STATUS OF DEPARTMENT OF VETERANS AFFAIRS POST-TRAUMATIC STRESS DISORDER PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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HOUSE OF REPRESENTATIVES

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THURSDAY, MARCH 11, 2004

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 334, Cannon House Office Building, Hon. Rob Simmons (chairman of the subcommittee) presiding.

Present: Representatives Simmons, Strickland, Boozman, Renzi, and Murphy.

Ex officio present: Representative Evans.

OPENING STATEMENT OF CHAIRMAN SIMMONS

Mr. SIMMONS. The subcommittee will come to order.

This morning the Subcommittee on Health of the Veterans' Affairs Committee will conduct an oversight hearing on the status of post-traumatic stress syndrome programs in the care of veterans of combat and hardship deployments.

The subcommittee will be exercising its routine oversight duties on this important issue, and we look forward to having three panels of very distinguished physicians, chaplains, and experts on this subject. I have a full statement that I would like to submit into the record, and for the sake of timeliness, I will summarize.

In September of 1864, Union General William Tecumseh Sherman made the comment "War is Hell." Speaking as a Vietnam veteran, he was absolutely correct. And it's interesting to note that when the Civil War was over—and it was the most divisive and bloodiest war in our history—in a number of locations volunteer soldier homes were created, or in the case of Rocky Hill, Connecticut, the Nation's first state home for veterans was created, to care for what was called the "war-weary." The war-weary.

There are different names, I guess, for what some call battle fatigue, combat fatigue, war weariness. We call it post-traumatic stress syndrome in today's language. And as a Vietnam veteran, it has an interesting history. Because when I returned back from two tours in Vietnam and began my work as a Senate staffer back in 1979 and 1980, a very senior senator who actually was a veteran of World War II, and of Korea, referred to the concern of Vietnam veterans as the concerns of cry-babies. Cry-babies. They lost the war and now they're just a bunch of cry-babies.

In a movie featuring General Patton, titled "Patton," there's a famous incident where he slapped a soldier for being a coward. But chances are, that same soldier was suffering from war weariness, battle fatigue, post-traumatic stress syndrome.

So it's a serious issue. It's a serious topic. And even though the names or the labels change over time, I would argue that the condition is the same. And when our men and women in uniform serve us in the field of battle, and when they return, we often seem to be so very good when it comes to dealing with physical injuries or injuries involving the limbs, the face, the jaw. But when it comes to the mental injuries and wounds that all soldiers are exposed to in a battle environment, we seem to do less well, except I would say that over the last 20 years, there has been a tremendous amount of focus on this specific issue, which I think is a very positive thing.

I note that Time Magazine this January named the person of the year as the American soldier, and I think that recognition is extremely appropriate. But I will also note that of the 130,000 or so soldiers returning back from service in Iraq and Afghanistan on the largest rotation since World War II, that many of these soldiers will be receiving their DT214 and they will be coming American veterans. And the challenge for us today and in the future is to be sure that we are prepared to care for them, whatever wounds they may carry from their service, whether they be physical or mental.

And so the purpose of today's hearing is a serious purpose, and we all take it seriously, and I look forward very much to hearing the testimony of our witnesses. And now I would like to recognize Mr. Strickland, who is sitting in as Ranking Member on behalf of our Ciro Rodriguez, who is still engaged in a tough battle down in Texas. And I also would like to recognize that Lane Evans, the Ranking Member of the full committee, is here, and I will defer to my Democrat colleagues to decide who wishes to speak next.

[The prepared statement of Chairman Simmons appears on p. 47.]

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTTEE

Mr. EVANS. Thank you, Mr. Chairman. We soon will have thousands of young men and women returning from Iraq and Afghanistan. Unfortunately, past experience indicates that many of them will suffer from PTSD. PTSD has been well documented among veterans from wars dating back to ancient times. In a recent study, the VA found that 10 percent of veterans from the Persian Gulf War had the disorder. The rate more than doubled if they experienced combat.

As a Vietnam-era veteran, I have a long-standing concern about PTSD. Adequate information and science hold the key to helping veterans. As a freshman, I introduced legislation to require the VA to carry out a study of the prevalence of PTSD among Vietnam veterans.

I still am working to push the VA to obtain this information and demonstrate that it is providing the services veterans need to combat this condition. I recently wrote a letter to the VA about its current efforts on behalf of our newest veterans with PTSD. Mr.

Chairman, I would like for the record to reflect my letter and the VA's response be included in the hearing record.

I want to thank you for your sensitivity on this issue. You have been a standout, I think, on all of our Vietnam veterans' issues. You're known largely for your accomplishments working with this committee and I'm very happy to continue to work with you. I do have to go before the Appropriations Committee here, and I'm already late, and I think that's probably where Chris is. So we'll head over, and we'll try to get back.

[The prepared statement of Congressman Evans appears on p. 52.]

Mr. SIMMONS. I thank the gentleman for his kind remarks. I thank him for his leadership and his bipartisanship, and I encourage him to go over to the Appropriations Committee and get the big bucks. (Laughter.)

Mr. EVANS. Thank you, Mr. Chairman.

Mr. SIMMONS. The chair orders that the letter and the statement will be inserted into the record, and I recognize my colleague, Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. And good luck, Mr. Evans. (Laughter.)

OPENING STATEMENT OF HON. TED STRICKLAND

Mr. STRICKLAND. I want to thank you, Mr. Chairman, for calling this hearing on the status of the Department of Veterans Affairs post-traumatic stress disorder and other mental health programs.

There are few topics, perhaps no topics within the VA health care system more timely or more significant to our servicemen and women who are returning from Iraq and Afghanistan.

Meeting the needs of men and women who have been injured in service to our Nation is both VA's responsibility and its privilege. It is my view that the VA has thus far embraced the challenge of smoothing the transition between military service and civilian life for the most seriously physically wounded of our returning soldiers. Things are not perfect, particularly for reservists and National Guardsmen, but the VA should be commended I believe for the efforts it has made to date. I hope that meeting the mental health care needs of the thousands of young men and women whose wounds will not be so visible will not be a different story.

It is fair to say that mental health services have not fared well in VA's transition away from hospital-focused care. Psychiatric bed care is certainly perhaps not the gold standard of care for the seriously mentally ill veterans, but in many cases, I believe it should be. VA's beds do serve as a means of keeping some semblance of mental health services intact through this health care system.

Since 1994, VA has closed thousands of psychiatric beds, dropping its census from 14,125 to 2,803. It has eliminated 43 percent of the employees once committed to psychiatric care. Many of the facilities targeted for closure or mission conversion under the Capital Assessment Realignment for Enhanced Services are primarily psychiatric facilities.

Even the VA acknowledges that it has fallen short of the mark in meeting Congress's requirement to meet the capacity of its programs for substance abuse disorders. But since neither beds nor

employees are used for a measure of compliance with the congressional requirement, it has been difficult to monitor how VA is reprogramming mental health resources. It does not appear that VA is using them to develop alternative mental health programs in the community. Only about half of the newly established community-based outpatient clinics offer mental health services.

The mental health intensive care management health teams which hold a great promise—they've been slow to be established. The General Accounting Office and VA's Inspector General are also skeptical of VA's claim that it is complying with the law in this regard.

Mr. Chairman, this is important when we begin to discuss VA's programs for post-traumatic stress disorder, which is an important specialty within VA's continuum of mental health care. VA has some of the preeminent experts on PTSD, but its resources are limited, and some say they're stretched beyond capacity with the current workload. Sadly, the rates of suicide among service members in Operation Iraqi Freedom might lead us to believe that this has been and is a particularly stressful military engagement.

I am pleased that we will hear from the frontline providers, our chaplains, in our final panel. It is unfortunate that the military does not appear to have identified a systematic means of readily sharing information with the VA about service members who will be discharged. As the chaplains will attest, immediate intervention is critical for allowing these men and women to successful process traumatic events before those events lead to chronic problems.

Already more than 11,000 veterans from Operation Enduring Freedom and Iraqi Freedom have used VA's services. About 13 to 15 percent of those veterans are in fact seeking care for mental health disorders, including PTSD. It is clear that the VA must be able to provide outreach, outreach and ready access to high quality, specialized PTSD treatment and other mental health services in order to successfully intervene.

And I would just like to close my remarks by saying before coming to the Congress, I worked in a maximum security prison in Ohio, and I worked in that prison with many Vietnam veterans who I am convinced are spending their lives in prison because they were not provided with timely and appropriate mental health interventions following their return to this country. And we must not let that happen to those who are fighting for us this day.

Thank you, Mr. Chairman.

Mr. SIMMONS. I thank the gentleman for his statement, in particular for his insight as somebody who has worked with the prison population. I see that I'm joined by three of my colleagues, and I would like to extend to each of them the opportunity for an opening statement if they would like to make it. Mr. Murphy? Renzi? Boozman? Boy, aren't they great. They're terrific.

We will now call the first panel to the table. We have Dr. Thomas Horvath, who is Chief of Staff of the Michael E. DeBakey Veterans' Affairs Medical Center in Houston, TX. We have Terence Keane, who has got his Ph.D. and is director of the National Center for Post-Traumatic Stress Disorder at the VA Boston Health Care System. We have Harold Kudler, a doctor, who is the co-chair of the Under Secretary for Health's Special Committee on PTSD in

the Durham, Virginia Medical Center, and Dr. Sally Satel—I hope I pronounced that correctly—Resident Scholar at the American Enterprise Institute.

I will advise the panel that we have three panels today, and I know that our membership probably wants to engage in some questions. And so we are going to keep a tight five-minute clock. And I would also suggest that if you have a length statement which we have as a matter of the record, you are free to consider summarizing that if that works for you.

And now I would like to begin with the testimony. Should we begin with you, Dr. Horvath? And if you could turn on your microphone by just pushing the button.

STATEMENTS OF THOMAS HORVATH, M.D., CHIEF OF STAFF, MICHAEL E. DeBAKEY VETERANS' AFFAIRS MEDICAL CENTER, HOUSTON, TX; TERENCE KEANE, DIRECTOR, NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER, VA BOSTON HEALTH CARE SYSTEM; HAROLD KUDLER, M.D., CO-CHAIR, UNDER SECRETARY FOR HEALTH'S SPECIAL COMMITTEE ON PTSD, DURHAM VA MEDICAL CENTER; AND SALLY SATEL, M.D., RESIDENT SCHOLAR, THE AMERICAN ENTERPRISE INSTITUTE

STATEMENT OF THOMAS HORVATH

Dr. HORVATH. My name is Thomas Horvath. Thank you, sir. I'm a neuropsychiatrist and am currently the chief of staff of one of the largest medical-surgical psychiatric facilities of the VA. I'm a professor at Baylor at Houston. I'm also the son and grandson of combat veterans who carried their painful war memories and symptoms throughout their productive lives. Thus for me, combat stress is a family experience, not a textbook abstraction.

My Army Reserve career taught me the doctrine of combat stress control, but the Hungarian Revolution of '56 gave me the whiff of mortal danger. Having seen the ravages of war in Hungary, having seen the delayed effects of World War II in Australian patients, I expected to learn a lot when I came to study at Stanford 30 years ago. But at the Palo Alto VA, we had no instruction whatsoever in military medicine, post-deployment psychiatry, or the problems of Vietnam veterans. What we learned, we learned from veterans. We came to understand the reality of the trauma and the symptoms.

That painful condition, which also affects hundreds of thousands of veterans of all wars, only received formal recognition in 1979–1980, first by the APA, then by the VA. To this day, some people confuse a set of political and cultural attitudes, the post-Vietnam syndrome, with a clinically coherent, statistically valid diagnostic entity, Code 309.81, 308.3 of DSMIV, which is triggered by a range of catastrophic stressors, including combat, ambush, carnage and rape. Yet to this day, many people regard this PTSD as a weakness, a yellow streak, and not the red badge of courage. This despite CT scan findings of the shrinking of a part of the brain involved in emotion and memory, which correlates with combat intensity scores. This despite persistent biochemical changes which eventually lead to higher rates of cardiovascular disease and of

mortality in general, shown in World War II veterans, POWs and Holocaust survivors.

PTSD is a persistent biological condition that maims the body as well as the mind. It correlates with combat intensity. But unit cohesion and warm homecoming support partly protects from it. Regrettably, the VA 30 years ago did not provide these. However, we've come a long way. Twenty-five years ago we had PTSD services, no vet centers, no homeless programs. We did, however, have a set of substance abuse services that we no longer have. Still, the growth of PTSD programs has been gratifying, but not quite enough for the demand.

These demands will now increase, especially by the many reservists who on their return from overseas are judged RPGs while nation building, will be eligible for the VA. But PTSD is only one of the consequences of stress: Suicide, unexplained physical illness, depression, even the precipitation of psychoses and addictive disorders or others.

So we must provide specific PTSD services, like our excellent vet centers and trauma teams. We must also provide a wide range of mental health programs appropriate for the age, sex, ethnicity of today's military, and we just continue to honor our commitment to the older veteran. Yet here the news is not good enough. Our committee, the Seriously Mentally Ill, chartered by Congress, has repeatedly observed that VHA is not in substantial compliance with the provisions of Public Law 104–262 and Public Law 107–135, inasmuch as it failed to maintain the full required capacity for special services for the mentally ill. Over the past seven years, VA inadvertently took 25 percent of inflation adjusted dollars and 23 percent of its staff for mental health services to support primary care and general medical/surgical services. This was not a single executive decision, but the unintended consequence of hundreds of well-meaning actions. Better access, better primary care and better preventive medicine—are laudable goals, and we've proudly achieved them. But this did not have to come at the expense of the mentally ill.

The wide variation among the networks from minus 20 percent to plus 35 percent shows that this could have been done better. Excessive decentralization and persistent stigma about mental illness contributed to this problem. The stigma in the VA is probably no worse than in the rest of health care, and it is being turned around by leaders like Mr. Principi, whose 15 years of support for the mentally ill veteran has earned him the highest award of the APA Assembly. The presence of Dr. Roswell and the support received from him and his three deputies, also express their commitment and their lack of bias.

But why do we have problems despite this stellar top leadership? Look. The VA is a huge oil tanker that responds very slowly to steering. The mentally ill were never a popular constituency. We made efforts in the 1980s to reverse this, but in the 1990s, we oversteered towards the inclusion of a large number of non-service-connected veterans who flock to us to get their expensive medications. We have become a safety valve of sorts for the problems of Medicare and drifted away from our core constituents who experienced the lasting wounds of war.

It is time to drag the wheel back, Mr. Chairman.

[The prepared statement of Dr. Horvath appears on p. 67.]

Mr. SIMMONS. I thank you for that testimony. I would ask that the other three panelists also make their statements, and then we'll get into questions.

Next, Dr. Keane.

STATEMENT OF TERENCE KEANE

Mr. KEANE. Thank you, Mr. Chairman. My name is Terry Keane. I'm Chief of Psychology at VA Boston Health Care System. I'm also Director of the National Center for Post-Traumatic Stress Disorder, a center that was established by Congress to address the needs of Vietnam veterans with PTSD and veterans of all eras, in particular assigned the responsibilities for research and for education and training.

I've been involved in the work of PTSD for more than 25 years, having been chief at the Sonny Montgomery VA Medical Center for five years before moving to Boston. As well, I've had oversight responsibility for the National Vietnam Veterans Readjustment Study, an epidemiological study that was commissioned, mandated by Congress and conducted by VA through a contract to understand the prevalence of war zone-related stress conditions and other related kinds of psychiatric problems.

I'm here today to make a number of points for your consideration. First, I want to assure you that the VA is unquestionably the international leader in treatment, education and research on war zone-related PTSD and related psychiatric conditions. Yet the quality, the quantity and the access of care for veterans with PTSD is quite variable across the country, even varying by networks.

