENERT. Section 1672 of the NDAA for Fiscal Year 2008 authorizes a family member who is not otherwise eligible for medical care at a Military Treatment Facility (MTF), and who is caring for a member of the Armed Forces recovering from serious injuries or illnesses, to receive medical care at the MTF on a space-available and reimbursable basis. Such care includes available mental health services in the MTF. Earlier this year, the Deputy Secretary of Defense signed out a memorandum on April 1, 2010 expanding eligibility of care to non-family members.

Additional help is available to primary caregivers of homebound injured active duty servicemembers. Respite care services are available to the family members of injured servicemembers and are provided by a home health agency authorized by TRICARE and approved by the servicemember's case manager. Respite care provides rest and change for the primary caregiver who has been caring for the patient at home and assisting with activities of daily living.

General AMOS. Section 1672 of the NDAA for Fiscal Year 2008 authorizes a family member who is not otherwise eligible for medical care at a Military Treatment Facility (MTF), and who is caring for a member of the Armed Forces recovering from serious injuries or illnesses, to receive medical care at a MTF on a space-available and reimbursable basis. Such care includes available mental health services in the MTF. Deputy Secretary of Defense Memorandum of April 1, 2010 expanded eligibility for this care to non-family members.

Additional help is available to primary caregivers of homebound injured active duty servicemembers. Respite care services are available to injured servicemembers and are provided by a Home Health Agency authorized by TRICARE and approved by the servicemember's case manager. Respite care provides rest and change for the primary caregiver who has been caring for the patient at home and assisting with activities of daily living.

General CHANDLER. Current policy does not provide these services to non-dependents such as parents unless they are designated as the caregiver by the servicemember. Caregivers must be certified by medical personnel prior to designation. Those designated as caregivers are authorized inpatient and outpatient care at a military treatment facility on a space-available basis.

DIFFERENCES IN SERVICES' STATISTICS

27. Senator BURRIS. General Chiarelli and General Amos, all of the Services have seen an increase in their suicide rates. However, the Army and Marine Corps have seen a much higher rate of suicides than the Navy and the Air Force. For example, in 2008, the Army and Marine Corps had suicide rates of 18.5 and 19.5 per 100,000 servicemembers, respectively. However, the Navy and the Air Force had rates of 11.6 and 12.1 per 100,000 servicemembers, respectively. Why do you believe suicide rates in the Army and Marine Corps are so much higher?

General CHIARELLI. The U.S. Army Public Health Command (Prov) technical paper dated 29 April 2010, based on an overall assessment over the study period from 2003–2009, indicates that the primary high risk population for suicide among Army soldiers is young males with a behavioral health (BH) condition, which is consistent with data on civilian risk factors. Other than having a BH diagnosis, other factors, such as participation on first deployment, levels of combat exposure, and personal and work-related stressors likely contribute to suicide risk. On the latter, they did indicate "further analysis is required to understand their relative impact and to prioritize areas for prevention and intervention."

According to the Army suicide reports used for the VCSA's Senior Review Group meetings, the leading factor associated with a completed suicide event involves a relationship problem (55.8 percent of 520 cases), with military/work stress being the

second leading factor (49.6 percent of the 520 cases). In most cases, there are multiple contributing factors.

General AMOS. The Marine Corps consists of an overwhelmingly young, male and mostly single population whose life-skills and resilience are still developing. Impulsivity is known to play a role in suicide-related behavior and we believe that our young marines are at increased risk. In addition, we believe that high sustained operational tempo is a stressor that may be experienced uniquely in the different Services.

28. Senator BURRIS. Admiral Greenert and General Chandler, do you believe there are any components of your suicide prevention programs that can account for your lower numbers?

Admiral GREENERT. We believe that a sustained, multi-faceted strategy that includes introducing and sustaining OSC training throughout the career continuum, local level leadership engagement, education, and outreach has reduced variability in Navy suicide rates over the years. We are committed to a systematic approach with continuous process improvement. We are glad to see lower numbers but hesitate to draw premature conclusions, and recognize the need to maintain vigilance regardless of the direction of the numbers.

General CHANDLER. Given the different missions and cultures of the Services, it is difficult to directly compare suicide prevention efforts between the Services. The Air Force is concerned with the health and resilience of all servicemembers and extends great effort to reduce the risk of loss of a single servicemember to the tragedy of suicide. The Air Force Suicide Prevention Program is founded upon 11 enduring elements as a community-based prevention program. The first, and key, element to this program is senior leader involvement. Messaging from senior leadership regarding the importance of seeking help when needed has been a critical factor in the success of the Air Force Suicide Prevention Program. The Air Force Suicide Prevention Program is also based on a strong research foundation. The prevention program is engaged in a number of studies with researchers at the USUHS to examine case data on past suicides, including data collected through our Suicide Event Surveillance System, and the DODSER and Personal Health Assessment data, to look for factors that may allow us to better identify those at risk for suicide. Recent efforts in this area have allowed us to identify career fields that appear to be at greater risk for suicide, allowing leadership to target additional prevention efforts at these groups.

The Air Force is also collecting data on new recruits entering the Air Force regarding past behavioral history. This data collection appears to show promise in allowing us to identify, from a recruit's earliest days in the Air Force, those airmen who may be at higher risk for a variety of problems. The Air Force is now exploring ways to reach out to these airmen to improve their ability to cope with the rigors of military life and improve resiliency.

WARRIOR TRANSITION UNITS

29. Senator BURRIS. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, numerous Warrior Transition Units (WTU) have been established to assist wounded servicemembers in their recovery. What types of programs are in place in the WTUs to assist servicemembers who are struggling with TBI and PTSD?

General CHIARELLI. Soldiers in WTUs are assigned to a healthcare team that includes a PCM, a case manager, and a social worker. This team conducts extensive screening for TBI and PTSD during their initial and ongoing visits with the soldier. If a soldier screens positive for either TBI or PTSD, the team has access to referral resources within the Military Health System and in the civilian community. The DCoE for Psychological Health and TBI provide resources to healthcare professionals through their outreach center and through monthly video conferences.

There are a number of resources available to soldiers and families. U.S. Army MEDCOM has developed a number of TBI clinics and specialty programs located at Military Treatment Facilities at installations throughout the United States and Europe. The VA and DOD have collaborated on and published a TBI clinical practice guideline fact sheet. Similarly, soldiers diagnosed with PTSD have access to Behavioral Health specialists who are experts in the treatment of PTSD. The DOD DHCC, a component of the DCoE for Psychological Health and TBI, offers a specialized care program for patients experiencing PTSD. Soldiers and family members also have access to Behavior Health Specialists through Military OneSource.

Admiral GREENERT. Safe Harbor is the Navy's Wounded Warrior Program for non-medical care management of recovering servicemembers. Safe Harbor does not operate WTUs. The Navy's model for warrior care is to transition sailors enrolled in the program close to their original homeport or command or wherever they can receive top quality medical care and be close to their support network of family members and Shipmates. While the Army and Marine Corps wounded warrior population tends to be younger, unwed and living in a barracks environment prior to injury, Navy has an older population. The average Navy wounded warrior is 34 years of age, married and no longer a barracks resident. These factors make the Navy model of not garrisoning wounded, ill, and injured a good choice for our sailors and coastguardsmen and optimize the success of their recovery, rehabilitation and reintegration activities.

Safe Harbor works closely with Navy Medicine and other agencies/organizations both in the government and private sectors to ensure that sailors and coastguardsmen who are struggling with TBI and post-traumatic stress receive the care and assistance necessary to meet all their needs and those of their families. All Navy Wounded Warriors have access to TBI and PTSD care offered within DOD and VA Health Systems, including the Navy's Comprehensive Combat and Complex Casualty Care (C5) at Naval Medical Center San Diego, the NICoE and the DVA Polytrauma Centers. Examples of other programs that Safe Harbor assists in facilitating access to include DOD Computer/Electronic Accommodations Program, the Bob Woodruff Foundation initiatives, Navy Marine Corp Relief Society Visiting Nurse, and many more.

General AMOS. In its non-medical care capacity, the Marine Corps' WWR has different programs in place to assist our marines and their families struggling with TBI and PTSD. Licensed clinical consultants, who are located at the WWR's headquarters in Quantico, VA, and its battalions at Camp Lejeune, NC, and Camp Pendleton, CA, provide resources and coordinate referrals to military, VA and community treatment facilities. The WWR's TBI program coordinator screens marines with blast exposures for entry into Hyperbaric Oxygen Treatment (HBOT) research studies. RCCs assist Active Duty and Reserve marines with TBI and PTSD through coordination of a marine's non-medical and medical care providers and the completion of a comprehensive transition plan (CTP) that helps marines define their personal goals for recovery, rehabilitation and reintegration. The WWR's Warrior Athletic Rehabilitation Program and its involvement in DOD's Warrior Games give marines an outlet to overcome TBI and PTSD through physical activity and competition. The Families OverComing Under Stress Program is a resiliency program designed to assist and promote strong Marine Corps families so they are better equipped to contend with the stressors associated with military life and injuries such as TBI and PTSD.

General CHANDLER. While the Air Force does not operate WTUs, we provide close support to our wounded, ill, and injured airmen through our medical staffs and the Air Force Warrior and Survivor Care program. Our RCC provide close personalized support to our airmen, monitor those with signs of post-traumatic stress and make referrals to the appropriate medical specialist. The team approach of clinical case manager, RCC, and the unit command works in concert to identify and treat airmen with PTSD or TBI. Additionally, our Air Force Wounded Warrior Program provides long-term outreach support and referral to medical specialists as needed. Since we have experienced excellent success with our RCC program, we are expanding that program this year by adding 14 additional RCCs throughout the country. Our goal is to provide improved coverage, especially for Reserve component units in an effort to ensure we are supporting all of our wounded, ill, and injured airmen.

The Air Force works in conjunction with the DCoE for Psychological Health and TBI in development of protocols, education and training, prevention, patient, family and community outreach. The DVBIC is the DOD point of evaluation, treatment and clinical research on TBI. It provides treatment and follow-up TBI care to active duty servicemembers, veterans and their family members.

Air Force mental health providers deliver evidence-based treatments for PTSD, including prolonged exposure therapy and cognitive processing therapy. In addition, eight Air Force sites conduct virtual reality treatment for PTSD patients. The Air Force operates a TBI clinic at Elmendorf Air Force Base (AFB).

Through joint collaboration with the Centers for Deployment Psychology (CDP) at the USUHS, psychology and social work residents attend a two week training that focuses on identification and treatment of TBI and PTSD. In addition, CDP also offers training on evidence-based treatments for PTSD to Air Force providers. DVBIC offers similar education on TBI which Air Force providers have attended.

30. Senator BURRIS. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, by the very nature of the population in the WTUs, is it reasonable to conclude that there is a higher instance of substance abuse in these units?

General CHIARELLI. While it certainly is true that soldiers in WTUs represent a concentration of those with behavioral health issues such as depression and PTSD, as well as TBIs, it is not accurate to characterize these conditions, in and of themselves as predisposing these soldiers to greater risk of substance abuse behavior than other soldiers. There is no data to suggest soldiers in a WTU have a higher incidence of substance abuse or are at a higher risk than the general Army population. Substance abuse is as much a social phenomenon as it is related to behavioral issues. This is why the Army has made such a considerable investment in cultivating resilient soldiers and families so that they adopt alternative means for coping and dealing with anxiety and stress and maintain healthy lifestyles. Any soldier in a WTU who exhibits substance abuse problems is immediately referred to the Army Substance Abuse Program. For those warriors in transition who are determined to be at risk, the PCM will enter that soldier into the Sole Provider Program. This program limits access to prescriptions, requires weekly medication reconciliation by the WTU pharmacist and close monitoring by the PCM of all prescribed medication.

