

**THE DEPARTMENT OF DEFENSE AND
DEPARTMENT OF VETERANS AFFAIRS:
THE CONTINUUM OF CARE FOR POST
TRAUMATIC STRESS DISORDER**

HEARING

BEFORE THE

**COMMITTEE ON
VETERANS' AFFAIRS**

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

JULY 27, 2005

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THE DEPARTMENT OF DEFENSE (DOD) AND DEPARTMENT OF VETERANS AFFAIRS (VA): THE CONTINUUM OF CARE FOR POST TRAUMATIC STRESS ISORDER (PTSD)

WEDNESDAY, JULY 27, 2005

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 10:27 a.m., in Room 334, Cannon House Office Building, Hon. Steve Buyer [Chairman of the Committee] presiding.

Present: Representatives Buyer, Burton, Miller of Florida, Boozman, Evans, Filner, Michaud, Herseth, Strickland, Hooley, Berkley, and Udall.

Also Present: Hon. Ted Poe of Texas, Hon. Grace Napolitano of California, and Committee Counsel Linda Bennett.

THE CHAIRMAN. The full Committee hearing on the House Veterans' Affairs Committee July 27th, 2005 will come to order.

Today the Committee is meeting to examine efforts of the Departments of Defense and Veterans' Affairs to identify recent combat service members at risk for post-traumatic stress disorder, referred to as PTSD, including Reserve and National Guard members, and to assess their capabilities to meet an increase in demand for PTSD-related services from Operations Enduring Freedom and Iraqi Freedom.

The wounds of wartime service are not always as visible as those caused by a bullet or shrapnel. Wounds to the mind and spirit, however, are just as serious and demand every bit as much care and attention.

We have, since the days when it was called "shell shock," learned much about PTSD. Yet we have much more to learn so that we can accurately diagnose and effectively treat it. Perhaps there are ways that we can prepare our young warriors before they deploy so that they will be less vulnerable to the trauma.

These are things we must learn about so that we can take appropriate action.

Recently, the VA Inspector General report indicated that waiting times for health care appointments have been underreported, and we owe our veterans better, regardless of the burdens of their service that they bear.

So I want to bring this up. I also will note, I read your statements last night, and I'm hopeful that the witnesses today will address this in your testimony. This recent IG report that was examining the state variances in VA disability compensation payments noted some really significant numbers. And that is rather alarming, and I welcome the comments from the experts here today.

During fiscal years 1999 to 2004, the number and percentage of PTSD cases increased significantly. Now this is from the IG report dated May 19th, 2005. While the total number of all veterans receiving disability compensation grew by only 12.2 percent, the number of PTSD cases grew by 79.5 percent, from 120,265 cases in Fiscal Year 1999 to 215,871 cases in Fiscal Year 2004. During the same period, PTSD benefit payments increased 1248 percent from \$1.7 billion to \$4.3 billion.

Compensation for all other disability categories only increased by 41 percent. While veterans being compensated for PTSD represented 8.7 percent of all compensation recipients, they're receiving 20.5 percent of all compensation payments. That's a "wow." It's a distortion also in the compensation system. I don't understand the reasons for what's happening out there, and I welcome the input from the experts on this today. And we may even have to do follow-up with regard to this.

I now yield to my Ranking Member, Mr. Evans, for his opening remarks.

MR. EVANS. Thank you, Mr. Chairman, for holding this hearing. It's really important to hear from these witnesses today. I hope we can move forward quickly on legislation to ensure that the VA and DOD are taking steps to address mental health care needs for returning servicemen and women.

I also want to thank Mrs. Stefanie Pelkey for her service to our country in the Army Reserve and for her husband Michael's honorable service. We owe so much to you that we can never repay for what you have suffered, what you have lost.

She told her husband's story in her written statement, and it indicated to me the truth of the perception among veterans that the war's outcome doesn't end when they come home. Their service to this country demands that they get the health care they need, the compensation, pension programs and educational benefits and the GI Bill benefits they need.

So, thank you, Mr. Chairman. I appreciate your yielding and your time.

[The statement of Hon. Lane Evans appears on p. 69]

THE CHAIRMAN. Thank you. Our colleague from Texas, Judge Ted Poe, wanted to be here to introduce his constituent who will testify next, and if you would indulge me, rather than take his statement and submit it, if I may read the introduction of his constituent, our first witness. This is the statement on behalf of our colleague, Ted Poe, of Houston, Texas. Quote: "I want to thank Chairman Buyer and Ranking Member Lane Evans for holding this important hearing on a problem that impacts all of our communities. Stefanie Pelkey is a constituent of mine from Spring, Texas. She was a captain in the Army where she served with her husband, Captain Michael John Pelkey. Today, Stefanie Pelkey will tell you the story of her husband, a man whom she loved who and loved his country and how he was a changed man when he came back from Iraq. She will talk about their experience as they tried to deal with her husband's emotional turmoil, and she will talk about how post traumatic stress disorder hurt both the patient and everyone within their circle of friends and families. Her story is an important story as it serves to underline an important and growing problem as more and more of our armed forces members return from combat with injuries, not all of which are physical, and turn to the VA and DOD for assistance." Ms. Pelkey, you are recognized and may take as much time as you like.

STATEMENT OF STEFANIE PELKEY, SPRING, TEXAS; ACCOMPANIED BY MS. SHERRY FORBISH

STATEMENT OF STEFANIE PELKEY

MS. PELKEY. Mr. Chairman, Ranking Member Evans, and other members of the Committee, my name is Stefanie Pelkey and I am a former captain in the U.S. Army. This testimony is on behalf of my husband, CPT Michael Jon Pelkey, who died on November 5th, 2004. Although he was a brave veteran of Operation Iraqi Freedom, he did not die in battle, at least not in Iraq. He died in a battle of his heart and mind. He passed away in our home at Fort Sill, Oklahoma from a gunshot wound to the chest. My Michael was diagnosed with post traumatic stress disorder, PTSD, only one week before his death, by a licensed therapist authorized by TRICARE.

The official ruling by the Department of Defense is suicide. However, many people, including myself, believe it may have been a horrible accident. We also believe that he would not have been sleeping with a loaded weapon if it weren't for PTSD.

When I met my husband, he was responsible and hardworking. He loved life, traveling and having fun. He hailed from Wolcott, Connecticut and was one of six siblings. He received his commission from the University of Connecticut. Being a soldier was a childhood dream for him.

We were married in November 2001, and our journey as a military family began. Michael deployed for Iraq with the 1st Armored Division in late March of 2003, three weeks after our son Benjamin was born. He left a happy and proud father. He returned in late July 2003. It seemed upon his return that our family was complete and that we had made it through our first real world deployment. He seemed so happy to be home.

A few days after returning to Germany, he reported to his primary care physician on July 28, 2003, as part of a post-deployment health assessment. He expressed concerns to his primary care physician that he was worried about having serious conflicts with loved ones. The physician referred him to see a counselor. However, the mental health staff on our post was severely understaffed with only one or two psychiatrists. Michael was unable to get an appointment before we moved from our post in Germany to Fort Sill, Oklahoma.

He noted several concerns on his DD Form 2796, post-deployment health assessment. However, the most worrisome notation from this form was the admission of feeling down, depressed and sometimes hopeless. He also noted that he was constantly on guard and easily startled after returning from his deployment.

When we got to Fort Sill, we both settled into our assignments. Everything seemed normal for a while. Six months later, the symptoms of PTSD started to surface, only we did not know enough about PTSD to connect the dots.

When my husband returned from Iraq, there were no debriefings for family members, service members, or forced evaluations from Army Mental Health in Germany. As a soldier and wife, I never received any preparation on what to expect upon my husband's return. I believe that it is crucial that spouses be informed about the symptoms of PTSD. Spouses are sometimes the only ones who will encourage a soldier to seek help. Most soldiers I know will not willingly seek help at any military mental facility, for fear of repercussions or even jibes from fellow soldiers.

After months arriving in Oklahoma, there were several instances in which I would find a fully loaded 9mm pistol under Michael's pillow or under his side of the bed. I could not seem to get through to him that having this weapon was not necessary and it posed a danger to our family. Michael finally agreed to put his pistols away. I thought the situation was resolved. As a soldier myself, I could understand that having a weapon after being in war might somewhat be habitual for him.

Little by little, other symptoms started to arrive, including forgetfulness, chest pains, high blood pressure and trouble sleeping. Remembering to mail bills and recalling simple things became a great problem for him. One of the greatest tests PTSD posed to our marriage was that Michael began to suffer from erectile dysfunction,

which would cause him to break into tears. He did not understand what was happening. I did not know what was happening to my husband.

On other occasions, he would overreact to simple things. One night we heard something in the garage. It was still light outside. Michael proceeded to run outside with a fully loaded weapon and almost fired at a neighbor's cat. These overreactions occurred on several occasions.

These symptoms would come and go to a point that they didn't seem like a problem at the time. There were times that everything seemed just right in our home, and he seemed capable enough. He was succeeding in his career as the only captain in a research and development unit at Fort Sill. It was a job in which he was entrusted with researching and contributing to the Army's latest in targeting developments.

We soon bought a new house, and he was so proud of it. We were finally getting settled. Finally, the nightmares began. This would be the last symptom of PTSD to arise, and it was the one symptom that I feel ultimately contributed to my husband's death. These nightmares were so disturbing that Michael would sometimes kick me in his sleep or wake up running to turn on the lights. He would wake up covered in sweat, and I would hold him until he went back to sleep. He was almost child-like in these moments. In the morning, he would joke around, and, sadly, we both laughed it off.

However, at this time I do want to point out that Michael was seeking help for all of these symptoms I have discussed. He was put on high blood pressure medication. He also complained of chest pains and was seen on three occasions in the month preceding his death. He even sought a prescription for Viagra to ease marital tensions. However, no military physician who ever saw Michael could give him any answers. No doctor ever asked him about depression or linked his symptoms to the war.

Michael tried to seek help from the Fort Sill mental health facility but was discouraged that the appointments he was given were sometimes a month away. So he called TRICARE and was told that he could receive outside therapy if it was family therapy, so we took it. Family therapy, marital counseling, or whatever they wanted to call it, we were desperate to save our marriage. After all, the symptoms of PTSD were causing most of our heartache.

In the two weeks prior to his death, we saw a therapist as a couple and individually. This therapist told Michael that he had PTSD and that she would recommend to his primary care provider that he be put on medication. He was so excited and expressed to me that he could see a light at the end of the tunnel. He finally had an answer to all of his problems and some of our marital troubles. It was an exciting day for us, not to mention two weeks before his death, he

interviewed for a position in which he would be running the staff of a general officer. He was beaming with pride.

He met with the therapist on a Monday. Tuesday we celebrated our third wedding anniversary. It was a happy time. I felt hope and relief with the recent positive events. Michael must have felt something else. Friday my parents were visiting. I was at a church function, and my father returned from playing golf to find Michael. He looked as if he were sleeping peacefully, except for the wet spot on his chest. His pain was finally over and his battle with PTSD was won. No, he wasn't in Iraq, but in his mind, he was there day in and day out. Although Michael would never discuss the details of his experiences in Iraq, I know he saw casualties, children suffering, dead civilians and soldiers perish. For my soft-hearted Michael, this was enough. Every man's heart is different. For my Michael, it may not have taken much, but it changed his heart and his mind forever.

My husband served the Army and his country with honor. He was a hard worker, a wonderful husband and father. He leaves behind a 28-month-old son, Benjamin. One day I would like to tell my son what a hero his father was. He went to war and came back with an illness.

Although PTSD is evident in his medical records and in my experiences with Michael, the Army has chosen to rule Michael's death a suicide without documenting this serious illness. I have been told by the investigator that PTSD diagnoses must be documented by Army mental health psychiatrists to be considered valid. At the time Michael sought help, he knew it was an urgent matter and was not willing to wait a month or even a few days. We accepted the help TRICARE offered us, and now Michael is not going to get the credit that he deserves. Why pay outside mental health providers to care for our soldiers if their diagnoses are not considered valid? He is a casualty of war. I have heard this spoken from the mouths of two generals. He came home with an injured mind. And to let him become just a suicide is an injustice to someone who served their country so bravely. He loved being a soldier and he put his heart into it.

I will be submitting petitions to have PTSD officially documented and to have my husband put on the official Operation Iraqi Freedom Casualty of War list. There are so many soldiers who have committed suicide due to PTSD in Iraq and received full honors and benefits without an official PTSD diagnosis. Michael deserves the same honor.

If only the military community at that time had reached out to family members in some manner to prepare them for and make them aware of the symptoms of PTSD, my family's tragedy could have been averted.

So many soldiers are suffering from this disorder, and so many families are suffering from the aftermath of this war. I don't want my

Michael to have died in vain. He had a purpose in this life, and that was to watch over his soldiers. I intend to keep helping him do so by spreading our story. He suffered greatly from the classic symptoms of PTSD. It is plain to see in retrospect. His weapon became a great source of comfort for him. He endured sleepless nights due to nightmares and images of suffering that only Michael knew.

My husband died of wounds sustained in battle. That is the bottom line. And the war does not end when they come home.

Thank you.

[The statement of Stefanie E. Pelkey appears on p. 76]

THE CHAIRMAN. Mrs. Pelkey, thank you for sharing your story. It takes courage for you to sit there and share publicly, but I know you do that on behalf of your husband. Actually you're telling his story, and I think it's extremely important.

Sitting to your left is your congressman, Congressman Ted Poe. And he was with the President, but I'm glad he's now arrived. I want you to know, Congressman Poe, I read your introduction of your constituent into the record, but I'll yield to you for any comments that you may have.

MR. POE. Thank you, Mr. Chairman, and thanks for having this hearing. Besides the fact that Mrs. Pelkey is a constituent of mine, a little more background about her.

She graduated with an Associate degree from the New Mexico Military Institute in Roswell, New Mexico back in 1996 and went on to graduate and receive her commission as a second lieutenant from the New Mexico State University in Las Cruces, New Mexico. And then graduating officer's basic course, Mrs. Pelkey received her first assignment as the battalion chemical officer for the 1st 94th Field Artillery Battalion in Germany. It is important to note that she was the first woman to serve in this field artillery battalion and one of the first three women in Germany to ever be placed in an all-male combat arms unit.

After she met her husband, they were married on November they were married on November 2, 2001, and their son Benjamin was born on March 15, 2003 in Germany. Her second assignment was as the brigade chemical officer for the 75th Field Artillery Brigade at Fort Sill, Oklahoma.

She left the Army and ended her time in service in September of 2004. And her husband Michael died on November the 5th, 2004.

And I want to thank you, Mr. Chairman, for having this hearing, and I also want to thank Mrs. Pelkey for her moving testimony.

I yield back. Thank you.

THE CHAIRMAN. Thank you very much. Mrs. Pelkey, your pain will last for some time, and I think as those of us here listening to your story, we seek to empathize and sympathize with your position. I

could not help reflect upon my best friend, who was 16, and took his own life with a pistol. His baseball cap sits behind my desk so I can look at it every day. And a lot of people walk into my office and they think probably it's my baseball cap, but it's my best friend's. And, you know, I have for the last 27 years, when I think of him, thought of why, and what could I have done to prevent it. And it's going to happen to you, you're going to ask in your mind, "Did I do all that I should have done?" Now when you do that, what is important for us, though, is for you not to place that burden so much upon yourself. You're going to. I do, and will continue to ask, "What could I have done?"

But let me shift it. You touched on the fact that your husband sought treatment, but there was an access problem. Can you develop that a little more for us to understand? Because here, for those of us who have oversight over the VA, the reason we've asked the military to come here is that these soldiers transition, as you know, from the military to veteran status. The VA also cares for some of the active duty in our system and then they transition back and VA gets reimbursed for that care.

For this transition, we are trying to make sure that that health care is seamless, so that help is available when you find yourself in a position that is very challenging. Help us understand when you play this back in your mind, where did the system break down, and where should the help have been?

MS. PELKEY. I want to point out that at this time that my husband was redeployed back to Germany was in the very early stages of them even bringing people back from Iraq. I think they were more, or the Army was more on a level of preparing for units to come back at that time and not individual soldiers.

They did have the post-deployment health assessment in place, and the doctors did refer him to see mental health. But I think the breakdown in the system overall for my husband was the lack of staff at the mental health facility in Germany at that time. And I know there have been improvements since.

But also, when he was seen at Fort Sill, there was no system in place for when these symptoms arise for the primary care providers, the nurses, the doctors, to recognize these symptoms. They should be able to trigger some kind of post traumatic stress disorder diagnosis, you know, or referral when they see some of these symptoms, and that's just not in place, to my knowledge. And I think that's where my husband really, really lost out was that they just didn't recognize the physical symptoms.

THE CHAIRMAN. So when the doctors were treating the physical symptoms, they were being very narrow rather than taking it to a PTSD level?

MS. PELKEY. Right.

THE CHAIRMAN. How many doctors did he see, do you recall? How many different medical doctors at Fort Sill?

MS. PELKEY. He saw his primary care provider, who consulted with the same physician each time. And I can tell you there were about seven or eight different visits for chest pains, high blood pressure, erectile dysfunction and even noted depression.

THE CHAIRMAN. At any time did you think of or suspect PTSD?

MS. PELKEY. No, I did not suspect PTSD. I didn't really know anything about it at that point. I think that my husband and I thought that we were just going through marital problems.

THE CHAIRMAN. So when was the first time you heard about PTSD?

MS. PELKEY. I heard of PTSD shortly before my husband died, when he was diagnosed, by his outside provider.

THE CHAIRMAN. And who was the outside provider?

MS. PELKEY. She was a therapist. Her name was Joanie Sailor, and she was an off-post provider that generally TRICARE sends the soldiers to for treatment.

THE CHAIRMAN. So she's a civilian therapist. Is she a doctor?

MS. PELKEY. She's a civilian therapist. She's an MA. She's a licensed therapist.

THE CHAIRMAN. So at Fort Sill -- well, maybe this is a question for others -- do you know how many referrals there were -- were there others that you knew who were being referred to TRICARE?

MS. PELKEY. I know that, I mean, from general knowledge, that the Army as a whole is having problems with marriage in general, divorce rates and everything. So I can imagine that there are plenty of people that are being seen --

THE CHAIRMAN. That's right. You got there through family therapy as the access, because you weren't getting that access from the military?

MS. PELKEY. Yes sir. We had the opportunity to, but like I said, my husband was not willing to wait. I think at that point he knew that we needed to do something immediately, and he was not willing to wait the amount of time which was given to him, which was a month.

THE CHAIRMAN. You know, in the military we talk about the Army family, right, the Army of One. And somewhere in there was a breakdown in the family to help take care of our own. I mean, that's my sense by your story here. And that's very bothersome to me.

Let me yield at this time to Mr. Filner for any questions he may have. You're now recognized for five minutes.

MR. FILNER. Thank you, Mr. Chairman. And thank you for having this hearing, and thank you for scheduling Mrs. Pelkey here with us. I know we were all affected, Mrs. Pelkey. I appreciate your courage and your willingness to testify in public. It's very important. I'm glad there are people from the DOD and VA here to hear it. I don't know

if you've tried to talk to them, go up that chain of command, but I'm glad they heard it.

We talk a lot, we argue about numbers here. Is a billion dollars enough, two billion? But it gets down to whether we have the services for people like you and your husband, and we simply don't. It comes down to being able to get the needed help; appointments not being available, and veterans having to wait. It's not just statistics, it's human beings, and you've pointed that out.

First of all, you made a very powerful statement about families being educated. I mean, that's rather an obvious and fairly simple thing in essence, if the Army, and other defense agencies recognized it.

We've seen it with our atomic veterans, our Agent Orange from Vietnam, PTSD. At first, nobody wanted to recognize the truth. They said it's only just, as the Chairman said, shell shock or it's in your head. And it looks to me, there's an institutional dynamic to deny illnesses, maybe because it's going to cost money, or they don't want to admit mental problems on behalf of our brave young men and women.

But the outreach to families, the outreach to soldiers coming back has to be incredibly expanded. I think you would agree with me that if you had known this from the beginning, you could have pressed for the proper attention. And even if you press for that, by the way, I can tell you there's not enough resources now. And for some reason, the VA is still messing around with a mathematical model to tell us how many people are going to have mental health problems.

It just doesn't seem to me they're recognizing it still. You have an important role to play. I hope we can work with you to do that.

Even with your knowledge now of PTSD, if your husband was not diagnosed as PTSD service-connected, there's no provision for services, is there? If something happened, let's say two years, more than two years down the line, if these symptoms became graver then, he would have had the same problems. Is that your sense of it?

MS. PELKEY. He would have had the same problems, but I do want to make very clear that I have seen with my own eyes that, after my husband's death, that the Army became very proactive on the Fort Sill community. They started a program there that has just grown, and they're not waiting around for any models to come out. They're trying to see what works for the soldiers. And they have some very low budget programs that are working wonderfully for the soldiers.

There are group therapies. There are things out there that are working that don't cost a whole lot of money. And they're working. Soldiers don't want to see PowerPoint presentations. They don't want to see videos. They want to be in a safe environment.

They want to talk with one another, just as I know in my experience talking to Vietnam veterans and other war veterans, that they feel

safe amongst themselves talking about it, and this is what they've done at Fort Sill.

They've modeled the program to integrate the soldiers wherever they're comfortable. They go into motor pools wherever they have to, and they're talking to the soldiers, and then the soldiers that have apparent problems are put into group sessions and they talk, they joke around, and then they really get down to the problems that they have. And this is what's working, from what I've seen.

So there are things out there that are being done.

MR. FILNER. I think we know how to deal with it if we put the resources in. Do you think the families, whether it's the spouses or the children are getting -- while the service member is deployed, that's when some education should be done. Is that being done also at Fort Sill?

MS. PELKEY. They are -- they have a very strong pre- and post-deployment there now. I mean, yeah, it did take a loss or maybe even, you know, a couple of losses. But the command has been very proactive there. They now brief spouses, and they're starting a program for children where they even sit the children down and tell them, you know, these are the things that scare mommy or daddy. These are the things, slamming doors and -- they try to educate the children and they're trying their hardest, but it's crucial I think to educate the spouses, because spouses, whether they're male or female, are ultimately the ones that are going to push their spouse to go and get help, whether it's because of marital tension or, you know, just they're the ones. They're the ones that are going to urge the soldier to go.

MR. FILNER. Yes. I've sat in some of the PTSD discussions. They're very powerful. I just hope what you're describing at Fort Sill keeps going even after a change of command. Sometimes these things are personally driven as opposed to institutionally driven. And what you've taken as your job and which we want to support is to get all this institutionalized, provide whatever money is needed. We've seen what happens in Vietnam if you don't treat the mental state. You know, half of the people on the streets today are Vietnam vets, and that's partially because we didn't take it very seriously.

THE CHAIRMAN. Thank you.

MR. FILNER. And we see it happening again, and I appreciate your efforts.

THE CHAIRMAN. Thank you, Mr. Filner, for your contribution. I now recognize Mr. Michaud. Ma'am, he's the Ranking Member on our Health Subcommittee. He's from the State of Maine.

MR. MICHAUD. Thank you very much, Mr. Chairman. I'd ask unanimous consent for my full opening statement to be submitted for the record.

THE CHAIRMAN. Hearing no objection, so ordered.

[The statement of Hon. Michael Michaud appears on p. 74]

MR. MICHAUD. Also, Mr. Chairman, I'd ask that testimony from the National Mental Health Association be entered into the record.

THE CHAIRMAN. We have an entire list when I get to the end that will be submitted. They are on the list.

MR. MICHAUD. Okay. Great. Thank you, Mr. Chairman. Mrs. Pelkey, first of all, I want to thank you for your courage and your willingness to come before this Committee and share your experience. It is tragic what happened to your husband, but your willingness to speak out will help many other families who will face the challenges of caring for family members with PTSD.

Many American military families are in your debt for your testimony here today, and for that, I want to thank you for that testimony because, unfortunate that it happened, but I think hopefully we'll learn from it and be able to help others.

I just have one question. In your testimony, you indicated that you would like your husband to be recognized as a casualty of combat. Has the Army explained to you the process by which you can petition to have your husband acknowledged as a casualty of war?

MS. PELKEY. The fact that it's not being recognized in his file, in his case file, is one reason that the subject has never come up between myself or a casualty officer. So it hasn't been discussed yet. It's something I would like to do, because I believe that it will open the door to this being recognized as a wound of war and for them to be recognized as casualties.

And they've already done so in recognizing one soldier that I know of. His name is Master Sergeant Koontz from Katy, Texas. His family submitted a petition to have him recognized as a casualty of war. He committed suicide at Walter Reed in their outpatient -- I don't believe it was a care facility. It was like a motel room, outpatient living quarters. And they successfully had him put on the Casualty of War list.

They have opened the door for this to be recognized, and I would like to have my husband also on the Casualty of War list because I truly with all my heart believe that I have the medical evidence and just my own experiences that he suffered from this disorder. And it will open the door further for other soldiers to be recognized and for the illness to be taken seriously.

MR. MICHAUD. Okay. But as of yet, you have not asked and they have not offered that process to you as of yet?

MS. PELKEY. No one has offered to explain the process. But I also have not inquired about the process.

MR. MICHAUD. Okay. Thank you.

MR. FILNER. Mr. Michaud, would you yield for a minute?

MR. MICHAUD. Yes.

MR. FILNER. I do have some legislation aimed at Vietnam, that I think could be expanded here. If you are a casualty but not from the battle itself in Vietnam, your name can't be on the wall at the Vietnam War Memorial. And this seems to be the same problem.

In other words, we do not recognize the heroism because of some bureaucratic sense that, you didn't die in battle. We need to work together to make that happen both for previous wars and for this.

MR. MICHAUD. Thank you, Mr. Filner. At this time I'd yield back my time.

THE CHAIRMAN. I'll be more than generous to give you time which Mr. Filner had taken from you. All right. Ms. Herseth.

MS. HERSETH. Thank you, Mr. Chairman, and I apologize for arriving late to hear your testimony, but I've had a chance to review your written statement for the record, and I'd like to echo the thoughts of my colleagues here today.

THE CHAIRMAN. You know what, Ms. Herseth? I apologize. You need to stand down.

MS. HERSETH. We should defer to other of my colleagues who have been here a while.

THE CHAIRMAN. We would request that you would defer to your --

MS. HERSETH. That's what I will do. Thank you.

THE CHAIRMAN. Thank you. Ms. Hooley I think is next.

MS. HOOLEY. Thank you, Mr. Chair. First of all, Mrs. Pelkey, thank you so much for taking your time to be here. Your story reminds all of us that we need to have a comprehensive approach to addressing the mental health needs of our men and women of the armed services.

With soldiers returning from Iraq and Afghanistan, it places a greater burden and demand on our VA hospitals. And I know that it is incredibly important that we have the means necessary to treat our soldiers that are returning.

I'm from Oregon, and from our VA hospital, we have had, because of budget freezes, we've had to reduce the number of therapists. For example, we're about 25 percent short of needed therapists in the Portland VA hospital. They've been asked to cut their sessions down from 50 minutes to 30 minutes. They've been asked to have a greater length of time between sessions. It used to be well, can you deal with this in ten sessions? Well, we all know when you have mental health problems, some of those sessions, I mean, sometimes you can deal with it fine, sometimes it's going to take 35 or 50, whatever it takes is what we need to be doing.

One of the things -- because in Oregon we don't have a base, we have a lot of soldiers returning from the military, but a lot of them are Guard and Reserve. So one of the things we did because we knew this was going to be a problem, and we brought everyone involved in the military together with employers.

We brought our mental health workers together and said we need

to do more than just a debriefing when the soldiers return. We need to make sure their families are included, and that we do this not just the first time when they return, but we do it three months, six months, because a lot of these problems don't come up until much later. I mean, sometimes it happens six months later, sometimes it happens a year later.

My question is, what kind -- I mean, you talked a little bit about what resources were available and if you wanted to get in sooner than a month, he had to go off base. But is there now any place for a spouse to go or a soldier that's returning to just say, hey, something's wrong here? I don't know what it is, but something's wrong. Is there someplace you can go now?

Ms. PELKEY. Yes. And I apologize for only being able to use Fort Sill as a resource, but --

Ms. HOOLEY. Right. That's what you know.

Ms. PELKEY. -- that's near and dear to my heart and they have done an excellent job in trying to reform their program, and they have also really started to focus on the spouses there.

I know that just recently, a group of drill sergeants that returned from Iraq were counseled, and out of about 50 drill sergeants, 12 of those needed referrals, as well as they had a session with just the wives of the drill sergeants, and it was just kind of a closed, informal discussion. And that's the way they're approaching it at Fort Sill is a comfortable setting. These spouses all had a chance to say, you know, I feel the same way. I feel like my husband is not here anymore, or he's disconnected. He doesn't love me. I don't feel pretty any more. I don't feel wanted by my husband. And they realized, hey, this is not just some kind of divorce phenomenon, it's for a reason.

And that's the approach they're taking there. Another point I wanted to make is that the consistency with the care providers, whether they be primary care providers, physicians, or mental health physicians, the soldiers have even said, I see a different person every time. I'd like to see the same person for at least six months, for at least a year, the same person who will be able to recall some of the things that I've spoke about, some of the things, the deep personal things that I've shared with them.

And the armed services, they're having a problem keeping these contracted people to stay there for that length of time. And they need to support, they need the money to keep that consistency, to keep those providers there for up to a year to follow up with these soldiers. And they do need a system of checks and balances.

And there are also hotlines that have been set up where even some soldiers can talk directly 24 hours a day to the on call mental health physician there. And they have actually intervened 20 suicide attempts.

Ms. HOOLEY. That's really good news. The thing that bothered me

most is that if you have to see a different person every time, it seems to me you're telling your story over and over and over again and not making forward progress.

Did your husband when he came back, or did you -- did they talk about what signs to look for, for PTSD?

Ms. PELKEY. They did not talk to me as a spouse about it.

Ms. HOOLEY. Did they talk to him about what you need to look for? Do you know if that happened?

Ms. PELKEY. The only counseling my husband got when he came home was like I said, in the post-deployment health assessment, but they mostly talked about backaches, knee pains. She made a referral to see a mental health physician, but like I said, in Germany at that time, there was only one or two psychiatrists for the whole community.

Ms. HOOLEY. How long did it take before you or your husband recognized that this was a serious problem after he came back? Was it a week, a day, two months?

Ms. PELKEY. Well, initially, he showed signs of anxiety, appetite loss, but these all subsided within weeks. When we got back to the United States, it seemed like they were almost all gone and everything was back to normal. And six months later, everything started to surface in small increments.

The pistol, him sleeping with the pistol or carrying a loaded pistol around lasted for, you know, one to two months until I finally thought it was resolved. He put it in a high place in his closet. And I thought, okay, well, that's done. Then, you know, a couple of months later, he started having problems with his blood pressure, chest pains, erectile dysfunction, and -- thoughts. Okay, well, he has a problem with blood pressure. He got it physically treated with blood pressure medication. The erectile dysfunction caused marital problems.

Ms. HOOLEY. Right.

Ms. PELKEY. But they are also noted physical symptoms of post traumatic stress disorder. And I truly believe with all my heart that that was the root of our marital troubles, family problems. And as a spouse, if I had been informed about these things and I had talked to other women or just a counselor about these things, I think that not only would I have understood what was going on, I would have urged my husband to get help more quickly, and I would not have had the reactions that I did to my husband's problems.

When he would forget things, I would yell at him. I would say how can you forget to mail a bill? You're a captain in the Army. I just don't understand. You are not -- this is not the same person that left. But if I thought something else was wrong with him, I would have never labeled it or known that it was post traumatic stress disorder. And with the intimacy issues, it's very personal, but it needs to be said. A lot of the soldiers are suffering from intimacy issues with their wives,

and I believe it's directly related to the high divorce rate. Because that is one of the symptoms, and it does cause problems when you are so consumed with what you saw over there that you can't function with your wife and with your family. Some of the soldiers have even noted that they come home and they send their children to their rooms. They don't want to interact with their families.

THE CHAIRMAN. Thank you, Ms. Hooley.

MS. HOOLEY. Thank you so much for taking your time and your testimony.

THE CHAIRMAN. Thank you. I now recognize Ms. Berkeley. Ma'am, she's our Ranking Member on Disability Assistance and Memorial Affairs from the State of Nevada.

MS. BERKLEY. Thank you, Mr. Chairman. Mrs. Pelkey, I want to thank you very much for coming here and sharing what is a very intimate tragedy with all of us and with our country. People need to hear these things. While you were speaking and when I read your testimony last night, I was trying to put myself in not only your husband's place but in your place. You never know how you're going to react to something unless you're actually thrust into the situation.

I grew up during the Vietnam War. I was in high school and college. And so many of the kids that I went to school with that went to Vietnam came back dramatically changed, and it seems like those that were the most quiet and the most sensitive were the ones that were most dramatically affected by what they saw and experienced over there, and I suspect it's very similar in Iraq right now.

What astounds me now as a member of Congress is that knowing what transpired in Vietnam with our veterans that returned and knowing the mental problems that they experienced, and knowing that so many of our homeless in this country are veterans of the Vietnam War, and I meet with my homeless veterans quite often in Las Vegas. They're my contemporaries. And, you know, you think if not for the grace of God. They went to war as kids, 19, 20, 21 years old, and they came back changed forever.

I would have hoped by now that we would not put such a stigma on mental illness as to pretend it doesn't exist or to avert our eyes or don't put the necessary resources in so that we can truly holistically treat these men and women that are coming back and help to educate the families that are here so they could recognize the symptoms and get help.

So it seems to me from what you were saying and from what I feel is that we need a multi-pronged approach to this, but we need to provide resources so we can counsel the families before their loved ones return so you know what to expect, and then put the necessary resources in so we can hire the right amount of professional people that deal with mental illness.

Because you are quite right. Taking care -- providing medication

for high blood pressure or providing Viagra for erectile dysfunction is just superficially treating symptoms that aren't really going to get to the core of the problem.

So I again want to thank you for being here and for all of your sacrifice on behalf of this country. And let's make sure that your husband's death is not in vain and that we help hundreds of thousands of other Americans that are coming home and are suffering needlessly. And if there's any way that we can help and support them, we should be in this with both feet.

So thank you very much. And perhaps if I can suggest it, I'm sure your member of Congress already has this in the back of his mind, perhaps you can work with him and make sure that your husband is recognized appropriately. I think we would all be very happy when that happens for you.

Thank you very much for being here.

MS. PELKEY. Thank you.

THE CHAIRMAN. Thank you, Ms. Berkley. Congresswoman Grace Napolitano, please come on up here and you may sit on the other side of Ms. Berkley. That's where Mr. Udall sits. You may join us here on the dias.

She is Co-Chair of the Mental Health Caucus, and we welcome you to the Committee. With no objection, we're pleased for you to join us.

Okay. Ms. Herseith, we've been waiting for this.

[Laughter.]

MS. HERSEITH. Well, I appreciate that, Mr. Chairman. And in deferring to my colleagues who have certainly shared with our witness today our concern, our empathy for the situation that you face and our appreciation for your courage and your willingness to share your experiences and how that guides this Committee and other members of Congress.

Congresswoman Napolitano and the hard work that she's doing with many of our colleagues with the Mental Health Caucus to eradicate the stigma that Ms. Berkley indicated is a shame still exists. And in your written statement, you had indicated that you sensed particularly perhaps in the military environment on the base how that may or may not be exacerbated when one returns and what that means for one's career and the fears that perhaps your husband had in that regard.

So I appreciate you being here and working with us to address this issue as a matter of sufficient resources, but also how we go about allocating various resources in ways that are not only going to get at the heart of the problem but help us to identify what symptoms are becoming manifest sooner so that we can seek treatment that is going to be unique and particular to each individual based on what he or

she may be suffering.

Just a couple of questions. The first is, some military treatment facilities are using nurses to help manage patients' care. Do you believe that a person whose job it is to look at the whole picture of the patient's care may have helped your primary care doctor to connect the dots of your husband's symptoms and led to an earlier and better treatment of the PTSD from which he suffered?

MS. PELKEY. Yes I do. And I believe that it is of tremendous importance for not only -- I know we've been talking about educating the families and the spouses and the children, but something has to be done also for the medical profession to also help them because they're overwhelmed. It's not -- it's a lack of education too there and a lack of time and a lack of funding there also.

They do the same thing with pregnant women on most military posts. I know when I was in Landstuhl, Germany, I saw a different provider every time, a different health care provider every time I was given a screening for my pregnancy. And it's the same thing that's going on with these soldiers. They're seeing some one different every time. They need to see one person that's in charge of everything and that's keyed onto these physical symptoms also.

MS. HERSETH. So your sense is that if we're addressing the issue of turnover and the need for the continuity of care, but at the same time looking at individuals that are providing health care to our veterans, perhaps nurses, where we may or may not have as much turnover based on which facility the soldier may be getting treatment, that if we at least in the short term while we address these issues going forward more effectively that there needs to be one person that you get to see on a more ongoing basis rather than, as you just described, someone different each time you come in, each week, each month, each three months, however frequently one is going to seek the care?

MS. PELKEY. Yes. Consistency is --

MS. HERSETH. And then the last question is, when you completed your service, were you briefed on your VA benefits and resources for your family? Were you aware that the vet centers offer bereavement counseling, and has the vet center in your area been of help to you and your family during your time of grief following your loss?

MS. PELKEY. When I exited the service of course my husband was not deceased, but I was given a very intense briefing on my benefits. And I also had help with my disability, with my application for disability. And, yes, I have used the grieving services with the VA.

MS. HERSETH. I'm pleased to hear that. And, Mrs. Pelkey, thank you very much for being here today. I yield back, Mr. Chairman.

THE CHAIRMAN. Thank you very much. And I yield to Mr. Udall.

MR. UDALL. Mr. Chairman, thank you very much, and I appreciate very much the Committee focusing on this very important issue.

Mrs. Pelkey, thank you for your testimony. Clearly, it's very dif-

ficult, as all of us can see, for you to tell your husband's story here today. But rest assured, I think with your courage and the courage of others and all of you stepping forward and talking about this, I think it really makes a difference in terms of moving the cause forward, and not only do we hear it, but I think the word spreads to many, many others.

I was struck by what you talked about in terms of the contrast between the military and TRICARE. And I think what I heard is that it was in TRICARE where this was discovered and was starting to be dealt with.

And that tells me a couple of things. One is that the military were not focusing enough, although there's very hopeful things you've talked about in terms of Fort Sill and the involvement that's going on there. But tell me a little bit about the TRICARE situation and what enabled them to discover what was going on? And did you feel that they were on the right path at the time?

MS. PELKEY. I believe the reason that my husband and I had to seek help from TRICARE is that the military, and especially the medical facilities, are not receiving the funding and the help that they need to make these diagnoses, have the consistency that I've been talking about.

TRICARE offered marriage or family counseling for my husband and I. And like I said in my testimony, we took it, because we felt at that point that our marriage was falling apart, and we wanted to save it. And whatever you want to call it, TRICARE sent us to an off care provider for quote/unquote "family therapy." That's what it was coded as.

And I think that's where the problem is, is that a lot of these soldiers are having family problems and family issues connected to post traumatic stress disorder which you can directly link to the divorce rates and the suicides.

But TRICARE does have off post providers, and she did immediately recognize the symptoms of post traumatic stress disorder. I have a letter that she's written. And I just really feel that the military medical community is overwhelmed with not only post traumatic stress disorder, but with everything that goes along with that; the families, the stress in the families. I mean, so many things.

I know as a soldier myself, I could get a same-day appointment to see a military medical doctor. But the problem is, is that with post traumatic stress disorder, they just need some help with connecting the dots there, some kind of system of checks and balances.

MR. UDALL. What was the time period from when he finished his service in Iraq until the actual family therapy and you started discovering what the problem was?

MS. PELKEY. Well, the symptoms started arising about six months after he came back from Iraq, and the family therapy started only one

week before his death. So it was a little over a year.

MR. UDALL. And one of the things that I think you said that was striking about what they're doing at Fort Sill now involving group therapy and having the soldiers talk with each other. And then the essence of that is really them not feeling that they're alone in these kinds of mental health issues that are coming up.

Do you think that knowing what they're doing now and kind of seeing what is happening there at Fort Sill as a result of what they saw happen with your husband, that if he'd had that kind of support, that might have been a much different situation for him? That if they had spotted it early and given him the opportunity to visit with other soldiers and have a chance to share the things that he was feeling inside, do you think there would have been a different outcome?

MS. PELKEY. I feel like there would have been a different outcome, because like I said, I think the soldiers that have served in Iraq in Operation Enduring Freedom, they have a comfort level amongst each other that is unlike being in front of a counselor, or unlike discussing it with your spouse who has no connection. I mean, even though I was an Army captain myself, I hadn't been to Iraq. So the comfort level still wasn't there between my husband and I.

And what they've done at Fort Sill is provide a comfortable environment. I don't even know if this matters, but they've provided, you know, comfortable furniture, just kind of like a living room environment for these soldiers to sit down and share their thoughts on it. And there's a moderator for this in which afterwards the soldiers, after they feel comfortable, can come up to that provider and ask for a referral, and that's how they're identifying most of the patients there is in these group therapy sessions that are being moderated. And then afterwards, they all stand in line and, you know, take a questionnaire.

But I do feel like this can be brought on on a bigger scale. I mean, a facility to deal with post traumatic stress disorder in the same kind of comfortable environment. I can see it on a bigger scale.

