

Statement of
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Department of Veterans Affairs
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Mr. Chairman, I appreciate this second opportunity to testify before the Subcommittee on the care of American military men and women serving in Afghanistan and Iraq as they transition from the Department of Defense (DoD) to the Department of Veterans Affairs (VA). My remarks reflect over twenty years experience as a VA psychiatrist, my perspective as Co-Chair of the Under Secretary for Health's Special Committee on Posttraumatic Stress Disorder (PTSD), and my role in developing the new joint VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress.

On the day after my October 16, 2003 testimony, I followed up on Subcommittee members' comments by visiting Walter Reed Army Medical Center. There I met with the VA/DoD Liaison Social Worker, Xiomara Telfer, toured the wards, and talked with staff and patients. I was deeply impressed. The patients appeared strong and positive even when their wounds were serious. This was particularly evident on the orthopedics ward where I spent the most time. As an expert in PTSD, it was my sincere hope that these combat casualties weren't going to need my help. Unfortunately, when I asked the nursing staff how I might best assist them, their request was that I get the Honor Guard to stop firing the cannon every day at 4 p.m. because it took half an hour to get the patients back in their beds afterwards. They also described how several patients refused to stray off the paved walks on hospital grounds because they were terrified of landmines. I later met with the staff of the Army's Deployment Health Center who informed me that, at 3 month follow up, 40% of

all the casualties of Afghanistan and Iraq hospitalized at Walter Reed (including the medical and surgical casualties) reported symptoms consistent with a diagnosis of PTSD.

Information from a variety of other sources confirms a growing mental health problem among recent combatants. United Press International recently reported that 10% of the 12,000 soldiers evacuated through the military medical center at Landstuhl, Germany had "psychiatric or behavioral health issues." On February 19, 2004, the *Washington Post* reported that nearly 600 Army soldiers from Iraq were sent to mental health treatment facilities last year. Based on information provided by DoD on February 12, 2004, VA's Office of Public Health and Environmental Hazards reports that over 13,000 Iraqi Freedom veterans and nearly 1,800 Enduring Freedom veterans have already presented to VA Medical Centers for a variety of health concerns. Another 4,500 have contacted Vet Centers as of March. Of these 4,500, 12% have reported symptoms consistent with psychological trauma.

The developing picture is consistent with VA experience in the years immediately following the Vietnam War. By 1980, the year that I began my psychiatry training at the West Haven VA, Vietnam veterans were at least five years out from combat. They were a difficult group to treat. Even though PTSD had been officially defined earlier that same year, few VA doctors knew about PTSD. Combat veterans were often dismissed as either schizophrenic or as having untreatable character problems. Because of a lack of education about PTSD and the poor timing of our interventions, VA's ability to treat Vietnam combat veterans was tragically limited.

Fortunately, we've learned a lot about psychological trauma since those days. DoD and VA have a unique opportunity to intervene now, while the majority of new combatants are still in uniform. We can proactively educate staff and prepare programs so that we can 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. We can create the world's largest database on response to treatment and use it to develop still better treatments.

As with other medical disorders, the complications of traumatic stress are often as dangerous as PTSD, itself. These can include major depression, alcohol abuse (often beginning as an effort to sleep), narcotic addiction (often beginning with pain medication prescribed because of combat wounds), job loss, family dissolution, homelessness, violence towards self and others, and incarceration. We may be able to prevent these complications if we act decisively now.

Action must begin with an integration of services. We must center services on the person with the problem rather than hope that each person will find his or her way to the right mix of services. To this end, we must concentrate on strengthening the DoD/VA continuum of care including benefit services through VBA. DoD and VA need to break out of their silos in order to provide informed, flexible responses that follow people as they move from one system to the next.

By the same token, while we must ensure that PTSD resources are strong in DoD and VA, we cannot expect to channel every returning veteran through subspecialty PTSD services. The concept of PTSD is valid and essential but it is too narrow a lens with which to view the big picture before us. Some patients will only have very acute stress reactions, others will develop chronic depression or substance abuse that would not be addressed if we focus all resources on PTSD alone. We need to proceed with a broad understanding of post-deployment issues.

One of these is Military Sexual Trauma (MST). Dr. Jessica Wolfe of the National Center for PTSD reported that 8% of female Gulf War Veterans that she surveyed reported attempted or completed sexual assault during deployment. The US Army has released statistics indicating that 26 women reported rape or other sexual abuse during the first Gulf War. It is important to remember that only about 16% of rapes are ever reported. It is also important to realize that the number of male veterans who have reported sexual trauma during military

service is roughly equal to the number of female veterans reporting MST. This is because of the preponderance of men in the armed forces. The *New York Times* reported on February 26, 2004 that there have already been 112 reports of sexual misconduct over the past 18 months in the Central Command area of operations, which includes Kuwait, Afghanistan, and Iraq. As we bring service men and women home, we must screen for the effects of MST and be ready to provide treatment when it is needed.