Admiral GREENERT. Navy's equivalent of the WTU is Safe Harbor, which has not noted any major substance abuse problems. While the other Services' average wounded warrior population is 19–20 years old, unwed and live in a barracks environment, Navy has an older population. The average Navy wounded warrior is 34 years of age. Sixty-one percent of the Safe Harbor population is married. Navy transition sailors in this program close to their homeport or command, whichever is more convenient for the servicemember. Both of these factors, older average age and environmental stability, may tend to reduce substance abuse.

General AMOS. By virtue of their wounds, illnesses or injuries and subsequent treatment, our Wounded Warriors are an at-risk population for substance abuse. Wounded, ill or injured servicemembers utilize prescribed pain medications at a higher rate than the general military population because of their medical conditions. We are aware that servicemembers, in particular, with PTSD may use alcohol as a way to try to relieve PTSD symptoms. With this heightened awareness, our wounded warrior battalion staff screens new admissions, reconciles their medication use, and refers marines in need to appropriate treatment programs. The WWR also supports alternatives to pain medication such as acupuncture, yoga, electrical stimulation and biofeedback to decrease the need for traditional pain medications.

General CHANDLER. The Air Force does not have WTUs. Based upon information from PDHAs and PDHRAs, there is no current evidence of a significant trend in substance abuse issues for deploying personnel in the Air Force.

PSYCHOTHERAPEUTIC DRUGS

31. Senator BURRIS. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, in light of recent concerns that some psychotherapeutic drugs could actually increase the risk of suicide, what controls are in place to ensure that patients taking multiple drugs are receiving proper clinical review?

General CHIARELLI. The increasing rate of soldier suicide in the past 5 years has received the proactive attention of senior Army leadership and has led to an unprecedented effort to comprehensively address all known domains of risk reduction, to include recent policies directing more in-depth oversight of medication prescribing. The intent is to minimize iatrogenic risks e.g., overdosing on respiratory drive depressants such as narcotics, particularly in combination with alcohol and/or other central nervous system depressants, etc.

In June 2009 the Office of the Surgeon General/U.S. Army MEDCOM issued guidance to providers caring for patients who receive treatment with multiple medications. This policy was revised in September 2009, and is currently being updated further to fully address the concerns of polypharmacy among soldiers receiving treatment, especially when psychotropic agents or central nervous system depressants are involved. The purpose of this policy is to provide guidance on the prevention and management of polypharmacy with psychotropic medications and central nervous system depressants to reduce adverse events and optimize clinical outcomes among soldiers. This policy mandates that care providers carefully monitor soldiers with complex or multiple medical and/or behavioral health problems to reduce the risk of serious drug interactions and polypharmacy. Providers will review the medication profile at each visit, assess for ongoing clinical indications for medication treatment, screen for the potential side effects, including the effects of drug-drug

interactions, and refer to a clinical pharmacist for further review and reconciliation if the number and nature of the patient's medications triggers a pharmacy referral.

Risk has been greatly reduced for WTU soldiers, who are at the highest risk among our troops, by implementing intensive monitoring by primary care physicians in close collaboration with pharmacists assigned to the WTUs. Consequently, soldiers' medications are reviewed within 24 hours of arrival in the WTU, reviewed thereafter at least weekly, and more often if changes in dosage or medication are made in the course of treatment. High risk soldiers are assigned to only one health care provider to access controlled medications that may put them at greater risk. Soldiers who have demonstrated difficulties in complying with treatment on opioid analgesics and other controlled medications are enrolled in the Sole Provider Program for more intense monitoring and control.

Admiral GREENERT. National Patient Safety Goals of the Joint Commission of Hospital Accreditation regarding medication requires medication reconciliation at each patient encounter which includes a full review of all medications a patient is currently taking. The review is performed not only by the provider, but also the pharmacist dispensing the medication.

The local Military Treatment Facility (MTF) Pharmacy and Therapeutics Committees also review all adverse drug reactions and report those of significance to the FDA via a MEDWATCH form. The FDA also requires a Risk Evaluation and Mitigation Strategy (REMS) on certain drugs (many psychotropics and opiates are included) to ensure the benefits outweigh the risks. As part of the REM a Medication Guide is required to be dispensed to the patient to help avoid serious adverse events and warn the patient of any risks.

Additionally, Case Management works closely with the behavioral health providers to ensure that members receive the correct medications and understand the instructions for use. Case managers perform medication review/reconciliation in AHLTA (electronic records system) and provide education and drug interaction information for those patients taking multiple drugs.

General AMOS. While I defer to the military medicine professionals regarding appropriate management of all medical conditions, the Marine Corps is committed to engaged leadership. We are attentive to the mental health of our warriors and we are dedicated to ensuring that all marines and family members who bear the invisible wounds caused by stress receive the best help possible. We developed the Combat Operational Stress Control (COSC) program to prevent, identify, and holistically treat mental injuries caused by combat or other operations.

General CHANDLER. Proper clinical review is assured through education, policy, and process.

It is correct that psychotropic medications such as antidepressants and anticonvulsants may cause a small increase in suicidal risk in patients. Air Force providers have received education on this risk from multiple sources including professional organizations, their medical treatment center leadership, pharmaceutical companies, and the DOD Patient Safety Center.

AF MTF pharmacy and therapeutics committees review medication safety information and medication alerts from agencies such as the Food and Drug Administration (FDA) and educate providers at professional staff meetings on new safety information on medications.

By Air Force Surgeon General policy, the Chief of the Medical Staff at each MTF is charged with assuring the proper education of providers on medications and their effect on suitability for continued service and deployment. Deploying airmen are required to demonstrate more than 90 consecutive days of stability on psychotherapeutic medications before deployment. In the case of suicidal risk, airmen at higher risk are tracked weekly by the mental health clinic, which communicates with the command and the patient's primary care physician.

Overuse of pain medications can pose a larger risk. In January 2009 the Surgeon General instructed ongoing review of patients with chronic pain by MTFs via pharmacy and therapeutics committees, a staff communication log or multidisciplinary review forum. These venues help assure that individuals at risk for overuse of opiate medications are prevented from engaging in dangerous use of the medication.

Finally, pharmacy staff are trained to check for therapeutic duplications, drug-drug interactions, and that the patient is taking medications as prescribed (e.g., not receiving early prescription refills).

In summary, adverse effects from medication or misuse of medications do occur, but through education, policy and procedure, the Air Force works to minimize these risks.

PREVENTION PROGRAMS

32. Senator BURRIS. General Chiarelli, Admiral Greenert, General Amos, General Chandler, and Dr. Jesse, DOD and VA, as well as each of the individual Services, have numerous programs and initiatives in place to put emphasis on suicide prevention. However, as the statistics show, the success of these programs is questionable. Are there any independent oversight entities at DOD and VA to monitor these programs?

General CHIARELLI. At this time there are no independent oversight entities within DOD to monitor the programs and initiatives in place. However, the SPARRC meets regularly to share and discuss the numerous programs and initiatives in place across DOD. In addition, the SPARRC has representation from the VA to ensure interagency collaboration on suicide prevention efforts.

The congressionally mandated DOD Suicide Prevention Task Force has spent the past year conducting a comprehensive analysis of the numerous programs and initiatives currently being used within DOD. Their findings will highlight areas of strength and identify areas for improvement for DOD's suicide prevention programs.

Admiral GREENERT. The DCoE for Psychological Health and TBI chairs the SPARRC, which was formed to establish standard definitions, standardize reporting requirements, track suicide rates, collaborate with other experts in the field, and advise and coordinate future DOD prevention initiatives. The DCOE and the SPARRC consult numerous entities, such as the RAND Corporation, for program evaluation and feedback.

Members of the SPARRC include non-service entities such as VA, Substance Abuse and Mental Health Association, the USUHS, and recognized civil sector experts.

The Annual DOD/VA Suicide Prevention Conference is a collaborative body for sharing best practices.

The Joint Commission provides oversight to MTFs.

Navy efforts to assess effectiveness of programs have included an upcoming study, in conjunction with USUHS, on the effectiveness of the latest suicide prevention training.

General AMOS. I defer to DOD and VA.

General CHANDLER. The DOD SPARRC serves as an important forum for sharing Service initiatives and has established standardized data collection and reporting processes. This data standardization is essential for evaluating the ultimate effectiveness of Service suicide prevention programs. The forum for sharing initiatives allows the Services to benchmark the practices reviewed at the SPARRC. The SPARRC also leads the annual DOD/VA Suicide Prevention Conference, which provides a review of military and civilian programs from around the country. The Surgeons General and Assistant Secretary of Defense for Health Affairs monitor and discuss suicide prevention efforts through the Senior Military Medicine Advisory Council. There is also strategic planning for provision of mental health services, including suicide prevention, between the DOD and VA under the DOD/VA Senior Oversight Council. Within the Air Force, suicide prevention data is monitored weekly by the Chief of Staff. Additionally, the Air Force had its suicide prevention program evaluated by outside experts and the Air Force Suicide Prevention Program has been identified as a best practice on the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration list of evidence-based programs for the prevention of suicide.

Dr. JESSE. Oversight of VA's Suicide Prevention Program is managed by internal administrative structures as well as the VA Suicide Prevention Steering Committee, a group composed of members representing various and relevant VA groups. The member list follows:

Ira Katz, MD, PhD, Senior Consultant for Mental Health Program Analysis, Co-Chair

Kerry Knox, PhD, Director, Center of Excellence at Canandaigua, Co-Chair

Robert Bossarte, PhD, Acting Chief, Epidemiology and Health Services Research, Center of Excellence

Charles Clancy, MSW, Chief, Social Work Service, Louisville VAMC

Susan G. Cooley, PhD, Chief, Geriatric Research and Evaluation, Chief, Dementia Initiatives, Office of Geriatrics and Extended Care

Charles Flora, Associate Director, Readjustment Counseling Services (RCS)

Theresa Gleason, PhD, Program Specialist, Office of Research and Development, VACO

Kim Hamlett-Berry, PhD, Director, Office of Public Health Policy and Prevention, VACO
 Terri Huh, PhD, Associate Director for Education and Evaluation, VA Palo Alto GRECC
 Mark Ilgen, PhD, VA Serious Mental Illness Treatment Research and Evaluation Center (SMITREC)
 Bradley Karlin, PhD, Director, Psychotherapy Programs, Office of Mental Health Services, VACO
 Janet Kemp, PhD, Mental Health Program Director, Suicide Prevention and Chief Education, Training and Dissemination, VISN 2 Center of Excellence
 Laurent Lehman, MD, Coordinator, Mental Health Disaster Response, VACO
 Peter Mills, PhD, Director, Field Office, VA National Center for Patient Safety, White River Junction VAMC
 Edward Post, MD, PhD, VA Health Service Research and Development (HSR&D), SMITREC
 Todd Semla, MS, PharmD, Pharmacist Specialist, Hines VAMC
 Suzanne Thorne-Odem, RN, MS, Mental Health Clinical Nurse Advisor, Office of Nursing Services
 Gary Tyndall, MD, Emergency Department Medical Director, Syracuse VAMC
 Marcia Valenstein, MD, VA HSR&D, SMITREC
 Antonette Zeiss, PhD, Acting Deputy Chief, Mental Health Services, VACO

VA is beginning to see some level of success since the inception of our comprehensive suicide prevention programs. Although the trends are promising, it is still too early to determine if they are sustainable. There has been a decrease in suicide rates among Veterans who receive care in the VA from 2001 through 2007 (the last year for which national data are available). We will continue to monitor these rates. In addition, there are numerous anecdotal stories and documented information concerning callers to the Hotline and referrals to the Suicide Prevention Coordinators that indicate that the numbers would be much higher without these programs. We will continue to implement new programs as the evidence builds for specific interventions and strategies, but in the meantime we will maintain the programs we have in place with continued emphasis on the identification of those Veterans at risk in order to provide enhanced levels of care.