MR. UDALL. Mrs. Pelkey, thank you very much for your testimony, and we really appreciate you stepping forward on behalf of all veterans that are in a similar situation. Thank you.

MS. PELKEY. Thank you.

THE CHAIRMAN. I thank the gentleman for his contribution. I ask unanimous consent from the members that Grace Napolitano of California, not a member of the Committee, would be recognized at end of all members of the Committee having asked questions, and if she would like to ask any questions, she would be recognized at this moment.

MRS. NAPOLITANO. Thank you, Mr. Chair, and yes, I would.

THE CHAIRMAN. Hearing no objection, so ordered. You are now recognized.

MRS. NAPOLITANO. Thank you, Mr. Chair, and thank you to the members. I'm very interested in the issue of PTSD for a number of reasons.

It has been something that has been a long-standing issue with city members of councils throughout the United States, simply because a lot of our soldiers from previous wars have not been able to deal with the issue of PTSD and end up being homeless, and therefore being found under freeway overpasses and in many areas of, especially cities like Los Angeles, where everybody thinks they're just crazy, and there's no way that anybody has been able to address the problem, wrap their arms around it, and be able to really identify what has happened to the individuals who have had a long-standing, 20, 30 years of dealing with mental health issues.

That said, I have been to both Bethesda and Walter Reed and have visited with some of soldiers that have returned with disabilities and asked the surgeons in charge whether or not they provide mental health services to the people they're treating. The answer is yes, very, very good services. They also have on the third floor the ability to have drop-in, day care, if you will, or big clinics rather.

My concern has been that only those that are identified or self-identified get help. Others go home thinking they can deal with it, that it is something that they can withstand, and eventually it begins to rear its ugly head. Just recently I was traveling to Washington, sitting in an airport next to an individual who wore a pin that I recognized, and we got into a conversation.

And he indicated to me, because he asked me what Committees I sat on and what I was doing in Washington, and I indicated I was co-chair of the Mental Health Caucus, and he told me a story that kind of set me back, and that was that he was a Vietnam veteran and had 17 jobs in 20 years. Something is wrong, that we are not helping our soldiers be able to cope with it.

And, besides that, the most important thing, if a soldier is going home to a family, how is that family going to learn how to identify? You're a captain. You were able to understand because at least you've served with part of it, or you've been exposed to it. What about the families that have not? Those that take irrational behavior as something they can no longer tolerate. And so then that individual either gets thrown out, or the family moves away, and they are left to their own devices.

I have had individual VFW groups approach me that now they're seeing soldiers returning, needing help and asking them for help at the VFW and American Legion posts.

We are not dealing with it. And my concern has been that we need to not only deal with the actual service to the service individual, but also their family so that they can have a strong support system that can recognize and be able to refer them to adequate assistance,

whether through the VA or a local, like a TRICARE, especially if the wife has additional insurance. Notwithstanding the fact that our medical institutions do not train doctors to recognize depression and areas that need to be recognized at any level, whether it's a soldier or an individual who has suffered trauma, which also is classified as PTSD.

So I'm thankful that you're here, and I'm sorry -- thank you, Mr. Chair. It's of grave importance to all of us. And I think that we need to stress the need to expand beyond that scope of service that we are now rendering our servicepeople. And I thank you so very much for being here and for being so open about your testimony.

Thank you, Mr. Chair.

THE CHAIRMAN. I thank the gentlewoman for her contribution. I'd like to thank you for coming. And before you leave, would you please introduce the lady who is accompanying you to your right?

MS. PELKEY. This is my dear friend, Sherry Forbish, who is actually the moderator of my grief group through my church in my home town, and she's been a tremendous support to me as well as my Christian church community. And she's a wonderful friend.

THE CHAIRMAN. At any time did you ever turn to the chaplaincy corps of the Army?

MS. PELKEY. Yes. We did receive or go for marriage counseling twice to a chaplain. However, I do want to say that he was a family friend. So some of the things we were sharing with him were, you know, on a very personal level and just more personal than we would have been with just a counselor I think.

THE CHAIRMAN. People know their boundaries, right?

MS. PELKEY. Yes.

THE CHAIRMAN. Whether it's the chaplaincy, whether it's therapists, whether it's psychiatry, whether it's an MD or internal medicine, everybody knows their boundaries, but they also then do referrals, right? When they know it presses the bounds, then they do that referral. But did referrals occur here from the chaplaincy?

MS. PELKEY. No. We again saw him for two sessions, and there of course were other things discussed.

THE CHAIRMAN. Right.

MS. PELKEY. And I think it's a good point too that the chaplains need to be educated on this, because a lot of soldiers do feel very comfortable with turning to the chaplains. But you also have to remember that chaplains are few and far between, and they're very short-handed on chaplains also.

THE CHAIRMAN. The point is, there are many different entries.

MS. PELKEY. Yes.

THE CHAIRMAN. Let me conclude with this, ma'am. You have within your rights to make an appeal through the Surgeon General of the Army with regard to your husband's case, and you have a very able

and compassionate Member of Congress there to your left who can also be of assistance to you in that appellate right. And I would encourage you to do that.

MR. FILNER. Mr. Chairman?

THE CHAIRMAN. Mr. Filner.

MR. FILNER. I just want to follow up on that if I may.

THE CHAIRMAN. Sure.

MR. FILNER. Have you met with the Secretary of VA or Secretary of Defense, or have you requested that?

MS. PELKEY. No sir, I haven't.

MR. FILNER. Mr. Chairman, I think this Committee should work with Mrs. Pelkey to try to get those appointments. I think it would be very helpful. As you saw, she's an incredible source of knowledge and compassion. And I would hope that we could help her get those appointments.

I thank you for yielding.

THE CHAIRMAN. If I may finish, ma'am, I would encourage you to work with your congressman, who understands this process. You are here as a witness of this Committee. We will work with him. You do not need an appointment with the Secretary of Defense or with the Secretary of the Army. There are processes for this to occur, and we will work with you to do that.

I think what would be helpful here also is if I invite you to stay, because we have two more panels that are going to testify, and we're going to hear from the Army. We're going to also hear from experts. And I'd like for you to listen to what they have to say, and then I'd like to come back and speak with you afterwards about your thoughts on what you hear. Will you be helpful to us in that fashion?

MS. PELKEY. Yes. I would be proud to.

THE CHAIRMAN. All right. Thank you very much. We appreciate your testimony.

MS. PELKEY. Thank you.

THE CHAIRMAN. Thank you. You are now excused.

The second panel would please come forward. And when they step up from their seats, ma'am, you can occupy one of theirs. First is Colonel Charles W. Hoge, M.D., who currently directs collaborative research programs to enhance resiliency and reduce the impact of mental disorders among soldiers and their family members. He directs the WRAIR Land Combat Study designed to assess the mental health impact of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), and identify new prevention and intervention strategies.

Next we will hear from Colonel Charles C. Engel, Jr., M.D., MPH. He is the Assistant Chair of the Department of Psychiatry at the Uniformed Services University and the Director of the Department of Defense Deployment Health Clinical Center at Walter Reed in Wash-

ington, D.C. He was the 1st Cav Division Psychiatrist during the 1991 Gulf War and since then has served as a DOD medical adviser on post-war physical and mental health, particularly as it relates to post-war idiopathic physical symptoms, physical health concerns, and the improvement of post-deployment clinical services.

We'll then hear from Matthew J. Friedman, M.D., Ph.D. He is the Executive Director of the U.S. Department of Veterans' Affairs National Center for Post-Traumatic Stress Disorder, and Professor of Psychiatry and Pharmacology at Dartmouth Medical School. He has worked with PTSD patients as a clinician and researcher for 30 years, and has published extensively on stress and PTSD, biological psychiatry, psychopharmacology, and clinical outcome studies on depression, anxiety, schizophrenia, and chemical dependency.

We'll then hear from Alfonso R. Batres, a Ph.D. MSSW. He is the Chief Officer of the Department of Veterans' Affairs Readjustment Counseling Service. He has direct oversight of the 206 Vet Centers providing readjustment counseling service to war zone veterans nationally. He is recognized as a national and international leader in pioneering the development and provision of services for veterans with combat-related trauma. Dr. Batres serves on the VA's National Leadership board and is currently extensively working in the VA's response to the needs of returning combat veterans of Iraq, Afghanistan and the Global War on Terrorism.

We'll then hear from Terence M. Keane, Ph.D. Dr. Keane is a Professor and Vice Chairman of Research and Psychiatry at Boston University of Medicine. He is also the Chief of Psychology and Director of the National Center for PTSD at the VA Boston Healthcare System. The past President of the International Society for Traumatic Stress Studies, Dr. Keane has published three books and over 140 articles on the assessment and treatment of PTSD. His contributions to the field have been recognized by many honors, and we appreciate you being here today.

At this point, I will now yield to Dr. Hoge. You are recognized.

STATEMENTS OF COLONEL CHARLES W. HOGE, M.D., CHIEF OF PSYCHIATRY AND BEHAVIOR SCIENCES, DIVISION OF NEUROSCIENCES, WALTER REED ARMY INSTITUTE RESEARCH, UNITED STATES ARMY; ACCOMPANIED BY LTC CHARLES C. ENGEL, JR., M.D., MPH, CHIEF, DOD DEPLOYMENT HEALTH CLINICAL CENTER, WALTER REED ARMY MEDICAL CENTER, UNITED STATES ARMY; MATTHEW J. FRIEDMAN, M.D., PH.D., EXECUTIVE DIRECTOR, NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER, DEPARTMENT OF VETERANS' AFFAIRS; ALFONSO R. BATES, PH.D., MSSW, CHIEF, OFFICE OF READJUSTMENT COUNSELING, DEPARTMENT OF VET-

ERANS' AFFAIRS; AND TERENCE M. KEANE, PH.D., PRESIDENT, ASSOCIATION OF VA PSYCHOLOGIST LEADERS, VA BOSTON HEALTH CARE SYSTEM

STATEMENT OF DR. CHARLES W. HOGE

DR. HOGE. Thank you, Mr. Chairman, and members of the Committee. It's a great honor --

THE CHAIRMAN. If you could pull the mic closer to you and turn it on. Thank you.

DR. HOGE. It's a great honor to be here and I thank you for the opportunity to discuss the Army's research on PTSD and other mental health issues associated with deployments to Iraq and Afghanistan.

I'm also grateful for the opportunity that I had to be here for the moving testimony of Mrs. Pelkey and the subsequent questions from the Committee.

I'm Colonel Hoge. I'm Chief of Psychiatry and Neurosciences at Walter Reed Army Institute of Research. The Army and Department of Defense have taken a proactive approach to understanding and mitigating the mental health concerns associated with deployments to Iraq and Afghanistan. We've 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 and their family members. And your interest in this matter along with previous support from Congress has greatly enhanced the body of scientific knowledge.

Mental health symptoms are common and expected reactions to combat, and the research following other military conflicts has demonstrated that combat exposure confers considerable risk of mental health problems, to include PTSD, major depression, substance abuse and social, family, and occupational problems, as we've heard previously.

However, virtually all studies that have assessed the mental health effects of prior combat in prior wars, including the first Gulf War, we conducted years after soldiers returned from the combat zone. To address these concerns, a team of Walter Reed Army Institute of Research, which I'm privileged to lead, initiated a large study in January 2003 with support from senior Army medical and line leaders and Marine line leaders as well, to assess the impact of current military operations on the health and well being of soldiers and their family members.

This study is ongoing, and we have collected over 20,000 surveys to date from soldiers from multiple brigade combat teams deploying to Iraq and Afghanistan, both active component and National Guard, as well as personnel from Marine Expeditionary Forces.

We have conducted assessments now out to 12 months after returning from deployment. We've published results of our initial find-

ings from three months post-deployment in July of 2004. We have also conducted similar assessments in theater as part of the mental health advisory team efforts.

Our studies confirm the importance of PTSD and other mental health concerns associated particularly with deployments to Iraq. Overall, based on our latest findings, 15 to 17 percent of service members surveyed three to twelve months post-deployment met the screening criteria for post traumatic stress disorder, and 19 to 21 percent met criteria for depression, PTSD and anxiety. In parallel with our survey-based data, there has also been a substantial increase in military health care utilization and use of military health services in military treatment facilities among our OIF veterans.

Alcohol misuse, which is strongly associated with PTSD, also has increased post-deployment. Other outcomes that we're looking at include aggression in 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 studies showed that soldier and marines are not very likely to seek professional help if they have a mental health problem, and they are concerned that they may be somehow treated differently if they do. Our data has helped us to focus on approaches to facilitate access to care.

We're conducting a number of ongoing research projects to improve identification and intervention, reduce stigma and barriers, and our primary focus really is on improving access to care. And we're also attempting to evaluate programs that are being implemented, such as the Department of Defense post-deployment health assessments.

Our research has shown that soldiers are much more likely to report their mental health problems three to four months or subsequently after coming home than immediately on their return. And as a result, DOD has expanded the post-deployment health assessment program to include a survey now at three to six months post-deployment. We are also evaluating interventions such as psychological group debriefings, and we're developing standardized training modules for soldiers, leaders, and health care providers.

Considerations for improving access to care include co-locating mental health services in primary care clinics. And we heard this morning discussion about the fact that soldiers, virtually all soldiers access primary care, and this is obviously one portal for soldiers to get help.

We want to improve awareness among primary care professionals of depression, PTSD evaluation and treatment, and it's important

to ensure that there's adequate resources to support continued services in the operational setting in Iraq and Afghanistan as well as to ensure that service members who are identified through our screening programs or who refer themselves receive timely evaluation and treatment.

One of the most important aspects of our work is to provide the best interventions 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.

Thank you very much.

[The statement of Dr. Charles W. Hoge appears on p. 84]

THE CHAIRMAN. Thank you very much for your testimony. Colonel Engel, you are now recognized.

STATEMENT OF DR. CHARLES C. ENGEL

DR. ENGEL. Mr. Chairman, members of the Committee, I appreciate the opportunity to appear before you today and discuss the ways that the Departments of Defense and Army are working proactively to identify and help military personnel with mental illness after service in Iraq and Afghanistan. We appreciate Congress's interest in this topic and this Committee's consistent support of DOD and VA mental health.

I have three main points. First is the need to bring safe, accessible and confidential care to service members rather than waiting for them to seek care. Second, primary care affords an excellent opportunity for early recognition and care. And third, many DOD efforts are currently underway to reach out to providers, service members, families, the severely ill and wounded.

I am privileged to direct a unique DOD center of health care excellence called the Deployment Health Clinical Center. We began caring for Gulf War veterans in 1994 at Walter Reed. In 1999, we were designated the Deployment Health Clinical Center, and our mission expanded to include provision and improvement of tri-service post-deployment medical care.

We have provided care for over 15,000 service members with health concerns following service in various deployments, including Iraq and Afghanistan. We have helped those with both physical and mental wounds. Colonel Hoge tells us mental illness occurs to one in four of those returning from Iraq, with rates rising.

A study of injured soldiers evacuated through Walter Reed led by CPT Tom Grieger, Colonel Steve Cozza, shows that about half of those with initial PTSD and depression quickly improve, but overall,

rates rise two- or three-fold in the next few months.

What should we do about this? First, we must provide, safe, confidential and continuous care. We cannot diagnose mental illness simply by looking, and there are no laboratory tests. We must build trust so service members offer frank accounts of their mental state and we can do accurate screening and provide proper care. Without protection from adverse career actions, mental illness is driven underground. Soldiers keep problems private until they balloon out of control, and we miss opportunities to prevent tragedies and threats to mission success.

Second, Colonel Hoge's data reinforced civilian findings that most people with trauma-related mental illness don't receive care. Misconception, stigma and local barriers to care are prevalent. These data compel us to bring services to soldiers rather than waiting for them to seek it.

Third, mental illness occurs on a spectrum of severity, and we must provide care to the whole spectrum. A mild definition of PTSD yields rates of pre-war PTSD of nearly 25 percent, and post-war rates over 50 percent. This tells us that many are distressed after war, and most distressed is not severe. Only 5 to 10 percent of military personnel seek specialty mental health care every year, but over 90 percent use primary care. The impact will be great if we improve the mental health of those getting primary care.

Deployment Health Clinical Center has partnered with the MacArthur Foundation, Dartmouth, Durham VA, and Indiana University in a Fort Bragg Primary Care Improvement Initiative. The goal is successful implementation of VA-DOD mental health guidelines. The program is called "RESPECT-MIL" and builds on a scientifically tested approach for depression developed by Allen Dietrich at Dartmouth. Use of RESPECT-MIL improves continuity, maximizes existing primary care resources, and frees mental health providers to practice specialty care. We look for broader implementation and evaluation in the future.

Many with PTSD may benefit from psychosocial approaches offered in primary care. Our investigators have collaborated with Brett Litz of the Boston VA and the National Center for Post Traumatic Stress Disorder, Richard Bryant in Australia to develop an NIH-funded computer-assisted therapy tool called DESTRESS. DESTRESS offers anonymity and a scientifically valid approach that primary care doctors can prescribe to patients in need. Many will obtain relief, and for others, DESTRESS may reduce stigma.

We are also pushing information to clinicians through the Deployment Health Clinical Centers pdhealth.mil website and Uniformed Services University's Courage to Care program. pdhealth.mil gets over 700,000 hits a month. Thirteen hundred providers receive our daily science and news e-mail digest, and we have distributed 10,000

deployment health tool boxes to primary care providers across the services. We also run toll free telephone and e-mail help line for providers, service members and families.

Providing care for the severely wounded and ill is a fulfillment of a sacred trust, the promise every combat medic makes to assist injured comrades. Walter Reed's Psychiatry Consultation Service led by Hal Wain follows ever wounded soldier. Deployment Health Clinical Center serves as a worldwide referral center for severe post-deployment illness. We have run nearly 120 cycles of two different specialized care programs, one for unexplained illness and another for PTSD.

We published the unexplained illness approach in JAMA, the Journal of the American Medical Association, after a 20-site VA cooperative studies program study.

Mr. Chairman and members of the Committee, I hope I have communicated my three main points. First, we must bring safe and confidential mental health care to service members rather than waiting for them to seek it. Second, primary care is an excellent opportunity for doing just that. And third, many DOD efforts are underway to reach providers, service members, families, the severely ill and the wounded.

The Deployment Health Clinical Center and its devoted staff are privileged to assist the inspiring men and women who serve our nation. We owe our success to an unwavering support from Congress, DOD, Uniformed Services University 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.

[The statement of Dr. Charles Engel appears on p. 91]

THE CHAIRMAN. Thank you very much for your testimony. I now recognize Dr. Friedman.

STATEMENT OF DR. MATTHEW J. FRIEDMAN

DR. FRIEDMAN. Mr. Chairman, distinguished members of the Committee, I am Matthew Friedman. I am the Executive Director of VA's National Center for PTSD, Professor of Psychiatry, Pharmacology and Toxicology at Dartmouth Medical School.

I've been a VA psychiatrist for over 30 years and spent much of that time treating men and women who have developed PTSD and other problems as a result of their service in combat areas.

I've been asked to comment on the PTSD syndrome itself, and I've submitted extensive information about that in my written testimony which I will not cover in my oral comments.

I would like to emphasize, however, as have the previous speakers, that most people who return from a combat zone do not have psychi-

atric or psychological problems. A large number of them who do, have transient problems, adjustment disorders, from which they recover quite quickly. But there is a significant minority, an important minority, who will develop recurring and sometimes totally incapacitating psychiatric problems, of which PTSD is the most symptomatic.

I've been asked to comment about the comparisons between the current situation and the post-Vietnam era in which I cut my teeth as a clinician. And I think the news is good. I want to emphasize two points in particular. First of all, when our men and women returned from Vietnam, they returned to a hostile public, a public that did not reward or recognize their courage. That's not the case today, and I think it's very important. We know that social support is a key factor in whether or not people are going to readjust successfully after their combat experiences. Hopefully it is a very good sign that we're having these hearings today which may help our returnees from the OIF and OEF deployments.

The second news is also good, and that is that there has been a great deal of scientific progress in the past 30 years. When we were first faced with the Vietnam veterans, we didn't have any evidence-based treatments. We didn't really know what to do for them. It was really a bootstrap, seat-of-your-pants type of an operation. Now we have medications that work, two of which have FDA approval. We have psychosocial treatments that are very, very effective.

Last year there was a joint VA-DOD practice guideline process to develop state-of-the-art, evidenced-based treatments for PTSD. And now the VA has made an institutional commitment to support that effort through a best practices project through which PTSD will be the pilot project to disseminate this information so all VA clinicians can provide the best care for people who come into our offices.

The problem is, will they come? Will the stigma that Dr. Hoge's research has indicated keep them away? Will they know, as Mrs. Pelkey did not know, what's available, what the signs of PTSD are, what kinds of services are available should they recognize a treatable problem among a loved one or within themselves? I think that the challenge of dissemination of information to families and to servicemen and to veterans is a great one and a very, very important one.

Unlike our DOD colleagues, we VA clinicians do not have a mandate to provide direct services to families. I think that's a disadvantage, with the glaring exception -- or the wonderful exception of the Vet Centers that Dr. Batres will comment on, we clinicians can only see families as adjunctive to treatment of our veterans. I think that were our mandate changed and there were appropriate resources to serve that mandate, we could do a much better job and perhaps prevent some of the problems that might otherwise develop.

In addition to my concern about stigma, I'm worried about the Guard and reserves. And I've commented on that in two "New Eng-

land Journal of Medicine” editorials. They really fall into the cracks. Will they recognize what’s available in the VA hospitals? Will they know about their eligibility? I don’t know. I think we need to make every effort to inform them. To get the word out.

Other concerns are military sexual trauma, which is even more toxic than combat trauma, in terms of producing PTSD. I’m concerned about the men and women returning from these deployments, who will have severe medical problems. A loss of limbs, loss of eyesight. Other kinds of persistent problems. They’re a very high risk for PTSD, and we need to be able to monitor and provide the best treatment that we can.

We need to recognize that we have a new, young cohort of people seeking our treatment, with fresh trauma problems, and we need to be able to provide the best services. In short, the VA has the best expertise, the most sophisticated clinicians, the best spectrum of treatment in the world. We need to make sure, and cherish what has been accomplished, and have our services available, so that we can help those who seek our help.

My final comments, which I’ll run through quickly, concern collaborations between the National Center and the DOD. You’ve heard about three of them. We’ve been working with Colonel Hoge, in terms of the de-briefing study which was done in Kosovo and which will be repeated with OIF/OEF troops. We’re working with Dr. Engel on the Web-based treatment at Walter Reed, as well as the pilot project at Fort Bragg, integrating primary care and mental health care, which, I think, had it been accomplished, might have helped Mrs. Pelkey and her husband.

We’re looking at doing brain imaging, with troops from Fort Drum, as well as drug studies. We’re doing a major post-deployment study of 17,000 troops. And so, I would like to close by just thanking the Committee for its attention and concern, and thanking all the support that we’ve received from VA and DOD. Thank you.

[The statement of Matthew J. Friedman appears on p. 103]

THE CHAIRMAN. I thank the gentleman for his testimony. And could we pause to ask Colonel Hoge, Colonel Engel, Dr. Friedman, Dr. Batres, Dr. Keane -- do each of you have written testimony? And would each of the witnesses like that to be submitted for the record? All witnesses have answered in the affirmative.

Hearing no objection, it will be so ordered.

We’ll now recognize Dr. Batres.

STATEMENT OF DR. ALFONSO R. BATRES

DR. BATRES. Thank you, Mr. Chairman and Committee members, for the opportunity to present on services provided by the program

that I am privileged to head, to returning veterans from Operation Enduring and Iraqi Freedom.

I just wanted to add a few brief points to the comments I submitted to the Committee with my written testimony. The VA program that I represent, was initiated by Congress 25 years ago, to address readjustment challenges in Vietnam combat veterans. Matt Friedman, to my right, was one of the field docs who actually was instrumental in putting up one of very first Vet Centers, at that time.

The Vet Center is the first of its kind, and represents the foundation from which VA became the world leader in providing these services to war veterans. The Congress subsequently extended these services to all our combat veterans and their families. Therefore, any veteran who served in a combat zone, is eligible. Not unusual to find a World War II veteran alongside with a Korean War veteran, and now, an Iraqi Freedom veteran, at our Vet Centers.

The heart of our program is veterans and their families. The 207 Vet Centers dispersed nation-wide are staffed, primarily, by veterans, many of whom have served in a combat zone, and who understand the culture of the military, and the sacrifices that service members make to this country.

On a personal note, I want to put into the record that my dad was a World War II veteran, as well as his five brothers. They all served in World War II. I am a Vietnam combat veteran, and I have a son who served in the Persian Gulf, with the 82nd Airborne. I am typical of the employees in the Vet Center program.

The Vet Center program is a VA gold standard in veteran and family satisfaction. 99 percent of our clients and families not only rate us highly, but they would recommend us to other veterans. We are also the gold standard in VA, for employee satisfaction. We are located in easy-to-access locations within their community, and we have minimal bureaucratic barriers to accessing care.

A veteran will be seen when they walk in -- we have no waiting list -- along with their families. The program laid the foundation for outreach services to combat veterans in our great country, characterized by a focus on providing a safe, confidential environment, where veterans who have been traumatized, or have gone through experiences, can come in, and receive timely and friendly services.

In Fiscal Year 2003, with a few months of war under our belts, we saw about 1,900 OEF/OIF veterans. In Fiscal Year 2004, we saw over 9,600. And for this year, we're projecting over 14,000 new OEF/OIF veterans walking through our Vet Centers. They currently represent about 10 percent of our client workload.

We do not include in this count, the growing number of veterans and their families, to whom we provide education, de-briefing, and outreach services to beam-up sites, and National Guard and Reserve locations all over this country. In order to get a better handle on that,

we just did a survey for the month of June in this Fiscal Year, in which we documented 5,000 servicemen and women in that particular month, who received services in that category.

Included in that are family members of National Guard and Reserve folks, who have deployed, but are currently not eligible for VA services, because their family member is an active military member. We are reaching a fair amount of these veterans, but I have to honestly say that we have a lot of work to do, in making sure that we are providing comprehensiveness to all these veterans.

The Secretary of VA, and my bosses, Dr. Kussman and Dr. Pearlman, authorized the hiring of 50 veterans from Operation Enduring Freedom and Iraqi Freedom, to become outreach workers for my program, approximately a year ago. Again, these are recently-returned combat veterans, many of them disabled, who have recently returned from their tours in Iraq and Afghanistan.

The initial 50 program proved so successful, that the underSecretary has authorized an additional 50 FTEE positions for this year. These veteran employees continue the program emphasis -- our program emphasis on hiring veterans into the VA.

As you have read in my written testimony, we have initiated a bereavement program for family members of those who died while on active duty. In coordination and referral from DOD casualty assistance officers, we have provided services to well over 400 families in the last year and a half. The majority -- over 300 of them -- coming from KIAs in Iraq.

Our standard is to offer services directly to the family, within two days of the notification, in the community in which they reside. We will be conducting an analysis of our year-and-a-half worth of work with DOD, to see if we can improve on our services, and get feedback from our consumers, about how we can move to improve these types of services.

We are very cost effective in that. As a rough benchmark, the VA reported OEF/OIF veterans who have been seen for comparable mental health services within the VA. Our numbers are about 50 percent of those that have been seen. It's not including in the ones we provide outreach services to.

The Vet Centers continue to provide a unique service, that is integrated with traditional mental health services, and adds value to serving veterans and their families. I don't want to confuse what we do, with what the VA medical centers do. We only provide one component of the services, primarily focused on outreach, assessment, and treatment of veterans who are closer to home, and may not require the extensive services that VA offers.

The DOD concepts of having mental health services available to soldiers while in the combat area, represent a major investment in dealing with the social and psychological psychological of combat service.

The study by Colonel Hoge, and the work done by Dr. Engel -- Colonel Engel -- are really instrumental in providing a continuum of care for the soldiers.

The soldiers are going to face a transition, where when you blink, you go from a very supportive community environment, back into civilian life. And I think they need all the assistance that we can provide to them, to make that step into civilian life. And to keep them healthy, and connected. And quite frankly, to provide a varied assortment of service, to include employment issues. Benefit kinds of things, that is critical, not only to the soldier, but to their family, in an integrated fashion.

Yesterday, I heard a presentation by the surgeon general of the Navy, I believe VADM Arnold, who described their Marine Corps OSCAR teams, and how they operate. Along with the Army combat stress teams, I think the Marine Corps has done an exceptional job -- both of them have -- in developing these types of interventions within the combat zone.

The OSCAR teams are embedded in their unit, and are not a separate component, or a medical unit, therefore, promoting an integration into the Marine Corps unit, for functioning. This is an exact model of how Vet Centers operate. We are embedded in your local communities, and geographically located outside of VA medical centers.

This goes a long way to avoid the stigma of accessing care, and promotes the normalization of issues that will arise in most of our veterans, that being the recognition that serving in a combat zone presents challenges to any soldier. And that the integration of these types of services, as has been indicated before, is really critical. Thank you.

[The statement of Alfonso Batres appears on p. 111]

THE CHAIRMAN. Dr. Batres, on behalf of this Committee, let me extend an appreciation to your family, for their service to their country, not only including your uncles and your father, but yourself and your son.

MR. BATRES. Thank you, sir.

THE CHAIRMAN. Dr. Keane, you're now recognized.

STATEMENT OF TERENCE M. KEANE

DR. KEANE. Thank you, Mr. Chairman. And thank you, too, members of the Committee, for permitting me to testify here today, with my distinguished colleagues. Today, I am representing the Association of VA Psychologist Leaders. And while I've spent some 28 years in the Department of Veterans' Affairs, in three different VA medical centers, as chief of psychology, my comments today represent that group of VA psychology leaders.

The VA represents the best in mental health systems in the world. This has been touted in both the "New England Journal of Medicine," as well as in the "Lancet" in the past two years. With expertise in post-traumatic stress disorder, schizophrenia, the neuro sciences, geropsychiatry, and substance abuse, we address the full range and spectrum of combat-related psychological problems.

With reference to today's hearings, I do want to say that as a professor and faculty member at Boston University, one of the largest health care systems in the City of Boston, there is not a single expert in the area of post traumatic stress disorder on faculty. Not one. It would seem hard for me to fathom how private-sector resources could be marshalled to provide the kinds of care that's provided by VA, in the Vet Center program, and in the many different installations across the country.

I do want to comment, for a moment, about the VA's leadership role in the President's New Freedom Commission. The VA has established an outstanding action agenda. And with the current administration, there is tremendous support for moving forward, and implementing many of the ideas represented, and creatively developed, by the VA mental health care employees.

There are many examples of VA's tremendous support for the returning OEF and OIF veterans. But there are also some important issues for us to discuss here today. Our group -- and that is the AVAPL VA psychologist leaders -- fully supports the notion of a fully-resourced President's New Freedom Commission agenda. These resources should be implemented. They should be evaluated, they should be monitored.

And the question that remains for us, is how will these resources, and a system that is strained for resources -- how will these resources be protected, to ensure that they deliver the kind of care that is intended? With the growing numbers of mental health needs, we also, in VA, need to employ the most contemporary, the most creative methods of delivery of services.

This will require that our aging workforce be re-tooled, and re-trained, with a major educational initiative. And what direction should this take? This should be training in the use of tele-health, already one of Dr. Pearlin's major initiatives. This should be directed in the area of mental health, so that services can be provided. As well, Web-based interventions should be prioritized, so that patients can get needed education, and needed support, when and where they need it.

We have information that the availability of Internet is quite strong, among younger generations, and we should make use of this resource for the delivery of whatever services are viable in that modality. As well, continued collaborations with the Department of Defense, in integrating care and conducting research on these newest veterans,

needs to continue to be the highest priority.

Our organization also supports, as many of my colleagues have already stated, the changes in eligibility that have already been made, and would like to see increased eligibility, again, for families, for spouses, for partners, affected by activation, deployment, injury, or death. As well, we support the completion of the National Vietnam Veterans' Longitudinal Study.

We support the completion of this study, not only for what it will tell us about Vietnam veterans, the largest cohort of veterans that exists in VA today, but as well, what it will tell us about the current group of the newest veterans. Our group also supports an increase in the research budget that's allocated to study mental health and behavioral health problems.

It is, indeed, the case, that the behavioral science, the mental health research workforce, is graying in VA. There needs to be a concerted effort to support junior people, to study the problems associated with military service, and combat trauma. But as well, and perhaps, most importantly, from my perspective, behavioral health services, psychiatric and psychological, need to be paired with physical rehabilitation, in order to maximize and optimize the outcome.

VA is one of the world's leaders in the area of physical rehabilitation. We suggest that combining mental health services, at significant levels, with the outstanding physical rehabilitation, will yield the best possible outcomes for the people who are so injured. There are many other recommendations reflected in my written report. I'd be happy to answer any questions, and thank you all for the opportunity to speak with you here today.

[The statement of Terence Keane appears on p. 118]

THE CHAIRMAN. Thank you very much for your testimony. I would like to exercise a cautionary counsel to my colleagues, with regard to Mrs. Pelkey's testimony from the first panel. Only she has the right to privacy, and if she waived the right to privacy, with regard to her comments regarding her husband's case, we now know that she has an interest in filing an appeal with the surgeon general of the Army.

So, I would exercise caution, and I think it would be inappropriate to ask any of the experts on this panel or the next panel to comment directly upon her husband's case. But obviously, process and procedures are open. And that would be my counsel to my colleagues.

Where do new doctors turn in the private sector, and in military settings, to gain awareness and then develop an expertise with regard to how to deal with PTSD? Because it's not just those who serve in the military. You're also dealing with police officers, after gun battles. You're dealing with firefighters. You know, the first responders in our society.

We also have teams that will arrive upon the scenes of tornadoes,

hurricanes, and traumatic events. So, how are we doing as a country, and where is this really being generated? I'll just open it up. Anybody that would like to comment.

DR. KEANE. I'll begin. I'm sure there'll be others who will speak. It is a major initiative of ours at the National Center for PTSD, to try to influence the education and training programs, in both psychiatry residency training programs, as well as in psychology. Clinical psychology training programs.

We have engaged in this initiative for the full 16 years, that we've been involved in this work. We've been supported by the National Institute of Mental Health, in providing education and training, at the most advanced levels, for some 12 years, now. And it's through these mechanisms, that we have actually conducted, I think, significant education and training, both in our own institutions, but as well, in a variety of different places across the country.

It is solving a problem -- given that PTSD's really only widely recognized since 1980, it's been solving a problem for this country, that has taken some of our time. How do you create and generate a whole cadre -- a whole cohort of people, who can take care of people who have been sexually assaulted? Or the other kinds of events that you've mentioned?

It has not been easy to do this. There are not experts at every medical school in the country. There are not experts at every clinical psychology training program in the country, in these areas. Yet, it's actually a vastly-improved situation today, than it was when I entered the field 28 years ago.

THE CHAIRMAN. Dr. Friedman?

DR. FRIEDMAN. I appreciate your question, Mr. Chairman. I think that you're right on target, that although PTSD treatment and research began in VA, I think that we have really been a major force in influencing the civilian sector in many, many different ways.

In addition to our -- our graduates, and people who've benefitted from our programs, and people who come into VA, and gone on to influence the training programs in psychiatry, psychology, social work, and nursing throughout the United States, and certainly in the developed nations, as well, there has been recognition that sexual trauma, that disaster trauma, the recent tsunami, to be one of many examples, call for the kind of expertise that was first developed for treating veterans with PTSD.

One of the things that the National Center, and the field in general, has done, has moved from the VA, as the spawning ground, and taken the same technologies, the same conceptual tools, the same clinical tools, and used them with women who've been sexually traumatized, with disaster victims. The National Center has had a five-year collaboration with SAMHSA, with the emergency disaster branch of SAMHSA. And we were major players in the post-9/11 recovery.

In terms of what's happened institutionally, within the field in general -- there have been independent efforts, with a lot of overlap and collaboration with VA practitioners, to develop evidence-based practice guidelines from other organizations. The International Society for Traumatic Stress Studies, of which Dr. Keane and I are both past presidents, actually developed the first practice guideline for PTSD, which was published in 2000.

Since then, there have been two other practice guidelines. One was the American Psychiatric Association's practice guideline, which came out last year. And the joint VA/DOD practice guideline, which I mentioned in my testimony. So, perhaps that's responsive to your question.

THE CHAIRMAN. With regard to the seamless transition, medical records. DOD to VA, VA back to DOD. Are these occurring electronically, or is this paper? What's happening, out there, right now? Does anybody know?

DR. KEANE. Most of the -- most of the -- the hand-offs are by paper, and by phone. And it actually, at least, by my report, in my experience, it's actually working very well, in many, many, many instances. So, we're very pleased about how this integration has occurred. I think you were asking --

THE CHAIRMAN. What about the post-deployment health surveys? Do you get those? Is the VA getting those?

DR. KEANE. No.

THE CHAIRMAN. Great. You know, we put a lot of effort into this. I wrote the law for a reason. For you to do these as pre-deployments, and post-deployments, and then, to make sure they get to the VA. So, if DOD doesn't care about them getting to the VA, are they getting there? Let me turn to DOD. Tell me what's happening.

Dr. Engel. If I may. There are a number of challenges in the data sharing area, not the least of which is -- are the HIPPA laws.

THE CHAIRMAN. No, no, no. You can't pull HIPPA on me. Uh-uh.

DR. ENGEL. Sir --

THE CHAIRMAN. No, you can't pull HIPPA, no, no, no, no. You can't do that. We, Congress, say you can move that data. So, go to the next comment. You can't pull HIPPA on us.

DR. ENGEL. Well, sir, I'm really not trying to pull --

THE CHAIRMAN. Right. Well, I'm just saying, --

DR. ENGEL. I --

THE CHAIRMAN. Just erase HIPPA.

DR. ENGEL. I --

THE CHAIRMAN. Now, go to the next --

DR. ENGEL. -- the level at which I operate, these are challenges that we -- that we are -- that we --

THE CHAIRMAN. HIPPA's a challenge, but it's not a challenge with regard to the sharing of information, and how we get it from DOD to

VA. That's the only point I want to make.

DR. ENGEL. Yes, sir. I mean, I think we've made enormous strides in taking the post-deployment health assessment data. It's all in a data repository, where it can be analyzed in near-real time. And I think that we, as an organization, would welcome the opportunity to share that data with the VA, and do so rapidly.

THE CHAIRMAN. All right. Mr. Filner.

MR. FILNER. Thank you, Mr. Chairman. Just for the record, I wish you were not so defensive about anything that comes from this side of the aisle. But if I were you, I would walk Mrs. Pelkey over to the Secretary of Defense, and the Secretary of Veterans Affairs, and have her talk to them. Maybe we can help her do that.

What amazes me, gentlemen, when I hear people from various bureaucracies talking, doing their studies, and working hard -- it's almost as if you're working in a vacuum, outside the real world. You all have just heard an incredibly emotional and moving testimony by Mrs. Pelkey. I didn't hear one statement reacting to that. I didn't hear any passion about "oh, we're going to correct that, and here's what we need."

You read your statements, that you wrote earlier. You make incredible claims, like Colonel Hoge said we have a distinctly pro-active approach. That's demonstrably false, at least in terms of the vast majority of our soldiers. We don't have a pro-active approach, and I don't know how you can say that. Everybody there is Pollyanna. You haven't made one suggestion for change!

I thought we would hear from you after listening to the testimony, "what do we have to do, and how much money do we need to do it?" It seems to me, that that's what you ought to be reacting to, on a human scale, and not on your bureaucratic studies. I have a Ph.D. I understand research. But Colonel Hoge, you told us nothing meaningful.

Mrs. Pelkey could have told you all that, just by sitting down with the interviewer and telling her experiences. And a lot of spouses could have done the same thing. I hope you're going more than a year out, but that's all you talked about. And we know these symptoms occur later on.

And even within the context of your own testimony, which was so Pollyannish, I don't understand how you can not sit there and be angry about what we are doing as a nation to meet these needs. I think Colonel Hoge, or as Colonel Engel said, your center had seen 1,500 post-Iraq servicemen. 1,500, out of the tens of thousands? You said in your own testimony, there's 700,000 hits a month on your Web site. And that means -- that's an incredible number of people interested in what we are doing. And we're meeting only a few.

Your one-in-four statement, after 12 months, I don't understand why you would stick to that, when we know these things first, come up after 12 months. And second, how difficult it is for people to admit

this kind of situation, or to even get data on it, as we have heard so movingly in the testimony. CPT Pelkey wouldn't have been in one of your statistics, and yet, there he was, very sick. Very ill.

I appreciate Dr. Friedman saying, the only suggestion I really heard from you, is that you don't have a mandate in the VA to deal with families, as opposed to the individual veterans. That's an important statement, and we ought to remedy that. And I appreciate you saying that. But we could have heard 25 things, probably, from you all who are experts, to tell us what we had to do. And I didn't -- all I hear is, we're doing everything right.

The statement that the Vet Center had gone up from a few thousand to 14,000 in last year, that shows what you're trying to do, and the need. I don't think there's been a great increase in the number of staff there, to serve this incredible increase. You need to say, we went from 3,000 to 14,000, and our staff had too few people to deal with that.

That's what we have to know. What do we have to do, to meet the needs? And all I hear is that everything is fine. Everything is not fine. We have suicides, we have divorces, we have domestic violence, we have crime, we have homelessness. Let's get passionate about these problems.