Suicide is another concern during and after deployments. A DoD report on suicides among American troops who are serving or have served in the Gulf is pending but the Army has reported that 21 soldiers in Iraq and Kuwait have killed themselves since the beginning of Operation Iraqi Freedom. This does not include suicides among those who have already returned home. Two soldiers have committed suicide at Walter Reed post deployment.

In creating an early intervention program in the context of our current situation, the emphasis must be on wellness rather than pathology; on training rather than treatment. The bottom line is prevention and, when necessary, rehabilitation. Rather than set up an endless maze of specialty programs, each geared to a separate diagnosis and institution, we need to create a progressive system of engagement and care. A large number of initiatives have already been undertaken across DoD and VA. The Special Committee on PTSD has reviewed the major components of this plan by contacting individual representatives of the Army, Navy, Guard and Reserve, VA Mental Health, Readjustment Counseling Service, Women's Health and the Seamless Transition Task Force. Their programs combine to form a rich array of services but there is a pressing need for still greater integration.

For example, a relatively small investment could significantly improve health outcomes in the process by which new combat veterans enter the VA system. VA has identified a Point of Contact (POC) staff person for GWOT veterans at every VA Medical Center. Most are social workers who, by virtue of their professional training, are particularly good at the kind of interventions needed when a new patient first makes contact with VA- yet few POCs have

been trained to recognize or manage traumatic stress disorders in new combat veterans. It would be relatively easy to define a brief curriculum for the POCs that would alert them to signs of traumatic stress, its complications, and its effects on patients and their families. It would not be necessary to make each POC a specialist. It would suffice to prepare them to spot a problem and know when and how to triage. The second aspect of this training would be to educate the POCs about the resources to which these new veterans and their families can be triaged. This would provide exceptional coverage for new combat veterans in the Seamless Transition process.

A more formidable challenge exists in addressing the needs of the majority of returning troops as they return home by way of demobilization sites across the country. Many of them will remain in active service and are not about to be triaged to VA. 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 and their families might receive more community support. By the time service men and women have gotten home to their families, they've had the "Don't Beat Your Wife Talk" (received before getting on the plane home), the in-flight video on VA services and benefits, and a long series of talks and meetings at the demobilization site. During demobilization, each returning soldier completes the Post Deployment Evaluation Screen (Form 2796). The screening process is well established at MTFs but may be less uniform at other demobilization sites.

Although Post Deployment Screen results include essential information about stressors and signs of posttraumatic responses, they are not currently made available to VA planners or clinicians. This must change. Taken in aggregate, this post deployment data would provide an important early indicator of PTSD prevalence among our troops that would enable planners to better identify and meet their needs. If each service man/woman's individual responses were available to his/her VA clinician at the time of presentation for services, the

information would be of critical importance in developing an appropriate treatment plan.

Although it makes intuitive sense to include a formal Mental Health intervention during the acute demobilization process, it would probably not prove helpful. As one Army Medical Corps officer recently back from Afghanistan told me, returning soldiers don't have "the emotional bandwidth" to deal with those issues as yet. They are entirely focused on getting home and on the things they promised themselves and their loved ones. To insert an intervention at that point would be seen as coming between them and going home. It is more likely to lead to resentment and to greater stigmatization of the subject of psychological trauma. Based on input from military experts, a better time to intervene would be after soldiers have had a chance to go home, sleep in their own beds, and spend time with their families. For many, returning home may be the best therapy in and of itself but others may find that they still can't sleep and that they remain jumpy and irritable. They may feel unable to cope with changes that happened while they were gone. They may simply feel that they no longer fit.

After a few weeks at home, soldiers are more likely to recognize any existing readjustment problems and may be better able to talk about them. In the Guard and Reserves, troops have 90 days leave before they again report for weekend duty following deployment. We suggest that 90 days be the standard period after which the post deployment mental health intervention would be made. Mental health professionals would best perform this because they have special skills in developing rapport and in recognizing psychological distress. The Special Committee recommends that this intervention NOT be performed as a formal mental health examination. It should, instead, be presented as routine post deployment training. An apt metaphor is that this is the same as routine maintenance for combat equipment. Military personnel understand the importance of running a systematic check of their equipment following a mission. These meetings should be presented as routine maintenance for combat personnel.

The intervention should be performed with an individual service man/woman or in small functional groups (platoon size at the most). It should begin with a "plain English" statement that people who have lived through combat know things that other people may not understand. The discussion will proceed to a review of normal difficulties reported by combat veterans. It will offer ways to share experiences, thoughts and feelings with family and friends and lay out ways to anticipate and deal with common family concerns and tensions (soldiers are often hesitant to discuss their own responses but usually eager to talk about their family's concerns). Throughout the meeting, the emphasis will remain on normalizing responses; not on pathologizing them. This is an educational intervention based on principles of wellness and rehabilitation and not an examination for purposes of diagnosis and determination of fitness for duty. The focus is on coping. Towards the end of the intervention, participants will be advised about the resources available to them should any problems they are having should persist or become worse.

