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FINAL VERSION

STATEMENT BY

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COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 110TH CONGRESS

MENTAL HEALTH OVERVIEW

14 MARCH 2008

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

Chairwoman Davis, Congressman McHugh and distinguished members of the military personnel subcommittee: thank you for the opportunity to discuss the Army's efforts in improving the mental healthcare for our Soldiers and their Family members. We are committed to getting this right and providing a level of care and support to our Warriors and Families that is equal to the quality of their service. Secretary Geren, General Casey, General Cody, and the rest of the Army leadership actively support our efforts to improve the access to and quality of mental healthcare services. They are also aggressively engaged in changing the culture and eliminating the stigma associated with seeking mental healthcare that not only our Army, but our Nation, experiences.

We all recognize that the increased operational demand of our military force to fight the global war on terror has stressed our Army and our Families. The DoD and the Army have made a concerted effort to proactively research the effects of this conflict through the DOD's Mental Health Task Force as well as the Mental Health Advisory Team's annual assessments. We know from this research that repeated and extended deployments have led to increased distress, family difficulties, and other psychological effects of war, such as symptoms of post-traumatic stress as well as post-traumatic stress disorder (PTSD). The Army is absolutely committed to ensuring all Soldiers and their Families are healthy, both physically and psychologically. We have made a concerted effort to mitigate risks and enhance mental healthcare services through various programs and initiatives which directly align with the DoD's Mental Health Task Force Report's 4 major recommendations: 1) Build a culture of support for psychological health; 2) Ensure a full continuum of excellent care for service members and their families; 3) Provide sufficient resources and allocate them according to requirements; 4) Empower leadership.

Enhancing, protecting, and improving the mental health for our Soldiers and Families starts from the time a Soldier enters the Army, through various stages of their service, which includes getting ready for deployment, being deployed, and returning from deployment (often referred to as the Army Force Generation or ARFORGEN cycle) as well as departure from service.

From the moment they start Basic Combat Training and at every successive assignment, Soldiers and their Families have access to a wide range of support services – the Installation's Army Community Service program, the Chaplain's network, Leadership and Family Readiness Groups, and of course healthcare at either the military facilities on post or the extensive TRICARE network of providers in the civilian community.

During a Soldier's service it is very likely that he or she can be called to deploy to a remote location of the world away from their Families for various and sometimes extensive lengths of time. The Army has wisely recognized that building Soldier and Family resiliency is key to maintaining their health and welfare. We developed "Battlemind" training products to increase this resiliency and we have several different training programs available for pre, during and post-deployment. These programs are designed for Soldiers and their Families, including children as young as pre-school age, and they are distributed throughout the force. These programs are also available online at www.behavioralhealth.army.mil.

In a powerful effort to both raise awareness and reduce the stigma associated with seeking mental healthcare, the Secretary of the Army and Chief of Staff of the Army initiated a leader chain teaching program to educate all Soldiers and leaders about post-traumatic stress and signs and symptoms of concussive brain injury. This was intended to help us all recognize symptoms and encourage seeking treatment for these conditions. All Soldiers were mandated to receive this training between July and October 2007, during which time we trained over 800,000 Soldiers. We are now institutionalizing this training within our Army education and training systems to continue to share the information with our new Soldiers and Leaders and to continue to emphasize that these signs and symptoms are normal reactions to a stressful situation. I encourage Soldiers to seek assistance to cope with these issues.

During deployments, the Army found tremendous value in providing mental health treatment far forward in the operational areas. Our primary method of providing both preventive and required mental health treatment was through Combat Stress Control Teams. From the beginning of combat operations, there has been a robust Combat Stress Control presence in theater, with approximately 200 deployed behavioral

health providers to Iraq alone. These combat stress control assets are heavily used to monitor and mitigate the effects of multiple and extended deployments. This is now a joint effort, with the Air Force assisting us in Iraq and Afghanistan and the Navy in Kuwait. The Army has also done unprecedented work in surveillance of Soldiers, both in the combat theater and back home. The Mental Health Advisory Teams (MHATs) have gone to theater every fall since 2003 and surveyed Soldiers, care providers, chaplains and others. Their findings on epidemiology of symptoms, access to care, and stigma, have led to direct and immediate improvements in the way that we deliver care. I have included information specific to MHAT V as an appendix to this statement.