The fact that a veteran is not being helped, and commits suicide, or is on the street, should get everybody angry, as an American citizen, about this issue. We know how to treat these illnesses. We know how to do it. We've advanced that far. And yet, we're not getting the services that veterans need.

So, I'm very disappointed by all your testimony. You are locked in these studies, and your journals. Go out and talk to veterans and their families, and you'll get all the information you need. I just want to know, how much money does it cost to do the kind of work that Mrs. Pelkey laid out? We know we have to deal with the families. We know we have to spread the information to all the service providers. We know we have to have peer discussions.

Just tell me how much that's going to cost, and let's do it. Thank you, Mr. Chairman.

DR. HOGE. Sir, if I may --

MR. BURTON. [Presiding] Go ahead. Respond.

DR. HOGE. -- respond to that. I think that the - the critical -- if I understand your question, sir, the critical element is, given the research, which shows that there is a significant risk of mental health problems, particularly PTSD, are the resources sufficient to take care of our servicemembers coming back, and --

MR. FILNER. That was a great translation of my emotion, into bureaucratic language. I don't know why you have to talk that way. Talk as a human being, and not, you know, "the study based on," and "we have to get the resources conditioned on" -- I mean, come

on. These are people who are suffering. I want to know how much money do we need, to make sure they stop suffering? That's all you have to do.

MR. BURTON. Okay. I think he understands this. Let him respond.

DR. KEANE. I would just like to add, if I can, that there are approximately 10 very specific recommendations in my written testimony, that, I think, warrant consideration by the group. And I'd be happy to elaborate on them, if given the opportunity.

MR. BURTON. Since I'm sitting in for the Chairman, and he's not yet returned -- I'm interested in some of the comments from my colleague. In the last couple of years, there've been, as the chief of staff was just pointing out here, that there have been about 100 people added to take care of the need. Is that sufficient in the Vet Centers.

MR. BATRES. We just got an additional 50. The original 50 --

MR. BURTON. Yes, I understand that. He just told me that, too. But if what my colleague has said is correct, there was 15,000 last year? Is that what you said? 14,000? Are 100 new people in the last couple of years sufficient to deal with that problem? And I'd also like for you to elaborate a little bit more on what he was asking about the families. Is there a mechanism for these families, to get the kind of assistance that they need as well?

You know, I know some people that were in Vietnam. And when they came back, there was a great deal of stress upon them, but also on their families, because the adjustment to these people was really substantial. You know when they have a loved one that goes, that's a pretty warm, fuzzy guy, and when he comes back, he's a hardened veteran, who's seen some of the worst atrocities, and tragedies that you can imagine. And the family has to adjust. Is there any provision, as well, for the family members? And if not, should there be?

MR. BATRES. A point of clarification. And I don't think you were here when it was said. My program --

MR. BURTON. Well, I apologize for that. Go ahead.

MR. BATRES. -- does have eligibility for family members. So, we see family members. We see these significant others, and the children. In our bereavement program, the whole aim is to treat the whole family, because DOD only treats one individual. Usually, the significant other. We've expanded our services to the entire family of operation. And we've been doing that for awhile.

The other thing is that you're exactly right. We became very proactive, early on, to get those 50 FTEE authorized, so we can begin to do the outreach mechanisms. Before this operation, we had no experience with the number of National Guard and Reserve folks that are being activated, and some of them doing their second and third tours, right now.

So, in anticipation for that, we designated those folks, and we hired from within, the returning soldiers, to do the outreach. And to pro-

vide access to care for the VA. And they're bringing in a significant number. I suspect that the next 50 will also be equally as effective, in doing that. I think we need to assess, and see if 100 is enough. And if it's not, I think we should get more, or I would certainly advocate for more resources, through my particular avenue.

I do want to dispel the perception that we're not passionate. I'm a disabled Vietnam combat veteran, and I take my job seriously, as I think most VA folks do. And we are working very pro-actively, to do what we can for our fellow veterans, and I think that I would extend that to a good number of our folks in our program.

The problem is, from my perspective, that, you know, figuring out what would be appropriate for the increasing numbers, when you don't know what they're going to be initially. And then, as you go along, developing those, and then, quickly staff them. I am -- I feel very fortunate to have the additional 100 FTEE, and I'll guarantee you, they're being put to very good use.

DR. FRIEDMAN. I'd like to comment, also, in response to some of the earlier statements. It's a new ballgame. I think that looking, and trying to project resources based on traditional accounts of people that come through the turnstiles, to VA clinics, or Vet Center clinics, is only a piece of it.

As Mrs. Pelkey indicated, and as some of us indicated in our testimony, there are new initiative. New kinds of things that we really are just beginning to get our heads around. The collaboration between the VA and the DOD is unprecedented, in my experience. It's very, very welcome. The fact that I'm doing a number of projects with these two gentlemen, as well as many other people in uniform, is something that hasn't happened until very, very recently.

Much of the effort, I think, has to be about prevention, about education. As Dr. Keane said, using Web-based technologies. We've developed -- and I gave four CD-ROM copies to the Committee -- in conjunction with Walter Reed Army Medical Center, the Iraq War clinician guide, which is a state-of-the art manual on how to treat these people. It's available on the Web, it's available by CD-ROM. Prevention. Outreach to families.

Costing that out, I think, is something that we're really unfamiliar with.

MR. BURTON. Well --

DR. FRIEDMAN. And I think we need to do it, because it's a major part of what has to be done.

MR. BURTON. Well, we have a Vietnam veteran sitting there, next to you. And with the experience in Vietnam and Korea, and the other conflicts with which we've been involved, it strikes me as unusual that you're saying you don't have the experience to deal with some of these problems. I mean, we've had war after war after war in our history. And each one of those wars gave information to the various

agencies on how to deal with these stressful problems that are created.

And I mean, you know, they had horrible things in World War I and II, trench warfare, and Korea and Vietnam. And from what I'm gathering from you folks is that you're experiencing something new, because maybe the National Guard's involved. They're still military personnel who are involved in combat. It seems to me that the statistical data that you've had from previous conflicts could be a real benefit.

I just don't understand why you seem, I don't know, somewhat bewildered, because this is something new. I don't think it is anything new, is it?

DR. FRIEDMAN. May I clarify?

MR. BURTON. Sure. I'd like to know.

DR. FRIEDMAN. I thought I covered some --

MR. BURTON. You'd better turn your mike on.

DR. FRIEDMAN. I thought I covered some of that in my testimony.

MR. BURTON. Well, I apologize. I wasn't here.

DR. FRIEDMAN. What's certainly new, are evidence-based treatments. And as I said, we didn't have the kind of treatments 30 years ago for the Vietnam vets, that we have now. And we're learned a great deal from Vietnam.

What is new, is the immediacy and the collaboration with the DOD. It was 10, 15, 20 years after people returned from Vietnam, before VA had the capacity and offered the eligibility so that Vietnam veterans could come to VA. What's new, now, is the fact that there are families out there, with returnees who've just come in a day or two ago. That's new.

It's new for VA, and it's an important opportunity. It's an opportunity that we welcome, so it's not about being bewildered. It's about recognizing the problem, identifying it, and trying to be as pro-active as possible.

MR. BURTON. Well, how long will it take before you know how many additional personnel you're going to need to deal with this large number of people who need attention and care? I mean, I think you said 14,000? Is that correct? 14,000?

DR. FRIEDMAN. I think it's very hard to make projections. I'll defer to Dr. Hoge. I mean, it's very early in the game. The data we have on Vietnam veterans, we obtained in the mid-1980s.

MR. BURTON. Okay, based upon the data you had back then, how long would it take to take care of 14,000 people and give them the attention they need? And how much would you need additional personnel for that?

DR. HOGE. Sir, I think there's ample data available for us to project service utilization needs, and resource needs. And I would like to take the question for the record, and get back to you on specifics

of exactly what resources we would like to request, to best serve our service members.

MR. BURTON. So, what you're saying is, from the experience you've had in the past, Colonel, that you could project the need fairly accurately.

DR. HOGE. Yes, sir. I --

MR. BURTON. Why hasn't that been done before now? I'm just curious.

DR. HOGE. Well, I think that the combined data of what we --

MR. BURTON. I mean, the war's been going on, there, for over two years.

DR. HOGE. Yeah.

MR. BURTON. And we also had Desert Storm before that. Why hasn't there been some statistical data, showing what the need would be before now?

DR. HOGE. Virtually every study that was conducted in prior wars, sir, were done literally years, sometimes decades after servicemembers came home. This is the first war where we're actually collecting data in real time, and calculating rates. But we now have two years' worth of data. And I think that's sufficient to make reasonable -- you know, maybe not the most accurate, but I think reasonable projections --

MR. BURTON. How long would it take for us to get that here on the Committee? I know the Chairman and others would like to have that.

DR. HOGE. Well, I'm a researcher, and I -- and I will do the -- my very best, to go to my leadership, and get that answer for you, as quickly as possible, sir.

MR. BURTON. You can't give us any timeframe? A month? Two months? Two weeks?

DR. HOGE. I don't see any reason why it can't be done in the next month, or so. I mean, I'm -- I can't speak for my leadership, but it's -- it's something which we have been wrestling with. What are the resource needs, for instance, with the upcoming post-deployment reassessment, that's going to be done at three to six months?

MR. BURTON. Uh-huh.

DR. HOGE. That reassessment is going to generate a large number of soldiers coming in for care. And there's a lot of serious questions being asked about what are the resources that are necessary to provide the services for those servicemembers that identified. And my --

MR. BURTON. Well, let me just say, because I know the Chairman's going to be back here in a minute, I would personally, as a member of the Committee and one who's been on and off this Committee for about 20 some years, like to have not only the statistical data on how many people you would need to take care of those who are coming back, but also, if you could project out how many people you would

need, based upon past experience, to deal with some of the family members that are suffering from the results of the stress caused by the conflict on these soldiers.

So, you don't have to be precise. I don't think anybody expects you to be precise. But we'd like to know what the need is. Congress can't authorize or appropriate the resources necessary to take care of a problem, unless we've got some pretty good data.

DR. HOGE. Yeah.

MR. BURTON. And if people are vague about that, you know, we go to the authorizing Committee, and they say, well, how much do you need, and why? And if nobody has an answer, then they can't authorize. And the appropriators are very difficult to deal with, if you can't give them some pretty clear-cut information. So, if you could get that for us, you said you think maybe within a month, you could get it, that would be great.

DR. HOGE. I'll work with the leadership at the surgeon general's office, and DOD, to try to get those -- those more specific estimates of resource needs, to the Committee.

MR. BURTON. So, for the record, do you think you can get that within a month, maybe?

DR. HOGE. I -- I shouldn't promise that --

MR. BURTON. Will you try to get it within --

DR. HOGE. I will -- I will do the best I can, to nudge the system along, to -- do that. Yes.

MR. BURTON. Okay. Thank you, Colonel, very much. I see the Chairman's back. I'll turn the chair back over to him.

THE CHAIRMAN. [Presiding] Mr. Udall.

MR. UDALL. Thank you, Mr. Chairman. Thank you all, for your testimony here, today. Many of the veterans that return, come from rural areas. And I don't -- at least, from my own experience, in my Congressional district, in my state, it seems like they're disproportionately from rural areas.

And I was wondering, the -- in terms of the services that each of you have talked about, and what's being provided now, do we have the capability to deal with veterans that are two, and three, and four hundred miles from the large hospitals -- are rural veterans treated differently, because they live so far from those facilities? I mean, what is being done to deal with that kind of situation?

And any of the members of the panel that can speak to that.

DR. ENGEL. Sir, if I may. I would like to say that CPT Pelkey's terrible story is, for me, a sober reminder of the overwhelming charge that we have, to care for our own. At the Deployment Health Clinical Center, what we are doing with Respect Mil study, and as Dr. Friedman mentioned, we're collaborating with the National Center on this, and exploring ways to go broader, within DOD.

This is a potential -- has the potential to maximize services for peo-

ple who are in outlying places. People who are otherwise, maybe falling through the cracks. So, I think that again, the -- the opportunity to afford good mental health care, through primary care, is a way of reaching out to rural communities. And if we can bolster continuity in primary care, people will not fall through the cracks, and we won't experience the sorts of terrible tragedies that we've heard about today.

MR. UDALL. And do you think they're getting the training they need, out in these primary care facilities, to recognize PTSD, and --

DR. ENGEL. Sir, one of the -- in the Respect Mil effort, we have developed a primary care education module, for primary care docs, that speak to them at their level of understanding of post-traumatic stress disorder, and facilitate care, and improve the structure of primary care, by allowing them to use good screening tools, and tools that measure the severity of patients' illness.

It's not just a knowledge issue. There are also important structural changes that have to take place in the clinic, so that patients who struggle with these sorts of challenges, get the intensive time and attention that they need.

I would also add too, that Uniformed Services University's department of psychiatry and its Center for the Study of Traumatic Stress is a leader in creating educational materials through its Courage to Care program for communities that are dealing with disaster or terrorism, and our PD.mil website has extensive information about the clinical practice guidelines for post-traumatic stress disorder, for depression and other mental health conditions. We make specific efforts to design that site so that primary care clinicians can access them quickly.

As a mental health practitioner who has worked in a rural area all of his professional life, I thank you for your question. I think that the challenges of any health delivery, especially mental health delivery in rural areas are very unique and very important.

I think that within VA there are a number of options. Certainly the vet center program is one of them and Dr. Batres can describe that. There are also community-based outreach clinics or outpatient clinics where VA practitioner and VA clinics are set up in places at a distance from the flagship hospital, so the transportation and road condition programs that often are barriers to access in rural areas can be overcome.

There are also partnership with community mental health centers that have been done in certain areas.

In addition -- this is kind of traditional stuff, but I think that given the information age, the internet, the tele-health capability, this is really -- and this is one of the things I have been wanting to address in some of my answers or my initial comments is this is a very good way to reach rural practitioners.

The national center's website, which is getting 65,000 unique users a month, is one way that people can access the latest on treatments and download it no matter where they are. We have even been able to do this with people providing help in the tsunami-stricken areas.

We are working on a state-of-the-art curriculum. We call it PTSD 101, which will be a web-based production.

In partnership with the Uniformed Services University health sciences, we have proposed a very, very ambitious and extensive educational initiative, which will be using tele-health and web-based technologies as well as face-to-face to upgrade the skills of DOD and VA practitioners, so I think that there are many, many options that we have available, and we need to make good use of them.

MR. UDALL. Any other comments from the panel?

DR. BATRES. I just wanted to briefly say a few things.

One of the ways we extend our services is our contract for a fees program within the Vet Center program where we contract with private providers in rural areas. Although limited, we have found that that particular program is very effective if we can find the providers with the skills and the training to provide the services.

We have also established outreach centers that are what we call "outstations."

For example, we have five vet centers on Native American land. These are very rural areas, places like Hopi and Navajo and other reservations we have gone out and established an outstation in the particular reservation to provide services closer to their communities.

For example, if you were a Hopi or Navajo, as you well know, you have to drive a long way to get to Phoenix or to Albuquerque. So we promote services and are local and attempt to do that.

The other thing that we are doing, especially with the National Guard and Reserve, is working very closely with General Blum and the National Guard registry as well as the reservists. We are establishing, and I think the National Guard will be rolling out a plan that is state-based where we are creating coalitions of all community resources and coordinating the services, and I think that will help to improve our services to rural areas, but I want to also say what Matt said, and that is that is a challenge, when veterans are dispersed all over a great geographical area and getting the appropriate services to them.

Those are some of the things that we have enacted.

MR. BURTON. [Presiding] Mrs. Napolitano --

MR. UDALL. Thank you.

MRS. NAPOLITANO. Has he finished?

MR. BURTON. Are you finished? Do you have a follow-up question?

MR. UDALL. No, I didn't have a follow-up. My time was out, but I noticed Dr. Keane wanted --

MR. BURTON. Oh, sure. Proceed. Sure, that's fine. Thank you.

DR. KEANE. I just want to concur that these are complicated matters when you have a centralized system, but the CBOCs, the community-based outpatient clinics, is one important answer, as are the many programs that Dr. Batres has put into place.

The issue with CBOCs, however, is the extent to which there is specialized care, and among the concerns that many of us have is that primary care doctors are already extraordinarily busy and very hard-working, and to take on the burden of both diagnosing and treating combat related problems becomes a burden that may just be too much for them to bear.

The question of course is at what point can we have and how can we have mental health services in these clinics, and this is being actively debated and discussed and in many places implemented, but I think we could likely do more there.

MR. UDALL. Thank you very much.

MR. BURTON. If I might follow up before we yield to Mrs. Napolitano, could not be included in the information that I requested earlier some kind of analysis on how much revenue would have to be requested from the government to take care of the need for these people in the rural areas who need psychiatric help. If you could give us that. As I said before, I think one of the problems with this Committee and every Committee in Congress -- I was Chairman of the Government Reform Committee for six years -- is that we don't get enough information from the various bureaucracies to be able to ascertain how much money we need to spend and how many people are going to be needed to do the job, so if you could try to get that along with Colonel Hoge?

DR. HOGE. Yes, sir.

MR. BURTON. We would really appreciate it. I mean he has already said he could get all this done in about two weeks -- or did you say four weeks?

[Laughter.]

DR. HOGE. Sir, I said I would go to my leadership and pass on your request for --

MR. BURTON. Well, we'll call your leadership and tell them you made a hard commitment for a week, how's that? As quickly as you can get it done. I'm sorry. Does that answer your question?

Mrs. Napolitano.

MRS. NAPOLITANO. Thank you, Mr. Chair, and I have listened with great interest because PTSD has been something that I have been very interested in, very involved in since my days in state assembly in California.

Some of the questions -- one of the answers that Dr. Batres gave in regard to the treatment, I believe you said it was bereavement

only. What happens with treatment to the families or assistance to the families and those that have not lost a member? Because that is important. It isn't just those that have lost a loved one, but it is a family whose member has gone through these atrocities, who has been injured -- not necessarily dead -- and cannot deal with because they don't know how.

So does that include also services to the families?

DR. BATRES. We would cover that. Any problem that is related to their military service we would cover, so it is not limited to just bereavement.

MRS. NAPOLITANO. So the resources needs would be for the service individual and the family?

DR. BATRES. Correct.

MRS. NAPOLITANO. Is the family aware of the services? Is it something that is given to them, talked about, sent to/mailed to them, emailed? How do you get that information to them?

DR. BATRES. We get the information out through the typical formats. It is on our website. We inform folks. We do our debriefings at the demob sites and wherever we interact with the military we pass out that information to them, that they are eligible.

And they have been eligible for 25 years. It's not a new eligibility. We have always included the families as part of our treatment.

MRS. NAPOLITANO. Okay, but that still does not -- many families don't have access to computers so they can't access the website. Is it possible then that you might include in writing when the VA sends information to a veteran to remind them that these services are available, that their families might seek help in instances where there is an issue of PTSD that may not recognize it's PTSD.

I am trying to figure out a way to be able to get information to the family itself as to how they can help it. They may not recognize it. They may not know what PTSD is.

Also you indicated that you have a website. Can you share the website so members of Congress -- I'd love to have on my website the ability to link some of my veterans' organizations and say "Go" because I am being asked now what do we send these -- you know, we are starting to get these youngsters coming in, asking for help at the local VFW and American Legion.

How do we tell them here is a place for you to go or refer them to? I'm sure somebody at the VFW has an access to a computer, but assistance to them at that level, because you can't do it all, but how do we know what you are doing and how we can lend a hand in that?

DR. FRIEDMAN. Our web address is in my testimony. The National Center has sent its annual report to this Committee every year. We have a section devoted to the web, with the web address, telling you all the bells and whistles and stuff. If you would like more information, I would be delighted to tell you about our website.

MRS. NAPOLITANO. I'm sorry. I don't have your testimony. Maybe I missed it, because I am not a member of the Committee. I did happen to pick up stuff from outside, but I will look for it.

Any other website that you gentlemen might have?

DR. ENGEL. If I may, our website is pdhealth.mil -- m-i-l -- and the other comment I would make, ma'am, is that if you have a constituent friend or otherwise that needs assistance I would be glad to bring the full resources of my center to assist. We are taking care of patients directly at my center. Certainly the numbers that we take care of are nowhere near the total number of people who are injured, but we come face to face with these folks every day and we are trying to develop innovative programs, and I assure you if you refer anyone to me and my center, we will take good care of them.

MRS. NAPOLITANO. Thank you for the offer. I will take you up on it if I need and my staff needs it. But Mr. Chair, may I ask that you include in your request for information from Colonel Hoge how best to get information out to families on PTSD. That might take some doing, whether it is advertisement -- we have done it for the recruitment of personnel for the armed forces. Why cannot we start making some kind of inroads in indicating that there is help for those individuals who may be -- and their families for that matter -- who may need help, services that you can provide.

Again, this will take money and this is something that maybe this Committee might be interested in working with you.

Going to primary care, primary care is TRICARE, I am assuming?

DR. ENGEL. Ma'am, primary care is a treatment setting before specialty care. There is primary care within TRICARE. There is primary care within the VA and there is primary care within the Department of Defense.

MRS. NAPOLITANO. My concern has been because in my area I had one clinic for my veterans, and I have a high percentage of veterans in my area, they were going to close it down. This was about six years ago. We have had a new clinic open, but it is outsourced. I am being told by the physicians that they cannot give certain services because they are not reimbursed for them.

That creates a problem for me, because if veterans are going in, indicating that they have PTSD and they are required to -- how would I say -- prove that it happened during a wartime, whether it was Vietnam, whether it was a prior war, and these individuals are having problems. I am just telling you what problems I face in my area, so I am concerned about how can we get veterans who might not be identified as possible PTSD, that they can then go to an individual, whether it is a private servicer or VA, and say to them we need some mental health services.

I'm sorry, but this macho thing prevents a lot of my veterans from admitting that they do have a problem. Unfortunately, we just need

to be able to de-stigmatize so that it is something that they know they can be treated for and get help for. Question?

DR. FRIEDMAN. The primary care initiative is really an important one from a number of perspectives. I think that in the case of Mrs. Pelkey's husband, where he did see a primary care practitioner, that was a missed opportunity. I think that just to take that particular example, not knowing any of the other details, one of the goals -- and Dr. Engel has been in front on that -- Dr. Gerald Cross, head of VA's primary care has been very, very supportive in this regard -- is to acknowledge that because of stigma, other issues, and associated medical problems, veterans or Guardsmen, et cetera, with PTSD aren't recognized by primary care practitioners. This, unfortunately, is often the case. This needs to change since the first clinical port of call will often be the primary care clinic.

That is the reason why we are so committed to trying to develop integrated primary behavioral health models of care which have been shown to be successful with depression.

A project that we are doing in collaboration with Dr. Engel at Fort Bragg is testing this model. Dr. Cross has been very enthusiastic in supportive about this. Indeed, every veteran who comes to a primary care clinic will receive a PTSD screen annually so that --

MRS. NAPOLITANO. Sir, I'm sorry, but what if they don't go to the primary care on PTSD? What if they just go for an issue? Can that primary care provider be able to identify that there is an issue with mental health?

DR. FRIEDMAN. That is the point of the screening. That is exactly the point of the screening.

MRS. NAPOLITANO. But are they trained? That's my point. Are they given that?

DR. FRIEDMAN. That is an initiative that is underway.

MRS. NAPOLITANO. That is why we are asking for the funding to be able to additional trained personnel so that we can then say we have enough people to address what we perceive is a growing issue.

DR. ENGEL. Ma'am, as part of this program that Dr. Friedman is speaking to that we are piloting at Fort Bragg, there is an education package for the primary care doctor, and there is a sort of clinic design that is put in place. It is called the prepared practice for recognizing people. The dissemination of that is something that we look forward to the opportunity to do.

MRS. NAPOLITANO. So it's still in progress. One more follow-up, just very quickly --

THE CHAIRMAN. [Presiding] I have been very patient.

MRS. NAPOLITANO. Thank you so much. Very quickly -- go ahead, never mind. Just go on.

THE CHAIRMAN. Go ahead. Make it quick.

MRS. NAPOLITANO. It's gone -- went in one ear and out the other.

THE CHAIRMAN. Thank you. We have votes coming up and we have another panel. That was the only reason, ma'am, that --

MRS. NAPOLITANO. Thank you.

THE CHAIRMAN. The last thing, Dr. Hoge, we really haven't talked about your study, and you put a lot of time into this. Mr. Burton asked a question about data and getting that information to the Committee. In order for that to ever occur, how predictive are the results of your study?

DR. HOGE. I think the results of our study are predictive, and we have additional analysis that we have conducted, such as looking at how many servicemembers who have come back from OIF have accessed services, what percent have seen mental health, what are the reasons that they have accessed services. So we know, I think we can predict with some degree of accuracy what percentage of our servicemembers are in need of services, mental health services, and then obviously the second question to that is are the resources adequate.

That is something I just can't comment directly on in my position

--

THE CHAIRMAN. Is the data being shared with the VA?

DR. HOGE. Excuse me?

THE CHAIRMAN. Is it being shared with the VA?

DR. HOGE. Yes, sir. Yes, sir. All of our data, and that is one of our primary missions is to get the information out in a timely manner so that it can influence policy directly.

THE CHAIRMAN. Well, we recognize that the President in his budget increased \$100 million in the VA for mental health.

DR. FRIEDMAN, I want to thank you for the team you sent to Newark city immediately after September 11th on behalf of the country. Your response to that and help is noted.

I would like to thank this panel. You have invested a great deal of your life into these studies and being able to help our soldiers and the families.

We know we have got them in the military but we don't pause and say why? You know, we train them to kill and break things, when you think about it, and there are some mental consequences from warriors doing such things, and we train them to be rough and tough, but they are also someone's cuddly son, right? Cuddly spouse? And they do have a warm, compassionate side to that warrior spirit, and when that veil gets pierced there are real consequences, and that is where you as professionals step in.

At some point in time though, through PTSD and a diagnosis, through treatment, they can get better, can they not?

DR. HOGE. Yes, sir.

THE CHAIRMAN. It is a curious matter with regard to the escalation of 100 percent PTSD disabilities and how people get worse, and all of a sudden when they get a 100 percent disability rating, then they get

better. So I think what we are going to have to do is when we come back we may have to do a secondary hearing with regard to the IG report, because it is pretty alarming with what is happening out there. We want to make sure that the precious resources we have, that the care and attention go to individuals that need it and not to individuals who are perhaps using some form of excuse for bad behavior.

It is a delicate matter and a delicate issue but it's one we have to confront, and I know that you were able to sit here and listen to the testimony from the first panel witness and I am glad you were here and could hear that.

There are reasons we call certain circumstances a tragedy, and we label them a tragedy because when you go back and you do an analysis of it, there are failures all around. This member of the army family didn't get the support that he needed, and every port of entry for access or referral wasn't there. I mean that is why we call it a tragedy, and so I imagine that perhaps there are some other cases out there, but I appreciate your leading forward, and this panel is now excused.

The third panel will please come forward.

Michael E. Kilpatrick, M.D., is deputy director of the Deployment Health Support, office of the Deputy Assistant Secretary of Defense (Force Health Protection and Readiness). Dr. Kilpatrick is responsible for providing assistance to Gulf War veterans and facilitating the operational support for Force Health Protection initiatives and the coordination of health-related deployment issues between the Office of Assistant Secretary of Defense for Health Affairs and the military departments.

We will also hear from Brigadier General Michael J. Kussman, M.D., MACP, who is U.S. Army, Retired. He was appointed Deputy Under Secretary for Health for the Veterans Health Administration, of the Department of Veterans Affairs on May 29, 2005, and in this capacity he leads the clinical policy and programs for the nation's largest integrated health system.

If both of you would introduce who you have accompanying you, and then I would then yield to Dr. Kilpatrick.

DR. KILPATRICK. Mr. Chairman, I have Dr. Jack Smith with me. He is head of the Clinical and Program Policy in Health Affairs for DOD.

THE CHAIRMAN. Very good. Thank you. You are now recognized. If you have a written statement, both of you gentlemen? You do?

I ask unanimous consent that it be submitted for the record. Hearing no objection, it shall be entered. Dr. Kilpatrick, you are now recognized.

STATEMENTS OF DR. MICHAEL E. KILPATRICK, DEPUTY DIRECTOR, DEPLOYMENT HEALTH SUPPORT DIRECTORATE, OFFICE OF THE DEPUTY ASSISTANT SECRETARY OF DEFENSE, DEPARTMENT OF DEFENSE; ACCOMPANIED BY DR. JACK W. SMITH, DIRECTOR OF CLINICAL AND PROGRAM POLICY INTEGRATION, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE; DR. MICHAEL J. KUSSMAN, DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS' HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS' AFFAIRS; JOHN E. BARILICH, OPERATIONS OFFICER FOR VISN 110, DEPARTMENT OF VETERANS' AFFAIRS; AND DR. MARK SHELHORSE, DEPUTY CHIEF PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH AND CHIEF MEDICAL OFFICER FOR VISN 6, DEPARTMENT OF VETERANS' AFFAIRS

STATEMENT OF DR. MICHAEL E. KILPATRICK

DR. KILPATRICK. Mr. Chairman, distinguished members of the Committee, thank you for the opportunity to appear before you today and discuss the Department of Defense's efforts to prevent, identify and treat post-traumatic stress disorder.

I would like to provide some brief opening comments.

I would first like to start by thanking Ms. Pelkey for her courageous testimony today. I would like to also express my sincere condolences to her for her loss.

I am going to be talking about policies and health in the Department of Defense and then the ultimate evaluation policies that must be evaluated and how well they serve and support our men and women in uniform who serve. When that doesn't happen, then we need to take a look at is there an issue with the policy, is there an issue with the implementation, and I think that those are areas where we must continue to learn as an organization and as a society.

The Department of Defense is firmly committed to safeguarding the health and fitness of our active and reserve component servicemembers both before, during and after deployments, and this includes emotional health.

The department's ongoing education programs for military health providers focus on prevention programs and early intervention for behavior and health issues. You have heard about those education programs. They're still early. We need to have similar education programs for our military leadership, the operational leadership, so that they can support their soldiers, sailors, airmen, Marines getting help early when they need it.

We need to make sure that that education program reaches out to

touch the families so they are part of this issue on bringing to bear early intervention and then finally our servicemembers must understand that they have a safe haven to come to seek that health care.

I believe we have made great progress in the areas of prevention, identification and care for stress-related health risks such as anxiety, depression, and acute stress reaction and we are really focusing now on post-traumatic stress disorder. These conditions are part of a continuum of mental health issues that are caused by operational stressors and combat trauma.

The Department of Defense is making a sincere effort to screen our people for mental health problems annually as part of their preventive health assessment. Servicemembers attend briefings about the psychological challenges of deployment during pre and post deployment processing, often with family members. They learn what to expect on homecoming and how to reduce anxiety and family tensions. They also learn to recognize when and how to seek professional help.

From the beginning of the current Operation Iraqi Freedom deployment we employed medical and environmental surveillance to monitor possible health risks. We deployed combat stress teams to provide education and address specific member concerns. At the request of the OIF leadership, the Army sent a 12p-person mental health advisory team to Iraq and Kuwait. This was the first time we have ever assessed behavioral health care in the field.

Based on the advisory team's recommendations we deployed additional combat stress teams for the OIF deployed force. In addition to the medical support, members of the chaplaincy provide counseling before departure, in the theater, and after troops return.

Upon their return, servicemembers receive a post-deployment health assessment, with a face to face discussion with the primary care health provider. The assessment includes specific questions about behavioral health issues associated with deployments. If the individual's responses indicate a risk of behavioral health issues, he or she is referred for medical consultation if PTSD or other behavioral health issues can be identified.

Of the 138,000 troops who returned in calendar year 2004 and received a post-deployment health assessment, 16 percent were subsequently seen by mental health providers for evaluation.

We are now implementing the new post-deployment health reassessment program to identify and recommend treatment for deployment-related health concerns that may arise three to six months after deployment. We are reaching out to veterans three to six months after they have returned to provide a proactive wellness check to see how they are doing, especially those servicemembers transitioning from active duty to inactive or civilian status.

The reassessment begins with a questionnaire that includes questions designed to highlight possible stress-related issues. Important-

ly, the questionnaire is followed by a one on one consultation with a primary health provider. Again the professional administering the reassessment will refer individuals to follow up evaluation when it is indicated.

This program certainly requires that education of the primary health care providers so they understand the program, making sure leadership understands this.

Dr. Winkenwerder yesterday testified that the Department of Defense has committed \$100 million to do this program this year and next fiscal year for the servicemembers who will be in that three to six month window. After servicemembers return from deployments, military and VA providers provide a jointly-developed post-traumatic stress clinical practice guideline and a post-deployment health clinical practice guideline to provide focused health care on post-deployment health problems and concerns. There are really algorithms for the care providers to follow to make sure that those issues are appropriately addressed.

Military members and their families can also proactively seek health care through Military OneSource, a 24-hour, seven-day a week toll-free family support service accessible by telephone, internet and email. Military OneSource offers information and educational services, referrals and face to face counseling for individuals and families. This confidential service is especially helpful for those who are not sure if their symptoms merit medical attention. Their going to Military OneSource does not get reported to the military leadership. If needed, counselors can refer the individuals for suitable care.

OneSource is provided in addition to local installation family support services. The National Guard Bureau has recently signed a memorandum of understanding with the Department of Veterans' Affairs to promote a seamless transition from DOD to VA. The DOD provides timely data regarding a demobilization of National Guard troops so the VA can provide those individuals with information regarding available care and support. This includes the use of Vet Centers which provide professional readjustment counseling and are a link between the veteran and the VA.

The department recognizes that stress-related health risks are ongoing threats to our servicemembers and that we must continue to improve our efforts to safeguard their emotional and behavioral health. Our education programs for military and family members and leaders and health care providers have been well received. Our early intervention programs, combat stress teams and health assessments have proven to be effective. All of this has been done in partnership with the VA, bringing us closer to our ultimate goal of a seamless transition from DOD to VA care.

Mr. Chairman, I thank you again for inviting me here today. I am pleased to answer your questions.

[The statement of Dr. Kilpatrick appears on p. 124]

THE CHAIRMAN. Dr. Kussman.

STATEMENT OF DR. MICHAEL J. KUSSMAN

DR. KUSSMAN. Thank you, Mr. Chairman. Let me introduce, on my immediate left is Mr. Barilich and then Dr. Shelhorse to his left. Both of these gentlemen have been critically important to us and have been heroes in developing our mental health strategic plan and the implementation of our mental health processes, and I am very proud to have them with me today.

Before I get to my remarks, I'll make a few comments. I also had the opportunity to stop and talk to Mrs. Pelkey, and obviously told her how much I appreciated her courage and dedication and conviction and told her how sorry I was for her loss. I mean clearly it is a case where, as you articulated, that we should learn from, both DOD and the VA.

Sir, just one other thing. I have been in this position since 29 May but as you know I was acting in this position for over a year, so I would like to say I am no longer acting but I am still pretending.

[Laughter.]

DR. KUSSMAN. Mr. Chairman and members of the subCommittee, I appreciate the opportunity to be here today. Nearly every servicemember who actively participates in combat comes away with some degree of emotional distress. Some have short-term reactions but thankfully the majority do not suffer long-term consequences from that experience and we have heard that from the previous panel.

Current efforts at early identification of emotional stress by DOD and VA clinicians increases the possibility of lowering the incidence of long-term mental health problems through a concerted effort at early detection and care. With DOD's help, the VA regularly compiles a roster of servicemembers who have separated after active duty in the Iraq and Afghanistan theaters.

VA medical centers have treated over 100,000 of the close to 400,000 OIF/OEF veterans who have separated from active service. Two of the most common diagnoses of health problems that have been cited so far are musculoskeletal ailments and dental problems. However, as was mentioned, we have a drop-down menu, so that when the person comes for whatever the issue is, a menu drops down and stimulates the primary care provider to do a mental health assessment to include PTSD.

So of the people we have seen, the over 100,000, 24,000 have been diagnosed with potential mental health disorders including adjustment reaction, substance abuse, psychoses, as well as PTSD.

Over 14,000 of this group, OEF/OIF veterans, have sought VA care at both Vet Centers and VA medical centers for issues associated to their adjustment reactions, such as PTSD.

VA's approach to treating these servicemen and women is guided by an emphasis on the principles of health promotion and preventive care and is compliance with the President's New Freedom Commission on Mental Health. We focus on providing the patient and the patient's family education about good health practices and behaviors. We believe that education and destigmatization will go a long way in helping people get care and benefit from that.

VA is engaged in a number of activities to inform veterans and their families of the benefits and services available to them. In collaboration with DOD we have emphasis on outreach to returning members of the Reserve and National Guard, and this is of special concern to us, and has expanded significantly.

In Fiscal Year 2003, VA briefings reached nearly 47,000 Reserve and Guard members. So far this year, we have briefed more than 68,000 Reserve and Guard members. In addition, both departments have developed a brochure together, which is entitled, "A Summary of VA Benefits for National Guard and Reserve Personnel." The VA has distributed over a million copies of this brochure.

In the interests of time, I was going to comment on the Vet Centers and the Global War on Terrorism counselors that we have hired, and there were 50 for the first year. We have increased now to hire another 50, and Dr. Batres commented on that, so I won't reiterate his comments.

OIF/OEF returning servicemembers seek out and enter the VA care from a variety of sources, including referral from military treatment facilities, Transition Assistant Program briefings, Vet Centers, and home town community service providers. When OEF/OIF veterans present to VA clinicians with mental, emotional, or behavioral complaints, they are assessed both for the symptoms, functional problems and total clinical needs. Treatment plans may include referral to mental health and Vet Centers for specific treatment of mental health issues.

So, as was discussed by the previous panel, there is a tiered approach that people can get to us through our 157 facilities, our 206 Vet Centers, as well as our 850 CVOCs that are distributed all around the country.

The goal of the VA's public health approach is to decrease the incidence of serious mental disorders. There is evidence from VA's initial activities in the field that these approaches are accepted both by clinicians and the veterans they serve. They may well decrease the incidence of chronic mental disorder for veterans. For those who do develop mental disorders, decreasing the stigma or receiving care by teaching the public about the effect and efficacy of evidence-based

treatment can increase the beneficial use of these services whose goal is the restoration and preservation of optimal social and occupational functioning.

In conclusion, the VA will continue to monitor and address the mental health needs of OIF/OEF servicemembers. We are prepared to provide state-of-the-art evidence-based care to all those who come to see us.

Now Mr. Chairman, that concludes my statement and I would be happy to answer any questions you have

[The statement of Dr. Kussman appears on p. 131]

THE CHAIRMAN. I would like for you to explain a little bit more about this 24,000 of 100,000. You've got to break that number down. That is like saying one in four. Something just doesn't fit right, feel right. Come on. We have all worn the uniform here. We know what it is like to go over there. We know what it is like to come home. We know what the mental adjustments are.

It is hard for me to look at my soldiers and say one in four have what?

DR. KUSSMAN. Oh -- let me try to answer a little more thoroughly than I did. As I hope I was getting across, and the message that we are all saying, is that almost everybody who serves has some kind of readjustment or reintegration problem. Most of the time it's not illness. It is normal reactions to abnormal conditions, and to label this as "mental illness" would be inappropriate --

THE CHAIRMAN. Thank you.

DR. KUSSMAN. -- clinically and would be inappropriate for the servicemembers and their family. It's just not a true statement. But of that 100,000 who came, 24,000 had a diagnosis that would be consistent with adjustment reaction beyond what I just described to you.

THE CHAIRMAN. Take the next step. Of the 24,000, then what happens?

DR. KUSSMAN. Of those 24,000 there's 14,000 of them that have actually got a diagnosis of a mental health thing and there's a gamut of that diagnosis. Some are adjustment reactions, of which PTSD is one of the adjustment reactions. There can be substance abuse, pure psychoses, acute stress reactions, and they fall into that 14,000 who actually do get a diagnosis under the ICD code.

THE CHAIRMAN. You have to break this down a lot farther for me. I don't want there to be any confusion.

Of that 14,000 then, however you're coding that, break them out into all the categories, because if you are including alcoholism, drug abuse, narcolepsy, sleep disorders -- just go down the list. What are we talking about?

DR. KUSSMAN. Sir, Dr. Shelhorse will get that list. It's by percentage. I believe that -- and he will get that out of the lists for you. Just

a second.

Sir, what I have is the actual, most updated, and the number is 15,000 versus 14,000. I wasn't trying to be disingenuous. What I put into the statement came before the latest number.

Of the numbers of patients who have -- and you can have more than one -- and it is entitled, "The Frequency of Possible Mental Disorders among Iraqi and Afghanistan Veterans," adjustment reactions, which is ICD code 309. I would be happy to give this to you for the record.

There were 15,000 of them, who had a potential adjustment reaction, of which -- and this is administrative data, as you know, sir, and so you would have to go back and look at the charts to determine whether they really end up having PTSD or not, or what kind of adjustment reaction because you could put down as a primary care internist, if somebody came to me and I was evaluating for whatever their physical thing was as well as their full evaluation, I might put down "Rule out PTSD" or "Rule out adjustment reaction" and that gets coded and gets picked up on these numbers.

But then you would have to go back and look at the chart and see whether "rule out" actually turned out to have PTSD, as may have referred them to a mental health provider to actually make that diagnosis.

