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MENTAL HEALTH

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Mr. Chairman and distinguished members of this committee, thank you for the opportunity today to discuss Department of Defense mental health services and programs. We are working hard to ensure the well-being of all soldiers, sailors, airmen and Marines in the active, Reserve, and National Guard components, as well as their families. We are especially focused on the veterans of OPERATIONS ENDURING FREEDOM and IRAQI FREEDOM. Deployments place added stressors on Service members and their families, and have the potential to affect mental health.

Leadership, community prevention programs, and dedicated helping professionals in garrison and in operational theaters form the core of mental health support for our service members and their families. This mental health support is a continuum from community-based services, including buddy care, non-medical support resources and chaplains; to command level involvement, monitoring morale, improving living conditions and supporting quality of life initiatives; to the full spectrum of clinical care and patient movement of the Military Health System for those with a need for more intensive support.

Deployed military units embed mental health teams to support the unique needs of each service. The Army utilizes Combat Stress Control Teams in addition to mental health providers in Troop Medical Clinics. The Navy employs Specialized Psychiatric Intervention Teams (SPRINT) to rapidly respond to disasters. The Marines utilize an Operational Stress Control and Readiness program (OSCAR). The Air Force deploys Mental Health Rapid Response and Augmentation Teams for deployments and to respond

to disasters. Behavioral health specialists "take the pulse" of their units' morale and provide consultation and advice to leadership under challenging circumstances to address morale and mental health needs. All of these teams are operating today in Iraq and Afghanistan, and they are making a real difference.

Operational stressors, such as family separation and field conditions, and combat trauma may result in Service members experiencing anxiety and depression symptoms. Some traumatized members experience acute stress symptoms that can persist to become posttraumatic stress disorder. While no proven method exists to entirely prevent posttraumatic stress disorder shortly after a traumatic exposure, supportive care is provided immediately in theater.

Depression, anxiety and traumatic stress symptoms often respond to psychotherapy carried out individually or in groups. The use of psychotropic medications, including antidepressants, may also be helpful, and are available for use in theater. Members may be temporarily unable to perform their duties as a result of these conditions. Service members with incapacitating symptoms lasting more than 1 to 3 days are usually evacuated from theater. Between 2003 and 2004, while medical evacuations dropped for all causes (-12%), mental health evacuations from OPERATION IRAQI FREEDOM declined even more (-25%).

Service members suffering mental disorders may avoid professional help because of perceived stigma or because of the effect of the disorder itself on their judgment.

Services actively encourage the mind-set of "buddy care" or being a good "wingman" to encourage looking out for one another's mental health and getting help when necessary. Services also provide multiple opportunities for members to identify their needs.

Educational and prevention programs are designed to encourage Service members to identify and take care of small problems before they become overwhelming. In this way Service members remain at a high state of readiness. Service members complete predeployment screening prior to deployment. If a member is receiving mental health care, it is determined whether or not the member is fit for deployment according to medical standards. Members with unremitting mental health disorders are not deployed. If medical standards allow, a member whose condition is fully resolved may be allowed to continue maintenance medication in theater. For example, it is prudent to continue antidepressants 6 to 18 months after an episode of major depression has fully resolved in order to prevent relapse.

Every year, members are screened for mental health problems when they complete a preventive health assessment. They are again screened before they deploy. Before returning home from deployment, members complete a post-deployment health assessment, including questions about acute stress, posttraumatic stress disorder, depression, substance abuse, and unexplained symptoms. Services are now in the process of implementing an additional health reassessment that is conducted 3-6 months after returning home. Our experience has taught us that problems are not always apparent at

the time service members are immediately returning home, but they may surface a few weeks or months later. We want to catch these problems, and help.

Service members also participate in briefings about the psychological challenges of deployment cycles during pre- and post-deployment processing, often with family members. They learn what to expect on homecoming, about experiencing anxiety and family tensions, and how to reduce these symptoms. They also learn to recognize when to seek professional help; and how to find it.

New resources are now available to help service members during acute crises. The Air Force's and Navy's CD- and web-based *Leaders' Guides for Managing Personnel in Distress* provide direct guidance to supervisors and commanders to respond to soldiers in specific crises, from bereavement to marital challenges. Within seconds, leaders know the right questions to ask, best advice available, and where to go for help.

Military members and their families may also use *Military OneSource*, a 24-hour, 7-day a week toll-free family support service, which they access by telephone, Internet and e-mail . *Military OneSource* offers information and education services, referrals, and family and personal face-to-face counseling. *OneSource* is confidential, especially helpful for those members seeking to know whether their symptoms merit medical attention. Should they show evidence of mental health disorders, counselors refer members for suitable care. *OneSource* is provided in addition to local Family Support services.

The Department strongly supports Service leaders' suicide prevention programs, a series of initiatives that increase both leaders' and troops' awareness of members in distress. These programs lower the threshold for intervening when a Service member is showing signs of concern, and they lessen potential stigma associated with seeking mental health care. The military services now integrate suicide prevention into recurring military training for all levels, from recruits to senior leaders. Even with wartime stresses today, military suicide rates have not significantly increased and still remain lower than those of our civilian age- and gender-matched population.

We continue to look for ways to decrease these rates even further. In addition to in-garrison prevention programs, military services initiated suicide prevention programs in theaters of operations. In small populations (e.g. our military population), it is not unusual for rates of rare events to dramatically fluctuate. In 2003, clusters of suicide in OPERATION IRAQI FREEDOM resulted in a theater suicide rate approaching that of our age- and gender-matched civilian population (18.8 suicides per 100,000 per year). In 2004, however, suicide rates in OPERATION IRAQI FREEDOM returned to levels even lower than our historical military rates (8.5 suicides per 100,000 per year versus a historical rate of approximately 12 per 100,000 per year).

The Department of Defense's Suicide Prevention and Risk Reduction Committee monthly brings together Suicide Prevention Program Managers of each Service to improve prevention efforts. This committee hosts the annual Military Suicide Prevention

Conference, bringing military prevention leaders and suicide experts together. In addition, the Department is developing a common database to track multiservice suicides to detect trends that help with our prevention efforts.

Some service members, a minority, may develop chronic mental health symptoms. Experts from the Department of Veterans Affairs and Department of Defense co-developed clinical practice guidelines for acute stress, posttraumatic stress disorder, depression, substance use disorders, medically unexplained symptoms, and general post-deployment health concerns. Local military or TRICARE providers (a benefit extended for up to 180 days post-deactivation for reservists) treat affected service members. The Department of Veterans Affairs also provides mental health services to OIF and OEF veterans who are no longer on active duty. The Department of Defense and the Department of Veterans Affairs set up the Council on Post-Deployment Mental Health, increasing collaborative efforts to provide a seamless transition of care from the Department of Defense to the Department of Veterans Affairs. I am very pleased with the way in which our two departments are working together so closely and effectively.

To support those severely wounded, additional support services are available. These include the Military Severely Injured Joint Support Operations Center, the Army's Disabled Soldier Support System, and the Marine for Life Program.

The U.S. Army has now conducted two Mental Health Assessment Team surveys in deployed settings in 2003 and 2004. Their results for the second assessment, released

this month, demonstrate positive trends about which the Army Surgeon General will brief you shortly.

The burden of Service members deployed on our behalf includes substantial psychological challenges. We in the Department of Defense Military Health System join the nation at large in our gratitude to all of our Service members and their families. We are grateful for their personal sacrifices and for their contributions to security and freedom around the world. They have answered our call—we must answer theirs!

Thank you.