Specialty programs across VA are struggling to meet the demand for PTSD services from veterans of earlier eras. Individualized care, the rock bed of psychiatric interventions, individualized care has frequently been replaced by group interventions that do not have an evidence base in the area of PTSD. VA as well loses three to five of these hard-earned specialty PTSD programs each year. Reestablishing these programs in geographic locations will be costly, and the loss of corporate knowledge when programs close is great.

With the existing demand for services high and the possibility for increased demand from new veterans, there is a need for creativity in the development and the delivery of effective interventions. New resources, redirected resources or greater use of resources saved by reengineering inpatient to outpatient should be seriously considered and reconsidered. PTSD treatment programs for women veterans exist to some extent in the vet center program, which has done a particularly good job in this arena, less so in VA medical centers nationwide.

The needs for treating combat stress in women, but as well, war zone stress, sexual harassment and sexual assault, are an increasing component of the needs for care in VA. Recent studies highlight these findings.

But now to the issue of incoming veterans. VA is presented with a unique opportunity now to take the national lead in the development and the evaluation of the effectiveness of early psychological

and psychopharmacological interventions for promoting resiliency and preventing adverse outcomes, a broad array of adverse outcomes following exposure to military trauma.

Consideration for sponsoring centers for early intervention for trauma is one way to assert international leadership in this arena. The use of telecommunications, especially the World Wide Web, for surveillance, for treatment and evaluation of these early interventions will be one efficient way of managing these complex emotional and behavioral problems. They may prove to be indispensable for the seamless transition implemented between VA and DOD.

As well, we need support for developing innovative rehabilitative methods for war-injured veterans through our MIRECCs, through medical research and academic affiliations, and the National Center for PTSD will continue with possibly increased support to provide to top clinicians, to top academics, a place where they can scientifically study respectably the problems of exposure to war.

I'd like to say that I believe that it's critical for us to be filling vacancies in these PTSD specialty programs. I think establishing centers of excellence for early intervention in trauma is a timely recommendation for you to consider. The prevention of the chronic course of PTSD should be foremost in our minds as we proceed to try to take care of this next generation of veterans, particularly those people who are at high risk for developing psychological problems, those who have suffered or sustained serious war injuries, and those who have experienced extreme distress as a result of their exposures.

Thank you very much for the opportunity to speak with you today.

[The prepared statement of Dr. Keane appears on p. 73.]

Mr. SIMMONS. Thank you, Doctor, and apologies for the buzzer. I hope that—you probably thought it was somebody's alarm clock or something like that. But in any event, those will go on throughout the day.

Dr. Kudler, welcome.

STATEMENT OF HAROLD KUDLER

Dr. KUDLER. Thank you, Mr. Chairman. I appreciate this second opportunity to testify before the subcommittee. My name is Harold Kudler, and my remarks reflect 20 years as a VA psychiatrist, my service as co-chair of the Under Secretary for Health's Special Committee on PTSD, and my role in developing the new joint VA/DOD Clinical Practice Guidelines for the Treatment of Traumatic Stress.

On the day after my October 16 testimony to this committee, partly based on committee members' comments, I decided to take a cab up to Walter Reed, and I took a tour. As an expert in PTSD, I sincerely hoped that the patients there would not need my help. But when I asked the nurses how could I be of help to them, they said, could you find a way to get them to stop firing that cannon at 4 o'clock every afternoon? Because it takes us half an hour to get the guys back into bed.

Mr. SIMMONS. I can associate with that.

Dr. KUDLER. Yeah. Well, I thought you might. And the fact is that the Army's deployment health program has found that three months after admission to Walter Reed, 40 percent of the casualties treated there develop symptoms consistent with PTSD. Now that's including all med/surg casualties. It's not just mental health casualties. It's 40 percent.

The Department of Defense and VA have a unique opportunity to intervene now while the majority of new combatants are still in uniform to address the complications of traumatic stress. And it's not just PTSD. It includes major depression, substance abuse, job loss, family dissolution, homelessness, violence towards self and others, and as mentioned, incarceration.

There's also military sexual trauma and suicide. We need to create a progressive system of engagement and care. We need to focus on prevention and integration. For a relatively small investment we could significantly improve health outcomes. For instance, VA has a point of contact at every VA medical center for new combat veterans. But these people are not trained to recognize traumatic stress, especially acute traumatic stress. It would be relatively easy to teach them to spot a problem and triage it, not make them specialists, but spot a problem and triage it.

During demobilization, returning soldiers complete the post-deployment evaluation screen, but the results are not yet available to VA planners or clinicians. This must change. As one Army doctor just back from Afghanistan told me, returning soldiers don't have the emotional bandwidth to explore psychological issues during the demobilization process. It's not practical. An intervention then would be seen as an obstacle to coming home and would be resented and lead to further stigmatization. It would be better to intervene after soldiers had a chance to sleep in their own beds and spend time with their families, and then they'd be more likely to recognize readjustment problems when they do exist and perhaps to talk about them.

Mental health professionals would be best at talking with them because they have special skill in developing rapport and recognizing early signs of distress. A confidential interview could be made with individuals or small functional groups, and the emphasis would be on normalizing responses, not on pathologizing them. A pamphlet summarizing the information—because people never listen or remember much of what happens in interviews like this—would be handed out, and a separate pamphlet would be mailed to the family identifying resources and reviewing again the core information.

The co-chairs of the PTSD and SMI Committees recently met with the Under Secretary to recommend a partnership with DOD to provide this intervention because it would serve as a force multiplier in DOD and improve health outcomes in VA.

VA could extend its counseling services by training peer counselors drawn from military unit associations. These are veterans who are already on site and part of the unit culture. It wouldn't be hard to bring them and their spouses into helping new combat veterans and their spouses.

VA cannot meet the needs of new combat veterans and still treat its current patients. Only half of all VA medical centers actually

have PTSD teams, and even at those sites, many positions have been drawn off to other programs or lost to attrition.

The Special Committee calls for a fully operational PTSD team at every medical center and an additional family therapist at every vet center. We suggested VA prioritize sites adjacent to military bases and locations where guard and reserve units are based as a first step.

We recommend implementation of the Director's Performance Measure for PTSD. We recommend that the Clinical Practice Guideline be aggressively rolled out, and that a PTSD coordinator be identified within each VISN to ensure that every site has a plan backed by sufficient resources.

Further, I'd like to recommend the development of note-generating software to support the Clinical Practice Guideline. People will not use it unless it makes their life easier, and this kind of information technology is easily within our grasp.

The Special Committee has pressed for a National Steering Committee on PTSD Education, but given the situation we're in right now, I'd like to roll that idea into a joint DOD/VA Council on Post Deployment Mental Health. This joint council would hammer out the remaining details and be responsible for documenting successes, problems, lessons learned and opportunities for the future.

Given that we have, for 2 years, had a standing group working on the Clinical Practice Guideline, VA and DOD, and that most of the DOD staff involved have been to the Gulf and back, we have a real jumpstart on a group that trusts each other, knows each other and understands the general backbone for PTSD services in VA and DOD.

It's time to act on behalf of those who have borne our latest battles and to prepare for future operations. Mr. Chairman, this concludes my remarks, and I'll be happy to respond to any questions.

[The prepared statement of Dr. Kudler appears on p. 78.]

Mr. SIMMONS. Thank you very much. Dr. Satel? Did I pronounce your name correctly?

Dr. SATEL. Yes, that's right.

Mr. SIMMONS. Thank you.

STATEMENT OF SALLY SATEL

Dr. SATEL. Thank you, Mr. Chairman and members of the committee. I'm also a psychiatrist, and actually, I did work at a VA for five-and-a-half years, Westhaven, CT, and I certainly know that post-traumatic stress disorder is a real and painful condition and that undoubtedly it will affect some men and women returning from Iraq. Clearly, a humane and grateful country needs to care for them.

One question that's arisen, though, is how many might there be? And we've been hearing in the news over the past few weeks that roughly, perhaps one-third of returnees from Vietnam suffered from PTSD, and based on that, we can roughly expect the same count this time. And I want to address the first part of my comments to the debatability of that assertion.

There are several reasons why I think those data are questionable, but perhaps the most compelling piece of evidence was just released two days ago by the VA Health Administration. This re-

port here called "Operation Iraqi Freedom: Analysis of VA Health Care Utilization," this report found that of the 107,540 soldiers who have returned from Iraq, 436 have so far been diagnosed with PTSD. That's 0.4 percent of veterans.

Now according to the adherence of what's called the National Vietnam Veterans Readjustment Study, which I'll call the NVVRS, that's where the 30 percent number came from, that would mean that there would need to somehow be a seventy-fold increase in PTSD cases between now and 10 to 20 years from now. Because, remember, the NVVRS examined veterans who had been back from the war a minimum of one decade. So somehow we're going to get, according to some folks I've heard speak about this, from 0.4 percent to 30 percent. I think that is a highly unrealistic and misleading forecast.

But supposedly such an amplification of pathology already took place once before with Vietnam veterans. Now consider during the years of most intense fighting in Vietnam, Army psychiatrists calculated that between 12 and 15 soldiers per thousand were psychiatric casualties, between 12 and 15 per thousand. That's essentially less than 2 percent. And moreover, the vast majority of those men did not see combat. They were called to psychiatric attention for behavioral problems and substance abuse. So, in other words, the bulk of the 12 to 15 per thousand psych casualties during Vietnam were not even in combat. Thus, if the NVVRS number is correct, that 30 in 100 veterans after the war developed PTSD, that is a vast multiplication of the number of psych casualties during the war, which is to say 1 to 2 out of 100, and most of them did not even see combat.

How do we begin to explain that kind of explosion in cases in PTSD? Well, one explanation that's offered is the concept of delayed PTSD. And I just want to state that this is the psychiatric equivalent of an urban legend. It has very little support in the epidemiologic literature. Certainly people delay seeking care, and that can be mistaken for delayed PTSD, but that doesn't mean that the symptoms appear out of the blue months and years later. In fact, most studies, in fact all of the studies that have actually looked at symptom formation, find that in the vast majority of cases, they develop within a week after a traumatic syndrome, and the tendency of PTSD is to go away over time, certainly not to emerge after the fact.

Another aspect of the NVVRS, and I think this is a very compelling explanation for why, again, they found such a high rate, again, 30 percent of veterans with PTSD 10 to 20 years after, is because there was a very low cutoff for making the diagnosis. Nowadays when clinicians make a diagnosis of PTSD, there has to be a degree of impairment in the person's daily functioning or extreme psychic pain. Symptoms of nightmares, painful memories, trouble concentrating, while distressing—I'm not minimizing them—that's not enough for a diagnosis of a mental illness. And in fact, a number of psychologists and psychiatrists have begun to question the rigor with which diagnoses of other conditions, not just PTSD, are being made.

In short, I think the NVVRS results are very shaky and not a good guidepost. So what is a good guidepost to what we should be

doing? Well, I agree with a lot of what Dr. Kudler said. We've learned a lot of lessons from treating Vietnam veterans. One is a very practical focus group or individual treatment should be focused on solving practical problems and rehabilitation, putting trauma experience in perspective. It is not healthy or helpful to entail repeated rehashing of terrifying or demoralizing stories. These often interfere with coping and agitate the patient further.

Long inpatient treatment should be reserved for those who cannot function. The VA used to have, and I think some VAs still do, specialized inpatient VA treatment units. They've been very problematic, often promote regression rather than facilitate readjustment, and in fact the Westhaven VA no longer has them.

I see the red sign, so I'll just finish up by saying——

Mr. SIMMONS. It's all part of our training here.

Dr. SATEL. Okay. Also beware of the disability trap. I would hate to see therapists pushing patients too quickly towards obtaining service-connection disability for PTSD. And the reason is because once a patient gets permanent disability, the motivation to ever hold a job declines, and the patient assumes, often incorrectly, that he can't work, that he is not employable, and his confidence in any kind of skills he might have once had erode, and his confidence in himself atrophy. Work is often the best therapy. And I know the VA is developing supported employment, which is very important.

I suppose I'll stop, since it's red, but we can continue this later, I hope. Thank you.

[The prepared statement of Dr. Satel appears on p. 88.]

Mr. SIMMONS. Thank you very much. And we do have your written testimony, and I notice my colleagues whipping through it as you speak.

Dr. SATEL. And I have this report, extra copies of it.

Mr. SIMMONS. Yes. I'd like to address two questions to the panel. The first, I will go to Dr. Horvath's statement, page 2, where he says: "PTSD is not a little old 'adjustment disorder' which is 'all in the veteran's head.' It is not a hyped-up myth. It is a persistent, dangerous biological condition that maims the body as well as the mind, the brain as well as social relationships."

I'd like to focus on the words "persistent, dangerous biological condition," because I think that is important for us to understand, and it's important for our veterans to understand that as I understand the issue, your exposure to combat, combat conditions, or just the stress of service can actually change the physical chemical nature of your brain, which then leads to the symptoms that we identify as post-traumatic stress disorder.

So it's not a fiction or a myth; it's an actual physical condition. Is that generally the view of the panel?

Dr. HORVATH. Well, it certainly is my view, and it's clear in the literature, and some of the work was done actually at the Westhaven VA, replicated at several other places. And it's actually supported by animal work. The hippocampus is the part of the brain that shows atrophy, and this correlates with objectively obtained, careful details of combat and other trauma exposure; the higher that exposure, the more—the greater is the degree of atrophy, which is an anatomical change.

This is also seen in monkeys who are traumatized, psychologically traumatized. It is seen in children who underwent child abuse. We probably know the mechanism, which is high cortisol levels, which are these spurts of a stress hormone. Some of the best work in this area, again, was done at the National Center for PTSD at the Westhaven VA. Currently that unit is also working on looking at resilience, because not everybody gets it. And it does appear that some people are fortunate enough to have a neuropeptide Y, another chemical which counteracts the effect of this other hormone called norephenephrine. If you wish, in subsequent questions I'm more than willing to provide a literature review on this. National Center has done this.

I think it's really important to understand, and I have shown this to Mr. Harvey when he was in the Senate staff some time ago, showing that in fact the severe stress which is then continued to be re-lived, this doesn't go away. It's like King Amfortas' wound in Parsifal. It's the persistent wound. It is when every time you duck for cover when you hear the gunshot, there is a startle reaction in your body. If you could stop that, if you could ameliorate it, if you could intervene early as indeed Harold suggests, that would be one way. The fact is that we didn't. We ignored these guys. I know. I was there. We ignored them. And therefore we have a responsibility for them.

To call them to task, to call them compensation seeking after 30 years of neglect, is a cheap shot.

Mr. SIMMONS. I thank you for that response, and I would ask that that document be placed in the record. My second question goes to the testimony of Dr. Satel. As I understand the problems of the Vietnam veteran, lack of unit cohesion, lack of a welcome home if you will, were contributing factors to those numbers. And it seems to me that in some respects, those conditions don't exist today. Certainly the country is much more united in their support for veterans, although there is division on the policy of the war. I have attended a number of welcome home ceremonies in my state, and I understand they're taking place elsewhere.

What effect will those changes have on the overall numbers, in your opinion? And anyone else can answer the question as well.

Dr. SATEL. That's a very good point, and one would predict, and certainly follow the numbers to see if the prediction holds up, but one would predict that just as you say, factors like unit cohesion and good training and good morale, appreciation of sacrifice from the public and good training are very important protective factors. So that may make a very big difference.

Mr. SIMMONS. I appreciate that. Dr. Kudler?