Upon redeployment, we continue to gather information about physical and psychological health symptoms on the Post-Deployment Health Assessment. Through our use of scientific studies to drive evidence-based practices, such as the work of the Mental Health Advisory Teams, we developed the Post Deployment Health Re-Assessment to screen Soldiers again during a later stage of the reintegration and post-redeployment period. Typically we find the signs and symptoms of post-traumatic stress are not fully apparent until after a 60 – 90 day readjustment period. In addition to these two event driven assessments, we have also implemented an annual screening tool, the Periodic Health Assessment, to further supplement our information.

As expected, through our efforts to reduce stigma, raise awareness, and assess the health of our Soldiers, the need for behavioral healthcare is increasing. We do have gaps at some locations in meeting behavioral healthcare demand, but we are diligently working on solutions. The Army developed a program titled the Army Family Covenant, which formally commits us to improving access to high quality behavioral health for Soldiers and Families. Through Congressional Supplemental Funding targeted at caring for psychological health, we have been able to focus resources on hiring behavioral health providers. So far, we have been able to hire and put in place 147 providers in a very competitive hiring environment. We are striving to hire almost 200 more behavioral health providers. We are also pursuing the hire of an additional 40 substance abuse counselors and over 50 marriage and family therapists and have added about 90 social workers to our Warrior Transition Units. My medical treatment facility commanders tell me that these hires are making a difference. We also have

numerous long-term efforts to enhance recruitment and retention of uniformed behavioral health providers.

We are also trying to address behavioral health care through increased education and training of our primary care providers. This committee is familiar with RESPECT-MIL, a program designed to decrease stigma and improve access to care by providing behavioral healthcare in primary care settings. Because of the success of this program, we have initiated further efforts to train primary care providers and integrate behavioral health with primary care. The combination of ongoing education and improved access to care through numerous portals should again help encourage Soldiers to seek care early.

As part of the Army Medical Action Plan (AMAP), we've developed a program for our Warriors in Transition called the Comprehensive Care Plan which is implemented across our 35 Warrior Transition Units (WTU). The continuum of care that a Soldier receives while in the WTU culminates in a care plan which integrates the more conventional medical and surgical interventions we administer to our wounded, ill and injured Warriors with efforts to optimize the Soldiers' return to uniformed service or transition into successful life as a veteran. These insights were derived from our experiences over the last year and have now been institutionalized under the direction of my Assistant Surgeon General for Warrior Care and Transition, Brigadier General Mike Tucker. Soldiers in the WTUs are expected to be physically, mentally, socially, and spiritually strengthened. This program sets the conditions for a successful transition to the Department of Veterans Affairs or society.

As the Army Surgeon General, I am aware of the toll that increased demand has placed on my health care team. The Army's uniformed behavioral health providers are among the most highly deployed of any of our specialties. We use numerous recruitment and retention initiatives to encourage them to join and stay in the Army, including increased bonuses for psychologists and increased educational opportunities for social workers. As part of our detailed force management review being led by Major General Gale Pollock, we are assessing our manpower requirements and will recommend changes to the force structure as needed. We also developed Provider Resiliency Training to mitigate burn-out not only for our medical providers, but also for

Army Chaplains and other specialists who are in the business of serving our Soldiers and Families.

Although we have had many successes, I have some areas of concern. These include the increasing suicide rate, accidental deaths due to overdose, and public perceptions that Soldiers are being inappropriately discharged from the Army for personality disorder when they may have underlying medical conditions.

Unfortunately, active Army suicide rates have increased over the last seven years. Although the Active Army suicide rate is comparable to the demographically-adjusted civilian population rate, it is at an all-time Army high and we are taking action to address it. Over the last two years, there has been a concerted effort to improve suicide prevention. The Army G-1 is leading this effort with support from the medical and chaplain communities. The Army Medical Department's Army Suicide Event Report continues to offer surveillance and perform analysis. Recent analyses of suicides have resulted in concrete recommendations, which are currently being implemented, both in theater and on our installations.

We have also chartered a General Officer Steering Committee to address suicide prevention. We will develop an action plan focused on five areas of emphasis: 1) develop life-coping skills; 2) maintain constant vigilance; 3) encourage help-seeking behaviors and reduce stigma; 4) maintain constant surveillance of behavioral health data, and 5) integrate and synchronize unit and community programs. We must develop actionable intelligence that provides our leaders an analysis of each suicide or attempted suicide that includes lessons learned, trend data, and potential factors to monitor. The intent is to modify leader behavior towards Soldiers who are impacted by stressors and are at risk of harming themselves.