But in the administrative data, about 15,000 people have the adjustment reaction, but under the 24,000 -- the total people who have come that might have mental illness -- under that are nondependent drug abuse -- there's 10,000 people who could have had an adjustment reaction and drug abuse. Depressive disorders are 8,000. Affective disorders, 7,000. Affective Psychoses, 4,000. Alcohol dependency syndrome, 1,000. Sexual deviation disorder -- sounds awful -- 1,200. Special symptoms that are classified -- I'll leave it to Dr. Shelhorse to describe that -- about 1,100. Acute reaction to stress, 945. And drug dependency, 740.

THE CHAIRMAN. Thank you for the breakout. Ma'am?

MRS. NAPOLITANO. Thank you, Mr. Chair. Quickly, what was the 100,000 basis? Is that actually identified? Out of how many?

DR. KUSSMAN. We categorize people who come that were OIF/OEF veterans. There were 100,000 people who have come to us so far that had served in the two theaters.

MRS. NAPOLITANO. Self referred?

DR. KUSSMAN. Well, there is a mix of those. Some of them are transfers of care that are, as you may or may not know -- the Chairman knows this very well -- that we have a lot of seriously injured people that are case managed with the DOD, particularly at Bethesda Walter Reed, Brook, Eisenhower, and we have also branched out into Fort Hood and Fort Carson and some Navy basis, Marines as well, where we case manage those cases, so they are in that 100,000 as well.

Most of them -- that is a relatively small number -- most of them

have come to us for whatever they want, because they are veterans and they have a DD-214.

MRS. NAPOLITANO. But have you done any outreach to those veterans from the Afghanistan war?

DR. KUSSMAN. Oh, yes, ma'am. The outreach is a very critical thing for us, both in mental health and whatever the disease may be, because, as we have heard from the previous panel, you can have all the infrastructure you want, but if people don't avail themselves of it or know it's there, it is not very productive, and this is particularly challenging in mental health issues because of society's stigma, and we are not immune to that and people are reluctant to go.

What we have tried to do is be sure through briefings, the BDD process, the TAP, and all these different things, be sure that the separating individual, whether they go back to being a Reserve or a National Guard person, or they just get out of the active duty and no longer serve, have as much information as possible, understand what the websites are, the 800 numbers.

As we all know, people remember and keep track of a very small percentage of what you tell them in briefings, especially when you have come back from a place like Iraq and Afghanistan, and they want to get home. Indeed, as we have learned, it is not required for the National Guard or Reserve to actually go through the process, so a lot of them actually leave their demobilization site, whatever, without ever getting the thing. So what we have tried to do is be sure that we have videotapes.

We have partnered with the National Guard and Reserve, the states, to go their sites, where they get back together, to have our VBA and VHA counselors go under our seamless transition office chaired by Colonel (Retired) John Brown and Major General (Retired) Matthewson-Chapman who work for him. She has been a leader and a point person on the National Guard and Reserve.

But one of the things that we have done is these pocket cards. You know, people lose everything that we give them, but we are hoping that -- people don't usually lose their wallets, so we could give them a pocket card that they could stick in. If it is six months later or a year later, when they are having problems or their spouse is having problems, somebody might remember.

Do you remember that pocket care we gave you?

MRS. NAPOLITANO. I don't want to stop you --

DR. KUSSMAN. I'm sorry?

MRS. NAPOLITANO. -- but at my age I am losing it before I can get to the next question, which has to do with exactly what you are talking about.

In regard to the National Guard, because they are National Guard, and just recently I think we were considering a measure whereby they would only be given three months of TRICARE services. If they

are not identified at the time they are mustered out or had not sought help for mental health treatment, does that preclude them from getting treatment at a VA hospital or any other institution that will help them? There's no record of it.

DR. KUSSMAN. Let me say that we are potentially mixing two things. I mean they get their TRICARE benefit as having served on active duty, and the Department of Defense has extended that to be sure there was more time for them and their families to get care, but there is a two year window after you leave, if you have served in combat, to come to the VA for anything that came up during that period of time when you served, and with no co-pays.

You are categorized as a Category 6 person, so it doesn't make any difference what your income is or anything like that, and you have that two year window.

After that they have a DD-214, and they are veterans, so they can come to us any time that they have for whatever they may need.

MRS. NAPOLITANO. But it wasn't identified prior to their being released and being mustered out of service or they'd been still eligible, and I am thinking of one veteran who didn't recognize he was suffering from PTSD until 20 years later, until he had a group, a mentoring group of other veterans, who were rendezvousing, had been going through the same feelings and he was not alone, and then he sought help. But what happens to that veteran?

DR. KUSSMAN. Well, we don't just -- I mean with the enrollment management change that took place in the 1990s, 1996 I believe, we changed it to you don't have to have a service-connected illness to come to the VA. Now having said that, there is one priority that we have, the decision was made if you are a Priority 8, and that is developed on an economic basis, but short of that you don't have to prove connection to be seen.

What you might have to prove is connection to get comp and pen, but we still would take care of the person.

MRS. NAPOLITANO. Thank you, Mr. Chairman.

THE CHAIRMAN. Thank you. Dr. Kussman, what DOD data would be most helpful to the VA as you attempt to assess future mental health workload? What would be helpful to you?

DR. KUSSMAN. Well, as I mentioned in my testimony, we are working very closely with DOD to get as much information as we can as early as we can, and the comment was made about the post-deployment screen, and I would leave that to Dr. Kilpatrick, but I believe that they are scanning those and trying to make them electronic and then forwarding them to us, and there has been a great deal of progress on that. It's not perfect.

Other piece of information that we would like to have, whether it is mental health or anything else, is that we have learned clearly with our outreach at Walter Reed and Bethesda with the individuals

that have what we describe as polytrauma, that if we are going to be effective in our ability to make this as seamless as possible, and god knows we still have a way to go, but I believe in my heart that we are much better than we were two years ago in what we are doing.

We would like to know who entered the disability process and when they entered it so we could then determine if they choose to use the VA -- and as you know, sir, if the individual gets medically separated or discharged, particularly medically discharged, they have different options. They can continue to use the military system. They can use TRICARE or they could come to the VA. But if they do want to come to the V.A., the sooner we can find out that information, get their comp and pen exam done, and get them appointments at the VA so when they leave they don't fall through the cracks and have to tumble along themselves.

And as you know, sir, the V.B.A. has been reasonably good in the past about trying to make sure that at TAP and BDD there was education on non-health care benefits. The VA in the past has not been as aggressive as we would like to be, and the servicemember had to show up and knock on the door.

But we have changed that and we are actually partnering and being sure that not only do they get their comp and pen evaluation but, if appropriate, they get the appropriate appointments and get enrolled in the VA long before they actually get their DD-214.

As you know also, we can't provide them anything or give comp and pen to anybody until they are a veteran. They have got to get that DD-214, but the thrust is that everything is in place when they actually get the DD-214 and there isn't a long gap.

THE CHAIRMAN. Well, I accept your testimony about progress. I remember Dr. Winkenwerder being over here two years ago talking about this, so please convey this to Dr. Winkenwerder. He was invited to come here. He came to the Armed Services Committee, and chose not to come here. He sent you instead and I still haven't seen the progress, so you can tell him that for me, okay?

DR. KUSSMAN. Yes, sir.

THE CHAIRMAN. I yield to counsel for the limited purpose of three questions.

MS. BENNETT. Thank you, Chairman. I am looking at VA's own data, in which they look at evaluation of programs. I believe that is your NEPEC Center, the Northeast Evaluation Program Center, that looks at the mental health service projections.

They show that from the first half of '03, fiscal year '03 to now the first half of fiscal year '05 that the VA's seen at least a 10 percent increase in the number of veterans for just the very limited area of outpatient by the special PTSD clinical teams.

Those veterans then have generated a 21 percent increase in the number of visits.

VA has been working on a mental health model to do projections for capacity, to identify gaps in services.

Did your model accurately project in just even that narrow area a 10 percent increase?

DR. SHELHORSE. PTSD symptoms, PTSD diagnoses are actually wrapped into a group within the model and they are combined with compensated work therapy and some other specialized programs. In hindsight, it would have been advantageous for us to separate PTSD out as a separate entity from that group so we could begin to make the accurate comparisons that you are mentioning, and that will indeed be something we do in a future iteration.

So as it stands right now, I cannot tell you that the model predicted "x" percentage of PTSD diagnoses versus what we actually experienced because it's actually blended with these other diagnostic entities within the group and in the model.

MS. BENNETT. In VA's model that you created basically to identify these gaps, that model does have implications for VA's budget.

The first iteration of the model identified deficiencies in mental health service capacity that would require roughly at least \$1.6 billion to address the chasm between the demand and the capacity for mental health services, including substance abuse, PTSD, depression, and a range of mental health care issues.

The model was then revised and re-projected. There was a significant drop in the gaps that were identified.

In the revision of the model, it was estimated that roughly \$700 million, or less than half of the original projection, would be needed to close the gaps by fiscal year 2007.

Did the model include projections for OIF and OEF veterans that are coming, and does it -- are you now revising it to take into account Colonel Hoge's research and the outcoming research of increasing need for mental health services from returning soldiers?

DR. KUSSMAN. Let me take a stab at the first part of your question.

Yes, it's true that the original assessment was in the numbers that you have described. However, when we looked at it critically and reviewed it -- and by the way, this wasn't done in a vacuum, it was done with our subject matter experts including people who work in the NEPC and our seriously mental ill and all the other groups found that there were serious flaws in the design to look at that that didn't take into account reliance, age cohorts, and things like that, because clearly mental health resources potentially we have seen from historically the Vietnam veteran needs more than the World War Two veteran, so that got revised on the \$700 million.

It was agreed upon and appreciated by all the people inclined, and as you know, our mental health providers and advocates are not shy and they certainly would have held us to a much level if they didn't agree with that number that was projected.

I'll ask Mark about the second part of the question.

DR. SHELHORSE. The model is essentially run off of data that is three years old, so '05 would be run off '02 actuals; '06 would be run off '03 actuals, so by '02 and '03 we would have seen very little of the influx of patients that we might be seeing at present from OIF, OEF. The next year's run will take into account '04 data, and so it probably will be a better approximation of the information that you are asking for about what the impact of OIF and OEF will be.

MR. BARILICH. And if I could also add, in addition each year the model is revised and refined. Speaking with Barbara Manning this morning, who is one of the people who works on this, these type of things come up and need to be projected into the future obviously that weren't known at the time of the baseline year.

Also along with that, I think it is important to note, too, that one of the other things that is included in that model is what is referred to as "vet pop" and what that is is the list of discharges from service of our potential veteran population, so that information is also blended into these models.

MS. BENNETT. Just to follow up, have you yet revised your '07 projections, because that was a \$700 million number that did not take into account OEF, OIF, or the intensity of their usage of mental health services from VA

Are you revising it for your '07 budget?

DR. KUSSMAN. Let me try to answer that by saying that we believe that that \$700 million was an iterative thing over the course of our efforts to -- of the strategic plan, and as you know, the underSecretary to kick-start that put \$100 million toward that goal in '05 and it will be continued in '06. We are developing the '07 budget right now.

THE CHAIRMAN. There was a DOD collaborative effort to provide clinical practice guidelines to be useful tools. Are they being utilized?

DR. KILPATRICK. On the DOD side, the use is not what we would like to see. What we are seeing at this point is about one to three percent of people coming back coming in to primary care on answering, "Yes. I am here today with a concern that may be related to a deployment."

With the numbers of folks coming back, I would expect that that ought to be a lot higher and so we are taking a look at, with the services drilling down, to say how is this being used?

Some places you swipe your ID card and you have to electronically answer, "Have you returned from a deployment? Is this a deployment related issue?"

That data is very robust. In some areas people are actually not asked that, so the policies there, the implementation, is not as robust as we would like. But currently we are seeing about three percent of people coming in to primary care are indicating this is for a deployment-related issue.

THE CHAIRMAN. Dr. Kussman?

DR. KUSSMAN. Sir, as I mentioned to you, when anybody comes to us

and comes to enroll and needs an appointment, part of the protocol is to ask, "Are you OIF?" "Oh, yes." Because we were giving and are giving them top priority to get in for access to whatever, to be sure that they get in within 30 days, obviously faster if it is urgent or emergent.

Also I mentioned that in our electronic health record, if you come, even if you come for your back pain or headache or arm pain, the primary care provider who sees you, a drop down menu automatically forces the individual practitioner to ask questions related to potential deployment.

We also have a very robust employee education system, as you know, that is geared toward educating not only patients and we also have a very robust employee education system, as you know, that is geared toward educating not only patients but our staff, both doctors, nurses, nurse clinicians, PAs on the best approaches to PTSD and mental health in general, because, quite frankly, nationally there aren't enough mental health providers to provide the full need that the country needs, and so you couldn't rely on the number of psychiatrists and psychologists in the job. You have to rely on your primary care people to provide appropriate level of mental health care as part of their full service care to their patients.

When I was a practicing internist, that was part of my job, to evaluate my patient for mental health, and if I didn't think or by the guidelines I was using if that was inappropriate for me to do it, they needed more advanced, then I would refer them on, but you can't treat the full patient without assessing the mental health as well, but again it is hard to get people to admit that they have got problems and we go back to the stigma. The particular issue with mental health is that if the individual doesn't recognize that they have a problem, it's particularly challenging to treat them because if they keep denying the problem it is hard to force people to get help.

THE CHAIRMAN. Dr. Kussman, I think we are going to have to come back and maybe do it for another day, and that is I want you to, I am going to ask of you to become intimate with the IG report, because trying to separate out of all of this -- as soldiers and as we are matriculated into a system, a value system, an ethos -- we don't understand how some would then try to seek to use the system and do fraudulent claims and we don't like to talk about that.

It's sort of like the big elephant in the room that everyone wants to ignore that there would actually be someone who would deface that value and then try to file fraudulent claims, and the IG has identified a practice going on out there and websites, and here is how you file your claims and if you get denied in this particular region, then start forum shopping.

And we have this huge mushroom, an explosion now, of claimants, and what we want to do is make sure that we take care of people who particularly need it, right? There is a challenge that we are confronting here, are we not?

DR. KUSSMAN. If I could comment --

THE CHAIRMAN. Yes.

DR. KUSSMAN. -- because you asked for that in your opening remarks. Obviously, as you quoted, it is a delicate issue and we are truly sensitive and aware of that problem. It is a combined VA/VBA/VHA issue of benefits as well as making the diagnosis.

As you know, the Secretary is acutely aware of this, but we are not unique, by the way, in our interaction with our fellow countries that practice medicine and provide benefits like we do. The Brits, the Canadians, the Aussies and the New Zealanders are actually seeing the same type of problem exploding with a lot of benefits, particularly mental health benefits, and they are struggling the same way that we are.

The Secretary has charged us to look at that critically and make some recommendations to him and that is what we are starting to do, sir.

THE CHAIRMAN. When someone receives a 100 percent disability rating for PTSD, can't they continue to receive treatment and get better, so the disability rating could actually go down?

DR. KUSSMAN. Yes, sir.

THE CHAIRMAN. The system doesn't prevent --

DR. KUSSMAN. Oh, no, sir, it doesn't prevent them from doing it. We encourage them. I mean obviously if somebody has a 100 percent disability for any kind of mental health thing, we would presume that ongoing therapy would be a good thing and that they drop out of service. Obviously we can't admit -- I mean impact on the course of their events.

THE CHAIRMAN. Once they get their check, and they get their 100 percent disability rating, and now they drop out of treatment, they have achieved a particular goal.

DR. KUSSMAN. You could, sir, suggest that there are perverse incentives here.

THE CHAIRMAN. Well, that is what the IG report is indicating with this explosion. It is something we need to look at.

DR. KUSSMAN. Yes, sir, we are.

THE CHAIRMAN. Let me ask this one to professionals, and I'm sure that is the other panel.

Is there a reluctance among the practice of psychiatry to really give that second opinion about someone else's diagnosis or not? Is it pretty free-flowing?

DR. KUSSMAN. I don't think so, but I will turn to my psychiatrist here.

THE CHAIRMAN. I am just curious.

DR. SHELHORSE. Not to my knowledge. I, in fact, did these exams for many, many years and we had many remands where we had second opinions or even third opinions. A panel would be required. They

were quite common. No reluctance, no hesitation to give a second opinion even if it was a different opinion than the original examiner.

THE CHAIRMAN. Okay. Well, that's good.

Well, please convey my earlier remarks to Dr. Winkenwerder. I mean the reason I came up with pre- and post- deployments was from the lessons learned coming out of the Gulf War and the synergies of my service on the Armed Services Committee and here, and so we put a lot of people through these, and then if that data is not being referred on to the VA, then we've got problems, so I just want you to know that it is very bothersome to me that this is continuing to occur.

I want to thank you for your work that you are doing out there and continue to remain vigilant. And this hearing is now concluded. Thank you.

[Whereupon, at 1:57 p.m., the Committee adjourned.]

APPENDIX

STATEMENT OF LANE EVANS RANKING DEMOCRATIC MEMBER HOUSE COMMITTEE ON VETERANS' AFFAIRS

HEARING ON POST-TRAUMATIC STRESS DISORDER JULY 27, 2005

Thank you, Chairman Buyer for holding this hearing. I am anxious to hear from our witnesses today, and hope that we can move forward expeditiously on legislation to ensure that the Departments of Veterans Affairs (VA) and Defense (DoD) are taking comprehensive steps to address the mental health needs of returning service personnel and veterans.

As many of you know, I am a veteran of the Vietnam-era and I have a long-standing concern about Post-traumatic Stress Disorder (PTSD) based on the experiences of so many of my peers from that time. As a freshman Congressman, one of my first orders of business was to introduce legislation to extend Vietnam veterans' eligibility for readjustment counseling services and to require VA to carry out a study of the prevalence of PTSD among Vietnam-era veterans.

Since that time, we have learned that we must continually: work to ensure that DoD and VA have the information they need to understand the magnitude and severity of this disability and what risk factors are associated with developing it, in order to intervene as early as possible; understand what treatments and therapies are most effective in dealing with PTSD; and, develop tools to demonstrate the adequacy of the continuum of services for addressing veterans' needs.

I want to thank Mrs. Stefanie Pelkey for her service to our country in the Army Reserves and for her husband Michael's honorable service. I thank her for her courage in coming here to tell her husband's -- and her -- story. She is correct - the war does not always end when our soldiers come home.

The tragedy of the Pelkey family is a prism by which we can see weaknesses in both VA's and DoD's approaches to helping returning service personnel and their families with any mental health problems.

We are a nation at war, and we must recognize that service men and women can sustain injuries to their bodies *and* their minds. Unrecognized and untreated PTSD can lead to a numbing of the heart, an abandonment of home and family, the inability to trust, work and feel safe.

VA and DoD need to educate servicemembers and veterans on the readjustment problems they might experience. It is also important to make sure families know what is typical and how to recognize symptoms associated with PTSD. Early outreach, identification, intervention and treatment are essential if we are to help returning soldiers and veterans make the journey home from combat. In establishing an early intervention program we must build the capacity for prevention. But when prevention falters, we must have the capacity to help veterans recover.

Many veterans will see their primary care providers for physical symptoms of PTSD. Recent research shows that primary care clinics at VA hospitals are failing to recognize PTSD. The study, published in the June issue of *General Hospital Psychiatry*, found that VA primary care clinics recognized less than half (46.5%) of the PTSD cases identified by the researchers, who used the gold standard in diagnostics for PTSD. The lead investigator, Dr. Kathryn M. Magruder, said, "What the research really shows is the need for a more structured approach to identifying veterans suffering from PTSD."

For both VA and DoD, the primary care program is becoming the de facto mental health care system. Given that the prevalence of PTSD for the general population is lower than for veterans, we have significant challenges to make sure that no matter how veterans receive their care, their providers are knowledgeable about PTSD diagnosis and treatment.

CPT Pelkey's story reminds us of the urgency to act and the potential for tragedy if we fail to act. We cannot sit and wait. We must ensure that VA and DoD have the capacity to care for those PTSD and all mental health problems.

While I am pleased that VA and DoD have taken steps to identify and help those in uniform and veterans with mental health care needs, more must be done.

My bill, H.R. 1588, the Comprehensive Assistance for Veterans Exposed to Traumatic Stressors Act of 2005," offers a comprehensive approach to addressing the mental health needs of servicemembers exposed to combat, including those members of our Armed Forces now serving in Iraq and Afghanistan. My bill directs VA and DoD to engage in a variety of activities from the frontlines to the bedside to ensure that our veterans and servicemembers are provided with access to the specialized mental health care they deserve.

Mr. Chairman, again, I thank you for holding this hearing. I look forward to hearing the testimony of our witnesses. I hope that we can soon move on my legislation.

**STATEMENT OF THE
HONORABLE VIC SNYDER**

HOUSE COMMITTEE ON VETERANS' AFFAIRS

MENTAL HEALTH

July 27, 2005

Thank you, Mr. Chairman. Let me join you in welcoming all of our witnesses on each panel, and in particular, I want to thank Mrs. Stefanie Pelkey for being here. She has made a tremendous sacrifice to share her story with us, but I believe that her presence here today will send a strong signal to our men and women in uniform that mental health is not something that should be taken lightly or be hidden from view.

The fact is that a majority of service members will experience some level of combat stress and trauma—while some will be able to recover relatively quickly with care and support, others may need more long term assistance. And, we must not forget that family members can also experience mental health issues, such as separation anxiety, depression, irritability and other symptoms that impact their health and relationships with a spouse, children, family and friends.

I and many of my colleagues here in Congress are very concerned that the Services have the programs and resources necessary to support the mental health needs of service members and their families. While combat related mental health concerns have been noted throughout history, recognition of combat stress has been documented and researched over the years and various treatments alternatives have been implemented.

The Services have made significant improvements to recognize and treat mental health issues. However, a recent report found that only 40 percent of soldiers with mental health problems reported receiving professional help during deployment. That means that 60 percent are not receiving the help that they may need. I know that we can and must do better for our service members.

I am not surprised that the team found that stigma remains an issue for seeking care in the system. This problem is not necessarily a military problem, mental health care and treatment remains a sensitive subject in our society, and the problem is exacerbated in the military because many believe that seeking help could end a military career. While society is slowly changing its perception of mental health, our military leaders have the ability to tackle this issue head on and make mental health care a priority that is an integral factor to military readiness. Athletes are often

told to get their head in game when they are competing. The same has even greater meaning for soldiers, sailors, airmen and Marines on a battlefield—if you are not able to focus on the mission—not only could the mission fail, it can get people get killed.

I look forward to hearing from our service members on their experiences in seeking care, and in particular, any concerns they may have on obstacles they found while seeking mental health services. I am also interested in what efforts the Services are taking to remove such barriers and increase access to care. The ongoing military operations in Iraq and Afghanistan do not seem to be subsiding. In fact, the President has indicated that the war on terror may last for many years into the future, Congress has the responsibility to ensure that we not only provide service members the necessary equipment and training that they need to go to war, but we need to ensure that we are also addressing their mental and physical health as well. And, we need to ensure that once they leave the Armed Forces, that support and care is there for them and their families if they are needed.

I want to thank all of our witnesses. Their participation is important and beneficial as we look to the future in meeting the mental health care needs of our military. Working together we can ensure that our men and women in uniform receive the quality health care that they deserve.

Congress of the United States
House of Representatives
Washington, DC 20515-1902

Statement of Congressman Michael Michaud
Ranking Democratic Member
House Committee on Veterans' Affairs Health Subcommittee
Hearing on Post-Traumatic Stress Disorder
July 27, 2005

Thank you Chairman Buyer and Ranking Member Evans for holding this hearing. I believe that this is an extremely important hearing given what we are doing in Iraq and Afghanistan and the types of challenges our military personnel face.

As Mrs. Pelkey's testimony so painfully illustrates, the cost of war is not only paid on the battlefield. It is also paid by our military personnel and their families when they come home. I would like to thank Mrs. Pelkey for her courage and for sharing her story with us.

What soldiers experience in the field will stay with them for the rest of their lives. They should not be left to deal with these challenges alone. It is the responsibility of the Department of Defense, the VA and this Congress to ensure that they have access to whatever care they need.

I am particularly interested in what efforts are being made to address PTSD suffered by our Guard and Reserves who are carrying much of the load in Operation Iraqi Freedom and Operation Enduring Freedom. My state of Maine has had one of the highest percentage activation rates in the country.

We are now seeing many of these soldiers — approximately 21% according to the VA in Maine, which I understand to be about the national average — come home and seek care for PTSD or another mental health problem.

In a large rural state like mine, it is difficult for Guards or Reservists or their families to easily access this type of care. While I believe that the VA in my state is reaching out to these soldiers and their families, I know that we can do more, and I believe that begins with Washington sharing information and providing the tools needed by care providers in the field.

How well are DOD and VA sharing information?

How well are the symptoms of PTSD or other mental health issues, including substance abuse being recognized by health care providers? I believe that we still have many unanswered questions like these when it comes to effectively recognizing and treating PTSD.

I also believe that it is time for this Congress to examine legislation like H.R. 1588, introduced by Mr. Evans, so that we can institute a comprehensive plan to tackle this problem.

I look forward to hearing from our witnesses today. I would especially like to thank Mrs. Stefanie Pelkey for sharing her very personal story with us.

Thank you Mr. Chairman.

Statement of Stefanie E. Pelkey

before the

Committee on Veterans Affairs

House of Representatives

27 July 2005

My name is Stefanie Pelkey and I am a former Captain in the U.S. Army. This testimony is on behalf of my husband, CPT Michael Jon Pelkey, who died on November 5, 2004. Although he was a brave veteran of Operation Iraqi Freedom, he did not die in battle, at least not in Iraq. He died in a battle of his heart and mind. He passed away in our home at Fort Sill, Oklahoma from a gunshot wound to the chest. My Michael was diagnosed with Post Traumatic Stress Disorder (PTSD) only one week before his death by a licensed therapist authorized by Tricare.

The official ruling by the Department of Defense is suicide, however, many people, including myself, believe it was a horrible accident. We also believe that he would not have been sleeping with a loaded pistol if it weren't for the PTSD.

When I met my husband, we were both officers in a Field Artillery unit in Idar-Oberstein, Germany. Michael was working as the assistant Operations Officer for the unit. He was responsible and hard-working. He loved life, traveling, and having fun. He hailed from Wolcott, Connecticut and was one of six siblings. He received his commission from the University of Connecticut. Being a soldier was a childhood dream.

We were married in November 2001 and our journey as a military family began. Michael deployed for Iraq with the 1st Armored Division in March 2003, three weeks after our son, Benjamin, was born. He left a happy and proud father. He returned in late July of 2003. It seemed upon his return that our family was complete and we had made it through our first real world deployment.

Aside from his lack of appetite and a brief adjustment period, he seemed so happy to be home.

He noted several concerns on his DD Form 2796, post-deployment health assessment, to include diarrhea, frequent indigestion, ringing in the ears, feeling tired after sleeping, headaches, and strange rashes. He also noted on this form that he had felt that he was in great danger of being killed while in Iraq and he witnessed the killings of dead coalition and civilians during this time. However, the most worrisome notation on this form was the admission of feeling down, depressed, and sometimes hopeless. He also noted that he was constantly on guard, and easily startled after returning from his deployment

A few days after returning to Germany, he reported to his primary care physician on July 28, 2003, as a part of a post-deployment health assessment. He expressed concerns to his primary care physician that he was worried about having serious conflicts with his spouse and close friends. The physician referred him to see a counselor, however, the mental health staff on our post was severely understaffed with only one or two psychiatrists. Michael was unable to get an appointment before we moved from our post in Germany to Fort Sill, Oklahoma only five days later.

There was no time for therapy and doctors' visits, as we were packing our home and taking care of our then six-month-old son. When we got to Fort Sill, we both settled into our assignments. Everything seemed normal for a while. Michael was in the Officers Advanced Course for Field Artillery and I was a Chemical Officer for a Brigade. We settled into our home and about six months later, the symptoms of PTSD started to surface, only, we did not know enough about PTSD to connect the dots.

When my husband returned from Iraq, there were no debriefings for family members, service members, or forced evaluations from Army Mental Health in Germany. As a soldier and wife, I never received any preparation on what to

expect upon my husband's return. If only the military community had reached out to family members in some manner to prepare them for and make them aware of the symptoms of PTSD, my family's tragedy could have been averted. I believe that it is crucial that spouses be informed about the symptoms and make a point in telling them that PTSD can happen long after what psychiatrists call an adjustment period. Spouses are sometimes the only ones who will encourage a soldier to seek help. Most soldiers I know will not willingly seek help at any military mental facility for fear of repercussions from commanders and even jibes from fellow soldiers. My husband worked around many high ranking officers and was most likely embarrassed about seeking help. What would they think of an officer having nightmares, being forgetful, and having to take anti-depressants?

Months after arriving in Oklahoma, there were several instances in which I found a fully loaded 9mm pistol under Michael's pillow or under his side of the bed. I would yell at him and tell him that the baby could find it and get hurt. Then I would find it under the mattress or in his nightstand. I could not seem to get through to him that having this weapon was not necessary and it posed a danger. These episodes alone started to cause marital tension. Finally, after about two months of haggling over the issue of this weapon, Michael finally agreed to put his pistols away. I thought the situation was resolved. As a soldier myself, I could understand that having a weapon after being in a war might be somewhat habitual for him. Little by little, other symptoms started to arise, including forgetfulness. Michael would not even remember to mail a bill or pick-up his own prescriptions. This became a great problem for him. How could a Captain in the US Army forget to mail bills and miss appointments? He was not like this before his deployment. One of the greatest tests PTSD posed to our marriage was that Michael began to suffer from erectile dysfunction, which would cause him to break into tears. He did not understand what was happening. I did not know what was happening.

On other occasions, he would over-react to simple things. One night, we heard something in the garage around 8 pm. It was still fairly light outside and it

could have simply been a child or an animal. We lived in a small town with very little crime. Michael proceeded to run outside with a fully loaded weapon and almost fired at a neighbor's cat. These over-reactions occurred on several occasions.

The symptoms would come and go to a point that they didn't seem like a problem at the time. We would later laugh about them and make jokes about the little scares we had. He would always make excuses and tell me that we needed to be careful, so I let it go. There were times that everything seemed just right in our home and he seemed capable enough. He was succeeding in his career as the only Captain in a research and development unit at Fort Sill. It was a job in which he was entrusted with researching and contributing to the Army's latest in targeting developments.

We soon bought a new house and he was so proud of it. We were finally getting settled. Then the high-blood pressure and severe chest pains surfaced along with erectile dysfunction. Finally, the nightmares began. This would be the last symptom of PTSD to arise and it was the one symptom that I feel ultimately contributed to my husband's death. These nightmares were so disturbing that Michael would sometimes kick me in his sleep or wake up running to turn on the lights. He would wake up covered in sweat and I would hold him until he went back to sleep. He was almost child-like in these moments. In the morning, he would joke around and tell me the boogie man was going to get him and sadly, we both laughed it off.

However, at this time, I do want to point out that Michael was seeking help for all of the symptoms I have discussed. He was put on high blood pressure medication. He also complained of chest pains and was seen on three occasions in the month preceding his death. He even sought a prescription for Viagra to ease marital tensions. However, no military physician Michael ever saw could give him any answers. No doctor ever asked him about depression or linked his symptoms to the war.

Michael tried to seek help from the Fort Sill Mental Health facility but, was discouraged that the appointments he was given were sometimes a month away. So, he called Tricare and was told that he could receive outside therapy, if it was "Family Therapy" so, we took it. Family therapy, marital counseling, or whatever they wanted to call it, we were desperate to save our marriage. After all, the symptoms of PTSD were causing most of our heartaches. In the two weeks prior to his death, we saw a therapist authorized by Tricare as a couple and individually. This therapist told Michael that he had PTSD and that she would recommend to his primary care physician that he be put on medication. She also told him that she had a method of treating PTSD and she felt she could help him because he was open to receiving help. He was so excited and finally expressed to me that he could see a light at the end of the tunnel. He finally had an answer to all of his problems and some of our marital troubles. It was an exciting day for us. Not to mention, two weeks before his death, he interviewed for a position in which he would be running the staff of a General Officer. He was so proud that he was given the job after speaking with the General for only fifteen minutes. He was beaming with pride and so excited about his new job. Things were looking up for him.

He met with the therapist on a Monday. Tuesday, we celebrated our third wedding anniversary. It was a happy time. I felt hope and relief with the recent positive events. Michael must have felt something else. Friday my parents were visiting. I was at a church function and my father returned from playing golf to find Michael. He looked as if he were sleeping peacefully, except for the wet spot on his chest. His pain was finally over and his battle with PTSD was won. No, he wasn't in Iraq but, in his mind he was there day in and day out. Although Michael would never discuss the details of his experiences in Iraq, I know he saw casualties, children suffering, dead civilians, and soldiers perish. For my soft-hearted Michael, that was enough. Every man's heart is different. For my Michael it may not have taken much, but, it changed his heart and mind forever.

There were no indications of suicide but, plenty of signs to indicate PTSD. He suffered greatly from the classic symptoms of PTSD. It's plain to see in retrospect. His weapon became a great source of comfort for him. He endured sleepless nights due to nightmares and images of suffering that only Michael knew.

My husband served the Army and his country with honor. He was a hard worker, wonderful husband and father. He leaves behind a 28-month-old son, Benjamin. One day I would like to tell my son what a hero his father was. He went to war and came back with an illness. Although PTSD is evident in his medical records and in my experiences with Michael, the Army has chosen to rule Michael's death a suicide without documenting this serious illness. I have been told by the investigator that any PTSD diagnosis must be documented by an Army Mental Health Psychiatrist to be considered valid. At the time Michael sought help, he knew it was an urgent matter and was not willing to wait a month or even a few days. He knew it was time. Michael sought the help Tricare offered us and took it. Due to the fact that we were in family therapy and the fact that it was coded as family therapy, Michael is not going to get the credit he deserves. He is a casualty of war. I have heard this spoken from the mouths of two Generals. He came home from war with an injured mind and to let him become just a "suicide" is an injustice to someone who served their country so bravely. He loved being a soldier and he put his heart into it. I will be submitting petitions to have the PTSD officially documented and to have my husband put on the Official Operation Iraqi Freedom Casualty of War list. There are many soldiers who have committed suicide due to PTSD in Iraq and received full honors and benefits. Army Master Sergeant James C. Coons of Katy, Texas committed suicide and was found dead in his room at a hotel for outpatients being treated at Walter Reed Army Medical. Although Coons died outside a combat zone, his family's petition to have him counted as a casualty of combat was approved. Michael deserves the same honors.

There are so many soldiers suffering from this disorder and so many families suffering the aftermath. I don't want my Michael to have died in vain. He had a purpose in this life and that was to watch over his soldiers. I intend to keep helping him do so by spreading our story.

My husband died of wounds sustained in battle. That is the bottom line. The war does not end when they come home.

Biography of Stefanie Pelkey

Stefanie Pelkey was born in Houston, Texas and raised in Spring, Texas. She graduated from Spring High School in 1994. As a teenager she was always interested in the military and was a member of the Civil Air Patrol, an organization affiliated with the Air Force.

She graduated with an Associates Degree from New Mexico Military Institute in Roswell, NM in 1996. She went on to graduate and receive her commission as a 2nd Lieutenant from New Mexico State University in Las Cruces, NM.

She started her Military career at Fort Leonardwood, MO at the Chemical Officers Basic Course. After graduating from the Officers Basic Course she received her first assignment as the Battalion Chemical Officer for 1st of the 94th Field Artillery Battalion in Idar-Oberstien, Germany. This was a Multiple Launch Rocket Systems (MLRS) unit. This assignment was challenging for her as she was the first female to serve in this Field Artillery Battalion and one of the first three females in Germany to ever be placed in an all-male combat arms unit.

She met her husband Michael in 1-94 FA. They were married on November 2, 2001. Their son Benjamin was born on March 15, 2003 in Germany.

Her second assignment was as the Brigade Chemical Officer for 75th Field Artillery Brigade at Fort Sill, OK. She left the Army (ETS) and ended her time of service in September 2004. Michael died on November 5, 2004.

STATEMENT BY

COLONEL CHARLES W. HOGE, M.D., UNITED STATES ARMY
CHIEF OF PSYCHIATRY AND BEHAVIOR SERVICES
WALTER REED ARMY INSTITUTE OF RESEARCH

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH

FIRST SESSION, 109TH CONGRESS

MENTAL HEALTH SERVICES

27 JULY 2005

NOT FOR PUBLICATION

UNTIL RELEASED BY THE

COMMITTEE ON VETERANS' AFFAIRS

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.

STATEMENT BY

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UNITED STATES HOUSE OF REPRESENTATIVES
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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 meprobamate 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.

**Testimony for
United States House of Representatives
House Veterans' Affairs Committee
Subcommittee on Health
July 27, 2005**

**Matthew J. Friedman M.D., Ph.D.
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My name is Matthew J. Friedman, MD, PhD. Since 1989 I have been Executive Director of the VA's National Center for Post-Traumatic Stress Disorder (NCPTSD). The Center consists of seven divisions, located at VA facilities extending from Boston to Honolulu which are dedicated to advancing research and education on the causes and treatment of PTSD and related disorders among veterans exposed to warzone-related PTSD. I have also been Professor of Psychiatry and Pharmacology & Toxicology at Dartmouth Medical School since 1988. I have worked to provide and improve VA treatment, research, and education for veterans with PTSD since 1973.

In 1984, while serving as Chief of Psychiatry at the VA Medical and Regional Office in White River Junction, VT, I was appointed Chairman of the Chief Medical Director's Special Committee on PTSD. This Congressionally mandated committee was charged to report to congress about VA's capacity: 1) to provide treatment for veterans with PTSD; 2) to support research on scientific questions concerning the etiology, clinical course and treatment of PTSD; 3) to provide education and training to VA professionals in order to improve their clinical skills regarding PTSD-related problems; and 4) to adjudicate PTSD disability claims in a timely manner. I served for 5 years (from 1984-1989) as Chairman of the Special Committee which submitted annual reports to congress concerning the status of VA PTSD programmatic capacity. Since 1989, when I was appointed Executive Director of the National Center for PTSD, my focus has primarily been on research and education. In short, I have been treating veterans with PTSD for 32 years, and have had a national perspective on VA's clinical, research, and educational programs for 21 years.

The Committee has requested my testimony on a number of topics: [1] an overview of PTSD with respect to etiology, epidemiology, diagnosis, functional limitations, its impact on families and available treatments; [2] comparisons between PTSD among Vietnam as compared to OIF/OEF veterans; [3] treatment issues from the perspective of VA practitioners (others are better suited to comment on treatment issues from a VA system perspective; [4] my current concerns about the clinical needs of OIF/returnees; and [5] collaborative research and educational initiatives between NCPTSD and DoD. Given time limits, I will address each topic briefly but will be happy to elaborate during the question period.

I. Overview on PTSD

In the interest of time, I have appended to this testimony a brief overview of PTSD, which is available on the National Center's website, www.ncptsd.va.gov (Attachment 1). Briefly, PTSD occurs when an individual has been exposed to an overwhelming stressor (such as warzone trauma, sexual/or physical assault, a terrorist attack, or a natural disaster) involving actual or threatened death or injury, or a threat to the physical integrity of him/herself or others. During such traumatic exposure, the survivor has had an intense emotional response such as fear, helplessness or horror.

I'd like to emphasize that most people exposed to such events do not develop PTSD. Most will cope with the traumatic event(s) successfully without any psychological problems. Others will exhibit behavioral or emotional difficulties for a brief time from which they recover completely. These are Adjustment Reactions. However, a significant minority of survivors may develop PTSD. Among Vietnam veterans, for example, 30% of male and 26% of female veterans developed PTSD at some point following service in Southeast Asia. PTSD prevalence was lower, approximately 10%, following the Gulf War, and 8% following the Somalia deployment. Colonel Hoge is currently monitoring PTSD prevalence among OIF/OEF veterans. It will not be clear for some time how much PTSD will be related to current deployments to Iraq and Afghanistan. As I have noted in a recent editorial in the *New England Journal of Medicine* (Attachment 2), it is too early to project the eventual magnitude of PTSD prevalence that will emerge among OIF/OEF returnees.

People with PTSD exhibit three different types of symptoms.

1. Re-experiencing Symptoms represent symptoms in which the traumatic experience remains a dominating psychological event, sometimes lasting decades or a lifetime. Intolerable traumatic memories provoke panic, terror, dread, grief or despair as daytime recollections, traumatic nightmares or PTSD flashbacks.
2. Avoidant/Numbing Symptoms represent behavioral or cognitive strategies by which the person with PTSD attempts to ward off

such traumatic memories. These include avoidance of thoughts and activities that might provoke reexperiencing symptoms or an emotional shutdown, “psychic numbing,” through which PTSD patients attempt to control the intolerable emotions associated with such memories.

3. **Hyperarousal Symptoms** include insomnia, irritability, inability to concentrate, excessive jumpiness known as the startle reaction, and hypervigilance in which PTSD patients are constantly concerned about personal safety.

To qualify for a PTSD diagnosis, individuals must exhibit these symptoms for at least one month and must be significantly distressed or functionally incapacitated by the aforementioned re-experiencing, avoidant/numbing and hyperarousal symptoms. Domains in which such functional incapacity may be expressed include marital, family, social, or occupational function. It is clear that marriages and family well-being are frequent casualties in households where one member has PTSD. This is why outreach to families will be such an important component of any efforts to help OIF/OEF returnees with PTSD.