TRAUMATIC BRAIN INJURY TREATMENTS

33. Senator BURRIS. General Chiarelli, Admiral Greenert, General Amos, General Chandler, and Dr. Jesse, a recent study at Louisiana State University's School of Medicine used hyperbaric oxygen therapy on blast-injured veterans to repair brain injuries. The results were rather impressive, with treated veterans showing a 15-point IQ increase, a 40 percent reduction in post-concussion syndrome symptoms, a 30 percent reduction in post-TBI symptoms, and a 51 percent reduction in concussive depression. Is this a treatment option that is currently being examined by DOD or by VA?

General CHIARELLI. Yes, in the next few weeks the U.S. Army Medical Research and Materiel Command and the DCoE for Psychological Health and TBI will be initiating a pilot study of hyperbaric oxygen for traumatic brain injured patients. We are aware that the Navy and Air Force are also conducting or participating in research involving oxygen therapies. The results of all of these DOD trials will solidify the pivotal, larger, multicenter clinical trial scheduled to begin early 2011.

We believe the military studies by design will further answer definitive questions where other studies anecdotally report results without adequate controls to distinguish real treatment safety and effectiveness from other confounding factors such as the placebo effect, the Hawthorne effect and the practice effect from repeated testing. The Louisiana work mentioned above are initial results from a pilot study that has not been published in the peer-reviewed medical literature at this time, so details of this study are limited and the strength of inferences about the effect of hyperbaric treatment are limited because this study lacked a non-hyperbaric oxygen control group.

Admiral GREENERT. Navy Medicine is committed to providing all available therapies to servicemembers and their families as soon as there is sufficient evidence to ensure safety and efficacy of the therapy. DOD has three placebo-controlled clinical trials planned or in progress on the use of hyperbaric oxygen. Two of these are feasi-

bility studies which will provide information on appropriate selection of hyperbaric oxygen doses and pressures as well as efficacy of procedures utilized in providing exposure to affected individuals. One of these is a large prospective, efficacy study to assess the effects of hyperbaric oxygen therapy on the symptoms of mild and moderate TBI. One of the feasibility studies is expected to have data available in early 2011 and the other in late 2011. The large efficacy study will have data available in 2014. Navy Medicine is funding travel for active duty servicemembers to participate in these studies and, in partnership with the VA, is the lead for one feasibility study.

The study which is referred to in this question does not appear to have been published in a peer-reviewed journal; the results, however, are encouraging and it is hoped the DOD trials will provide confirmation as to efficacy and safety, as this would allow our wounded servicemembers and their physicians to have another therapeutic option available.

General AMOS. DOD has three placebo-controlled clinical trials planned or in progress. Marines who desire to participate in these studies, after appropriate informed consent, will have leadership support in doing so. In fact, in one study currently underway 90 percent of the subjects are marines or former marines.

General CHANDLER. Congressional support for current Air Force HBOT for TBI research is sufficient and greatly appreciated. DOD research on HBOT for TBI is in its infancy and is centered on chronic mild and moderate TBI. It remains an unproven therapy and is not accepted as a standard of care because only anecdotal case reports and a small series of trial reports indicate some potential benefit for TBI. Several prospective randomized clinical trials are underway within DOD and civilian institutions to provide more conclusive evidence regarding HBOT's use for TBI. Definitive phase 3 trials, which will take 2–3 years and include randomized, multi-center (DOD facilities only), double blind, definitive studies under the auspices of the FDA with an investigational new drug registration, are projected to start in the fall of 2010. If this research validates the efficacy of HBOT for TBI, we will request additional congressional support for the sustainment and possible expansion of hyperbaric chambers and personnel in addition to presenting the evidence to the Undersea and Hyperbaric Medical Society for consideration as an accepted indication for use.

Dr. JESSE. Yes. DOD and VA are actively collaborating on the development and implementation of a portfolio of research projects focused on understanding the benefits of hyperbaric oxygen therapy (HBOT) on the efficacy and utilization of HBOT for treating mild traumatic brain injury (TBI) and post-concussive symptoms. This collaboration has three pilot trials and one large definitive trial. A joint VA, DOD, and academic task force recommended the research designs, implementation and outcome measures for all of the trials.

A VA clinical researcher is participating in the clinical trial that has begun recruiting subjects at Quantico Marine Base, and VA neuropsychologists are coordinating the data collection and analysis of the definitive trial. The full definitive trial in Salt Lake City, UT, is projected to begin in late 2010.

While HBOT demonstrates effectiveness in treating certain disorders, there are presently only clinical reports but no demonstrated double-blinded, controlled, scientific evidence that supports using HBOT to treat mild TBI. Presently, neither the Food and Drug Administration (FDA) nor the Undersea and Hyperbaric Medical Society—the medical specialty society and authority that provides guidance to Centers for Medicare and Medicaid Services (CMS) for use of HBOT—recognize use of HBOT as a primary or adjunctive therapy for TBI.

QUESTIONS SUBMITTED BY SENATOR JAMES M. INHOFE

NPR AND PROPUBLICA INVESTIGATION INTERVIEW

34. Senator INHOFE. General Chiarelli, please provide your interview responses to the NPR and ProPublica for the record.

General CHIARELLI. A copy of my letter to NPR is attached. There are no other recorded responses. David Zwerdling of NPR spent 6 hours with me at Fort Carson, CO, touring the WTU, but there was no formal recorded interview.



DEPARTMENT OF THE ARMY
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201 ARMY PENTAGON
WASHINGTON DC 20310-0201

JUN 14 2010

Ms. Vivian Schiller
President & CEO
National Public Radio
635 Massachusetts Avenue, NW
Washington, DC 20001

Dear Ms Schiller:

I am compelled to respond to the recent articles by NPR reporter, Dan Zwerdling regarding care of our Wounded Warriors suffering from Traumatic Brain Injury (TBI). I do believe we agree on one important issue: our Soldiers deserve the very best medical treatment and support available.

That said, while I acknowledge Mr. Zwerdling's right to express his opinions, I strongly disagree with his depiction of efforts by Army senior leaders and medical professionals related to the care and treatment of Soldiers suffering from TBI. In particular, his assertion that Army leaders and medical professionals are minimizing – or worse – deliberately neglecting these injuries is simply not true. Certainly the abundance of evidence readily available today to Members of Congress, the general public and journalists alike clearly contradicts such assertions. Your audience was not afforded an opportunity to see a far more current balanced view of the efforts being made along the continuum of care from prevention to mitigation, early management healing and rehabilitation.

NPR's disparaging commentary is particularly disappointing as I personally invited Mr. Zwerdling to accompany me on a recent trip to Fort Carson, Colorado to visit the Warrior Transition Unit (WTU). Throughout the duration of the one-day trip he was provided access to facilities and medical personnel caring for Soldiers and family members. My goal was to ensure he gained a full, accurate appreciation for the programs and efforts in place specific to TBI and also post-traumatic stress (PTS). Yet, very little of the information relayed or gathered during that visit is reflected in Mr. Zwerdling's articles.

I consider PTS and TBI to be very difficult invisible injuries of the 'signature weapon' of this war: blast. In fact, the majority (60%) of the Soldiers enrolled in the Army's Wounded Warrior program have PTS (43%) and/or TBI (17%) as a primary diagnosis. I, and the Army's other senior leaders, are absolutely committed to doing anything and everything possible to help these Soldiers at all stages of care, even after they leave military service.

We readily acknowledge these injuries pose unique challenges, especially as compared to easily-detectable wounds such as amputations and burns. In fact, PTS and TBI are among the most difficult and debilitating in terms of accurate diagnosis,

care and recovery. The study of the human brain is an emerging science, and there is still much to be learned about these and other highly-complex injuries involving the brain. This pertains not just within the military medical community, but throughout the entire medical community as a whole, worldwide.

We are making progress, both in theater and at medical facilities around the world. In a concerted effort to minimize the number and severity of injuries, the Army implemented a new TBI management strategy across the force aimed at prevention, early detection and effective treatment of injuries. Education is key; we must teach our Leaders, Soldiers and family members about these injuries, the possible symptoms and what is required for full recovery. Additionally, the Army is instituting a revised program of instruction for medics and other behavioral health providers that includes training specific to TBI and PTS injuries. The new TBI management strategy also includes strict 'event-based' protocols that govern exactly what Leaders and Soldiers must do if involved in any type of concussive event. At a minimum, every Soldier must undergo a medical evaluation followed by a mandatory 24-hour downtime period and a second exam before returning to duty. We cannot permit the Warrior spirit of our Soldiers, which leads them to ignore their concussions and remain in the fight to dominate the competing need to protect themselves against another injury during the vulnerable period of healing.

Meanwhile, back at home, since 2002 the Department of Defense has opened 52 TBI treatment centers across the country. These centers are staffed with multidisciplinary teams of medical providers capable of treating the full range of TBI, from mild to severe. The National Intrepid Center of Excellence, dedicated to research and the treatment of military personnel and veterans suffering from TBI and other behavioral health issues will open this summer. It is built on the Bethesda, Maryland campus of what will become the new Walter Reed National Military Medical Center, the DoD's largest and most advanced medical complex and across from the National Institutes of Health—a key partner in advancing the science and treatment of these injuries and illnesses.

The reality is today some of these neurological injuries or conditions cannot be fully repaired or healed even with the most advanced medical treatment available. Unlike an amputation, for example, there is no standard procedure or prognosis for care of severe TBI. This can understandably add to the frustration felt by affected Soldiers and family members. While they are entitled to speak freely about their injuries to members of the media, HIPPA regulations and medical ethics restrict others, to include U.S. Army officials and medical personnel from doing so.

In the past, individuals suffering from TBI, PTS or what was previously referred to as "battle fatigue" were often told there was nothing more that could be done for them. They were discharged from the military and left to suffer in silence. This is absolutely unacceptable. Next to the prosecution of current and future conflicts, our highest priority remains caring for the men and women who serve and sacrifice on behalf of our Nation.

In 2007, the Army established Warrior Transition Units (WTU) to facilitate the treatment and rehabilitation of Soldiers determined to require complex medical care for six months or longer. Today, there are 29 installation-based WTUs and nine community-based WTUs located around the world. Approximately 9,300 wounded or injured Soldiers are receiving treatment at these facilities. Teams comprised of nurse case managers, health care providers and cadre members assist them and their families through the full recovery process. The feedback has consistently been very positive. And, we are continually making improvements to the care and services provided at these facilities based on lessons learned.

The Army activated the Warrior Transition Command to oversee the WTUs and to guide the ongoing execution and development of the Warrior Care and Transition Program. The overarching goal is to help Soldiers and Veterans to heal physically and mentally while building bridges to positive opportunities that lie ahead for them in the future.

These are just a few of the many collaborative efforts currently underway relevant to the very real and complex challenges of TBI and PTS injuries. As the Army's Vice Chief of Staff, I remain dedicated to ensuring our Soldiers suffering from TBI and PTS receive the proper care and treatment required. We owe the men and women who serve our Nation a tremendous debt of gratitude, especially those who sacrificed so greatly. The United States Army's Warrior Ethos states: "I will never leave a fallen comrade." I assure you and others that we remain fully committed to keeping that promise to our Soldiers every day of their lives. I would welcome any invitation to discuss this issue further at your convenience.

Sincerely,



Peter W. Chiarelli
General, U.S. Army
Vice Chief of Staff

THIS LETTER FALLS
SHORT OF CONVEY-
ING THE DEPTH OF
MY CONCERN ABOUT
THIS "INVESTIGATIVE"
REPORTING.

HEALTH AND QUALITY OF THE FORCE

35. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, the strength of our military is in its people—our service men and women, their families, and our civilians who support them. We know the deployments over the past decade have astronomically increased the strain and stress on the force, presenting specific indicators such as an increase in suicide rates, divorces, substance abuse, and in some instances, murders and other serious criminal activity. This committee is aware of shortfalls in the manning of our medical units in certain medical specialty areas such as mental health care specialists and providers. What is being done to get after the mental health care provider issue?