Dr. KUDLER. Yes, Mr. Simmons, one would predict that. However, we couldn't have done a better job of welcoming home people than we did with the Gulf War, and having been working in the Westhaven VA in 1980, I can tell you—now that was a different story—but the Gulf War, we did everything right I think in terms of welcoming people home. When those people came home, they often gratuitously said, we don't have that Vietnam stuff, so don't worry about us.

Now if we look at the numbers from the Gulf War, we have an outstanding study just published last year in the American Journal

of Epidemiology, 30,000 Gulf War veterans, 15,000 Gulf War era but not deployed, 15,000 Gulf War and deployed to the Gulf, found, if you look across everybody who went to the Gulf, 10 percent incidence of post-traumatic stress disorder using a very well validated PTSD tool. If you look at people who were in heavy combat in the Gulf, not just everybody who went there, but those who were in combat, it doubles to 20 percent. It's not just about politics. It's not just about what happened in Vietnam. When you put people in combat—and this is the lesson of World War II where one out of five combat casualties was psychiatric—if you put people in combat, some people are going to have problems, and we have to be able to deal with them.

Mr. KEANE. Mr. Chairman, may I respond as well please?

Mr. SIMMONS. Yes.

Mr. KEANE. I do appreciate the information that's been put forth here this morning, and I want to go back to your opening remarks which indicate the historical precedence of recognition of post-traumatic stress disorder. And it is indeed the case that World War II veterans received remarkably positive and warm welcomes back from the country. Yet we had a proliferation of psychiatric facilities that were necessary to take care of people who had psychiatric problems, not termed PTSD at the time, but yet there were thousands of men and some women who required treatment for what we would consider today to be PTSD.

I would like to take my comments further into another arena, which I think is relevant here. In a March 6th *New York Times* op ed, Dr. Satel suggested that the National Vietnam Veterans Readjustment Study did not explore military records. And I want to assure this committee that indeed we vetted through thousands of military records looking for evidence and information about exposure to war. Unfortunately, those records were remarkably inadequate to the task. And so to repudiate that study without regard to the hard work and tremendous effort on the part of VA to document military stress exposure is simply unacceptable. And it seems to me as well, that among the most impressive findings of the NVVRS was the association of PTSD with several very powerful indicators of social dysfunction among people who were having difficulty earning a living, people who were having difficulty with their marriages, people who were having difficulty managing their children, and people who were having difficulty with alcohol and drug abuse as well. All of these things fell in collections of findings.

So the idea that there was no functional impairment, as she stated earlier today, is simply an incorrect appraisal of the evidence.

Thank you.

Mr. SIMMONS. I thank you for those remarks. I can remember when I mustered out, my goal was to get the hell out of town and get home, which is one of the reasons why this committee and this subcommittee have focused on the demobilization process. And the 1109th, which just returned, which is a Connecticut unit, actually spent five days at Fort Drum demobilizing before they would be released home, and I think that's an important change. And I thank the panel for their remarks.

Mr. Strickland?

Mr. STRICKLAND. Thank you. And I want to thank the panel for an interesting and stimulating set of presentations. I would like to return to the urban myth of delayed PTSD, because—and I find myself agreeing with much of what the good Dr. Satel says and disagreeing with much of what she says, so. (Laughter.)

So I'm a flip-flopper, okay. I'll admit it. Is it possible that a returning soldier can suck it in, so to speak, deny problems and so on, and then at a later time in that individual's experience, perhaps there's some triggering mechanism, there's some other traumatic events that may occur in the individual's life that causes or allows these behavioral symptoms to surface when they may have been masked or hidden in the past?

Dr. SATEL. That's true. What you typically find with supposed delayed onset when you look at the patient more carefully is that they have had perhaps sub-threshold symptoms all along, right? And then some kind of intercurrent stress might tip them over. That's definitely true.

But I should say again, I'm not here to argue that there's not going to be PTSD. What I'm actually more concerned about is that when we have a person who's suffering, and sometimes you don't need a full-fledged diagnosis still to need some help and benefit from it, that we don't take that and turn it—that the help itself doesn't become iatrogenic, doesn't turn it into a more chronic problem.

Mr. STRICKLAND. Do you agree with the criteria that's presented in the DSMIV regarding the diagnosis of this disorder?

Dr. SATEL. I do, but I actually think they changed—you're a psychologist by training. Isn't that right?

Mr. STRICKLAND. Yes.

Dr. SATEL. In 1994 the DSM changed criterion 1. Now, I think it's too easy to qualify for PTSD. In other words, you could hear about—as you know now, you could hear about something horrible happening to someone else and still qualify. I think that trivializes the kinds of horrible trauma that people in combat or rape victims suffer. But, yes, I basically agree with it. And I think PTSD is legitimate. As I say, it's a fear reaction that essentially hasn't extinguished.

Mr. STRICKLAND. When did we first acknowledged PTSD as a distinct disorder?

Dr. SATEL. Well, it was ratified, so to speak, by the American Psychiatric Association in 1980. I've heard people say that, you know, it used to be called shell shock and battle fatigue and trauma neurosis. That's not quite true. Shell shock is a much more acute situation that happens in the course of battle. And the typical treatment for that, as you probably know, is to treat people as close to the front as possible, as quickly and with the expectation that they return, and most people actually do. The folks who tend to have the most trouble, who don't reconstitute with that kind of care, typically have preexisting problems with substance abuse or depression or anxiety.

Mr. STRICKLAND. I see Dr. Kudler shaking his head, so I'd like to know——

Dr. SATEL. I can provide you all the references. I'm sure we'll have dueling references.

Mr. STRICKLAND. Dr. Kudler, why were you shaking your head?

Dr. KUDLER. Because the lesson of World War II is that given enough stress, anybody can break.

Dr. SATEL. Shell shock.

Dr. KUDLER. No, no, it wasn't just shell shock, although they didn't call it PTSD thereafter. Dr. Satel is absolutely right that acute stress, and we have this in the treatment guidelines, is different than chronic. On the other hand, we've found through good recent literature that if you have these early signs you are at higher risk. And therefore, the logical thing to do is to try to intervene. And that's what we're arguing for.

Mr. STRICKLAND. Okay, Dr. Horvath. I'm sorry.

Dr. HORVATH. If I may go back to World War II again.

Mr. STRICKLAND. Sure.

Dr. HORVATH. It seems to be a safer topic. (Laughter.)

And look at a study that had nothing to do with traumatic stress, namely the so-called Grant Study of Normal Human Development that was done at Harvard and looked at Harvard undergraduates entering 1938, 1939, 1940. And then incidentally, they also went to war. These were the days when Harvard people still went to war. But that wasn't the purpose of the study. The purpose of the study was to see what happens to these wealthy, influential good Americans, 50, you know, 20, 50 years later.

Somebody went back, George Valiant and his group went back, published in the American Journal of Psychiatry, which I will submit for you, and looked at it and found that you could actually rate their combat intensity; that you could actually rate in the transcripts of interviews done in 1947, 1952, et cetera, you could glean symptoms which we now know to be PTSD.

These people didn't seek care. And you could identify a constellation of symptoms that was subthreshold or threshold PTSD. These were not treatment-seeking people. These were scions of wealthy America of the good war. And guess what? The interesting, the truly interesting finding is that they did have early morbidity and mortality; that even without the diagnosis of PTSD, combat kills and combat can kill 30, 40 years later by increasing I suspect—and I'm now speculating—that is the persistence of the stress, of the unrecognized stress.

So we're taking it away from the social pathology and the culture wars of the 1960s, go back to basic combat. And basic combat has effect on the system that we in the VA must include in our planning. And it seems that we are determined to send our kids to war, and therefore we have a responsibility to plan not for the next 2 years, not for the next PCT alone, but for the 30, 40 years that our kids will be coming back to this VA.

Mr. STRICKLAND. Mr. Chairman, my time is up. I would just like to say one more thing to Dr. Kudler, and I won't take time to have you respond, but I think you've presented some good ideas, suggestions. In the absence of obtaining a post-deployment health assessment from DOD, I think we should think about what VA can do immediately to identify these acute cases.

But I want to thank you all for a stimulating presentation. I found it very interesting. Thank you. Thank you, Mr. Chairman.

Mr. SIMMONS. I thank the gentleman. The next question goes to Mr. Smith, or was it Mr. Renzi who was here first? Excuse me, Mr. Murphy. And I will apologize to the panel. I will give the gavel to Mr. Murphy, if he's willing, and I hope to come back after another meeting. Mr. Murphy.

OPENING STATEMENT OF HON. TIM MURPHY

Mr. MURPHY (presiding). Thank you, Mr. Chairman. We'll keep the seat warm for you.

I really appreciate the testimony that all of you are giving here. I'm a psychologist myself, and my field has often times been in dealing with children, adolescents and families who have themselves faced trauma on multiple levels, abuse and other trauma. And much of the training that I received was from people in the military who are also passing on information and lessons learned from veterans. And there are a couple of things that I want to help myself and the panelists understand in this as well. As I look at the whole sequence of what appears to happen during combat, there are several steps that I understand research tells us are critically important. One is what happens on the battlefield itself with the commanding officer, the unit cohesion, the exposure, the length of exposure, and several other elements there, as well as if someone does experience some acute trauma, the shell shock concept, the idea of three hots and a cot nearby the battlefield and return, and what occurs at a field hospital, what occurs if they were evacuated to another site, what occurs when they're at a continental United States site, and then what occurs with long-term care. All those things are important.

But throughout that—and it's brought up, particularly Dr. Satel, has been this continuing threat of expectations, expectancy for improvement of symptoms, as well as the expectation for occurrence of symptoms. Now I find it particularly interesting, Dr. Satel, your testimony when you talk about the actual incidents that occurred by that one study of reports of PTSD from Vietnam veterans, and yet there could not have possibly have been that many veterans who actually were in combat. Am I correct in that? So if it's 31 percent, 31 percent of Vietnam veterans were not in combat?

Dr. SATEL. Thirty-one percent with PTSD and 15 percent in combat units, even though people not in combat units sometimes did get in dangerous situations.

Mr. MURPHY. In your assessment, that might be that some of them may also be—there's different thresholds of what people could pick up. So, based upon again their expectations, their exposure, what happened to them earlier in life.

I want to ask about another issue, too, and that has to do with, let's remember the era of the 1960s and 1970s and the society they were returning to. Yes, part of that was the greeting that people received when they came home, but also it was the world that we lived in back here in the States was having its own struggles and traumas on many levels. We had throughout the 1960s presidential assassinations, the assassination of Martin Luther King, demonstrations, drug use, et cetera.

And I'm wondering if the kind of things that were occurring too with regard to when people return home and their own makeup,

drug use, their social lives, et cetera, I'm wondering what influence those may have had, as well, to exacerbate or provoke symptoms in our veterans.

Dr. SATEL. That's a good question. Actually, in terms of the drug use, there's a very well-known study from Washington University in St. Louis looking at the veterans in Vietnam who had a heroin problem, and the majority of them, as you know, stopped when they came back. And the people who continued to have problems, that minority who did have problems stateside, were those who actually had drug addiction problems even before they were deployed.

But in terms, as you say, of, you know, potential hostility, of an unwelcome milieu, can exacerbate distress, certainly. And I suppose for some people it might be that stressor that pushes them over the edge. I don't know if you read, Robert J. Lifton's letter to the editor today about that op ed that I had written, but he talked about the demoralization and the bitterness and the anger and the resentment of some of the soldiers, and I don't doubt that. But that constellation of human reactions is not necessarily pathology, is not necessarily mental illness. It's a reaction.

Mr. MURPHY. That's a very important point. And that is the ways that we react under stress—part of my curiosity here, and it seems like you're saying it—sometimes we're too quick to diagnose something as mental illness when it would actually be within the bandwidth of what human beings face under stress.

Dr. SATEL. I agree 100 percent.

Mr. MURPHY. And, therefore, if the expectation is, well, these symptoms you're experiencing we're going to label as PTSD or some other adjustment disorder, some other major disorder, when part of the comments might be, and I know this is part of what we do as treatment is say this is not necessarily a long-term chronic problem you have, but you are having a normal human reaction, and sometimes normal human reactions need treatment. Is that fair?

Dr. SATEL. You know, sir, this is awful. I can't hear you very well. I'm so sorry.

Mr. MURPHY. I'm sorry, too. I don't know what to do about the speakers.

Dr. SATEL. No, the acoustics are strange.

Mr. MURPHY. Well, perhaps somebody else could respond to that, too. Dr. Kudler, you're nodding at that?

Dr. KUDLER. I'll take you back to the American Civil War for a moment. There were two very famous doctors working out of Turner's Lane Military Hospital in Philadelphia, a fellow named DeCosta, one of the most famous diagnosticians in medicine and one of the first American cardiologists, and his very good friend, Dr. Weir-Michell, a neurologist. And the two of them looked at combat veterans of the American Civil War in the Union army. One said this is a cardiological disorder, the guy who was a cardiologist. And the guy who was a neurologist said it was a neurological disorder.

This is what always happens. These are arbitrary constructions in an attempt to define a real human process. But I think you're right on the point, though. It is a real human process, and there are interventions that need to be done. And so we've got work to do.

Dr. SATEL. Okay. Now I know what you're saying. Sometimes there are interventions. That's true. And the ones you suggested I think are very, very sensible. But sometimes there are not, and that's all I'm saying, is that not everyone who is distressed necessarily needs mental health care. And if the person wants it, that's fine. If they're so dysfunctional, yes, they need it and I would advocate strongly that they have it. But some people use the chaplains. Some people use all kinds of support systems. Some people really do need formal professional care, and that's fine too. But not every distressed person needs a psychologist or a psychiatrist.

Mr. MURPHY. Thank you. Mr. Renzi.

OPENING STATEMENT OF HON. RICK RENZI

Mr. RENZI. Thank you, my friend. I want to than you all for your testimony. Very interesting. Dr. Keane, I felt like you really touched on a real niche when you talked about women in combat. I had the honor of representing Lori Piestewa, the first Native American woman killed in combat. I'm being pressured right now to open up classified information as it relates to what her days were, the last few days that she went through. And that group that wants that information is the group who is opposed to women in combat. So I want to ask with your expertise, sir, is there more of a resilience in women or less a resilience? Or what do you see? And can you just expand on—you know, you can see where I'm going with my questioning here. Please.

Mr. KEANE. Well, I don't know whether or not there are excellent empirical studies to substantiate the direction that you're taking it, whether women are more or less vulnerable to the stressors of combat. It's an important question for us to consider.

Many of the people who have examined the stress that women have been in in the military have examined it across multiple different kinds of experiences. You may know that already it's fairly well documented that the rate of physical abuse and sexual abuse among women who enter the military is elevated compared to the general population, and we also know that these are things that are placing people at increased risk, as we've been talking about this morning, for when a stressor occurs for psychiatric problems to ensue.

That, however, should not be a screen-in or screen-out variable. It's something that's important for us to understand. Many people are utilizing the military in ways that will help them get a leg up and a step out of bad situations and give them opportunities to acquire knowledge, education and thrive in their lives. The discussion about whether women are more vulnerable is a very complicated one. It's not one that I'm prepared to give you an answer to today, but I think it's worthy of discussion.

Mr. RENZI. Thank you. For the women in the audience, I saw a study also that says that women eventually will surpass men as it relates to their times in the marathon, so that the Olympic marathon someday will be won by a woman, because of their ability for endurance. Dr. Horvath, did you want to expand?

