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STATEMENT BY

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Mr. Chairman, distinguished members of the committee, thank you for inviting me to testify on current trends and initiatives in the treatment of Soldiers with post traumatic stress disorder. I am currently assigned as the psychiatric consultant to The Army Surgeon General. In that role, I assist in the development of Army policies on a wide range of issues from the accessions, training, privileging, and assignment of psychiatrists to coordinating policies, with my counterparts in psychology and social work services, on the treatment of Soldiers with a wide variety of behavioral health problems.

Going to war affects all Soldiers. The number of Soldiers with Post Traumatic Stress Disorder (PTSD) and other war related symptoms has gradually risen. The Army Medical Department has been supporting our Soldiers at war for five years, during 9/11 at the Pentagon, in Afghanistan, in Iraq and around the globe. We take care of Soldiers with physical wounds, and with the psychological issues from combat.

The Army is committed to ensuring all returning veterans receive the physical and behavioral healthcare they need. An extensive array of mental health services has long been available. Since 9/11, the Army has augmented behavioral health services and post-traumatic stress disorder (PTSD) counseling throughout the world, but especially at Walter Reed Army Medical Center and at the major Army installations where we mobilize, train, deploy, and demobilize Army forces. We anticipate that the demand for these services will not decrease and we are committed to providing the necessary help to respond.

The Army Medical Department is performing behavioral health surveillance and research in an unprecedented manner. There have been four Mental Health Advisory Teams performing real time surveillance in the theater of operations, three in Iraq and one in Afghanistan. Another team is in Iraq at this time. COL Charles Hoge has led a team from the Walter Reed Army Institute of Research in a wide variety of behavioral health research activities, some of which have been published in the New England

Journal of Medicine, the Journal of the American Medical Association and other publications. His research shows that generally the most seriously affected by PTSD are those most exposed to frequent direct combat.

The Army Medical Department has also performed several epidemiological consultations (EPICONs) at installations in the United States, such as the assessment following the cluster of suicide-homicides at Fort Bragg, North Carolina in 2002. We held a workshop on updates in Combat Psychiatry at the Uniformed Services University of the Health Sciences in 2004, where we gathered together practitioners who had been in the field with academicians and policy makers. We have used the results of all these assessments to continuously improve the behavioral health services that we offer our Soldiers and their families. Some of these initiatives follow below.

The Army Deputy Chief of Staff for Personnel (DCSPER) and The Army Surgeon General (TSG) share responsibility for the prevention and screening for PTSD for both active and reserve component Soldiers serving in the Global War on Terrorism (GWOT). Derived partly from the results of the Fort Bragg EPICON, the DCSPER has responsibility for the Deployment Cycle Support Program (DCSP) aimed at Soldiers and family members. US Army Medical Command `provides behavioral health services at Army medical centers around the world for Soldiers and family members with PTSD and other behavioral health issues.

Since the beginning of Operation Iraqi Freedom (OIF) in 2003 there has been a robust Combat and Operational Stress Control (COSC) presence in theater. Today, more than 200 behavioral health providers are deployed in Iraq and another 25 are deployed in Afghanistan. The Mental Health Advisory Team reports have demonstrated both the successes and some of the limitations of these combat stress control teams. As a result of learning of the limitations, we have improved the distribution of behavioral health providers and expertise throughout the theater. Access to care and quality of care have improved as a result.

Before deployment, Soldiers are screened for medical issues, including family problems and behavioral health issues. If the screening is positive, they receive further evaluation by a primary care and/or behavioral health care provider, to ensure their fitness to deploy. If they have symptoms which will interfere with their health or their ability to perform their job, they may receive a profile to allow them to continue to

receive treatment at their home station or a military treatment facility. In some cases the diagnosed disorder may require the Soldier to undergo a Medical Evaluation Board.