General CHIARELLI. Since 2007, the Army has added 1,265 civilian, military and contract behavioral health (BH) providers to help meet the needs of a stressed and growing force. This represents a 69 percent increase in BH assets. The Army currently has approximately 89 percent of its current BH provider requirements. The Army Medical Department continuously monitors the need for BH providers based on the reliant population's ongoing and changing demand. While access to BH care providers is critical, it is just one aspect of the holistic approach the Army is implementing to address the mental fitness and resilience of our soldiers.

Behavioral Health (BH) hiring difficulties are not due to lack of funding. Hiring difficulties continue to stem from the National shortage of qualified providers, the need for these providers in remote locations, and compensation limitations inherent to government employment. The Army is using numerous mechanisms to recruit and retain both civilian and military providers including bonuses, scholarships, and an expansion in training programs. The U.S. Army MEDCOM has increased funding for scholarships and bonuses to support expansion of our provider inventory.

The Army expanded the use of the Active Duty Health Professions Loan Repayment Program and offers a \$20,000 accessions bonus for Medical and Dental Corps Health Professions Scholarship Program (HPSP) applicants. MEDCOM increased the number of HPSP allocations dedicated to Clinical Psychology and significantly increased the annual number of graduate students admitted to its Clinical Psychology Internship Program. Prior to 2004 the Army historically trained 12 interns per year and has progressively increased that number, admitting 33 interns in 2009. In addition, the Army is attempting to hire or contract an additional 146 psychologists.

MEDCOM provided centrally funded reimbursement of recruiting, relocation, and retention bonuses for civilian BH providers to enhance recruitment of potential candidates and retention of staff. The Army used a one-time Critical Skills Retention Bonus (CSR) for social workers and BH nurses and the Army Medicine CSR for clinical psychologists. The Army also implemented an officer accessions pilot program that allows older healthcare providers to enter the Army, serve 2 years, and return to their communities.

In partnership with Fayetteville State University, MEDCOM developed a Masters of Social Work program which graduated 19 in the first class in 2009. The program has a current capacity of 30 candidates.

Admiral GREENERT. The current Navy mental health workforce (including uniformed, government service and contract personnel) are trained to address combat, operational, developmental, and occupational mental health needs and meet the access to care standard for an initial assessment.

Navy Medicine is expanding its medical end-strength that is organic to the Marine Corps, including mental health providers. Further, Navy has met the fiscal year 2010 NDAA Section 714 requirement to grow mental health by 25 percent, which has been programmed to begin in fiscal year 2011. This would be additive to the figures identified below. The resulting increase in our beneficiary mission is currently planned and funded to be handled through direct and private sector care.

Despite outstanding efforts to aggressively recruit and retain qualified medical personnel, manning remains below authorized levels.

As of June 2010 uniformed Mental Health manning percent (Inventory/Billets) is as follows:

- Psychiatry - 83 percent (93/112)
- Clinical Psychology - 81 percent (105/127)
- Social Work - 69 percent (24/35)
- Mental Health Nurse Practitioners - 60 percent (12/20)

Navy Recruiting Command is addressing these shortages through aggressive recruiting/accession programs. Incentives are a key component of recruiting. fiscal year 2010 incentives include:

- Psychiatrists - eligible for critical wartime specialty bonus of \$272,000
- Clinical Psychologists - eligible for \$37,000 (with 3 year contract) or \$60,000 (with 4 year contract)
- Social Workers - eligible for \$18,750 (with 3 yr contract) or \$30,000 (with 4 year contract)
- Mental Health Nurse Practitioners - All nurses are eligible for the standard bonus of \$20,000 (with 3 year contract) or \$30,000 (with 4 year contract).

General AMOS. First off, the billets within the Marine Corps for psychological health care providers are a priority fill for Navy Medicine. To date, all of these billets have been successfully filled. I defer to Navy Medicine to answer their manning issues for the medical enterprise in its entirety.

General CHANDLER. The Air Force continues to face challenges to recruit and retain fully qualified mental health specialists as we compete with the private sector and other Federal agencies where multiple deployments are not an issue. There are significant pay disparities, increasing sign-on bonuses, annual compensation packages, and retirement packages offering similar benefits as the military.

To address these issues, the Air Force has an aggressive three-pronged approach to enhance recruitment and retention of mental health care providers.

The first is to offer educational scholarships and "grow our own" specialists over time. This includes training through the Uniformed Services University of the Health Sciences and through civilian or military-sponsored psychiatry and psychology residency and subspecialty programs. We have also optimized our enlisted commissioning programs, such as the Nurse Enlisted Commissioning Program as a pipeline into the mental health specialties of mental health nurse and psychiatric nurse practitioner. Additionally, the Air Force gains new health professionals through other training venues, such as the Airman Education Commissioning Pro-

gram, Reserve Officer Training Corps, and United States Air Force Academy. The Nurse Transition Program is a robust recruiting tool that also feeds the mental health nurse pipeline. It provides an incentive for new nursing graduates to consider Air Force nursing as a career option upon graduation. Other educational opportunities include aggressive use of subspecialty training and post-baccalaureate-awarding degree programs for our Nurse Corps officers to go into specialties such as the mental health field. Our optimization project partners mental health specialties with Veteran Affairs hospitals and other non-Federal facilities. "Growing our own" encompasses accessing new recruits, developing their skills and specialties, and maintaining and expanding on those capabilities for use in both state-of-the-art medical centers and to the deployed and austere environments of wartime and humanitarian missions.

The second is enhanced recruiting and retention of mental health professionals is through direct compensation with associated service obligations to encourage mental health specialists to make the Air Force their career. The Air Force has funded accession and multiyear bonuses, and incentive pay to recruit and retain selected fully qualified mental health specialists. These have a positive effect on recruiting and retention. Each bonus has caps and the larger bonuses have multiyear contractual requirements. Although it does not reach parity, the contractual incentive packages help offset some of the pay disparities between the military and private sector compensation packages. The ability to recruit and retain fully qualified specialists without bonuses is extremely limited.

Lastly, our members grapple with decisions to remain in the service and we understand the family is greatly involved in this decision. Quality of life issues concerning the availability of schools, frequency of moves and deployments, and general base services are at the forefront of any discussion. We have addressed many of these issues both for the new member and the 20-plus year veteran. For those mental health specialties with increasing wartime deployments, we are able to spread the deployment load more evenly among our bases and members. By keeping our deployments at 6 months in duration, we can maintain predictability, stabilize our force and retain more of our skilled assets. The Family Health Initiative with embedded Behavioral Health is a medical model that better leverages our personnel. We are partnering to build force sustainment models and being more proactive in managing the numbers of professionals in each mental health specialty.

While recruiting and retention of the mental health professions remains a challenge, we remain committed to exercise all available authorities in concert with the other Services and under Health Affairs to obtain the best value in mental health care for our Nation's military and their family members through enhanced recruiting and retention efforts maximizing the tools provided for education, compensation, and quality of life efforts for our mental health professionals.

PRE- AND POST-DEPLOYMENT COGNITIVE ASSESSMENTS

36. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, the NDAA for Fiscal Year 2008 (Public Law 110-181) required capability to conduct both pre- and post-deployment cognitive assessments of the same type for a comprehensive, comparable process. Recent reports by the Army Surgeon General state that data from an in-theater study of cognitive assessment technology selected by DOD for pre- and post-deployment assessment was no better than a "coin-toss". However, a recent study of more than 10,000 pre- and post-deployment assessments collected at Fort Campbell, KY, indicates that cognitive assessment accurately reported cognitive change associated with TBI and even differentiated levels of cognitive change associated with mild TBI incidents. Why are cognitive assessments good enough for the pre-deployment assessments but not for the post-deployment assessments?

General CHIARELLI. The intent of Army medicine is to use the best available evidence-based tools to identify, evaluate, and treat our soldiers. The Automated Neuropsychological Assessment Metrics (ANAM) is administered prior to deployment in order to obtain a baseline of cognitive functioning. This is necessary because there is a wide range of individual differences in cognitive function. The ANAM baseline can be compared to post-injury assessments and help guide decisions about further assessments and intervention. Follow-up cognitive assessment is conducted if a soldier experiences any event that results in potential decreased cognitive functioning. The results of the ANAM test may help healthcare staff compare a soldier's speed and accuracy of attention, memory, and thinking ability before and after an injury.

Screening for mild TBI, also known as concussion, is intended to capture those soldiers who may have sustained a TBI while deployed and perhaps have symptoms that require further assessment and treatment. Positive screens are not diagnostic of TBI but do trigger a clinician interview for further evaluation. Screening for TBI now takes place proximate to the time of the injury event, similar to how medical clearance is required after aviation incidents. The Army implemented the “Educate, Train, Treat, and Track” mTBI/concussive injury management strategy in late 2009. This management strategy was reinforced by DTM 09-033 dated 21 June 2010, titled “Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting”. This DTM directs that that any soldier who sustains a direct blow to the head, or is dismounted within 50 meters of a blast, or is in a building or vehicle damaged by a blast/accident must undergo a medical evaluation. This early identification of concussion and immediate intervention with 24 hours rest and medical clearance prior to return to duty should go a long way to improve the health of our soldiers.

Since May 2008 all soldiers returning from deployment answer a series of questions on the PDHA that report exposure to injury event, presence of subsequent loss of consciousness or alterations in consciousness, presence of symptoms at time of injury, and presence of current symptoms. The third post-deployment screen occurs during the PDHRA conducted 90–180 days after return from deployment. These tools reveal whether an event occurred and whether any symptoms have resulted. Detailed cognitive assessments, which the ANAM is a component, can then be performed as part of a larger medical workup as necessary.

Admiral GREENERT. The NDAA for Fiscal Year 2008 required pre-deployment testing but did not specify that post-deployment testing be done with the same instrument as for pre-deployment testing. The Automated Neurocognitive Assessment Metrics (ANAM) assesses only cognition, but in the pre-deployment window serves adequately to establish a baseline for comparison later on if an individual is exposed to blast or suffers a concussion. It sets a baseline, but does not serve as a screening test.

The goal of the post-deployment screening is to identify all servicemembers who may be having persistent symptoms from a concussion/TBI and thus need further evaluation. This is accomplished through the PDHA and PDHRA. The most common clinical symptom following concussion is headache. Concussion can produce a variety of symptoms (with or without cognitive dysfunction) such as headache, dizziness, insomnia, irritability, mood and anxiety disturbances, in addition to isolated cognitive disturbances. Navy Medicine is focused on evaluating and treating all aspects of post-concussion symptoms.

Navy Medicine providers using their clinical judgment, request detailed neurocognitive testing in the post-deployment period as warranted. Neurocognitive assessments are focused exclusively on assessing cognition and the ANAM measures only select areas of global cognition. Comprehensive neuropsychological testing is indicated when servicemembers are being seen for comprehensive evaluation. The recent Ft. Campbell study uses ANAM for pre- and post-deployment screening and reports (although not yet in a peer-reviewed journal) significant improvement in minimizing false-positive test results. However, this study did not examine the false-negative rate (where servicemember is re-assured that testing is normal yet has cognitive impairment); this is a significant omission and would have implications on the utility of ANAM for routine post-deployment testing.

General AMOS. The recent Fort Campbell study uses ANAM for pre- and post-deployment screening and reports (although not yet in a peer-reviewed journal) significant improvement in minimizing false-positive test results. However, this study did not examine the false-negative rate (where servicemember is re-assured that testing is normal yet has cognitive impairment); this is a significant omission and would have implications on the utility of ANAM for routine post-deployment testing.

The NDAA required pre-deployment testing but did not specify that post-deployment testing be done with the same instrument as for pre-deployment testing.

The Automated Neurocognitive Assessment Metrics (ANAM) serves adequately to establish a baseline for comparison later on if an individual is exposed to blast or suffers a concussion. It sets a baseline, but does not function well as a population screening test.

