RECORD VERSION

STATEMENT BY

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Mr. Chairman and Members of the committee, thank you for the opportunity to discuss the Army's research into mental health issues associated with deployments in the Global War on Terrorism. I am Colonel Charles W. Hoge, M.D, Chief of Psychiatry and Behavior Services at the Walter Reed Army Institute of Research. The Army and the Department of Defense (DoD) have taken a distinctly pro-active approach to understanding and mitigating the mental health concerns associated with the deployments to Iraq and Afghanistan. Your interest in this matter, along the previous support of Congress into our efforts, has greatly enhanced the body of scientific information available regarding combat stress, post traumatic stress disorder (PTSD), and other mental health issues. The Army is committed to continuing to expand our knowledge of the symptoms of deployment-related stress disorders and to identifying and treating Soldiers and families manifesting these symptoms as early and effectively as possible.

Mental health symptoms are common and expected reactions to combat, and the Army and DoD have made it a priority to learn as much as possible and adjust programs as the war is ongoing to meet the needs of our service members. Research following other military conflicts has demonstrated that deployment stressors and combat exposure confer considerable risk of mental health problems to include PTSD, major depression, substance abuse, social and occupational impairment, and increased health care utilization. However, virtually all studies that have assessed the mental health effects of combat from prior wars, including the first Gulf War were conducted years after Soldiers returned from the combat zone. A key methodological problem with these studies is the long recall periods following combat exposure.

Many gaps exist in our understanding of the full psychosocial impact of combat. The recent U.S. military operations in Iraq and Afghanistan have involved the first sustained ground combat since the Vietnam war, as well as hazardous security duties. Previous studies have not assessed the broad range of mental health outcomes proximal to the time of deployment. Of particular importance is the limited amount of research prior to the current conflict in Afghanistan and Iraq to guide policy regarding how best to promote access and deliver behavioral health services to military service members. There have been very few studies that have assessed the utilization of behavioral health services, perceived need, and barriers to treatment among military personnel shortly before or after combat deployment.

To address these concerns, a team at Walter Reed Army Institute of Research, which I am honored to lead, initiated a large study in January 2003, with the support of senior Army medical and line leaders, to assess the impact of current military operations in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) on the health and well-being of Soldiers and family members. This study is ongoing and is being funded under the Department of the Army Intramural Operational Medicine Research Program. The study involves anonymous surveys administered with informed consent under an approved research protocol. The study has focused on combat operational units, and over 20,000 surveys have been collected to date. Soldiers from multiple brigade combat teams, both Active Component and National Guard, as well as members of Marine Expeditionary Forces deploying to OIF and OEF have been surveyed before deployment, and / or after returning from deployment. Post-deployment assessments have been conducted at 3-4 months, 6 months, and 12

months after returning from deployment. We have also conducted similar surveys during deployment in OIF-1 and OIF-2 as part of the Mental Health Advisory Team reports. The surveys include questions about deployment stressors, combat experiences, and unit climate variables such as cohesion and morale. Depression, anxiety, and PTSD are measured using validated self-administered checklists, such as the PTSD checklist developed by the National Center for PTSD. Other outcomes include alcohol use, aggression, and family functioning.

Our study has confirmed that PTSD symptoms are much more commonly reported after deployment than before deployment, particularly among Soldiers who have returned from combat duty in Iraq. Results of surveys collected among units 3-4 months post-deployment from Iraq were published in the New England Journal of Medicine in July 2004. Subsequent data collections out to 12 months post-deployment show modest increases in the percent of Soldiers reporting PTSD over the published figures, but have not yet been published. Overall, 15-17% of service members who were surveyed 3-12 months post-deployment met the screening criteria for PTSD using a widely accepted definition that requires endorsement of multiple symptoms at a moderate or severe range (resulting in a total score of at least 50 on a symptom scale that ranges from 17-85). Nineteen to 21% of Soldiers surveyed met criteria for PTSD, depression, or anxiety. Overall, results have been highly consistent among the various units studied after deployment to OIF, although some unit-level differences have been observed, largely related to the frequency and intensity of combat experiences. We do not have definitive data regarding the impact of longer deployments or repeated deployments, but in general higher rates of PTSD have been observed among units

deployed for 12 months or more compared with units deployed for shorter time periods. The prevalence rates of PTSD are much lower following deployment to Afghanistan (6%) than deployment to Iraq. This is directly related to the lower level of combat intensity in Afghanistan. In parallel with our survey-based data there has been a substantial increase in military mental health care utilization among OIF veterans.

Alcohol misuse often is associated with PTSD, and we have also observed increases in reported alcohol misuse among Soldiers after returning from deployment to Iraq compared with Soldiers before deployment. Other outcomes that we are looking at include aggression and family functioning, and preliminary data indicates that there are likely deployment related effects in these areas, similar to what previous studies have shown. The strain of repeated deployments on Soldier and family well-being is evident in some units anecdotally.

One of the most important findings of our research is what we've learned about barriers to care in the military, particularly stigma. Our study showed that Soldiers and Marines are not very likely to seek professional help if they have a mental health problem, and that they are concerned that they may somehow be treated differently if they do. Stigma includes factors such as being concerned that one will be viewed or treated differently by peers or leaders if they are known to be receiving mental health treatment. Other barriers to care include not being able to get time off work or not having adequate transportation to get to the location where care is available. Stigma and barriers to mental health care are well-known problems in civilian treatment settings, especially among males, who are not as likely to seek help for a problem than

females. Our data has helped us to focus on approaches to facilitate access to care for our OIF and OEF veterans.

Given the importance of PTSD and other mental health concerns among military service members deploying to OIF and OEF, as well as what we have learned about stigma and barriers to care, we have begun research projects focused on improving early identification and intervention, facilitating access to care, and evaluating programs that are being implemented by the Army and DoD, such as the post-deployment health assessments. Our ongoing research program includes efforts to identify factors that predict high rates of mental health problems, identify gaps in service delivery, reduce stigma and barriers to care, and other efforts to help guide policy and to assure optimal delivery of services. We are evaluating assessment tools to provide effective methods of conducting psychological health screening in deployed troops which are cornerstones of facilitating access and early intervention, and improve methods for units to evaluate the behavioral health status at the unit level anonymously. Our research has shown that Soldiers are much more likely to report mental health problems 3-4 months after return from deployment than immediately on return from deployment, and as a result DoD has expanded the post-deployment health assessment program. We are also evaluating interventions such as psychological debriefing, and developing training modules for Soldiers, leaders, and health care providers. One of the most important aspects of our work is to assure that we provide the best services within the medical model of care, while conveying the message to our service members that many of the reactions that they experience after combat are common and expected. Helping to normalize these reactions is a key to stigma reduction and early intervention.

Considerations for improving access to care include co-locating mental health services in primary care clinics and improving awareness among primary care professionals of depression and PTSD evaluation and treatment. DoD and the Department of Veterans Affairs have collaborated on developing clinical practice guidelines for these conditions and have recommended routine screening in primary care. Standardized training of leaders and Soldiers about PTSD and other mental health effects of combat pre- and post-deployment are being developed, and further research and program evaluation is needed to ensure implementation of evidence-based practices. One of the most important things is to ensure there are adequate resources to support continued mental health and operational stress control services in the combat environment as well as to ensure that service members who are identified through post-deployment screening or who refer themselves after coming home (as well as their family members) receive timely evaluation and treatment.