As part of the reintegration process, Soldiers are briefed on: what stressors to expect on homecoming; the common symptoms of post-deployment stress such as hyper-arousal and friction; ways to mitigate these symptoms; how to recognize when further professional help is needed; and how to access treatment services. The briefings are tailored to the specific unit and what unit members experienced during the deployment. Again these briefings have improved over time based on feedback from providers and Soldiers. In addition each demobilization site now has care managers who manage the behavioral health aspect of care and ensure behavioral health referrals are made.

The Post-Deployment Health Assessment (DD Form 2796), is used to screen for physical complaints, PTSD, major depression, family issues, and concerns about alcohol abuse. The primary care provider reviews the form, interviews the Soldier, determines the need for a physical examination, and refers the Soldier to a behavioral healthcare provider or specialty providers as required. The primary care provider may make referrals to on-site counselors or to military treatment facilities. Current data shows that 4-6% of returning Soldiers receive referrals for mental health concerns.

On March 10, 2005, the Assistant Secretary of Defense for Health Affairs directed an extension of the current Post-Deployment Health Assessment Program to provide a Post-Deployment Health Reassessment (PDHRA) of global health with a specific emphasis on mental health. The Army requires all Soldiers redeployed from a combat zone, whether they are active or reserve component, to complete a PDHRA screening 90 to 180 days post-deployment. The PDHRA was fully implemented in January 2006. So far, over 70,000 screens have been performed. The Office of the Surgeon General (OTSG) staff is monitoring referral rates as implementation of PDHRA continues

If a Soldier has post-traumatic stress disorder or other psychological difficulties, they will be further evaluated and treated using well-recognized treatment guidelines. These include psychotherapy and pharmacotherapy. These treatments may be delivered in a variety of venues, to include in theater and garrison, in an outpatient or inpatient setting, and individually or in a group.

Traumatic brain injury (TBI) is also a focus of our attention. TBI is a broad grouping of injuries that range from mild concussions to penetrating head wounds. An overwhelming majority of TBI patients have mild and moderate concussion syndromes with symptoms not different from those experienced by athletes with a history of concussions. Many of these symptoms are similar to post-traumatic stress symptoms, especially the symptoms of difficulty concentrating and irritability. It is important for all providers to be able to recognize these similarities and consider the effects of blast exposures in their diagnosis. Colonel Robert Labutta, Chief of Neurology at Walter Reed Army Medical Center, and Dr. Louis French from the Defense and Veterans Brain Injury Center at Walter Reed are with me today to answer any questions you may have on the screening, diagnosis, and treatment of TBI.

We recognize that there is a perceived stigma associated with seeking mental health care, both in the military and civilian world. Therefore we are moving to integrate behavioral health care into primary care, wherever feasible. Our pilot program at Fort Bragg, Respect.Mil, which provides education, screening tools, and treatment guidelines to primary care providers, was very successful. We are in the process of implementing this program at thirteen other sites across the Army.

There is legitimate concern about our isolated Reserve Component Soldiers. The Army One Source program was developed to support these Soldiers and their families. Now adopted by all the Services and called Military One-Source, this program offers 24/7/365 telephonic support and availability of referrals for six or more no-cost confidential counseling sessions for Soldiers and their family members.

Our physically wounded Soldiers also have been a focus of attention. All Soldiers evacuated to Walter Reed, for example, receive a behavioral health evaluation and, if needed, therapy. The Army Wounded Warrior program offers extensive physical and psychological support to Soldiers and families. Additionally, psychological support to wounded Soldiers and families at the Community Based Health Care Organizations (CBHCOs) has been expanded.

We have been focusing on improving our suicide prevention efforts and adapting our traditional garrison model to the theater environment. The DCSPER is the proponent for suicide prevention. Chaplains usually conduct suicide prevention classes.

Behavioral health providers perform interventional counseling and treatment when a Soldier is identified as a suicide risk. The AMEDD also does surveillance. Several years ago we developed and fielded a new tool, The Army Suicide Event Report (ASER), to improve our surveillance of suicides and serious suicide attempts. All suicides and serious suicide attempts require this report to be completed by a behavioral health care provider. The data is compiled quarterly to help identify trends. We are in the process of standing up a new medical component of the Suicide Prevention Program to compliment the other work being done, with real time analysis and feedback to commanders and the medical system.