DOD is actively researching a variety of cognitive assessments that will efficiently and accurately sort out servicemembers who have or at high risk for persistent TBI signs or symptoms from those who do not.

The recent publication of the DTM 09-033 that mandates tracking of servicemembers exposed to potentially concussive events will significantly improve defining the highest risk marines that require close follow up.

General CHANDLER. The Air Force agrees with the Army Surgeon General that the Automated Neuropsychological Assessment Metric (ANAM) is poor at detecting TBI. The broad scientific consensus is that ANAM is not a useful tool for pre- and post-deployment assessment of cognitive impairment due to lack of specificity about impaired scores on testing. Neurocognitive assessments are very sensitive to external factors such as sleep disturbances (which are common in post-deployment servicemembers due to extended travel and time zone changes), as well as testing environments (rooms filled with multiple people taking tests simultaneously). Also, since cognitive performance patterns for uninjured post-deployed servicemembers are not known; the clinical utility of these test results from all post-deploying servicemembers would be minimal. Given high false positive rates, retesting everyone on redeployment would result in a prohibitive number of unnecessary referrals. Currently, using ANAM only when clinically indicated (after concussive event) together with neurocognitive assessments, is useful to assist in clarifying the extent of cognitive impairments in those who may subjectively complain of cognitive symptoms.

37. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, why aren't post-deployment assessments being conducted by the Services?

General CHIARELLI. Post-deployment assessments are currently underway by all Services. The PDHA and the PDHRA solicits any history of TBI and any symptoms resulting from TBI. Based on a review of all PDHA responses from 2004 as reported in the Journal of the American Medical Association in 2006, the PDHA detects a 19.1 percent positive screening rate. These symptom questionnaires are a proven reliable and valid method of determining if servicemembers require or desire further evaluation/treatment. Both the PDHA and PDHRA are constantly being improved, and are now entering their third generation of development. In addition, the Army is fielding an Automated Behavioral Health system to enhance screening for PTSD and other behavioral health problems.

Admiral GREENERT. Post-deployment assessments are being conducted by the Navy and include screening for TBI. Post-deployment assessment of individuals follows Institute of Medicine recommendations to evaluate the spectrum of concussion symptoms (cognitive, behavioral, and physical) and then to complete neurocognitive testing on individuals who have a positive TBI screen when the clinical assessment requires it. The current method to complete this TBI screen is through the PDHA and PDHRA, which all returning deployers are required to complete. Navy reports overall Navy PDHRA compliance at 90 percent (87 percent Active component and 96 percent Reserve component).

General AMOS. Post-deployment assessments are being conducted. Post-deployment Assessment of individuals follows Institute of Medicine recommendations to evaluate the spectrum of concussion symptoms (Cognitive, Behavioral, and Physical) and then to complete neurocognitive testing on individuals who have a positive TBI screen when the clinical assessment requires it. The current method to complete this TBI screen is through the PDHA and PDHRA, which all returning deployers are required to complete.

General CHANDLER. The Services are conducting post-deployment assessment by asking about concussive events during deployment and TBI symptoms the patient is experiencing. If the patient reports a concussive event or cognitive symptoms they are referred to a provider for assessment. The broad scientific consensus is that the ANAM is not a useful tool for post-deployment assessment of cognitive impairment due to lack of specificity about impaired scores on testing. In addition, given a high false positive rate, retesting everyone on redeployment would result in a prohibitive number of unnecessary referrals. Current retest using ANAM only when clinically indicated (after concussive event) is preferred. In addition, patients with continued cognitive complaints are referred to a neuropsychologist for a series of cognitive tests able to diagnose the specific problems better than the ANAM. The Air Force is conducting post-deployment assessments via the PDHA and Post-Deployment Health Risk Assessment (PHDRA) and TBI questions were added to the PDHRA Questionnaire in Jan 2008.

38. Senator INHOFE. General Chiarelli, is there an official version of the in-theater study by the Army available? If so, can we be provided with the details of the study to include the study design, the data, and the study summary?

General CHIARELLI. Yes, the National Academy of Neuropsychology has the in-theater results available at: <http://www.nanonline.org/NAN/Conference/Handouts.aspx> under Course 51, Russell et al.

39. Senator INHOFE. General Chiarelli, the ANAM pre-deployment/post-deployment study at Fort Campbell showed the following results regarding false positives:

- 2 percent when a post-deployment assessment was compared with a baseline pre-deployment assessment
- 20 percent when a post-deployment assessment was not compared with a baseline pre-deployment assessment

Are you aware of the study at Fort Campbell and can you provide comment to the results, to include clarification on false positives?

General CHIARELLI. The official results of the Fort Campbell study, conducted by researchers from the Walter Reed Army Institute for Research, have not been completed nor published. I will provide you with a copy of the results when they are published.

TRAUMATIC BRAIN INJURY

40. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, General Chandler, and Dr. Jesse, I am glad that both General Chiarelli and Dr. Jesse made mention of the VA led collaboration with DOD and National Center for Health Statistics regarding the effort to revise methods for identifying, classifying, tracking, and reporting of TBI, PTSD, depression, substance abuse, and other combat related injuries. However, reporting from multiple open sources have stated that DOD does not have full accountability of how many servicemembers have TBI and that even with millions of dollars spent on programs since 2005, positive results have been marginal. Additional reporting indicates that the information share between DOD (all Services, Active, Guard, and Reserve components) and the VA has not improved accordingly and that there is still a backlog of cases in the medical board process and that information transference remains a significant issue. A major concern is that a disconnect exists between DOD and the VA for the transference of servicemember data. In some instances, new veterans have to start over, due to the loss of their medical information. Is this a valid assessment and, if so, what needs to be done to correct this?

General CHIARELLI. Information sharing between DOD and VA has improved significantly since the 2004 implementation of the DHIMS BHIE. This system permits providers at DOD Military Treatment Facilities and VA health facilities to view, in real time, electronic clinical data from each other's systems when a shared patient presents for care. BHIE currently covers clinical data between DOD and VA on over 3.66 million correlated patients.

Currently, there is not a disconnect between the Army and VA in the transfer of medical records for servicemembers participating in the Disability Evaluation System (DES) pilot. On average medical record transfer in the DES Pilot occurs within 7 calendar days, exceeding the standard of 10 calendar days and allowing servicemembers an opportunity to start the claim development phase. The DES Pilot sites meet current DOD standard of 290 days total processing time, from initiation to transition and receipt of VA benefits. For sites not participating in the DES Pilot, transfer of medical records is not as rapid, but continuous efforts are underway to migrate all Army sites to the DES pilot process.

Admiral GREENERT. There is a strong connection between DOD and the VA for the transference of servicemembers' health information. The Federal Health Information Exchange is a DOD/VA Information Technology health care initiative by which DOD health information on separated servicemembers is electronically transferred to a secure joint repository accessible by VA. This bi-directional information exchange was established in 2002, and provides Electronic Health Record data to VA clinicians who are able to view all clinically pertinent, historical health information. There are issues pertaining to controlling access to health information and is related to safeguarding the privacy of the information, not the data sharing capability.

General AMOS. I defer to DOD and VA.

General CHANDLER. The Air Force recognizes the importance of closing perceived gaps in medical care provided to patients with TBI. The Air Force concurs with DOD and VA diagnostic criteria for mild, moderate, severe and penetrating TBI as defined by the DVVIC. DOD has identified, classified, and compiled the number of servicemembers diagnosed with TBI and determined the severity of the injury using electronic medical records data on an annual basis dating back to 2000. We remain committed to providing the most accurate and available medical information to the (VA) for all of our airmen transitioning from the Military Health System to the VA or private-sector based health care.

Achieving a seamless, bi-directional healthcare information exchange (BHIE) process between the DOD and VA electronic health record systems remains an important Information Management/Information Technology (IM/IT) goal. Although limited BHIE is currently available, existing capabilities do not offer the ability for providers to review comprehensive medical information at either the DOD or VA user interface points. DOD and VA IM/IT officials continue to improve existing mechanisms and develop and evaluate potential automated solutions to achieve a more robust BHIE process.

Over the last 18 months, the Air Force has implemented a new process that more efficiently transfers the Service Treatment Record (the paper medical and dental records) for each retiring or separating airman from his or her active duty military treatment facility (MTF) or Reserve component medical unit to the VA. This new process requires all entries from the DOD electronic health record be printed and added to the paper record(s) before the records are transferred to one central Air Force health records disposition center located at Randolph AFB, TX. The central records disposition center verifies all required medical and dental records (if available) have been obtained, documented as received, and mailed to either the VA regional office processing the airman's VA disability claim or to the VA's Records Management Center in St Louis, MO. VA records managers now only have to interact with one central Air Force medical records center instead of almost 130 Air Force active duty MTFs and Reserve component medical units. Performance metrics indicate the new process is working.

Through the DOD-VA DES Pilot program, servicemembers receive a single disability exam from the VA and a single VA disability rating. The VA disability exam takes place prior to the beginning of a Medical Evaluation Board (MEB). Before the VA exam, the participating military treatment facility (MTF) is required to provide the VA with a copy of the member's complete health record. This new program offers a unique opportunity for the VA to medically evaluate members and determine their disability ratings. If the servicemember is determined to not meet retention standards by the Informal Physical Evaluation Board (I-PEB), the VA exam results are rated by the VA Disability Rating Office. In this way, the Board's findings and the VA ratings can be provided to the servicemember at the same time.

Dr. JESSE VA, in collaboration with DOD, continues to strive to improve communication and coordination across Departments in our Service to injured veterans and servicemembers. Since 2005, VA has supported over 2,200 Post-Deployment Health Reassessment (PDHRA) events for Reserve and National Guard units.

VA and DOD currently share considerable health information through the Bi-Directional Health Information Exchange (BHIE) framework. In addition, there are specific data exchange capabilities between major DOD centers and the VA Polytrauma Centers to facilitate the exchange of information including scanned documents. VA and DOD are working together to expand the types of data exchanged to include additional reports from procedures and items such as Audiology Reports and Neuro-Cognitive Assessments. This is the list of data types that can be shared from the most recent BHIE Fact Sheet:

BHIE data includes:

- Clinical theater data
- Drug and food allergy data
- Inpatient discharge summaries from DOD's major military treatment facilities
- Laboratory orders
- Laboratory results
- Outpatient pharmacy data
- Pre- and Post-Deployment Health Assessments and Post-Deployment Health Reassessments
- Ambulatory clinical encounter notes
- Radiology text reports
- Vital sign data

Response to Comment: BHIE is fully deployed across the VA enterprise so that clinicians at every VA Medical Center and clinic have access to DOD data shared through BHIE. At VA facilities, clinicians view BHIE data by using Remote Data Views within the Vista Computerized Patient Record System (CPRS); VA clinicians may also choose to view BHIE data through Vista Web. Both applications are implemented at every VA facility. To the extent that some hospital staff believe they cannot view BHIE data, VA is working to improve clinician awareness as well as clinician training on how to use the system. VA has identified some of the factors that contribute to clinician confusion about the availability of DOD data. For example, the term "BHIE" refers to the technical framework that supports data sharing; how-

ever, the names of the VA applications used to access DOD data that are known to VA clinicians are “Remote Data Views” or “Vista Web.” When clinicians are asked about BHIE, they may not be familiar with the term although they do have the tools that are used to view DOD data. Additionally, at times, technical issues within the BHIE framework may prevent the viewing of specific types of data, such as DOD clinical progress notes; however, this does not preclude access to all other DOD health data shared over the framework. There are ongoing efforts to resolve all technical issues with BHIE. These efforts are closely managed by both VA and DOD leadership and involve the development of software and hardware enhancements that are being jointly implemented and tested by VA and DOD.

