

**Statement of  
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Department of Veterans Affairs  
Before the  
Committee on Veterans' Affairs  
Subcommittee on Health  
on Handoffs or Fumbles? Are DoD and VA Providing Seamless Health Care  
Coverage to Transitioning Veterans?**

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Mr. Chairman, I appreciate this 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 ongoing service as Co-Chair of the Under Secretary for Health's Special Committee on Posttraumatic Stress Disorder (PTSD), and my active involvement in the development of a new joint DoD/VA Clinical Practice Guideline for the Management of Posttraumatic Stress.

VA is the world leader in PTSD treatment and research but it still has to overcome a longstanding misperception that PTSD treatment and research are primarily concerned with mental scars from long-past conflicts. Like many VA clinicians, I learned about PTSD by treating Vietnam veterans years after the war ended. In fact, when I first joined VA in 1980, the disorder was known as Vietnam Stress Syndrome. Later, we recognized that PTSD was also a significant problem among veterans of Korea and WWII. Over the next several years, VA developed clinical and research programs to meet the needs of patients with chronic PTSD. But, starting with the first Gulf War and then gaining momentum following the events of September 11, 2001 and the conflicts in Afghanistan and Iraq, VA is increasingly focused on tackling PTSD *proactively*.

We must preserve our capacity to serve veterans of past conflicts but we must also step up to meet the needs of a new generation of combat veterans. This means developing treatments for acute posttraumatic reactions and, whenever possible, preventing the development of chronic PTSD.

## **The Under Secretary's Special Committee on PTSD**

### The Charge of the Special Committee

The statutory charge to the Special Committee, laid out in section 110 of Public Law (PL) 98-528 (1984), as amended by section 206 of PL 106-117, the Veterans Millennium Health Care and Benefits Act, is to determine VA's capacity to provide assessment and treatment for Post-traumatic Stress Disorder and to guide VA's educational, research and benefits activities with regard to PTSD. The Special Committee is composed of PTSD experts from across a broad spectrum of VA's Mental Health and Readjustment Counseling Services (RCS). The Committee is currently developing its fourth and final annual report as required by PL 98-528, as amended.

### Status of the Committee's Work

The Committee has found that VA faces significant challenges in its efforts on behalf of veterans suffering from this most prevalent mental disorder arising from combat. Our first annual report, prepared in 2001, reviewed the needs of veterans with PTSD and made 37 specific recommendations for action. In our second report, we honed and bundled those recommendations into 22 measurable objectives, each with a defined time frame. We continue to track progress on these recommendations and objectives in a spreadsheet that serves as an attachment to our third and (pending) fourth reports.

### The Committee's Key Recommendations

Based on our four years of study, the essential things that VA must accomplish to meet the challenge of PTSD are:

1. Provide the range and intensity of specialized programs necessary to meet the service-related needs of veterans with PTSD

2. Promote best practices and evidence-based care for PTSD and other debilitating psychological responses to military trauma and:
3. Ensure VA's readiness to respond to the mental health consequences of combat, terrorism, and incidents of mass violence by supporting programs that are essential to its PTSD mission

## **The Joint DoD/VA Clinical Practice Guideline for the Management of Posttraumatic Stress**

### An Essential Step in Meeting the Committee's Recommendations

As a result of my work with the Special Committee, I was asked to help organize the development of the Joint DoD/VA Clinical Practice Guideline for the Management of Posttraumatic Stress. The working group for this project included members of Army, Navy, and Air Force as well as VA Medical Centers, RCS, and VA's National Center for PTSD. Disciplines represented included psychiatrists, primary care physicians, psychologists, nurses, pharmacists, occupational therapists, social workers, counselors, chaplains, and administrators. The goal was to create an evidence-based algorithm for the prevention, assessment, and treatment of military men and women who have survived traumatic events. These events include (but are not limited to) combat, peacekeeping and humanitarian operations, bioterrorism or disaster response or sexual or domestic abuse.

### The Challenges

Although PTSD is the most widely known mental disorder resulting from exposure to such overwhelming events, it is not the only such disorder. The Work Group had to develop a guideline that addresses the full range of posttraumatic reactions/disorders including: Acute Stress Response/Combat and Operational Stress Response (a mixed group of reactions that affect the survivor within moments and up to a few days after the event); Acute Stress Disorder (a narrower group of symptoms and signs that develop within the first month after the event), and PTSD (which may be acute, chronic, or of delayed response and which may be complicated by other mental and physical disorders). In pursuing

its charge, the Work Group had to confront the fact that DoD and VA have two very different cultures with respect to disorders of traumatic stress.

Within DoD, many consider it a very bad idea to report symptoms of PTSD because they are concerned that it will interfere with their mission, disrupt the morale of their colleagues, and possibly curtail their military careers. In contrast, veterans within VA often consider talking about PTSD a good thing because it can lead to effective treatment and, sometimes, to needed disability benefits. Providers and leadership in DoD are therefore less likely to hear about pathological responses to traumatic events within their unit and may not realize the extent to which such problems exist.