Mr. HORVATH. Less a science and more of a personal anecdote, my daughter is a naval aviator, now flying for the Coast Guard who went through SAR training. Many of her friends, also naval

aviators, went through the full horror show. They survived it as well as the men. I think whenever you compare men and women, you'll find a tremendous overlap, and there are women whom I would trust in combat far more than I would trust some men. On the other hand, we are working very hard, in fact there is new information coming on, I alluded earlier to these resilience factors, these biological resilience factors in addition to the psychosocial resilience or vulnerability factors. And I can assure you that the National Center for PTSD is doing great work in places like Fort Bragg looking at the rangers. I hope they'll do some studies with Naval aviators in their particular training so that we do and we will find the kind of answer that you seek, which frankly right now is not available.

But to talk about the weak sex who can't fly jets, can't go to combat, can't survive SAR training, disrespects a whole group of people, to one of whom I'm related.

Mr. RENZI. Yeah, I agree. And particularly—I agree. Dr. Satel, thank you. You did a great job, I thought, on touching on the aspect of work and the healing effect that it has. This committee is really pushing it in areas as it relates to transitioning our guys and gals out of the military and quickly helping them with training, with using their Montgomery GI bill for education. We're focused a lot on entrepreneurship.

One of the criticisms that I got on my bill last session was that to use your Montgomery GI bill for entrepreneurship courses to be able to use it to buy computers to set up your own business, that we weren't going to be able to reach to those troops that had the post-traumatic syndrome disorder. Do you believe a greater disadvantage—do those people who suffer even slightly in this area have the inability to take on added stress as it relates to entrepreneurship?

Dr. SATEL. It's case-by-case, certainly. But I would think for—well, I have to tell you, I do think we make that diagnosis too liberally, so that people who might have—a particular individual who might have the PTSD label might be someone who is capable of doing a lot, and what's keeping him kind of mired in this dysfunctional state and being demoralized is the fact that he doesn't feel purposeful or doesn't see an opportunity for the future. So I could see that capacity to take advantage of these programs as being very therapeutic.

Mr. RENZI. Yeah. Thank you. Let me finish with Dr. Kudler. And thank you for your testimony. Excellent expertise. You talked about your visit to Walter Reed. You talked about the cannon shot that you heard. Is there—can we help you with the pressure on DOD to get a letter out that all hospitals nationwide should eliminate any kind of aggravating procedures, not just cannon shots, but maybe war movies? Are there other observations you have in that field?

Dr. KUDLER. It's not that simple. One of the other things that went on there is that these fellows won't walk off the paved paths on the grounds because they're afraid of land mines. They just can't walk on the grass. We can't pave the whole place.

What we need to do is to create the interventions that get at the common denominator, which is that they're very stressed. They

don't want to talk about being stressed, because it's bad for morale. It's bad for their buddies. It's bad for the mission. It's bad for their careers. We have to create interventions that are safe, that allow them to see that if they talk about it and work on it they're actually—it's good for the mission, it's good for their buddies, and it's good, well, hopefully for their careers. We'll see. We have to work on that level.

Mr. RENZI. Excellent testimony from all of you. Thank you. Mr. Chairman.

Mr. MURPHY. Thank you, Mr. Renzi. Mr. Boozman.

Mr. BOOZMAN. Yes, I also have really enjoyed the testimony. As a panel, then, do you agree that we've got a problem with—do we have a good diagnosis as far as, you know, when we make the diagnosis, is there any conformity at all amongst the professions as to what it is? And if so, or if not, do we agree, are we overidentifying or underidentifying?

Mr. KEANE. Actually, I think that there is great consensus about this condition, and I'll give you a few pieces of information about that. There is a lot of suggestion that PTSD was a Western construction, that it really applied to Europeans and North Americans. And in the last five years, there have been remarkable epidemiological studies completed in countries as far away as Southeast Asia, Africa and the Middle East. Very different cultures, very different religious backgrounds, very different ways of representing a wide variety of emotional states. PTSD was found across all of these countries, and it was found with the same kinds of relationships that we have found here in America.

There seems to be, as I think Dr. Horvath introduced in his remarks, a biological drive to many of the symptoms that we're seeing in PTSD. So I think there is a great deal of consistency.

Now to the point that Dr. Satel raises, are we letting the threshold down too low? That's always a point of departure and always a point of a discussion in any mental health disorder. The real question is, what's the relationship of the diagnosis to disability? And that's where measures of disability and dysfunction must be used in conjunction with the diagnosis in order for us to understand how complicated a situation one person presents with.

So, you never do make a decision simply on the basis of a diagnosis. It's about a much greater array of information.

Mr. BOOZMAN. Once we label, to we unlabel? I mean, is this a——

Mr. KEANE. Yes. We have terms for it.

Mr. BOOZMAN. Is this a condition that once a person has this diagnosis that they're, you know, like a learning disability, they have a learning disability forever?

Mr. KEANE. Well, we have terms for PTSD, for example, in remission, which means that it's not present at the time that you're examining somebody, but it was present previously. It's my experience that people with PTSD actually do have a phasic course. In other words, there are times when they are better and there are times when they are worse.

The difficulty for us, of course, is where you have problems in where you take that cross-sectional inspection. If you take it at the anniversary date of a major military encounter, it's likely you're

going to have extreme symptomatology—nightmares, flashbacks, lots of anxiety and stress. If, however, you take it while someone is on vacation, it's a different story.

The other thing that I'd like to point out, too, is that people who develop PTSD often retain a sensitivity to other kinds of life stressors, so that if there's another major loss in their lives, if a child dies, for example, a case that I've had very recently, nightmares of Vietnam returned in this patient. So these stressors contribute to the whole being. We are a single person. There is this sensitivity that remains for people with PTSD. People are affected for their lives. Whether or not they're disabled for their lives is a separate question.

Mr. BOOZMAN. Dr. Horvath?

Dr. HORVATH. May I make two points?

Mr. BOOZMAN. Sure.

Dr. HORVATH. First of all, diagnostic accuracy and stability in the United States stank to high heaven 30 years ago. I came from Australia. I was astonished at the loose diagnostic practices we had 30 years ago. Since then we had more than 25 years of hard-nosed empirical science imposed on us. We do know how to make the diagnosis. We have inter rater reliability. It is far better than it used to be. The construct for PTSD is as strong as any medical diagnosis. It is as strong as any medical diagnosis. Are there some people who lie about it? Yes. Are there some doctors who don't read the textbook, don't read the criteria? Yes. But on the whole, I'm actually very proud of the VA where we actually do know and we have gone through studies showing good inter rater reliability.

Mr. BOOZMAN. And I'm not arguing. Don't misunderstand. I'm not arguing that there's not. I know that, again, you know, you say learning disability, some of these things, it's so broad that it's difficult to quantify. Is there a disease process—you know, we've had many periods of times of peace, okay. Is there a disease process that's not labeled with this label but has a similar construct just from being in the service and in a—or for whatever reason, for servicemen and women, do we see the same sort of symptoms and call it something else?

Dr. HORVATH. Yes sir. In fact, in my military training, on combat stress. Combat stress is not a diagnosis. It is very carefully kept away from this whole diagnostic notion. Our motto in AMEDD is to "preserve the fighting strength." In those days we made no diagnosis. We do return people to duty, and our first priority is the well being of the unit and the well being of the mission. It's a mission-oriented approach, and in fact we de-pathologize and de-mythologize the very same stress conditions that under civilian conditions we may very well call an acute stress condition. But it's a very conscious decision. And in fact we are often quite successful. However, these people still live that experience, and it is very possible, and their biology continues underground, and when they return to civilian life and they manifest certain symptoms, they're not faking it. They're not exaggerating it, they're just stating it how it is, and we can make the diagnosis with very good inter rated reliability.

Mr. BOOZMAN. Mr. Chairman, can I just ask one thing? And they don't even have to respond to it. But the other thing I was interested in Chairman Simmons, he talked about the difference in, you

know, right now the troops are supported when they're going away and coming back, and, you know, the difference. Again, maybe you could give me some information about if there's a difference in the guard troops versus the other draftees versus, you know, non-draftees, professional, those kind of things. Thank you.

Mr. MURPHY. Thank you. We're going to give each member here one minute for a follow-up question if you want. Mr. Strickland?

Mr. STRICKLAND. Yes. There's been discussion here of women. And in this regard, my understanding is that the VA currently has authority to provide military sexual trauma counseling and treatment, and that that authority is due to expire in December. Now the chairman of the subcommittee, Mr. Rodriguez, has introduced legislation to permanently extend that authority. And I would like just, you know, a quick opinion from each of you if you think that that authority should be extended.

Dr. HORVATH. It should be extended.

Mr. KEANE. Data from the National Center for PTSD in a report indicate that prevalence rates of sexual assault and related PTSD are extraordinary among women in the National Guard. I would suggest that we continue this program.

Dr. KUDLER. And that there's a high incidence of military sexual trauma in people coming back from the Gulf now. I want to include, though, that we shouldn't be too narrow in our view of this because women are 20 times more likely than men to have sexual trauma during their military service. There are 20 times more men in the VA system than there are women. It comes out to equal numbers. And we're talking about tens, and actually more than hundreds of thousands of people, men and women. We have to make sure the services are built in for men as well as for women.

Mr. STRICKLAND. Thank you for that response. I was wondering that myself, and I appreciate that.

Dr. SATEL. That's interesting because we know that actually male rape creates a higher rate of PTSD than even female. But I certainly defer to my colleagues about their judgment on whether this should be continued. They're on the front lines of the VA system, so I would say yes.

Mr. STRICKLAND. Mr. Chairman, given the response, I would hope that all of us on this committee would consider signing on to that legislation and doing whatever we can to see that it's enacted. Thank you all very much.

Mr. MURPHY. I have one question too. I'd like Dr. Horvath, for you to respond to Dr. Satel's concerns about the incentives of paying veterans to be sick with PTSD and paying them more to be sicker. Is there anything wrong with this model of disability compensation? Does it clash, as suggested by Dr. Satel, with the goals of rehabilitation and expectations of improvement?

Dr. HORVATH. Any compensation system has that difficulty built in, and it would be naive to deny it. You would have to know that the VA goes a long way towards working towards rehabilitation despite the fact that somebody has benefits. And in fact, we will give you a, if you don't mind, sir, a review from Dr. Rosenheck from Westhaven, Yale who studies this issue at some length, and that in fact you will find no significant difference between compensated and uncompensated groups in getting back to work.

If you look at the level of clinical disability and then you factor in those who have compensation and those who do not, compensation alone isn't an obstacle to rehabilitation. On the other hand, opportunity for rehabilitation is a very important issue, and I'm delighted that recent legislative changes plus changes that I hope Dr. Roswell will speak to improve the VA's capacity for supported employment, and I on this one topic—on this one topic—I agree with Dr. Satel that work is excellent therapy.

Mr. MURPHY. Thank you very much. Mr. Renzi, do you have a follow-up? Mr. Boozman?

We appreciate the testimony. This panel has been very illuminating. Thank you so much.

While they're stepping away to get the next panel ready, I'll introduce them. We have the Honorable Robert H. Roswell, M.D., Under Secretary for Health, Department of Veterans Affairs. We're also joined by Alfonso Batres, the Chief Officer, Readjustment Counseling Services, Department of Veterans Affairs. And also Dr. Laurent Lehmann, Chief Consultant, Mental Health Strategic Health Care Group, Department of Veterans Affairs.

Dr. Roswell, I believe you're opening up with a statement from the VA.

Dr. ROSWELL. Thank you, Mr. Murphy.

Mr. MURPHY. We'll have the usual five minutes for you.

STATEMENT OF ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY: ALFONSO R. BATRES, CHIEF OFFICER, READJUSTMENT COUNSELING SERVICE, DEPARTMENT OF VETERANS AFFAIRS; AND LAURENT S. LEHMANN, M.D., CHIEF CONSULTANT, MENTAL HEALTH STRATEGIC HEALTH CARE GROUP, DEPARTMENT OF VETERANS AFFAIRS

Dr. ROSWELL. Thank you very much. It's a pleasure to be here before the committee today to talk about a subject I feel very personally and strongly about. And in so doing, I feel compelled to deviate from the statement I intended to make.

I'll be the first to admit that I'm not a psychiatrist. But I can tell you this. The Hippocratic Oath that I took said I would comfort the suffering, not to question whether they have sufficient combat stress exposure to cause suffering. We have to understand that these men and women in uniform who are in Iraq right now are being subjected to circumstances that almost certainly will cause suffering. And I submit to you and this committee that it's inappropriate to argue about the causality of that symptom but to recognize that there is suffering and do everything we can to reach out and comfort those who will return with suffering.

Let me point out the experience we had following the Gulf War of some 12 years ago. Men and women came back and they had suffering, sometimes weeks, sometimes months, sometimes years after that conflict of only 12 years ago. And some of that suffering took the form of unexplained physical illnesses. And we as a government and we in the Department of Veterans Affairs and this Congress spent too much time arguing about what might have caused those physical ailments instead of reaching out and pro-

viding the care that the men and women who provided the freedom we enjoy in this country earned for us.

So I'm not a psychiatrist, but I took a Hippocratic Oath, and as Under Secretary for Health, I am committed to do everything I possibly can to reach out to those who have served and comfort their suffering.

I'm sorry for that outburst, Mr. Chairman.

Mr. MURPHY. Understood.

Dr. ROSWELL. The information we have received from DOD has been unprecedented. Let me point out that there have been 107,000 troops who have returned from Operation Enduring Freedom and Iraqi Freedom, but the diagnosis of PTSD is not in less than one half a percent of those who have received care from the VA. Some 15,000 of the 107,000 have received care from the VA. And of those we have already seen approximately 4 percent have been diagnosed with PTSD, using the very DSMIV criteria you spoke of.

For returning service members who are experiencing emotional and behavioral problems, VA has mental health programs including the Readjustment Counseling Program specifically developed to assess and address their problems. VA provides care through general mental health clinics, through PTSD specialists in general mental health programs and through specialized PTSD programs.

Last month VA and DOD released a clinical practice guideline for the management of stress associated with trauma, both in the combat theater and post-deployment. The guideline pools DOD and VA expertise to help build a joint assessment and treatment infrastructure between the two systems in order to coordinate primary care and mental health care for the purposes of managing, and if possible, preventing acute and chronic PTSD. I have provided a copy of the guideline for the committee.

We have also deployed a screening instrument in the form of a clinical reminder system triggered by the veteran's separation date from returning Iraqi Freedom or Enduring Freedom veterans who come to VA for health care. This assessment tool will prompt the provider, any provider, including all primary care providers, with specific screening requirements to assure that the veterans are evaluated for medical and psychological conditions that may be related to recent combat deployment.

The Veterans Health Initiative is a program designed to increase recognition of the connection between military service and certain health effects, better document veterans' military and exposure histories, improve patient care and establish a database for further study. The education component of VHI prepares VA health care providers to better serve their patients. The VHI program includes a module on PTSD and another module on caring for war wounded that's just recently been released. These modules are available to all VA clinicians. They're also available on a compact disk that can be viewed from any computer.

Last year Congress mandated additional funding for mental health programs in fiscal years 2004 through 2006, and I'm pleased to tell you that $25 million in additional funding will be allocated this year to enhance mental health programs for treating patients suffering with PTSD and related disorders regardless of the diagnosis. In fact, from 2002 to 2004, VA funding for treatment of seri-

ous mentally ill veterans increased from $2.2 billion to $2.5 billion, an increase of over 9 percent. PTSD funding went from $138 million to $178 million, a 25 percent increase, and substance abuse funding went from $425 million to $491 million, a 15 percent increase.

On February 3rd of this year I approved funding to hire an additional 50 employees for our Readjustment Counseling Service for the specific purpose of providing outreach to veterans of Operation Enduring Freedom and Operation Iraqi Freedom as well as veterans of the global war on terrorism. Our hope is to hire people who have actually served in these conflicts so that they can reach out to their peer group and identify the services and treatment available through the VA.

