Prepared Statement

of

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REGARDING

THE CURRENT STATE AND FUTURE AIMS OF PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY—CLINICAL AND RESEARCH PROGRAM ASSESSMENT

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON MILITARY PERSONNEL

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Chairman Coffman, Ranking Member Speier, and members of the Committee, thank you for the opportunity to discuss the Department of Defense's (DoD's) efforts to promote psychological health and to prevent, diagnose, and treat Traumatic Brain Injury (TBI), posttraumatic stress disorder (PTSD) and associated mental health conditions . I am honored to join my colleagues from the Army, Navy and Air Force for today's testimony.

I would like to thank the Committee for its sustained leadership and support for the work we perform in the Military Health System (MHS) to care for our Nation's Service members, veterans, and their families—especially those dealing with complex issues related to mental health and TBI. Your investments in medical research have led to important advances in care and a greater understanding of where future research should be targeted.

The MHS' overriding mission—centered on readiness—is to ensure a medically ready force and a ready medical force. This mission has grown in complexity. As our advances shed new light on our principal areas of research, we also are confronting new medical challenges every day—from developing more sophisticated capabilities that increase survivability from trauma, to treating Ebola and other infectious diseases, to creating advanced prosthetics that aid in the recovery of our wounded and injured Service members. All the while, we are addressing threats in the arenas of PTSD and other mental health issues, TBI, suicide and substance use.

Although the MHS is still learning and striving to treat mental health illness more effectively, we are one of the only health systems in the Nation that is reliably obtaining outcomes for the treatment of mental health conditions, and we are a leader in treating severe mental illness in the population of young adults who often present with these illnesses for the first time. RAND validated much of DoD's progress in a recently published a report on the quality of care for Posttraumatic Stress Disorder (PTSD) and depression in the MHS. The MHS

continues to outperform civilian health care systems by ensuring that patients with PTSD or depression receive an outpatient follow-up visit within 7 to 30 days after psychiatric hospitalization. Over 87% of patients received a follow-up visit within 7 days, and over 95% received this visit within 30 days. Additionally, in new treatment episodes, the MHS demonstrated high rates of assessment for suicide risk—96%in a PTSD cohort and 88% in a depression cohort—and high rates of assessment for substance use—93% in a PTSD cohort and 90 % in a depression cohort.

DoD has sustained efforts to track the long-term effects of TBI. In 2009, the Secretary of Defense directed the Defense and Veterans Brain Injury Center, a component of DCoE, to address DoD's portion of the "Longitudinal Study on Traumatic Brain Injury Incurred by Members of the Armed Forces in Operation IRAQI FREEDOM and Operation ENDURING FREEDOM." DCoE is responsible for two component studies within this directive. The first, "The 15-Year Studies," focuses on the long-term physical and mental health needs of Service members, veterans, and their families. The second, "Improved Understanding of Medical and Psychological Needs in Service Members and Veterans with Chronic Traumatic Brain Injury," or "IMAP," examines the rehabilitation and health care needs of Service members and veterans with TBI.

Both the "15-Year Studies" and the "IMAP" make it clear that comorbidities—such as PTSD, acute stress, and sleep disruption—complicate TBI recovery and create a need for a complementary suite of mental health and rehabilitation services for effective TBI treatment. The studies also identify variation in effective treatments for male versus female Service members and highlight the necessity of providing services and training to family members.

The year 2017 marks the seven-year update on the 15 year study. Our work reflects the collaborative efforts of DoD, other government agencies, academic research institutions, and the private sector.

DoD is engaged in an ongoing fight to improve mental health and stem suicide deaths among our Service members. We have established programs and policies intended to prevent suicide, as well as a behavioral health database, the Behavioral Health Data Portal (BHDP), which tracks the effectiveness of clinical interventions in the MHS. In addition, my office, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), has nearly finished its structured five-year evaluation of many non-clinical mental health efforts, including suicide prevention programs. We will share preliminary findings today. Based on these findings, we are helping focus clinical research on both predicting suicide and responding to suicidal behavior.

Throughout the United States, a new and complex health issue has appeared in our communities—an epidemic of opioid overdose deaths. DoD has instituted scientifically informed, effective policies and clinical guidance to reduce opioid abuse and overdose deaths within its ranks. In 2016, 2,148 Active Duty Service members had a diagnosis of Opioid Use Disorder, a decrease of 38% from 2012. Likewise, opiate positive drug tests among Active Duty Service members declined over 60% between fiscal year (FY) 2013 and FY 2016. Finally, in 2015, there were 35 deaths among Active Duty Service members from opioid overdose (2.7 deaths per 100,000 Active Duty Service members): while even one overdose is one too many,

this was approximately one-fourth of the general U.S. population rate, and even less of a fraction of the rate in an age- and sex-matched cohort.