VA staff, on the other hand, get to know the end of a veteran's PTSD story and often wonder why they can't learn more about how the problem began from DoD records or why intervention did not begin during the patient's military service. In the course of developing the Joint Guideline, the Work Group came to recognize the important implications of this cultural divide for service personnel transitioning from DoD to VA. In the House Subcommittee's metaphor, we set about ensuring good handoffs and preventing fumbles.

### **Applying the Lessons Learned**

#### **The Importance of Screening**

Perhaps the most fundamental element of the Joint Guideline is the recommendation to screen every man and woman at specific intervals for symptoms of posttraumatic stress in every DoD and VA primary care and mental health clinic. The screening tool is a four-question instrument developed by the National Center for PTSD and validated in primary care populations. These same four questions have now been incorporated into DoD's Post-Deployment Questionnaire. It is hoped that, by identifying those at risk as early as possible, we can prevent new cases of chronic PTSD. A good deal of clinical experience and research will be needed before we can determine if this is, in fact, possible. Despite improvements in record sharing between DoD and VA, VA clinicians still lack the ability to access the post-deployment responses of the veterans they serve.

### Weaving a Continuum of Care between DoD and VA

VA has already identified VHA/DoD Liaisons to major DoD Military Treatment Facilities (MTFs) to assure seamless transition and transfer of care. VA has also identified staff members to serve as Points of Contact (POCs) at every VAMC. The principle role of the POC is to receive and expedite referrals and transfers of care from the VA/DoD Liaison and to assure that appropriate linkage is made for clinical follow-up services.

### Enhancing the Continuum of Care

The Special Committee is currently reviewing the role of the POCs and Vet Centers in providing information to combat veterans of Afghanistan and Iraq and their families at the time of the veteran's separation from service on the possible effects of combat stress. POCs could be provided with scripts based on the scenarios they are most likely to confront and distribute brochures based on materials already developed by the National Center for PTSD (available on the web at <http://ncptsd.org/topics/war/html>), and would provide information about where to get help. POCs would continue to be responsible for meeting the needs of active duty personnel and new veterans and their families as they present for VA services at their respective medical centers.

The Special Committee is also considering how military unit associations and Veterans Service Organizations might be engaged to help identify, refer and help support veterans who need care.

The Special Committee, in its third report, identified two actions needed to complete the VA continuum of care: (1) the establishment of a PTSD Clinical Team (PCT) at every VA medical center and (2) the location of a family therapist within each Vet Center. The VHA has concurred in concept with these recommendations and will address them consistent with local needs assessments and availability of resources.

## **Cultural Change in DoD and VA with Respect to Disorders of Posttraumatic Stress**

### Changing the Culture

In military language, “real grunts” see posttraumatic stress disorders not as the reaction of a normal person living through a very abnormal situation (such as combat) but rather as a failure of training, leadership, strength or character. This stigma is reflected at all levels of DoD and VA and forms the greatest single impediment to effective intervention and continuity of care. Cultural change is required across both systems. At present, the single most effective recommendation I can offer is to embed the DoD/VA Joint Treatment Guideline (with its assessment, treatment, and potential prevention capabilities) into DoD and VA primary care and mental health clinics and to consistently apply them during DoD operations. This will require development of software packages capable of seamlessly integrating the Joint Guideline into DoD and VA computer medical record systems in a manner that makes it easy and even preferable, for clinicians to use it. VA is also developing a system that monitors and encourages utilization of the Joint Guideline.

Current DoD efforts such as the Army’s CSC (Combat Stress Control) Program and the Navy/Marine Corps’ OSCAR (Operational Stress Control and Readiness) Program, both of which aim at peer-based early intervention with appropriate health care followup, are excellent vehicles for implementing the Joint Guideline during ongoing military operations. Aspects of the new Joint Guideline have already been applied in Iraq and have been found useful. These DoD programs are essential elements of the DoD/VA continuum of prevention and care and should be supported and cultivated across DoD.

### **Summary**

DoD and VA must work together to build, integrate, and maintain the continuum of care needed by active duty men and women and veterans, present and future, who have placed themselves in harm’s way in defense of our Nation. In their effort to meet the evolving challenge of posttraumatic stress, DoD and VA

are now focused on the practical problem of identifying new cases, researching and applying new interventions, and, whenever possible, preventing chronic PTSD. The efforts of the VA Under Secretary for Health's Special Committee on PTSD and the DoD and VA staff who developed the Joint Clinical Practice Guideline for the Management of Disorders of Traumatic Stress will help ensure effective handoffs rather than fumbles as military men and women transition from DoD to VA. Many elements of a comprehensive transition process already exist but they need to be strengthened, integrated, and more sharply focused. Ultimately, success in this area will require cultural change in both DoD and VA. This can best be accomplished through the development of specific performance measures that favor the implementation of the evidence-based Joint Guideline.

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