Early this summer we're planning a conference for readjustment counseling staff, primary care and mental health staff to improve skills in assessing and managing problems of returning Iraqi Freedom and Enduring Freedom veterans. This conference is being planned in collaboration with the Under Secretary's Committee on PTSD and the National Center for PTSD to focus our efforts on treating this important disorder.

Also later this year we're planning a national conference to commemorate the 25th anniversary of the Readjustment Counseling Program and to bring experts from all fields together to assess this important topic.

Numerous other steps in coordination with DOD have assured that we'll have a seamless transition for those who have been deployed. We've used a variety of mechanisms to reach out to them.

But let me summarize by saying that service members separating from military service and seeking health care through VA today will benefit from VA's decade-long experience treating Vietnam and Gulf War veterans. We're working hard to inform and encourage returning service members to seek available VA services. We have undertaken significant educational efforts and provide clinical tools to our staff to make sure that all veterans who have a need for care and who may be suffering now or in the future have access to the care they need.

Mr. Chairman, I'll be happy and so will my colleagues to answer any questions you may have. Thank you.

[The prepared statement of Dr. Roswell appears on p. 95.]

Mr. MURPHY. I'm grateful. Thank you very much, Doctor. I'm told your colleagues don't have any statements at this point, so I will go to Mr. Strickland.

Mr. STRICKLAND. Dr. Roswell, thank you for your outburst. I for one appreciate it. It gives me confidence that—I mean, I didn't need the confidence because I know you well enough to know that you are committed. But it's good to occasionally see some real human feeling coming from someone in your position, and I really appreciate it.

I had a question about family support for returning veterans as they readjust and so on, but that question kind of triggered another concern that I have that really involves active duty folks right now. A young friend of mine who is a recent West Point graduate and currently serving in Iraq e-mails me occasionally—frequently as a matter of fact. His most recent e-mail indicated that

a significant number of the men under his authority have experienced family breakup and divorce since they have been deployed.

And I'm unaware of what resources may be available to an active duty soldier in those kind of circumstances that may not only be dealing with the stress and the trauma of war and conflict but also at the same time dealing with, you know, the most traumatizing perhaps personal experience. I don't know if you can speak to that or not, because I know that's——

Dr. ROSWELL. It's an important issue. I actually just retired myself from 30 years of military service, most of it in the reserves. The Department of Defense has put a tremendous emphasis on family support programs to try to address and minimize the very factors you've talked about. It concerns me as a clinician not only while service members are deployed and the disruption that causes in the nuclear family unit, but quite frankly, we see it in veterans after they've redeployed as well.

The sad truth is, combat changes many people who are exposed to that, and the weeks, months, sometimes years of separation between a service member and their family result in irreparable changes in personality. And what we've seen in virtually every previous conflict is that redeploying soldiers over time find that the readjustment is very difficult, and there are subsequent divorces or breakups, which necessitates a need for intervention.

That's why our Readjustment Counseling Service plays such an important role, and I'd like to ask Dr. Batres to just briefly address how we reach out not only to service members but support their families.

Dr. BATRES. Thank you. One of the concerns we've had with this particular cohort has been the high percentage of National Guard and reserve folks that I think present an even larger challenge in terms of providing a spectrum of services for families, especially as they're disbursed over a great area and may not be close to a military base. Because certainly DOD has a vast array of family services available to them while they're on post.

What we've done is we're providing outreach to these families wherever we can in communities to sponsor affairs and get togethers where we can provide them education, not only that DOD has and VA, but their entire communities, and bring them together in a peer-to-peer fashion to embellish support systems within their community and to keep track of them.

They have many questions, and not only questions about concerns about the safety of their loved ones, he or she—and by the way, we have to keep in mind that the combat veteran now typically can be a she, not just a he—and what kinds of support systems we have for those families in terms of education and to answer their questions not only in terms of, again, concern, but concerns with their children and concerns with jobs and security an those kinds of situations.

One group that Dr. Roswell has authorized us to provide services to are those families of veterans who are killed while on active duty. And in the last year we've initiated a bereavement program which we run out of the Readjustment Counseling Service where we are providing bereavement service and support to those family members of those killed while on active duty. And right now we've

run about 45 different families. We're getting a lot of referrals from the DOD casualty officers, our VBA casualty system and then self-referrals from families. And I think that's another service that VA is providing that I think kind of addresses issues that are I think our country is in great need of.

Mr. STRICKLAND. Thank you, sir. I see my time is running out here. Dr. Roswell, I would like to ask you, will the VA be seeking or supporting the authority to extend the sexual trauma program that is due to expire in December?

Dr. ROSWELL. Absolutely.

Mr. STRICKLAND. Thank you so much for that. One additional question—I see the yellow light is on, so I don't have much time. Dr. Batres, in your judgment, do the vet centers have enough resources to meet the demand that you're now experiencing with returning troops?

Dr. BATRES. Yes sir. I have approximately 940 positions to serve my program nationwide. We process about 130,000 unique veterans every year, and we provide about a million visits each year. My budget has remained fixed and costs other than for cost of living adjustments for the last ten years which represents my tenure at the vet center. During this time we've extended eligibility to all veterans who have served in a combat zone.

Over those ten years, we've utilized optimal efficiency strategies. In other words, we're doing a lot more with less over the years. I represent a group of folks that are highly motivated. Most of them are combat veterans. Eighty percent are veterans in my program. We understand and empathize with the folks that we serve, much like Dr. Roswell just demonstrated. We have that commitment to our clients.

If there is a recommendation to increase family services at vet centers is accepted, we will need a new cadre of employees to address that need. The increased number of National Guard and reserve units in OEF/OIF presents increasing challenges, and we hope to get resources to address these issues in the future. And, of course, I want to again commend Dr. Roswell for allowing us those 50 FTEE to go out and promote this outreach effort. It's unique. Given where we are, I think it represents his statement that this is a very important cohort that we want to outreach to and provide services to.

Mr. STRICKLAND. Thank you very much for that answer, and I think that gives us on this committee information that we need, and so I really appreciate that response. Thank you so much. Thank you, Mr. Chairman.

Mr. RENZI (presiding). I thank the gentleman. I've got a couple of questions I want to ask. The previous panel I thought did a wonderful job of setting the stage of where we are right now, where we've come from, mistakes of the past, certainly trying to peer into the future as to the research that's provided.

And, Dr. Roswell, you know that I'm not a real advocate of some of the budget tightening discussions and wrestling matches that we're going through right now. There has been I think honest criticism as it relates to cutting the budget in the area of the mental health. And could you help me understand a little bit if we are looking at tightening our belt within the VA and some of the pro-

posed budget cuts in mental health research, what effect that might have on our discussions today with this unique situation? Go ahead.

Dr. ROSWELL. Well, there's no question that we're in an austere budget climate. I think the issue, though, is looking at demand, doing everything we can to identify potential need and meeting that need.

We do have an increase in money going into mental health care. I alluded to that in my testimony, on the order of 15 to, in some cases, 25 percent increases in money committed to mental health services with a single exception, the range of services across the recent capacity report showed an increase in funding. We are moving to new accounting or measuring or tracking methods, a monthly program cost report that will allow us to better track the expenditure of funds to be sure that they're going to serve the needs of mental health.

But mental health, like all of medicine, is an emerging field, and the way we approach mental health, the newer treatment modalities, more effective medications, new interdisciplinary interventions. And as highlighted by the President's New Freedom Commission, a model focused on recovery, not stabilization or institutional care, but recovery and reintegration into the community and reintegration into a productive livelihood is a model that in many cases is actually less resource intensive with regard to the traditional measures of capacity, those being inpatient beds and dollars.

So I'm much more focused on making sure that the outreach identifies the entire universe of potential need, that we then meet that need timely and comprehensively, and that we track outcomes to make sure that reintegration and recovery are paramount in our efforts.

Mr. RENZI. I just want to agree with you that given what I've learned today, and as you've stated accurately, that it is an emerging medicine and is an area where we really need to focus our dollars on research that we be sure to be careful with our tightening in this area.

Are you, Dr. Roswell, involved at all with DOD as it relates to the suicide studies that are going on over at the Pentagon? Are you working collaboration efforts?

Dr. ROSWELL. We are. I've had some lengthy discussions with my counterpart, Dr. Bill Winkenwerder, at DOD, and we are trying to understand the combat stressors and the situations that may have resulted in the increase in suicide. I would point out in fairness to DOD that there has been a concerted effort over the past number of years, some eight, ten years, to reduce suicide rates in military service members both during peacetime and during deployment. And those efforts, in fairness, have had a measurable and sustained success in reducing suicide rates in the military. This recent distressing increase in suicide rate is cause for concern and it is being looked at very carefully and we are working with DOD.

Mr. RENZI. I appreciate the answer. And let me finish up, anyone on the panel. Our next panel is going to be a group of chaplains, and I just wanted to give you an opportunity before they come on to expand on the role that they're playing at the VA or your thoughts at all on how the spiritual aspect of healing really is, in

my opinion, probably as paramount as being able to address the chemical imbalances, the medication portion.

Dr. ROSWELL. Well, speaking personally, I believe that care must be holistic; that spiritual care is a critical part of the care we provide. I believe that chaplains, particularly with the clinical pastoral education program that we emphasize so strongly in VA, can be in fact very effective and play a tremendously valuable role in the care of our patients. But I would certainly defer to Dr. Lehmann for any comments he might wish to make.

Dr. LEHMANN. Thank you. We very much value the services of chaplains in the mental health arena, because they really can reach out and help people in ways other than other types of mental health clinicians. And very many of our chaplains actually do have mental health training. We have the services of chaplains are in fact cited in the Clinical Practice Guideline. And in addition, we have consulted and worked with chaplains in the training programs that we're developing for our clinicians.

So, yes, they absolutely are part of our range of service providers.

Mr. RENZI. I hope I'm not stealing anybody's thunder here, but I just want to do a little commercial. Apparently the VA chaplains just put out under your auspices, Dr. Roswell, and your leadership, this new CD. Did you want to comment on it all? The spirituality of inspiring hope and healing?

Dr. ROSWELL. It's a wonderful video. I would encourage you to look at it. It really I think very dramatically demonstrates the potential role that spiritual care plays in the service we provide to the Nation's veterans.

Mr. RENZI. Let me thank you all. I appreciate very much your time and your testimony, and thank you for the service.

We'll go ahead and welcome our next panel, Panel Number 3. As they approach, I'll go ahead and introduce you. Lieutenant Colonel Kenneth Brown, Chaplain, U.S. Army; Lieutenant Charles Hodges, Chaplain Corps, U.S. Naval Reserve; Commander Mark Jumper, U.S. Coast Guard Academy; Chaplain Robert Mikol, Clinical Chaplain, VA New Jersey Health Care System; and Father Philip Salois, who is a Chaplain Program Manager with the Boston Health Care System.

We welcome all of you today and thank you for providing us with your expertise that you're about to lend to us. We'll give you some time to get settled in. Chaplain Brown, I think we'll start with you if you're ready. Recognized for five minutes. The lights control the room.

Chaplain Brown? Go ahead, sir.

STATEMENTS OF LT. COL. KENNETH N. BROWN, CHAPLAIN, U.S. ARMY; LT. CHARLES E. HODGES, CHAPLAIN CORPS, U.S. NAVAL RESERVE, PARRIS ISLAND, SC; COMDR. MARK A. JUMPER, STAFF CHAPLAIN, U.S. COAST GUARD ACADEMY; CHAPLAIN ROBERT W. MIKOL, CLINICAL CHAPLAIN, LYONS CAMPUS OF THE VA NEW JERSEY HEALTH CARE SYSTEM; AND FATHER PHILIP G. SALOIS, VISN 1 CHAPLAIN PROGRAM MANAGER, VA BOSTON HEALTH CARE SYSTEM

STATEMENT OF LT. COL. KENNETH N. BROWN

Lt. COL. BROWN. It's a real privilege for me to appear here today. Thank you very much. I served as the Division Chaplain in the 101st Airborne Division (Air Assault) during combat operations in Afghanistan and Iraq, and I saw first hand some of the effects of PTSD on our fighting force.

But the beginning of this story has its roots prior to the entry of soldiers into the combat arena. Pastoral ministry provided our soldiers and families by U.S. Army Chaplains began pre-combat, and chaplains of the 101st Airborne Division trained in accordance with the core principle of U.S. Army Chaplains Corps as the centerpiece of their preparation for combat. And those core principles are: Nurture the living, care for the wounded, and honor the dead.

This framework provided the foundation for the 46 chaplains that went into combat in Iraq. Chaplains provided comprehensive pastoral care across the full spectrum of operations throughout each phase and pushed forward with their assault units in combat operations just as they had trained, providing nurture, care and honor in the face of enemy fire, traumatic wounds, battlefield chaos, death and fear.

The Army chaplain's unique positioning at the battalion level enabled chaplains to go forward with infantry and other maneuver units to provide first line care in helping soldiers deal with immediate trauma-producing events. Chaplains were trained to accomplish on-scene defusing which occurred within a few hours of the critical causation event.

The Critical Incident Stress Management framework that the chaplains of the 101st trained to standard on proved to be an important tool in decreasing PTSD complications and certainly I think lessened the effects of chronic PTSD.

A vital part of the chaplains' success directly correlates to their well-developed spiritual preparedness and their certainty of their calling to provide this ministry to soldiers. The chaplains theologically integrated combat into their sense of call and as a part of their calling to the military chaplaincy and their responsibility and privilege as a soldier-minister. They brought the presence of God into the most horrific situations, reviving hope in the face of unspeakable horrors, sights, sounds and smells.

The intangibles became reality in the presence of such courage and fortitude. They did this during enemy body recovery and burial and here too were critical in keeping the fighting strength of force emotionally, mentally and spiritually healthy. They did this during the unearthing of mass grave sites, providing care and comfort given to the mass grave site teams. They did this during mass casualty incidents where there were many wounded and dead.

They did this through their close pastoral relationship with their soldiers before combat and built on those relationships during the hardships of deployment and hostilities. They were unique go-to persons for soldiers who were experiencing PTSD or other problematic dysfunctions. They continued to provide suicide intervention, family and marital issues counsel, personal problem intervention, screenings of homeward bound soldiers and PTSD follow-up of some of the chronic occurrences or flareups.

Army chaplains remain a constant force of good on the battlefield. They bring a dynamic healing, comfort and care to soldiers and leaders that I think no one else does, through dozens of difficult memorial services, post-wound ministry, funerals, family care, grief processing assistance and sustained pastoral care that continues today at home station.

The chaplains of the 101st were prepared, and they gave themselves in such a way that many soldiers benefitted tremendously because their chaplain was there. The chaplain is a shepherd. That is an irreducible. The shepherd takes care of the sheep, those that are well, and those that are wounded. The healing continues. No soldier or family member is left to struggle with PTSD alone.

I think it is imperative that the lessons learned about PTSD during this conflict are correctly understood, templated and applied so as to improve on early intervention techniques and prevention of chronic PTSD. The best hope for accomplishing this objective in my opinion is exemplified in the first line defender in this battle—the well-trained, uniquely called and fully prepared battalion chaplain.

And I'd like to close with this statement. It's a statement that could have been made by an American commander in any of our wars. It was made by Fleet Admiral Chester M. Nimitz who wrote about the combat ministry in World War II, and I quote: "My own esteem for the chaplains is not so much based upon deeds of valor as it is of appreciation for their routine accomplishments. No one will ever know how many young men were diverted from acts of depression by a heart-to-heart talk with the padre. By his patient, sympathetic labors with men day in and day out and through many a night, every chaplain I know contributed immeasurably to the moral courage of our fighting men. None of that appears in statistics. It is for that toil in the cause of God and country that I honor the chaplains most."