Finally, it should be noted that PTSD rarely occurs alone. It is often accompanied by other psychiatric disorders, especially depression, other anxiety disorders, and alcohol/substance abuse. We all believe that early detection and treatment is the best way to prevent the development of such co-morbid conditions. Early detection and treatment is also the best way to prevent treatable PTSD from escalating into a chronic and permanently incapacitating state that may last for decades or a lifetime. Finally, recent research indicates that PTSD is a risk factor for comorbid medical as well as psychiatric illnesses. This is why primary and specialty medical practitioners need to screen for PTSD in their clinics since many PTSD patients seek medical rather than mental health care when they become symptomatic.

II. Comparisons between Vietnam vs. OIF/OEF veterans with PTSD

Current research findings suggest that among people who develop PTSD, the syndrome looks the same no matter what the cause. This statement does not merely apply to veterans of different wars but to people who develop PTSD as a result of rape, assault, torture, traffic accidents, and natural disasters. It is not simply the pattern of symptoms or functional impairment that appears similar from one PTSD patient to the next; there are significant biological and psychological alterations, as well. Research involving brain imaging shows that people with PTSD exhibit similar abnormalities in brain structure and brain functioning. Psychophysiological reactivity is altered. Hormonal balance is changed. Cognitive processing and memory function are altered. The capacity to

cope with every day stressors is compromised. And marital, family, and social functioning is adversely affected, as noted previously.

As I've stated in a the *New England Journal of Medicine* (Attachment 3), the biggest differences between the post-Vietnam and current era concern the American public's support for its veterans and the advances in PTSD diagnosis and treatment since the 1970's. As for public reaction, OIF/OEF veterans are returning to a nation that recognizes their heroism and sacrifice. Despite deep political divisions about national policy concerning the current conflicts, Americans remain united in supporting veterans. This is crucial since the homecoming is a decisive event for any veteran and returning to a supportive nation can facilitate readjustment to civilian life. Unfortunately, most Vietnam veterans returned to a divided, if not hostile, public. Such an adverse homecoming appears to have exacerbated PTSD in many cases.

III. Treatment Issues

There has been great progress in the treatment of PTSD. Whereas there were no evidence-based treatments for returning Vietnam veterans with PTSD, we now have treatments that work. The recently developed joint VA/DoD clinical practice guidelines for PTSD (www.oqp.med.va.gov/cpg/ptsd/ptsd_base.htm) to provide state-of-the-art guidance for any practitioner wishing to provide optimal treatment for patients with PTSD. There are both psychotherapeutic and pharmacological evidence-based options available for practitioners. A number of cognitive-behavioral therapies (CBT), Prolonged Exposure, and Cognitive Processing Therapy, have met the most rigorous scientific criteria for efficacy. Other psychotherapeutic techniques are also being tested. Two medications, sertraline and paroxetine, both SSRI antidepressants, have received FDA approval as indicated treatments for PTSD. A number of other promising medications are at various levels of testing. In other words, VA and DoD practitioners have a number of effective treatments available at this time while several other treatments are in the pipeline.

Finally, VA has initiated a Best Practice initiative to ensure that veterans receive the best evidence-based treatments. I am please to tell you that PTSD has been selected as the first disorder to be addressed by this initiative. This should accelerate the pace at which VA clinicians can upgrade their skills in order to provide state-of-the-art PTSD treatment.

Other important advances (cited in my March 11, 2004 testimony before this Committee) include: [1] state-of-the-art assessment and diagnostic capability; [2] the sophistication and motivation of VA practitioners; [3] the availability of PTSD training programs, mentoring and web-based materials for VA practitioners; [4] the Iraq War Clinician Guide developed jointly by

the National Center for PTSD and Walter Reed Army Medical Center (available on our website www.ncptsd.va.gov and as a CD-ROM); [5] development of the aforementioned VA/DoD clinical practice guidelines; and [6] a number of exciting collaborative projects between VA and DoD regarding OIF/OEF returnees.

I'd like to emphasize, at this point, that VA has maintained its position as the world leader in PTSD. It is only because of ongoing VA support for PTSD clinical programs, research, education, and for centers of excellence such as the MIRECCs and the National Center for PTSD that we have been able to continue to make such progress in this field.

IV. My current concerns about meeting the needs of OIF/OEF returnees with PTSD

As a longtime VA practitioner, it is heartening to observe the joint VA/DoD efforts to make PTSD services available to OIF/OEF returnees and to make every effort to make sure that people don't fall into the cracks. I have a number of concerns, some of which are elaborated in my two *New England Journal of Medicine* editorials (Attachments 2 and 3) or were mentioned during my March 11, 2004 testimony before this Committee:

1. As noted by Col. Hoge's data, stigma appears to be a major barrier to seeking treatment among military personnel. Furthermore, those who are most severely affected are those who are least likely to seek help. This is especially unfortunate, in view of our current ability to provide effective treatments for veterans, if we can just get them into our offices. I believe that stigma will also adversely affect requests for VA treatment among OIF/OEF returnees but not to the extent it is affecting active duty personnel. A number of potential strategies are currently being considered to counteract the impact of stigma, such as: integrated primary/behavioral health clinics, patient and family education, outreach, sensitizing primary care practitioners to screening for PTSD, and strategic use of technology such as telemedicine and web-based information. It is encouraging that both VA and DoD have begun to implement a number of these approaches, especially periodic PTSD screening in VA primary care settings, but all of these initiatives are at an early stage.
2. There is great concern that active duty OIF/OEF returnees will not avail themselves of VA follow-up once they have left military service. There is even greater concern that National Guard and Military Reserve personnel will neither seek VA treatment when symptomatic nor will even be aware of their eligibility for VA services. Data from the Gulf War indicate that PTSD prevalence is higher among Guard and Reserve than among active duty troops, so we consider them a major priority for outreach and follow-up, when indicated. One important advantage that DoD practitioners

have over their VA counterparts is the availability of services for military families. Given the importance of family involvement in PTSD treatment, it would be very helpful if VA practitioners had similar clinical options. At present, only the Vet Centers have this flexibility.

3. **Military sexual trauma** is recognized by VA as one cause of PTSD among men and women. The stigma of such trauma is compounded by peer pressure, unreceptive leadership, or fear of jeopardizing one's career. This can only be overcome if safety and confidentiality can be ensured for victims who wish to disclose such events and if timely treatment can be provided.
4. An unprecedented number of wounded troops - 90% - are surviving their injuries, sometimes with loss of limb(s), eyesight, or other long-lasting medical problems. Veterans with war injuries rank among those at highest risk for PTSD and should be among those with the highest priority for consistent follow-up care.
5. Efforts to support VA clinicians through provision of adequate resources and, when necessary, to upgrade their skills must remain a major priority. The key to VA's pre-eminence in PTSD is the sophistication of its clinicians and the spectrum of treatment options extending from Vet Centers, to community based outpatient clinics, to primary care clinics, to mental health services, to specialized PTSD outpatient and inpatient programs. Since the post-Vietnam era, VA has developed the best, most extensive and most sophisticated spectrum of clinical programs for PTSD in the world. It must be sustained and fortified to meet the new demand from OIF/OEF returnees.
6. A new challenge for many VA clinicians is the acuteness of symptoms among veterans with adjustment reactions or PTSD. During the post-Vietnam era, most veterans with PTSD were much older and had much more chronic PTSD before they sought or received VA treatment. With the vast improvement in VA/DoD collaboration, an increasing number of OIF/OEF returnees are requesting care at a much earlier stage in their post-traumatic clinical course. This is an important challenge that can be met with a large-scale system-wide training program to address this matter. I am pleased to report that a joint VA/DoD initiative has been set in motion for this purpose.

V. Collaborative Research and Educational Initiatives between NCPTSD and DoD

There are many ongoing collaborative activities between the National Center for PTSD and different DoD components. They fall into three categories. I will list some major initiatives.

1. **Gathering the best information available and disseminating it to as many clinicians at as many locations as quickly as possible.** This was accomplished by development of the **Iraq War Clinician Guide** in collaboration with Walter Reed Army Medical Center (available on our website www.ncptsd.va.gov or as a CD-ROM). The Guide covers general topics such as psychiatric treatment of military personnel, assessment guidelines concerning OIF/OEF returnees and a chapter on treatment. Special topics include: treatment of medical casualty evacuees, treatment of amputees, treatment in the primary care setting, military sexual trauma, traumatic grief, substance abuse, family issues and caring for clinicians who treat traumatically injured patients.
2. **Training and support: consulting with active duty military personnel.** NCPTSD has responded to requests for training on PTSD treatment from many DoD sites. At last count we were actively collaborating with 15 Army, Navy, Marine, and Air Force facilities. In addition, there has been a close working relationship between NCPTSD and the Uniformed Services University of Health Sciences (USUHS) in Bethesda, MD.
3. **Collaborative NCPTSD/DoD research**
 - a. Research on resilience has been conducted at Ft. Bragg to understand biological and social factors that distinguish troops who perform well under high stress conditions from those who do not.
 - b. The Parris Island Attrition Study has shown that Marine recruits who had been sexually or physically traumatized prior to enlistment were 1.5 times more likely to drop out of recruit training.
 - c. A project with troops deployed to Kosovo, in conjunction with Col. Hoge's staff at the Walter Reed Army Institute of Research (WRAIR) showed that Critical Incident Stress Debriefing provided no benefit with regard to PTSD, depression, well-being, and other factors. Over 1,700 troops entered the study and over 1,000 were assessed 9-10 months later. This study will be repeated with OIF troops.
 - d. A prospective pre- post-deployment assessment of PTSD has measured neuropsychological and psychological outcomes related to combat theater assessment. This study will follow over 1,500 troops deployed from Ft. Hood and Ft. Lewis. It will also follow several hundred guard and reserve troops. It is a joint effort by the US Army, VA, and VISN 16 MIRECC.
 - e. DE-STRESS, a brief internet intervention for PTSD, is currently being tested at Walter Reed Army Medical Center.
 - f. Functional brain imaging, psychophysiological, neurohormonal, and genetic assessment is being carried out on troops from Ft. Drum with and without PTSD.

- g. A medication trial is also being carried out at Ft. Drum.**
- h. Dissemination of evidence-based PTSD treatment is being provided o military mental health professionals at Wilford Hall and Lackland Air Force Base.**
- i. Integrated primary/mental health care for PTSD is being tested in a pilot project at Ft. Bragg in which Col. Engel has played a leading role.**

At this point, I would welcome any questions. On behalf of all my colleagues at the National Center for PTSD, as well as key supporters and collaborators in both VA and DoD, I thank the Committee for this opportunity to testify. I believe we have a remarkable opportunity to learn from past experience, current actions, and ongoing research to provide more help for veterans and military personnel with PTSD than has ever been possible in the past.

**Statement of
Alfonso R. Batres, Ph.D., M.S.S.W.
Chief Readjustment Counseling Officer
Veterans Health Administration
Department of Veterans Affairs
Before the
Committee on Veterans' Affairs
U. S. House of Representatives**

July 27, 2005

Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to discuss the Vet Center program of the Department of Veterans Affairs (VA) and the role it plays in providing care and services to veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

The Vet Center program is a special Veterans Health Administration (VHA) program designed to provide readjustment counseling to veterans exposed to the uniquely stressful rigors of military service in a combat theatre of operation. In terms of service mission, readjustment counseling consists of a holistic system of care that provides professional readjustment counseling to help veterans cope with and transcend the psychological traumas of war, and a number of other community-based services to help veterans improve the whole range of their post-military social, economic and family functioning. The Vet Centers are a unique complement to VA's arsenal of medical center-based PTSD programs by combining professional readjustment counseling for war trauma with family services, outreach and community coordination of care. The treatment of PTSD is a core mission of VA and of the Vet Center program.

The law authorizes the Vet Centers to provide services to veterans' family members as a core component of readjustment counseling. Veterans' family members are eligible for care at Vet Centers and are included in the counseling process as necessary to address the whole range of adjustment issues stemming from the veterans' military experience and/or post-deployment homecoming readjustment. Specifically tailored in every community to meet the specific needs of the local veteran population, the Vet Centers promote early intervention to help veterans stabilize post-deployment readjustment problems and family relations through community outreach, education, preventive health care information and extensive case coordination and referral activities.

In terms of facilities, VA's Vet Center program consists of 207 community-based Vet Centers nation-wide, operating in the community outside of the larger medical facilities, in easily accessible, consumer-oriented facilities. Vet Centers are staffed by small multidisciplinary teams that are highly responsive to the needs of the local veterans. By original intent the Vet Centers were designed to promote veterans helping veterans. Nationally, a majority of Vet Center service providers are themselves veterans, most of whom served in a combat theater of operations. Vet Centers also tailor services delivered to meet the specific cultural and psychological needs of the veteran populations they are serving by promoting representative diversity among the staff. Also, every Vet Center has at least one VHA qualified mental health professional on staff. Over 60 percent of all Vet Center service providers are licensed mental health professionals. The Vet Center program reports the highest level of veteran satisfaction recorded for any VA program. For the last six years, over 99 percent of veterans using the Vet Centers consistently reported being satisfied with services received and responded that they would recommend the Vet Center to other veterans.

VA's authority to provide readjustment counseling to eligible veterans was established by law in 1979 to alleviate the specific psychological symptoms and social readjustment problems that arose from veterans' traumatic combat

experiences in Vietnam. Today, in the anniversary of the program's 25th year, the Vet Centers are providing outreach and readjustment counseling to all veterans that served during any war or in an area during a period of armed hostility. Since the inception of this authority in 1979, the Vet Center program has served over 2 million veterans, and on an annual basis the Vet Centers see approximately 130,000 veterans and provide over 1,000,000 visits to veterans and family members.

In FY 2004 the Vet Centers served 125,737 veterans and provided 1,031,765 visits to veterans and family members. For the first two quarters of FY 2005 the Vet Centers system-wide served 76,567 veterans and provided 505,901 visits to veterans and family members. A continuation of this rate of service delivery for the remainder of the year will produce 153,134 veterans served and 1,011, 802 visits provided. This represents an increase in veterans seen of 21.7%.

Following Secretarial direction in the wake of hostilities in Afghanistan and Iraq, the Vet Centers commenced in 2003 to actively outreach and extend services to the new cohort of war veterans returning from OIF and OEF. To date the Vet Centers have provided substantive services to over 20,000 veteran returnees from OEF and OIF. Given a continuation of the current rate of service delivery, the Vet Centers collectively will have served over 25,000 OEF/OIF veterans cumulative by the close of FY 2005. For FY 2005 this amounts to approximately 14,000 OEF/OIF veterans that will have been served by the end of the year. This represents approximately 9% of the projected Vet Center workload for 2005. In addition, this number represents only those veterans with a case file at the Vet Center. It does not represent a large number of OEF/OIF veterans contacted by Vet Center staff via outreach activities. A significant amount of outreach activity was not recorded because the encounters do not include sufficient substantive one-on-one interaction with Vet Center staff to enable collecting veterans' demographic data.

Vet Center OEF/OIF veteran PTSD-related cases are reconciled against VHA medical center-based information and included in the cumulative VHA report of all veterans provided with PTSD services. As reported by VHA, the Vet Centers provided services to 3,596 OEF/OIF veterans for PTSD issues from 2003 through the end of the third quarter in FY 2005.

Following Secretarial direction in August 2003, the Vet Centers also initiated a program to provide bereavement counseling to surviving family members of Armed Forces personnel who died while on active duty in service to their country. The Vet Centers are now actively providing bereavement counseling to military family members whose loved ones were killed in Afghanistan and Iraq. Since inception of the program, over 400 cases of active duty, military-related deaths have been referred to the Vet Centers for bereavement counseling, resulting in services provided to over 600 family members. This is a new component of the Vet Center mission.

As an integral part of its defined service mission, the Vet Centers provide a unique outreach function within VHA. A primary service provided by the Vet Center program is to locate, inform, and professionally engage veterans and family members as to VA benefits and services as they return from theaters of combat operations. The Vet Center program's capacity to provide outreach to veterans returning from combat operations in OEF and OIF was augmented by VHA's Under Secretary for Health (USH) in February 2004. Specifically, the Vet Centers hired and trained a cadre of up to 50 new outreach workers from among the ranks of recently separated Global War on Terrorism (GWOT) veterans at targeted Vet Centers. Augmented Vet Center outreach is primarily for the purpose of providing information that will facilitate the early provision of VA services to returning veterans and their family members immediately upon their separation from the military. These positions are located on or near active military out-processing stations, as well as National Guard and Reserve facilities.

New GWOT veteran hires augment Vet Center services by providing briefing services to transitioning servicemen and women regarding military-related readjustment needs, as well as the complete spectrum of available VA services and benefits. Based upon the success of the initial GWOT veteran outreach program as implemented in 2004, the Under Secretary for Health authorized the hiring of an additional OEF/OIF veteran outreach workers. The Vet Centers are now engaged in hiring 50 more GWOT veteran outreach workers.

This Vet Center program initiative is of the caliber of a Best Practice Model. Veterans helping veterans is a central feature of the Vet Center program throughout its 25 years of service to homecoming war veterans. Nothing can replace the immediate rapport generated by veterans with similar military experiences. These initial outreach encounters provide the initial stage for healing and successful readjustment, as well as set the stage for a seamless transition to their home community and into local VA care. This Vet Center initiative also promotes early intervention and preventive educational activities of value to veterans and family members to help stabilize their life situations and prevent the more debilitating onset of chronic war-related PTSD.

The Vet Centers have extensive experience working with veterans to overcome negative attitudes and stigmas typical of combat veterans related to accessing professional assistance. Community outreach and other accommodations to improve access to care for veterans are essential to veterans' readjustment. This is true both from the standpoint of ensuring timely provision of services for new eras of veterans returning from combat and peace-keeping missions, as well as, for overcoming psychological and cultural barriers to care. With particular reference to socially alienated, war traumatized veterans, the "avoidance symptoms" associated with PTSD can in some cases function as a psychological barrier to care. This barrier can be diminished by using a safe and accepting therapeutic setting, allowing PTSD treatment to begin. Cultural barriers to the receipt of PTSD treatment exists in some local communities,

socio-economic groups, and ethnic groups. These barriers include traditional negative attitudes concerning the accessing of mental health services. In this regard, Vet Center counselors are especially effective in forging alliances with local veterans through outreach contacts in the community prior to initiating more formal individual and/or group counseling at the Vet Center.

Vet Center community-based outreach, preventive education and brokering of care also provides many veterans with a point of contact for access into the larger VA system health care and benefits programs. The Vet Centers make over 200,000 veteran referrals annually to VA medical centers and regional offices combined. In return the Vet Centers receive less than 50,000 of these referrals. Comprehensive analysis of Vet Center workload at the end of each fiscal year shows that approximately 30 to 40 percent of Vet Center unique clients are not seen in any other VHA facility. These veterans constitute a core group of frequent users who access care specifically for psychological trauma, to include war-related PTSD, and most Vet Center visits are devoted to this core group of veterans.

It was also the express purpose of the Vet Center program that services be readily available and accessible and that all unnecessary barriers to care be removed. Veterans are always welcome to stop by their local Vet Center at any time. Vet Center staff members are always available to welcome veterans and family members, and to provide useful information about available services. As Vet Centers have no waiting lists, veterans may be seen by a counselor the same day they stop by or call for an appointment. The Vet Centers also maintain nontraditional after-hours appointments to accommodate veterans' work schedules.

To locate their local Vet Center, veterans can consult the yellow pages, as well as the federal government listings. In both places the listing is under "Vet Center". Vet Centers are also listed in the following web site: www.va.gov/rcs.

Mr. Chairman, this concludes my statement. I will am now available to answer any questions that you or other members of the Committee may have.

TESTIMONY FOR HOUSE VETERANS AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
July 27, 2005

Terence M. Keane, Ph.D.
President
Association of VA Psychologist Leaders

Thank you Mr. Chairman and members of the Committee.

My name is Terence M. Keane, Ph.D. and I am a clinical psychologist from Boston and today I am representing the Association for VA Psychologist Leaders serving as this year's President. Our organization is more than twenty-seven years old and its mission is to improve and enhance mental health services for military veterans through the delivery of outstanding clinical services, the conduct of relevant behavioral health research, and the training of the next generation of psychologists.

In my career I've served as the Chief of Psychology at three different VA's, first at the Sonny Montgomery VA Medical Center in Jackson, Mississippi; next at the Boston VA Medical Center, and most recently at the consolidated VA Boston Healthcare System. Currently, I am the Associate Chief of Staff for Research and Development at the VA Boston and Professor of Psychiatry, Psychology, and Behavioral Neuroscience at Boston University. However, to be clear, my comments today are as the President of the Psychology Leadership group.

Our organization is concerned, as is the Nation, about American troops' exposure to high levels of combat stress and its impact on individuals, their families, and their communities. Thus, our comments are relevant to the active military workforce, veterans, as well as those serving in the Reserves and the National Guard. Each group presents a special challenge for delivering optimal mental health services. Stigma, fear of alienation, and access influence who does and who doesn't seek mental health services in these groups. All groups will one day consider getting healthcare in VA.

As mental health professionals we are committed to providing the best possible services to returning troops. As well, we are committed to employing the most contemporary means of providing these services with the goals of fostering positive adjustment and minimizing long term, chronic mental health problems. The President's New Freedom Commission and the VA's Action Agenda contain important new ways to manage the large number of veterans with mental health and behavioral health problems. These initiatives creatively driven by VA mental health experts need to be fully resourced, implemented, evaluated, and monitored.

Today, VA may well be the finest mental health system in the United States, providing an array of services for treating trauma, substance abuse, and other serious combat related mental health problems. Mental health professionals provide services to veterans and

their families in Vet Centers, Primary Care Clinics, Specialized PTSD Clinics, Substance Abuse Programs, Homeless Programs, and in general mental health clinics.

As VA has changed in the past ten years so have the models of mental health care delivery. To keep pace, the mental health workforce in VA is in need of a major educational initiative so that our skills in prevention and treatment can be provided to the growing numbers of new veterans coming to VA for mental health care. Models of individual psychotherapy need to be used judiciously while supplemented by the use of the modern methods of tele-mental health, integrated primary care and mental health care, the use of self help methods, the internet and web based interventions, and peer assisted support.

For the returning troops all efforts should be towards the promotion of recovery and the fostering of independence. But implementation of these new interventions requires a retooling of the workforce with significant attention to the evidence bases derived from VA specialized programs, private sector services, and from other healthcare systems worldwide. Our organization is committed to working with VA in such an educational initiative. Such a broad based educational effort will require modest resources to establish and maintain.

In addition, our organization supports greater integration and collaboration with the Department of Defense's healthcare system. Combined initiatives in health care, such as the use of a common, integrated medical record, are critical to achieving our mission of providing the best possible healthcare to military veterans.

Initiatives that promote collaborative care, collaborative education, and collaborative research between VA and DOD are critical to the success of our mission. We support those initiatives that bring the healthcare and the mental healthcare services of these two agencies into greater alignment. While many examples of this collaboration exist, more are needed in order to optimally provide mental health services for military veterans and their families. VA and DOD healthcare services can benefit from additional collaborations centered around the people to be served, whether these services are to be provided now or five years from now.

We are aware of the limitations that exist for provision of mental health services within VA to the Guard, Reservists, and veteran's families. We support the changes in eligibility that have been already made and support increased inclusion of mental health services for families that are affected by activation, deployment, injury, or death.

Although most cases of PTSD develop shortly after combat service, it is indeed the case that, for some, mental health needs can emerge years after their military service. Two months ago I spoke on the phone with a veteran who happened to be a psychologist in his eighties who was part of the American forces that took beachheads in Italy during World War II. He described his experiences and wondered out loud to me if he needed my help; his wife urged him to call VA as she thought he was becoming increasingly preoccupied

with his distressing war experiences. Reports of a gap of decades between war and the appearance of war related distress are all too common.

The jewels in VA mental health services exist in the specialized programs that it possesses. Specialized services generated the outstanding reputation VA has for its work in war related PTSD, Substance Abuse, Geriatric Mental Health, and in the care of those with psychotic conditions. Preserving these specialized services is central to the excellence of VA noted in the *New England Journal of Medicine* and the *Lancet* in 2004. Buttressing these specialized programs are VA's mental health centers of excellence. The Mental Illness Research Education and Clinical Centers (i.e., MIRECC's), the National Center for PTSD, the Substance Abuse Centers of Excellence, and the Geriatric Research Education and Clinical Centers (GRECC's) all enhance the luster of the VA system of mental health care. We urge continued strong support for these leading lights in VA.

In the mid 1980's VA conducted the National Vietnam Veterans Readjustment Study. This study was remarkable in two respects. First, it was the first time that any country had ever attempted to systematically study the psychological and social impact of participation in a war; second, it was the first mental health study employing a nationally representative sample of Vietnam veterans. Today we have the opportunity to understand the long term psychological and physical impact of participation in war as Vietnam veterans are reaching their late fifties. Our organization supports the completion of the follow-up study of Vietnam veterans as it will provide us an outstanding opportunity to plan for the future needs of this, the largest group of veterans at this time. As well, this study will further help us in preparing for the needs of the newest group of veterans from OEF-OIF.

Leadership in research on veterans' mental health problems is one of the major contributions of all VA. To maintain this resource there is a distinct need to train younger investigators as the research work force is graying; additional fellowships are needed in order to insure that there is a new generation of researchers in mental health trained to study veterans' health problems. Once their training is complete, there is a need for research funding that will support them early in their careers. Our group supports the gradual increase in the proportion of the research budget allocated to mental health and behavioral health problems. If the initiative to gradually increase the mental health research budget to approximately 20% of the total Research budget is successful, it will insure that the country has a younger generation of researchers dedicated to studying veterans' mental health problems.

In April, Psychology leadership convened its annual meeting in Dallas, Texas. Our Keynote Speakers were the Honorable Gordon H. Mansfield, Deputy Secretary of VA and the Honorable Jonathan Perlin, Undersecretary of Health. Each exhorted members of our group to assume even greater leadership roles in promoting the recovery and rehabilitation of returning injured veterans. Mr. Mansfield requested from our group a list of recommendations for him to consider in improving services for the newest veteran cohort using our healthcare system. A group of dedicated members from AVAPL, the APA, and APA's VA Section of Public Service Psychologists spent countless hours

identifying and articulating these recommendations. They were recently forwarded to Mr. Mansfield for his review. I am including herein a number of the most immediately relevant recommendations from this effort:

I. Contributions to Returning OEF/OIF Veterans and Their Families

VA mental health professionals are prepared to foster a seamless transition between DOD and DVA by providing treatment for those OEF and OIF troops previously identified by DOD providers. There is a need for specialists in the care of male and female combatants and the disorders that they preferentially display.

We also recognize that the psychological wounds of OEF/OIF veterans will also affect their loved ones. Family members are critical partners in promoting the healing and recovery process of the veteran.

OEF/OIF veterans are more likely to seek medical services than services identified as "mental health" as they attempt to return to normal lives. Mental health professionals on site in primary care clinics, working either as direct care providers or as immediate consultants to the primary care provider, can facilitate the identification of the symptoms of traumatic stress and other psychological disorders, or can provide timely, patient-centered behavioral interventions when appropriate.

Recommendation 1: We support the establishment of at least one Post Traumatic Stress Disorder Clinical Teams (PCTs) in every medical center and endorse a staffing profile that includes the expertise to provide a range of psychological services, including special services for women veterans as well as services to spouses and families.

II. The Treatment of Veterans with Physical Injuries

Members of the Military are sustaining multiple severe injuries as a result of suicide bombers, rockets, and improvised explosive devices. Accordingly, many veterans will be treated for polytraumatic injuries that result in physical, cognitive, psychological, and/or functional impairments. These conditions frequently occur in combination with other disabling conditions such as amputation, auditory and visual impairments, spinal cord injury (SCI), post-traumatic stress disorder (PTSD), and other mental health conditions.

Through specialized training, Behavioral Health professionals bring expertise in rehabilitation, the neurosciences, and the addictions and can make unique contributions to the care of veterans with these conditions.

Recommendation 2: We recommend that mental health professionals be present as full time members of treatment teams in rehabilitation medicine programs across the country in order to provide the highest standard of care possible. Providing behavioral health services through a model of integrated care with other health care specialists offers the best opportunity for early detection of mental

health problems, for promoting optimal recovery, and facilitating adherence to medical and rehabilitative regimens.

Recommendation 3: To identify and to disseminate the most effective treatment strategies for promoting full recovery from polytrauma injuries, Interprofessional Research Fellowships should be established through Office of Academic Affiliations in which psychologists, physicians, and other rehabilitative health care specialists will work collaboratively and from transdisciplinary perspectives to identify best practices of care.

III. Advancing the Recovery and Rehabilitation Model of Treatment

The VA's Action Agenda for the President's New Freedom Commission on Mental Health promotes a treatment model based on recovery and rehabilitation for veterans diagnosed with serious mental illnesses. Psychologists and Psychiatrists are, and historically have been, the team leaders in VA Mental Health recovery and rehabilitation programs. We endorse this core value model of recovery and are committed to achieving the goal of this model: "Recovery is.....to live a fulfilling and productive life despite a disability" (President's New Freedom Commission Report).

Recommendation 4: We recommend that responsibility for a Recovery Model and Rehabilitation Model, and its implementation across the country, be given high priority within VHA and by the MHSHG. Planned resources should be allocated to this objective and a monitoring program established to insure that these resources are utilized to meet these goals.

IV. Adopt Best Practice Guidelines for PTSD Compensation and Pension Examinations

Psychologists and Psychiatrists collaboratively developed the Best Practice Manual for Post-traumatic Stress Disorder (PTSD) Compensation and Pension Examinations. These guidelines were designed to provide clinicians with the optimal means for arriving at the most accurate information for the Adjudicator examiners. They were developed in a collaborative effort between Veterans Benefits Administration (VBA) and the National Center for PTSD (VHA). As the number of veterans seeking compensation for war-related injuries, including PTSD, continues to grow, it is essential that this entry point into the VA's health care system provide accurate information upon which future treatment needs and compensation can be based.

Recommendation 5: We recommend that the Best Practice Guidelines for PTSD Examinations be presented to the National Leadership Board (NLB) as potentially one of the system's most cost beneficial initiatives. The methods outlined therein should reduce the backlog and improve the confidence of the Adjudicators in their decisions based on available data. The NLB should take necessary steps to assure that these Guidelines are adopted on a nationwide basis.

V. Promote the Further Expansion of Telehealth into Behavioral and Mental Health Field

We recognize that a significant number of veterans seeking behavioral and mental health services live in rural areas and lack either the time and/or resources to travel to VA stations. We also recognize the growing demand for mental health services. Research has documented the benefits to veterans of receiving treatment via a telehealth system. Web-based interventions now exist for PTSD, depression, psychoses, and other behavioral and mental health needs. Psychologists support the use of telehealth in providing a variety of clinical health services and recognize this is a practice that is a part of the Under Secretary's Mission and Planning Strategies vision for promoting clinical effectiveness. Telehealth will foster a culture that encourages innovation while providing enhanced access to mental health care.

Recommendation 6: We recommend that additional resources be directed toward the expansion and implementation of telehealth services for treating behavioral health problems. To achieve this goal, resources are needed for an infrastructure to support practice, as well as education and training for behavioral health providers, and for research to evaluate the impact of these services.

VII. Revising the Current Disability Compensation System.

Historically, one of the major concerns of VA mental health professionals has been that the current disability and compensation system potentially rewards "staying ill". Fear of losing disability payments can be a disincentive for veterans to engage in recovery based activities. We would welcome the opportunity to participate in a review of current compensation practices with an eye towards the development of policies that would support veterans as they transition back to health, but would permit those in recovery to have a safety net when and if they experience a deterioration of their condition

Recommendation 7: We recommend that representatives of Mental Health be appointed to the new Veteran's Disability Benefits Commission or an internal implementation group to help address the strengths and limitations of the current disability compensation system.

Thank you for this opportunity to speak on behalf of my organization and we urge the committee to work in collaborative ways with VA, AVAPL, and other professional groups to address the needs of current and future military veterans and their families.

MICHAEL E. KILPATRICK, M.D.
DEPUTY DIRECTOR, DEPLOYMENT HEALTH SUPPORT

BEFORE THE
VETERANS AFFAIRS COMMITTEE
U.S. HOUSE OF REPRESENTATIVES

POST TRAUMATIC STRESS DISORDER

July 27, 2005

Mr. Chairman and distinguished members of this committee, thank you for the opportunity today to discuss Department of Defense efforts to prevent, identify and treat post-traumatic stress disorder. Safeguarding the health of our servicemembers and their families is the primary mission of the military medical system. Deployments place added stressors on service members and their families, and can potentially affect their mental health. We've made a great deal of progress in the area of education, prevention, identification, and care for anxiety, depression, acute stress reaction and other stress-related health risks. We are focused on early intervention of these issues during and after deployment. The Department's ongoing education programs for military health care providers focus on prevention programs at home and while deployed.

All of these conditions are part of a continuum of mental health issues, but may or may not result in a diagnosis which may include Post-Traumatic Stress Disorder or PTSD. Operational stressors and combat trauma can result in service members experiencing anxiety and depression symptoms. Sometimes acute stress symptoms can persist to become posttraumatic stress disorder.

Part of our challenge is that service members facing behavioral health concerns may avoid professional help because they are unaware of available services, perceived stigma, or because the acute stress reaction or anxiety may affect their judgment. The military services actively encourage an attitude for "buddy care" to get service members to look out for one another's physical and mental health and to help their fellow military

members get help when necessary. The Services also provide multiple opportunities for members to identify their needs.

Before deployment, service members are screened for mental health problems annually, when they complete a preventive health assessment. Service members attend educational 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.

Early intervention is important to prevent post-traumatic stress disorder. We provide supportive care immediately in theater. From the beginning of the current OIF deployment, we employed medical and environmental surveillance to monitor any possible health risks. Based on lessons learned, the Service have deployed combat stress teams to provide education and address specific service member concerns. At the request of the Operation Iraqi Freedom leadership, General James Peake, then-Army Surgeon General, sent the a 12-person Mental Health Advisory Team to Iraq and Kuwait – the first such team fielded in history – to assess behavioral health care for OIF military members. Based on the advisory team’s recommendations, we have augmented the support available with additional combat stress teams for the OIF deployed force.

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 to rapidly respond to civilian disasters. The Marines use an Operational Stress Control and Readiness program. The Air Force deploys Mental Health Rapid Response and Augmentation Teams for deployments and to respond to civilian disasters. Behavioral health specialists evaluate their units' morale and provide consultation and advice to leadership under challenging circumstances to address morale and mental health needs. In addition to the medical support, members of the chaplaincy provide counseling before departure, in theater, and after troops return.

When service members redeploy, they receive a post-deployment health assessment. That assessment includes a face-to-face health discussion with a licensed health care provider and documentation of the individual's responses to the health assessment questions on the four-page form, including specific questions that screen for behavioral health issues associated with deployments. This assessment is a screening tool and individuals whose responses indicate a risk of behavioral health issues will receive referral for medical consultation. At that consultation, possible behavioral health issues or PTSD will be identified. Of the 138,000 thousand troops who returned in 2004 and received a post-deployment health assessment, 16 percent have been referred to mental health providers for further evaluation.

As part of our ongoing efforts to safeguard the health of members of our servicemembers, DoD has recently begun implementation of the Post-Deployment Health Re-assessment program. The purpose of this new program is to identify and recommend

treatment for deployment-related health concerns that may arise during the three- to six-month time period after military members return from deployment. The re-assessment begins with a questionnaire that can be filled out electronically and contains questions designed to highlight possible stress-related health issues. Importantly, the questionnaire is followed by a one-on-one consultation with a licensed health care provider. Our purpose in reaching out to veterans of deployments three to six months after they have returned is to provide a proactive wellness check, to see how they're doing – especially those servicemembers transitioning from active duty to inactive or civilian status. Again, the professional administering the re-assessment will refer individuals to follow-up evaluation when it is indicated.

After service members return from deployments, military and VA providers use the jointly developed Post-traumatic Stress Clinical Practice Guideline and Post-Deployment Health Clinical Practice Guideline to provide health care focused on post-deployment problems and concerns. The guidelines provide a structure for the evaluation and care of service members and veterans with deployment-related concerns, including possible stress-related issues. Our education program also prepares primary care personnel to use the when indicated during patient care. And the Deployment Health Clinical Center provides health care professionals access to expert clinical support for patients with stress-related symptoms, as well as deployment-related information.

Among the resources available to military leaders to help service members during acute crises are the Air Force's and Navy's CD- and web-based *Leaders' Guides for*

Managing Personnel in Distress. These resources provide direct guidance to supervisors and commanders to respond to soldiers in specific crises.

Military members and their families may also use *Military OneSource*, a 24-hour, seven-day a week toll-free family support service, accessible by telephone, Internet and e-mail. *Military OneSource* offers information and education services, referrals, and face-to-face counseling for individuals or families. *OneSource* is confidential, and 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 installation family support services.

Paying particular attention to our reserve component members, the National Guard Bureau has recently signed a memorandum of understanding with the Department of Veterans Affairs to promote a seamless transition of services from DoD to the VA. DoD provides timely data regarding the demobilization of National Guard troops, so that the VA can provide those individuals with information regarding the care and support they can receive. This includes the use of Vet Centers, which provide a continuum of care that includes professional readjustment counseling and provides a link between veterans and the VA. And 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.

Mr. Chairman, the Department recognizes that anxiety, depression, acute stress reaction and other stress-related health risks are ongoing threats to our service members, and that we must continue to improve our efforts to safeguard their emotional and behavioral health. Our educational programs for military and family members, leaders and health care providers have been well received. Our early intervention programs, combat stress teams, and health assessments are proving to be effective. All of this has been done in partnership with the VA, bringing us closer to our ultimate goal of a seamless transition from DoD to VA care.

Mr. Chairman, this concludes my statement. I thank you and the members of this committee for your outstanding and continuing support for our veterans.

**Statement of
Michael J. Kussman, MD
Deputy Under Secretary for Health
Department of Veterans' Affairs
On
VA Mental Health Services
Before the
Committee on Veterans' Affairs
U.S. House of Representatives
July 27, 2005**

Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to discuss the Department of Veterans' Affairs' (VA) Post Traumatic Stress Disorder (PTSD) programs, and our capability of meeting the mental health and physical health needs of veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), in their seamless transition from Department of Defense (DoD) to (VA) care.

VA is well positioned to provide health care to returning OIF and OEF veterans. As the largest integrated health care organization in the United States, we can meet returning veterans' needs through nearly 1,300 health care facilities throughout the country, including 721 community-based outpatient clinics that provide health care access near most veterans' homes. We also have 207 Vet Centers, which are often the first contact points for returning veterans seeking health care and benefits near their homes.

Thankfully, the great majority of OEF/OIF veterans will not suffer long-term consequences of their war zone experience, although many will have some short-term reactions to events witnessed in the combat theater. Of those who do develop mental and emotional problems, PTSD may not be the only problem we must attend to. They may also have other medical or psychological injuries. The July 2004 *New England Journal of Medicine* article, "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care" by Charles W. Hoge, M.D., et. al, concluded that 17 percent of troops returning from Iraq met strict screening criteria for major depression, generalized anxiety, or PTSD. The development of PTSD symptoms in some veterans will be delayed. Not all will come for care at the same time. Some may seek care

outside of VA. Still others, for a variety of reasons, including the stigma associated with mental disorders, may not seek care at all.

I plan to speak to you today about: 1) the mental healthcare services utilized to date by OIF/OEF veterans; 2) VA's outreach to OIF/OEF veterans to inform and educate them about the mental healthcare services available to them; 3) portals of entry, screening for mental health conditions, and referral patterns within VA; 4) mental healthcare programs that already exist to support those reaching out for help; 5) challenges that we face in terms of data sharing so that we might identify potential candidates for mental healthcare services; 6) VA's planning for future mental health services; and 7) lessons we have learned to help us be better prepared for the future mental healthcare needs of all veterans, including the OIF/OEF population.

Use of VA Mental Health Services by OIF/OEF Veterans:

With DoD's help, VA regularly compiles a roster of service members who have separated after active duty in Iraq and Afghanistan theatres. VA matched the roster with information on VA healthcare utilization and found that VHA medical centers have treated almost 101,000 of the 393,000 OIF/OEF veterans separated from active service. The two most common potential health problems of war veterans in this population to date have been musculoskeletal ailments and dental problems.

Almost 24,000 patients have been diagnosed with potential mental health disorders including adjustment reaction and PTSD. Over 14,000 OIF/OEF veterans have sought VA care at both Vet Centers and VA medical centers for issues associated with PTSD.

PTSD and adjustment reactions are not the only potential mental health consequence of war. Other potential mental health conditions include depressive disorder, acute reaction to stress (often a precursor of PTSD) and nondependent abuse of drugs or alcohol dependence syndrome.

When considering the mental health consequences of war zone service, it must be recognized that nearly every service member who is exposed to the horrors of war comes away with some degree of emotional distress. Some will have some short-term

adjustment reactions, but the majority will not suffer long-term consequences from their combat experience.

Outreach:

VA is engaged in a number of activities to inform veterans and their families of the benefits and services available to them. VA's orientation towards returning service members from the Global War on Terror (GWOT) incorporates a public health approach to care and is guided by the principles of the President's New Freedom Commission (PNFC) on Mental Health. VA's Mental Health Strategic Plan (MHSP) is based on the principles of that Commission, including the principles of health promotion and preventive care. The initiatives in the MHSP emphasize patient and family education about good health care practices and identify behaviors to avoid. VHA is working to lower the incidence of long-term mental health problems in the OIF/OEF population through a concentrated effort at early detection and intervention.