On the issue of accidental overdoses, I recently chartered a multi-disciplinary team of 17 dedicated professionals (psychologists, psychiatrists, physicians, nurses, unit commanders, First Sergeants and Sergeants Major) to analyze and develop risk mitigation strategies to reduce the number of accidental deaths and accidental drug overdoses within our WTUs. This team recommended 71 strategies that focus on improving identification, training, and monitoring systems. We have already adopted 26 of those recommendations. The Army will improve its capability to identify high-risk

soldiers. We will also improve the training of our clinical staff, leaders and Soldiers on risk reduction measures. We have changed policies and procedures to facilitate these risk-reduction measures and we will improve our capability to monitor and track accidental deaths and accidental drug overdoses.

Finally, there has been a perception that Soldiers are being inappropriately discharged for personality disorder. All Soldiers discharged for personality disorder are required to receive a mental status evaluation as per Army Regulation 635-200. MEDCOM implemented a new policy in August 2007 that requires the installation's behavioral health chief to review all personality disorder discharge recommendations. We will also require Soldiers being discharged for misconduct to receive mandatory screenings for PTSD and mild TBI. This change in policy will mitigate the risk of discharging Soldiers with health conditions that were acquired while serving their country.

I greatly appreciate the privilege to command the United States Army Medical Command and the opportunity to report on the progress we have been making on providing quality mental healthcare to our Soldiers and Families. We appreciate your support as you interact with servicemen and women and their families in your districts in communicating our strategic successes in this area. We also appreciate your help in influencing the mental healthcare providers in your areas to accept TRICARE patients which will expand our behavioral healthcare capacity.

In closing, I'd like to share with you a quote from the DoD Mental Health Task Force Report: "In the history of warfare, no other nation or its leadership has invested such an intensive or sophisticated effort across all echelons to support the psychological health of its military service members and families as the Department of Defense has invested during the Global War on Terrorism." Thank you for holding this hearing and giving us the opportunity to share our accomplishments and to reaffirm our unyielding commitment to provide the best care to all our Soldiers and their Families.

APPENDIX

INFORMATION PAPER

SUBJECT Army's Fifth Mental Health Advisory Team (MHAT) Assessment

On March 6, 2008 the Department of the Army announced the results of the Army's fifth Mental Health Advisory Team (MHAT) report: MHAT V. This assessment examined the morale and mental health of Soldiers deployed to Iraq and Afghanistan in the fall of 2007. MHAT V continued the precedent of deploying advisory teams to Iraq and Afghanistan to assess behavioral healthcare requirements of Soldiers.

MHAT assessments are established by the Army Surgeon General, and have deployed to Iraq every year since 2003 at the request of the Commanding General, Multi-National Force-Iraq. The Army uses the results of these studies to shape programs, policies and procedures and to allocate resources to better meet the Mental Health needs of our Soldiers. Since the first MHAT, the Army has conducted chain teaching, implemented Battlemind training, expanded training for health care providers, redistributed mental health assets in theater, and hired additional mental health providers.

In 2007, MHAT V also deployed to Afghanistan at the request of the Service Chief, Army Central Command (ARCENT). Army leaders in Iraq, Afghanistan and at home began implementing MHAT recommendations upon completion of the assessment.

In Iraq, the MHAT collected 2,279 anonymous surveys from Soldiers, and 350 anonymous surveys from behavioral health, primary care and unit ministry team members. In Afghanistan, 889 Soldiers completed the anonymous Soldier survey, and 87 anonymous surveys were completed by behavioral health, primary care and unit ministry team members.

Soldiers in Iraq reported an increase in unit morale in 2007 relative to 2006. The percent of Soldiers screening positive for mental health problems was similar to previous years, although the report found that Soldiers on their third or fourth deployment reported higher mental health and work-related problems than Soldiers on their first or second deployment. Soldiers who received pre-deployment Battlemind training reported fewer mental health problems. The Army-wide implementation of Battlemind training was an MHAT IV recommendation made in 2006 (http://www.battlemind.org).