Thank you very much for allowing me to have a say. Pro Deo Et Patria.

[The prepared statement of Colonel Brown appears on p. 102.]

Mr. RENZI. Thank you, Chaplain Brown. I want to thank you too. I was just informed of the fact that you were with our troops, the 101st from Kuwait all the way into the bunkers of Baghdad and you fought shoulder-to-shoulder with them and in other ways. So, sir, thank you very much for the service.

Lt. COL. BROWN. Yes, sir. Thank you.

Mr. RENZI. Chaplain Hodges.

STATEMENT OF LT. CHARLES E. HODGES

Lt. HODGES. Mr. Renzi and Mr. Strickland, thank you, sir, for this opportunity to speak. On Friday 11 April 2003, Headquarters and Service Company, a second assault amphibian battalion, estab-

lished a position just north of the Baghdad city limits. Our convoy was a mix of various large trucks, Humvees, and amphibious assault vehicles, also known as tracks. At sunset the crew chief of a nearby track came over and asked me to speak to one of the Marines on his track. On the way into the city, they had witnessed the tragic aftermath of a hit-and-run accident in which several children were critically injured.

When our convoy entered the city, we encountered something similar to rush hour. And complicating the situation were mobs of cheering people standing in the streets greeting us. We frequently had to stop as the convoy worked its way through congestion, and at one of these stops, an impatient local motorist zoomed around one of our tracks and hit a crowd of people. The two Marines in the open hatches on top of the track saw the accident, and when the Iraqis came to the track, the commander instructed his crew to render assistance in any way that they could. While they were not required to do so, since they were not responsible for the injuries, they wanted to do as much as they could as long as the situation permitted.

The Marine in charge of security was the first out the back hatch, and he quickly directed about half a dozen other Marines to set up a quick defensive perimeter to keep people away from the vehicle. A Navy corpsman was the last one to come out. The corpsman later reported to me that three children were brought to him. One child had flesh which had been ripped off the back of his legs from his knees to his waist, exposing bone and connective tissue. Since there was nothing that the corpsman could do, he turned his attention to another boy. The second boy had multiple compound fractures in his legs and showed symptoms of internal injuries and bleeding. Again, there was little the corpsman could do for that child. The third child also had sustained serious injuries, but just as the corpsman was rendering aid to that child, the word came that the convoy was again on the move and that the Marines and the corpsman needed to get on board. All they could do was leave gauze and compression bandages for the children.

As the security Marine ordered everyone back into the track, he felt like he was in a dream. Time didn't flow naturally. Some of this may also have been due to the fact that his attention was drawn in several different directions at once as he maintained security and supervised the situation. As that security Marine closed the hatch behind him, one terrified father lunged at him with outstretched arms and screamed in English, "Do not leave." Unfortunately, the track had to move or risk the security of the entire convoy.

It was growing dark when I reached the track and met the Marine. He was extremely agitated and had been crying. I asked him to tell me what had happened, and with a shaky voice he told me a fractured and confused story. When he finished, I sorted through the story with him. I then asked him to first focus on what had happened, then his thoughts as it happened, his reactions to the incident and how he was feeling in that moment as we talked. It turned out that the stress of the incident caused him to twist his perceptions and blend his memories. One of his buddies had come over to us just as the Marine got to the part in his story about the

children, and his buddy told him that what the Marine thought he had seen had not actually happened. The corpsman also later confirmed this. It helped that this buddy had walked up and joined the conversation, because with his input, we helped that distressed Marine work through the anguish and guilt as we reviewed what happened.

As the night grew darker around us and as we felt some security within our defensive perimeter, we had given that stressed Marine a safe environment in which to work through his anguish, and we believe that that can help mitigate and sometimes prevent later stress problems after deployment.

Well, the next morning I went over to the track to check on the Marine. He appeared to be feeling fine. I asked him how he slept and he seemed amazed that he had experienced the best night's sleep since the beginning of the war. I continued to check on him over the next few days and look for him on several other occasions before we came back to the United States. And he said he would never forget what happened that day, but he did not think that the event would haunt him as it did that evening in Baghdad. The last I talked to this Marine before being assigned to Parris Island, he was still doing fine.

Thank you.

[The prepared statement of Chaplain Hodges appears on p. 109.]

Mr. RENZI. Sir, your words are compelling. I'm grateful. Chaplain Jumper.

STATEMENT OF COMDR. MARK A. JUMPER

Comdr. JUMPER. I have served as Project Officer of the Warrior Transition Program for the U.S. Marine Corps. On behalf of Navy chaplains, thank you for the opportunity to provide our ministry to the personnel and families of the armed forces. We consider this access to our people's lives, sharing their deployments and dangers, and satisfactions, in the name of God, to be a high privilege, to be exercised with utmost care, respect and diligence.

Our Navy Chaplain Corps has been providing this ministry since the Continental Congress first authorized Naval chaplains in 1775 228 years ago. We pray that we may continue this precious heritage faithfully invoking the presence and the power of God as an incomparable resource among our people for many years to come.

In recent years, several of the helping professions -- chaplain, medical, mental health and social work—have come to understand much better those dynamics experienced by our veterans who experience combat. Several scholars such as Jonathan Shay have helped us recover the truth that such dynamics have always applied to warriors. Various rituals of cleansing, talking, absolving, restoring and renewing have been helpful traditions among warriors of many times and places from Greek Hoplites to Roman Legionnaires to Medieval knights, to Native American braves, and now to modern American veterans.

Chaplains since the Vietnam war have been involved in several responses to the issues faced by warriors who find that their very souls have been seared and changed by their experience of combat and trauma. CREDO, of which I was a CREDO director, was founded in 1971 as a retreat ministry offered to active duty vet-

erans returning from Vietnam. Interdisciplinary sprint teams have intervened in several crisis situations. Chaplains have also been involved in critical incident stress management programs, including debriefs of personnel.

We active duty chaplains recognize that our presence is most valuable near the front lines, offering the ministry of presence that you have just heard about. For those displaying symptoms of distress, we work with our professional colleagues to offer some spiritual first aid and comfort and a gentle guiding hand through those doors leading to more specialized and intensive help and hope for tomorrow. And for all those who have faced trauma, we offer a new ministry that we believe can make a positive difference for their future health. The Warrior Transition Program provided by chaplains at the invitation of the commandant of the U.S. Marine Corps following Operations Enduring Freedom and Iraqi Freedom offers what we believe to be a somewhat modest but very valuable program for those on the road back to their normal lives in society.

We help those veterans look at the changes that have happened in their own hearts and souls as a result of their experience. We model for them the value of a debriefing experience as an experience of normative maintenance rather than the repair of something broken. We train them to recognize, renounce and recover from those attitudes and actions whose toxicity causes the long-term destruction of one's own character, including berserking, violations of what's right, and dehumanization of the enemy.

And we encourage our warriors to seek intentionally an integrated balance in life of positive physical, mental and spiritual practices. To date our surveys of those who went through the warrior transition program, and the commandant required all Marines in theater to go through the program before going home, have shown approval and appreciation of our efforts consistently. Well over 90 percent of Marines who went through the program would recommend the program to another Marine. We have so far some positive anecdotal evidence, observations of our warriors back home following our program that they're doing well. Again, our program is modest. We may not work wonders in our 60 to 90-minute program, though God may. But we can accomplish some valuable things to help our veterans. It's our moral obligation to do so. We do this from a powerful perspective of divine belief and spiritual reality that we wish to make available to every veteran. We are trained to make such an offer in such a way as to completely respect each veteran's own belief. Many we believe will find this offer beneficial.

For any program seeking to deal with trauma, it is essential to include the spiritual component that chaplains best offer, working with other professionals as cooperative colleagues for the sake of our veterans. Such is our hope, such is our prayer, and such is our plan with God's help.

Thank you from the heart for this opportunity to share our story. And may God bless you in your mission supporting veterans, and may God bless America and those who serve her together, one nation under God.

[The prepared statement of Commander Jumper appears on p. 118.]

Mr. RENZI. Chaplain, your words express unique insight. Thank you. Chaplain Mikol.

STATEMENT OF ROBERT W. MIKOL

Chaplain MIKOL. Mr. Chairman and members of the subcommittee, I thank you for this privilege of appearing before you this morning. I'm not a military chaplain. I'm a VA chaplain. I'm a full time VA chaplain in mental health in the Medical Center, Lyons, NJ.

We are proud of our program of post-traumatic stress rehabilitation with our combat vets, and I'm proud to be part of a team that I believe and I know to be the best of the best.

I pondered over the days before coming here of how I would present chaplaincy to post-traumatic stress combat veterans as they attempt to reintegrate into society. The men and women whom I have had the opportunity and privilege of sharing time and counsel were mostly from the combat era of Vietnam. I have had the opportunity and privilege of meeting a few combat veterans from Desert Storm and Bosnia, and I find it a privilege to work with them and to be with them and to share their lives.

So I'd like to talk a little bit about chaplaincy and psychiatry and addiction and PTSD. Over my 15-year experience as a unit chaplain, I find that it's multidimensional. It is very personal and private, and it's sacred to the veteran. The brokenness and pain that they carry with them each day as they struggle to be, in quotes, "normal." It impacts their spouse and their children, their parents and their significant others 24/7. It affects communities in which they live. It affects extended families and friends, neighbors, coworkers and their churches. It presents challenges to government, social and religious, medical psychiatric resources, personnel at all levels.

PTSD is the direct result of a person experiencing extreme trauma beyond the capability and the capacity to absorb it and to cope with it. When a combat vet comes to a chaplain seeking help, they come with the same mixed emotions and feelings that they have when they enter the VA system. There are issues that I will share with you briefly that have to be understood and that have to be addressed directly.

When they come to a chaplain, they look at the chaplain, from what I understand from them, in role and in identity. They look at the chaplain and they see a healer, different from a physician or a psychiatrist or a psychologist. They see a healer of the spirit and the soul. The come to a chaplain as a confessor, as an adviser, as an intercessor, as a shepherd, as a guide, as a teacher, as a friend, but most of all as an absolver.

They see in the chaplain in his or her identity a fallible human being who has baggage of their own. They also see the chaplain as normal and honest and living in confidentiality. They see a chaplain as a listener, and they see a chaplain and hope a chaplain is authentic. When a veteran presents themselves to me either by referral or consult or by direct intervention, I usually follow a modality that I found to work.

The first thing we will do is we will review the pre-military belief systems, their practices and values. Then we will assess the pain

and brokenness of their lives and we will learn from the veteran what he hopes for himself and dreams about. And then we will begin to reform and restore that which we have lost to the degree that we can.

All of this is built upon the foundation of faith, of belief, of trust and of the undying hope that they can recover and eventually come home.

Thank you very much.

[The prepared statement of Chaplain Mikol appears on p. 124.]

Mr. RENZI. Thank you very much. Father Salois, my mom was an Irish Catholic from Massachusetts, so I've got a lot of guilt and probably need to see you after this session. (Laughter.)

Father SALOIS. I'll hang my shingle right after the hearing.

Mr. RENZI. Please go ahead.

STATEMENT OF FATHER PHILIP G. SALOIS

Father SALOIS. Thank you, Mr. Chairman and committee members, for the opportunity to be here to address all of you on a very important subject very near and dear to my heart—the psycho-spiritual effects on men and women who have participated in and witnessed first hand the horrors of war on the battlefield. First of all, let me preface my remarks by giving you all a small picture of what qualifies me to speak to the subject. At the age of 20 I was drafted into the U.S. Army and served as a combat infantryman from 1969 to 1970. As a result of leading a rescue mission on March 1, 1970, I was awarded a silver star. I also served 12 years in the U.S. Army Reserves as a chaplain to hospital units. My last assignment was with the 883rd Medical Company (Combat Stress Control). In addition, I have worked the last 15 years as a chaplain at the VA Boston Healthcare System, with a special focus on PTSD and spiritual healing.

Having gone through an extensive journey of healing myself, and the journey is by far not over, I can speak as a witness to the fact that when one has been exposed to war up close and personal, that person is forever changed, scarred and spiritually wounded. Even with the best of foreknowledge and training available, there's absolutely nothing that can prepare a young man or woman for the horrors that war will embed in one's mind, heart and soul.

That being said, it is important to learn from lessons from the past, particularly the war in Vietnam and the devastating effects it has had on thousands of men and women. We share the experiences and the wisdom we have gained for our young men and women returning from Iraq and Afghanistan. The February 15 issue of the *New York Times Magazine* featured a lengthy article entitled "The Permanent Scars of Iraq" by Sara Corbett. It relates the story of a few returning soldiers from the 101st Airborne Division who were wounded both physically and psychologically. Reading this article transported me back some 30-plus years as something that could have been written in the 1970s, only the characters and geography have changed. Sleepless nights. Nightmares. Flashbacks. Self-medicating with alcohol and drugs. Not communicating with the spouse. Thousand yard star, and the saga rages on. The psychosocial-spiritual effects of war are universal, and I learned that when I met war veterans from all over the world at

the First International Conference of Psyco-Social Consequences of War in Dubrovnik, Croatia in April 1998. There is a common denominator among persons who have engaged in hostile fire in time of war, and that common denominator is the deep-seated wounds that appear at every human level. The memory is forever branded into the fabric of one's life.

How do we meet the challenge of reaching out to our brother and sister veterans who have been to hell and come back to talk about it? It is often said in the circle of ministers I associate with that religion is for those who are afraid of hell, and spirituality is for those who have been there and don't want to return.

Veterans' Affairs chaplains are certified and clinically trained to serve the spiritual needs of the returning veterans from Iraq and Afghanistan. It is of paramount importance that VA chaplains play an integral role on the mental health interdisciplinary teams in our medical facilities. They continue to provide excellent one-on-one spiritual and pastoral counseling to our veteran patients. They also facilitate spirituality groups for those suffering from PTSD and substance abuse. In fact, there are several 12-step models that have been drafted with a special focus on PTSD modeled after the 12 steps of AA.

In 1989 I founded the National Conference of Viet Nam Veteran Ministers, an organization comprised of people like myself who served in Vietnam as enlisted men and women and later answered the call to ordained ministry. WE also invited Vietnam chaplains to join. The purpose was to share our own trauma stories with one another on the level of faith and spirituality so that we could receive affirmation and healing of our own souls. It truly was and still is a clinic for wounded PTSD-ridden ministers. As an outgrowth of this organization, which is better referred to as a community, we began to explore ways of sharing our stories with combat veterans.

Combat veterans, by the very nature of their exposure to battle—that is, killing and witnessing death -- develop a poisonous world view causing a wounded "Imago Dei." This phrase, "Imago Dei," or Image of God, refers to the belief that all persons are created in God's image. That wounded "Imago Dei" is characterized by secret-keeping, loss of voice and self-enforced separation. Secret-keeping. How can I ever talk about what I witnessed and participated in on the battlefield to my spouse, my children, my friends? As a result, this causes us to lose our voice. If we are keeping secrets, then we stop communicating, which then forces the third factor, self-enforced separation, isolation, or more commonly referred to as "bunkering in." Our combat veterans experience deep guilt, which comes in many forms: guilt from killing or maiming civilians, children who may be booby-trapped, or enemies disguised as friendlies. It could be guilt over a mistake which caused the mutilation or death of a comrade. It could be guilt over being a survivor when buddies are killed, and the list goes on.