Participants will be assured of the confidentiality of these sessions. No medical charts will be flagged and no one else will be brought into the process unless there is significant evidence of danger to self or others or unless the service man or woman specifically requests that such contact be made. A pamphlet will then be given that reinforces the information provided and which identifies local resources along with specific contact names, websites, phone numbers, and a confidential 1-800 call-in number for further confidential help. A separate pamphlet designed for the family will also be handed out (and a second copy will be mailed to the family home).

The Co-Chairs of the VA PTSD and SMI Committees recently met with the Under Secretary to recommend that he work with DoD to develop an MOA under which VA staff would provide this intervention. This intervention is practical and is likely to be well received and deemed helpful by service men and women. It is designed to overcome resistance to disclosing problems with post deployment stress early in its course and before complications take hold. If implemented, it

has the potential to serve as a force multiplier in DoD settings and improve health outcomes in VA settings.

In my October 2003 testimony, I noted that VA was considering extending its ability to offer counseling services through the selection and training of peer counselors drawn from Military Unit Associations. Military Unit Associations have the distinct advantage of being local at each site and of already being a part of unit culture. They also have the advantage of having "really been there." The spouses of members of Military Unit Associations could also provide support and mentorship to the spouses of those who have been deployed. This is an opportunity to utilize a large, untapped resource of highly motivated and uniquely qualified mentors. Arrangements for their selection and training could also be included in the proposed MOA.

These proposed interventions would complement the recently approved Vet Center outreach program which is in the process of hiring 50 veterans of the GWOT in order to provide support and triage to services to service men and women and their families at the time of separation from service.

In addition, VA must act now to develop the capacity necessary to meet the needs of new combat veterans while still providing appropriate service for its current workload. Unfortunately needed services are lacking in many VA medical centers and are limited at CBOCs. During the 1980's, the original 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 FY2003 edition of *The Long Journey Home* (the annual report on VA PTSD programs from VA's Northeast Evaluation Program Center) documents that the intensity of services in VA PTSD Clinics has decreased by 13.2% since 1995. The number of veterans SC for PTSD doubled during those same years. This indicates that VA PTSD specialty services are saturated such that they will not be able to meet the coming need. Findings in the VA Capacity Report suggest that, in at least some VISNs, only a fraction of the VA funds spent in the baseline year

of 1996 are currently being invested in PTSD. The Office of the Inspector General recently raised the question of whether 39 of the existing 84 PTSD Clinical Teams have *any* staff still assigned to them.

The current Special Committee continues to call for a fully operational PCT at every medical center and has defined standards for those teams. Since we need to stage our efforts to meet immediate needs, we suggest that VA begin by prioritizing the staffing of PCTs at VA's adjacent to major military sites and in locations where mobilized Guard and Reserve units are based.

RCS resources remain severely stretched, particularly in the area of family services. The Special Committee continues to advocate for the addition of a family therapist at each Vet Center to provide family services once a deployed family member returns home and is discharged or released from active service. We suggest that additional staffing be prioritized at Vet Centers near military bases and in Guard and Reserve communities.

The Special Committee continues to recommend implementation of a Director's Performance Measure for PTSD that will gauge each Network's commitment and achievement in this area. Special emphasis should be placed on implementation of the CPG. The PTSD Committee has recommended that a PTSD Coordinator be identified within each VISN. The Coordinator's job would be to ensure that each CBOC, clinic and Medical Center has a plan and sufficient resources for meeting the needs of patients with PTSD, for championing the implementation of the CPG, and for communicating between the station level and the national level on these issues.

The Special Committee has also recommended that a National Steering Committee on PTSD Education be convened to assess training needs and direct PTSD education across VA. In light of the current situation, we recommend that this function be invested in a Joint DoD/VA Council on Post Deployment Mental Health. The work group that created the CPG was an effective partnership between members of these two cultures and could serve as a nidus for the new Council. The Joint DoD/VA Council would review the present continuum of care, design and implement an educational program, and hammer out the next steps

to be taken. The Council will define the roles of staff at each point in the continuum of care and ensure implementation. It will be able to draw from a full range of DoD and VA resources including the Uniformed Services University of the Health Sciences, the National Center for PTSD, Readjustment Counseling Services and the Seamless Transition Task Force. The Council will be responsible for developing an oversight mechanism to monitor, measure, and document (in real time) successes, problems, lessons learned and opportunities for timely course corrections if needed.

Now is the time to act on behalf of those who have borne our country's latest battles and to prepare for future operations, and I am pleased that VA will allocate additional resources, as authorized by P.L. 108-170, for PTSD programs to enhance later this spring.

Mr. Chairman, this concludes my statement, which can be placed in the record. Thank you for this opportunity to present my report. I will be happy to respond to any questions that you or other members of the subcommittee might have.