In 2009, VA launched a VA-wide BHIE awareness initiative. The purpose was to improve clinician awareness of the availability of DOD data. As part of this effort, VA sent awareness materials, such as brochures, videos, and pamphlets, to every VA Medical Center through the facility Chiefs of Staff and Public Affairs Officers. Additional ongoing efforts include briefings and participation at National Veterans Health Administration face-to-face and phone conferences attended by VA clinicians, including clinical leadership from each facility. At some of these conferences, such as the recent Veterans e-Health University (VeHU) held in August 2010, a number of classroom “how to access DOD information” seminars were provided to VA clinical staff. Finally, to ensure that the clinicians treating our most severely wounded patients are trained on the availability of DOD data, VA technical and implementation staff make routine site visits to our four level one polytrauma rehabilitation centers to conduct clinician training and provide onsite support.

41. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, General Chandler, and Dr. Jesse, what does the screening portion of this joint venture consist of?

General CHIARELLI. Screening for mild Traumatic Brain Injury (TBI), also known as concussion, is intended to capture those servicemembers who may have sustained a TBI while deployed and perhaps have symptoms that require further assessment and treatment. Positive screens are not diagnostic of TBI but do trigger a clinician interview for further evaluation. Screening for TBI now takes place proximate to the time of the injury event, similar to how medical clearance is required after aviation incidents. The Army implemented the “Educate, Train, Treat, and Track” mTBI/concussive injury management strategy in late 2009. This management strategy was reinforced by DTM 09-033 dated 21 June 2010, titled: “Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting”. This DTM directs that that any servicemember who sustains a direct blow to the head, or is dismounted within 50 meters of a blast, or is in a building or vehicle damaged by a blast/accident must undergo a medical evaluation. This early identification of concussion and immediate intervention with 24 hours rest and medical clearance prior to return to duty should go a long way to improve the health of our soldiers. Additionally, TBI screening occurs at several intervals and locations once a soldier leaves theater. Soldiers aeroevacuated from theater will receive their first screen when they arrive at Landstuhl Regional Medical Center (LRMC) in Germany. Since May 2006, all servicemembers evacuated from theater for battle or non-battle injuries and illnesses are screened for TBI upon arrival to LRMC. The main purpose of this screen is to identify co-morbid TBI in the context of polytrauma and to ensure proper evacuation to an appropriate facility in the Continental United States. Second, since May 2008 all servicemembers returning from deployment answer a series of questions on the PDHA that report exposure to injury event, presence of subsequent loss of consciousness or alterations in consciousness, presence of symptoms at time of injury, and presence of current symptoms. The third post-deployment screen occurs during the PDHRA conducted 90–180 days after return from deployment. Finally, since April 2007 any servicemember entering the VA medical facility for any clinical care undergoes TBI screening identical to that of the PDHA with an instrument called the “TBI Clinical Reminder”.

The questions used in the PDHA, PDHRA, and VA’s TBI Clinical Reminder are an adaptation of an instrument called the “Brief TBI Screen (BTBIS)”. This instrument has had preliminary validation published in peer-reviewed medical literature. These reviews were utilized by the White-House-appointed TBI External Advisory Committee to the Defense Health Board and the Institute of Medicine. These panels both recommended the use of the BTBIS. In December 2008, the Defense Health Board recommended continued use with minor modifications.

Admiral GREENERT. TBI is screened for by questions in the PDHA and PDHRA. If a servicemember has clinical symptoms, the unit’s medical personnel evaluate and then refer for specialty care as needed. Servicemembers with clinical symptoms are also encouraged to seek medical care independent of post-deployment screenings.

General AMOS. I defer to DOD and VA.

General CHANDLER. Screening for mild Traumatic Brain Injury (TBI) is intended to ensure those servicemembers who may have sustained a TBI while deployed and have symptoms receive further assessment and treatment. Positive screens are not diagnostic of TBI but do trigger a clinician interview for further evaluation. TBI screening occurs at several time points and locations once an airman leaves theater. For airmen air evacuated from theater the first screen occurs when they arrive at LRMC in Germany. Since May 2006, all servicemembers evacuated from theater for battle or non-battle injuries and illnesses are screened for TBI upon arrival to LRMC. The main purpose of this screen is to identify co-morbid TBI in the context of polytrauma and to ensure proper evacuation to an appropriate facility in the Continental United States. Second, since May 2008 all servicemembers returning from deployment answer a series of questions on the PDHA that reports exposure to injury event, presence of subsequent loss of consciousness or alterations in consciousness, presence of symptoms at time of injury, and presence of current symptoms. The third post-deployment screen occurs during the PDHRA conducted 90–180 days after return from deployment. Finally, since April 2007 any servicemember entering the VA medical facility for any clinical care undergoes TBI screening identical to that of the PDHA with an instrument called the “TBI Clinical Reminder.”

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In addition to TBI screening, the VA and DOD have expanded the bi-directional healthcare information exchange capability to make the following information viewable by the VA from the PHA: patient answered questions for general health, tobacco use, alcohol use, injury prevention, chronic diseases or conditions, dental health, reproductive health issues and mental health concerns.

Dr. JESSE. VA requires that all new patients presenting to VA for the first time be screened for the presence of PTSD, depression, and alcohol misuse. If the Veteran screens positive for any of these problems, they are further evaluated by a primary care provider or by referral to a mental health clinic for confirmation of the diagnosis. This may be followed by initiation of mental health services, if needed, in the primary care setting or through referral to mental health specialty care. Veterans who screen positive for PTSD or depression are also assessed for suicide risk. Veterans who screen positive for alcohol misuse are provided with alcohol counseling, as well. Veterans are screened for PTSD every year for the first 5 years the Veteran is in VA care and every 5 years thereafter, unless there is a clinical need to screen earlier. Veterans are screened for depression and alcohol misuse annually.

New patients with mental health concerns (those who have not been seen in a mental health clinic in the last 24 months) or have a positive screening for PTSD, depression or alcohol misuse, are contacted within 24 hours of the referral by a clinician competent to evaluate the urgency of the Veteran’s mental health needs. If it is determined that the Veteran has an urgent care need, appropriate arrangements (e.g., an immediate admission) are required. If the need is not urgent, the patient must be seen for a full mental health diagnostic evaluation and development and initiation of an appropriate treatment plan within 14 days.

VA also developed and implemented the TBI Screening and Evaluation Program for all Veterans who have served in Iraq or Afghanistan, upon their initial entry into VA for health care. Veterans who screen positively for possible mild TBI are referred for a comprehensive evaluation by an interdisciplinary rehabilitation team, and receive follow-up care and services appropriate for their diagnosis and their symptoms.

For patients identified through these screens, VA has established access standards that require prompt evaluation of new patients. For Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans who have a positive TBI Screening, the VA standard is that: (1) timely contact is made to schedule an appointment for comprehensive evaluation (contact within 5 days of a positive screening); and (2) that a comprehensive evaluation is completed in a timely manner (within 30 days of having a positive screening).

42. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, General Chandler, and Dr. Jesse, is data available to healthcare providers in the VA, TRICARE, and private practice for those providing care for members of all components of the armed services?

General CHIARELLI. Yes. The results of the TBI screening performed at LRMC and in the Veteran's Affairs health facilities using the VA's TBI Clinical Reminder are part of the soldier/veteran's medical record and is available to VA, TRICARE, and private practice healthcare providers. The PDHA and PDHRA for soldiers of all components can be accessed either in the paper medical record or in AHLTA if scanned or soldiers can print out copies of their completed Deployment Health Assessments via AKO and release this information to their providers. More importantly, servicemembers of all components who screen positive on the PDHA and PDHRA are sent for a clinical confirmation evaluation and that care is documented as part of their medical record.

Admiral GREENERT. Yes. There are a number of instances in which medical information is provided to the VA by the Services. Specifically regarding TBI patients undergoing care through the VA, the following directly applies:

"VA and DOD Memorandum of Agreement (MOA) Regarding Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury, TBI, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitation Services"

This MOA was effective 1 Jan 2007. It specifies that "The referring MTF will provide a copy of all pertinent patient medical record documentation requested by the VA health care facility needed to make a medical decision." Therefore, if a patient is transferred to the VA for treatment, their medical information should be provided to facilitate their care and reduce duplication of effort and delays in care.

In addition to providing medical records, the care teams ensure that the servicemembers have a smooth transition of care in a number of other ways including:

- Navy Military Treatment Facilities and VA Poly Trauma Facilities hold multidisciplinary clinical case management video teleconferences to discuss patient transition and care needs and to provide follow up information on previously transferred patients.
- Transition support within the Navy consists of medical care case managers and non-medical care managers working collaboratively and with RCCs and VA Federal Recovery Coordinators and Case Managers. This close cooperation ensures a smooth and seamless handoff of each patient's recovery needs as a member transitions between DOD care locations, or from DOD to the VA and/or into the civilian sector.
- Navy Medicine and Safe Harbor are involved in a DOD-VA Information Sharing Initiative that is linked to a larger effort called Virtual Lifetime Electronic Record. This effort shares medical and non-medical (benefits, service records, pay, etc.) data in electronic means, allowing for "one-stop shopping" of information on an individual.

General AMOS. Yes. There are a number of instances in which medical information is provided to the VA by the Services. Specifically regarding TBI patients undergoing care through the VA, the following directly applies:

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2. Transition support within the Navy consists of medical care case managers and non-medical care managers working collaboratively and with RCC and VA Federal Recovery Coordinators and Case Managers. This close cooperation ensures a smooth and seamless handoff of each patient's recovery needs as a member transitions between DOD care locations, or from DOD to the VA and/or into the civilian sector.

General CHANDLER. For patients being treated by both DOD and VA, the Departments continue to maintain the jointly developed Bi-directional Health Information Exchange (BHIE) system. Using BHIE, DOD and VA clinicians are able to access each other's health data in real-time, including the following types of information:

allergy, outpatient pharmacy, inpatient and outpatient laboratory and radiology reports, demographic data, diagnoses, vital signs, problem lists, family history, social history, other history, questionnaires, and theater clinical data, including inpatient notes, outpatient encounters, and ancillary clinical data, such as pharmacy data, allergies, laboratory results, and radiology reports. To increase the availability of clinical information on a shared patient population, VA and DOD collaborated to further leverage BHIE functionality to allow bi-directional access to inpatient discharge summaries from DOD's inpatient documentation system. Access to DOD discharge summaries is operational at some of DOD's largest inpatient facilities representing approximately 71 percent of total DOD inpatient beds. In addition to sharing viewable text data, VA and DOD have expanded the BHIE capability to make the following information viewable by the VA from the PHA: patient answered questions for general health, tobacco use, alcohol use, injury prevention, chronic diseases or conditions, dental health, reproductive health issues and mental health concerns.

The Federal Health Information Exchange provides the VA with a one-way transfer of medical data from the DOD on servicemembers who have separated the military. Information supplied to the VA includes: outpatient pharmacy data, lab and radiology results, inpatient laboratory and radiology results, allergy data, consult reports, admission, disposition and transfer data, standard ambulatory data record elements including diagnosis and treating physician, pre/post-deployment health assessments (PPDHA), and PDHRA. As of June 2010, over 2.8 million PPDHA and PDHRA forms on more than 1.2 million individuals have been sent from DOD to VA.

Data exchange between the DOD and non-VA providers is limited to transferring copies of paper records to the civilian provider. The National Health Information Network (NHIN) is in its infancy and at present is being developed and tested via pilot programs. As the NHIN is built out, it will allow information to be exchanged between private practices, the VA and the DOD using standards-based data elements. The information that can be exchanged at this stage is very limited and available in only a few geographical locations.

Dr. JESSE. VA data sharing with private practices or health care systems is still in a very early stage with active National Health Information Network Pilots in place in San Diego, CA, and Hampton Roads, VA.

43. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, General Chandler, and Dr. Jesse, are all personnel who are diagnosed with TBI having that information entered into their medical records or only those who have received Purple Hearts?

General CHIARELLI. All personnel diagnosed with TBI have their medical care documented in the medical record.

Admiral GREENERT. Any servicemember undergoing care for any type of medical condition should have their information entered into the medical record. Their receipt of a medal has no impact on the medical care provided, nor the requirement to properly document care in the medical record.

