

**HEARING TO RECEIVE TESTIMONY ON THE  
FINDINGS AND RECOMMENDATIONS OF  
THE DEPARTMENT OF DEFENSE TASK  
FORCE ON MENTAL HEALTH, THE ARMY'S  
MENTAL HEALTH ADVISORY TEAM RE-  
PORTS, AND DEPARTMENT OF DEFENSE  
AND SERVICE-WIDE IMPROVEMENTS IN  
MENTAL HEALTH RESOURCES, INCLUDING  
SUICIDE PREVENTION, FOR  
SERVICEMEMBERS AND THEIR FAMILIES**

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**Wednesday, March 5, 2008**

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

The subcommittee met, pursuant to notice, at 2:35 p.m. in Room SR-232A, Russell Senate Office Building, Hon. E Benjamin Nelson, chairman of the subcommittee, presiding.

Committee Members Present: E. Benjamin Nelson [presiding], Lieberman, and Graham.

Committee staff members present: Leah C. Brewer, Nominations and Hearings Clerk.

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

Minority staff members present: Diana G. Tabler, Professional Staff Member, and Richard F. Walsh, Minority Counsel.

Staff assistants present: Jessica L. Kingston and Benjamin L. Rubin.

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

**OPENING STATEMENT OF HON. E. BENJAMIN NELSON, U.S.  
SENATOR FROM NEBRASKA**

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

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

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

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

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

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

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

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

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

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

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

Senator Boxer: Well, Senator Nelson and Senator Lieberman, I'm just very honored to be before your subcommittee. If we remember back, with the gracious help of this committee, Senator Lieberman and I working together, we were able to include language establishing the Mental Health Task Force in the fiscal year 2006 Department of Defense authorization bill.

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

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

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

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

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

According to a study published in the Journal of the American Medical Association on November 14, '07, 20 percent or one in five of all active duty Army soldiers and 42 percent of all Reserve component soldiers, including Army Reserve and Army National Guard, who served in Iraq are reporting that they need mental health treatment for a range of problems—one in five. This means that tens of thousands of men and women need and deserve the best mental health care that we can provide.

I have to say, Mr. Chairman and Senator Lieberman, in all the years that I've been in Congress, and for a period of time in the 80s I served on the Armed Services Committee, I saw that when the military decides to do something they do it right and they do it as a model for the rest of the Nation. I don't care whether it's

child care or health care or whatever it is. So I am so optimistic that with the resources that we can make sure they have they can really not only solve the problems that we're facing in the military, but send a very clear signal to the civilian community of what the civilian community must do.

Too many servicemembers have been discharged for preexisting personality disorders when they actually had mental health problems from their combat experience. Imagine, they were discharged for preexisting conditions when they had mental health problems from their combat experience. That's wrong, because, as you know, those people are not going to get the help they need.

Too many servicemembers have turned to drugs and alcohol, and the number of DUIs has risen at bases across this Nation. Too many servicemen and women have attempted or committed suicide. In '07 alone, 121 soldiers committed suicide and another 2,100 attempted suicide, a sixfold increase since '02. This is tragic. I know you agree with me because I've talked to you about these things.

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

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

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

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

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

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

Mr. Chairman, it's rare, it's rare that members of Congress look at a subcommittee—excuse me—at a special committee that was set up to work within the DOD and say you're right on every count, you have done your work well. We are of one mind on this. Now, I know there are differences about the war in Iraq. There's bitter differences, difficult differences. But I know that all of us agree, re-

ardless of how we feel about the war. We all feel the same way about the warriors. We honor them, we trust them, we want to stand by their side.

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

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

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

Senator Ben Nelson: Thank you, Senator.

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

Senator Boxer: I would love to hear it. I would love to hear it.

Senator LIEBERMAN. No, Mr. Chairman. Why don't you go ahead and then I'll wait my turn. Thank you.

Senator Ben Nelson: Well, go right ahead.

**STATEMENT OF HON. JOSEPH I. LIEBERMAN, U.S. SENATOR  
FROM CONNECTICUT**

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

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

There's been a lot of work done on this. I'm very proud of the Mental Health Care for Our Wounded Warriors Act, which was in the fiscal year 2008 National Defense Authorization Act. I appreciate the work that is being done within the health services in the military.

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

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

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

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

It's not going to be easy, particularly because of some very practical problems, that some of our military installations are in places that are not, shall we say, in the middle of cosmopolitan metropolitan areas. Would those in uniform agree with that? Yes. And some of the mental health professionals prefer to be in such places. None of these are in South Carolina, Senator Graham. [Laughter.]

Senator LIEBERMAN. The entire State is cosmopolitan as far as we're concerned.

So we have to figure out ways to attract people.

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

So the legislation Senator Boxer and I are working on would in short create a new across-the-services prevention program modeled on a highly successful aircraft incident prevention program which is run by the Air Force. And I hope that my colleagues will look at both of these pieces of legislation and ideally, as you were kind enough to include the previous legislation in the Defense Authorization Act of '08, perhaps we could include these two in the Defense Authorization Act of '09.

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

Thank you very much.

Senator Ben Nelson: Thank you.

Senator Boxer: Thank you, Senators.

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

Senator Graham: Thank you, Senator. I agree with you.

Senator Ben Nelson: Senator Graham, would you—thank you, Senator. Would you have an opening statement?

**STATEMENT OF HON. LINDSEY O. GRAHAM, U.S. SENATOR  
FROM SOUTH CAROLINA**

Senator Graham: Very briefly. When Senators Lieberman, Boxer, Nelson, and hopefully Graham can come together, that's a big day for the Senate. The topic brings us together, and I would just like to say to the witnesses who are going to testify about the stress on the force, thank you for coming and telling us about what's going on out there. I think I have somewhat of an understanding how

stressful it may be, but there have been so many acts of bravery and kindness of our troops in incredibly hostile circumstances and a lot of people have gone back more than twice, and it's got to wear on them and their families.

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

Senator Ben Nelson: Thank you, Senator Graham.

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

Without objection, so ordered. [The material referred to follows:]  
[SUBCOMMITTEE INSERT]

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

Senator Graham: We should just run the whole government, the way I look at it.

Senator Ben Nelson: It's certainly tempting. [Laughter.]

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

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

for his extensive work in the area of mental health care in the military.

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

Let me say that I commend the Army for starting these Mental Health Advisory Team studies on its own initiative.

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

**STATEMENT OF VICE ADMIRAL DONALD C. ARTHUR, U.S. NAVY-RETIRED, CO-CHAIR, DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH**

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

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

Dr. MacDermid: Thank you. The full report of the Task Force on Mental Health is being submitted for the record.

Senator Ben Nelson: You might pull the microphone a little closer.

Dr. MacDermid: The full report is being submitted for the record, and I thank you very much for inviting both of us to speak today. I'm honored to be here and I'm honored to be among the very distinguished speakers that you will hear from today.

As you know, the report presented an achievable vision for supporting the psychological health of military members and their families. The task force recommended building a culture of support for psychological health throughout DOD in order to combat stigma, shortages of staff and training, and procedural and policy barriers that were interfering with access to quality care.

The task force also made recommendations aimed at ensuring a full continuum of excellent care for servicemembers and their families. Because of specific gaps that were found during its investigations, the task force recommended increases in resources and staff and changes in staff allocations in order to address shortages that were impeding adequate care.

Finally, the task force recommended that leadership be created and empowered to ensure consistent attention to and advocacy for the psychological health of military members and their families.

I will now turn to Admiral Arthur.

Admiral Arthur: Thank you.

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

I would like to talk about the three pillars of mental health as concentrated on by this report: prevention, mitigation, and treatment. In the prevention, we focused on establishing a culture in

the military services that looks at mental health as part of an overall health policy, as looking at mental health fitness with the same degree of concern that we have for physical fitness. Today we measure mile runs and pushups and pullups, but we don't really measure how psychologically fit or resilient people are to the very difficult stresses of military service. We feel that vulnerability should, can and should be assessed in our military members and that we accept military members, officers and enlisted, who already have significant issues of stress in their lives, that we can measure, we can measure and mitigate those stresses that they come to us with.

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

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

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

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

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

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

The last point I would like to make on mitigation is that we have many “volunteer”—and I put that in quotes —organizations, such as the key volunteers of the Marine Corps, the ombudsmen of the Navy, and there are organizations of spouses and other concerned people who support the families. These are volunteers. They’re unfunded. I think that these programs ought to be in some way formalized, funded, so that every family member has a uniform degree of support.

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

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

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

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

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

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

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

Dr. MacDermid: Thank you.

As you know, the task force made 95 recommendations, almost all of which were endorsed by the Secretary of Defense, who submitted a detailed implementation plan to Congress in September 2007, several months in advance of its statutory deadline. I know that many dedicated individuals within DOD and the military services have been working very hard to improve support for mental health and several of the recommendations already have been fully implemented. Many remaining recommendations are targeted for complete implementation by May of 2008, a few short weeks from now.

You have many experts here today who can tell you about what is being done and what has been done. So all that I will do in my remaining remarks is to identify three areas where I am eager to hear about positive progress.