Overall, Soldiers in Afghanistan reported rates of mental health problems similar to rates observed among Soldiers in Iraq. The one exception was that reports of depression were higher in Afghanistan in 2007 than in Iraq during the same timeframe. Rates of mental health problems in Afghanistan in 2007 were higher than rates of mental health problems reported in the last Afghanistan assessment in 2005.

In Iraq, an increase in the number of months deployed was directly related to a variety of outcomes. Reports of work-related problems and plans for Soldiers to pursue divorces or separations increased with each subsequent month deployed. Reports of mental health problems increased over time, but showed an improvement in the months immediately before returning home; this is most likely due to redeployment optimism.

In Iraq, overall levels of combat exposure in 2007 declined relative to 2006 although levels of combat exposure varied significantly among units. Soldiers in Afghanistan reported significant increases in combat exposure relative to the Afghanistan assessment in 2005. The sub-sample of 282 Soldiers in Brigade Combat Teams (BCTs) in Afghanistan reported levels of combat exposure similar to or higher than levels reported by BCT Soldiers in Iraq.

Soldiers deployed to Iraq in 2007 reported lower rates of stigma associated with accessing behavioral health care, but more difficulty accessing health care than in 2006. Access to care was impacted by the increase in smaller outposts in Iraq in 2007. Behavioral health personnel reported conducting more command consultations than in 2006 indicating that commanders are increasingly relying on behavioral health personnel for a variety of behavioral health support missions. Behavioral health personnel also indicated a need for more personnel.

In Afghanistan, Soldiers reported significant barriers to mental health care, and behavioral health personnel reported difficulties getting to Soldiers.

For the first time, MHAT personnel examined sleep patterns in theater. Sleep problems are a strong predictor of work-related performance and are associated with other mental health problems such as depression and post-traumatic stress. Soldiers in OIF reported an average of 5.6 hours of sleep, too few to maintain optimal performance; however, self reports of sleep are not always objective. Therefore, a need to look at sleep patterns more objectively was indicated.

MHAT IV and MHAT V showed that Soldiers who screen positive for mental health problems and anger are significantly more likely to report engaging in unethical behaviors. In OIF, reports of unethical behaviors were largely unchanged from 2006.

Annual suicide rates for Soldiers in both Iraq and Afghanistan were elevated relative to historic Army rates. The OIF MHAT found that self reports of suicidal thoughts peaked around mid-deployment then dropped off, and there was also some evidence suggesting that suicides increased after being deployed 6 months or more. As for frequency of deployments, the MHAT found no evidence to suggest that multiple deployments were associated with increased suicidal thoughts.

In Iraq and Afghanistan, the teams made a number of recommendations that Army leaders began reviewing or implementing as soon as the assessment was completed.

These include:

Non-Theater Specific

- Allow government civilian or contracted behavioral health personnel to fill select positions in theater to augment military personnel.
- Create and fill behavioral health officer and enlisted positions in aviation brigades as these personnel are not organic to the units.
- Ensure that all combat medics receive Battlemind Warrior Resiliency training before deploying in support of OEF or OIF so that they can augment behavioral health personnel.
- Move division psychiatrists from sustainment brigades to a division surgeon cell, and move brigade mental health officers from brigade support battalions to brigade surgeon cells. These moves will allow mental health officers to serve as special staff to Commanders on mental health issues.
- Update the Combat Operational Stress Course (COSC) to ensure it stays relevant to division and brigade combat team behavioral health assets.
- Increase number of Family-life providers to work with spouses and Family members.
- Enhance training for Non-Commissioned Officers on their role in maintaining Soldier resiliency through counseling & mentorship training.
- Develop and implement senior leader Battlemind training.

Theater Specific to Iraq

- Modifying the position of the theater mental health consultant and senior mental health Non-Commissioned Officer in Charge (NCOIC) to allow broader overview of the theater.
- Hold quarterly behavioral health conferences to enhance networking, communication, coordination and to increase personnel morale and well-being.
- Ensure use of COSC Workload and Activity Reporting System throughout the theater of operations.
- Develop suicide prevention action plan at the operational and tactical levels.
- Develop consistent policies for evaluation after a concussive event and standards for return to duty.

Theater-Specific to Afghanistan

- Appoint a Behavioral Health Consultant to the Command Surgeon who understands the mental health needs within theater, and can advise the Commander on optimal allocation of mental health resources.
- Redistribute behavioral health assets and conduct an aggressive outreach program.