General AMOS. Any servicemember undergoing care of any type should have their information entered into the medical record. Their receipt of a medal has no impact on the medical care provided or the requirement to properly document care in the medical record.

General CHANDLER. Yes, all airmen with a diagnosis related to TBI have those diagnoses entered in their medical charts. This is done at the time of diagnosis and is part of the process of the medical appointment. It occurs regardless of whether the airman receives a Purple Heart.

Dr. JESSE. All Veterans who are diagnosed with TBI have information entered into their medical record regarding their evaluation, diagnosis, and treatment. In addition, VA developed and implemented a national template to ensure that it provides every Veteran receiving inpatient or outpatient treatment for TBI, who requires ongoing rehabilitation care, an individualized rehabilitation and community reintegration plan. VA integrates this national template into the electronic medical record, and includes results of the comprehensive assessment, measureable goals, and recommendations for specific rehabilitative treatments.

ALTERNATIVE TREATMENTS FOR TRAUMATIC BRAIN INJURIES

44. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, General Chandler, and Dr. Jesse, alternative treatments for TBI have been a significant focus of many members in Congress, specifically the use of HBOT. In conjunction with oxygen carrier drugs, such as Oxycyte, the positive impacts of the HBOT treat-

ment may be magnified. In the fiscal year 2011 markup, the House passed language that will continue support for HBOT research and development. What are your thoughts on alternative treatments for TBI and specifically HBOT, and the associated TBI drugs and what needs to be done to expedite the research and development process?

General CHIARELLI. It is very important that we evaluate safety and effectiveness of all therapeutic and alternative medicine options through controlled trials for TBI prevention, treatment, and rehabilitation. Currently DOD is examining hyperbaric oxygen for those with persistent brain-related sequelae. The U.S. Army Medical Research and Materiel Command and the DCoE for Psychological Health and TBI and will be initiating a pilot study of hyperbaric oxygen for traumatic brain injured patients in the next few weeks with a goal completion by December. We are aware that the Navy and Air Force are also conducting or participating in research involving oxygen therapies.

The results of all of these DOD trials will solidify the pivotal, larger, multicenter clinical trial scheduled to begin early 2011.

The military has funded Oxygen Biotherapeutics research using the fiscal year 2007 PH/TBI war supplemental funding to conduct clinical trials using Oxycyte with the ultimate goal of improving brain oxygen delivery, and patient outcome, after severe TBI. After seeing good results in nine patients, the FDA put the Phase II trial on clinical hold because of transient platelet suppression, which did not have any documented clinical adverse effect, until the mechanism of that transient suppression is determined. The U.S. Army Medical Research and Materiel Command has just funded a number of projects that are designed to answer that mechanism question with the intent to restart the clinical trial in the near future.

To expedite the research and development process it is necessary to conduct programs, not projects. It is most efficient to develop a programmatic approach rather than conduct a multitude of disconnected studies. A programmatic approach will utilize goals, milestones, timelines and future funding projected over several years to maximize the potential of selecting and advancing products or new technologies through FDA approval into the hands of health care providers. To minimize the loss of data, research time and risk to the human research subjects, it is imperative that studies be conducted as well controlled clinical trials. Data repositories and data sharing allow a far greater number of researchers to analyze existing pieces of information therefore increasing the size of the research base. It is also very important to engage the FDA in clinical trials research early and often to focus the research efforts on questions and issues that will need to be addressed for FDA review and approval.

Admiral GREENERT. Navy Medicine continually seeks to identify and implement the best methods to evaluate and treat servicemembers who sustain a TBI. Prior to implementing therapies for our servicemembers Navy Medicine, in adhering to nationally and internationally recognized standards of good clinical practice, require that any treatment provided to our servicemembers has demonstrated safety and effectiveness. In those cases where the treatment fulfills these critical criteria, Navy Medicine will expedite use. Conversely, if a treatment does not have scientific merit or is found to be more detrimental than beneficial, Navy Medicine will not make it available until further research demonstrates a benefit.

DOD has three placebo-controlled clinical trials planned or in progress on the use of hyperbaric oxygen. Two of these are feasibility studies which will provide information on appropriate selection of hyperbaric oxygen doses and pressures as well as efficacy of procedures utilized in providing exposure to affected individuals. One of these is a large prospective, efficacy study to assess the effects of hyperbaric oxygen therapy on the symptoms of mild and moderate TBI. One of the feasibility studies is expected to have data available in early 2011 and the other in late 2011. The large efficacy study will have data available in 2014. Navy Medicine is funding travel for active duty servicemembers to participate in these studies and, in partnership with the VA, is the lead for one feasibility study.

The drug, Oxycyte, is currently undergoing evaluation in a clinical trial to treat severe TBI. The initial results are promising but this larger study will allow us to better gauge its efficacy and appropriateness for our population. Of note, examining the categories of Navy TBI numbers from 2000–2009 (provided by the Defense Veteran and Brain Injury Center), an estimated 76 percent are mild, 20 percent are moderate, 2 percent are penetrating, and only 1 percent are severe. Navy Medicine actively supports and engages in clinical investigation to determine better methods of detecting and treating TBI.

General AMOS. DOD has three placebo-controlled clinical trials planned or in progress. Marines who desire to participate in these studies, after appropriate in-

formed consent, will have leadership support in doing so. In fact, in one study currently underway 90 percent of the subjects are marines or former marines.

Moving forward I expect to continue to collaborate with and challenge the medical community for ever better tools for the diagnosis and treatment of all the wounds of war, both visible and invisible.

General CHANDLER. I do not believe there are any current studies looking at the use of oxygen carrier drugs.

There are ongoing studies to validate the efficacy of HBOT in TBI patients and we are eagerly awaiting the results. The use of associated TBI drugs will be undertaken as further information about them evolves. The continued support from Congress for research and development is appreciated.

Dr. JESSE. DOD and VA are actively investigating the efficacy and utilization of hyperbaric oxygen therapy (HBOT) for treating mild traumatic brain injury (TBI) and post-concussive symptoms. While HBOT demonstrates effectiveness in treating certain disorders, there are presently only clinical reports but no demonstrated double-blinded, controlled, scientific evidence that supports using HBOT to treat mild TBI. Presently, neither the Food and Drug Administration nor the Undersea and Hyperbaric Medical Society—the medical specialty society and authority that provides guidance to Centers for Medicare and Medicaid Services (CMS) for use of HBOT—recognize use of HBOT as a primary or adjunctive therapy for TBI.

There is presently no rigorous research evidence to support usage of alternative therapies on a clinical level for TBI of any severity; e.g., HBOT, vibratory treatments, acupuncture, herbals and supplements, yoga and other movement therapy, music therapy, oxygen carrying drugs, or any experimental drugs. VA stringently supports the need for additional research to design and execute randomized controlled trials of all of these agents to better understand their potential for TBI care. Currently, the potential risks of all these treatments must be considered higher than their potential for benefit and therefore they should not be recommended.

In order to expedite research and development related to TBI, VA strongly advocates collaborative research and joint research initiatives across all federal agencies. VA is currently engaged in collaborative TBI-related research efforts with DOD, academia, the National Center for Disability and Rehabilitation Research, and other agencies.

MEDICATIONS

45. Senator INHOFE. General Chiarelli, the Army is the only Service I have heard directly address the topic of prevention and management of polypharmacy with psychotropic medications and central nervous system depressants. This could have a significant impact on our suicide numbers and the extended suffering by our servicemembers. Can you elaborate on your statement of how this new policy will assist in reducing adverse clinical outcomes?

General CHIARELLI. The ASPTF has identified polypharmacy as one of the risk factors involved in some suicides and accidental fatalities among soldiers in treatment. To address these concerns, the U.S. Army MEDCOM and the Office of the Surgeon General has published policies for the WTUs in particular and for the Army Medical System in general to reduce the risks of polypharmacy.

In April 2009 the MEDCOM published a policy for the Warriors in Transition High Risk Medication Review and Sole Provider Program. This program is in part a medication reconciliation program for our Wounded Warriors assigned to the WTUs. Components of this program include the assignment of clinical pharmacists to the WTUs to monitor and support safe and effective medication of soldiers in treatment; they review medication profiles of their cases at least weekly. The Primary Care providers in the WTUs perform medication reconciliation for each soldier in treatment within 24 hours of arrival at the WTU and each time the soldier's medication regimen is changed to identify and prevent potential adverse medication interactions, side effects, or potentially lethal medication combinations. Additionally, case managers in the WTUs perform clinical risk assessments on each soldier assigned to the unit to identify soldiers who may be at risk of intentionally or accidentally harming themselves. Soldiers at risk are closely monitored as well as immediately referred to the appropriate behavioral health resources. Soldiers identified to be at risk of abusing their medications are closely monitored and dispensed small amounts of medication (1-week supply) with frequent clinical visits, and can be restricted to one prescriber and one pharmacy for their medications. Soldiers identified to be at risk of abusing drugs or alcohol while on their medications are educated regarding the risks and referred to the Army Substance Abuse Program, and routinely undergo screening with random urine drug testing.

In September 2009 the MEDCOM published Guidance for Enhancing Risk Reduction and Patient Safety via Appropriate Behavioral Health Referral and the Conservative Use of Central Nervous System Depressants. This policy guides the conservative use of medications to reduce the occurrence of harmful polypharmacy for our troops in general. Healthcare providers are strongly encouraged to refer soldiers to specialty care (e.g. behavioral health resources) for non-medication therapies to augment medication therapy and obtain the best clinical outcomes. Additionally, medication reconciliation is a requirement of the joint commission to reduce the risks of polypharmacy. Medication profiles are reviewed and reconciled upon initial contact and periodically thereafter by each prescribing healthcare provider, especially as they transition from one care setting to another (admission or discharge from hospital). Finally, the MEDCOM has deployed electronic measures system-wide that automatically screen medications each time healthcare providers order them for our soldiers. This screen identifies and flags duplicate orders for the same medication, duplicate orders for the same class of medication, and potential interactions among medications prescribed to the soldier that may put them at risk.

TOTAL FORCE HEALTH CARE AND TRANSITION TO VETERAN CARE

46. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, how are each of the Services dealing with Reserve components—providing care once they are off Active Duty, following up on mental health care, and ensuring their families are cared for?

General CHIARELLI. The Army routinely coordinates healthcare delivery for Reserve component soldiers coming off active duty with the VA. At the local installations, VA representatives attend many PDHRA sessions and provide follow-up appointments as necessary within their system. The VA provides direct care for Reserve component and other remote/geographically dispersed soldiers. Soldiers, both Active and Reserve component, have routinely utilized VA PTSD treatment programs, such as the one at the Palo Alto VA Medical Center. Additionally, the Army utilizes VA liaisons to coordinate healthcare. Through the Army and VA partnership, VA Liaison Case Managers are embedded in 14 prioritized Army MTFs under an initiative called VA Liaison and Care Management Program. This ensures soldiers receive seamless continuity of care as they migrate from active duty to veteran status in the VA Healthcare System.

TRICARE also has programs that assist Guard and Reserve soldiers and families. A National Guard or Reserve member separating from a period of active duty that was more than 30 consecutive days in support of a contingency operation is eligible for TAMP. The TAMP provides 180 days of transitional health care benefits to help certain uniformed services members and their families transition to civilian life. TRICARE Reserve Select is a premium-based health plan that qualified National Guard and Reserve members may purchase to receive care in their local area. TRICARE Reserve Select requires a monthly premium and offers coverage similar to TRICARE Extra and Standard.

Additionally, Guard and Reserve members who are experiencing common psychological health concerns like combat stress and family separation, may use a new initiative called TRIAP which provides video chat and instant messaging to give quick and easy access to counseling services. This program is also available to all spouses and other family members that are 18 years or older.

Admiral GREENERT. reservists and their families have access to TRICARE health care benefits for 180 days following their separation from Active Duty.