The first issue I would like to address is TRICARE. The task force recommended several specific changes needed to ensure that the TRICARE system could provide adequate care for the psychological health of military members and their families who cannot receive their care at MTFs. Some of these changes have been made. For example, TRICARE Reserve Select has been simplified to be more accessible and efforts have been made to make it easier to find mental health providers.

I'm aware of little progress, however, on some of the other recommended changes. Let me give you one example which pertains to intensive outpatient services, a highly utilized benefit in most health plans and a cost-effective treatment of choice for many patients with substance abuse or other serious psychological problems. 18 months ago the task force heard testimony from staff in the TRICARE management authority and representatives of the TRICARE contractors that cumbersome TRICARE rules resulted in intensive outpatient care not being covered under TRICARE. They asked for change. We made a recommendation to correct the deficiency.

Yet little progress appears to have been made. These services are offered and heavily used in VA, available at many MTFs, and are a frequently utilized service in Medicaid and Medicare. Thus, military members and their families whose primary source of health care is the TRICARE system have no access to care that is available to the poor, the elderly, veterans, and their military brothers and sisters who are fortunate enough to receive care at MTFs. On its face, this seems quite inequitable.

The second issue I would like to address is the supply of professionals who are well prepared to provide the prevention, assessment, treatment, and follow-on of services to military members and family members who require care. The task force made several recommendations aimed at increasing the number of such providers and I think several efforts are under way in this area. I'm especially eager to learn about progress in the area of recruiting and retaining mental health professionals.

The task force received numerous indications that it is difficult to get and keep highly qualified mental health professionals, especially when there are already shortages in the civilian community and DOD must compete with the Department of Veterans Affairs

and others for staff. But as the cumulative load of deployments on the force mounts there is no question that the need to support psychological health is only becoming more urgent. I hope that the importance of individuals who do that work is being recognized by very strong efforts to recruit and retain them.

Also in the area of staffing, I'm eager to hear about changes in contracting procedures. The task force made site visits to 38 installations, where we heard over and over again that contracting mechanisms were cumbersome, temporary staff already in place often could not be retained because it wasn't possible to give them timely information about whether their contract would be extended, hiring and processing procedures for new temporary staff took so long that the funds were gone before the person could begin work, critical GS positions lay empty for long periods even when a qualified and willing person had already been identified.

These procedural problems were significant hurdles in the race to meet the needs of service members and their families. I'm eager to hear how they have been addressed.

While Congress has been helpful in allocating funds, I am eager to hear whether the right mix has been provided. For example, substantial funds have been allocated on a nonrecurring basis, which makes it difficult to address infrastructure issues and makes it difficult to hire the best staff.

The task force report emphasized that the shortcomings we observed in the military mental health system were not caused by the protracted conflicts in which the United States is now engaged and are unlikely to disappear when the conflicts end. Nonrecurring funds, while helpful, do not allow the fundamental challenges to be addressed.

Finally, as someone who has devoted her life to studying and advocating for families, I will close by saying that I am especially eager to learn how services for family members have been improved since the task force submitted its report. We made several specific recommendations in this area. For example, we wanted to be sure that parents or others caring for wounded or injured servicemembers could easily get access to installations, care managers, and other services. Because they have no official status within the military system, parents sometimes face barriers which systematically disadvantage young unmarried servicemembers.

We also recommended that the substantial delays many children were experiencing in accessing care be addressed, and we recommended that inequities between families who were nearby and could receive treatment at MTFs and families who were far away and had to rely on TRICARE be eliminated. I'm eager to hear about progress in all of these areas.

In conclusion, Mr. Chairman and distinguished members, I appreciate your sustained attention to these issues. I also very much appreciated the prompt and detailed plan submitted by the Secretary of Defense. But many weeks have elapsed and I know the strong sense of urgency which we all feel pales before the daily struggles that confront families dealing with depression, substance abuse, children's disorders, or PTSD. I'm very much looking forward to the day the plan is fully implemented.

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

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

I would like you to understand the fundamentals of how it differs from traumatic brain injury that we see in the United States. First is the mechanism. In the United States, all over the world, we have traffic accidents, we have football injuries, we have domestic violence, and they are relatively low velocity injuries. Something strikes the person's head and the brain moves, the skull moves, and it causes a bouncing where you get an injury where the strike was and an injury on the other side, and it's a relatively low velocity injury.

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

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

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

So we've asked the blast industry to construct an omnidirectional indicator that we can use, that will allow us to tell what the exposure has been, correlate that with the symptomatology and with treatment efficacy, and even give the Veterans Administration an ability to base compensation on actual environmental exposure. [The prepared statements of Admiral Arthur and Dr. MacDermid follow:]

Senator Graham: Where is that at?

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

We also would like a baseline cognitive test. Football players, soccer players, already have that. If we had a baseline cognitive

test going into combat or even coming into the service, we could in the field assess an individual's exposure and the resultant cognitive effect and have some idea.

When I had my traumatic brain injury 2-1/2 years ago, the psychologist gave me a whole battery of tests, and in the air he drew a line. He said: But you're normal; you are here on the battery of tests, you score very high. I said: I know, but I did not start there; I started at some other level.

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

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

Admiral Arthur: I can't calculate how much to give on a tip at a restaurant. And these are abnormal for me, so people will present with a myriad of symptoms that are not normal behavior for them and must be recognized and treated.

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

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

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

Senator Nelson, Senator Graham, thank you very much for this opportunity. It's a true honor to be able to come back and testify

before you, and thank you for your attention that you're paying to this very important issue.

Senator Ben Nelson: Thank you, Admiral. Thank you, doctor.  
Colonel Hoge?

**STATEMENT OF HON. COLONEL CHARLES W. HOGE, U.S. ARMY,  
DIRECTOR, DIVISION OF PSYCHIATRY AND NEUROSCIENCE,  
WALTER REED ARMY INSTITUTION OF RESEARCH; ACCOMPANIED BY COLONEL CARL A. CASTRO, U.S. ARMY, RESEARCH AREA DIRECTOR, MILITARY OPERATIONAL MEDICINE RESEARCH PROGRAM**

Colonel Hoge: Senator Nelson, Senator Graham: I have a very brief statement for both Colonel Castro and myself regarding the Mental Health Advisory Team assessments that we've conducted annually in Iraq, also called MHATs. So I may use that acronym.

The MHAT missions were established by the Army Surgeon General at the request of the MNFI commanding general and CENTCOM. They've been conducted annually in Iraq since the start of Operation Iraqi Freedom, and we've also conducted two assessments in Afghanistan in 2005 and 2007. The MHATs are part of an ongoing scientific effort to understand the mental health impact of deployment to Iraq and Afghanistan and then utilize this knowledge to improve the care that we deliver to the servicemembers in the deployed environment and post-deployment.

This effort is unparalleled compared with previous wars, where mental health issues really weren't addressed until years and sometimes decades after servicemembers came home.

The MHATs have maintained a consistent focus on soldiers and brigade combat teams or, in the case of Marine units, regimental combat teams. We've looked at both active and National Guard units and units that have directly supported those brigade combat teams. The in-theater MHAT assessments have utilized the same methodology that we've utilized in some of our studies post-deployment that we published in the New England Journal of Medicine and other top-tier journals.

The results of these investigations have shown that 15 to 20 percent of combat troops deployed to Iraq experience significant symptoms of acute stress, post-traumatic stress disorder, or depression, and 15 to 20 percent of married servicemembers experience serious marital concerns. The MHATs have shown that longer deployments, multiple deployments, greater time away from the base camps, and combat frequency and intensity all contributed to higher rates of mental health problems.

The most recent MHAT V report is in the process of being released, but the key finding—one of the key findings concerns the cumulative effects of deployment, because this was the first time we were able to look at servicemembers who were on their third rotation to Iraq, compared with two and one rotation or their first rotation. What we found was that mental health problems rose with each cumulative deployment, reaching nearly 30 percent among those soldiers on their third deployment to Iraq.

The MHAT V effort also showed that soldiers deployed to Afghanistan are now experiencing levels of combat exposure and mental health rates equivalent to levels in Iraq and substantially

higher than they were experiencing in 2005 during our last assessment.

The data from the MHAT missions have led to a number of important policy changes. Most importantly, the findings have led to revised doctrine and combat stress control procedures that we use in the theater, an improved training and distribution of behavioral health personnel. They've assured that there's sufficient mental health personnel deployed in theater and are providing support to soldiers at remote locations.

The MHATs have demonstrated the critical role of strong leadership in maintaining the mental health of combat units, and it's led to the development and testing of new interventions, such as the training program called Battle Mind, which is now being implemented Army-wide.

Thank you very much for your continued interest in our research and your support for our servicemembers. We look forward to answering your questions. [The prepared statement of Colonel Hoge follows:]

Senator Ben Nelson: Colonel Castro, do you have anything to add?

Colonel Castro: No, I do not, sir.

Senator Ben Nelson: Well, thank you very much for your testimony here today.

I'm going to ask a question about what we can do for mental health care in the rural areas that are not going to have a proximity of a base or may not even have a large city within a certain distance. Did you find—Dr. MacDermid, did you find any protocols in place or that could be put in place to ensure that you could still have adequate mental health services even—I'm thinking primarily of National Guardsmen and reservists, who are by comparison stranded in other areas, not necessarily close by a base or other location for an operation.

