RECORD VERSION

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Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to discuss efforts to investigate and provide early outreach, recognition and health care for active and reserve component service members returning from deployments around the globe, most notably the current deployments to Iraq and Afghanistan. The Department of Defense (DoD) and the Army are working pro-actively to identify service members who are experiencing deployment-related stressors and to treat them in a timely and appropriate fashion. We appreciate Congress' interest in this topic and we also appreciate the past support of this committee and Congress for DoD and Department of Veterans' Affairs (VA) mental health programs.

My testimony will cover the nature of mental health challenges among returning service members; the efforts we are making to respond to their needs; and finally, some ideas regarding future directions most likely to comprehensively address those needs. The points I wish to convey are: 1) the need to bring safe, accessible, and confidential care to the service member in need rather than waiting for him or her to seek it; 2) the importance of primary care as an opportunity for early recognition and care within DoD; and 3) there is an array of efforts underway to reach out to military primary care clinicians, service members and families, and the seriously wounded.

The perspectives I offer are based in part on my training as a psychiatrist, epidemiologist, and health care researcher having published over 70 papers in scholarly medical journals and books, in part on my experiences as a Division Psychiatrist for the 1st Cavalry Division during the 1991 Gulf War, and most importantly based on nine years experience as the director of a unique Department of Defense Center of

Excellence and health care advocacy for returning military personnel, the Deployment Health Clinical Center, located at Walter Reed Army Medical Center in Washington DC. The Deployment Health Clinical Center was first chartered in 1994 as the Gulf War Health Center and given the mission of caring for 1991 Gulf War veterans with war-related physical and mental health concerns. The Center was renamed the Deployment Health Clinical Center (DHCC) in 1999 pursuant to Section 743 of the Strom Thurmond National Defense Authorization Act and our mission broadened to providing direct care and improving post-deployment health services for military personnel returning from any deployment and their families.

Since its inception, the Deployment Health Clinical Center has provided direct medical services to over 15,000 service members with health concerns including over 1,500 related to the current conflicts in Iraq and Afghanistan as well as others affected by the Pentagon and World Trade Center attacks on September 11 2001, Kosovo and the Balkan conflict, and the 1991 Gulf War. Health issues we have addressed have ranged from highly visible physical wounds and injuries, clearly defined diseases such as diabetes and Lou Gehrig's disease, all the way to similarly disabling disorders that cannot be easily discerned on visual inspection or even detected with a lab test. It is of course these latter "invisible" ailments that I direct most of my comments toward today, war-related ailments such as post-traumatic stress disorder (PTSD), major depression, generalized anxiety, and medically unexplained physical symptoms such as those experienced following the 1991 Gulf War.

As you have heard from Colonel Hoge, psychiatric disorders such as PTSD, major depression and generalized anxiety are occurring in as many as one in four

troops returning from Iraq and Afghanistan. Other recent research, such as a six-month study of injured soldiers medically evacuated through Walter Reed led by my colleagues CAPT Tom Grieger at Uniformed Services University and COL Steve Cozza at Walter Reed Army Medical Center, has shown that about half of evacuated service members with PTSD and depression quickly improve. However, during the three to six months following evacuation, overall rates of PTSD and depression rise two or three-fold. So far, the research has been limited mainly to Soldiers and Marines either injured or from combat elements; very little is known about Sailors and Airmen. Similarly little is known about how women have been affected by their wartime service.

When interpreting these results and deciding what to do about them, it is important to recognize some key issues. 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 as a rule and where exactly to draw that line 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 illness but a definition that some have advocated for PTSD, the rates of PTSD can appear quite high. For example, a score of 30 on the measure that COL Hoge uses in his studies yields rates of pre-war PTSD of nearly 25% with 50% or more meeting this milder definition after the conflict. The point here is not to suggest that we are underestimating the rate of post-war PTSD, but to remind us all that there are many returning service members who, even though they may not have a full blown psychiatric disorder, are also experiencing psychological distress after their wartime service. I will

return to this group of service members with milder symptoms when I discuss the potential for health care system interventions.

