RECORD VERSION

STATEMENT BY

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INTRODUCTION

Mr. Chairman and Distinguished Members of the Committee, I wish to thank you for the opportunity to testify before you about the extremely important subject of the mental health of the Armed Forces. I am COL Virgil J. Patterson, Social Work Consultant to the Army Surgeon General and Team Chief for the Mental Health Advisory Team that has deployed into Iraq, Kuwait and Afghanistan.

The Office of The Surgeon General (OTSG) of the U. S. Army established the Operation Iraqi Freedom (OIF-II) Mental Health Advisory Team (MHAT-II) in July 2004 to follow up on the OIF-I Mental Health Advisory Team of 2003, to assess OIF-II related mental health (MH) issues, and to provide recommendations. The MHAT-II conducted a comprehensive assessment of the OIF-II behavioral healthcare (BH) system, focusing its assessment and recommendations on three broad areas and the OIF-II Suicide Prevention Program.

(1) The BH needs assessment of the OIF-II area of operations (AO)

(2) The BH delivery system of the OIF-II area of operations

(3) The BH training requirements of the OIF-II area of operations

(4) Implementation of the MHAT-I recommendations for the OIF-II area of operation Suicide Prevention Program

FINDINGS

The MHAT-II found that like OIF-I Soldiers, OIF-II Soldiers are experiencing numerous combat stressors. However, noncombat deployment stressors related to quality of life have shown considerable improvement since OIF-I. Deployment length remains a top concern for OIF-II Soldiers. Fifty-four percent of OIF-II Soldiers reported their unit morale as low or very low. However, unit morale was significantly higher in OIF-II compared with OIF-I, when 72% of Soldiers reported low or very low unit morale.

Mental health and well-being improved from OIF-I to OIF-II, reflected by a lower percentage of Soldiers who screened positive for a MH problem in OIF-II compared with OIF-I (13% vs. 18%, respectively). Acute or post traumatic stress symptoms remain the top MH concern, affecting at least 10% of OIF-II Soldiers. Soldiers in transportation and nonmedical combat service support (CSS) National Guard and Reserve units had significantly higher rates of MH problems and lower perceptions of combat readiness and training than Soldiers in other units.

The OIF-II behavioral healthcare system has improved compared with OIF-I. Most BH personnel in theater report conducting outreach on a regular basis. Coordination is occurring between BH personnel, Unit Ministry Teams (UMTs), and primary care providers (PCPs). The BH return-to-duty (RTD) rates are high and comparable to OIF-I. Both the number of BH personnel in theater and the ratio of BH personnel to Soldiers are higher in OIF-II than in OIF-I. Behavioral

health personnel are more evenly distributed in OIF-II than in OIF-I. Combat stress control (CSC) units, medical companies with MH sections, and combat support hospitals (CSHs) can manage routine and surge period demands for holding Soldiers with BH problems.

Forty percent of Soldiers with MH problems reported receiving professional help during the deployment. This was significantly higher than the 29% of Soldiers with MH problems who received professional help in OIF-I. Stigma and organizational barriers to receiving care remain concerns for Soldiers. Two-thirds of Soldiers reported that they had received training in handling the stressors of deployment but only 41% felt that the training was adequate for the mission. This was significantly higher than the 29% of Soldiers who reported receiving adequate training during OIF-I.

There was no significant difference between the prevalence of BH disorders among Soldiers in custodial positions in detainee operations and those of other Soldiers surveyed in OIF-II. Custodial staff members shared stressors in common with OIF-II peers. Behavioral health care was conducted in accordance with combat and operational stress control (COSC) doctrine. Insufficient training in correctional BH diminished optimal support for custodial staff.

The majority of OIF-I Mental Health Advisory Team recommendations has been implemented or is in the process of being implemented. Opportunities for

improvement still exist in the OIF-II behavioral healthcare system. While coordination between BH care personnel, UMTs, and PCPs is good, coordination could increase between these three professional groups. Significant challenges remain in providing BH care. Most BH personnel received pre-deployment refresher training in BH/COSC tactics, techniques, and procedures, but reported additional training is needed. Standards of care, documentation management, and statistical reporting methods were unclear to some BH personnel. Behavioral health care personnel are using multiple methods to assess the BH/COSC needs of Soldiers and units; a standardized needs assessment process needs to be implemented.

For the same 7-month period (1 March–30 September 2004), 23% fewer Soldiers were evacuated for BH problems in 2004 than those evacuated in 2003. Evacuation procedures and policies have matured as evidenced by written standing operating procedures (SOPs), increased accountability, efficient information tracking, and improved transmission of clinical information between levels of care.

The community-based Army Suicide Prevention Program (ASPP) objectives have been adapted and a unit Suicide Prevention Program is evident at all OIF major commands of the combat units in Iraq as recommended. The January-December 2004 suicide rate for Soldiers deployed in OIF-II was 10.5 per

100,000, which is lower than Calendar Year (CY) 2003 and recent Army historical rates of 12 per 100,000 Soldiers.

RECOMMENDATIONS

The MHAT-II recommended that the OIF theater continue to improve awareness of MH issues, access to care, and efforts to reduce stigma. Considerations include:

a) Emphasizing the role of leaders at all levels in facilitating recognition of MH concerns, training in handling the stresses of deployment, and encouraging the use of available resources.

b) Assuring that there is accessible MH support to all units throughout the theater.

c) Where feasible, integrating MH care with primary care in troop medical clinics/battalion aid stations (BASs) so that MH care becomes routine in these settings.

We also recommended that the Army develop and assess the effectiveness of standardized training modules to prepare Soldiers to handle the psychological demands of deployment and combat-related stressors throughout the deployment cycle. Establish/maintain deployment policies that support Soldier morale and well-being across various forward operating bases (FOBs). Improve Soldier and leadership training in BH issues.

We recommended that the Army Medical Department continue to support BH services to Soldiers by:

- Continuing forward-deployed outreach to facilitate Soldier access to BH services.
- Ensuring all BH personnel can provide (with supervision and medical support) the full range of BH services.
- Completing the development and fielding of a Unit Needs Assessment Program and Survey Tool.
- Utilizing an empirically derived staffing model for BH personnel allocation and distribution.
- Publishing the updated field manual (FM).
- Completing the development of the Behavioral Health COSC Course.
- Researching and developing a program for burnout and compassion fatigue.

We recommended that the Army continuously assess how well the BH needs of families are being met in the rear.

- Continue existing (community-based) objectives of the ASPP for OIF Soldiers and units during pre-deployment, deployment, and re-deployment. Continue monitoring and reporting of completed suicides and serious suicide attempts with the Army Suicide Events Report (ASER).

- Continue the appointment of a Theater/Area of Operation BH consultant to advise the Surgeon on BH issues.

I want to thank you again for the opportunity to testify here today. I want to thank the Committee and Congress for their interest in the well-being of our Soldiers. I would like to emphasize that Army Medicine is committed to ensuring that appropriate and accessible mental health care is available to all our combat veterans. We will continue to seek improvement and do everything in our power to support Soldiers and their families.

I want to thank you again for your Support of our Soldiers.