One way that the National Conference of Viet Nam Veteran Ministers found to be helpful was to develop a Spiritual Healing Weekend Retreat Program for combat veterans and their spouses or significant others. In the past seven years we have offered 15 of these retreats throughout the country, and although it's a mere drop in

the bucket, veterans and their families have been greatly comforted and assisted spiritually in these retreats. Many couples have come back to these retreats and brought other couples with them. We felt it was important to try to get the veteran to bring their spouse or significant other to these retreats because our goal was to help heal the family and not just the veteran—to reopen those doors of communication, the lack of which can destroy a relationship.

The main point I want to make here before this committee is the importance of making the combat veteran, particularly those who are now coming home from overseas deployment, begin the process of telling this story to someone who can encourage them and guide them in a healing, loving and accepting manner. They may feel they are damaged goods. The role of the chaplain is to help them recognize that their experience offers them a unique perspective on the meaning of life and that their suffering is not meaningless but can be redemptive. The chaplain can help the veteran learn what it means to be a wounded healer, which the veteran in his or her woundedness can help heal another wounded veteran. This is the gift of life one person gives to another.

The theory of the sacred story which we teach them is the use of their personal story as a vehicle of hearing. The development of one's unique story through the eyes of faith and ultimately the redemptive value of their sacred story can move them from a state of being scared, recognizing that they are scarred, and ultimately see themselves as sacred. It's a far greater task for the minister to guide the veteran in this direction than simply moving letters around in a wordplay to get the point across.

We tell our veterans that there is no one else on earth like them. Just as there are not two fingerprints the same, neither is their story. It is the gift of love when they can speak the story with all the trauma, pain, suffering, tears and emotions and share that story with another human being who is hurting.

Over the years, I cannot count how many Vietnam veterans and veterans of World War II and Korea I have counseled, but the end result of war and its impact on our psyche is the same. I, along with my colleagues, welcome the opportunity to reach out to returning soldiers, Marines, sailors and airmen and women t begin that healing process so it does not begin to fester and grow like a cancer that eats away at the core of their being. If we knew back in the 1970s and 1980s what we know today, how many lives could have been saved? How many marriages could have been saved? Who knows?

Thank you for the opportunity to address this esteemed body.

Mr. RENZI. Father, I'm grateful. Very full and complete testimony.

We'll move to some questioning now and I'll begin with my colleague, Mr. Strickland.

Mr. STRICKLAND. I want to thank each of you, and I want to thank you, Father, for distinguishing between spirituality and religiosity. As someone who is a former member of the clergy myself, I am quite frankly sometimes skeptical and perhaps more cynical than I should be of religious leaders and religious spokespersons. But I can tell you that listening to you today, you are the kind of

people that I would want to sit with, talk with, go to if I had a problem that was troublesome to me.

I've been very impressed by your statements. You obviously are people of great maturity, insight and tolerance. And the question I have is, where do you go? You deal with human suffering and pain and trauma. Where do you go for your nurturance and assistance as you deal with your own needs?

Father SALOIS. I can address that very simply. That's the reason why I started the National Conference of Viet Nam Veteran Ministers, because I had no one to go to. So I had to find other people like myself who had been in war and begin to talk about it, because my religious community told me, Phil, this has been 13 years ago. Get over it. So they weren't listening to me, and I couldn't dump on my patients, so I needed to find a group of people, and I did, and that's how I founded this organization. We have 50 members throughout the country, and they're all Vietnam War veterans. Some of them are women, and we come together every year and we support each other, and that's how we do it. I don't know about the others.

Chaplain MIKOL. I would like to address that question. The clinical team is very helpful to the chaplain. There are many times that I find myself presented with a problem, an issue that makes it quite difficult to address. Rather than use cliches or what the veterans call pious platitudes, I go to the team, and they give me a different dimension, a different spin that I bring back, theologize and share with the veteran.

Personally, I find Vietnam—well, I find all veterans to be very helpful to the chaplain. I guess we could see that or understand that as a reward for what little we do for them. But when we talk to each other on the heart level and we speak from our souls, it is not difficult to find someone that you can go to and be honest with and candid with and find support.

I believe in ministry that the veterans look for support. They want someone to stand in their sacred place with them. It is a privilege and an honor to do that. And they, therefore, I would assume, look for the opportunity to do that with us as well.

Comdr. JUMPER. I've been part of a CREDO retreat and recovery ministry, which is extremely intensive. And I have seen CREDO chaplains crash and burn. When I came to CREDO in Groton, Connecticut, I instituted a system of pastoral care for our chaplains in CREDO, and each of us saw a therapist once a month.

I also go to my fellow chaplains—I went to a couple last night—to be updated on my own progress. I also go to the Military Chaplains Association, which I have found -- which is chartered by Congress and which I have found to be an extremely valuable mentoring experience. I'm looking forward to going to a reunion of my ship this coming June, and I expect that at this reunion—it will be our first reunion -- and we will be sharing about the profound experiences that occurred to us during Operation Desert Storm.

And finally, I go to my wife, who is more supportive than any man deserves, and I thank God for my wife, Ginger.

Lt. HODGES. The Geneva conventions do not permit chaplains to carry weapons in the field, and so we have to have a bodyguard with us. In the Navy we call that person a religious program spe-

cialist. And down in Parris Island, there is an RP who was also over in Iraq, and he's been through some things himself, and what he and I do is sometimes we just get together and talk.

The RP I had with me in Afghanistan has recently crossed from the RP rate over into crypto, and he was passing through Parris Island on his way down to his new school in Florida. And he and I got together for lunch and we talked about things, and thinking back to the things that happened to us in Afghanistan was again, it was like detox. It was really great to talk about these things, and, hey, do you remember when? And what about this, that and other. And we chuckled and laughed.

There's another chaplain down in Parris Island that I run with on a daily basis, and he and I just talk. We talk as we run. And we go by this one place at Parris Island where they do bayonet training, and there's this mannequin tied up, and it's olive drab, olive drab green. And the first time I ran back there, I did a double take because it looked a lot like a body I saw lying on the ground in Amazaria, and the chaplain says, you all right? What's wrong? And I tell him the story, and he just quietly ran beside me while I told him what was going on.

And then when we came back from Iraq, I was at Camp Lejeune at the time, division chaplain ensured that we had somebody there for the chaplains to talk to. It was strongly recommended that we attend this little meeting, and all the chaplains that had been there talked about our experiences. We had a mental health professional there to recognize that there were problems, tell us what we could do if we had problems, and to remind us that we were not invulnerable to stress, mental health issues, and we had a responsibility to take care of ourselves as much as we had to take care of other people.

Lt. COL. BROWN. I think my experience pretty much mirrors what's already been said. I think I would add that during Iraq as the division chaplain, you have a little more difficulty doing some of the things because of the construct and the way that it's developed. We had what we specifically trained to have a buddy system where we took care of one another. I was fortunate to have a good friend in the division, a surgeon who really became my confidante, and I could talk with him about a lot of things that I needed to get out of my system and talk. And I've been around long enough, not that that makes me wise, but I've been around long enough that I know when I need to go and talk with someone about things that may be going on in my life.

We had a fine system. And then we have a system back in place at home station where chaplains go through redeployment cycling, and then we have our mental health community also interrelated in that, and we had a great relationship with our division surgeon in that department, and we coalesced with them and really had some fine coordination there for helping us in those areas.

Mr. STRICKLAND. The good chairman has given me an extra few moments here just to say something to you. I want to honor you for your service. I sense something about each of you that I think is important. Listening to you, I'm reminded of one of my constituents who is in Iraq right now, hopefully going to be coming home next month. His name is Chris Shafer. Father, being a Catholic, I

think you'll take special pride in this young man. He sends me CDs of Gregorian chants. And every e-mail I get from him, he describes what he's doing and the trauma of war. But in every e-mail he also talks about the other part of his life and how he tries to comfort his men, those who are going through divorce, those who are missing their children and the like.

So there's a lot of spirituality within and throughout the military, which I think for me as the representative of this young man, I tell people he is the best this country can produce. He's patriotic and loyal and smart, committed and dedicated, but he is especially caring. And he's caring not just for the men that he's responsible for leading, but in nearly every e-mail, he expresses to me how much he cares for the Iraqi people and for the children. And I am just incredibly proud of him today and your words reminded me of him. Thank you so much.

Mr. SIMMONS. Mr. Boozman?

Mr. BOOZMAN. I just want to make a quick comment. I'm sorry I had to—I was here and left and came back. But I really want to thank you, Mr. Chairman, and the ranking member for holding this hearing, and the staff. I've been to many, many meetings, and again, the testimony today has been excellent and very helpful.

I grew up in a time—I graduated from high school in about 1968 at the height of things going on in Vietnam, went on to college. And about the time I got done with college, then the draft had ended. My brother is four years older, and so as a result, I was good friends with his friends, you know, my friends, and so I had so many, you know, just really good friends that went off to war and saw in many cases the effect that that had on them. And now I think really the thing that has kept them going in many cases, the thing that kept so many going during the conflict and then after and coming back has been their faith.

And so I really do appreciate, you know, as was said earlier, all that you all do, your faithfulness and, you know, you really do in providing the counseling that you do and things, you really do change lives. So thank you very much.

Mr. SIMMONS. Mr. Renzi?

Mr. RENZI. Thank you, Mr. Chairman. I want to share an interesting statistic. Chaplain Jumper, you talked a little bit about history. Our good staff here was able to find out that when Abraham Lincoln established the legislation for the first national home for disabled volunteer soldiers, chaplains were paid $1,500 a year and enough forage for one horse. (Laughter.)

So you all have come a long way.

Mr. SIMMONS. It's about the same.

Comdr. JUMPER. The first naval chaplains were allowed a share of the prize money.

Mr. RENZI. Of the prize. (Laughter.)

Always for the prize. I had an opportunity to go down to Guantanamo Bay, and when I was there, I was accompanied by a Muslim chaplain who later was brought up on espionage charges, and since then I believe those charges have been decreased. And I had an interesting conversation with him about an area that I have been studying for many years and the chairman and I have also talked about, Whahabism, the extreme fundamentalism evolving in Mus-

lim practice. And the idea that the Whahabists who engage in holy jihad believe that killing innocent people because they are polytheists—whether you be Christian, Jew, whatever your religion—even a moderate Muslim is viewed as a heretic, and that taking our lives, taking the lives of our children is an absolution to them. And I thought how interesting in listening to your comments when you talk about absolution, when you talk about forgiveness, letting go, that it's the opposite of what we're fighting against in the war on terrorism.

And I'd just like to ask if anyone has encountered, particularly in the field, the idea of the relationship of having to fight back against an individual who believes that they're in a holy war or how God comes into play in that. Any thoughts on Wahabism?

[No response.]

Mr. RENZI. Okay. We'll pass on that one. (Laughter.)

Lt. COL. BROWN. I'll make a stab.

Mr. RENZI. Thank you, Colonel.

Lt. COL. BROWN. We encountered, in Phase 4 operations, sustainment and security—stability and security operations, we began to go out and talk with the local Imams, and part of our work involved in that. And as a result of that, we encountered some of the Wahabie methods and some of the persons that were involved in that, not in a personal way but through the more stable, more middle-of-the-road Islamic Imams who talked about the Wahabists to us. So just strictly from that standpoint. But they did cause us some difficulty.

Mr. RENZI. Thank you. Colonel, you hit on the whole nexus of my point that I've been making with my colleagues, and that is that we will be involved in the war on terror until we are able to help move Saudi Arabia and some of the Nations who have Wahabism as their national religion to become more moderate, to becoming open to the ways of the spiritualism that we talk about, whether it be among diverse different religions. But if they don't moderate their faith in Saudi Arabia where they're constantly teaching it in the schools, in the universities, in the mosques, we will be dealing with terrorism for generations to come.

Let me finish up by asking, there was good testimony today from our good doctors on statistics, and we saw a little bit of wrestling there. As first kind of responders in the field when it comes to seeing probably first hand, even before the soldiers approach you, I'm sure you can observe it in the field, and we talked about early intervention. Dr. Kudler talked about it, Dr. Keane. What do you see, what do you think, just off the cuff, is your statistical analysis of -- how many soldiers do you feel in the field, what are you observations on what statistics might be per thousand, per hundred? Another question? Another balloon?

Lt. HODGES. I'll try to do the math real quick in my head, and I know that in Afghanistan we had—I had about 1,500 Marines in my care throughout our entire battalion landing team. And the bad guys attacked us on 10 January and we had a brief firefight, and the next day when I was going along the defensive perimeter, fighting hole to fighting hole, everyone that was on that side of the airport that was attacked reacted in some way. Every one of them. Some of them were like laughing it off.

Man, I survived it. I'm a big guy now. I got my combat action ribbon. I'm a badass. But then there were a couple that were truly terrified. And one Marine was talking to me, and he was genuinely scared to the very core of his soul because the word going around was they were going to do it again the next night. Somehow or other, I don't know why they thought they could be doing these kind of things, but the word going around was, they're going to do it again tonight. They never came back. Not while we were there. But that one Marine was genuinely scared.

The math, I think that, you know, just quick math in my head, I think that—I think the math is fairly accurate based on my personal experiences. After we went through An Nasiriyah we saw a lot of death and destruction and broken bodies. And of all the Marines in my care, I'd say the math is probably——

Mr. RENZI. That math being close to 20 percent, as Dr. Kudler spoke about with the combat? I don't want to misquote Dr. Kudler, but when we talk about people who have been in combat, who have been in the severe—point of the spear, 20 percent, Dr. Kudler?

Lt. HODGES. Twenty percent were what, please, sir?

Mr. RENZI. Twenty percent having to come back and deal with not just lower incidences of PTSD but having to deal with clinical incidences of it.

Lt. HODGES. Oh, I can't speak to that. I don't know.

Mr. RENZI. Okay. But that's the number, the math?

Lt. HODGES. Okay. I thought you were speaking about the 1 percent or something like that.

Mr. RENZI. Well, that was the contradiction was that it was half a percent or was it 20 percent.

Lt. HODGES. When I was out there, I think the 1 percent that I saw right then and there. Now, coming back to the United States, I can't speak to that. I don't know.

Mr. RENZI. Okay. Let me finish. No more questioning, but I just want to make a statement that I believe we're all in this society beginning to move to an understanding of a balanced approach, whether it be science or medicine, and God. The idea of the separation of theories and that we can't blend and take advantage of a holistic approach, I think that's falling away in ignorance. So thank you all very much for today. I'm grateful.

Mr. SIMMONS. If there are no more questions, I would like to give a special thanks to Commander Jumper for coming down from Connecticut, East Lime, within my district. It's great to have you here. How's the family? He's got seven children. You know, that's—wow, that's a lot of voters. (Laughter.)

If I can do anything for you, let me know. (Laughter.)

But on a more serious note, I'd also like to thank all of the panelists, and I'd like to thank all of the people who testified here this morning. And in particular I'd like to thank my colleagues for their very sensitive and perceptive approach to this very difficult problem.

I remember from my own Army experience that, you know, if you got a Dear John of you complained too much, they'd say take it to the chaplain. Stop whining, stop complaining. Take it to the chaplain. But the fact of the matter is, I came back from my wartime experiences with a deeper Christian faith, which has been with me

ever since. And a sense that the chaplains really helped me and helped so many of my comrades. And it's true that perhaps in dealing with issues such as post-traumatic stress disorder, we need the medical professionals. They do a great job. But as Mr. Renzi pointed out, they can't necessarily do it alone. And I just want to thank this panel for their work to assist our men and women in uniform dealing with the most difficult experiences that we can ever deal with, which are the experiences of war. And war is hell. And thank you for helping us see that there is a vision of heaven, too.

With that, I conclude the hearing.

[Whereupon, at 2:10 p.m., the subcommittee was adjourned.]