Dr. MacDermid: Thank you for your question. We made a number of recommendations about ways to reach National Guard and Reserve folks, one of which was to simply increase the infrastructure within those organizations, because, for example, in each State there's not necessarily someone who has the responsibility to oversee and monitor and take action about psychological health issues.

I think it is also the case that the TRICARE system has to be functional for Guard and Reserve members, and the VA has also been increasing resources in that area. I think it doesn't make sense in my mind to try to create something new when there are services already out there, but it's not clear that those services are working effectively. And we recognized, for example, that we were told on many installations that even in those areas the TRICARE network records did not appear to be very accurate, and that is likely to be similar and even more problematic in areas where there is not an installation.

Senator Ben Nelson: Did you encounter anything having to do with confidentiality, or were you able to look at all of the records?

Dr. MacDermid: We did not look at medical records, sir. That was not something that we had the authority to do. Our conversations were with leaders of health care facilities, with patients, and with community providers.

Admiral Arthur: Senator, may I add. There's an even more vulnerable population. That's the people who come back and are no longer affiliated with the active or Reserve or guard component, those people who've gotten out. And they go back to work and back in their community, where people really don't understand what they have been through and don't have any context for some of their mental health issues.

One of the programs that I think is very successful is the Marine for Life program, where the Marines have people all over the country who are retired or who have just done one or two tours in the Marine Corps and feel it is their obligation, their responsibility, to take care of marines who have gotten out. I think that population really is the unseen population for us.

Senator Ben Nelson: In terms of the family that would be experiencing this vicariously, what have your thoughts been about how we might deal with the family members, particularly if they're in a stranded location far away from a base or another provider?

Dr. MacDermid: Well, there are substantial shortages in the civilian community, as you know, for a variety of medical specialties, and it is a problem. And that's true for active folks as well. When they have to go to communities to find specialists, they have trouble, too, which is one of the reasons why we put as much emphasis as we did on uniformed providers.

I think in many cases the solutions for families are the same as the solutions for reaching National Guard and Reserve members, because it's families that are out there in communities and that is where they have to get most of their care, and there's a lot we could still do to try to make sure those communities are well prepared to receive them.

These policy issues we identify that have the effect of impeding access to care I think might be low-hanging fruit. There probably are things I don't understand. I'm sure that there are. But on their face, when it's a matter of changing a policy that looks to be a good target for something that might open up quite a bit of access fairly quickly, so I am happy to be told that I'm wrong about that, but I think it's certainly worth a look.

Admiral Arthur: We also need to provide access for the families where they can receive the assistance, the social assistance, not just where it's convenient for us. One of the things we talked about in the report is even going down to school counselors and teachers to educate school counselors and teachers about the particular stresses of the military and allow them to assist the children right in their schools.

So there are a lot of things that we can do, but we shouldn't make the families necessarily come to us when they have a problem. We should be accessible to them before they have a problem.

Senator Ben Nelson: If you were to identify as a percentage of shortage, percentage shortage of the providers, the care providers that would be available to help, do you think we're 50 percent below where we should be, or are we more than that, or do you have an opinion?

Dr. MacDermid: This is Admiral Arthur's favorite question, sir.

Admiral Arthur: Well, I mentioned the population-based risk-adjusted model, and that speaks to assessing what the risks are. The

risk for a deploying combat battalion might be more than for a non-deploying motor transportation battalion, for example. So I think we have to assess what the risks are, the number of people, and then provide an appropriate number of resources and the appropriate kinds of personnel. It is not just psychiatrists. We tend to focus on the doctor stuff, but it's really the sociologists, it's the social workers, it's the psychologist, it's the mental health practice nurses—anyone who can be involved, at the lowest level possible.

Senator Ben Nelson: So do you have an opinion about how adequate we are in terms of numbers? Is it say 50 percent, 40 percent? Any estimate of that sort?

Admiral Arthur: I would like to leave that up to my service colleagues, because I think they've done a lot more assessment recently, and I actually don't know where we are in the full contracting and the supplying of people for battalion support, particularly in the field. So if I may I would leave that for my esteemed active duty colleagues.

Senator Ben Nelson: There's been a lot—there have been a lot of questions raised about the length of deployment and then how much time should lapse between deployment number one and deployment number two, in other words how much time back home should there be. I think we're looking at trying to make the number the same or something similar to that, which I think probably the longer the time at home that a soldier has or an airman or a marine probably the better. But I don't know that statistically I can prove that.

Probably it seems self-evident that that time back would be very, very helpful and be required. But is that an assumption on our part that is founded on anything that you've been able to determine in your studies?

Admiral Arthur: I think that's a very valid conclusion. It also matters greatly where you are in the combat arena. If you're right up front in combat operations day after day, or you're in convoys day after day with the threat of adverse combat action, then you're much more stressed and need more time back at home.

If you're in a rear echelon or a headquarters element in some place like Bahrain or other rear locations, then you may not need as much rest.

The greatest concern I have are for the Special Forces people in the Army and the SEALs in the Navy, the recon people in the Marines, who have an incredibly high operational tempo and a very high degree of mental health issues in themselves and their families when they return.

Colonel Hoge: Sir, if I may answer that question as well. We have good data that after a 12-month deployment, 12 months back home is not sufficient to reset. We actually see rates of mental health concerns rise slightly during that 12-month period. They certainly don't go down.

Senator Ben Nelson: Would it be fair to say, though, that the shorter the time in between, it wouldn't be better; it would be worse? In other words, is there an optimum time, or is each case an individual case? Or have you been able to establish what would be an optimal time frame in between?

Colonel Castro: Sir, it is important to also keep in mind the length of deployment. For example, the Army deploys much longer and probably then it would require much longer in between deployments. For the Marine Corps, which deploys the shorter amount of time, 7 months, then their recovery time probably doesn't need to be as long. But as Admiral Arthur points out, it's very, very critical to look at what exactly is happening to the servicemember, the warrior, while they're over there.

One of the key findings from the MHAT IV, the Mental Health Assessment Team IV, is that those soldiers and marines who are in day to day combat operations day in and day out, their mental health rates were two to three times higher than the overall force. So it's very, very important to look at all of the variables that we know are related to and impacting on the psychological health of the servicemember. But we certainly know, as Colonel Hoge points out, a year is not long enough if you're deployed for a year or longer. But perhaps if you're shorter, you deployed shorter, it's not as long.

But the bottom line is we don't know because our soldiers deploy so frequently we have never been able to give you an exact time.

Senator Ben Nelson: Well, that raises some obvious questions about the dwell time, as you say, depending upon whether you were forward deployed or where you were in the deployment. It's hard enough to try to get something that is uniform across the board for each branch the way it is. I imagine it gets a little byzantine if you try to make it a pattern or tailor make it to each individual case.

So 15 months may not be long enough. Do you have a recommendation just overall, a one size fits all type of well time recommendation?

Colonel Castro: Well, one of the recommendations we made in the MHAT IV report was 18 to 24 months dwell time. But that was a quite controversial recommendation.

Senator Ben Nelson: I imagine it was, yes.

Senator Graham?

Senator Graham: Thank you, sir. Mr. Chairman, thanks for having the hearing. This has been fascinating. When it seems on the money front you expand TRICARE to include mental health services available in the civilian community, that would be a great start. It seems we're going down that road.

The invest in technology to understand the brain injury situation better, I am fascinated by some of the ideas out there and will follow—we will follow up and see where this monitoring device is at. I know I just want America to know we do spend a lot of money trying to find out what is the best equipment, what's the best way to prepare our folks for war, and it's always an ongoing endeavor.

About you said 30 percent, I think, Colonel Hoge, of people who have gone back for the second or third time are having some mental health-related problems, is that right?

Colonel Hoge: Yes, sir.

Senator Graham: Is it affecting retention rates?

Colonel Hoge: I can't answer that. I don't have access to that. I haven't looked at that particular outcome.

Senator Graham: Is it affecting the ability to go back to duty? Are these incapacitating problems?

Colonel Hoge: They aren't necessarily incapacitating to the point of not being able to do their duty. But that 30 percent rate is based on self-report survey data, where we ask a series of questions about what types of mental health problems the soldier is experiencing, and they have to report a substantial number of symptoms to meet that threshold. So it is not just a few symptoms. They have to report a fair number of symptoms.

Senator Graham: I guess what I'm asking is at what point in time does one become—what kind of impact does it have on retention? What kind of impact does it have on being able to go back to duty? If you could maybe explore that a little bit and get back with us.

Colonel Hoge: Yes, sir, I'd be happy to do that.

Senator Graham: Contractors, civilian contractors. We have 130,000 folks over there. Has anybody looked at the civilian contracting force? I see some heads nod. To be asked later, I guess, in the next panel.

Well, we will do what money can do. We will try to grow the Army. I think that's one of the goals, is to grow the Army to make sure the rotation schedules are not so onerous.

Admiral, you had something?