We continue to assess the access to and quality of our services. We utilize both internal and external methods. The Army Medical Command is in the process of hiring an outside independent contractor to assist us with this process. They will be reviewing about twenty of our installations. Lieutenant General Kiley, The Army Surgeon General, is the Co-Chair of the Department of Defense Mental Health Task Force created by the Fiscal Year 2006 National Defense Authorization Act. This Task Force, comprised of military, civilian and Department of Veterans Affairs' representative is conducting site visits around the world to evaluate mental health systems, identify trends and to recommend changes to our mental health services. The Task Force will complete its work and submit its report to Congress in May 2007. Lieutenant General Kiley has also made management of PTSD and other behavioral health concerns a priority for his subordinate commanders. He has hosted two General Officer level Behavioral Health summits to discuss research data, emerging treatment initiatives, and lessons learned. All of Army Medical Command's General Officers and other key medical leaders participated in these summits.

Training of our leadership in behavioral health issues is ongoing in numerous forums. For example, the AMEDD Center and School has developed training programs on small unit leader recognition of combat stress for use in other Army career development courses such as Officer Basic and Advanced Courses and in the Non-Commissioned Officer Education System. The Combat and Operational Health Course taught at the AMEDD Center and School has been updated to include emerging

changes in our combat stress control doctrine. The revised training also includes training on detainee mental health care management and treatment.

Another question that is often asked is, what about after Soldiers leave the Army? The transition to the Department of Veterans Affairs health system or other health care systems is critical. The Department of Defense and Department of Veterans Affairs have had numerous conferences and other meetings to share information, research, and emerging best clinical practices. Soldiers who leave the Army are informed of their benefits and on how to obtain care through both the Department of Veterans Affairs and the TRICARE Network, if eligible. The Transition Assistance Management Program (TAMP) provides extended periods of TRICARE coverage for reserve component Soldiers and family members. This coverage applies when the member's Active Duty service was in support of a contingency operation for more than 30 days.

It is critical that civilian providers get educated in how to evaluate and treat our veterans; I personally have conducted Grand Rounds lectures at numerous academic institutions, to include Columbia University, Massachusetts General Hospital, and University of Texas at San Antonio. My colleagues have been doing the same, at the American Psychiatric Association, the American Psychological Association, and numerous other venues. In conjunction with the Department of Defense, the Substance Abuse and Mental Health Services Administration (SAMSHA), within the Department of Health and Human Services, sponsored a major conference this spring, entitled "The Road Home", to help educate civilian providers on the recognition and treatment of combat-related behavioral health problems.

In summary, we have been at war for five years. Unquestionably, war challenges the psychological health of our troops and their families. The overwhelming majority of them continue to demonstrate resilience and dedication. PTSD is not a debilitating disease and can be managed effectively if diagnosed and treated early. The Army and our sister services have been adding to and augmenting our behavioral health assets and programs, applying emerging treatment guidelines, and sharing our research with the Department of Veterans Affairs (VA) and civilian behavioral health providers. We have been in constant dialogue with our counterparts in the VA and other civilian health

care organizations. This is not just an Army or Department of Defense issue, and not just a Veterans Administration issue. It is a national one. Thus it is an area that requires the attention of leaders at all levels. But it is manageable with early intervention, accessible counseling assets, and command emphasis on reducing stigma.

I would like to thank the Congress for your continued support of our Soldiers and veterans and I would especially like to thank this committee for its continued interest in the psychological health of our veterans and our future veterans alike. Coordination of care with the Department of Veterans Affairs and sharing research to improve of clinical treatment of Soldiers and veterans with PTSD has always been a top priority for Army Medicine. Thank you for inviting me to testify today. I look forward to answering your questions.