Second, COL Hoge's data clearly show that, just as in the civilian population, many of those with mental illness from psychological trauma have yet to receive any care for their problems because they are intimidated by the stigma attached with suffering from PTSD or because they simply believe they can work through the issues by themselves These returning service members often report concerns about how they will be viewed by their peers and leaders and about how seeking mental health care will affect their careers. We have made great strides in improving access to mental health care programs, but if you consider all the untapped demand out there we may still have challenges to overcome. These data strongly suggest that we must rely on primary care providers to screen, evaluate and, when appropriate, treat service members rather than waiting for them to seek care. A third issue also has implications for improving mental health services for those with needs. A line commander I worked for once said, "If a Soldier LOOKS fat, then he IS fat". In contrast to obesity and contrary to popular belief, one can seldom tell whether someone suffers from a mental illness simply by looking. This fact is particularly true for the disorders of greatest concern after war – for example PTSD and depressive and anxiety disorders. Therefore, in health care settings and the best conceived screening programs, we have no choice but to rely on service members' willingness and ability to offer a frank account of their mental state. The consequences of this fact seem clear enough: if we do not make military mental health care safe to obtain and offer service members clear and public confidentiality safeguards, then we will not be able to reliably detect and diagnose these illnesses and provide proper care

and assistance. If we cannot build adequate trust, afford health care continuity, honor wartime service and protect from harmful career actions, then those in need will reject our services and keep their personal problems to themselves until they balloon out of control.

The hidden costs to the military of undiagnosed mental illness “driven underground” are difficult to measure but almost certainly include missed opportunities to prevent domestic violence, military misconduct, poor performance of military duties, lost duty days, and other important challenges to mission success.

Given the apparent mental health needs of returning troops and their loved ones, what can we do to disseminate information, reduce barriers and stigma, and provide care for the large numbers with unrecognized illness who are currently untreated? There are many groups working earnestly to answer these questions and challenges. Let me speak to some Deployment Health Clinical Center efforts. At the Deployment Health Clinical Center, our efforts involve three major thrusts: direct health service delivery accompanied by continuous quality improvement efforts, outreach and provider education to include dissemination of best clinical practices, and finally a program of health services research that relies on state-of-the-art scientific methods to identify what works.

We believe that a particularly promising service delivery direction includes efforts to improve mental health services in military primary care, a direction I first published in the peer-reviewed medical literature in 1994. Multiple lines of evidence accumulated over the past quarter century have shown that nearly two-thirds of mental health services in the civilian sector are delivered in primary care. Automated military health

care data shows that between 90 and 95% of troops receive one or more primary care visits each year. In contrast, only 5-10% of military personnel have historically sought mental health care each year. The overall impact would surely be great if we could improve the recognition and effective management of mental illness in the 90-95% of service members seeking primary care each year. Multiagency efforts to improve mental health services in primary care are even more logical and important now that all reserve component personnel are eligible for VA medical services.

In fairness, however, we must be circumspect with regard for our expectations of primary care. Primary care providers are very busy, and gaps in the quality of mental health care afforded in civilian primary care settings are already well documented. Nonetheless, if we can close or even narrow these gaps in the military, the successful provision of mental health care in primary care settings may help a very large proportion of those who are currently hesitant about seeking needed services. Sound primary care for otherwise untreated mental illness may allow for early recognition, and the use of a general medical rather than a behavioral health setting may normalize, demystify, and destigmatize needed mental health services.

Accordingly, the Deployment Health Clinical Center is currently partnering with MacArthur Foundation funded investigators from Dartmouth Medical School, Duke University and the Durham VA, and Indiana University to implement a primary care quality improvement initiative targeting the adoption of existing VA-DoD clinical practice guidelines for major depressive disorder, PTSD, and medically unexplained physical symptoms. The initiative, called “Reengineering Systems of Primary Care Treatment of Mental Illness in the Military” or simply “RESPeCT-MIL” is based on an expansion of a

pioneering intervention for primary care treatment of depression developed under the leadership of Dr. Allen Dietrich, Professor of Family Medicine at Dartmouth Medical School. The modified RESPeCT-MIL approach uses a nurse care manager that interfaces with the Soldier, the primary care provider, and the mental health specialist in an effort to bolster continuity, symptom monitoring, and treatment adherence. The use of a nurse rather than a mental health specialist insures that the intervention is firmly embedded in primary care, creates potential for clinics to maximize the use of existing personnel thereby reducing associated costs, and frees scarce mental health resources to do specialty based care. This approach for major depression was shown to be effective in a large multisite controlled scientific study published about a year ago in the British Medical Journal. The RESPeCT-MIL program is now enrolling Soldiers who are receiving their care at the 82nd Airborne Division's Robinson Clinic at Fort Bragg. Our goal is to use the data we obtain from this single site initiative to justify a larger scale implementation and program evaluation.