Admiral Arthur: Sir, I'd like to make a comment about the money. We've talked about money and TRICARE and modifying the TRICARE benefit. I'd just like to put a plug in that the reason we have such a wonderful save rate or resuscitation rate of combat injuries and so much attention that can be paid to our veterans in the field is because we have maintained an Army, Navy, and Air Force medical system that has not only taken care of our servicemembers and their families, but has maintained a state of readiness over so many decades and is ready to do whatever the Nation calls on it, and that requires that the services and their medical functions be properly funded to train and equip for their combat role as well as their normal health care role.

Senator Graham: Well, that's well said. I think one of the unsung heroes of this war are the men and women in the medical services. If you could make it through the door of a hospital in Iraq, they say you have about a 90 percent survival rate, which is phenomenal. But these injuries are solid. They have to be detected, having your buddies understand what to look for, having commanders sensitive.

What you're doing is good work for the country. War is a terrible thing. Just listening to this—my dad went off to World War II before I was born, but a lot of people went away for 4 years, never saw their family.

Admiral Arthur: For the duration.

Senator Graham: For the duration. So America's been through these tough times before. But this war is unique and we need to make sure that we're stepping up to the plate and providing all of the services possible, and retention and recruitment is amazingly good to me. The one thing I hear from these beds in hospitals when I go visit, like Senator Nelson, is the number one comment I get

is: I want to go back to be with my buddies, which just astonishes me.

So I think our force needs to be protected and nurtured. But we're blessed to have them. So thank you.

Senator Ben Nelson: We certainly don't have to work that much harder on creating a team concept in the military, because that is the reaction that you pick up from a wounded warrior, a feeling of guilt that they're no longer able to be there with their comrades. And if we can establish stronger mental health care and recognition of challenges at the time for prevention or intervention, it seems to me that we'll be doing what needs to be done.

The suicide rate, is there any comment that any of you would like to make about what is an alarming suicide rate for our military personnel today?

We can take that up with the next panel. But I'm also thinking perhaps from your standpoint you may have some thoughts about it from the reports that you've been involved with.

Colonel Hoge: Yes, sir. We've looked at suicide rates in theater with every one of the MHATs and we have seen consistently for the last couple of years a higher rate than they expected, the expected baseline rate of suicides. I think the factors that generally drive suicides, there's an element of impulsivity, there's access, obviously, easy access to weapons. So that there's not—the soldier may not—in an impulsive moment may make a decision that he wouldn't make when he's back home.

Then a lot of times these things are precipitated by relationship problems that the soldier is having, that type of thing.

Senator Ben Nelson: Any connection that you could draw between the length of deployment or the number of deployments or the short time frame for dwell time tied to suicide?

Colonel Hoge: Sir, we haven't been able to make a direct link because suicides are still quite rare events. We can make that kind of link for overall mental health concerns, mental health problems. We know there's a relationship between mental health problems and suicide, and so we could make the link in that way. But we haven't been able to make it in a direct way.

Senator Ben Nelson: Thank you very much. We appreciate what you're doing and thanks for being here today. [Pause.]

Senator Ben Nelson: Last, but certainly not least, on our third panel we welcome: Lieutenant General Eric Schoomaker, United States Army, Surgeon General of the Army and Commanding General, United States Army Medical Command; Vice Admiral Adam M. Robinson, Jr., United States Navy, Surgeon General of the Navy and Chief, Bureau of Medicine and Surgery; Lieutenant General James G. Roudebush, United States Air Force, Surgeon General of the Air Force, and a resident of Gearing, Nebraska. We appreciate that connection, General. And Colonel Loree K. Sutton, United States Army, Special assistant to the assistant Secretary of Defense for Health Affairs on Psychological Health and Traumatic Brain Injury.

Colonel Sutton, we congratulate you on your recent selection for promotion to brigadier general. Colonel Sutton is responsible for, among other things, implementation of the DOD centers of excellence for PTSD and TBI, which were mandated by the Wounded

Warrior Act in the National Defense Authorization Act for fiscal year 2008.

General Roudebush, I understand you received both your bachelor of medicine and doctor of medicine degrees from the University of Nebraska, another fine institution. So we have high expectations for you as a result of your stellar education.

I know that, General Schoomaker, you have a brother living in Omaha, Nebraska. As your brother, the other general, has told me on so many occasions, he's had more than one good steak in Omaha.

So we look forward to hearing your assessments today of service and DOD-wide plans to implement all of the findings and recommendations we've just heard about in great detail. So with that, General Schoomaker, the platform is yours.

**STATEMENT OF LIEUTENANT GENERAL ERIC B. SCHOOMAKER, U.S. ARMY, SURGEON GENERAL OF THE UNITED STATES ARMY AND COMMANDING GENERAL, UNITED STATES ARMY MEDICAL COMMAND**

General Schoomaker: Sir, I guess the rivalry precluded your mentioning that I'm a graduate of the University of Michigan. [Laughter.]

Chairman Nelson, Senator Graham, distinguished members of the Personnel Subcommittee: Thank you for this opportunity to discuss the Army's efforts to improve mental health care for soldiers and family members. Our Army Secretary, Pete Geren, our Chief of Staff of the Army, General George Casey, and the rest of Army leadership strongly support our efforts to improve the quality and access to mental health services and are also actively leading and remain engaged in our efforts to eliminate the stigma associated with seeking mental health care.

As you know, the stigma is not just found in the military community. It is a national concern and should really be addressed in all communities.

Our soldiers and our Army are doing amazing work in an Army that is demanding and has an extremely high operational tempo that you have heard spoken about by our previous two panels. But our soldiers and families are stressed. The global war on terror has placed increased operational demands on our military force. We know that repeated and extended deployments, as you've heard from the group that has performed our MHAT surveys, are experiencing increased stress, family difficulties, other psychological effects of war, such as depression, anxiety, withdrawal, and social isolation, and symptoms of post-traumatic stress, which, if not identified and treated promptly, may evolve into a more resistant psychological injury known as post-traumatic stress disorder.

The Army is absolutely committed to ensuring all soldiers and families are healthy both physically and psychologically. We have embraced the recommendations of the DOD Task Force on Mental Health and commend its authors. We are striving to provide the best mental health care for our soldiers and families. From the time a soldier enters the Army to the time that they depart, they are assessed, trained, and offered treatment for mental health care should they need it. This includes their families as well.

Much of our efforts are concentrated on the activities associated with deployments, whether that's building resiliency through training and awareness prior to deployment or assessing, training, and treating while being deployed. We then follow soldiers very closely upon redeployment and several months after redeployment to ensure that the mental health needs are assessed and are being met.

I'll only touch on a few of the many programs that we have that address the recommendations of the Task Force on Mental Health. I hope it shows that we are taking significant action in line with each of these six key objectives that are described in the task force report and in their testimony. Let me just expand on a few.

As described by Colonels Hoge and Castro just a moment ago, the Mental Health Advisory Teams are a groundbreaking achievement. Never before has a military force studied the psychological strains of combat as intensely during the conflict. This work of our best and brightest minds is published year after year in the world's leading medical journals, like the *New England Journal of Medicine* and the *Journal of the American Medical Association*.

I was pleased to hear Senator Boxer in her comments actually refer to one of those published studies. The authors of that study were sitting here in front of you a moment ago.

Based on these assessments, we make changes, some immediately, to make our work and things work better. Sometimes it is not pleasant to hear what they found. Self-assessment is often not pleasant, but it is important we hear their unvarnished feedback so we can take the necessary steps to improve.

The Army's unprecedented Lead-Train-Teach was a powerful initiative started at the top of the Army by the Secretary and by the Chief, that simultaneously and powerfully addressed leadership culture and advocacy. The program has now trained over 800,000 soldiers in a massive education effort in the summer and fall of last year, and has now been incorporated into various soldier and leader training programs throughout the Army.

Our Battle Mind training program, which is the brand that we essentially call all of our resiliency and recognition and prevention programs in the Army, is an outgrowth directly of the MHAT assessments. It focuses on building fitness and resilience, which Vice Admiral Retired Arthur talked about. MHAT V findings indicate that Battle Mind training is hitting the target and making soldiers less susceptible to combat stress.

The Chief of Staff of the Army and Secretary of the Army have challenged us to incorporate all of this training and prevention and early recognition of the psychological consequences of deployment and family separation and combat. We're doing so throughout the career of every soldier and every leader. Excellent quality care is being addressed throughout through improved and expanded training courses, like the new combat operational stress control course which is now mandatory for all deployed behavioral mental health providers.

We've, under my predecessor Major General Bill Pollock, we have launched an initiative to hire over 300 behavioral health providers, of which we have now hired 149 in the United States. These will have direct and lasting impact on access.

Finally, we've taken the recommendation of the task force to heart and have incorporated access and enhancing skills through primary care providers through a program called Respect-MIL. This program had a pilot at Fort Bragg and was so successful we have now expanded this to 15 other installations.

I enumerate these initiatives, not to assert that we are 100 percent, that we have a 100 percent solution here, but to make the point that the Army takes reasoned, focused action everywhere we see the opportunity to make a difference.

I applaud Senator Boxer and the Congress for standing up the Task Force on Mental Health in 2006. I applaud the Congress in 2007 for directing the establishment of the Centers for Excellence for Psychological Health and Traumatic Brain Injury being directed by my colleague Dr. Loree Sutton. She is absolutely the right person, as I think you will see, to lead that organization and generate the kind of results that you the Congress are seeking.

