STATEMENT

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Chairman Davis, Representative McHugh, Distinguished Members of the Subcommittee, other Distinguished Members of Congress, ladies and gentlemen, good morning. I am honored to be in the company of the distinguished speakers who are here to discuss with you today the mental health resources available to military members and their families. As you know, I completed service several months ago as the co-chair of the Department of Defense Task Force on Mental Health, and I am very pleased to be here today.

The full report of the Task Force on Mental Health has been submitted for the record. 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 in 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 service members and their families, because of significant gaps that were found during its investigations. Third, 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.

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 ahead of its statutory deadline. I know that many dedicated individuals within DoD and the military services have been working very hard to improve supports for mental health, and several of the recommendations already have been fully implemented. Many remaining recommendations are targeted for complete implementation by

May 2008, a few short weeks from now. You have many experts here today who can tell you about what is being and 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 am aware of little progress, however, on many 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. Eighteen months ago the Task Force heard public 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 us for change. We made a recommendation to immediately correct this deficiency, and the Secretary of Defense endorsed the recommendation. Yet little progress appears to have been made. These services are offered and used heavily in VA, available at many MTF's, 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-up services to military members and family members who require care. The task force made several recommendations aimed at increasing the number of such providers within the military, and I think several efforts are underway in this area.

A question Admiral Arthur and I have often been asked is how many more professionals are needed to meet the need. The task force did not answer this question because it required the development of a new model for allocating the staff who support psychological health – specifically, a risk-adjusted population-based system. The existing staff allocation system is based on 'relative value units' that undercount prevention activities and unmet demand. The task force recommended that staff instead be allocated according to the size of the population in a given area, adjusted according to the presence of risks such as combat deployments and other challenging conditions. According to the workplan released in September, the new model has been designed, which should make it possible to identify quite precisely where sufficient staff are in place to meet the estimated need, where the numbers are insufficient, and by how much.

I am also eager to learn about successes in 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 the individuals who do that work is being recognized by very strong efforts to recruit and retain them, including incentives and opportunities for career development.

Also in the area of staffing, I am eager to here 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 was impossible 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 am 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 non-recurring 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. Non-recurring 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 service members could easily get access to installations, care managers, and other services. Because they have no official status as family members within military systems, parents sometimes faced barriers which systematically disadvantaged young unmarried

service members. 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 am eager to hear about progress in all of these areas.

In conclusion, Madam 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 we all feel pales before the daily struggles that confront families dealing with depression, substance abuse, children's disorders, or PTSD. I am very much looking forward to the day the plan is fully implemented. That concludes my remarks, and I thank you for your attention.