Current State of Evaluating Treatment for Mental Health Conditions and TBI

In FY 2013, directorates in the Office of the Assistant Secretary of Defense for Health Affairs compiled a list of 377 possible programs, both line and medical, with a nexus to psychological health, substance use disorders, suicide and TBI to review for inclusion in a program evaluation process. In an iterative process through FY2014, several programs—about 160, were removed from the list because they no longer received DoD funding, they were no longer in existence, or they were folded into other programs. Of the remaining 210 programs, approximately 35 more were removed between FY 14 and FY 17 because they did not meet or no longer met inclusion criteria for the review. The current total is approximately 175. OSD CAPE has requested the individual Services review final findings when available and make determinations regarding any program modifications including redundancies or discontinuation.

The effectiveness of the remaining DoD-funded psychological health, TBI, substance use and suicide prevention programs, is addressed below. About 30 mental health programs use "train-the-trainer" methods that encourage the use of best practices to deliver assistance to Service members at risk of suicide or behavioral health problems. Our evaluation confirmed the importance of fostering a community of acceptance and de-stigmatizing the act of seeking assistance for mental health issues. The effectiveness of these programs depends greatly on the instructors' capabilities, as well as adaptability in meeting the needs of target populations. To date, there is a dearth of good data supporting the effectiveness of many peer-to-peer

interventions. The program evaluation initiative identifies efforts that are not achieving success and helps to focus our work on the most promising interventions.

DoD is likewise learning important lessons about suicide response programs, which often provide short-term support to individuals exposed to traumatic events. These programs foster resilience and unit cohesion by providing education, stabilization, and referrals to resources; according to our initial findings from program evaluations, they enjoy support from the communities served. Yet outcomes are challenging to systematically track. Although many programs track output metrics (e.g., participant counts, demographics) and obtain feedback from participants through mechanisms such as participant surveys, the need to both standardize metrics and also improve monitoring that better assesses successful initiatives is urgent.

Of course, the outcome measure that matters most in suicide is the death rate, which remains unacceptably high despite years of sustained effort at prevention and intervention. The DoD Suicide Event Report surveillance system collects data on every suicide that occurs while a Service member is in a duty status within the Active, Reserve, and National Guard Components of the Air Force, Army, Navy, and Marine Corps. This system has been in operation since calendar year (CY) 2008. This system reports that there has been no measureable change, neither increase nor decrease, in the annual suicide rate for Active Duty Service members since 2009. Data from CY 2015 and preliminary data from CY 2016 suggest that roughly 1 in 5,000 Active Duty Service members died by suicide in the last two years. The rate was approximately 1 in 4,000 between the combined National Guard and Reserve forces. Similarly, raw counts of the occurrence of suicide from 2016 show that Active Duty deaths had increased by 10 cases from 2015 but had not changed in a statistically significant manner from the 4 years prior.

Trends in suicide remain disturbing, as does the loss of the "warrior effect." This "warrior effect" once seemed to protect a DoD cohort because such a cohort was employed, screened at accession for common mental illnesses, and primed for ongoing leadership intervention as well as the most extensive array of psychosocial support in the history of public health.

Future of Mental Health and TBI Research, Treatment, and Therapies

We are encouraged by the successes DoD has seen in combatting the opioid crisis and by improvements in assessment and treatment of PTSD and TBI that stem from attention to outcome data. Likewise, DoD strives to improve its program evaluation and knowledge translation systems. These systems work in tandem to ensure that the best evidence-based practices make their way from researchers to the field as efficiently as possible.

DoD implemented its Behavioral Health Data Portal (BHDP) across many clinical mental health programs to better standardize data collection and reporting measures. A computerized patient kiosk collects baseline and follow-up data on symptoms related to common mental health conditions (e.g., depression, anxiety). It augments the MHS' existing electronic health record system by efficiently tracking, sorting, and filtering information about mental health treatment and outcomes. The BHDP allows for real-time graphing of outcome measures for clinical care, consolidation of data from multiple sources into one clinician dashboard, and aggregation of data for meaningful program evaluation. Collated data across multiple programs is allowing DoD to determine the effectiveness of mental health programs in real time.