This committee, along with the leaders of the Department of Defense and the Army, is troubled by some of the negative trends that are related to psychological health of our force. I'm very conscious of these reports. I know we will address some of these issues in these hearings. But I'm also heartened to see the terrific effort and the energy being applied to reverse these trends, and I am confident that with continued strong support from this committee and from Congress, we will provide the care and support that our warriors and their families deserve.

Thank you again for holding this hearing. Thank you for the privilege of being here and responding to your questions. [The prepared statement of General Schoomaker follows:]

Senator Ben Nelson: We thank you, General.  
Admiral Robinson?

**STATEMENT OF VICE ADMIRAL ADAM M. ROBINSON, JR., U.S. NAVY, SURGEON GENERAL OF THE UNITED STATES NAVY AND CHIEF, BUREAU OF MEDICINE AND SURGERY**

Admiral Robinson: Good afternoon, Chairman Nelson. Thank you very much. I appreciate the opportunity to share with you Navy medicine's efforts in preventing, diagnosing, and treating psychological health issues affecting our active duty and Reserve sailors, marines, and their families. As the provider of medical services for both the Navy and the Marine Corps, we have to be prepared to meet the needs of these similar and yet unique military populations. Navy medicine is continuously adapting to meet the short and long-term psychological health needs of servicemembers and their families before, during, and after deployments.

We are well aware of the fact that the number and length of deployments have the potential to impact the mental health of servicemembers, as well as the wellbeing of their families. The Navy and Marine Corps operational tempo in support of the global war on terror is unprecedented. We need to remain vigilant of the potential long-term impact our mission requirements will have on the physical and mental health of our sailors and marines and their families.

To accomplish this, Navy medicine engages at several levels along the continuum of care, from commanding officers to small

unit leaders to individual servicemembers, and of course with their families. Our goal is psychological health services will be available to all who need them, when they need them.

The same way physical conditioning prepares sailors and marines for the rigors and challenges of high tempo operational deployments, we are psychologically preparing servicemembers and their leaders to build resiliency, which will help manage the physical and psychological stresses of battle. We do this by preventive education programs introduced at every career training point, which help educate servicemembers on the importance of psychological health, in an effort to decrease the stigma often associated with being given a mental health diagnosis and receiving mental health services.

Command involvement, together with dedicated and embedded stress management teams comprised of mental health providers and other professionals, are critical in helping sailors and marines become comfortable with the concept of building resiliency and decreasing stigma.

Our experiences in previous conflicts, most notably Vietnam, suggest that delays in seeking mental health services increase the risk of developing mental illness and may exacerbate physiological symptoms.

We are attacking the stigma in a variety of ways to ensure servicemembers receive full and timely treatment. This also is a critical component in our efforts to decrease the number of suicides among sailors and marines. Although suicide rates in the Navy and Marine Corps have not significantly fluctuated in recent years, our efforts to improve leadership's understanding and acceptance of the importance of treating mental health conditions is as important as preparing servicemembers to deal with the stresses of military life.

Both the Navy and the Marine Corps have published leaders guides for managing marines/sailors in distress. These products are available in various formats and are part of a greater effort to ensure front-line supervisors, including junior leaders, are able to identify when others in their unit may need help. The Marine Corps Marine Operational Stress Surveillance and Training Program, which is also called "MOSST," includes briefings, health assessments, and tools to deal with combat and operational stress. The MOSST program includes warrior preparation, warrior sustainment, warrior transition, which happens immediately before marines return home, and warrior resetting.

Navy medicine, in coordination with the line leaders in the Navy and the Marine Corps, is building on current training programs for leaders and our own caregivers. The curriculum focuses on combat stress identification and developing coping skills. Our goal is for members dealing with combat stress to be as comfortable in dealing with it as any other medical issue.

For the servicemember, the predeployment health assessment is one way to become aware of potential psychological health needs and the health care services available. The symptoms of a mental health condition may not necessarily make an individual nondeployable, but this assessment helps emphasize the importance of psychological health as part of physical health and may decrease any delay in seeking treatment.

Since the late 1990s, Navy medicine has embedded mental health professionals with operational components of the Navy and the Marine Corps. Clinical psychologists have been regularly embarked aboard all of our aircraft carriers and have become a valuable member of ship's company. Not only have mental health assets helped crews deal with stresses associated with living in isolated and unique conditions, but medevacs and administrative discharges for conditions typically managed by mental health personnel have decreased. Having a mental health professional who is easily accessible and going through many of the same challenges has increased operational and battle readiness aboard these floating platforms, saving lives as well as hundreds of thousands of dollars in operational cost.

For the Marines, Navy medicine division psychiatrists stationed with the Marines developed OSCAR teams—"OSCAR" stands for Operational Stress Control and Readiness—which embed mental health professionals as organic assets in operational units. OSCAR teams provide early intervention and prevention support through all of the phases of deployment. The same team providing care in garrison also deploys with the units, which improves cohesion and helps to minimize stigma.

Since the beginning of Operation Enduring Freedom and Iraqi Freedom, mental health-related medical evacuations for marines have been significantly lower among units supported by OSCAR, and currently there is strong support for making these programs permanent and ensuring they are resourced with the right staff and funding.

Before returning from the operational theater, sailors and marines are typically provided a series of briefings that familiarize them with issues related to combat stress, as well as how to manage their expectations after returning home.

The post-deployment health assessment measures the health status of returning servicemembers and must be completed within 30 days before or after redeployment. Navy and Marine Corps post-deployment health assessments are being accomplished in theater, during Warrior Transition, and at Navy mobilization processing sites.

Warrior Transition, initiated during OIF and expanded each year, has now become an inherent part of the sailor's redeployment process home. Recognizing the hardest part of going to war is reconciling the experience inclusive of one's losses, mental health professionals and chaplains assist servicemembers to reflect, recall, and reconcile the enormity of their deployment before returning home. Warrior Transition is now mandatory for all Seabees, individual augmentees, and soon our SEALs.

Since 2005 Navy medicine has been administering the post-deployment health reassessment, as directed by Health Affairs. Implementing this program was a joint effort between the Navy's Bureau of Medicine and Surgery, the Bureau of Navy Personnel, Headquarters Marine Corps, and the Deputy Commandant of the Marine Corps for Manpower and Reserve Affairs.

The PDHRA extends the continuum of care, targeting servicemembers for screening at 3 to 6 months post-deployment. Navy medicine played a critical role from the program's inception

to sustainment and coordinated implementation in line units. Beginning in 2006, Navy medicine established deployment health centers to serve as non-stigmatizing portals of entry in high fleet and Marine Corps concentration areas, and to augment primary care services offered at the medical treatment facilities or in garrison.

Staffed by primary care providers and mental health teams, the centers are designed to provide care for marines and sailors who self-identify mental health concerns on the post-deployment assessment and reassessment. We now have 17 such clinics, up from 14 last year.

In urgent or extraordinary situations, Navy medicine meets the psychological health needs of sailors and marines and their communities by deploying Special Psychiatric Rapid Intervention Response Teams, also called "SPRIRT." These teams have been in existence over 15 years and provide short-term mental health and emotional support immediately after a disaster, with the goal of preventing long-term psychiatric dysfunction or disability.

The team may provide educational and consultative services to local supporting agencies for long-term problem solutions. Never before has the mental health and well-being of sailors and marines deployed to a war zone been as intensely studied. In order to establish comprehensive psychological health services throughout Navy and Marine Corps and to evaluate and provide recommendations on the needs of deployed sailors and marines, Navy medicine has developed the Behavioral Health Needs Assessment Survey.

The BHNAS was adapted from the Army's series of mental health advisory team, the MHAT surveys, as previously discussed. Recently, Navy received funding for creation of a Navy-Marine Corps Center for the Study of Combat Stress, to be located at the National—at the Naval Medical Center, San Diego. This center is strategically located to work closely with our new comprehensive combat casualty center, our C-5, to better understand the impact upon Navy and Marine Corps families.

I have commissioned the Center for Naval Analysis to conduct a wide-ranging study of combat and operational stress control, impact and attitudes.

This survey, unlike the anonymous BHNAS, will target over 15,000 randomly selected families and provide the most comprehensive determination as to the cumulative effect of the global war on terror.

Reinforcing a culture which values psychological health will require an enduring commitment to the mental health needs of servicemembers, their families, and those who provide their care. It requires a commitment to ensuring psychological health services are available and accessible in the operational environment. Expanding surveillance and detection capabilities, equipping our providers with the best possible training, and minimizing the stigma associated with seeking treatment, we will underscore a culture that recognizes and embraces the value of enhancing our resilience to deal with the increasing stresses of military life and understands that in the end it may be less a question for medical science than a challenge for every leader to accept.

Chairman Nelson, Navy medicine continues to rise to the challenge of meeting the psychological needs of our brave sailors and

marines and their families. I thank you very much for your support to Navy medicine and look forward to answering your questions. [The prepared statement of Admiral Robinson follows:]

Senator Nelson: Thank you, Admiral.  
General Roudebush?