VA identifies new OIF and OEF veterans who have separated from the military based on names and addresses provided by DoD. The Secretary of Veterans Affairs mails new veterans a letter welcoming them home, thanking them for their service to their country, and briefly explaining which VA programs are available to them. This includes care for medical and mental health problems that may be related to their combat service. As of June 30, 2005, VA has mailed more than 357,000 letters to discharged service members.

Outreach to returning members of the Reserves and National Guard is a special concern for VA, and, in collaboration with DoD, emphasis on this has expanded significantly. In FY 2003, VA briefings reached nearly 47,000 reserve and guard members. During FY 2004, VA briefed more than 88,000 reserve and guard members, and in FY 2005, VA has already reached more than 68,000 reserve and guard members. In addition, both Departments have developed a new brochure together, entitled "A Summary of VA Benefits for National Guard and Reserve Personnel." The brochure summarizes the benefits available to these veterans upon their return to civilian life. VA has distributed over a million copies of the brochure through VA and

DoD channels. It is also available online at a new "Iraqi Freedom" link on VA's Internet Website, along with a variety of other VA brochures and health information.

A critical element of our outreach efforts are VA's Readjustment Counseling Service Centers (known as "Vet Centers"). Having served almost 21,000 veteran returnees to date, the Vet Center program locates, informs and professionally engages returning veterans and their family members about VA benefits and services including readjustment needs and the complete spectrum of VA services and benefits.

The Vet Center program's capacity to provide outreach to veterans returning from combat operations in OEF and OIF was augmented by VHA's Under Secretary for Health (USH) in February 2004. Targeted Vet Centers hired and trained a cadre of approximately 50 new outreach workers from the ranks of recently separated GWOT veterans. These positions are located on or near active military out-processing stations, as well as National Guard and Reserve facilities. Based on the success of the initial GWOT veteran outreach program, the Under Secretary for Health authorized the further hiring of 50 more GWOT veteran outreach workers. The Vet Centers are now engaged in hiring 50 more GWOT veteran outreach workers to welcome home and inform their colleagues returning from Afghanistan and Iraq.

Veterans helping veterans has been a central feature of the Vet Center program throughout its 25 years of service to homecoming war veterans. Nothing can replace the immediate rapport generated by veterans with similar military experiences. These first outreach encounters provide the initial stage for healing and successful readjustment. With early intervention, clinicians hope to prevent the more debilitating onset of chronic PTSD and set the stage for a seamless transition to their home community and into local VA care.

Portals of Entry, Screening, and Referrals for Specialized Care:

OIF/OEF returning service members seek out and enter VA care from a variety of sources including referral from military treatment facilities, Transition Assistant Program briefings, Vet Centers, and home town community service providers.

When OEF/OIF veterans present to VA clinicians with mental, emotional or behavioral complaints, they are assessed both for symptoms, functional problems, and

clinical needs. Treatment plans may include referral to a mental health clinic or Vet Center.

It is important to note, that once within VA, every OEF/OIF veteran who presents for care is screened for PTSD, depression, alcohol abuse and infectious diseases endemic to South West Asia through a reminder that “pops up” in the Consolidated Patient Record System. The clinician is obliged to complete the items on this screen, thereby ensuring that the veteran is assessed for these problems. In fact, the mental health items are identical to those that are used for routine annual screening of all veterans who are cared for by VA.

Programs:

VA has a variety of programs and settings in which mental health services are provided. Through our VA medical centers, VA provides comprehensive care for veterans with mental illness through a continuum of services designed to meet the patients' changing needs. The spectrum of care provided includes acute inpatient settings, residential services for those who require structured support prior to returning to the community, as well as a variety of outpatient services. Outpatient care options include mental health clinics; “partial hospitalization” programs such as day hospitals and day treatment centers that offer care 3 - 5 days a week to avert the need for acute or extended inpatient care; and intensive case management in the community. Long-term inpatient or nursing home care is also available, if needed. VA's specialized mental health programs include programs designed to meet the needs of patients with disorders such as schizophrenia, major depression, PTSD, and addictive disorders. Specialized PTSD programs exist in all VA's 21 Veterans Integrated Service Networks (VISNs or Networks), including outpatient, inpatient and residential care programs. As of 2005, each VISN has a PTSD Coordinator who facilitates PTSD services across the VISN and serves as liaison with the Mental Health Strategic Health Care Group in VA Central Office.

A primary goal of the Returning Veterans Outreach, Education and Care (RVOEC) program will be to promote awareness of health issues and health care opportunities and the full spectrum of VA benefits. Thirty-seven RVOEC programs were

funded, targeting sites associated with large numbers of returning service members. There is at least one in each VISN.

The Vet Center program is a special VHA program designed to provide readjustment counseling to veterans exposed to the uniquely stressful rigors of military service in a combat theater of operations. Providing holistic services to veterans and family members is a core component of VA's community-based Vet Center program. The Vet Centers are a unique complement to VA's arsenal of PTSD programs. They combine professional readjustment counseling for war trauma with family services, outreach and community coordination of care. Since August 2003, those services include bereavement counseling to surviving family members of Armed Forces personnel who died while on active duty in service to their country.

Data Sharing:

As VA began its efforts with DoD to seamlessly transition the most severely injured veterans and service members, both healthcare systems adapted quickly to use traditional manual processes to collect and share data to ensure continuity. VA assigned social workers and benefits counselors to eight major Military Treatment Facilities (MTFs). These VA social workers and benefits counselors receive referrals from DoD social work discharge planners and case managers on injured service members who will be transitioning to VA.

VA benefits counselors and social workers also participate in the military treatment team's multidisciplinary rounds. During rounds, each OEF/OIF veteran is discussed and his or her care reviewed. Through this collaboration, VA benefit counselors and social workers ensure that returning service members promptly receive benefits for which they are eligible, as well as other information and counseling about other VA benefits and services. At the time of discharge to VA, DoD provides summary clinical information. In many cases, DoD also provides a copy of the medical record for the most recent period of treatment. With this information, VA social workers coordinate the transfer of the service member to the appropriate VA health care facilities; enroll them into the VA health care system; and initiate paperwork for compensation claims and benefits.

As the war evolved, DoD began to share various national electronic data files of administrative data on discharged service members. While this information has been very useful to VA, the data is not as comprehensive as VA would want to provide truly seamless clinical care.

In order to address these data sharing issues, VA is working collaboratively with DoD to develop functionality that will support the transfer of the full history of pre- and post-deployment health assessment data on OEF, OIF and other deployed service members to VA physicians and claims examiners. DoD is scheduled to begin sending electronic copies of this data to a secure shared repository in the 4th Quarter of FY05. Monthly updates of this data will continue to be sent as additional deployed service members separate from military duty.

VA is presently working on enhancements, using the Federal Health Information Exchange (FHIE) infrastructure and its own health information record, that will permit authorized VA clinicians to view these data on demand at all VA facilities when a recently discharged combat or other veteran presents for care. VA anticipates completing this work during the 1st Quarter of FY06. Although the current work is focused on providing the pre and post deployment data for clinical care, the Departments are actively exploring the feasibility of using these data for epidemiological studies.

On June 21, 2005, VA and DoD signed a Memorandum of Understanding for the purposes of defining data sharing between the Departments. This agreement lays the foundation for VA to receive the list of service members who enter the Physical Evaluation Board (PEB) process. Although the seamless transition initiative was initially intended to support service members who served in OEF/OIF, it is intended to become an enduring process which will support all service members who, as a result of injury or illness, enter the disability process leading to medical separation or retirement.

The PEB list will identify those individuals who by virtue of their service sustained an injury or developed an illness that precluded them from continuing on active duty and resulted in medical separation or retirement. The list will enable VA to contact these service members to initiate benefit applications, disability compensation claims processing, and transfer of their health care to VA Medical Centers before they are

discharged from the military. DoD is developing a policy to govern the business rules of sharing this data, including applicable data privacy and security protections. Once the policy is approved and signed by both Departments, DoD will start sending the list to VA. Access to these data will help ensure that any service member who was seriously wounded or injured or has become seriously ill while in defense of our country will have seamless access to the timely and highest-quality services they need and deserve, regardless of where they are in the transition process. VA looks forward to the receipt of these data from DoD.

Planning for the Future:

VA has worked very hard to establish demand estimates for mental health services for all veterans for strategic planning purposes. Current utilization of VA mental health services is tracked as part of the population based assessment of needs that is embodied in the CARES process and is the driver for the clinical planning in the Mental Health Strategic Plan (MHSP). Over the past several years, the population of existing veterans receiving care for PTSD has increased by about 20,000 per year. Although the numbers of OEF/OIF returnees are relatively small it is essential that the numbers of veterans be brought into the actuarial planning model.

The VA Enrollee Health Care Projection Model forecasts demand for VA's inpatient and outpatient mental health and substance abuse services. Over the past several years, VHA has worked with a group of mental health experts to enhance the model methodology. An important improvement was to develop individual models for those services that are unique to VA, such as PTSD residential rehabilitation.

We have also incorporated "age cohorts" into the model. Age cohorts allow us to adjust the model for the special mental health demand of veteran enrollees as they age. For example, Vietnam-era veterans are expected to have higher demand for mental health and substance abuse services than World War II and Korean-era veterans as they age. In addition, we have developed a methodology to model a consistent level of access across the VA health care system. These enhanced projections support the implementation of the VHA Mental Health Strategic Plan and will enable VA to plan to meet enrollees' need for mental health and substance abuse services for the next

twenty years. The mental health workgroup is continuing its work to enhance the mental health model.

Lessons Learned:

As it relates to mental health care, VA has learned a number of lessons in addressing the needs of recently discharged OIF/OEF service members. One of these is the importance of the timely receipt of medical and administrative data from DoD on separated or **soon to be separated** service members. The PEB data will be invaluable in VA's ability to reach out to a high risk population. In addition, access to pre and post deployment screening data for **soon to be separated** service members is highly desirable.

The second lesson, and supporting the need for data, is the importance of early intervention when problems, especially mental health problems, arise -- whether this is while the person is on active duty or after they are separated. At the March 2005 Joint VA/DoD Conference on Post Deployment Mental Health, it was clearly acknowledged by VA and DoD clinicians that early intervention is an essential step in limiting the development of more severe and lasting psychopathology.

The third lesson is promoting approaches that minimize the stigma associated with mental health. These approaches will empower more service members to seek help. Combating the stigma attached to mental disorders is one of the first goals of the VA's Mental Health Strategic Plan. The application of the public health approach to returning GWOT veterans and the recovery and rehabilitation approach to the adjustment problems of war is based on de-pathologizing these problems before they harden into actual mental disorders.

Vet Centers have extensive experience working with veterans to overcome negative attitudes and stigmas typical of combat veterans related to accessing professional assistance. Community outreach and other accommodations to improve access to care for veterans are essential to veterans' readjustment. This is true both from the standpoint of ensuring services are provided in a timely manner for new eras of veterans returning from combat and peace-keeping missions, as well as from the standpoint of overcoming psychological and cultural barriers to care. Vet Center

counselors are especially effective in forging alliances with local veterans through outreach contacts in the community prior to initiating more formal individual or group counseling at the Vet Center.

Conclusion:

The goal of VA's public health approach is to decrease the incidence of serious mental disorders. There is evidence from VA's initial activities in the field that these approaches are accepted both by clinicians and the veterans they serve. We believe this approach may well decrease the incidence of chronic mental disorders for veterans. It will require up front resources which VA is putting in place, but will pay off in the long run, in terms of decreasing human pain and suffering and increasing the social and occupational function of veterans. For those who do develop mental disorders, decreasing the stigma of receiving care by teaching the public about the efficacy of evidence based treatment, can increase the beneficial use of these services whose goal is the restoration and preservation of optimal social and occupational functioning.

In conclusion, VA will continue to monitor and address the mental health needs of the OIF/OEF population, just as it does the general veteran population, through progressive, state-of-the-art programs. VA is approaching the mental health needs of returning veterans with an orientation that is designed to promote an optimal level of social and occupational function and participation in family and community life for our veterans. We are prepared to provide state of the art evidence based care to those coming to us for care, who through their service to our nation, deserve nothing less.



**STATEMENT OF
CATHLEEN WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION**

TO THE

**COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES**

ON

**THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF
DEFENSE ACTIONS CONCERNING POST TRAUMATIC STRESS DISORDER
TREATMENT, OUTREACH AND INTERVENTION TO DEPLOYED SERVICE
MEMBERS**

JULY 27, 2005

**STATEMENT OF
CATHLEEN WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
TO THE
COMMITTEE ON VETERANS AFFAIRS
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ON
DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE
ACTIONS CONCERNING POST TRAUMATIC STRESS DISORDER TREATMENT,
OUTREACH AND INTERVENTION TO DEPLOYED SERVICE MEMBERS**

JULY 27, 2005

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to comment on the Department of Defense (DoD) and Department of Veterans Affairs (VA) actions to address outreach, intervention, availability of services and appropriateness of resources regarding the demand for Post Traumatic Stress Disorder (PTSD) and other mental health services for deployed service members, including Reserve and National Guard members.

As the Global War on Terror continues, casualties are mounting and the ability of the nation to take care of those who have fought bravely continues to be tested. We must not fail. History has shown that the cost of war does not end on the battlefield.

Service members do not all suffer from obvious wounds such as amputations, traumatic brain injury (TBI) and other severely disabling conditions. Mental health experts estimate as high as 30 percent of those serving in Operations Enduring Freedom (OEF) and Iraqi Freedom will suffer the hidden wounds of traumatic stress due to combat exposure and the rigors of the battlefield.

The American Legion/Columbia University PTSD Study

OIF/OEF veterans should fare much better than their Vietnam veteran counterparts with regard to treatment of PTSD. Much more is now known about the factors that predispose an individual to chronic PTSD, the qualities of the stressors that may lead to PTSD and the factors in the post-trauma life course that may exacerbate or ameliorate PTSD symptoms. Contributing to this knowledge base, a study conducted by The American Legion and Columbia University was published in the *Journal of Consulting and Clinical Psychology*, Vol. 71, No. 6 (December 2003). The study was begun in 1984. In 1998 we had the opportunity to re-survey the population of Legionnaires we had studied in 1984, making this the first longitudinal study to examine risk factors related to the course of PTSD in a random sample of American Legionnaire Vietnam veterans. We now have a sample of 1,377 Legionnaires who served in Vietnam, completed the

survey in 1984 and again in 1998. We also have surveys from 1,941 veterans who served in other areas of the world during the Vietnam War and who responded both times.

The study showed that the strongest predictor for having PTSD at follow-up in 1998 was having had PTSD in 1984. Veterans who had PTSD in 1984 were 14 times more likely to have PTSD in 1998. Nearly 12 percent of the population met the criteria for a diagnosis of PTSD in 1998, which is a similar percentage to that observed by other researchers. Thus, large numbers of veterans are at high risk for continuing to suffer from PTSD. Combat exposure is the traumatic event most highly associated with PTSD in these veterans and we have observed a dose-response relationship: the higher the levels of combat exposure, the more likely the development of PTSD. We also observed a heterogeneous course for PTSD over the life span, that is, only 5.3 percent of the population met the criteria at both times. This implies a steady prevalence of about 12 to 15 percent. This is consistent with reports of World War II veterans. Today more than 123,000 veterans are service connected for PTSD, most as a direct result of combat exposure.

The study also identified other risk factors for a negative PTSD course: minority status, elevated depression and anger and the extent of perceived social support.

- We found that minority status along with perceived community negative attitudes at homecoming and lack of community involvement were risk factors for the course of PTSD. This suggests that social stigma or exclusion from the community plays a large role in the persistence of the disorder. Other studies have shown that lower socioeconomic status and educational strata factors may predispose PTSD. Minorities also appear to have the poorest prognosis for recovery from PTSD. The well-known negative attitudes of the public toward returning Vietnam veterans contributed mightily to the chronicity of PTSD in later life; attitudes which our currently returning veterans will not have to suffer. The higher educational levels of the present day all-volunteer force and the hero status being afforded our newly minted combat veterans, along with proactive prevention and treatment methods by both DoD and VA may well contribute to a lower incidence of PTSD in new this new cohort of veterans.
- Our study found that depression and anger were also risk factors for PTSD. Possible explanations for this finding is that that elevated depression and anger may be markers for PTSD severity and persistence and may interfere with the confrontation with and processing of traumatic memories that appear to be necessary for recovery from the disorder. Patient characteristics that predict negative treatment response such as a high level of anger at the beginning of the prolonged combat exposure may also be associated with more chronic PTSD in later life. Recent reports of higher than usual suicide rates among troops in Iraq should raise red flags for both VA and DoD.
- Intense exposure to combat was a major risk factor for Vietnam veterans and is no less so for veterans of the Afghanistan and Iraq wars. These conflicts entail stereotypical exposure to warfare experiences such as firing weapons at human beings, being fired upon by the enemy or in friendly-fire incidents, witnessing injury and death, going on special missions and patrols, handling remains of civilians, enemy forces and U.S. and allied personnel. In Vietnam, little was known of the effects of months of unabated

combat duty on troops. Save for the occasional in-country rest and relaxation (R&R) and a one-week R&R out-of-country, service personnel were more or less in combat for the full tour of duty. There were no “lines” to fall behind for relative safety. Troops in Afghanistan and Iraq are now facing the same type of insurgency environment where anything can and does happen without notice, leading to high anticipatory anxiety. Enlisted soldiers, non-commissioned officers and officers are now trained to identify the signs of normal “battle fatigue” as well as the signs of severe, incapacitating stress-reactions. Post-battle debriefings are now routinely used to allow soldiers to vent and share their emotional reactions. Troops who exhibit severe war-zone stress reactions are treated humanely and receive special care. The guiding principle is known as Proximity-Immediacy-Expectancy-Simplicity (PIES). Early and simple interventions are provided close to the soldiers unit and the soldier is told his or her reactions are normal and that he or she can expect to return to their unit shortly.

Outreach

The all-volunteer operations in Iraq and Afghanistan differ from previous conflicts in that the Reserve and National Guard make-up a higher percentage of those deployed, more women are deployed and experiencing combat conditions and more troops are married. These differences present problems that heretofore were not addressed on the scale they present today. Reserve and National Guard return home and try to reintegrate into their communities leaving the military support system that they have relied on for many months. The American Legion is concerned with the unique stressors faced by the Reserve and National Guard that are presented with repeated deployments. Not only do America’s servicemembers experience the horrible images of war, issues at home can also weigh heavily on their minds. Will they have a job when they return? Will they be able to keep their home? The unique experiences of military combat can create anxiety about their own situations at home and make them more susceptible to stress reactions.

In 2003, almost 17 percent of veterans used specialized mental health services provided by the Veterans Health Administration (VHA), and 22 to 29 percent of veterans are estimated to suffer from substance use disorders. A study in the New England Journal of Medicine of U.S. combat infantry troops returning from operations in Iraq and Afghanistan found that 15 to 17 percent screened positive for major depression, generalized anxiety disorder or PTSD after deployment. However, for those who screened positive only 23 to 40 percent actually sought care. The study concluded that while returning troops are at significant risk of stress-related mental health problems, “subjects reported important barriers to receiving mental health service.” The biggest concern voiced was about the stigma attached to mental health services. Indeed at the Joint Department of Defense (DoD)/ VA Conference on Post Deployment Mental Health held in March 2005 stigma was thought to be the major barrier to getting help.

Effective outreach is critical to ensuring needed mental health services are accessed in a timely manner. Outreach conducted by VA and DoD has improved considerably over the last few years. Outreach activities include:

- Transition Assistance Programs and Military Briefings (TAP);
- Reserve and Guard Briefings at the Unit level;
- Veterans Assistance at Discharge (VADS);
- Letters to service members by the Secretary of VA;
- Letters to Adjutant General by Secretary of VA;
- Remote areas services and outreach;
- Mental Health Screening at the Unit level.

Vet Centers

Vet Centers are invaluable resources to veterans and VA. Given the protracted nature of current combat operations, repeated deployments and the importance of retaining experienced combat service men and women in an all volunteer military, it is essential to promote the readjustment of service men and women and their families. The mission of the Vet Centers is to serve veterans and their families with professional readjustment counseling, community education, outreach to special populations, work with community organizations. Vet Centers are key links between veterans and other services available within VA. Vet Centers are located in the community and there are 207 of them throughout the country. Approximately 65 percent of the staff are veterans and of those over 40 percent are combat veterans.

On April 1, 2003 the Secretary of VA extended Vet Center eligibility to veterans of OEF and later that same year extended eligibility to veterans of OIF. On February 3, 2004 the VA Under Secretary for Health authorized the Vet Center program to hire 50 OEF/OIF veterans to conduct outreach to their comrades from the War on Terrorism. These outreach counselors were placed in 34 states and the District of Columbia. In addition, on August 5, 2003 Vet Centers were authorized to furnish bereavement counseling services to surviving parents, spouses, children and siblings of service members who die while on active duty, to include federally activated Reserve and National Guard personnel.

Vet Center staff reach out to thousands of veterans and family members at demobilization sites and TAP briefings. The American Legion continues to be an unwavering advocate for Vet Centers and their most important mission. We believe Vet Centers are central to the mission of VA and that they truly strive to fulfill their statement of purpose:

“We are the people in VA who welcome home war veterans with honor by providing quality readjustment counseling in a caring manner. Vet Centers understand and appreciate veterans’ war experiences while assisting them and their family members toward a successful post-war adjustment in or near their community.”

Post Deployment Health Reassessment

DoD has created a post-deployment health reassessment to be implemented 3-6 months upon the service members’ return from areas of combat. This new assessment will focus on the adverse health effects —especially mental health difficulties like PTSD, and social readjustment issues—

that the service members experience after attempting to resume their lives. It addresses the observation that many of these health effects may not manifest immediately. Some problems are not evident for months after the service member returns from combat duty.

The health information obtained from these reassessments is supposed to be used to improve communication between the health care provider and the service member and to help in assessing the service member's health. This program will be available to active duty, reserve and guard members through VA and TRICARE by the end of September 2005. All the services have submitted their respective implementation plans. The plan is to have a phased approach with adjustments made as needed.

The 1st Marine Expedition Force at Camp Pendleton, California was the first to test the program using an Internet-based version. However, technical problems with the electronic version subsequently led to the need to test a paper version that also ran into some difficulties. The program has also been tested by a group of reservists in the Midwest with feedback expected in September 2005.

Coordinated efforts between DoD and VA are essential in ensuring the mental health and well being of all returning service members. Implementation is always the most difficult part of the process. It takes time, funding, and most of all, cooperative leadership to ensure service members reap the benefits of a good solid program.

Early Intervention

Early screening, triage, and intervention may help to prevent the development of chronic post deployment mental health problems. However, due to the stigma associated with the admission that one may have mental health issues, it is thought that many service members do not truthfully answer the PTSD screening questions on the DD-2796 Post-Deployment Health Assessment.

One of the findings at the Joint DoD/VA Conference on Post Deployment Mental Health maintained that prevention and intervention should start as a squad-level responsibility. If those service members under the leadership of their first line supervisor were led through discussions on normal reactions to stressful events the service members may be capable of better self care and more supportive of their peers experiencing these reactions. The British Royal Marines have already proven this to be successful through their TRIM Program.

Combat Stress Control In-Theater

Combat stress control teams are stationed throughout Iraq to provide mental healthcare to service members who begin experiencing combat and operational stress reactions, and to help prevent others from developing them. Behavioral health teams are incorporated in some units in Iraq as well as Afghanistan. These teams serve to educate service members and their chains of command about symptoms of combat and operational stress reactions, teach self-help techniques and exercises that can be used to combat these reactions, and inform service members of the professional services available to assist them. Those who request it or appear to need extra help are typically referred for "restorative care," offered at fixed locations, generally limited to 72

hours. It includes more intensive stress and anger management, relaxation training and individual and group counseling.

While these stress teams are valuable and certainly a step forward, they are limited in staffing and only reach a fraction of the service members that need them.

Combat Stress Programs

Many programs and policies have been established to identify and mitigate the effects of combat stress on the lives of service members who served in areas of conflict. Returning service members are required to complete a post-deployment health assessment, a post-deployment health re-assessment 3 to 6 months after return and attend a risk communication and benefits briefing. Returning service members are also supposed to undergo deployment cycle support, unit reintegration, and family reintegration.

Some of the programs available include: Military One Source, an Internet and telephone-based counseling program that allows service members to discuss anything that causes them stress; the Specialized Care Program (SCP) that addresses therapeutic and relaxation methods to cope with pain and stress; and case management that tracks people as they go through the health care system.

The Combat Stress and Deployment Mental Health (OSDMH) working group has been established to address problem solving for combat-related stress. The working group, a joint DoD/VA entity, will re-examine and rewrite combat stress control regulations and guidance so that it will reflect new information and be interoperable for use among all the DoD services and VA.

Project DE-STRESS

Project Delivery of Self Training and Education for Stressful Situations (DE-STRESS), a pilot study funded by the National Institute of Mental Health in collaboration with Boston University School of Medicine and Boston Department of Veteran Affairs Medical Center is designed to test methods for reducing PTSD symptoms for those exposed to military-related trauma. The study uses Internet-based interventions to determine which one effectively helps the participant control his or her symptoms. Stress Inoculation Training (SIT) seeks to instill stress management strategies, teaching the participant that stress is inevitable.

This two year study will consist of in-depth assessments, intensive stress management training sessions and daily, self-paced, Internet-based follow up participation with 24/7 trainer monitoring and guidance. Each group will have 50 participants recruited primarily from Walter Reed Army Medical Center's health care system. The principle investigators are officers from Walter Reed Army Medical Center, staff from the Boston VA Medical Center and staff from the University of New South Wales.

Availability of Mental Health Services

VA leads the world in the treatment of PTSD and US veterans from all conflicts seek treatment from VA for mental health issues. The availability of mental health services in VA varies considerably from one Veterans Integrated Services Network (VISN) to the next. The reason for this is usually because the VISNs do not consider mental health a priority and do not spend the money to institute programs. While Community Based Outpatient Clinics (CBOCs) are supposed to be providing outpatient mental health services, not all of them do.

Capital Asset Realignment for Enhanced Services (CARES)

The CARES decision published in May 2004, called for the closing of Highland Drive VA Medical Center in Pittsburgh, PA; VAMC Brecksville, OH; and VAMC Gulfport, MS. All three of these facilities provide a broad range of mental health services, substance abuse treatment, PTSD treatment and outreach and referral services. Indeed, Highland Drive has also opened a complete Adult Day Health Care Program, and is home to the OEF/OIF Primary Care Clinic serving active duty and veterans of these two conflicts.

Access to and the provision of adequate mental health services to our nation's veterans was a provision left out of the most comprehensive evaluation and retooling of the largest health care system in the nation, VA. Because VA provides services that are not comparable to the private sector, it was difficult to devise an accurate model that could project mental health needs into the future. However, the CARES process proceeded forward with promises that mental health needs would be "folded in" to the overall strategic plan that also includes the implementation of CARES.

To VA's credit a Mental Health Strategic Health Care Group, made up of dedicated hard working individuals, developed a mental health strategic plan for the entire system. While the plan has been tentatively concurred with and partially released, implementation and integration of the plan will take years.

The American Legion has strenuously objected to the fact that mental health services were left out of the CARES process and we will continue to ensure that veterans services are not shut down before new facilities are completely functional.

Operation Enduring Freedom/Operation Iraqi Freedom

Implementation has not always been VA's strong suit. The VA's Special Committee on PTSD was established 20 years ago to aid Vietnam-era veterans diagnosed with PTSD. Since its establishment, the Special Committee has made many recommendations to VA on ways to improve PTSD services. A Government Accountability Office (GAO) report from February 2005 pointed out that VA delayed fully implementing the recommendations of the Special Committee, giving rise to questions regarding VA's capacity to treat veterans returning from military combat who may be at risk for developing PTSD while maintaining PTSD services for veterans currently receiving them. In September 2004 GAO also reported that officials at six of seven VA medical facilities stated that they might not be able to meet an increase in demand for

PTSD services. Additionally, the Special Committee reported in its 2004 report that sufficient capacity is not available within the VA system to meet the demand of new combat veterans and still provide services to other veterans.

Over the past three years The American Legion's System Worth Saving Task Force has completed site visits to every VAMC. We looked at mental health services provided and at the capacity of the facilities to handle the recent returnees. Like the GAO report, we found that many facilities were increasingly concerned with their ability to handle an increasing workload.

Resources

It has been estimated that nearly 30 percent of those returning veterans from OIF/OEF, both men and women, will be diagnosed with some type of stress disorder that will require treatment. The importance of VA to maintain capacity in the mental health area cannot be overstated. Recognized as a national leader in the treatment of mental illness, most notably PTSD, success in treatment protocols, recruiting and retaining capable mental health experts and implementing new and innovative initiatives is critical.

Our site visits revealed a critical shortage in the funding of VA health care. A great majority of the facilities reported having to convert capital improvement dollars to health care dollars in order to meet the service demands of the current veteran patient population. The result of this is not having enough money to make needed repairs on infrastructure needs, resulting in huge maintenance backlogs at facilities.

The House passed version of the fiscal year 2006 Military Quality of Life and Veterans Affairs Appropriations bill now pending in this Congress "fences off" \$2 billion for specialty mental health treatment. The American Legion appreciates Congress' recognition of the need for resources in this area; however, we believe that this will force VHA to further ration care in other areas. Shuffling funds within a weak budget is no way to run a health care system designed to take care of the soldiers wounded both in body and psyche while defending our freedoms. Congress should appropriate a supplemental \$2 billion in fiscal year 2006 to cover this critical need.

Conclusion

While much progress has been made in the efforts to identify and treat servicemembers suffering from the effects of PTSD, The American Legion urges this Committee to provide VA with the resources necessary to not only meet the current demand for mental health care, but also, the future needs of the young men and women returning home from the current conflicts in Iraq and Afghanistan.

The American Legion continues to support the efforts of VA and DoD and we look forward to working with Congress to ensure VA is capable of fulfilling its mission of providing the best treatment and care possible to this nation's veterans.



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July 27, 2005

Honorable Steve Buyer, Chairman
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Buyer:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the July 27th hearing, concerning The Department of Veterans Affairs and The Department of Defense Actions concerning Post Traumatic Stress Disorder Treatment, Outreach and Intervention to Deployed Service Members.

Sincerely,

A handwritten signature in black ink, appearing to read "Cathleen Wiblemo".

Cathleen Wiblemo, Deputy Director
Veterans Affairs & Rehabilitation Commission

BIOGRAPHY
CATHLEEN C. WIBLEMO
DEPUTY DIRECTOR, HEALTH CARE
VETERANS AFFAIRS AND REHABILITATION DIVISION

Ms. Wiblemo has been with The American Legion National headquarters since November 1999. She is currently the Deputy Director for Health Care. Prior to serving in her current position, she was the Assistant Director for Resource Development and before that she served as an Appeals Representative with the Special Claims Unit.

Ms. Wiblemo is a graduate of Black Hills State University in South Dakota, where she received her B.S. degree in History. She was the recipient of a ROTC scholarship and the George C. Marshall award. Upon graduation in December 1984, she was commissioned a 2nd Lieutenant in the United States Army. During her 10 years in the military she served in various positions both in country and overseas. She is currently a Major in the reserves.

During her military service, Ms. Wiblemo received many awards, most notably the Meritorious Service Medal. In August 1999 she received her Masters of Health Administration from Chapman University.

Ms. Wiblemo is a member of Post 176 in Alexandria, Virginia. Originally from Mitchell, South Dakota, she and her son, Zachary, currently reside in Alexandria, Virginia.



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Statement for the Record
Of
Vietnam Veterans of America
Regarding
Resources Committed and Actions Taken
To Identify and Treat Post-Traumatic Stress Disorder
In Currently and Recently Deployed Troops

Submitted by

Thomas H. Corey, National President

And

Thomas Berger, Chairman,
VVA National PTSD & Substance Abuse Committee

Before The

House of Representatives Committee on Veterans' Affairs

July 27, 2005

Chairman Buyer and distinguished members of the House Committee on Veterans' Affairs, Vietnam Veterans of America thank you for the opportunity to present for the record our views on the current state of readiness by the Departments of Veterans Affairs and Defense to deal with post-traumatic stress disorder in deployed and recently returned service members.

In brief, we do not believe that either Departments are doing nearly enough to combat this mentally crippling malady.

There can be no doubt that the combat experiences of veterans can and often do cause mental health injuries that can be just as debilitating as physical wounds. If left untreated, post-traumatic stress disorder and other psychological traumas can affect combat veterans to the point that, over time, even their daily functions become seriously impaired. This places them at higher risk for self-medication and abuse with alcohol and drugs, domestic violence, unemployment, homelessness, and even suicide.

No one really knows how many of our troops in Iraq and Afghanistan have been or will be affected by their wartime experiences; despite the early intervention by psychological personnel, no one really knows how serious their emotional and mental problems will become. A study published in the July 2004 issue of the *New England Journal of Medicine (NEJM)* reported that one in six soldiers and Marines surveyed after returning from deployment in Iraq "met the screening criteria for major depression, generalized anxiety, or post-traumatic stress disorder." The authors took pains to note that these numbers may understate the prevalence of these disorders. VVA has no reason to believe that the rate of veterans of this war having their lives significantly disrupted at some point in their lifetime by PTSD will be any less than the 37 percent estimated for Vietnam veterans by the National Vietnam Veterans Readjustment Study (NVVRS) conducted some 20 years ago.

We offer some comments specific to the mental health assistance currently being offered by these two departments.

- First, some praise for officials of both departments who recognize the need for early intervention.

DoD is "embedding" psychologists with units that regularly experience the trauma of combat and loss. This is to be praised. And the VA, after some prodding, has said that it is stationing personnel on military bases to aid returning troops in understanding the services – including mental health services – that are available to them when they reenter civilian life. Still, there seems to be real resistance by some to acknowledging that soldiers suffer emotional hurts by their war experiences.

- DoD 's two-page, fill-in-the-bubble Post-Deployment Health Assessment form lists only five questions that address mental health, including "Did you ever feel

you were in great danger of being killed?" This is hardly a useful mental health assessment tool.

VVA, along with the National Gulf War Resource Center (NGWRC) met with Assistant Secretary of Defense for Health Winkenwerder in October of 2003, to discuss the inadequacies of the pre-deployment medical exam and the post-deployment medical examination, particularly the so-called mental health assessment. We made all of the following points to him, yet he refused to even consider changes in the way those assessments were being conducted.

Soldiers have little incentive to tell the truth because an admission of emotional issues could delay discharge or reunification with family. Unless a soldier asks for help, there's a good chance that s/he will never receive it. Although post-war emotional problems are more widely understood than ever before, only a third of troubled Iraq veterans seek care. And some 65 percent of troops with problems say they worry that if they ask for help, they'll appear "weak."

- Another barrier to seeking help is veterans' fears that personal mental health information will become part of their permanent personnel file and keep them from being promoted in the future.

Such concerns are not unfounded. DoD's Program Manager for Operational Stress and Deployment Mental Health is on record as having stated that "If you have a health concern that's going to prevent you from deploying again and carrying out your job - from firing a rifle, for instance - we want to know about that." One officer with whom we spoke laughed when we told him that we had been assured by top officials in the Army that there is no longer any stigma attached to returning troops who seek psychological counseling. "A lot of my colleagues seek assistance privately," he told us, "because if they go through military channels their careers are toast."

- While U.S. casualties steadily mount in Iraq, another emotional toll is rising rapidly on the home front.

Evidence overwhelmingly supports the need for early intervention and treatment of PTSD and related mental health disorders not only for active duty troops and veterans but for their families as well. The difficulties and strains of return can be surprisingly and sometimes painfully disappointing to military families.

The divorce rate for military families has soared in the past three years, most notably for officers, as longer and more frequent war zone deployments place extra strains on couples. Between 2001 and 2004, divorces among active-duty Army officers and enlisted personnel nearly doubled, from 5,658 to 10,477, even though total troop strength remained stable. In 2002, the divorce rate among married officers was 1.9 percent - 1,060 divorces out of 54,542 marriages; by 2004, the rate had tripled to 6 percent, with 3,325 divorces out of 55,550 marriages.

The effects of these neuro-psychiatric wounds will emerge in some fashion. If there is no proper treatment, then the effects will manifest themselves negatively toward those closest to the soldier, which means family and close friends. This makes it even more important for proper treatment to be offered in a manner that people will accept it, that families may be spared needless emotional and sometimes physical violence.

It is the primary VA structure itself that is teetering because of reductions in staff and other key organizational capacity in general, and mental health staff in particular, since 1996. Even the \$100 million committed by Undersecretary for Health Dr. Jonathan Perlin at VA this year will not even come close to restoring the needed organizational capacity. Further, the Special Advisory Committee on Seriously Mentally Ill veterans for the past two years languish unheeded and not implemented. If there is to be a serious commitment to meeting the mental health needs of these new veterans, then action needs to be taken to swiftly implement these recommendations, and to restoring staffing levels for PTSD and other service related mental injuries.

Communities, too, need to understand this, particularly in the case of returning members of the National Guard and the Reserves. Many of these men and women cannot be expected to reintegrate into their communities without access to appropriate mental health support services akin to the support that should be afforded to active-duty troops at military facilities. The Vet Centers, operated by the VA Readjustment Counseling Service (RCS), must obviously be a key player in this response. The Vet Centers have the legal authority to serve the families of veterans (including returning National Guard & Reserve troops), as well as the acumen to serve a population that is leery of going anywhere near a traditional medical facility, whether run by the VA or by DoD.

The Vet Center program is the most studied program of the VA, and every study, by the Government Accountability Office and others, has found that it is the most cost-effective, cost-efficient program operated by the VA. An investment of a mere additional \$17 million in the Vet Centers would buy one full-time family counselor skilled in family counseling, grief counseling, and PTSD counseling in each of the 206 centers, as well as an additional 40 staff members to augment the staff at centers near clusters of the returning veteran population to meet their needs. Vet Centers help keep veterans employed, and help keep their families healthy and together.

Further, it is imperative that DoD, VA, and relevant state officials must do a far better job of coordinating the provision of appropriate mental health programs and services for returning National Guard members and Reserve troops and their families.

- Preliminary research indicates that women who serve in Iraq and Afghanistan are more likely to suffer from PTSD than their male counterparts.

Vietnam Veterans of America

*Statement for the Record
HVAC
July 27, 2005*

Although no one has firm statistics on the rates of PTSD for women vets, preliminary data gathered by the VA suggest that women are not only afflicted by PTSD more often than men, but that their PTSD may be worse. Twenty years ago, only about 2 percent of the patients at VA hospitals and clinics were women. Today they account for 14 percent of patients, and as a result the VA is scrambling to handle the growing number of female patients with both physical and mental scars.

- Other challenges remain in meeting the needs of reserve and National Guard service members

Despite the actions under way or planned to improve TAP, challenges remain -- particularly in designing transition services that better accommodate the schedules of demobilizing Reserve and National Guard service members. For example, staff who provide transition assistance may not know when Reserve and National Guard units are returning for demobilization, because national security concerns prevent the release of information on the movement of large numbers of service members. Moreover, the time schedules for demobilization vary by service and demobilization site. Commanders are challenged with trying to balance demobilizing some units while at the same time mobilizing others. They also must balance getting Reserve and National Guard members back to their families as quickly as possible with the extra time needed for transition assistance.

During their rapid demobilization, Reserve and National Guard members often do not receive all the information on possible benefits to which they are entitled. Notably, certain education benefits and medical coverage require service members to apply while they are still on active duty. However, even after being briefed, some Reserve and National Guard members do not know that they needed to apply for certain benefits while still on active duty.

Vietnam Veterans of America applauds the Committee for your obvious concern about the mental health of our troops and their families. VVA cautions, however, that providing the appropriate services to assist these women and men as they transition either back to stateside duty or to civilian life requires both an understanding of the stresses and stressors to which they have been exposed -- and the willingness to commit the resources necessary to help these veterans cope. It is our hope that these resources will be made available.

Thank you.

*Vietnam Veterans of America**Statement for the Record
HVAC
July 27, 2005*

VIETNAM VETERANS OF AMERICA
Funding Statement
July 27, 2005

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Thomas H. Corey

Tom Corey serves as President of Vietnam Veterans of America, the nation's only congressionally chartered organization exclusively serving the needs of Vietnam-era veterans and their families.

A native of Detroit, Corey entered the U.S. Army and was sent to Vietnam in May 1967 where he served as a squad leader with the 1st Air Cavalry Division. While engaged in an assault against enemy positions on January 31, 1968, he received an enemy round in the neck, which hit his spinal cord and left him paralyzed and a quadriplegic. He was medically retired in May 1968. Corey is a decorated combat veteran.

After an extended hospitalization, Corey returned to his family in Detroit where he spent his time in and out of the local VA hospital. He relocated to West Palm Beach, Florida, in 1972, where he is involved in community affairs and serves on many advisory boards, including those at the VA Medical Centers in Miami and West Palm Beach, the VA Research Foundation of Palm Beaches, and the VSIN 8 Management Assistance Council. He has received numerous awards for speaking out on veterans' and disabled persons' rights.

Corey has returned to Vietnam numerous times regarding our POW/MIAs and Agent Orange issues with successful results.

Corey was the first recipient of the Vietnam Veterans of America's Commendation Medal, VVA's highest award for service to veterans, their families, and the community.

