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Statement of

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of the

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Introduction

As you know, last year the Congress directed the Department of Defense (DOD) to perform a comprehensive review of mental health service provision in the military services. I had the privilege of serving as the military co-chair of that Task Force from March, 2007, until the final release of the report in June. As you also know, Secretary Gates received the Task Force report on 14 June and directed the services to immediately develop strategies to implement its recommendations.

Also, in April of this year, I was named as the military spokesperson for DOD's initiatives to consolidate Traumatic Brain Injury (TBI) treatment across the services. My co-chair, Ms. Ellen Embrey, and I requested the military medical departments to work together to identify key gaps in our understanding and treatment of TBI. Since May, we have convened three large-scale meetings of military clinicians and researchers and their civilian clinical and academic counterparts who represented the most knowledgeable experts in this challenging field. Two weeks ago, these groups forwarded a series of recommendations to us, spanning areas from basic research on the effects of blast to recommendations for enhancing long-term care and rehabilitation. Ms. Embrey and I have accepted these recommendations and representatives from each of the services and the Department of Veterans Affairs are now working on implementation plans.

Overview of the DOD Mental Health Task Force

The findings of the Mental Health Task Force form the basis of much of the remainder of my testimony, so I will briefly reiterate these. The report points to significant shortfalls in providing mental health care to our service members and their

families. We made 94 recommendations aimed at accomplishing the following four major tasks:

a. Build a culture of support for psychological health.
b. Ensure a full continuum of excellent care for service members and their families.
c. Provide sufficient resources for mental health services and allocate them according to requirements, and
d. Empower leadership to establish advocacy for a culture of psychological health.

The Assistant Secretary of Defense (Health Affairs) has directed a large scale effort to address these and other findings.

Navy Medicine is an active participant in this initiative. Additionally, Navy Medicine has taken significant steps to address shortcomings in mental health and TBI service delivery. I will now detail some of these accomplishments.

Care for redeploying Sailors and Marines. Our Deployment Health Clinics (DHCs) serve as non-stigmatizing portals of entry in high fleet and Marine Corps concentration areas and augment primary care services offered at the military treatment facilities or in garrison. Staffed by primary care providers and mental health teams, they are designed to provide care for Marines and Sailors who identify mental health concerns on the Post Deployment Health Assessment and Reassessment but also provide treatment for other service members. We now have 13 such clinics and plan to open an additional four in FY08. Through June 2007,

DHCs had more than 14,000 visits, approximately 30 percent of which were for mental health issues.

Stigma reduction. In November 2006, I directed the establishment of a directorate at the Bureau of Medicine and Surgery specifically dedicated to addressing mental health stigma, training for combat stress control, and the development of non-stigmatizing care for returning deployers and support services for Navy caregivers. Other initiatives aimed at reducing stigma, which I wholeheartedly endorse, include the removal on SF 86, the Questionnaire for National Security Positions, the so-called "mental health question." This is but one example of actions our leaders can take to reduce stigma associated with seeking mental health services. We have also provided recommendations on other policy changes, resulting in a revision of OPNAV 3591.1E: Small Arms Qualifications, allowing a waiver mechanism for service members with mental health diagnoses to, with careful and appropriate screening, continue to serve in their rating. The recently revised DOD Policy Memorandum for Deployment-limiting Psychiatric Conditions and Medications establishes new guidelines for deployment of service members with mental health conditions which should also protect service members.

In-theater behavioral health needs assessment. An in-theater mental health assessment, the Behavioral Health Needs Assessment Survey, has provided data critical to Navy Medicine and senior leadership for evaluating the well-being of corpsmen, other Medical Department personnel, and Seabees. Over 950

assessments have been completed thus far and this effort continues for deployed Navy personnel.