**STATEMENT OF LIEUTENANT GENERAL JAMES G. ROUDEBUSH, U.S. AIR FORCE, SURGEON GENERAL OF THE UNITED STATES AIR FORCE**

Admiral Roudebush: Yes, sir. First, Chairman Nelson, thank you. I know you are the driving force that brings us here today to discuss this and the information that has been shared already, that will be shared, the questions that have been asked. The concerns raised I think underscore the importance of this. So thank you for giving us the opportunity to come at this in a way that I think is very meaningful for us all within the Air Force.

I would first like to lay out the challenge and the opportunity, and then I will talk a bit about how we in the Air Force are approaching this. We clearly have airmen in harm's way, as do our sister services, perhaps not in the magnitude, but certainly within the intensity. We have airmen serving in the battlefield that are out there in the joint war fight, doing that mission every day, and we must take care of them.

In addition to that, we have an incredibly high Ops Tempo. As I believe you would agree, we've been at war 18 years. We did not come home after the Gulf War. We continued operations, and that has caused stress, strain, and wear on our forces. Certainly our forces and our equipment that we simply must attend to.

Now, we in the Air Force come at this in a way that is very coherent and resonant with our Air Force culture of accountability, caring for each other, a wingman culture, if you will. You always take care of your wingman. You protect their six. You make sure that nothing is below or behind that could be injurious, and that's how we succeed. We succeed as a team.

Very much the same in the way that we approach the challenges for our airmen. We medics support our line directly in doing this.

We are accountable for a fit, healthy force that's able to do the mission in some very demanding circumstances, both at home station and deployed, because every Air Force base is an operational platform whether we're providing global deterrence from F.U. Warren in Cheyenne, Wyoming, or global strike from Nodnoster, Missouri, or global mobility from Charleston. Every base is an operational platform, and we medics support our line in doing that, first by providing a healthy, fit force, but also by taking care of families providing resilience and families that are able to support these warriors as they go in harm's way and take on these intense and very demanding missions.

In addition to that, we provide constant surveillance, understanding, and attending to the health of our forces, so that rotationally and repeatedly and heroically we can deploy and do the mission, wherever that mission is found. And when illness or injury occurs, we are there with the right care, right time, right place to take care of those injuries and illnesses and, in support of our joint warfighters, to take care of those injuries and illnesses

forward, stabilize them, bring them home safely for definitive care here in the States.

The best care that we can provide, though, we believe is often preventive. If there is not an injury or an illness, that is the best outcome. That's economy of force. That's preserving health, and we think that is the best outcome right up front. But again, if illness or injury occurs, we're there to take care of it.

Now, we support the line in doing this. Within our Air Force culture, the line is very much accountable and responsible for the health and wellbeing of the forces. I mentioned the wingmen culture. The wingman program, if you will, wherein we take care of each other and we work to reduce the stigma—there is no stigma in needing help or asking for help. Certainly it can be uncomfortable, but sometimes that very uncomfortable conversation is the one that needs to happen: I need help or you need help. That's the best place for it to begin.

In addition to that, we have a suicide prevention program which is very much a line program. This was initiated in 1996 and serves as a model both for the military but for the Nation. During that time we've reduced our suicide—the incident of suicides, 28 percent. Any suicide is too many. However, to the full extent that we can prevent suicide we believe that that's very important to do. That's a community-based program, but requires attention every day, it requires training, and it requires buy-in that in fact we do take care of each other and there is no stigma in seeking or needing help.

Lastly, for those who are significantly wounded we have the Air Force Wounded Warrior Program, wherein a family liaison officer is assigned to every severely injured airman to assist, administratively assist the family, and to assure that all medical issues are attended to as well; that that injured or ill individual is properly taken care of.

So through this constellation of programs, both the medical and line, we are every day attending to our airmen to assure that we can repeatedly, heroically be there to support the mission, accomplish the mission, to dominate the domains, air space and cyber space in support of our sovereign options, and do it without fail.

Sir, I appreciate this opportunity to talk to you about Air Force medicine and I look forward to your questions. [The prepared statement of General Roudebush follows:]

Senator Ben Nelson: Thank you very much, General.

Colonel, General-to-be?

**STATEMENT OF COLONEL LOREE K. SUTTON, U.S. ARMY, SPECIAL ASSISTANT TO THE ASSISTANT SECRETARY OF DEFENSE [HEALTH AFFAIRS], PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY**

Colonel Sutton: Good afternoon, Chairman Nelson. Thank you so much for inviting me. We thank you also for your kind remarks in your introduction.

Let me just say for the record, sir, that my grandmother, Volga Bell Ward, she graduated from Lincoln, from Union College in Lincoln, Nebraska. I just wanted to establish that. [Laughter.]

Senator Ben Nelson: Great connection.

Colonel Sutton: Today, Mr. Chairman, I'm here to provide an update on the military health system improvements in psychological health and traumatic brain injury, with a particular emphasis on what is happening with the Defense Centers of Excellence for Psychological Health and TBI. Let me start out by saying I'm heartened by the optimism expressed by Senator Boxer and certainly shared by yourself and members of your committee, Admiral Arthur and Dr. MacDermid.

I'm deeply indebted to the Mental Health Task Force and to their emphasis on culture, on leadership, on the continuum of care, as well as the resources needed, particularly to reach those very tough populations that are particularly at risk, such as our Reserve components.

I would also like to share with you some of my excitement, sir, in terms of what's going on with Defense Centers of Excellence. We are becoming that front door for the Department for all matters of concern related to psychological health and TBI. I am pleased to report to you, sir, that we are on the verge of requiring a name change already, because Secretary Peake at my first meeting with him in January, he said: Loree, what you really need is you need a deputy for your center from the VA. I assured him that such an addition would be welcome, at which point we'll need to change our name from the "Defense Centers of Excellence" to, I would propose, the "National Centers of Excellence."

We opened our doors for initial operations on the 30th of November 2007, which meant that on the 1st of December we had a phone number, we had a receptionist, and we had a dugout in Rosslyn with a part-time chief of staff, a couple of contractors, and, fortunately, we are harnessing also the power, the momentum, the achievements of a number of centers.

So I would think of the center of excellence at this point, sir, as a center of centers. We are so pleased to be able to bring in the efforts and the track record, the achievements, of the Defense Veterans Brain Injury Center with their 16 years of research, education, and treatment. They were named in fact as the number one treatment and research network for TBI in the country in 2005.

We're also bringing in, led by David Riggs, the Center for Deployment Psychology, which will really help boost our efforts, not just to reach out to psychologists, but to mental health professionals, health professionals within our direct care system, as well as throughout the country, because we realize those 800,000 soldiers, sailors, airmen, and marines who've already served are out there as veterans in various areas of the country.

We're bringing in the efforts of the Defense—correction—the Deployment Health Clinical Center, led by Colonel Chuck Engel, as well as working very closely with the Center for the Study of Traumatic Stress at the Uniformed Services University, led by Dr. Bob Rusano.

Sir, we are also so blessed to be working with Mr. Arnold Fisher and the Intrepid Fallen Heroes Fund. Mr. Fisher has pledged to do for psychological health and TBI what he and his fund have already done for the care of amputees with the Center for the Intrepid.

We just recently convened our first strategic planning conference last week, sir. We had 160 folks that came together, a combination of both military, VA, advocacy groups. We had folks such as Meredith Beck from the Wounded Warrior Project, Ted and Sarah Wade, Barbara Cahun from the National Family—National Military Family Association. It was just a tremendous effort coming together to really get our first initial traction. This will be a quarterly conference and I'll look forward to reporting to you our ongoing results.

We also launched, we are in the process of launching, a national awareness campaign, building upon the efforts that the National Institute for Mental Health had several years ago: Real Men, Real Depression. We are now looking to harness the power of stories that come from real warriors, real battles, and real strength.

Sir, having said all of that, yes, we have done a lot. We are working on the issues of concern that were earlier addressed. I can certainly provide more details on that, and we have much more work ahead of us. We must continue to fully implement the Mental Health Task Force recommendations, redouble our efforts for suicide prevention, build that global network that will include not only DOD and the services, but the VA, our civilian colleagues. And yes, we've already been contacted and are in collaboration with folks in Israel, Great Britain, Australia, Canada, and we seek to add to that global network.

We're opening a clearinghouse and a call center which will really facilitate that communication between us and those that we serve. We want it to be two-way. The 18th of March this month we will initiate what will become a monthly VTC that will reach out to not only our folks within the services, but to anyone who wants to join our regular communication, followed by a newsletter coming out in April. We're also looking for ways to harness the power of not just 800 numbers and websites and newsletters, but YouTube and MySpace and podcasting and all of the ways that our generation of warriors and their families communicate.

Sir, we are also very, very interested in working on what really was emphasized first and foremost by the task force and has been mentioned by so many others this afternoon. That is the importance of culture. We can work the implementing all of the task force recommendations. We can come up with the best strategy, plans, programs, and policies. But unless and until we transform the culture that undergirds our efforts, we will fall flat.

So that is a particular area of focus coming out the gate. We are partnering with the National Institutes of Health. We've got that CDC, the Institutes of Medicine, SAMHSA. We are working with a group of founding Federal partners, working with the Federal Steering Group to initiate a priority working group to address the reintegration needs of our veterans, service members, and families, that will be co-chaired by Tony Zeiss, who is also on the task force. So clearly it's time for us to do a little less talking and a whole lot more action here, sir, and we're after it.

