RECORD VERSION

STATEMENT BY

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THE SURGEON GENERAL

UNITED STATES ARMY

COMMITTEE ON ARMED SERVICES

UNITED STATES HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON MILITARY PERSONNEL

FIRST SESSION, 109TH CONGRESS

MENTAL HEALTH SERVICES

26 JULY 2005

NOT FOR PUBLICATION

UNTIL RELEASED BY THE

COMMITTEE ON ARMED SERVICES

Mr. Chairman and distinguished members of the Committee, thank you for the opportunity to come before you today to discuss mental health services available to Soldiers and families. The mental health of our Soldiers and their families is a vital part of our Global War on Terrorism and thus of our national security. We have a comprehensive and integrated system of combat stress control, including prevention, intervention and care. It is important to recognize that there are a range of mental health issues related to deployment, not just post-deployment stress disorder. These include a host of deployment related stress reactions, to include irritability, reckless behavior, marital difficulties, and difficulties integrating into the workplace. Although I will share with you many of our successes, there are significant challenges which still lie ahead.

Recent research conduct by the Walter Reed Army Institute of Research and behavioral health providers at Walter Reed Army Medical Center, shows that about half of those with initial post traumatic stress disorder (PTSD) and depression quickly improve. Overall rates of PTSD and depression rise two or three-fold during the three to six months following their return from deployment. When interpreting these results and deciding what to do about them, it is important to recognize some key points. First, PTSD and other mental illness occur along a spectrum of severity. In contrast to diabetes for example, a disease that one either has or doesn't have, the line between illness and health for mental illness is indistinct and where exactly to draw the line between well-being and illnesses is the focus of ongoing discussion among experts. Where one draws this line in field research can have a dramatic impact on rates of illness that we observe. For example, if one uses a milder definition of PTSD advocated

by some researchers, the rates of PTSD can appear quite overwhelming. For example, one measure of PTSD used by the WRAIR yields rates of pre-war PTSD of nearly 25% with 50% or more meeting this milder definition after the conflict. But many of these Soldiers do not require acute psychiatric intervention. A large majority need to understand that they are experiencing a normal reaction to their combat experiences, need to know when and where to seek help, and need to be told there is no shame or stigma – personal or professional – attached to their condition.

I do not want to suggest that we are underestimating the rate of PTSD or other combat stresses, but to remind us all that a comprehensive policy toward treating PTSD involves much more than the Military and Veterans Affairs health systems. Our Army strategy integrates education and outreach by not only healthcare professionals, but by small unit leaders, chaplains, and family members.

Since the beginning of Operation Enduring Freedom, combat stress units and other mental health assets have been part of the medical force supporting our warfighters throughout Southwest Asia. Personnel include psychiatrists, psychologists, social workers, psychiatric nurses, occupational therapists and enlisted technicians. There are mental health assets organic to our combat units and our combat surgical hospitals. Additionally, specialized combat stress control units are deployed to both Afghanistan and Iraq to augment the mental health services available to the combatant commanders.

Our mental health personnel work closely with unit commanders and chaplains to help Soldiers cope with both the stresses of combat and the challenges of being away from families for long periods of time. Their role is to provide education, preventive

services, and treatment services. Typical educational activities include combat and operational stress control and suicide prevention classes, and preparation for reunion with their families. Clinical work includes individual and group evaluation and treatment.

The principles of combat stress control have been developed over the past century. They have been codified in the principles "PIES: proximity, immediacy, expectancy and simplicity." Combat stress control focuses on education and treatment as close to the front lines and/or the Soldier's unit as much as possible. Evacuations from the theater are avoided if at all possible, because we have learned from experience that few patients who are evacuated return to duty. However, if a patient is persistently dangerous to themselves or others, they may need to be evacuated to Landstuhl or the United States for further treatment.

Our current mental health footprint in Iraq and Afghanistan has evolved as a result of lessons learned early in the conflict and detailed assessments of two Mental Health Advisory teams (MHAT) that evaluated the mental health needs of deployed forces and developed strategies to meet these requirements.

The first MHAT (MHAT-1) deployed into Kuwait and Iraq in the fall of 2003. This was the first-ever formal assessment of mental health needs in a combat theater. It included focus groups and a survey instrument, "The Soldiers' Well-Being Survey", which was administered to Soldiers and other service members.

The MHAT report was released in the spring of 2004. The report identified two major barriers to mental health care among deployed forces. The first access barrier

was lack of knowledge about where and how to access providers. The second was the perception that seeking care would impact a Soldier's career.

Another assessment team (MHAT 2) deployed to Iraq in the fall of 2004 at the request of the combatant commander. The team evaluated theater mental health programs to determine how the MHAT-1 recommendations were implemented and to assess the effectiveness of these programs. The Army just released this report last week. It shows significant improvement in the following areas: 1) morale; 2) access to care; 3) ratio of providers to Soldiers; 4) willingness to seek treatment by Soldiers suffering from acute and post-traumatic stress disorder; 5) living conditions, and 6) morale and welfare facilities. The MHAT-2 team also conducted a comprehensive assessment of mental health services in Afghanistan in the Spring of 2005 and that portion of their report will be released in the near future.

Soldiers receive a variety of pre-deployment briefings. Many Soldiers have a variety of mental health or family concerns, which need not preclude them from serving their country and going to war. Pre-deployment briefings focus on mission requirements and family support services so Soldiers are aware of services available to them and their families during deployment.