Navy/Marine Corps Combat and Operational Stress Control Center of Excellence. We are standing up a Navy/Marine Corps Combat and Operational Stress Control (COSC) Center of Excellence at Naval Medical Center San Diego. Designed to identify best COSC practices, the Center of Excellence will develop combat stress training and resiliency programs, establish provider "Caring for the Caregiver" initiatives, and coordinate collaboration with other academic, clinical, and research activities. As the concept for a joint DOD/VA Center of Excellence develops, we will integrate, as appropriate, the work of this center.

Mental health training for medical department personnel and Caregiver Action Plan. Navy Medicine is developing a 'train the trainers' program offered to medical department personnel, providers and non-providers, officer and enlisted, as well as to our chaplain resources. The goal is standardized training in evidence based approaches to combat stress. This four-module approach addresses burnout in high-risk caregiver groups, such as our front-line corpsmen, independent duty corpsmen, forensic personnel and those providing services to detainees. Initial training will be offered in September 2007.

Expanded case management. Concurrent with the establishment of the Wounded Warrior Barracks, Marine for Life, and other initiatives, we have expanded USMC Liaison Offices at our major medical centers for the purpose of coordinating and supporting the needs of the Marines and their families. We have tremendously expanded our case management capabilities, increasing the number

of case managers from 85 in 2006 to 141 by July 2007. The DVA has established Liaison Offices at Navy MTFs for the purpose of coordinating follow-on care requirements and providing education on DVA benefits.

Conclusion

We have made significant strides towards addressing the shortcomings in services provided to military personnel with psychological health or TBI needs, their families and their caregivers. That said, much remains to be done. We must improve our ability to detect mild to moderate TBI, especially those forms of TBI in personnel who are exposed to blast but do not suffer other demonstrable physical injuries. Service members who return from deployment and have suffered such injuries may later manifest symptoms that do not have a readily identifiable cause, with potential negative effect on their military careers. As many of 20 percent of injured service members may have TBI in addition to their other injuries.

Navy Medicine, in concert with tri-service colleagues and civilian academic partners, is tackling the very difficult issue of universal neuro-cognitive screening. It is imperative to understand that such screening devices do not yet exist. It is incumbent upon us to devise a valid and reliable measure that can be cost-effectively administered and does not impose an additional burden on service members or commands to collect, and which has minimal risk of stigmatizing service members.

We must also enhance our capabilities for blast detection and mitigation. It is important to develop easily deployable assessment devices to allow field medical personnel to immediately detect the effects of exposure to blast or other hazards that might result in TBI. Such assessments will be of critical importance in making battlefield

determinations about the ability of combatants to return to the fight plus providing vital medical data. Along these lines, I have also directed Navy Medicine researchers, in partnership with civilian academic colleagues, to continue their work in developing a personnel-borne blast sensor that has the capability of detecting cumulative exposure to blasts so that TBI in personnel without observable physical injury can better be assessed and treated.

We must also address significant shortfalls in our active duty mental health community. Navy uniformed psychiatry and psychology communities continue to experience manning shortfalls. Our psychiatry community is at 92 percent manning, our clinical psychology community is at only 70 percent manning. The Navy social work community is currently fully manned, but has been slated for civilianization of all active duty social worker billets by FY 2010. Uniformed mental health providers, including psychiatrists, psychologists, advanced practice mental health nurses, and social workers are vital in our efforts to provide preventive and clinical services to deployed Marines and Sailors. We must continue to develop mechanisms, including consideration of accession and retention bonuses and special pays, to ensure an adequate complement of uniformed mental health providers.

Building a culture of psychological health requires an enduring commitment to the mental health needs of service members, their families, and those who provide their care. It requires a commitment to service provision in the operational environment, to expanded surveillance and detection capabilities, to equipping our providers with the best possible training, and to equitable access to non-stigmatizing interventions. But more fundamentally, building a culture of psychological health requires a focus on enhancing

the capabilities and resilience of the individual service member, and an understanding that in the end, this is less a question for medical science than a challenge that every leader must accept.