We thank you so much for your support. We thank you for your sustained collaboration. We've got a lot of work ahead, but I assure you, sir, we'll keep after it. [The prepared statement of Colonel Sutton follows:]

Senator Ben Nelson: Well, thank you very much, and I believe you will.

I'm concerned about how you transform the culture and how you identify the condition in such a way that it doesn't have stigma associated with it. Now, General Schoomaker, we were talking the other day. You made it clear, and I think most everybody would recognize this, that the stress associated with the warriors is not something brand new; it's from the beginning of time stress has been associated with conflict. Perhaps our knowledge of it is more refined today, and we're working to refine it even more as we move forward.

As we do that, is there really an expectation that we can somehow move from what is a macho attitude toward a recognition that we're really trying to build people's resiliency? Are there softer ways to talk about the situation, or does that even help?

General, maybe start with you and then ask the others as well.

General Schoomaker: Well, sir, I think it goes without saying that the U.S. military is a microcosm, is a subset of the American society as a whole, and reflects the attitudes of society as a whole. The problems that we encounter in stigma within the uniformed services is reflected in society at large. As I said in my opening comments, I think that this is an issue that needs to be addressed by all communities.

Having said that, I think that this is done not by medics, it's not done by people sitting at this table, but, as I think all my colleagues have emphasized, this is a problem for line leadership right down to the smallest unit leader and fellow soldiers, sailors, airmen, marine, Coast Guardsmen, who in a sense give license to the view that the human dimension of combat and the human dimension of deployment and separation from families involves stressors that are going to be manifesting symptoms that may make them—as you said in your opening comments and as Senator Graham said, are going to make them less than completely engaged warriors.

That's how we have to look at this. I think that our leadership has taken a very assertive role in doing exactly what you describe.

Senator Ben Nelson: Colonel, maybe I can ask you in terms of that, the cultural change in the way we think of this. In the training, basic training, building people into warriors requires building up self-confidence, teamwork, everything that we want to have somebody be, I guess, combat prepared. How far can we go at the beginning to build up that resiliency so to, if not eliminate the possibility, which is unlikely, but reduce the impact of the stress?

Is there some tie to that where people would be less stressed with more training, more specific training, more directed training toward that, so that maybe we can get ahead of it rather than have to treat it after the fact?

Colonel Sutton: I couldn't agree more with you, Mr. Chairman. In fact, I would say that that process of building resiliency for both soldiers, sailors, airmen, marines, coasties, and their families has to start at day 1. It starts not only with the tough training that challenges our young folks to go beyond that which they believe or know about themselves, and of course it's always fun to go to a basic training graduation where, after 12 weeks, when the buses

come in it looks like they've scooped up folks from the shopping malls of America, with purple hair and rings and all of the rest. 12 weeks later, the parents walk right by them and don't even know who they're seeing.

It's a transformation, and it starts with day 1. I think we also need to look towards baseline cognitive screening when folks come in at accession, as well as perhaps imaging. We're looking at that right now because, although we're currently focused on the deployment cycle, we know that we need to prolong that. We need to extend that over the life cycle of a young troop of her family member being with us.

It also has to do with the tough training that you mentioned. I would take issue with your comment earlier as to whether we need a softer approach. In fact, I would go back to a couple of weeks ago in the Washington Post newspaper there was an article with a young female, as it turns out, Cobra pilot. When she was asked at the end, you know, how do you cope with the stress of doing your job and engaging in combat, and she says: Don't ask me, how do I cope. That makes it sound like I have to get over something. Because when somebody's shooting at my marines, this is my job; this is what I'm trained to do and I'm proud to do it.

I think it's that kind of pride, buttressed by the confidence that can only come from tough training, as well as the framework, the framework of education to help folks understand what are the normal consequences of exposure to trauma, to killing, to losing one's buddy, and what are the support systems, what are the tools.

This generation wants tools. They don't see themselves as disabled or weak or needing help. They want tools to be able to keep themselves going and performing. So I think that's part of it.

Two other examples I would point to, sir, as already positive signs of this transformation in culture that we're aiming for. Several weeks ago in Tom Rick's Inbox in the Washington Post once again, he gave the story of a young marine staff sergeant, staff Sergeant Travis Twigg, who came back from his third deployment and had a tough time, lost several of his men, and was not readjusting well.

His sergeant major brought him in and said: Sit down, Twigg; do you know why you're here? No, Sergeant Major. You're here because you have PTSD. Do you know why I know? Because I have it, and you're going to get help.

He got Staff Sergeant Twigg to Bethesda, where he was hospitalized. He had a tough course of treatment, but did very well. He's back in the Corps today, and in the article Staff Sergeant Twigg says: Listen, here's my phone number, here's my email; I want to help anyone else who has these problems. I'm going to be contacting young Staff Sergeant Twigg here and bringing him on our team.

But think of what that says. The chain of command saw a problem, didn't say, ah, Twigg's weak, he's messed up, he can't hang. No. Recognized this young staff sergeant needs help, I'm going to get it to him, and he's going to be back in the force—that expectation of recovery, of performance, of resilience, whether it's in the classroom or the battlefield. It's paramount for our leaders to understand that we must, we must prepare our troops, we must give

them the tools that will allow them to gain the confidence and the expectation of recovery.

Lastly, sir, I would point to as another sign of this transformation in culture that is just really getting started, has to do with Secretary of Defense Gates, his leadership in saying that, you know, question 21 on the security clearance questionnaire, we need to change that. And I'm proud to say that there's been a lot of inter-agency work on that, but that is nearing fruition, and I think that's going to be a real improvement that will help our troops understand that the Department's stance toward seeking help, whether it be for mental or for physical health issues, is absolutely seeking help is a sign of strength and we want folks to feel like they can go forward without fear for their careers.

Senator Ben Nelson: Now, we as a society at large have stigmatized seeking help by the very question about have you ever had this. People get over appendicitis, I guess, when the appendix is removed and other conditions, but there isn't necessarily an indication that that condition has been removed with or without treatment. So we've probably done society as a whole a great disservice. We've got to move beyond that.

General Roudebush, maybe you can give us your perspective from the Air Force.

Admiral Roudebush: Yes, sir, and I think it does go the form follows function. We train individually. We select people for their capabilities and we train them in a particular area of expertise, and we expect them to execute in that particular area. But in reality we execute as a team. We very seldom ever execute individually. You're always reliant on a team member for some portion—

Senator Ben Nelson: On the wing, as you say, the wing man.

Admiral Roudebush: Yes, sir. We execute as a team, but quite literally, we take care of each other as a family. Now, we have the family that the good lord gave us, but we have the family that we're issued, and they're both really good families. I think is at the essence of taking care of each other.

Stigma is both self-perceived and outwardly or externally perceived. The individual may feel some reticence to say, I need help, may suspect or assume that the others in the unit will think less of them because they did in fact need some assistance. But if you break down those barriers and say, yes, we execute and we succeed as a team and we take care of each other as a family, those barriers become less noticeable and less onerous.

Now, I will tell you, it is far from perfect. I think the recommendations that the task force made are right on target, both in terms of assisting us in positioning the right resources, prioritizing the right activities, policies, issues. So I think we must do it better.

But at the end of the day it's going to be that accountability to each other and the willingness not to inflict stigma or assume stigma that I think will allow us to get to the other side. Once we get by that, and if you can get to a problem sooner, when it's this big, as opposed to later when it's this big, the whole process is enhanced. A better result, less time out; and frankly, it helps us deal with some very trying and demanding circumstances.

In our theater of operations, everyone has PTS. There is nothing normal about that circumstance. It's preventing that from becoming PTSD that we need to concentrate on.

Senator Ben Nelson: We don't have to establish the disorder associated with every PTS. It's the extent of the PTS, I assume, that then establishes whether it's a disorder or not.

Admiral Roudebush: Yes, sir, and getting to it sooner, in a proactive fashion, mitigating early, is clearly the preferred way to do this. But it does take a team to do that.

Senator Ben Nelson: In the case of active duty, when following the deployment the unit comes back and it stays pretty much intact. When you get to guard and Reserve in stranded situations, where a reservist comes back from a deployment and goes back into society, which probably does not have him or her associated with the team that they were with during the deployment, is there a greater risk of PTS becoming a disorder as time goes by if they don't get some care for that up front? Is there a greater risk with that group, and is the probability higher that they will have a greater problem than somebody that will stay with the unit?

Admiral Roudebush: Sir, I can give you the Air Force statistics. Our statistics as we have gathered them, and they are far from as complete as we would rather or they need to be, but we continue to make progress in that regard. Our findings for our guard and Reserve members are not significantly different than our active duty.

Now, the challenges for us is getting to those folks in a way in terms of both surveilling, screening to assure that that happens. To that end, certainly their line and their unit counterparts are instrumental in assuring that we don't lose track of them, as are their families, and sensitizing the families that if something does not seem right, if something is amiss, to ask the question much sooner than later, as both an ally and a resource, is helpful in that regard.

But it is more challenging with the Guard and Reserve, there is no doubt about that.