Commander, Navy Reserve Forces Command has assumed responsibility for overseeing implementation of the PDHRA program for the Navy Reserve. With strong leadership support they are actively engaged in program execution and because of this increased focus, servicemember compliance rates have improved. Providing mental health support to Reserve sailors is an integral component of Navy mental health care. To meet this need, the Navy implemented the NRPHO program in fiscal year 2008. The NRPHO program has a team of 25 Social Workers who provide initial mental health clinical assessment of Reserve component servicemembers and provide appropriate health care referral if needed. They are also making visits to two to three NOSC's per month in each of the five Navy Reserve Regions where they provide psychological health education including the OSC awareness brief to NOSC staff and Reserve unit members.

As of June 2010, the NRPHO Teams have clinically assessed and referred almost 2,400 reservists to appropriate sources of mental health care; have made outreach calls to an additional 1,860 reservists; and have made 281 visits to the NOSC's, providing the OSC awareness brief to over 29,400 RC members and NOSC staff. In ad-

dition, Navy Medicine has hired a full-time DPH for Navy Reserve to oversee and expand Reserve Navy Reserve psychological health programs.

The RWW has become the keynote Reintegration event, as this program has become available to RC and AC sailors, marines, and their spouses throughout the country. The Navy Reserve has led the way in crafting a standardized RWW that represents the ideals of DOD's YRRP, serving the RC and AC, and fulfilling the full spirit and intent of the Total Force initiatives. In 2009, more than 1,800 servicemembers and 1,400 family members attended one of 27 RWWs throughout the country. An additional 13 have been held in 2010, attended by 832 servicemembers and 699 family members and 2 more are scheduled through the end of the current contract (30 July 2010). 38 more RWWs are planned for the next contract through July 2012.

General AMOS. Reservists and their families have access to TRICARE health care benefits for 180 days following their separation from Active Duty.

While I defer to my military medicine colleagues on the actual delivery of care, our WWR and battalions stay connected to marines in need of services even after they leave active duty. I believe that our Wounded Warrior construct is a superb model and we will continue to leverage its successes moving forward.

General CHANDLER. The Air Force, regardless of component, regularly screens servicemembers for psychological conditions using the PHA, PDHA, and PDHRA. These tools ask questions to help screen for mental health conditions related to deployment. The Air National Guard (ANG) tracks combat injuries to include mental health conditions through the daily casualty reports. ANG members with mental health conditions are tracked through the ANG Medical Group (MDG) in coordination with the ANG DPH and the servicemember's home State/territory for follow-up care. The DPH is available to ANG members and families throughout their care and the remainder of their service.

ANG members may retain health benefits following deployment for deployment related conditions to include mental health. The Air Force offers Deployment Transition Centers (DTC) for airmen (including Guard and Reserve components) returning from combat theaters. The 2-day DTC readjustment agenda assists airmen with their return and provides mental health resource information. The ANG offers the federally-mandated YRRP to provide psychosocial and mental health education and referral resources for Guard members throughout the deployment cycle.

47. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, do all the Services follow the same process for transitioning your servicemembers from DOD control to VA control as part of the medical board process?

General CHIARELLI. Yes, the transition process is the DES consists of a MEB phase and a PEB phase. In the traditional or Legacy system there were minor differences in how MEB and PEB cases were processed. In the DOD/VA DES pilot process the phases are similar across all Services.

Admiral GREENERT. Yes, the transition process is the DES and it consists of a MEB phase and a PEB phase. In the traditional or Legacy DES system there were minor differences in how MEBs and PEBs were processed. In the DOD/VA DES pilot the phases are similar across all Services.

General AMOS. Yes, the transition process is the DES and it consists of a MEB phase and a PEB phase. In the traditional or legacy DES there were minor differences in how MEBs and PEBs were processed. In the DOD/VA DES pilot process the phases are similar across all Services.

General CHANDLER. An Air Force member who separates or retires, regardless of whether it is through the DES or not, is provided counseling on VA benefits and application procedures as part of transition assistance counseling. In a medical board process, the Integrated DES Program (formerly referred to as the DES Pilot) being implemented across DOD prescribes that servicemembers are evaluated for VA disability rating as part of their DES evaluation, saving servicemembers time in applying for VA benefits upon separation or retirement. The process includes a single physical examination conducted by the VA in the MED phase. The VA then provides a draft rating decision for all conditions claimed by the servicemember. The Service conducts a PEB to determine which medical conditions, if any, make the servicemember unfit for continued military service. The Service PEB uses the VA-determined disability ratings for fitting conditions to determine the servicemember's disposition (medical separation or retirement). This process is prescribed by DOD.

48. Senator INHOFE. General Chiarelli, Admiral Greenert, General Amos, and General Chandler, what are your observations on the process by which service-

members are assessed, diagnosed, treated, and transitioned either back to Active Duty or onward to the VA?

General CHIARELLI. When a soldier is assigned to a WTU, he or she develops a CTP in consultation with his or her family, unit leaders, and health professionals. The CTP is designed to be a roadmap for recovery and transition, with personal and professional milestones, such as passing a physical fitness test, taking college courses, or participating in internships and job training. The goal is to keep each soldier goal-oriented and constantly striving to recover. This helps focus his or her attention and energies on healing and the future, which produces a positive mental outlook.

The Warrior Care and Transition Plan includes developing a comprehensive and responsive network of available facilities to treat Warriors in Transition that include military treatment facilities, VA facilities, civilian facilities, and the TRICARE network of providers. The Triad of Care (Squad Leader, Nurse Case Manager, and PCM) manages each soldier's progress closely and coordinates care through this network of resources to ensure comprehensive coverage of care and support requirements.

In WTUs, pharmacists and medical providers collaborate to ensure appropriate medication use for each Warrior in Transition. Members of the health care team are trained to first consider utilizing treatment methodologies other than medicating soldiers as the best approach to ensuring appropriate care and treatment.

VBA counselors work on-site with Warriors in Transition to ensure coordination of all necessary services prior to a soldier leaving the Army. The Army established liaison teams at VA polytrauma centers to ensure appropriate care and support when soldiers enter VA health care programs. The Army and the VHA continually develop ways to ensure that the CTP follows each soldier into VA care and that the soldier's continuity of care is ongoing and consistent.

Admiral GREENERT. Challenges remain with stigma and other barriers to care, such as the desire of a sailor to not go to medical after an exposure to a blast because they are motivated to "stay in the fight." We must continue to work to reduce or eliminate these barriers. We need to encourage leaders to get their people to the medical experts who can assist them in getting the care they need.

Once our sailors get into the medical system they receive expert medical care throughout the continuum of care from assessment and diagnosis to recovery and return to duty or reintegration.

Case managers work with the care team to ensure that our wounded warriors receive the care they need and transition between DOD, VA, and civilian facilities smoothly. The DES Pilot, that is now being expanded across DOD, has been beneficial in ensuring that those members who must transition out of the military do so with their Military and VA benefits established prior to discharge. The medical care, coordination of care, and transition assistance, has improved and continues to improve to meet the needs of our wounded warriors.

To assist seriously wounded, ill, and injured sailors, coastguardsmen, and their families in their transition and reintegration back into their communities, Safe Harbor provides support through its Anchor Program. The Safe Harbor Anchor Program partners with 128 NOSCs across the country as well as Navy Retired Activities Offices, American Legion, Navy League, Fleet Reserve Association, and other community-based organizations to provide mentor volunteers to assist recovering servicemembers (RSM) and their families reintegrate back into the community. The mentors, whether a near-peer Navy reservist or a senior mentor from our partner organizations provide local professional, social and spiritual assistance to RSMs and their families solidifying the "lifetime of support" provided by Safe Harbor.

General AMOS. While I am not a medical expert, I believe there is more to be done to meet the needs of all Wounded Warriors. However, my lack of satisfaction with the status quo should not be construed to mean that I feel that the Marine Corps has failed to make significant strides in this area.

As a Marine leader, I believe the centerpiece of any successful Marine Corps effort in this arena, and especially in the areas of TBI and PTSD, is Engaged Leadership. No individual is better positioned to notice a change in a marine's behavior or apparent well-being than another marine.

Building on this understanding, we have already developed training and awareness programs for leaders at all levels of the Corps on these subjects with the goal of intervening at the earliest possible opportunity before a small problem balloons into an overwhelming problem.

After successful treatment of their condition, successful re-integration of a marine into the business of being a marine is critical for our force and for the individual. I am committed to seeing all of our leaders embrace this re-integration process. For

those marines with medical conditions that prevent them from continuing on active duty, the process of transitioning to the VA must be as seamless as possible.

For over 200 years we have prided ourselves on the fact that marines take care of marines. I am committed to seeing that tradition hold true far into the future.

General CHANDLER. The Air Force DES evaluates all cases where a member is found to have a duty limiting condition that is disqualifying for worldwide duty in accordance with Air Force Instruction (AFI) 48-123, Medical Examinations and Standards, and completes a fitness for duty determination. The complexity of the system depends greatly on the participant and the medical conditions they have. The goal in all cases is to complete a thorough medical evaluation and provide an appropriate disposition.

The simplest cases are processed through the Assignment Limitation Code Fast Track Program (ALC Fast Track). Such cases are Air Force members who present with conditions which, while limiting for worldwide duty, are stable, have a low risk of sudden incapacitation and minimally impact the ability to perform primary military duties. Approximately 60 percent of all cases fit these criteria. In these cases, the PCM reviews the condition, conducts the appropriate evaluations and, where appropriate, begins treatment. She/he then initiates a MEB which is referred to the profile officer for review. If the diagnosis is felt to be suitable for ALC Fast Track, the PCM is notified and completes a robust medical note outlining all current information regarding the condition, the severity and the associated sequelae. This is forwarded to Air Force Personnel Center (AFPC) medical standards branch where disposition is made. They may return the member to full duty, provide an assignment limitation code, or determine that the case is not compatible with the ALC Fast Track limitations and refer it for full MEB/PEB processing. These determinations can be completed usually within 7 days and greatly expedites the process.

Cases referred for full MEB/PEB processing are those which do not meet the criteria for inclusion in the ALC Fast Track Program. These cases undergo full MEB/PEB processing, and go through a similar evaluation by the PCM to determine the exact diagnosis, potential treatment and impact on the ability to perform future military duties. These cases are sent to the AFPC medical standards branch and go through the steps of the MEB, the I-PEB and the formal PEB as required. Similar to the ALC-Fast Track, the disposition may be return to duty, provision of an assignment limitation code, or recommendation for medical discharge.

In cases where a medical discharge is recommended (or down the road for individuals who are retained but later separate or retire), the disability rating is provided by the VA. The new DES-Pilot system (also being referred to as the Integrated DES) allows veterans to undergo a single rating physical exam and receive one disability rating.

QUESTION SUBMITTED BY SENATOR SUSAN COLLINS

INFORMATION SHARING

49. Senator COLLINS. Dr. Jesse, I have been contacted by officials from the Maine Office of Substance Abuse regarding their concern that the VA is preventing VA hospitals, such as Togus Medical Center, from participating in the State's Prescription Monitoring Program. The Prescription Monitoring Program shares prescription drug information among physicians to prevent drug abuse by ensuring that doctors know what prescriptions have already been provided to a patient. Without access to the prescription drug data from VA medical centers, physicians in Maine are concerned that they may inadvertently provide duplicative prescriptions to veterans, including prescriptions for particularly strong drugs, such as narcotics. Understanding that there are privacy consideration, is the VA committed to working with each State to ensure that necessary medical information is shared, while protecting the privacy rights of patients?

Dr. JESSE. Patient safety is always a major concern within VA. Within our internal national system we have mechanisms to monitor and evaluate prescription drug use. Currently, there are statutory barriers that prevent VA's participation with the States. VA is, however, evaluating possible remedies that may allow participation in these programs.

[Whereupon, at 11:40 a.m., the committee adjourned.]