As I previously described, the largest proportion of returning service members with post-war mental illness have relatively mild manifestations and can be managed with from lower intensity psychosocial interventions offered within the existing primary care system rather than a more intimidating specialty mental health care setting. With funding from the National Institute of Mental Health and in collaboration with Dr. Brett Litz at Boston University and the Boston VA and Dr. Richard Bryant at University of New South Wales in Australia, we have developed and are evaluating a computer-assisted therapy tool for PTSD. The tool, called DESTRESS, for "Delivery of Self-training for Stressful Situations," is designed to be Internet accessible, does not necessarily require

participants to identify themselves online, employs a scientifically sound stress inoculation training paradigm, and can be used by primary care doctors to introduce reluctant but distressed military personnel to effective care. Some service members will obtain symptom relief using the tool, while still others with persistent symptoms may find this non-threatening introduction to mental health care motivates them to seek mental health services they might not otherwise have sought.

New information related to deployment health is constantly and rapidly emerging and the Deployment Health Clinical Center and such as the Center for the Study of Traumatic Stress at Uniformed Services University are making aggressive continuous efforts to push that information into the hands of practicing clinicians in federal and nonfederal clinical settings. The Center for the Study of Traumatic Stress is providing high quality information to service members and families, particularly children via their "Courage to Care" program accessible from the Uniformed Services University website (http://www.usuhs.mil). The Deployment Health Clinical Center maintains a website called PDHealth.mil (http://www.pdhealth.mil) that is designed for clinicians who are providing care for deploying and returning service members. The site receives over 700,000 hits each month from around the world, a third of our users visit the site regularly, and the average length of stay on the site is an amazing 20 minutes per hit. The site offers up to date scientific information in the form of fact sheets for clinicians and for patients as well as notifications of new studies with relevance to post-deployment care. For example, we have carefully tracked and summarized new findings related to the neuropsychiatric manifestations of mefloquine and made them readily accessible for clinicians so they can stay abreast of this important issue. In

addition, over a thousand clinicians currently receive the Deployment Health News, a five days a week news digest of new information designed to keep providers up to date with the media literature their military patients may be reading as well as with breaking scientific findings. For those clinicians who do not like using the Internet, Deployment Health Clinical Center has also developed an award winning information "Toolbox" and disseminated them to approximately 10,000 primary care clinicians practicing across the Army, Navy, and Air Force. For those clinicians and patients who prefer to ask their questions directly, the Deployment Health Clinical Center operates email and toll-free telephone helplines with access from Europe and the United States, one helpline for active and reserve component service members and their families and another for clinicians and providers.

Other high risk groups of returning service members are the wounded, the medically evacuated; that is, those with the most severe war-related physical health problems. These service members fortunately represent the small minority of those with war-related disorders, but their disability is great and assistance for every service member with health care needs is ultimately the fulfillment of a sacred promise, the promise of the combat medic to assist his or her injured comrades. To help fulfill that promise, some model programs are in place. The Walter Reed Army Medical Center Psychiatry Consultation-Liaison Service, under the leadership of COL Steve Cozza and Dr. Hal Wain, has made routinely assessed and followed all wounded and ill soldiers that are medically evacuated through that facility using a model first explored with casualties of the 1991 Gulf War and refined since. The Deployment Health Clinical Center has served as a worldwide referral care center for these service members since

1995, having run approximately 120 three-week cycles of an intensive multidisciplinary treatment program for medically unexplained pain and fatigue, called the Specialized Care Program. A modified form of this model of care was successfully evaluated in a 20-site study employing the VA's state-of-the-art cooperative studies program and was published in Journal of the American Medical Association (JAMA) in March of 2003.

During the last few months, Deployment Health Clinical Center has developed a new version of the Specialized Care Program, this version for individuals with persistent PTSD and other war-related psychiatric disorders. This program, developed in response to the current need for an intensive Department of Defense program focusing on PTSD, employs evidence-based elements of care that have been endorsed in several PTSD practice guidelines including the VA-DoD PTSD Clinical Practice Guideline. We are currently evaluating this new clinical program and examining how we might export it to other regions in the military healthcare system.

Mr. Chairman and Members of the Committee, these are only a few of the things we are doing at the Deployment Health Clinical Center for military personnel returning from war. I have focused on our mental health directions and our views of some of the emerging mental health data from returnees. Hopefully I have conveyed Deployment Health Clinical Center efforts to: 1) help bring safe, accessible, and confidential care to service members in existing primary care clinics rather than waiting for them to seek care; 2) maximize the effective use of primary care as an opportunity for early recognition and care within DoD; and 3) bolster the array of innovative efforts underway to reach out to military primary care clinicians, service members and families, and the seriously wounded. Mr. Chairman, we at Deployment Health Clinical Center are

honored and privileged to assist the inspiring men and women who serve our Nation admirably at home and overseas, in peace and in war. The center owes its ongoing success to a very devoted and capable staff and over a decade of unwavering support from Congress, DoD and the Army Medical Department. Thank you for allowing me to appear before you today. I would be pleased to respond to any questions from Members of the Committee.