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Mr. Chairman and distinguished members of the committee, thank you for the opportunity to discuss the Department of Defense's Force Health Protection and Readiness Program and the programs within the Military Health System, with a focus on the mental health aspects of those programs.

Two primary objectives of the Military Health System are to ensure a medically ready force and to provide world class care for those who become ill or injured. The importance of these objectives is recognized throughout the Department of Defense, and we have a multitude of proactive programs in place to educate our Service members and their families and our military leadership about these programs. We also have robust surveillance programs in place to monitor the health of our force and to provide information that allows us to continue to modify and improve them whenever indicated.

The continuum of medical care in the Military Health System begins with the accession of the Service member and continues through deployment and redeployment cycles until the member separates or retires. Pre-deployment and post deployment health assessments were begun in 1998, based on medical lessons learned from the 1990-1991 Gulf War. The post deployment health assessment was augmented in 2004 to collect a standardized set of information about medical

symptoms or concerns, again because of medical lessons learned from those returning home from deployments. The post deployment health reassessment was begun in January 2006 to re-evaluate the health of those who returned from deployments some three to six months after their return. This reassessment was initiated because of military medical research data showing increased physical and mental health symptoms and concerns among Service members after they were home and reintegrating with their families and their work.

The post deployment health assessment and the post deployment health reassessment were both designed to have a healthcare provider interact one-on-one with each Service member to review the concerns identified by the member on the assessment and to make a determination of the medical indications for referral for further evaluation and diagnostic work-up. The assessments are not medical diagnostic instruments, but are screening evaluation tools to identify the need for medical evaluation.

Since 1998, DoD has been doing a pre-deployment health assessment that includes a question that asks if the individual has received mental health care in the past year, a question that asks about all medications currently taken, and a question about any other medical concerns the individual may have. The information from

this pre-deployment health assessment is added to information from a review of the individual's medical record, which would show clinic visits, hospitalizations, medications prescribed, and diagnoses. The medical provider can then determine if any further medical evaluations are needed before making a medical recommendation on the individual's deployability. We are consistently finding that about four percent of those being evaluated at the pre-deployment processing centers have medical problems identified that preclude them from being deployable at that time.

In-theater we have a smaller medical footprint that is agile, mobile and responsive to the needs of the mission. The Far Forward Surgical Teams are doing life-saving surgical care where the injuries are occurring. Transportation to battalion aide stations and combat area surgical hospitals for resuscitation and stabilization is then supported by aeromedical transportation with intensive care capabilities in the air.

We also have medical support for mental health care in-theater. Each branch of Service has specific combat stress and deployment mental health support programs available before, during, and after the deployment cycle. These provide support tailored to the service's mission and risk factors their personnel might face. In

addition, cross-functional planning teams bring together subject matter experts from across the services, the Joint Staff, and DoD. The approach taken by the Army, Combat Stress Control (CSC), is multi-faceted, using unit consultations, system intervention, stress control briefings, suicide prevention briefings and unit needs assessments. These assessments are followed by individual or unit-level interventions, further prevention work, and clinical intake and evaluation when appropriate. The Air Force has a highly mobile, comprehensive system of combat stress and deployment mental health teams. Air Force mental health personnel are currently deployed to 11 locations. Approximately 15 Air Force mental health providers deploy every 4-6 months. The Navy and Marine Corps' approach is to educate and provide the necessary resources to leaders, Marines, and their families to create a community support system to address stressors early, and to prevent, identify, and treat combat/operational stress injuries before, during, and after deployment.

Multi-faith Chaplains are an integral part of the military community. They provide family counseling and care for the spiritual needs of the community. A chaplain is available to every military unit and provides a "ministry of presence" that includes getting to know the needs of the unit. They deploy with units to maintain that presence. Although Chaplains do not provide medical treatment, they offer

confidential counseling and are safe havens for those who need someone to talk with during troubling times. They often facilitate access to other avenues of care. They provide much of the return and reunion educational content for the Army and Marine Corps deployment cycle support program and are an important part of the suicide prevention efforts of each Service.

From March 19, 2003 to May 5, 2007, there have been 26,701 aeromedical transports out of Operation Iraqi Freedom (OIF) theater. Twenty percent have been due to combat injuries and 20 percent have been due to non-combat injuries. The remaining 60 percent have been due to medical conditions that needed evaluation or treatment not available in theater. Mental health conditions have accounted for 16 percent of the medical conditions that were transported out of theater. A study that evaluated the subsequent mental health evaluation and diagnoses in these patients found that fifty percent of patients evacuated for psychiatric reasons did not receive a psychiatric or adjustment disorder diagnosis, which suggested that substantial clinical improvement had occurred since a decision for evacuation was made.

We have 1,082,121 post deployment health assessments from the world wide deployments of Service members from January 1, 2003 to February 12, 2007.

Reviews of these assessments show that ninety-three percent of Active Duty Service members indicate their general health as "good", "very good" or "excellent", twenty-two percent indicate they have medical concerns and five percent indicate they have mental health concerns. Referral rates after discussion with a medical provider show that eighteen percent are referred for further medical evaluation. The referrals are fairly equally divided between "medical" only, "mental health" only and both "medical and mental health". For the Reserve component, ninety percent rate their health as good, very good, or excellent, forty-one percent indicate they have medical problems, and six percent indicate they have mental health concerns, and twenty-four percent are referred.

