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MEDICAL EXAMS FOR SEPARATING MEMBERS DIAGNOSED WITH PTSD OR TBI

BEFORE THE  
HOUSE COMMITTEE ON ARMED SERVICES  
SUBCOMMITTEE ON MILITARY PERSONNEL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Separation Medical Examinations**

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

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

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

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

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

### **Mental Health Provider – System Capacity**

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

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

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

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

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

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

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

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

Since 2001, TRICARE has witnessed an 18 percent annual growth rate in mental health services, and our network support has adapted to this increased demand.



Over 50,000 behavioral health providers are in the network, with more than 10,000 added in the past three years to ensure TRICARE can continue meeting access to care standards.

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

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

In 2006, the Center for Deployment Psychology (CDP) was established at the Uniformed Services University of the Health Sciences in response to a nationally-recognized need for behavioral health providers with experience in deployment-related issues. The CDP is a DoD training consortium that supports a network of deployment behavioral health psychologists at 10 military medical centers throughout the country that offer American

Psychological Association-accredited psychology internship programs. The CDP offers several training programs, including a two-week comprehensive course for military providers, a one-week comprehensive course for civilian providers, 2-3 day courses focusing on treatments of PTSD, sleep problems and depression, and online courses that address topics including military cultural competence, PTSD and military families.

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

### **Separation Policy**

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

Medical fitness is an area of particular concern, and the Services must carefully reach such a determination. In that regard, the nature of the signature injuries sustained in

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

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

In addition, members who have served or are currently serving in imminent danger pay areas must have their diagnosis corroborated by a peer -- psychiatrist, PhD-level psychologist, or higher level mental health professional -- and endorsed by the Surgeon General of the Service concerned. While there is little evidence Service members would

be routinely misdiagnosed, there were concerns early in the conflicts that members suffering PTSD or TBI might be separated under the non-compensable, exclusive diagnosis of a personality disorder.

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

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

For administrative separations, to include those for misconduct not related to personality disorders, there are equally rigorous processes to ensure Service members receive the appropriate discharge characterization. Much of the rigor in the discharge process

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

To further ensure the Department identifies Service members with PTSD or TBI, title 10, United States Code, section 1145 and DoD policy, require the Secretary concerned to ensure a physical examination of Service members immediately before any discharge with the intent existing conditions are documented and to rule out PTSD or TBI diagnosis or other problematic or extenuating medical condition(s). If PTSD or TBI is identified by a medical professional or alleged by the Service member during this process, DoD

policy mandates the separation authority consider a PTSD or TBI diagnosis as an extenuating circumstance, and if this new evidence outweighs the conduct or cause for separation, consider denying or modifying the separation and /or separation characterization.

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

Looking ahead, and in response to Section 512 of the National Defense Authorization Act for FY 2010, the Department is developing policies to ensure medical examinations are conducted with the participation of mental health professionals experienced in diagnosing PTSD and TBI for those Service members who have deployed to a contingency operation within the past two years, have been experiencing or reasonably assert PTSD or TBI, and are being considered for discharge under conditions other than honorable. These emerging policies will also ensure the assessment of the effects of PTSD or TBI relating

to the basis for a separation under conditions other than honorable. An integrated effort across the Department, these new policies will necessitate changes to DoD separations, medical exam, and discharge review board legal policies as well as cascading changes to Military Department Instructions and Regulations. The Department is working hard to implement the statute in policies, regulations and in practice and is looking forward to reporting the status and accomplishment by June 2010.

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

## **Conclusion**

We want to thank you for the opportunity to talk with you about the status of our implementation of the requirement for medical examinations and separation policy for all personnel, and in particular for those Service members diagnosed with PTSD or TBI.

The Defense Department is complying with both the letter and, we believe, the spirit of the law, and is working to improve the means by which we perform these examinations, and to enhance the evidence-based guidelines we use in the process.

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

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