Now, when we find it we very aggressively go after it and treat it, either using uniformed capabilities or using our TRICARE networks if that's more appropriate, because keeping these folks close to their home of record and at home with their families we believe is an important part of reintegrating them and successfully taking care of these folks.

But yes, sir, it is a challenge.

General Schoomaker: Sir, this is a great question and it's one that all of us are very concerned about, and I'm going to lean on what we've learned from the medical—excuse me—the Mental Health Advisory Team studies. I think I could say without fear of contradiction that we know there are several factors that contribute to raising the risk of post-traumatic stress symptoms and other stress-related symptoms, like isolation and depression.

First is intensity of combat. The variability of combat teams, marine and soldier teams, the variability in their self-reported symptoms is a function of the intensity of combat.

Second is the coexistence of concussive or mild traumatic brain injury or severe injury. We think there is now some work done by

Dr. Hoge that was recently published that suggested it might be the context in which that concussive injury occurred. In contrast to the sport field, when it's in combat concussive injury is often associated with a life-threatening event, maybe associated with the loss of friends and the like.

The third is deployment length and frequency of deployment. These are all associated with a higher risk of stress.

Let me say one other thing that I think is very important that you've touched on in your last series of questions, and that has to do with stigma. I think one of the very positive effects of reexamining and rescreening soldiers, sailors, airmen, and marines, anyone who's been deployed, not just at reintegration, because we've learned through the MHAT studies that the excitement of reintegration, the desire to get home and to be fully incorporated into home and family and job if you're a reservist or a National Guardsman overwhelms what may be symptoms.

The MHAT studies have very closely shown us that you need to go back and reexamine at the 90 to 180-day period, and that is a challenge for the distributed Reserve and National Guard.

Finally, I'd say in regard to stigma, and this is Eric Schoomaker's opinion, the assumption of a stigma to oneself I think is attributed in part to fear. Part of that fear is that I am self-identifying a serious illness, a mysterious illness, one that may never end. One of the things that can be reassuring about our studies is that, with screening and identification of the early symptoms of post-traumatic stress, we can do things symptomatically that improve the individual soldier or marine's state and eliminate, as you said, their emergence into or maturation into a disorder, especially if we can keep them away from alcohol and drugs and family discord and violence and all the other things that may characterize the establishment of a well-established post-traumatic stress disorder.

So I think one of the clues and one of the keys to removing stigma for that individual is improved education about the fact that your having these symptoms does not label you with a permanent disability, that in fact we can treat these and we can prevent a much more long-lasting disability.

Admiral Robinson: Mr. Chairman, I would also like to add, just to the stigma question, I agree with what General Schoomaker said and also what General Roudebush said. Stigma is going to be a factor because it's a factor in our country. The keys that I think the Navy and Marine Corps have shown are leadership, number one, education number two, education from boot camp all the way through war college. It's a continuous process and there has to be education amongst the buddies that are caring for one another, the shipmates that are there, the leaders that are there, the small units that are there.

And additionally—and this is very important, and I think this may be one of the keys—to embed mental health resources in the units means that when you go see the chaplain, who could be part of that, but when you go see the psychologist, the psychiatrist, or the social worker who is a part of your unit and who has been living with you day in and day out, it becomes less of an issue of stig-

ma; it becomes more an issue of, that's one of my shipmates, that's one of my buddies, I've got to go see him, I have some issues.

So that together helps from the culture point of view. If at the same time families are given the opportunity to have deployment counseling, to have ombudsmen, to have different people who are available and units who are available to provide that mental health or that support that they need, so that they can in fact understand what their loved one's going through away on the deployment and they can also build up their resiliency and psychological health, it becomes a synergistic effect and it becomes very effective in terms of not only reducing the stigma, but also realizing that mental health and mental illnesses are as real as physical illnesses.

You said it yourself: If I break my leg, no one cares that I come in with a cane and have a limp. But if I've had some sort of mental issue, then everyone looks at me as if I'm not capable of ever functioning again, which is completely untrue.

Senator Ben Nelson: General?

Admiral Roudebush: Chairman Nelson, if I might add one thing. We've been focusing a great deal on mental health capabilities, psychiatrists, psychologists, social workers, and all the technical support that surrounds that. But as a family physician I can tell you that I was trained to anticipate and expect that upwards of two-thirds to perhaps even more of the issues that I would face as a family physician will have an emotional aspect to it or a psychological aspect to it.

So I think it's important, while we focus on the pure mental health resources or the more specifically focused, that we also pay very close attention to the whole constellation of care capabilities that we have, both primary care as well as specialty and subspecialty, to provide them training, as in fact we all have, to focus on getting the right kinds of diagnostic training and sensitization, if you will, to look for TBI, to look for PTSD, while you may be treating something that is a very visible issue relative to an injury or an illness, to look for those things that may not be quite so visible.

So we can really leverage the entire care capability that we have to further focus on this and assure that we're not overlooking those injuries that we ought to be paying attention to.

General Schoomaker: Admiral—excuse me. General Roudebush is right on target. In fact, I think that that is the main thrust of the military's respect-military effort. It's to further arm primary care providers of all kinds—nurse practitioners, PAs, general internists, family medicine docs, whoever that primary care provider is—with the tools and skills necessary to screen and do first-line treatment.

Admiral Robinson: And that's the plan for the deployment health centers that the Navy now has, so agreed.

Senator Ben Nelson: The screening that you do I suppose prior to somebody's joining one of the branches is important in trying to ferret out existing conditions of some sort of mental condition or perhaps identifying people that might have a greater potential for stress, as I think was indicated, put somebody as a mechanic as opposed to out in the front line if there's something that could be identified that might be predisposed to stress.

Then before they're sent to theater there's another screening. Do the screenings take it up to where you have—where you can really catch the people, somebody that might be more predisposed than someone else? Or can the person being screened hide it from the screening process? Colonel Sutton, do you have a thought?

Colonel Sutton: Sir, this is an important area. I think screening does play a role both at accession and certainly predeployment and ongoing during deployment and after they return, as well as the post-deployment reassessment of health. I would say, though, that rather than thinking of, for example, at accession this being a process designed to screen out, I would argue that this ought to be a process designed to screen in, that is to identify strengths as well as areas of potential vulnerability, and then to customize our leadership and our approach to help that troop really reach his or her potential.

You know, when three out of ten of our 18 to 25-year-olds qualify for military service, I would argue that we already have an elite force, and so I would argue to screen at the beginning and then as we go through the process—and this, by the way, is something that in light of Colonel Hoge's recent article and other emerging reports in the last year that have come out, we are relooking our screening process right now. We want to make sure that we are absolutely asking the right questions to elicit the information that we're after.

To do that, we're bringing in not only experts from DOD and the VA, but we're also going to bring in civilian experts from around the country, in fact around the world. And we will be coming forward with recommendations to the senior leadership within the next probably 6 to 8 weeks. But the screening process, the one that we had in place now, is a good one. I think that, armed with our latest knowledge, we can improve it even further.

General Schoomaker: But sir, with respect, I would say that the present state of what we have still centers around self-identification.

Admiral Roudebush: Exactly.

General Schoomaker: And this dovetails, this dovetails very clearly with your earlier line of questioning around stigma, that in a society that stigmatizes a mental health or behavioral health problem, it is the tendency for some of our soldiers to obscure or to withhold information that is sensitive.

I failed to mention one other stressor, one other factor that predisposes to post-traumatic stress, and I defer to my colleague the psychiatrist at the other end of the table to validate this. That is preexisting experiences prior to coming into the service. Severe trauma prior to coming into the service represents another predisposing element to developing, development of symptoms while in service. If that's obscured or withheld, then it does become a challenge to us.

Senator Ben Nelson: Well, I think there's supposed to be a vote in a couple of minutes. So is there anything else that anyone would like to say? Obviously we haven't covered the entire subject, but we've worked it over pretty good. Anything anybody would like to say at this point?

Well, thank you for what you're doing. It seems just even gratuitous for me to say how important it is, but I think we all recognize

the mental wellbeing of our men and women in uniform is critical, not only to performance, but to quality of life and to our society. So I really do appreciate what you're doing and I hope that we'll continue to learn more about what will help us in not only identifying but treating these different areas.

I'm encouraged by the fact that there's not just one category that everything falls into. The more that we're able to distinguish between various different situations or degree of post-traumatic stress is I think critically important to being able to do the job right and get the best result for our servicemembers and their families. So I commend you for what you're doing.

Colonel, thank you for taking the leap into a new area. We wish you very—the very best. And of course, we want to be responsive to the needs in terms of what financial resources and other resources will be necessary for us to be able to do this.

Working to have the VA together with DOD, with a new name, in your area and in so many other situations, such as for retirement, for disability determination, is extremely important to our members as well. So I hope that we'll be able to cross the lines to VA and DOD generously and not get blocked in that process.

Of course, General Schoomaker, we all appreciate your stepping into the breach with the Walter Reed situation and your willingness to take that, make that an opportunity and give us more confidence that, as you have, that the military really does care from the top down about the people who have the need for care of any kind. And our wounded warriors deserve no less than the best, and we thank you for providing it.

The hearing's adjourned.

[Whereupon, at 4:46 p.m., the hearing was adjourned.]