Soldiers also receive redeployment briefings as they return home. These focus on the challenges of reintegration with families and employers. They are cautioned that the families will have changed and grown, and that they may have a different role. They are also warned about possible symptoms of deployment related stress, such as irritability, bad dreams, and numbness or detachment and provided information on how

to access mental health services – from unit chaplains to acute psychiatric intervention – to help them cope with the challenges of reintegration and the stress of their combat experiences.

All Soldiers receive a medical assessment on redeployment, the Post-Deployment Health Assessment that includes an assessment of mental health. This assessment is reviewed jointly by a licensed healthcare provider and the Soldier. If Soldiers answer positively to the mental health questions, they are referred for further evaluation and/or treatment.

The Department of Defense's new Post-Deployment Health Reassessment (PDHRA) Program will better help identify post-deployment stress conditions and reinforce availability of mental health services. Part of the reason for this is that it is recognized that many service members will not manifest mental health symptoms at the time they return home, but may later. The Army is working on the challenges of administering this screening to both the active and reserve components with an implementation date of September 1, 2005.

The Army has developed a number of initiatives to assist Soldiers and their families. The Deployment Cycle Support Program, managed by the Deputy Chief of Staff for Personnel, was developed in May 2003 and includes the addresses the following phases of the deployment cycle: Pre-deployment-activities include mental, physical and professional preparation; Deployment-Called to duty and away from family and provided stress management skills; Re-Deployment-Preparation to return to home and family with screening, education and referral for assistance, if required; Post-

Deployment-reintegration training and support or referral for assistance, if required, and; Reconstitution–personnel, equipment, and material are returned to full readiness for future missions. Sustainment-on-going process of training and preparing for the next mission.

The Army One Source program was developed in October 2003 with focus on Soldiers and Department of the Army civilians redeploying from combat or operations to meet challenges of returning home. It is a 24-hour, seven-days-a-week toll-free phone information and referral telephone service. Initially developed for both active and reserve component Soldiers and family members worldwide, it has now been adopted by the other Services and renamed the Military One Source. Military One Source provides both general information and referrals for counseling and incorporates an Internet website in addition to the toll-free telephone service.

Apart from the above initiatives, the Army has a wide array of behavioral health services. They include traditional behavioral health clinics and psychiatric hospitals. Each Division has a Division Mental Health section (although this structure is transforming with our Brigade Combat Teams to integrate into each brigade's new, modular structure). Each Army Regional Medical Command has a stress response team. For example, the stress response team from Walter Reed provided extensive services to the Washington DC community following the terrorist attack on the Pentagon. The team's work evolved into Operation Solace, an ongoing service to Pentagon employees – military and civilian – throughout the National Capital Region.

Reserve component Soldiers who have been activated are entitled to all of the behavioral health services offered to active duty personnel. After demobilization, reserve component Soldiers are eligible for expanded TRICARE benefits. Veterans who have served in OIF/OEF are entitled to care at the Department of Veteran's Affairs. Implementation of the PDHRA for reserve component Soldiers is critically important and we are working closely with the Army Reserve and National Guard Bureau to initiate PDHRAs for reserve component Soldiers to ensure those who need counseling and treatment can receive it through the resources available in their local communities.

Hundreds of mental health providers have been or are currently deployed into theater. In most cases, they are deployed for a year at a time. This rapid operations tempo has put a strain on the provider population, as well as the Soldiers they serve. Many behavioral health providers are choosing to leave military service at the end of their obligation in order to avoid another long family separation. We continue to work closely with Department of Defense to ensure we are making best use of the authorities we already have to recruit and retain mental health providers in both the active and reserve components.

There are numerous initiatives to promote a seamless transition of care between military treatment facilities and the Department of Veterans Affairs (VA). For example, the VA has stationed case managers at the major military treatment facilities. The Army has stationed personnel at the four VA Polytrauma Centers. Historically only about 10 percent of veterans seek care within the VA system. Recent data indicate that about 20% of our OIF/OEF veterans are seeking treatment within the VA system. Therefore is imperative that our VA colleagues be part of the efforts to care for our

Soldiers and OIF/OEF veterans. As we implement the PDHRA for reserve component Soldiers, the VA will play an important role in treating those who require acute intervention.

The Army has granted researchers unprecedented access to Soldiers in time of conflict. The research has been done both with active and reserve component Soldiers. These ongoing studies have documented not only high rates of Soldier and family problems but also reluctance by most Soldiers who are having problems seeking needed mental health care. Getting help early prevents progression to more chronic serious illness. It also limits occupational (readiness) and family impacts. Waiting for the Soldier to present to a clinic asking for care is only reaching 40% of those in need. New initiatives configure newly requested resources in ways that enhance mental health access through low-stigma portals. They also provide training and ongoing 'forward support' in garrison to medics, chaplains, and unit members to promote unit level identification and pre-clinical consultations. Our goal is to not only to provide better care earlier in the process to the 40% of Soldiers we are seeing but to reach out to the 60% in need who we are presently not touching and provide them early care as well.

The mental health needs of our Soldiers and their families are critical to the security of our country. We have learned many lessons from the other wars of this past century. One other lesson is that we may not know what the psychological costs of this war will be for many years. While we are doing everything possible to mitigate the psychological impacts on Soldiers and families as they occur, we must also anticipate and prepare for the needs of our veterans for the years to come.