We have 237,735 post deployment health reassessments from the world wide deployments of Service members from June 2005 to March 2007. Reviews of these assessments show that eighty-five percent of Active Duty Service members indicate their general health as "good", "very good" or "excellent", thirty-three percent indicate they have medical concerns and twenty-seven percent indicate they have mental health concerns. Referral rates after discussion with a medical provider show that sixteen percent are referred for further medical evaluation. The referrals are fairly equally divided between "medical" only, "mental health" only and both "medical and mental health". For the Reserve component, eighty-two

percent indicate their health is good, very good or excellent, fifty-six percent indicate medical concerns, forty-two percent indicate mental health concerns and fifty-one percent are referred.

An important element of the PDHA and the PDHRA is education of the Service members about medical conditions, both physical and mental, and the signs and symptoms that indicate the need for further evaluation.

To better understand the mental health needs of the deployed forces, the Army sent a Mental Health Advisory Team (MHAT) to theater in September and October 2003. This was the first time that such an assessment was conducted during a wartime deployment. The Army has sent Mental Health Advisory Teams to theater three subsequent times, September and October 2004, October and November 2005, August and October 2006 to continue to evaluate adequacy of mental health support in theater and preparation of medical and support staff for mental health care.

Mental health deployment-related research is performed at local, Service, and interagency collaborative levels to maintain quality care in an environment of expanding knowledge. At the present time, 67 deployment-related mental health research projects are being conducted across various DoD, VA, HHS and other

federal and academic organizations. Thirty-two of the 67 projects are focused on Post Traumatic Stress Disorder. Since 1992 an additional 57 mental health research projects related to deployment health were initiated and completed. During the past 14 years more than 150 articles have been published in peer-reviewed medical and scientific journals on mental health deployment-related research.

The Department has also supported mental health research studies to understand responses over time, from pre-deployment to post deployment. These studies have been done anonymously, with the expectation that answers may be more forthright, so this research cannot be used to evaluate a cohort of individuals over time. However, these studies' findings have enabled the Department to make recommendations for improving health care approaches.

A research study on the mental health of Service members returning from OIF and OEF was published in the *New England Journal of Medicine* in 2004. The members of four combat infantry units were surveyed anonymously; 2,530 personnel before deploying to OIF, and another 3,671 personnel three to four months after returning from OIF or OEF. The surveys included screening questions about symptoms of major depression, generalized anxiety disorder, and

posttraumatic stress disorder (PTSD). These screening questions indicate a possible mental health problem, but they do not provide precise medical diagnoses. The study participants reported a very high level of combat experiences, and there was a direct relationship between the level of combat exposure and rate of PTSD. The proportion of personnel who met the screening criteria for each disorder was significantly higher after OIF than after OEF. The rates of each disorder were significantly higher in the post-deployment groups than in the pre-deployment group. In the pre-deployment group, the rates of depression, anxiety, and PTSD were five percent, six percent, and five percent, respectively. In the post-deployment group of Army soldiers deployed to OEF, the rates of depression, anxiety, and PTSD were seven percent, seven percent, and six percent, respectively. In the post-deployment group of Army soldiers deployed to OIF, the rates of depression, anxiety, and PTSD were eight percent, eight percent, and thirteen percent, respectively. In the post-deployment group of Marines deployed to OIF, the rates of depression, anxiety, and PTSD were seven percent, seven percent, and 12 percent, respectively. Personnel who screened positive for any one of these disorders were two times as likely to report concern about possible stigma and other barriers to seeking mental health care, compared to personnel who did not screen positive for a disorder. These barriers included concern about difficulties with getting time off of work for treatment, harm to the individual's

military career, leadership treating the individual differently, or perceptions of weakness.

A research study on the mental health of Service members returning from OIF and OEF was published in the *Journal of American Medical Association* in 2006. This study evaluated the responses on the post-deployment health assessments of all Army soldiers and Marines who completed it between May 1, 2003 and April 30, 2004. This included 222,620 individuals deployed to OIF, 16,318 deployed to OEF, and 64,967 deployed to other locations. The mental health concerns included symptoms of depression, symptoms of PTSD, ideas about suicide or hurting someone else, and serious interpersonal conflicts. The PDHA responses indicate a possible mental health problem, but they do not provide precise medical diagnoses. The prevalence of reporting a mental health problem was 19 percent among personnel returning from OIF, compared to 11 percent of personnel returning from OEF, and eight percent of personnel returning from other locations. Mental health problems were significantly related to combat experiences. More than 50 percent of the OIF personnel who were referred for mental health concerns identified during the PDHA were documented to have received mental health care during the following 12 months. 68,923 (35 percent) of all 222,620 OIF veterans accessed mental health services during the 12 months after they returned home. However,

among these 68,923 individuals who sought mental health care, only one-third received a mental health diagnosis. Only eight percent of the 68,923 individuals had been referred to mental health care during the PDHA screening process.