Medical research, on the other hand, takes time: advances accrue in an unpredictable course, and findings are published at a volume and rate that often outpaces clinicians' ability to

adopt best practices. Studies show that it often takes 15 years or more to incorporate a medical discovery into clinical care and policy. Fortunately, the MHS is uniquely positioned to address this public health challenge as an integrated health delivery system: we directly fund the research, assess the findings, educate and train our medical workforce, and operate a global health care delivery system for our patients. As a result, we have the potential to create a comprehensive model that moves evidence-based findings from bench to bedside rapidly.

To this end, DCoE developed a generalizable, evidence-based knowledge translation process for use in the MHS. This capability provides a standardized process for the targeted synthesis, analysis, translation, dissemination, and implementation of psychological health and TBI research into evidence-based practices and consistent standards of care. Having a functional and standardized knowledge translation process for mental health care may also herald advancements in MHS practices beyond psychological health and TBI.

Line and Medical Interventions to Combat Opioid Addiction

DoD is succeeding in combatting opiate addiction through sustained leadership efforts that focus on readiness and relentless attention to innovations in medical practice.

As mentioned, positive drug screens are down 60%, despite upgraded screening capabilities to detect metabolites of commonly abused prescription opiates. DoD's dedication to a drug free workplace, its culture of involved leadership and care for its Service members, and its vigilance in its detection of and care for Service members who struggle with substance abuse have led to trends that starkly contrast the worsening national scourge in recent years.

In cooperation with our interagency partners, DoD is working with prescribers and providers to address pain-management practices that contribute to abuse and addiction. We are expanding access to effective treatment options. We are putting tools into the hands of first responders—including opioid overdose reversal with naloxone—that are helping save the lives of overdose victims. We are simultaneously intensifying our outreach and education efforts.

Let me highlight some specifics. Appropriate pain management plays a critical role in preventing opioid abuse. In November 2016, DoD implemented its Opioid Prescriber Safety Training Program to improve patient outcomes in pain management and substance abuse. As of mid-April, more than 14,000 DoD prescribers completed this training, and all remaining prescribers are on track to complete training by September 2017. Rapid progress stemmed from medical leadership's focused attention and the ease of use of our online training programs, which automatically generate medical education credits for users. Plainly, urgency and technological innovation allowed DoD to scale-up training rapidly to meet the crisis. We hope to replicate this approach as we create new trainings for other clinical programs.

In 2013, we began two Joint Incentive Fund Projects to expand access to and use of non-opioid treatments for acute and chronic pain. The first, a $2.5M initiative we developed with VA, is a joint pain management curriculum to improve the pain management competencies of the federal clinical workforce. Its goal is to help reduce opioid overuse—and it is scheduled to be completed in August 2017. The second, a $3.1M initiative, developed, evaluated, and implemented a uniform tiered acupuncture education and training program (ATACS). The ATACS project was completed in August 2016. Evidence-based, non-pharmacological treatments such as acupuncture, movement therapy, or massage can effectively treat pain, and we

want to ensure that providers are aware of—and prescribe—these services for patients. Finally, we established an MHS Opioid Registry to provide decision-makers with real-time data that track and monitor patients at risk for misuse, abuse, and overdose.

DoD is taking significant steps to improve the access and the options available to patients living with the horrors of addiction. Last September, DoD issued TRICARE regulations that greatly expand coverage for medication-assisted treatment of opioid use disorder. This change made coverage available for therapies certified by our partners at the Substance Abuse and Mental Health Services Administration, such as buprenorphine and methadone. We increased the number of Drug Enforcement Administration-certified buprenorphine prescribers at our Military Treatment Facilities. Over the last 2 years, 182 prescribers received training. Another 120 will receive training this year. DoD will continue to expand access to this treatment, in compliance with legislation enacted last year permitting physician assistants and nurse practitioners to prescribe buprenorphine.

DoD continues to enhance our prevention, education, and outreach programs for Service members and their families. These efforts include classroom training, public service announcements, and online and social media campaigns. DoD codified one such outreach effort last year: the Drug Take Back Program, which seeks to remove medication from circulation that could potentially be used in suicide attempts, misuse, diversion, or accidental poisoning.

Though we have taken great measures to implement improvements across the spectrum from research to care, a continued and sustained effort is necessary to fight this epidemic. Continued collaboration at the interagency level will ensure that best practices and research make their way to clinicians and practitioners in the field.

Conclusion

With Congress' steadfast support for our research and operational requirements, we are making progress—but we are not claiming victory. The challenges faced by those we serve are life-long, and they demand our unwavering commitment to best practices grounded in public health principles, scientific research and discovery. We look forward to keeping Committee apprised of our progress, and I look forward to answering your questions.