Corey was the founding President of VVA Palm Beach County Chapter 25 in 1981. In 1991, the chapter was named the Thomas H. Corey Chapter at its tenth anniversary celebration. In 1985, he was elected to VVA's National Board of Directors. In 1987, he was elected VVA's national Secretary and was re-elected in 1989, 1991, 1993, and 1995 to that position. In 1997, he was elected VVA's national Vice President through 1999 and in 2001 he was elected VVA President and was re-elected in 2003.

Corey is a member of the Paralyzed Veterans of America, Military Order of the Purple Heart Association, Disabled American Veterans, American Legion, Veterans of Foreign War, 1st Cavalry Association, and the National Association of Uniformed Services.

Tom Corey resides in West Palm Beach, Florida. He has a son Brian, and a daughter, Trang.

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Statement of the
American Psychiatric Association
for the
House Veterans Committee
on
Post-Traumatic Stress Disorder (PTSD)

July 26, 2005

The American Psychiatric Association (APA) consists of over 36,000 psychiatric physicians nationwide who specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders. The APA thanks Chairman Buyer, Ranking Member Evans, members of Committee and your House colleagues for your commitment to providing the highest quality medical care for our nation's veterans and today's hearing on Post Traumatic Stress Disorder.

POSTTRAUMATIC STRESS DISORDER

Posttraumatic Stress Disorder, or PTSD, is a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged and these symptoms can be severe enough and last long enough to significantly impair the person's daily life. PTSD is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse (often beginning with pain medication prescribed because of combat wounds), problems of memory and cognition, and other problems of physical and mental health. The disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, homelessness and incarceration.

Four months ago, an article in the *New England Journal of Medicine* indicated that 10% of eligible ex-soldiers seeking medical treatment between October 2003 and February 2005 presented with PTSD and that 9% were struggling with drug and alcohol abuse. Further, 7% had been diagnosed with depression and 6% had anxiety or phobia disorders. Many ex-soldiers had multiple disorders.

One of the common misconceptions about PTSD is that it is highly subjective and not readily apparent to the trained professional. In fact, PTSD is marked by clear biological changes as well as emotional symptoms. PTSD is an illness that is related to structural and chemical changes in the brain. Using positron emission tomography (PET) and single photon emission computed tomography (SPECT) studies, researchers have found that the hippocampus—a part of the brain critical to memory and emotion—appears to be different in cases of PTSD. Scientists are investigating whether this is related to short-term memory problems. Changes in the hippocampus are thought to be responsible for intrusive memories and flashbacks that occur in people with this disorder.

Other studies demonstrate that people with PTSD tend to have abnormal levels of key hormones involved in response to stress. Some studies have shown that cortisol levels are lower than normal and epinephrine and norepinephrine are higher than normal. Current research at the National Institutes of Mental Health to understand the neurotransmitter systems involved in memories of emotionally charged events may lead to discovery of medications or psychosocial interventions that, if given early, could block the development of PTSD symptoms.

CURRENT TREATMENT RESOURCES ARE INADEQUATE

VA patients with severe PTSD increased 42% from 1998 to 2003, while expenditures increased only 22% during that same time. Veterans who are service-connected for PTSD use VA mental health services at a rate at least 50% higher than other mental health user groups. It is essential that identified PTSD programs be maintained consistent with the provision of P.L. 104-262, so that veterans may reap the benefits of specialized treatment delivered by clinicians who are experts in addressing the unique needs of veterans with PTSD and its associated co-morbid conditions.

Section 1706 of P.L. 104-262 states: "The Secretary shall ensure that the Department maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with...mental illness)...in a manner that affords those veterans reasonable access to care and services for the specialized needs, and ensures that overall capacity of the Department to provide those services as of the date of enactment."

The APA is concerned about significant inequalities in access and quality of care of specialized services across the 22 relatively autonomous Veterans Integrated Service Networks (VISNs). We understand that some VISNs have been reluctant to make needed improvement in mental health treatment and have made little progress in establishing community-based programs for the mentally ill veteran. This lack of action seems to reinforce continuing biases and discrimination regarding mental and substance use disorders, and thus runs contrary to policy and direction from the VA in Washington, D.C. It is very important for Congress to monitor local variations in service delivery to insure that the same high quality of care be maintained across all facilities and at all VISNs.

Fifteen years ago, the VA Special Committee on PTSD urged that there be a PTSD Clinical Team (PCT) at every VA medical center. At the present time only about half of all VA medical centers have PCTs, and many of the staff originally dedicated to PTSD services at those sites have long since been drawn off to other duties or lost to attrition. The Office of the Inspector General recently questioned whether 39 of the existing 84 PCTs have any staff still assigned to those duties.

Additionally, a formidable challenge exists in addressing the needs of the majority of troops serving in Iraq and Afghanistan as they return home by way of demobilization sites across the country. Many of them will remain in active service and are not triaged to VA health care system. This is especially problematic for Guard and Reserve members who have less access to DoD mental health services and who abruptly find themselves back in their communities rather than on military bases where they might receive more knowledgeable community support.

PTSD treatment programs for women veterans exist to some extent in Vet Centers with far fewer specialized resources in VA medical facilities. The need for treating combat stress, war zone stress, sexual harassment, and sexual assault are increasing in this component of the VA population. Recent studies of assault and harassment in Reservists and National Guard troops underscore the growing needs of these veterans for specialized treatment.

MENTAL HEALTH CARE OF VETERANS

- Since 1996, VA mental health spending has declined by 25% in real dollars.
- Over 470,000 veterans are service-connected for mental disorders.
- More than 185,000 are service-connected for PTSD, a disorder most often directly related to combat duty.
- In 2003 alone more than 77,800 veterans received specialized care for PTSD with tens of thousands more receiving some type of care through their primary care clinic.¹

MENTAL HEALTH SERVICES FOR VETERANS

Over the past ten years, there has been an increase in the number of veterans with serious mental illnesses being treated by the VA. This is partially attributable to other avenues of care becoming closed (e.g., when private insurance coverage for mental illness becomes exhausted or Medicaid systems are stretched to the breaking point). Over 90% of the veterans being treated for psychosis are so ill that they cannot maintain a significant income and therefore become indigent and heavily reliant on the VA for their care.

For too long, mental health care has *not* been a priority for VA. Virtually every entity with oversight of VA mental healthcare programs – including Congressional oversight committees, the GAO, VA’s Committee on Care of Veterans with Serious Mental Illness, and The Independent Budget – have documented both the extensive closures of specialized inpatient mental health programs and VA’s failure in many locations to replace those services with accessible community-based programs. The resultant dearth of specialized inpatient care capacity and the failure of many networks to establish or provide appropriate specialized programs effectively deny many veterans access to needed care. These gaps highlight VA’s ongoing problems in meeting statutory requirements to maintain a benchmark capacity to provide needed care and rehabilitation through distinct specialized treatment programs and a comprehensive array of services.

Congress has directed the VA to substantially expand the number and scope of specialized mental health and substance abuse programs to improve veterans’ access to needed specialized care and services (P.L. 107-135). The law details the VA’s obligation to make systemic changes network-by-network to reverse the erosion of that specialized capacity. Congress has made clear that the criteria by which the “maintain capacity” obligation is to be met are hard, measurable indicators that are to be followed by all Veterans Integrated Service Networks (VISNs).

Veterans with substance use disorders are drastically underserved. The dramatic decline in VA substance use treatment beds has reduced physicians’ ability to provide veterans a full continuum of care, often needed for those with chronic, severe problems. Funding for programs targeted to homeless veterans who have mental illnesses or co-occurring substance use problems does not now meet of the demand for care in that population. Additionally,

¹ Department of Veterans Affairs, Office of Public Affairs, Media Relations, PTSD Fact Sheet, December 2004.

despite the needs of an aging veteran population, relatively few VA facilities have specialized geropsychiatric programs.

The APA supports the calls of the VA Special Committee on PTSD for a fully operational PCT at every medical center and the implementation of defined standards for those teams. Filling vacancies in high priority areas such as combat related PTSD treatment should be a priority. The APA urges that VA prioritize the staffing of PCTs at VA's adjacent to major military sites and in locations where mobilized Guard and Reserve units are based. Congressional support for developing innovative rehabilitative methods for war injured veterans through MIRECC's, Medical Research, Academic Affairs, and the National Center for PTSD will assure that VA will continue to attract top clinicians, teachers, and researchers into its next generation of healthcare providers. This is an important priority.

The APA is pleased that VA will allocate additional resources, as authorized by P.L. 108-170, for enhancement of PTSD and mental health program capacity. However, given the scope of current and growing needs as well as the unfortunate cultural intransigence of some VISNs towards providing mental health services, the APA requests additional funding in FY06 for VA PTSD and severe mental health and substance abuse programs.

The Department of Defense and the Veterans Administration have a unique opportunity to intervene now, while the majority of new combatants are still in uniform. The proactive education of staff and preparation of programs can help providers take action before PTSD takes root. We can employ the new joint VA/DoD guideline on traumatic stress to follow these service men and women through the remainder of their DoD careers and throughout their VA care. Further, we can create a comprehensive database on response to treatment and use it to develop still better treatments.

WORKFORCE SHORTAGE

The shortage of physicians and other mental health professionals has compromised the services VA provides and has endangered patient safety. Many veterans with mental illnesses are medically fragile – with diabetes, liver or kidney failure, or cardiac disease, for example. Their care requires a specially trained physician. A revision of salary schedules, recognition of the contributions of International Medical Graduates and minority American Medical Graduates, and the availability of Continuing Medical Education (CME) courses and other professional opportunities for advancement need to be addressed. We understand there is a significant shortage of nursing staff, especially psychiatric nurses, and we request that the VA address this shortage area.

RECOMMENDATIONS

The APA is deeply concerned about veterans with mental illness. We recommend:

- Additional and specifically allocated funding for outreach, diagnosis and treatment;
- Immediate implementation of clinical programs mandated within the system;

- Compliance with legislation aimed at maintaining capacity; and
- Enhanced recruitment and retention of specialty personnel who will improve the care and lives of veterans with mental illnesses and substance abuse disorders.

Above all, a profound respect for the dignity of patients with mental and substance use disorders and their families must be duly reflected in serving the needs of veterans in the VA system and those attached to the National Guard.

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Please contact Lizbet Boroughs, Deputy Director of Government Relations,
American Psychiatric Association if there are any questions about our statement;
703-907-7800.



STATEMENT
of
MICHAEL FAENZA, PRESIDENT AND CEO
NATIONAL MENTAL HEALTH ASSOCIATION

before the

Committee on Veterans Affairs

House of Representatives

on

Mental Health Issues Facing Returning Service-members

July 27, 2005

Mr. Chairman, the National Mental Health Association commends you for scheduling this important hearing, and applauds as well Ranking Member Evans for introducing legislation that would tackle many of the issues under discussion today.

The National Mental Health Association (NMHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. In partnership with our network of 340 state and local Mental Health Association affiliates nationwide, NMHA works to improve policies, understanding, and services for individuals with mental illness and substance abuse disorders, as well as for all Americans. NMHA is also a founding member of the Campaign for Mental Health Reform, which seeks to improve mental health care in America, for veterans and non-veterans alike. President Bush's New Freedom Commission on Mental Health emphatically called for mental health reform in its powerful report, [Achieving the Promise: Transforming Mental Health Care in America](#) (2003). Of particular significance to the immediate challenges posed by growing numbers of service-members who are manifesting signs of post-traumatic stress disorder and other mental health problems, is the Commission's very hopeful message that early assessment and treatment of mental health disorders is critical.

Importantly, the Campaign for Mental Health Reform today released Emergency Response: A Roadmap for Federal Action on America's Mental Health Crisis. Our coalition of 16 national organizations designed the report as a "roadmap" for transforming the country's ailing mental health system. One of the seven critical steps to mental health reform highlighted in that report is its call to address the mental health needs of returning veterans and their families.

Today's hearing provides a critical foundation for this Committee to reverse a troubling pattern experienced in prior wars in which a significant percentage of those exposed to combat develop chronic, disabling mental health problems. At this important juncture, key questions remain unanswered. Will mental health problems being experienced by many service-members and veterans go undetected and untreated because of funding strains on, or other systemic problems in or between, the health care systems of the Departments of Defense or Veterans Affairs? Will service-members and veterans fail to recognize the nature of their symptoms or fail to seek care because of perceived stigma, or because of eligibility barriers? Will family members who have undergone their own trauma over the course of long deployments and redeployments have access to needed counseling and support? Of one thing we can be all too sure – left untreated, war-related mental disorders become more severe and chronic in nature.

We fear that without timely congressional action – on both legislation and funding -- the mental health needs of many veterans of Operations Iraqi Freedom and Enduring Freedom will go unmet, and, tragically, the legacy of these Operations will include significant family trauma, substance abuse, worsened physical health, unemployment, homelessness and even suicide.

Veterans and their families can feel fortunate that there is a strong body of research on PTSD and mental health generally on which to rely and that a range of effective interventions do exist. In fact, early intervention can relieve, and even eliminate, war-related mental health problems.

We commend the Committee for shining a spotlight on PTSD. We have learned much about this disorder and war-related mental health since the Vietnam War. We should, of course, also remain mindful that PTSD is but one of a number of psychological outcomes of war. Returning service-members may also experience depression, anxiety, substance-use problems, and still more severe mental illnesses.

In grappling with the mental health consequences of these ongoing military operations, VA and DoD have certainly made important progress, and have acted on some of the important lessons of prior wars. Nevertheless, a returning service-member can have no assurance that either system will necessarily meet his or her' mental health needs, given the following:

- Tragic instances of suicide among returning service-members;
- Cracks in what should be a seamless system between the Departments of Defense and Veterans Affairs;
- Lack of mental health staffing at some VA facilities;

With a grueling war taking an alarming toll on our men and women in uniform, this nation faces a stern test: will it meet its obligations to its warriors? Surely the nation has no higher obligation than to heal its combatants' wounds, whether physical or mental. Both must be a priority.

We look forward to working with the Committee to help achieve that goal.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans' Affairs
Member: Rep. Steve Buyer
Witness: Dr. Michael Kilpatrick
Question # 1

Question: What action is DoD taking, pre-deployment, to prepare and train Service members to handle war-zone experiences and to minimize the potential risk for developing Post Traumatic Stress Syndrome?

Answer: The two most effective buffers to stress are control and support. A Service member's increased perception of control comes from effective, realistic training. That training builds confidence and abilities needed to deal with war-zone experiences. Training and deploying as a unit further add to support from unit members, and joint training exercises increase that level of support.

In addition, Service members are instructed on what to expect when they arrive in the deployed environment. The various deployment cycle support programs include training in self-aid and buddy care related to operational stress. Stress inoculation or pre-exposure preparation training builds skills to deal with the potential stress they will experience.

Pre-deployment preparation for Service members also includes preventive services to enhance family stability and to take care of families while the Service members are away. Since stress is cumulative, reducing stressors associated with the family can reduce the overall stress-level for the Service member. DoD increased family support through Military OneSource. Military OneSource provides enhanced services and counseling to families of our military personnel, including Guard and Reserve personnel. This resource provides confidential counseling up to six sessions per person at no charge to the Service member or family. It also provides education and counseling on life issues, such as how to get the car fixed or find a plumber while the Service member is deployed.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans' Affairs
Member: Rep. Steve Buyer
Witness: Dr. Michael Kilpatrick
Question # 2

Question: Generally speaking, do you think the availability of clinical practice guidelines improves the knowledge and treatment practices of the healthcare provider?

Answer: Yes. Clinical practice guidelines (CPGs) bring together a compilation of evidence-based practices and lessons learned related to a particular health condition or concern. They provide clinicians with a readily available, structured and standardized method of assessment and treatment for frequently occurring conditions. CPGs give a public forum to clinical excellence and expert opinion that was not available across the board before they became widely accepted. CPGs are promulgated by a number of medical and professional organizations, including the Institute of Medicine and the National Quality Management Program.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans' Affairs
Member: Rep. Steve Buyer
Witness: Dr. Michael Kilpatrick
Question # 3

Question: Is there a department-wide mandate for DoD healthcare providers to use the DoD/VA provided clinical practice guidelines? If so, which tools are the most useful?

Answer: The DoD mandates use of the clinical practice guideline (CPG) for post-deployment health assessments because of its specialized purpose: to detect and manage any harm that Service members and their families experience as a result of military service. For example, it specifies the processes by which symptoms of undiagnosed conditions are systematically addressed, and it considers the most likely exposures to which a military population may have been exposed. The additional guidelines, including Acute and Post Traumatic Stress Disorder, Depression, Substance Use Disorder, and Medically Unexplained Symptoms, are recommended but not mandated because multiple scientific and clinical studies with new information are published daily for many conditions. In addition, there are several guidelines for the same condition, many of which can augment the contributions of any single set of guidelines.

The guidelines and related tools are available to military and VA clinicians. Toolkits have been created for all jointly developed DoD/VA CPGs. In addition to the toolkits, there is a website and training materials for clinicians to access to the Post-Deployment Health-CPG along with other supporting guidelines for specific potential deployment-related conditions and concerns. Providers have indicated that the algorithms, or decision trees, were the most useful tools associated with the CPG.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans' Affairs
Member: Rep. Steve Buyer
Witness: Dr. Michael Kilpatrick
Question # 4

Question: In addition to the clinical practice guidelines, is the data collected on Post Traumatic Stress Disorder (PTSD) shared within and between the Services? If not, why not?

Answer: Yes, information about PTSD is shared among the Services. For example, the Land Combat Study conducted by the Walter Reed Army Institute for Research included both Army and Marine Corps personnel, both of which involve land combat troops. There are also a number of working groups designed to develop shared information across the Services, including the DoD Operational Stress and Deployment Mental Health Working Group, the DoD Suicide Prevention and Risk Reduction Committee, the DoD/VA Deployment Health Working Group and the DoD/VA Deployment Mental Health Subgroup.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans Affairs
Member: Rep. Evans
Witness: Dr. Michael Kilpatrick
Question # 1

Question: What aggregated data do you provide the VA on the post-deployment health assessments?

Answer: The VA has asked for aggregated data on post-deployment health assessments; these are provided as requested. Data are routinely available through the joint DoD-VA Deployment Health Working Group. The Army Medical Surveillance Activity (AMSA) prepares a regular monthly report that is available to the VA, including data on Service member Reserve Component versus Active Duty category, deployment-related health concerns, exposure concerns, and rate of post-deployment referrals.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans Affairs
Member: Rep. Evans
Witness: Dr. Michael Kilpatrick
Question # 2

Question: The RESPECT-MIL primary care program at Fort Bragg is an innovative collaborative care model which helps to manage depression, Post-Traumatic Stress Disorder and post-deployment health concerns. When will this program be implemented more broadly?

Answer: The RESPECT-MIL program is a research initiative. It is currently being studied at Fort Bragg. The results from that research will assist in determining if it should be implemented more broadly and which components are more effective for widespread implementation.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans Affairs
Member: Rep. Evans
Witness: Dr. Michael Kilpatrick
Question # 3

Question: What is DoD doing to ensure that primary care providers, whether at MTFs or through the TRICARE program, are implementing state of the art diagnosis and treatment of PTSD?

Answer: The DoD/VA Clinical Practical Guideline for Post-Traumatic Stress Disorder (PTSD) addresses the role of primary care providers in the PTSD diagnosis and treatment process. Primary care providers, of course, are not expected to be the source of "state of the art" diagnosis and treatment for PTSD. The task of primary care providers is to recognize symptoms of many mental health conditions, including PTSD, and to make appropriate referrals to mental health providers when their patient's condition falls outside of their area of expertise.

A primary efficacious treatment for PTSD is cognitive behavioral therapy, primarily in the practice domain of psychologists. Some patients benefit from the use of antidepressants, which are commonly prescribed by primary care providers. Such providers frequently coordinate psychotropic therapy with psychologists.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans Affairs
Member: Rep. Evans
Witness: Dr. Michael Kilpatrick
Question # 4

Question: What steps has DoD taken to ensure that the VA/DoD Joint Post-Traumatic Stress Disorder clinical practice guidelines (CPGs) are being implemented in all DoD medical treatment facilities and through the TRICARE program?

Answer: The VA/DoD CPGs have been widely disseminated by military mental health clinical leaders directly to their Services' providers.

The Army is the designated agent for clinical practice guideline dissemination. It has collaborated with other DoD clinical centers to establish a website, facilitated the development and dissemination of toolkits, and sponsored training events for clinicians at all levels, including numerous professional association conferences.

In addition to VA/DoD developed guidelines, there are 141 published sets of mental health practice guidelines on the government's national clearinghouse website for clinical practice guidelines. These guidelines are not intended to be mandates, but rather to provide clinical guidance for providers in their practice. Guidelines point to efficacious medications and therapies – but are not intended to substitute for formal education and training in basic treatment modalities. The appropriate treatment modalities used by providers are derived from several sources of information, including recently published studies, training at conferences, previous education and experience levels, and clinical practice guidelines.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans Affairs
Member: Rep. Evans
Witness: Dr. Michael Kilpatrick
Question # 6

Question: What efforts are underway or planned to evaluate the post-deployment health assessment and the health reassessment programs?

Answer: A comprehensive program evaluation for the post-deployment health reassessment program, including both process and outcome evaluation components, will be conducted during Fiscal Year 2006. The evaluation will involve a scientifically valid procedure through contract with an external evaluation team. It will assist in determining the effectiveness of each element of the program in meeting the objectives of identifying health concerns and facilitating access to care for post-deployment health issues.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans Affairs
Member: Rep. Evans
Witness: Dr. Michael Kilpatrick
Question # 7

Question: Is there a systematic and continuous quality improvement plan for the post-deployment health assessment and reassessment programs? How will you know if the assessment system is working effectively?

Answer: The effectiveness of these programs is monitored both from the perspective of the health assessments being accomplished and also from the perspective of care being provided to those who need it. Our focus is initially on establishing the requirement for deployment health assessments as a commander's responsibility, and then toward improving the access to care and the outcomes of care through ongoing quality assurance programs of the military health system.

Hearing Date: July 27, 2005
Committee: House Committee on Veterans Affairs
Member: Rep. Berkley
Witness: Dr. Michael Kilpatrick
Question # 1

Question: In order to receive VA benefits for Post-Traumatic Stress Disorder (PTSD), veterans need to have a diagnosis of PTSD related to a “stressor” which occurred during military service. Veterans who claim a stressor related to “combat with the enemy” are conceded to have a stressor which VA will recognize. VA has interpreted the “combat with the enemy” criterion very narrowly. For example, in Iraq, there have been situations in which a Service member killed innocent civilians while taking evasive action with a vehicle.

You indicated that “operational stressors and combat trauma” can result in Service members experiencing anxiety and depression symptoms. Can you describe some of the stressors currently experienced by our Servicemen and women in Iraq and Afghanistan which may support a diagnosis of PTSD? How are these stressors documented in the individual Service member’s military records?

Answer: There is no definitive list of traumatic stressors. A diagnosis of PTSD requires by definition several criteria, one of which includes the experience or witness of a traumatic event or situation that threatened death, serious injury, or physical integrity of self or others and that created an immediate response of intense fear, helplessness, or horror. That exposure must result in the later experience of PTSD-related symptoms that create clinically significant distress or impairment in social, occupational, or other important functional areas that persist for a specified period of time. The exposure alone or the symptoms alone may not result in a diagnosis.

The post-deployment health assessment, or PDHA, includes an opportunity for the Service member to identify and document the types of exposures that may generate PTSD symptoms in the future. Standards of medical care further require documenting in the medical records how the criteria for a PTSD diagnosis are met.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Buyer
Witness: COL Hoge
Question #1

Post-Traumatic Stress Disorder

Question: Dr. Hoge, you stated that a great deal of data is currently being gathered by you and others—both in the field and post-deployment. Is that information being shared with the other services? Is it being shared with the VA so they can better understand what their realistic mental health requirements might be?

Answer: Yes, the data are shared as soon as they have been analyzed and have gone through the appropriate level of organizational and peer-review. The data are being presented at meetings that involve DoD and VA, for example the 2005 VA Psychology Leadership Conference, 2005 VA Mental Illness Research, Education, and Clinical Center conference, 2005 American Psychological Association annual meeting, and 2005 American Psychiatric Association annual meeting, the National Guard State Surgeons conference, and a variety of other forums.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Buyer
Witness: COL Hoge
Question #2

Post-Traumatic Stress Disorder

Question: How predictive are the results from your study? How much exposure to VA clinicians or policymakers since you released your original findings? To your knowledge, are your results currently being used in a predictive fashion by either DoD or VA to determine out-year mental health requirements?

Answer: Our studies provide reasonable estimates of the percent of service members who are at risk of serious mental health problems, particularly PTSD. The results of our studies have been highly consistent using different types of methods (for example survey-based studies as well as analysis of health care utilization) and across different units. They are also consistent with prior research. Our results have been used in a predictive fashion to estimate the resources needed to conduct the new post-deployment health reassessment for the Army. However, there remains concern about the adequacy of resources available to meet the mental health care needs of our returning OIF veterans, based on the results of our study, and the increased mental health care utilization documented among service members returning from Iraq. We have continued to share data with the VA, but I am not aware of whether or not our data have been used by the VA to determine out-year mental health requirements.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Buyer
Witness: COL Hoge
Question #3

Post-Traumatic Stress Disorder

Question: Do we lack the necessary longitudinal treatment research to determine the efficacy of the recognition, intervention, and prevention strategies currently being used by DOD and VA? Is time truly the only way to better understand the prevalence of PTSD in returning OEF/OIF veterans?

Answer: We have a large amount of data now on the prevalence of PTSD, although many questions remain such as the impact of longer or repeated deployments, and how earlier treatment will affect the results longer-term. What is most important now is to design and validate through controlled studies new prevention and early intervention strategies. These types of studies however are very difficult to conduct, are expensive, and often there is a necessity to implement new strategies before they have been fully validated due to high demand. Several intervention study efforts are underway, but there is clearly much more research that needs to be conducted to determine the best intervention strategies.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Buyer
Witness: COL Hoge
Question #4

Post-Traumatic Stress Disorder

Question What were the limitations of your analysis and do you believe we need to conduct further studies before drawing conclusions about the prevalence of PTSD in Iraqi and Afghanistan veterans?

Answer: There are ample data available now to draw conclusions about the prevalence of PTSD among returning OIF/ OEF veterans, based on our study, as well as other DoD/ VA sources, and literature from prior wars (Vietnam in particular). Limitations of our Land Combat Study are that it is based on self-administered surveys, rather than clinical interviews, and is mostly cross-sectional, focused on looking at similar units at different time points rather than the same Soldiers over time (our surveys are anonymous). However, our prevalence estimates are likely to be conservative, underestimating the percent of Soldiers with significant mental health concerns. This is due to the fact that we used strict case definitions, so that only those reporting a high number of symptoms or functional impairment are considered to screen positive for a mental health problem. Also our study focuses on the healthiest segment of the population, Soldiers on duty in their units, and thus may miss those who are not able to be on duty due to medical conditions. One of the reassuring aspects of our study has been the high consistency between data collected from different units, as well as consistency between data that we have collected anonymously and data collected from clinical screening efforts and analysis of mental health care utilization. Further studies are needed to understand the impact of longer or repeated deployments, understand the important predictors of PTSD over time, determine the rates of PTSD over time, and determine the best intervention and treatment strategies.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Evans
Witness: COL Hoge
Question #1

Post-Traumatic Stress Disorder

Question: In your testimony you state that alcohol misuse often is associated with PTSD. Please describe the association between alcohol misuse and PTSD. What are the PTSD treatment implications of alcohol misuse or substance abuse?

Answer: It is well known that PTSD is often associated with alcohol problems, and alcohol misuse can make PTSD symptoms worse. In our studies, Soldiers who meet the screening criteria for PTSD are significantly more likely to have alcohol problems than Soldiers who don't have PTSD. For Soldiers who have alcohol problems together with PTSD symptoms, it is important to treat both conditions simultaneously.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Evans
Witness: COL Hoge
Question #2

Post-Traumatic Stress Disorder

Question: In your testimony you highlighted the need to bring safe, accessible and confidential care to servicemembers in need rather than waiting for them to seek care. Stigma is a barrier. Do you believe a joint DoD-VA council could be a catalyst for policy recommendations on how to reduce stigma associated with seeking mental health care by active-duty, Reserve, and National Guard members?

Answer: DoD-VA partnerships can be very useful, such as in the development of clinical practice guidelines and standards of care. One of the things that is not known is to what degree barriers to care and stigma are different within the military health care system compared with the VA health care system. For example, many Soldiers report concerns that they would be treated differently by peers in their units if they sought mental health care, but this is not likely to be an important concern after separation from their unit. Further research is needed to understand barriers to care and stigma in the VA and DoD health care systems, and develop and test strategies to reduce barriers and stigma.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Evans
Witness: COL Hoge
Question #3

Post-Traumatic Stress Disorder

Question: Please describe the relationship between PTSD and suicide risk. What implications does this association have for training and educating primary care providers and mental health care clinicians?

Answer: Suicide is an extremely rare event (averaging 12 per 100,000 Soldiers per year in the Army), so it is difficult to identify a clear association with PTSD in this population. However, studies from civilian settings have shown associations between PTSD and increased risk of suicidal behaviors. This may in part be mediated by the close association of PTSD with depression and alcohol abuse, both of which are associated with increased suicide risk. One important strategy in preventing suicidal behaviors is to screen for depression (as well as PTSD and alcohol abuse) in primary care clinics.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Evans
Witness: COL Hoge
Question #4

Post-Traumatic Stress Disorder

Question: In the MHAT II the Army reported that suicide rates in Iraq and Afghanistan have gone down. Is the Army monitoring the suicide rates of OIF/OEF servicemembers post-deployment?

Answer: Yes, the Army tracks OIF/OEF post-deployment suicide data as well as suicide rates for Soldiers who have not deployed.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Evans
Witness: COL Hoge
Question #5

Post-Traumatic Stress Disorder

Question: Have servicemembers' utilization rates of mental health services increased? How does this utilization rate compare with servicemembers anonymous responses of their interest in seeking treatment or help with depression, anxiety or PTSD?

Answer: Rates of utilization of mental health services among OIF veterans are much higher than baseline rates of utilization among service members prior to OIF and OEF. Based on data we have collected, approximately 13% of all OIF-1 veterans received care in a military treatment facility for a mental health problem. This is similar to the rate reported in anonymous surveys we conducted among selected combat brigades, where approximately 11% of Soldiers returning from Iraq reported receiving professional help in the month before the survey.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Evans
Witness: COL Hoge
Question #6

Post-Traumatic Stress Disorder

Question: In your 12 months post-deployment survey, how much more likely were National Guard and Reserve troops to respond positively for screens for anxiety, depression and PTSD than other servicemembers?

Answer: We have no 12 month data yet on National Guard and Reserve Component troops. However, rates among the three components were compared during OIF 2 as part of the recent Mental Health Assessment Team report and were found to be similar.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Evans
Witness: COL Hoge
Question #7

Post-Traumatic Stress Disorder

Question: Is there extensive and conclusive research on the factors that decrease the likelihood of the development of chronic PTSD in servicemembers and veterans who have had combat exposure, including exposure to guerilla warfare?

Answer: There have been lots of studies characterizing the prevalence and risk factors for PTSD, but very few studies to guide preventive interventions. Earlier treatment with effective medications or counseling (such as cognitive behavioral therapy) is considered to be the most effective way to prevent chronic PTSD among those with symptoms. More research into new prevention and treatment interventions is urgently needed.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Buyer
Witness: LTC Engel
Question #1

Post-Traumatic Stress Disorder

Question: While few would argue with the possible utility of both the pre and post deployment questionnaires, can you detail the clinical and perhaps the actuarial value of the surveys at this point? In your opinion, are they powered sufficiently to be used as predictive tools? If not, how can they be improved?

Answer: A major clinical value of the post-deployment questionnaires is mental health screening. The questionnaire allows for identification of individuals at increased risk for key trauma-related mental disorders to include risk of domestic violence.

Pre and post-deployment questionnaires may help with actuarial prediction. Actuarial predication attempts to predict the level of needs for subgroups within a population rather than individual needs. The questions assessing mental health, environmental exposures, desire for care, and overall health status, while of little value for clinical and research purposes, may have long term value in predicting how health may vary for subgroups of war veterans. The actuarial uses of these measures should not be overestimated however. Many "downstream" events in the lives of veterans (e.g., smoking, drinking, accidents) are likely to have a much larger effect on future health than baseline and immediate post-war health and are very difficult to predict.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Buyer
Witness: LTC Engel
Question #2

Post-Traumatic Stress Disorder

Question: Generally speaking, how effective do you believe standardized, self-administered screening instruments are in determining major depression, generalized anxiety and PTSD?

Answer: Screening tools are not intended for “determining” mental illness; they are for identifying people at elevated risk of these disorders. Screening instruments are of limited value if they are not connected to clinical programs that can allow follow-up assessment and clinical management as appropriate for individuals who screen positive. Ultimately, the first level of clinical response to these screening procedures will be primary care, and military primary care providers will need education and practice preparation (e.g., nurse care managers, screening tools, outcome measures, clinical reminder systems, and automated registries) to effectively identify and address the needs of the influx of patients.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Buyer
Witness: LTC Engel
Question #3

Post-Traumatic Stress Disorder

Question: Provide us a sense of what the Deployment Health Clinical Center is doing to: (1) effectively establish a mental health baseline prior to a service members deployment; (2) determine what the prevalence in the field is of PTSD in both Afghanistan and Iraq; and (3) determine the overall percentage of those who are diagnosed with a mental health disorder (attendant to deployment) are actually PTSD.

Answer: The Deployment Health Clinical Center (DHCC) has a three-pronged approach to the overall mission of improving post-deployment health care in the Military Health System. First, DHCC provides intensive specialty services to those war veterans with the most severe PTSD, medically unexplained symptoms (symptoms not unlike those well known among 1991 Gulf War veterans but occurring in other war veteran populations), and health concerns. Second, we have a mass education program that aims to disseminate information to primary care providers on the health needs of returning war veterans (a central feature of this effort is the maintenance of www.pdhealth.mil for disseminating timely information about emerging post-deployment health issues). Third, DHCC is using science to evaluate new approaches to post-deployment primary health care. An example of this is DHCC's ongoing effort to evaluate the use of primary care screening, systematic outcomes monitoring, and a primary care-based nurse care manager to bolster the post-deployment primary care recognition and care of PTSD, depression, and medically unexplained symptoms.

Other DoD agencies are in charge of the effort to assess baseline health status. DHCC staff has contributed to the efforts to develop and field assessments of baseline health status of all new recruits in the military. For example, US Army Center for Health Promotion and Preventive Medicine and Walter Reed Army Institute of Research have implemented the Army version of the "RAP" (Recruit Assessment Program). The Naval Health Research Center in San Diego has piloted the use of the RAP in new Marine Corps recruits enlisting through the San Diego Marine Recruit Center. The Air Force has used a form of baseline health assessment called "HEAR". In the past year, efforts overseen by the Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA) have intensified to develop a single program instrument for baseline health assessment across all services. Currently this instrument, called "HART/A" is essentially completed and is undergoing legal and administrative reviews at the OASD/HA level. Planning and coordination is also underway with MEPCOM (Military Entrance Processing Command) to implement this instrument using computer automation at all MEP stations.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Buyer
Witness: LTC Engel
Question #4

Post-Traumatic Stress Disorder

Question: What are the deployed mental health teams doing on the ground to assess, diagnose and treat deployed troops who manifest with mental health-related conditions. What are the most modern in-theater treatment modalities? What is the success rate of these modalities in terms of the numbers of service members who can remain in-theater and not be evacuated?

Answer: Combat/Operational Stress Control (COSC) providers conduct prevention/awareness training and clinical evaluation and treatment. Prevention/ awareness interventions aim to educate Soldiers and Unit Leaders to identify early symptoms of behavioral health issues, provide psychological first-aid, and refer to COSC assets. Prevention/ awareness interventions also aim to decrease the stigma related to seeking behavioral healthcare. COSC providers conduct prevention/awareness interventions at the small unit worksite on a recurring basis.

Clinical evaluation and treatment interventions attempt to support the Soldier's ability to function in the deployed environment and to mitigate safety risks associated with the behavioral problems. Soldiers who are unable to be safely treated in theater are quickly evacuated to Landstuhl Regional Medical Center or the United States. COSC providers are skilled in and privileged to conduct wide array of up-to-date, evidence-based treatment interventions, including cognitive-behavioral therapy; exposure and response prevention; and supportive therapy. The Joint Deployment Formulary determines which medications are available in theater, providing greater variety at each higher level of care. The Joint Deployment Formulary was recently updated to reflect current best prescribing practices.

The Army Medical Department has completed two Mental Health Advisory Team assessments in the Central Command area of operations. The most recent assessment found that over 95% of all Soldiers seen by COSC providers in Iraq and Afghanistan are returned to duty.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Evans
Witness: LTC Engel
Question #1

Post-Traumatic Stress Disorder

Question: You discuss how primary care providers are key to early intervention of PTSD. I am concerned that many primary care providers are not receiving adequate support and time to diagnose PTSD. VA supported research by Dr. Kathryn Magruder, published in *General Hospital Psychiatry*, found that even with the template for mental health screening VA primary care providers failed to diagnose more than half of the PTSD cases. Only 48% of VA primary care patients with PTSD received specialty mental health care.

Would having specific outcome monitors and quality improvement instruments help ensure that the VA/DoD Joint PTSD Clinical Practice Guidelines are implemented by VA and DoD primary care providers?

Answer: Specific outcome measures and quality improvement metrics are one part of a quality improvement agenda for PTSD and related psychiatric disorders (mainly depression and substance abuse disorders particularly alcohol misuse). Education programs specifically tailored and targeted to primary care providers are also important. Research done in primary care related to improving depression outcomes suggest that education and measurement programs alone, however, have only a small and transient impact on health care quality. Changes in the “structure” of care – the way that care is delivered – are essential. This means that primary care practices must be properly prepared to do PTSD, depression, and substance abuse disorder care. Examples of strategies used to prepare primary care settings for PTSD, depression, and substance abuse disorder care include the use of nurse care managers, clinic registries, systematic primary care screening with automatic referral to a primary care-based nurse care manager, and electronic medical record clinician reminders. The combination of these strategies (provider education, measurement of outcomes and quality metrics, and a properly prepared primary care practice) is needed, especially the properly prepared practice can result in stable improvements in primary care approaches to trauma-spectrum disorders like PTSD, depression, and substance abuse disorders.

Hearing Date: 27 July 2005
Committee: HVAC
Member: Congressman Evans
Witness: LTC Engel
Question #2

Post-Traumatic Stress Disorder

Question: What would you recommend to improve the Post-Deployment Health Re-Assessment program?

Answer: An ongoing program evaluation component is the most important single addition to the current post-deployment health assessment program and the planned post-deployment health reassessment program. An evaluation program is essential to making positive incremental change. There is a real potential for unwittingly stigmatizing individuals with mass screening programs, overwhelming the primary care and mental health care system with unnecessary referrals, missing people with important but unmeasured mental health needs, and failing to properly assess people who screen positive. Any well intended mass screening program has the potential for harm if it is not carefully monitored, evaluated, and improved.

Secondly, greater involvement of the military primary care community in the planning and implementation of the program is essential to program success. To date, the program has been largely planned by the mental health community. For this program to work well, it should be owned, operated, and implemented in primary care with mental health consultants, not vice-versa.

**Questions for the Record for
The Honorable Shelley Berkley and The Honorable Lane Evans
House Committee on Veterans' Affairs
Responses from Michael Kussman, M.D., MS, MACP
July 27, 2005**

Question 1: I am concerned that many veterans have claims for PTSD denied because of a lack of stressor verification. In some cases, no effort is made to obtain records from the Center for Unit Record Research (CURR) or to follow leads concerning specific events described by the service member. What actions can VA take to improve the development of stressors in PTSD claims?

Response: VA regulations provide that service connection for Post Traumatic Stress Disorder (PTSD) requires: (1) medical evidence diagnosing the condition; (2) medical evidence establishing a link between current symptoms and an in-service stressor; and (3) "credible supporting evidence" that the claimed in-service stressor occurred. If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, or if the evidence establishes that the veteran was a prisoner-of-war (POW), and the claimed stressor is related to that POW experience, the veteran's lay testimony alone may establish occurrence of the claimed in-service stressor. In the absence of information to the contrary, receipt of certain individual decorations, such as the Combat Action Ribbon, are also considered by VA as evidence of participation in a stressful episode. In all other cases, in the absence of credible supporting evidence of the occurrence of the in-service stressor, the claim for service connection for PTSD must be denied.

Corroborating evidence of a stressor is not restricted to service records, but may be obtained from other sources, such as fellow servicemembers, family, and friends. In the case of a PTSD claim based on personal assault, VA regulations explain that evidence such as records from law enforcement authorities and hospitals, statements from family members, roommates, and clergy, and evidence of behavioral changes may corroborate a veteran's account of the stressor incident.

VA has a statutory duty to assist a claimant, including a claimant for service connection for PTSD, in obtaining relevant evidence necessary to substantiate a claim that the claimant adequately identifies to VA. VA's duty to assist in the case of a claim for disability compensation includes obtaining service medical records, records pertaining to the claimant's active military, naval, or air service that are held or maintained by a government entity, records of relevant medical treatment or examination at VA health-care facilities or at VA expense and any other relevant records held by any Federal department or agency. Whenever VA attempts to obtain records from a Federal department or agency, VA's efforts must continue until the records are obtained or it is reasonable certain that the records do not exist or that further efforts to obtain the records would be futile.