A research study on the health of Service members one year after returning from OIF was published in the *American Journal of Psychiatry* in 2007. The goal was to evaluate the relationship of PTSD symptoms with physical symptoms. 2,863 soldiers in Army combat units were surveyed anonymously. Physical symptoms included headaches, sleeping problems, stomach pains, back pain, and others (total of 15 symptoms). Soldiers were also asked the number of visits to sick call (primary care) and the number of missed work days in the past month. Sixteen percent of the soldiers met the screening criteria for PTSD. PTSD was significantly associated with each of the 15 physical symptoms. PTSD was also associated with more sick call visits and more missed work days. If the individual met screening criteria for other mental conditions (depression or alcohol misuse), in addition to PTSD, the number of physical symptoms increased. The authors recommended that combat veterans who are seen in medical care for substantial physical symptoms should be evaluated for PTSD and vice versa.

In 2006, Congress directed the Secretary of Defense to establish a task force to examine matters relating to mental health and the military. Task Force members, appointed in May, 2006, included equal numbers of military and civilian mental health professionals. The Task Force is completing a report based on their assessment of available research and survey data, public testimony from experts and advocates, and site visits to 38 military installations throughout the world, including the largest deployment platforms where thousands of Service members, family members, commanders, mental health professionals and community partners were given the opportunity to provide input.

The military health system is second to none in its ability to deliver timely, quality mental health and behavioral healthcare. This includes Behavioral Health in Primary Care, Mental Health Specialty Care, Clinical Practice Guidelines, and ready access to high quality, occupationally relevant primary care, along with model and demonstration programs designed to continuously learn and improve the system of care delivery. In addition, walk-in appointments are available in virtually all military mental health clinics around the world. Because no two individuals are exactly alike, multiple avenues of care are open to our military community to create a broad safety net that meets the preferences of the individual.

DoD does not rely on one single method or program to care for our military members and families.

Early intervention and prevention programs include pre-deployment education and training, suicide prevention training, Military OneSource (1-800-342-9647), the Mental Health Self Assessment Program, National Depression and Alcohol Day Screening, and health fairs (kits available at www.mentalhealthscreening.org).

DoD has formed a strong partnership with the Department of Veterans Affairs (VA) and other federal agencies and professional advocacy groups to provide outreach and prevention programs available to Reserve and National Guard members.

Military OneSource is a 24-hour, 7-day-a-week, confidential non-medical counseling program that can be accessed through the telephone, Internet, and e-mail, in addition to confidential family and personal counseling services in local communities across the country. The purpose of Military OneSource counseling is to promote early identification and intervention into life's problems before they reach clinical significance.

The Mental Health Self-Assessment Program began in February 2006. The initial program was designed to serve family members affected by deployments, military members who did not deploy but experience pressures associated with heavy workloads and long hours, and the deploying force who may experience symptoms at a time other than during a formal assessment cycle.

The programs that DoD has put into place to educate and evaluate are intended to provide early recognition of mental health concerns, encourage early health care seeking, early diagnosis and early treatment. As with any medical condition, the expectation is that early intervention will result in better long-term outcomes.

One DoD-VA collaborative study, The Millennium Cohort Study, was designed to evaluate the long-term health effects of military service, specifically deployments. The Department of Defense realized after the 1991 Gulf War that there was a need to collect more information about the long-term health of service members. The Millennium Cohort Study was designed to address that critical need, and the study was underway by 2001.

Funded by the Department of Defense, and supported by military, Department of Veterans Affairs, and civilian researchers, almost 140,000 people have already participated in this groundbreaking study. As force health protection continues to

be a priority for the future of the United States military, the Millennium Cohort Study will be providing a crucial step towards enhancing the long-term health of military service members.

The Department of Defense is very concerned about the short-term and long-term health effects of deployments and military service for all of its Service members. Our ability to analyze medical data related to deployments in a proactive way is enabling us to develop and modify programs to better prepare our Service members and their families for the stressors of military service, to educate them and our leadership on recognizing when to seek medical evaluation for concerns and to make changes when medically indicated. The recent findings of the MHAT IV survey show that not all Soldiers and Marines deployed to Iraq are at equal risk for screening positive for a mental health problem. The level of combat is the main determinant of mental health status. Other factors which contribute to that are strength of leadership and duration of deployment. Since we continuously assess the health of our force, both physical and mental, we will continue to analyze the information to assure we are doing everything possible to protect their health and to provide the care and treatment they need and deserve while they are deployed and when they come home.

We are extremely interested in the upcoming report from the Mental Health Task Force and are committed to work diligently to incorporate their recommendations into the Military Health System's program to care for our warriors and all our beneficiaries. We also appreciate the work of the Independent Review Group on “Rehabilitative Care and Administrative processes at Walter Reed Army Medical Center and National Naval Medical Center,” which made recommendations related to mental health care and treatment.

Mr. Chairman, I thank you for the opportunity to provide you and the members of the Committee with an overview of the Military Health System's program to provide mental health care for our Service members and their families. I am ready to answer your questions.