A claimant must cooperate fully with VA's efforts to obtain relevant records from non-Federal sources. The claimant must provide enough information to identify and locate existing records, and if necessary, the claimant must authorize the release of existing records.

VA procedures provide detailed guidance on how to develop evidence needed to substantiate the occurrence of an in-service stressor identified by a PTSD claimant. VA requests specific details of the in-service incident from the claimant, including date, place, unit of assignment at the time of the event, and names and other identifying information concerning any other individuals involved in the event. Any evidence available from the service department indicating that the veteran served in the area in which a stressful event is alleged to have occurred and any evidence supporting the description of the event must be made part of the record on the claim. At the request of VA, CURR researches Army, Navy, Air Force, and Coast Guard records containing historical information from individual units within these branches of service, as well as some personnel records, to verify occurrence of a stressful event described by a claimant. Marine Corps unit records for the Vietnam Era are available through Virtual VA.

CURR does not search records in an attempt to identify, rather than verify, an in-service stressor. Not every event that occurred during a claimant's service is recorded and service records rarely chronicle the specific experiences of individual servicemembers. CURR will only research records spanning a period of up to 60 days, so if a claimant is unable to accurately provide the actual date or time period in which a stressful event occurred, CURR will be unable to locate relevant records. If a veteran's stressor involves a casualty, CURR requires the full name and unit designation of the casualty.

VA is committed to providing quality training and information to field station employees on a variety of claims processing topics and currently has several initiatives underway related to PTSD claims development.

In September 2005, the Compensation and Pension (C&P) Service's Training Staff will air a satellite broadcast for all Veterans Service Representatives (VSRs) on how to properly develop PTSD claims, with special emphasis on the need to obtain records from CURR when appropriate. The broadcast script will then be made available to all regional offices and posted on the C&P Service intranet website as a reference.

C&P Service has many job aids and training materials related to PTSD claims processing that are available currently to field station employees. These include Training and Performance Support System (TPSS) modules and job aids, satellite broadcasts, and internal training letters and fast letters.

Current activities that C&P Service is undertaking include the following:

- Updating the PTSD Development lesson plans on the C&P Training Staff intranet website for VSRs.
- Developing an electronic job aid on "Development Issues" for VSRs for use in developing PTSD claims. This tool, which should be available by mid-September 2005, will be accessible to VSRs from their desktops and will assist them in determining if they are taking the correct steps to develop for PTSD by responding to questions as they progress through claims development.
- Undertaking development of a Training and Performance Support System (TPSS) electronic training module on PTSD for Rating VSRs, consisting of an introductory module on understanding, awareness, and sensitivity to PTSD cases followed by a rating decision-making module (scheduled for completion in early 2006).
- Undertaking development of another TPSS module on PTSD for VSRs that will serve as an introductory module on understanding, awareness, and sensitivity to PTSD cases (scheduled for completion mid-2006). This training takes place in a cooperative-learning setting in which two or three VSRs progress through practical exercises together and are tested at the end of the course.
- Introducing a new PTSD web page as part of Rating Job Aids on its intranet website. This PTSD web page will centralize reference materials related to PTSD in one location, along with links to various sanctioned external websites that contain information that may enable claims processors to verify stressors without having to make a request to CURR or MCUA.

Questions for the Record
Honorable Lane Evans
House Committee on Veterans' Affairs
Responses from Alfonso R. Batres, Ph.D., MSSW

Question 1: VA reports that the Vet Center budget was augmented in both FY 2004 and FY 2005 to support 100 Global War on Terrorism (GWOT) outreach workers. Since 1996, Congress has extended eligibility to all combat veterans. Has the Vet Center budget received more than inflationary increases in order to meet increased demand?

Response: The Readjustment Counseling Service (RCS) monitors the demand for services and advises the Under Secretary for Health when and if there are needs to increase resources to address demand. This routine feedback has led to the addition of staff and resources

- In FY 2005, the Under Secretary for Health (USH) authorized conversion of the initial 50 Global War on Terrorism (GWOT) outreach

workers to career VA positions. This represents a \$2.5 million dollar increase in the Vet Center recurring budget.

- Later in FY 2005, the USH also authorized an additional 50 GWOT positions as the Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) conflict continued.

- In FY 2004 the Under Secretary for Health (USH) approved a plan to establish a 4 person Vet Center in Nashville, Tennessee. This represents an increase of \$393,000 annually with the first full year of funding in FY 2006.

From FY 1996 through FY 2004 the Vet Center Program received inflationary increases in the annual operating budget.

Question 2: The 2005 Report of the Advisory Committee on the Readjustment of Veterans recommends that the Department augment the Vet Center's capacity to provide family counseling to traumatized veterans by adding qualified family therapists at additional Vet Centers.

a) What are the current gaps in the program's professional capacity to adequately address the needs for family counseling as it relates to the successful post-war readjustment of the veteran or the veteran's family?

Response: None have been identified. There has been discussion about the potential need for family therapists and the RCS program has been asked to provide workload reports to identify the need for such services/specialty. Currently no data has been provided. To the degree that VA would need to support marriage and family counseling, VA provides these services to eligible veterans and their family members through qualified psychiatrists, psychologists, clinical social workers, clinical nurse specialists and chaplains. Many of these clinicians are members of the American Association for Marriage and Family Therapy. VA does not specifically hire Marriage and Family Therapists because many of our clinicians are already qualified to provide these services and are doing so.

b) What are the specific gaps in the program's professional capacity to adequately address the needs for family counseling of veterans' whose family members have limited English proficiency?

Response: Currently, none of the Vet Center's licensed family therapists are bilingual. However, Vet Center staff may use other Vet Center multilingual staff (including licensed counselors), interpreters, or multilingual family members to assist in communication.

c) What are the specific gaps in the program's professional capacity to adequately address the needs for family counseling of veterans who reside in rural communities?

Response: None. See response to 2.a.

d) What is annual cost of funding one full-time family therapist at each Vet Center?

Response: The annual cost for 207 family therapists (one per Vet Center) is approximately \$13.8 million dollars. This estimate is based on the average salary and benefit level for a GS-11 therapist (\$67,000 annually).

Question 3: By the end of FY 2005, the Vet Centers are expected to have seen over 24,000 OIF/OEF veterans. From FY 2004 to FY 2005, the Vet Center program will have seen a workload increase of approximately 21percent. Given the general increase in caseload what fiscal resources are needed to augment the teams at rural and smaller Vet Centers?

Response: It is important to realize that the workload includes a mixture of service requirements. Some services require more manpower than others. So an absolute count of the number of veterans seen or the number of visits is not necessarily a proxy for the manpower requirements of the Vet Center program. The Readjustment Counseling Service (RCS) monitors the demand for services and advises the Under Secretary for Health when and if there are needs to increase resources to address demand.

Question 4: How would having 100 additional employee for Readjustment Counseling Service outstations improve your program's capacity to provide services to veterans and their families?

Response: If resources were available, 100 additional employees would be used across the system at various sites.

**Questions for the Record
Honorable Lane Evans
House Committee on Veterans' Affairs
Responses from Michael J. Kussman, M.D., MS, MACP**

Question 1: The Department of Defense (DoD) has recently begun implementation of the Post-Deployment Health Re-assessment (PHDRA) program to identify and recommend treatment for deployment-related health concerns that may arise during the three to six-month time period after deployment.

a) What role will the Department of Veterans Affairs (VA) have in assisting DoD in screening service members who have been separated after deployment?

Response: The PDHRA is a DoD program for the screening of combat veterans after deployment. This program has been developed and implemented by DoD and VA has no direct role in conducting this military program. However, VA has been asked through the Deployment Health Workgroup to provide points-of-

contact within VHA for the referral of military personnel identified on screening as possibly having a mental health problem. These points of contact are being provided to DoD.

b) What role will the Department of Veterans Affairs (VA) have in providing follow-on care for separated service members who are identified as needing care as a result of the three to -six-month PDHRA?

Response: VA can provide two years of free health care for any health problem possibly related to combat service in the Iraq and Afghanistan theater of operations. Through numerous outreach initiatives, VHA encourages *all combat veterans* with health concerns to come to the nearest VHA health care facility for a clinical examination. We will ensure that DoD post-deployment assessments are coordinated with appropriate VA health organization leadership and facility OEF/OIF Coordinators. This will ensure that VHA personnel are available to assist as necessary with the assessment at various locations and units, and that mental health and medical staff at the closest VA facilities are ready to provide all necessary care.

c) Will VA request additional resources to meet the increased healthcare demands that will likely occur as a result of the PHDRA program?

Response: PDHRA should help identify veterans with a mental health concern at an earlier time than without screening but should not increase the overall number of combat veterans needing health care for a mental health problem. In fact, earlier identification of combat veterans with a mental health problem may lead to more effective treatment and less long-term morbidity with less need for VHA health care. Even though no immediate needs are anticipated, VA will monitor the impact on healthcare demand of providing these services. We will work with DoD to provide a feedback loop from local PDHRA efforts to assess plan effectiveness and workload impacts.

Question 2: The development of the Iraq War Clinical Guidelines by VA's National Center for PTSD and DoD is an exemplar of VA-DoD collaboration.

a) What steps is VA taking to ensure that VISN directors are ensuring the appropriate deployment of resources to implement the treatment protocols in the Iraq War Clinical Guidelines?

Response: VA has taken steps to provide special funding to support innovative treatment modalities for PTSD, substance abuse, and to care for homeless veterans. In FY 2005, VA provided \$2.7 million for enhancement of PTSD programs and \$2.4 million for veterans of OEF/OIF. These funds are being tracked by specific obligations of resources to provided for PTSD, and providing special funding. The overall goal is to ensure that resources are adequate to provide care according to the VA Clinical Practice Guidelines for the treatment of PTSD and the VA/DoD Joint Clinical Practice Guidelines, and the NCPTSD and

DoD Iraq War Clinician Guide, which consists of brochures specifically addressing the stressors facing participants in the Iraqi conflict. They enhance providers' cultural sensitivity to the particular stressors faced by these combatants and provide an orientation to military service, but are within the realm of PTSD treatment protocols, and thus do not require additional resources. These tools, including the Veterans Health Initiative education materials, are all available electronically to all providers. They are also promoted through satellite broadcasts, teleconferences, and communications among professionals.

b) Would having a specific performance measure for VISN directors with respect to the Iraq War Clinical Guidelines increase the accountability for implementation of these important clinical protocols?

Response: VA already has a performance monitor in place. This monitor tracks the screening of veterans for PTSD in accordance with the Guideline. This screening of all OEF/OIF veterans also includes questions to discover possible depression, substance abuse, and infectious diseases endemic to Southwest Asia.

Question 3: Primary care providers are key to early intervention of PTSD. I am concerned that VA primary care providers are not receiving adequate support and time to diagnose PTSD. VA supported research by Dr. Kathryn Magruder, published in *General Hospital Psychiatry*, found that even with the template for mental health screening VA primary care providers failed to diagnose more than half of the PTSD cases. Only 48 percent of VA primary care patients with PTSD received specialty mental health care.

We would like to provide additional information concerning Dr. Magruder's research project. Dr. Magruder's research surveyed a random sample of veterans who were seen at primary care clinics at four Veteran Affairs Medical Centers (VAMCs) in Veteran Integrated Service Network (VISN) 7. Data collection ended in 2002. The veterans' service was pre-Global War on Terror; the average age was 60.9 years old and most of the veterans with PTSD were in the 45-64 age range. Dr. Magruder's team then did its own assessments of the 888 veterans who agreed to participate in the study using a telephone interview PCL-17 (PTSD Checklist) and also the CAPS (Clinician Administered PTSD Scale) to screen for PTSD. This assessment found 11.5 percent (102 veterans) of the 888 survey participants met the criteria for current PTSD. They found that 47 percent of those 102 patients who met the criteria for PTSD at the time of the screens had a note for PTSD in their health records, based on a 12-month retrospective review of patients' charts. This result is consistent with the performance of any health care environment, including the private sector, to screen for any mental disorder (e.g., depression) in a primary care population.

That only 48 percent of the 102 individuals received VA mental health care may reflect several issues (which the article cites) including that they may have chosen non-VA care. The actual study involved patient care in FY 1999. This is significant because since 2002 several things have happened in VA designed to

increase case finding and care for veterans with PTSD who are seen in primary care settings. The Veterans Health Initiative entitled, Post-Traumatic Stress Disorder: Implications for Primary Care was released in March 2002. Also, screening for PTSD (in addition to depression and alcohol abuse) was instituted with the publication of the new Joint VA/ DoD PTSD Clinical Practice Guideline in February 2004. PTSD screening is now a performance monitor and also a standard part of the "pop up screener" for all returning OEF/OIF veterans.

a) What is VHA doing to ensure that primary care providers are implementing state of the art diagnosis and treatment of PTSD?

Response: VA has taken several steps, through the leveraging of our computerized patient health record, with its prompts with specific questions to screen returning OEF/OIF participants for possible PTSD, thus ensuring prompt identification and early intervention. Training for primary care providers is a key element in VA's education strategy, forming a core element of the 2004 Primary Care Conference agenda, of the Mental Health Best Practices conference, and the Polytrauma conferences. It is addressed in national training broadcasts, Primary Care conference calls. The Veterans Health Initiative manual on PTSD is geared to the Primary Care provider, and is available on the VA Intranet. This use of the computer-prompted screen for symptoms, coupled with providers' enhanced knowledge of PTSD, ensures that individuals receive early diagnosis and treatment. VA has also placed mental health professionals in the primary care clinics, facilitating consultation and access to specialized mental health care. The NCPTSD is also working on a web based curriculum for basic and advanced clinicians on PTSD care called "PTSD 101".

b) What steps has VA taken to ensure that the VA/DoD Joint PTSD Clinical Practice Guidelines are being implemented in all VA medical facilities?

Response: As stated in the response to Question 2. b above, the Clinical Practice Guidelines form the basis of the screening questions to assist primary care providers with the early detection of possible PTSD. The incorporation of the PTSD screening questions into the basic history taking and examination process ensures that the Guidelines are folded into daily practice in the primary care clinics. This monitor ensures that the Guideline, released in February 2004, is being incorporated into clinical practice.

c) Would having specific outcome monitors and quality improvement instruments help ensure that the VA/DoD Joint PTSD Clinical Practice Guidelines are implemented by primary care providers?

Response: Yes, and as stated above, VA already has a performance monitor in place. This monitor tracks the screening of veterans for PTSD in accordance with the Guideline. This screening of all OEF/OIF veterans also includes questions to discover possible depression, substance abuse, and infectious diseases endemic to Southwest Asia. In addition, VA has formed a work group, led by the National Director for Primary Care, with participation from the Office of

Research & Development, VBA, and mental health experts, to develop measures that will track and ensure consistency of care, treatment, and disability rating examinations for PTSD. Finally, VA and DoD already collaborate at all levels of the organizations through the Joint Executive Committee, Health Executive Committee, and numerous subcommittees. Among the VA representatives to these groups are VA mental health experts, including PTSD.

Request from Question 4: In your written testimony you state that each VISN has a PTSD Coordinator. Please provide the Committee with the names and phone numbers of each VISN PTSD Coordinator.

Response: Please see the attached document for the names and contact information for the VISN PTSD Coordinators.

Question 5: Does VA have in place the capacity to provide mental health care for veterans who may need providers with security clearances so a veteran can disclose the specifics of their stressors?

Response: In the past, when this rare situation arose, we would try to locate a VA provider with current appropriate security clearance from prior DoD service. If that is not possible, we would partner with DoD to obtain the services of a mental health professional with the appropriate security clearances to assist that veteran.

Question 6: In your written testimony you point out that the stigma associated with mental disorders is a reason that many veterans do not seek care at all. Do you believe a joint DoD-VA council could be a useful catalyst for policy recommendations to reduce stigma associated with seeking mental health care by active-duty, Reserve, and National Guard members?

Response: We understand and appreciate the deterrent effect that stigma may have on some individuals' willingness to seek help for their anxiety, post-deployment adjustment disorders, or post-traumatic reactions. We are making access to mental health care in primary care clinics, using an integrative care model to provide mental health services directly in the primary care clinics, by placing mental health professionals in the clinics so that veterans can receive mental health care in familiar environments.

We also agree that continued collaboration between VA and DoD can improve outreach to all service members including active duty, reserve, and National Guard. To that end, a joint VA/DoD Mental Health Committee is being formed that will report to the Health Executive Council. This group is charged with increasing collaboration between VA and DoD with regard to the provision of mental health services to both VA and DoD beneficiaries.

Question 7: Does VA have a broad education and outreach plan to help veterans and their families identify a veterans' need for readjustment counseling or treatment? If so, please describe it?

Response: As an integral part of its defined service mission, the Vet Centers provide a unique outreach function within VHA. A primary service provided by the Vet Center program is to locate, inform and professionally engage veterans and family members as to VA benefits and services as they return from theaters of combat operations. The Vet Center program's capacity to provide outreach to veterans returning from combat operations in OEF and OIF was augmented by VA in 2004 and again in 2005. Specifically, the Vet Centers have hired and trained a cadre of 50 new outreach workers from among the ranks of recently separated Global War on Terrorism (GWOT) veterans at targeted Vet Centers. Based upon the success of this initial outreach program the Vet Centers are now engaged in hiring an additional 50 GWOT veteran outreach workers to welcome home and inform their colleagues returning from Afghanistan and Iraq. Augmented Vet Center outreach is primarily for the purpose of providing information that will facilitate the early provision of VA services to new returning veterans and their family members immediately upon their separation from the military. These positions are located on or near active military out-processing stations, as well as National Guard and Reserve facilities. New GWOT veteran hires augment Vet Center services by providing briefing services to transitioning servicemen and women regarding military-related readjustment needs, as well as the complete spectrum of VA services and benefits available to them and their family members. As referenced above, RCS has initiated a pilot program in June 2005 to capture the outreach services provided to returning OEF/OIF veterans to include the debriefing, education and information services provided. The program has now collected veteran SSN data for the three months of June, July and August 2005 to document that the program has contacted a total of 18,165 veterans via outreach activities for this three month period. With this initiative the Vet Center program has a system to precisely account for the previously unrecorded outreach services provided by VA.

Question 8: In your written testimony you state that "[a]lthough the numbers of OEF/OIF returnees are relatively small it is essential that the numbers of veterans be brought into the actuarial planning model." Colonel Hoge has testified that one in four OIF/OEF service members will meet the criteria for PTSD, depression and or anxiety some 12 months post-deployment. You refer to his research in your testimony. His research has important implications for the VA's mental health needs model and budget.

a) How has VA incorporated Colonel Hoge's findings into VA's model to project needed capacity to meet demand?

Response: Colonel Hoge's article was published after the development of the current version of the model. VA will assess the data from this study, other published studies and authoritative epidemiologic studies to evaluate the implications for actuarial model. It is also important to note that Colonel Hoge's

numbers include individuals whose symptoms are not as severe and would not, alone, support a diagnosis of PTSD. In addition, a certain percentage of any population group will meet the criteria for some form of mental disorder or illness at any point in time.

b) Has VA revised it's projections for FY 2007 to incorporate the expected demand for mental health services by returning OEF/OIF service members? If not, for which fiscal year will these projections be included? If they have been revised, I request a copy of the revised projections for mental health services.

Response: The FY 2007 budget proposal will include resources to provide for the health care needs of returning OIF/OEF veterans, including specific investments in mental health, polytrauma care, and prosthetics.

Question 9: From the first half of FY 2003 to the first half of FY 2005 the VA has seen a 10 percent increase in the number of veterans seen in outpatient care by special PTSD clinical teams: Did VA's mental health care demand model accurately project this increased need for capacity? If not, how have you revised and refined the mental health projection model to reflect this increased need for capacity?

Response: Response: In FY 2004, VHA worked with a group of mental health experts to enhance the methodology used in the actuarial model to project demand for mental health and substance abuse services. The model in this early iteration grouped together many types of Mental Health services by bed section type; PTSD was not broken out separately as a diagnosis but lumped with other residential treatment beds. From those projections, VA plans for care delivery in a variety of programs and settings, including services that are unique to VA, such as PTSD residential rehabilitation. Projections of PTSD program needs and staffing requirements were not possible. Correction of this deficiency will be attempted in next years modeling. In the interim, VA continues to monitor PTSD program usage and new cases to determine where new programs and staffing are required.

Question 10: VA belatedly recognized that it had a budget shortfall in FY 2005 and claimed that projection models did not anticipate the increase in demand for services from returning OEF/OIF veterans. Does VA's revised budget request for FY 2006 reflect increase in demand for mental health services from OEF/OIF veterans?

Response: The FY 2006 budget includes resources to provide for the health care needs of returning OIF/OEF veterans, including specific investments in mental health, polytrauma care, and prosthetics.

Question 11: Alcohol misuse and substance abuse often is associated with PTSD. Successful treatment of concurrent PTSD and substance abuse requires that both disorders be treated simultaneously and in

combination. Several VA reports have identified that VA's capacity to treat substance abuse is severely limited. VA's most recent capacity report that VA would have needed to spend an additional \$495 million in FY 2004 to meet the same level of substance abuse treatment resources as expended in FY 1996. VA's Comprehensive Mental Health Strategic Plan calls for a restoration of VA's capacity to treat substance abuse.

a) Given the association between substance abuse and PTSD, does VA's diminished capacity to treat substance abuse impact on early intervention of PTSD?

Response: VA acknowledges the importance of addressing an individual's substance abuse disorder in conjunction with any PTSD therapeutic intervention. VA makes an aggressive effort to screen for substance abuse and to work with veterans to address alcohol or licit drug misuse, tobacco consumption, and illegal drug use. It is important to note that, although VA's biggest challenge is in substance abuse capacity, for mental health patients with dual diagnoses for alcohol or drug abuse and a serious mental illness (which includes PTSD), VA has retained 100 percent of its capacity to treat these veterans, as reported in the 2003 Annual Report on Capacity for Specialized Treatment and Rehabilitative Needs for Veterans. VA has also targeted a portion of the FY 2005 funds for PTSD programs to enhancing and expanding substance abuse treatment capabilities.

b) How much of VA's FY 1996 substance abuse treatment capacity does VA plan to restore by FY 2006? By FY 2007?

Response: VA provided \$ 2.1 million in funding for new substance abuse services in 2005 in response to Public Law 108-170 and committed an additional \$324, 420 in additional resources. These programs were started late in the year and so received only part-year funding. In FY 2006, the programs will receive full funding of \$5 million and \$3 million, respectively. To fill the service gaps in five VISNs with the most acute shortage, \$8,918,589 and 125 full time employees have been allocated to bring substance abuse service capacity in these VISNs up to the VA-wide average. In FY 2006, additional expansions of approximately \$20,000,000 are planned. It should be noted that in terms of programming and cost, the approaches to substance abuse care were quite different in FY 1996 than they are now. In FY 1996, significant staffing and resources were invested in inpatient treatment format that have been replaced to a significant degree with outpatient and residential care programs, which have different staffing and operating costs. A direct comparison of dollars invested in 1996 to dollars invested today may be misleading.

Question 12: What is the status of National Vietnam Veterans Longitudinal Study and when can the Committee expect the project to be completed?

Response: The National Vietnam Veterans Longitudinal Study (NVVLS) has been on hold pending the outcome of an OIG investigation. The OIG released its

findings on September 30, 2005. VA has taken the corrective actions specified in the OIG's process recommendations. VHA leadership is beginning dialogue with the Committee to determine the most appropriate method to address the Congressional mandate given the findings of the OIG and scientific considerations.

Question 13: Can you provide the Committee with a detailed breakdown of how \$100 million VA budgeted for enhancing mental health programs and implementing the Comprehensive Strategic Mental Health Plan will be spent in FY 2005? It is our understanding that some of the monies have been distributed through the VERA model. Please explain how you will track the dollars that have been spent for expanded access for mental health services?

Response: Please see the attached spreadsheet that contains the FY 2005 plan for the \$100 million. As shown in the attachment, \$35 million was made part of the VERA allocation process for the VISNs, and \$65 million was provided to the national program office for distribution. That distribution from headquarters was made to networks and facilities to support new and targeted programs. Because the headquarters program office was able to allocate funds only after the beginning of the fiscal year, the amounts provided to the field were prorated for part-year program support.

VA is tracking the use of funds through accounting and expenditures reports, actual staffing levels, workload data, as well as facility-reported capacity and program expansions.

Questions for the Record
Honorable Lane Evans
House Committee on Veterans' Affairs
Questions from Matthew J. Friedman, M.D., Ph.D.

Question 1: Given all the research and educational collaborations NCPTSD is currently conducting with DoD to support OIF/OEF troops directly and to support DoD clinicians who are providing care for them, have you received any budget supplementation to cover these new initiatives?

Response: The NCPTSD has not received supplemental funding for the OIF/OEF initiatives since the services and products developed are an inherent part of the NCPTSD mission and are funded within the recurring budget for the NCPTSD. In FY 2005, the NCPTSD was funded at a level of just under \$9.8 million to support 88.0 FTEE. This level will continue in FY 2006. In addition, VA has set aside additional funds to support the PTSD Advisory Committee, on which NCPTSD staff serve as members. As with any program, it is incumbent upon NCPTSD leadership to prioritize the NCPTSD's work on various initiatives to ensure that high priority initiatives, such as those for OIF/OEF initiatives, are supported. Additionally, the Center has been able to leverage some of its

research projects through extramural grant funding. Out of 24 research and educational OIF/OEF projects currently proposed or underway at the NCPTSD:

- Three of these projects have begun using internal funds
- Seven of these are in the process of being submitted for external funding
- Three more are educational endeavors that need funding
- Six have been submitted but are under review
- Two are funded but have proposed extensions
- Three have small partial funding

Question 2: In your written testimony you describe how marriages and family well-being are frequent casualties in households where a veteran has PTSD and that this is why outreach to families will be an important component of any efforts to help OIF/OEF returnees with PTSD. What research or education efforts is the NCPTSD working on to improve outreach to families of service members and veterans?

Response: The National Center for PTSD is committed to assisting families of service members and veterans. Below is a partial list of the National Center's educational and outreach programs for the families of OIF/OEF returnees.

Training Seminars

- **Marine Corp Family Services:** Marine Corp Headquarters requested NCPTSD staff to provide clinical trainings on combat stress to all Marine Corp Community Services (MCCS) staff. Training has been provided to the majority of family services staff located at major Marine Corp bases in the US and Japan, including Camp Lejeune, Marine Corp Air Station (MCAS) Cherry Point, MCAS New River, Parris Island, MCAS Beaufort, Camp Pendleton, MCAS Miramar, Twenty-nine Palms Marine Corp Base (MCB), Camp Butler, and Iwakuni Air Station. NCPTSD also is providing ongoing consultation to MCCS and Family Services personnel who are serving active duty personnel and 30,000 families around Camp Pendleton.
- **Hawaii's 29th Infantry Brigade (National Guard) and Marines:** NCPTSD provided a series of outreach and educational trainings to the 3,000 deploying infantry members and their families in March 2005, and also to Marines at Kaneohe Marine Base. Trainings include lectures and education materials developed by NCPTSD about the impact of deployment and post-deployment stress upon families. Follow-up outreach and educational trainings will be provided to families prior to their spouses returning and again upon the National Guard's return in 2006.
- **US Army Educational Programs at Schofield Barracks:** NCPTSD collaborates with Army personnel stationed at Schofield Barracks Soldier Retransition Center and the Family Retransition Center to provide: monthly trainings to mental health providers on treatment of combat stress-related problems in OIF/OEF returnees, ongoing trainings for newly hired therapists and residents on best practices for PTSD treatment, assessment of combat stress-related disorders, early intervention for combat stress, intervention for sexual assault, and alcohol abuse treatment. NCPTSD staff members consult with the Directors of the Retransition Centers and oversee the collection of

needs assessment/clinical intake data for army soldiers who screen positive for combat-related stress. NCPTSD staff members also co-lead group interventions with military personnel at the Retransition Centers for returnees and their spouses.

- **Conference on War-Zone Related Issues for Active Duty Personnel:** In February 2005, members of the NCPTSD provided a 5-day conference at Tripler Army Medical Center and Schofield Barracks to over 100 tri-service mental health professionals, including Family Service Workers, Social Workers, Psychiatrists, Psychologists, Chaplains, and Primary Care Providers. NCPTSD will hold a second war-zone stress conference in Hawaii in 2006.
- **Taking Care of Vermont National Guard Post-Deployment: Training the Trainers:** Members of the VAMC at White River Junction, the Vet Center, leadership of the Vermont National Guard, the Family Readiness Program, and the NCPTSD joined forces to provide this training seminar to discuss issues and provide information and guidance to those who assist returning soldiers and their families.
- **Couple's Therapy Research and Education:** Cognitive-Behavioral Couple's Therapy for PTSD has been added to the Promising Practices VIP Website developed by NCPTSD to facilitate the dissemination of evidence-based treatments. The Center also recently submitted a research proposal to National Institute for Mental Health (NIMH) to support further study of the treatment.

Web sites

- The **NCPTSD Web site** provides information about families, relationships, and readjustment for a range of audiences, including family members, veterans, providers, and other professionals.
- The **Our Strength in Families (OSiF)** project builds on existing knowledge on family functioning to develop an interactive online relationship-enhancement intervention for military couples experiencing deployments. The website includes preparatory educational material and tools designed to enhance a range of coping skills, provide social support, and detect early signs of mental distress. A Field Trial with military families is planned at Ft. Drum, NY and Schofield Barracks, HI.
- The **OSiF for young children** project, currently under development, is a treatment intervention for 4-7 yr old children during parent deployment. This project, an extension of **OSiF**, is an age appropriate website for children including a handbook for parents.

Materials

The National Center, in collaboration with DoD produced the *Iraq War Clinician Guide*. It was developed specifically for clinicians and provides cultural awareness of military service in general for clinicians without prior military experience, as well as sensitivity to the unique needs of veterans of the Iraq war. One feature of the *Guide* is a section on materials that clinicians can use to help educate patients and family members. This section is being supplemented by two longer handouts for returning service men and women and their families: **Returning from the War**

Zone: A Guide for Military Personnel and Returning from the War Zone: A Guide for Families of Military Personnel. Two educational video sets are also being developed for use with veterans/returnees and their family members to educate them about combat stress, common responses, and what to expect in treatment. The videos are slated to be distributed to VA & Vet Centers nationwide in November 2005.

In addition, to the materials produced for the training and web projects, NCPTSD has produced **two issues of its newsletter**, the *PTSD Research Quarterly*, on topics relevant to family issues: "**Combat Exposure and PTSD**" (Winter 2005), by Dr. Stephen Cozza of Walter Reed Army Medical Center; and "**Family Functioning and PTSD**" (Fall 2005), by Dr. Candice Monson of NCPTSD's Women's Health Sciences Division. The newsletter is mailed to over 4,000 subscribers and is available free of charge on the NCPTSD website.

Question 3: In your testimony you discuss research involving brain imaging which shows that people with PTSD exhibit similar abnormalities in brain structure and brain functioning. Could you elaborate on the state of this research and whether it can be used as a diagnostic tool?

Response: A solid body of scientific information, to which NCPTSD investigators have made major contributions, is emerging about the functional and structural brain abnormalities associated with PTSD. Research with laboratory animals and human brain imaging research indicate that the neural circuitry for processing threatening situations is excessively activated among people with PTSD. However, although this information is very exciting and has furthered our understanding of the pathophysiology of PTSD, it is too early to consider brain imaging a useful diagnostic tool.

The presumed circuitry involves the amygdala, which processes threatening stimuli, the hippocampus, which contextualizes such input and promotes the consolidation of traumatic memories, and the medial prefrontal cortex, which exercises the major restraining influence on the amygdala. In PTSD, disinhibition of the amygdala produces a vicious spiral of recurrent fear conditioning in which ambiguous situations are appraised as threatening and in which the usual counterbalancing inhibitory influence of the prefrontal cortex is nullified. What this means is that people with PTSD are more likely to misperceive neutral stimuli as threatening and to take protective actions consistent with such a misperception. Such abnormalities in brain function have been detected in people with PTSD resulting from sexual trauma, motor vehicle accidents, and other traumatic events in addition to war-zone trauma.

Delineation of such dysfunctional fear circuitry in the brains of people with PTSD (and several other anxiety disorders) has prompted the American Psychiatric Association to consider a new diagnostic category for DSM-V, the next revision of the official diagnostic manual. This category, "Stress and Fear Circuitry

Disorders," would include PTSD along with Panic Disorder, Simple Phobia and Social Phobia.

Research on structural brain abnormalities has focused primarily on the size of the hippocampus. Most research has shown smaller hippocampal volume among people with PTSD, although it is currently controversial whether reduced hippocampal volume results from PTSD or is a risk factor for the disorder. A very recent study by National Center for PTSD investigators found reduced volume of the prefrontal cortex among Vietnam and Gulf War vets with PTSD. Studies on children suggest that other brain structures may be affected in the developing brains of traumatized children as well.

Despite this promising evidence, it is premature to consider brain imaging as a diagnostic tool. These are subtle and complex abnormalities that can only be detected when evaluated in labor-intensive research studies that compare PTSD subjects with a non-PTSD control group. Also, brain imaging is very expensive. Until specific PTSD-specific abnormalities can be unambiguously and inexpensively identified in a clinical laboratory, brain imaging for diagnostic purposes is not cost-effective.

Question 4: Could you expand more on the VA Best Practice Initiative on PTSD to ensure that veterans receive the best evidence-based treatments?

Response: Recognition of the gap between scientific evidence and clinical practice has prompted VA to initiate strategies to promote evidence-based practices throughout the VA system. Improving PTSD treatment has been selected as the pilot project for a recently convened VA Best Practices and Knowledge Management Committee. NCPTSD has taken a leading role in this initiative, which has both general and specific goals. First it seeks to develop and test the general feasibility of utilizing Knowledge Management techniques to improve clinician performance throughout the VA system. PTSD has been selected as the first of many possible disorders that could have been tested in this way. Second, it seeks to specifically improve the utilization of evidence-based best practices by VA clinicians treating patients with PTSD.

There are many reasons why PTSD was selected for this pilot phase of VA's Best Practices initiative. First, war zone-related PTSD ranks among VA's highest priorities because affected veterans have acquired this disorder during military service. Second, utilization of inpatient and outpatient services by veterans with PTSD represents a significant portion of VA's clinical caseload. Third, new cases of PTSD emerging from current deployments to Afghanistan and Iraq have made the implementation of Best PTSD Practices for many returning troops a very high priority. Fourth, recent development of joint VA/DoD practice guidelines for PTSD treatment has provided state-of-the-art guidance on evidence-based treatment.

Question 5: Could you elaborate on why it would be helpful for VA practitioners to be able to involve family members in the treatment of PTSD?

Response: It would be helpful for veterans if family members could be involved in treatment because PTSD can significantly disrupt family functioning. This disruption in turn can impair a veteran's response to treatment. Furthermore, family members can play a key role in facilitating the treatment process.

Involving family members in the treatment process helps to mobilize social support, which is one of the most important factors associated with decreased risk of PTSD. Involving family members also can strengthen a veteran's engagement with treatment and help to break the vicious cycle between the veteran's symptoms and family problems. Improving the emotional climate of significant relationships can enhance the efficacy of PTSD treatment as well.

Question 6: Alcohol misuse often is associated with PTSD. What are the PTSD treatment implications of alcohol misuse and or substance abuse?

Response: Substance users with PTSD are at increased risk of numerous problems, including greater severity of substance abuse, more treatment episodes, and functional difficulties. The increased rate of problems means that substance-abusing veterans with PTSD may require more frequent practitioner contact and longer treatment and have poorer outcomes following treatment.

Veterans usually receive help for these problems sequentially, first participating in substance use treatment and then being referred for PTSD treatment. Among veterans treated in this fashion, those who receive more PTSD treatment show the greatest improvement in substance abuse problems. Treating the two disorders separately can limit the capacity for collaborative service provision. There is increasing consideration being given to the potential benefits of addressing the two problems simultaneously.

Staff members from the NCPTSD have developed the "Seeking Safety" integrated group treatment. Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. The treatment is available as a book, providing both client handouts and guidance for clinicians. Seeking Safety has been used at a number of VA sites and is currently the focus of a VA program evaluation initiative. A version modified specifically for combat veterans has been taught to over 300 clinicians throughout the VA and Vet Centers.

Question 7: Is there extensive and conclusive research on the factors that decrease the likelihood of the development of chronic PTSD in service members and veterans who have had combat exposure, including exposure to guerilla warfare?

Response: Evidence on the epidemiology of PTSD indicates that PTSD is a prevalent condition among veterans and active duty personnel of all eras,

especially among subgroups that have been deployed or sexually assaulted. Only one comprehensive study has examined the mental health impact of the wars in Afghanistan and Iraq. This study evaluated soldiers' reports of their experiences in the war zones and reports of symptoms of psychological distress. The results of this study indicated that only 3-4 months after the soldiers' return the estimated risk for PTSD from service in the Iraq War was 18 percent and the estimated risk for PTSD from the Afghanistan mission was 11 percent. Preliminary inspection of 12 month follow-up data from these cohorts indicates that PTSD prevalence has continued to increase.

However, risk of PTSD varies considerably with the specific nature of military experiences. Greater duration of exposure, greater severity, injury, and exposure to atrocities all increase risk. Risk also varies as a function of pre-deployment and post-deployment factors. Among the most robust pre-deployment factors associated with lower risk of PTSD — known as “protective” factors — are older age and higher education at the time of exposure. Other protective factors include higher intelligence and an absence of prior traumatic experiences.

The effects associated with post-deployment factors are particularly strong. Stressful demands and traumatic exposure during this period are associated with increased risk. Post-deployment stressors even may increase the effect of traumatic military experience. However, elements of the post-deployment environment also can be protective. There is a strong inverse association between social support and the development of PTSD in combat veterans; some evidence suggests that the protective effects of social support may be stronger in veterans than in non-veterans exposed to trauma. The specific aspects of social support associated with decreased risk of PTSD include a positive homecoming, active community engagement, and greater family cohesion. A tendency to use social supports to disclose personal problems and to talk about events experienced during a deployment is also associated with improved post-deployment adjustment.

Studies suggest that in the face of severe military service demands, including combat, most men and women do remarkably well across the lifespan. On the other hand, if the mission is experienced as a failure, if service members deploy more than once, if new veterans who need services do not get the support they need, or if post-deployment demands and stressors mount, the lasting mental health toll of combat may increase over time.

Q.4: Listing of VISN PTSD Coordinators

VISN	Mental Health Liaison/ PTSD POC	Phone
1	Ethan (Sam) Rofman, MD	781.687.2405
2	Scott Murray, PhD	518.626.7310
3	Michael Sabo	914.737.4400 x 2460
4	Vincent Kane	215.823.5800 x 5903
5	Stephen Deutsch, MD	202.745.8156
6	Harold Kudler, MD	919.286.0411
7	Maurice Sprenger, MD	404.728.5066
8	Bryan Ballot	561.422.7252
9	Kendra Weaver, PhD	423.926.1171 x 7152
10	Dr. Peter Goyer	440.838.6007
11	Dr. Alan Mellow, MD, PhD	734.930.5630
12	Dean Krahn, MD	608.256.1901
15	John Pope	785.350.3111
16	Kathy Henderson, MD	501.257.1723
17	Kathryn J. Kotrla, MD	254.743.1270
18	Dr. Cynthia Rivera	915.564.6159
19	Dr. Roger Johnson	307.778.7307
20	Robert Barnes, MD	206.277.3007
21	Dr. Javaid I. Sheikh	650.858.3941
22	Ramanujam Komanduri, MD	702.636.3012
23	Sheri Herendeen, MD	320.255.6480 x 6541

Attachment to question #13

	Prorated for FY 2005
Mental Health Initiatives	
OEF-OIF	\$2,961,543
PTSD	\$4,143,682
Psychosocial Rehabilitation for Seriously Mentally Ill Veterans	\$1,806,454
Substance Abuse Programs	\$3,089,977
Mental Health Intensive Case Management	\$490,426
Poly Trauma Centers	\$463,966
Mental Health Expansion in CBOCs	\$1,251,107
Compensated Work Therapy Programs	
New CWT Programs	\$1,400,000
Enhanced CWT Programs	\$2,099,975
CWT/SE Mentoring Sites	\$4,535,738
Homeless Specific Initiatives	
Chronic Initiative to End Homelessness	\$1,649,306
Grant and Per Diem Liaisons	\$4,500,000
Stand Downs	\$365,000
Homeless Service Centers	\$783,000
Special Needs Grants	
Chronically Mentally Ill	\$2,615,474
Women (including children)	\$663,932
Frail Elderly	\$253,036
Terminally Ill	\$88,473
Residential Treatment Programs	
Domiciliary Residential Treatment Programs	
Domiciliary Expansion	\$271,463
Domiciliary Expansion Non-Recurring Funding	\$4,538,673
Domiciliary Augmentation	\$434,222
Residential Rehabilitation Treatment Program Improvements	\$11,578,992
Compensated Work Therapy Transitional Residences	
New CWT/TRs residences	\$75,000
CWT/TR Infrastructure Improvements	\$2,697,406
	\$52,756,845
Funding distributed through VERA	\$35,000,000
Funding turned over to Patient Care Services	\$4,000,000
	\$91,756,845