APPENDIX

OPENING STATEMENT
HONORABLE ROB SIMMONS
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS

OVERSIGHT HEARING ON THE STATUS OF POST TRAUMATIC STRESS (PTSD) PROGRAMS IN THE CARE OF VETERANS OF COMBAT AND HARDSHIP DEPLOYMENTS

March 11, 2004

The Subcommittee will come to order. I wish to thank everyone for coming this morning and welcome witnesses and our Members in attendance.

"War is hell." Union General William Tecumseh Sherman said these memorable words to the mayor and city councilmen of Atlanta, Georgia, in September 1864, shortly before he ordered his soldiers to burn the city to the ground. Sherman wrecked havoc throughout the old Confederacy in his infamous march to the sea. What those Yankee soldiers witnessed --and did—to their Confederate victims in response to Sherman's order in Atlanta, probably brought on the bouts of what became known as "war weariness." Out of necessity, the National Volunteer Soldier Homes in Leavenworth, Dayton, and Togus – now VA medical centers -- and in America's first State Home for Veterans, at Rocky Hill, Connecticut, were founded to care for the "war weary," wounded and disabled Union volunteers of the Civil War. One hundred forty years ago no one knew the words "post traumatic stress syndrome" or more properly nowadays, "disorder," but many people must have seen and felt its effects during that war and for years after the war, and after all wars down through the days of human history.

We are a peace loving nation but we have seen many wars, and as President Bush has stated, September 11th brought an overseas war home to us in a very personal way. From January of 2003 until today, we have had 300,000 active, reserve and Guard members deployed overseas in the wars in Afghanistan and Iraq, and in danger in Kuwait, Indonesia, Central America, Korea, Haiti, and in many other troubled lands. They have borne heavy burdens and as soldiers and sailors come home from war and rugged deployments, we have to take care of them. Anyone who doubts we are at war and in a dirty war, needs only look at some of the videotape of what our soldiers and Marines went through in Afghanistan and in Iraq to accomplish their missions. Whether one supports the

efforts overseas or not is not the question before this Committee. There is no question that we need to support our troops and to do what we can to make them whole again once their duty is done.

Today's hearing intends to provide oversight of federal programs, to be sure that our government does not fail to address the needs of the men and women who risk their lives to defend freedoms here and abroad, especially those service members and veterans who have been exposed to the rigors of war, combat, destruction and suffer what science now calls "post traumatic stress disorder". Once it was called "war weary"; later "shell shock". The label is unimportant – it's the response to this condition that we seek to illuminate today.

The Department of Veterans Affairs is arguably the world's greatest expert on PTSD. My war, the War in Vietnam of thirty years ago, and Congress's reaction to the needs of veterans who fought that war in particular, established the legislation that brought PTSD to the forefront of mental health care in VA and everywhere. VA research, funded by appropriations approved by Congress and subject to Congressional guidance and direction, solidified PTSD in the clinical archive of disorders afflicting certain parts of the veteran population. PTSD is broadly and well recognized today and better understood than any time in the history of mental health sciences.

This Committee has held a series of hearings over the past two years, initiated by our colleague and my predecessor, Chairman Jerry Moran and by Full Committee Chairman Chris Smith, as a preventative effort, and the Committee has continued that scrutiny over VA and Defense health care programs. We are trying to ensure that the military medical establishment, and the VA's health care system, are coordinating their efforts so that returning troops are welcomed back in the loving arms of our people; so that they get the care and treatment they have earned by their sacrifice. So far, the latest difficult engagements in overseas conflicts have produced very small casualty rates, and these veterans seem to be getting the best efforts of our military medical facilities. Truthfully little impact has yet to be felt in VA, but VA has stated it is ready to receive them when and if they need care.

But also we have seen that these systems are not perfect, and some veterans fall through the cracks and become victims. There are many challenges ahead, both for military health care and the VA in trying to do this difficult job. My job as Chairman is to have our Subcommittee serve as a reminder to the Administration, the Departments of Defense and of Veterans Affairs and other Government agencies that their job and ours are not done when the fighting ends.

Today we will hear from experts and accountable officials on the approach to dealing with post traumatic stress disorder on and off, and long after the battlefield. Some of these witnesses will report satisfaction; others are troubled by

what they see and know. Our chaplains' panel will share with us the role of pastoral counseling in healing the trauma of combat and in dealing with the stresses and hardships of deployments.

I am pleased to welcome one of my own constituents from the U.S. Coast Guard Academy in New London, Connecticut, Chaplain Mark Jumper. VA chaplains, I understand, trace their historic role in ministering to the wounded and disabled back to the Civil War and the establishment of those first National Homes I mentioned earlier. In 1864, chaplains were paid a salary of $1,500 per year and forage for one horse. I am pleased to acknowledge all of the chaplains presenting their unique perspective on PTSD here today.

OPENING STATEMENT OF
LUIS V. GUTIERREZ
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
"Hearing on the Status of Department of Veterans Affairs Post-Traumatic Stress Disorder Programs"
Thursday, March 11, 2004 9:30am

Mr. Chairman, I thank you for holding this very timely hearing today to investigate the progress VA has made in treating our veterans who suffer from Post Traumatic Stress Disorder (PTSD).

According to the Veterans Health Administration, more than a quarter of a million veterans have been diagnosed and treated for PTSD as outpatients in 2003 alone. PTSD is an especially dangerous disorder because of the potential emotional and physical harm it can inflict if left untreated. PTSD can easily lead individuals into unemployment, deepened depression, potential drug use and suicide.

I am pleased the subcommittee is taking up PTSD as the topic of their first hearing. Today, we are witnessing an enormous troop rotation of about 130,000 active-duty and Guard troops who have been in Iraq and Afghanistan.

Certainly, some of these brave men and women who have served their country abroad will be returning with various mental health care needs. And, some number of these service men and women will potentially be diagnosed with PSTD. Ensuring that these brave men and women have the best possible chances of full recovery is dependant on DOD and VA coordinating their efforts in order to diagnosis PSTD and treat it as early as possible. I am sure we will hear from our distinguished panelists how important early intervention is to successfully treating PSTD, and hope we take their guidance to heart and implement initiatives that aggressively address this issue.

In particular, I hope the witnesses address pragmatic ways the VA and the Department of Defense can work together to assure that we can help combat veterans who may be at risk. I also look forward to learning ways in which this committee can reengage and reenergize the VA's commitment to mental health care. We must not forget our commitment to the mental health of our veterans today and to our returning troops. Thank you

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

for the record

SUBCOMMITTEE ON HEALTH
HEARING ON POST-TRAUMATIC STRESS DISORDER
MARCH 11, 2004

Thank you, Mr. Chairman. I appreciate the opportunity to participate in this hearing. The availability of post-traumatic stress disorder (PTSD) treatment may be one of the most significant issues we will address this year. We will have hundreds of thousands of young men and women returning from Iraq and Afghanistan. Unfortunately, past experience indicates that many of them will suffer from PTSD.

Sadly, the phenomenon of PTSD has been well-documented among veterans of many war eras dating back to ancient times as Commander Jumper's statement reminds us. Most recently, VA found that 10% of veterans from the first Gulf War (and 22% of those veterans who had experienced combat) exhibited symptoms of the disorder. Recently, VA has collected some information on veterans of recent deployments—of those Iraqi Freedom veterans who have sought care from VA, 13.7% have been treated for mental disorders. This is remarkably similar to the 14.6% of veterans from Operation Enduring Freedom who have sought care. I have also heard anecdotally that as many as 20% of veterans returning to one major demobilization site have risk factors for PTSD, while in wounded soldiers the prevalence of PTSD may be doubled.

As many of you know, I am a veteran of the Vietnam-era and I have a long-standing concern about PTSD based on the experiences of so many of my peers from that time. I am keenly aware that the VA cannot combat the debilitating effects of PTSD without adequate information. As a freshman Congressman, one of my first orders of business was to introduce legislation to extend Vietnam-era veterans eligibility for readjustment counseling services and to require VA to carry out a study of the prevalence of PTSD among Vietnam-era veterans.

Throughout my tenure, I have continued to work to ensure that VA has the information it needs to understand how big this problem is and what risk factors are associated with developing it in order to: intervene with veterans as early as possible; to understand what treatments and therapies are most effective in dealing with PTSD; and, to develop the tools to demonstrate that its continuum of services for addressing veterans' needs is adequate to provide timely access to high-quality health care services.

In that regard, I must express disappointment with the progress VA has made on the updated study of post-traumatic stress disorder in Vietnam veterans that Congress required through Public Law 106-419 back in November 2000. This study was critical in helping us understand the long-term consequences of PTSD, what factors may account for veterans' risk for chronic PTSD and those health care services upon which these veterans rely. It would have helped us to understand how veterans continue to use VA's PTSD services and how VA can ensure that their care will be continued while dealing with the emerging needs of veterans from recent deployments. The results of this study are due to the Veterans Affairs Committees this coming October, yet I understand that this report will now be long delayed. I am unclear how VA allowed the initial contractor to get this study so off track, from VA's perspective, in terms of both cost and scheduling. I understand that VA has now disseminated a new request for information from outside contractors, including the original vendor! I am interested to hear from VA about how this project got so far from VA's intent and what steps VA is taking to ensure that this does not happen under the next contractor.

A couple of months ago, I wrote to you, Dr. Roswell, about how VA was working to acquire this data or fix some of the methods it employs to collect this information. I received your response yesterday afternoon.

-more-

Among the issues I brought to your attention were internal inconsistencies in the data reported to Congress on the capacity of specialized PTSD treatment programs as identified by VA's Office of Inspector General (IG). As I mentioned, the IG reported that some programs VA counted as operational reported no full-time employees. This is important because the Capacity Report is Congress's main tool for ensuring that VA complies with the law that requires capacity for certain specialized services to be maintained, yet, for the second year in a row, VA's own Inspector General maintains that data for some of the mental health programs is suspect. VA has indicated that it plans to use a different data source to develop this report and will convene working groups to address the problems identified by the IG. I appreciate your response and hope these steps give the Congress a credible tool with which to do its business.

I also inquired about data exchange between VA and the Department of Defense (DOD)—an ongoing concern of this Committee. I believe VA has made an effort to ensure the timely transfer of information from servicemembers transitioning from active- duty status, but I am not aware that the issue has been resolved. At the least, the routine transfer of data from aggregate, non-identified, post-deployment assessments, updated on at least a monthly basis, would ensure VA can adequately plan for providing services to veterans returning from the global war on terrorism. Individual pre- and post-deployment health assessments from DOD must also be routinely made available to VA to ensure continuity of care immediately upon a service member's discharge. You agreed that this information would be useful to VA and identified measures VA and DOD are taking to may allow this data to be exchanged at some indefinite point in the future. I know VA has tried to get this information, and I pledge to continue my efforts to assist you in obtaining it as soon as possible. We cannot allow these young men and women to slip through the cracks between military service and VA.

Dr. Kudler offered testimony to our full Committee last October to explain a new initiative VA and DOD were undertaking to implement new clinical practice guidelines for PTSD. I commended VA for proactively addressing the needs of our future veterans, but expressed my concerns about fully disseminating these important guidelines to clinical personnel in VA and DOD. I am pleased to be updated on VA's progress with this important initiative and hope that VA will consider having a National PTSD Educational Forum to highlight the availability of this guidance.

I also inquired about VA's capability to monitor veterans through its current information system. This would ensure continuity of care from VA's initial encounter with the veteran until he or she leaves the system—this capability is critical for veterans with any chronic condition. Ultimately, VA must also be able to access military medical records from the time of enlistment.

Finally, I wanted to ensure that VA is able to continue to address the needs of the veterans who currently rely upon VA for PTSD treatment in addition to beginning to meet the needs of returning troops for specialized treatment in VA and vet centers vis-à-vis recommendations made by your Special Committee on PTSD. To ensure PTSD care coordination along its continuum of care, the Committee recommended assigning a PTSD coordinator in each network and Readjustment Counseling Service region. These coordinators would comprise a Continuity Committee capable of working with VHA's Seamless Transition Task Force to assure and further integrate the DoD/VA continuum of care. This objective would be enhanced with information management tools that track veterans through each care setting. The Special Committee on PTSD also recommended establishing a PTSD Clinical Team at each VA medical center and assigning a family therapist to each vet center.

While I appreciate VA's full response to this inquiry, I remain unclear if VA is augmenting and coordinating its current services enough to adequately respond to the new demands veterans of the Global War on Terrorism may place on the system. I will appreciate being periodically updated on how VA is responding to new demands as more of our young heroes return home.

Mr. Chairman, again, thank you for allowing my participation. I will look forward to hearing the testimony of our witnesses.

January 15, 2004

Honorable Robert Roswell, MD
Under Secretary for Health
Department of Veterans' Affairs
Washington, DC 20420

Dear Dr. Roswell:

Allow me to commend the proactive approach the Veterans Health Administration has taken in addressing Post-traumatic Stress Disorder (PTSD) while American troops are still serving in the global war on terrorism. I was most pleased to hear Dr. Harold Kudler's testimony to the Committee on October 16, 2003, on the progress that the Department of Veterans Affairs (VA) and the Department of Defense (DOD) had made in developing clinical practice guidelines for the identification and treatment of PTSD. I hope that VA will continue to work expeditiously with DOD to ensure that these guidelines are widely implemented and that both clinical workforces are aware of their applicability and availability. Please do not fail to contact my office if you require assistance in addressing any obstacles to ensuring a successful implementation process that will make this care readily available to our returning service members.

The Committee on Veterans Affairs recently received the third annual report of the Department of Veterans Affairs' Under Secretary for Health's Special Committee on PTSD. As you know, Congress recently approved S. 1156 (recently signed into law as P.L. 108-170). This bill contained a provision that requires the Special Committee on PTSD to continue reporting to Congress on an annual basis through May 1, 2008. There are several recommendations in this report on which I would like to comment in light of my recent receipt of the 2002 Capacity Report.

While the Committee on Care of Veterans with Serious Mental Illness found that, based on the information provided VA is maintaining its commitment to serve veterans with PTSD in specialized programs, it challenges many of the individual networks' commitments to maintain the real (adjusted) dollar level to serve these veterans. VISN 19, for example, is spending only 30% of the real dollars it funded specialized PTSD treatment with in 1996. In addition, the report is clear that some VA medical centers have made devastating cuts in the personnel committed to specialized PTSD outpatient care. As you know, the Office of the Inspector General found that data from the specialized treatment programs regarding staffing and program may not be valid or reliable—39 of the outpatient PTSD programs said to exist have no staff assigned to them

which could indicate a far more widespread problem with compliance. These reporting problems for PTSD and other specialized mental health programs must be addressed to ensure that Congress has an accurate means of overseeing these important programs.

Not only that, but as the Committee also attests, the numbers of veterans service-connected for PTSD is more than 180,000 and is growing! Clinicians from across the nation tell my staff that troops returning from service in Iraq, Afghanistan and elsewhere will be coming home to a system that in many cases is barely treading water to meet the chronic needs of veterans already in the system.

To address the current and growing needs of the veteran population with PTSD, the Special Committee on PTSD has made a number of recommendations including encumbering the VISN director with a performance measure designed to gauge that network's success in achieving certain goals for veterans with PTSD—one way of measuring success is full implementation of VA and DOD's jointly developed clinical practice guidelines.

I also believe pre- and post- deployment health assessments are critical to early and optimal success in identifying and treating veterans that may otherwise suffer the long-term, disabling effects of chronic PTSD. I would like for VA and DOD to assure me that VA will have access to these surveys as soon as possible after veterans end their deployments on peace-keeping missions to Iraq, Afghanistan or elsewhere in the global war on terrorism.

Other recommendations more directly address resources available to the specialized PTSD programs. To ensure PTSD care coordination along its continuum of care, the Committee recommended assigning a PTSD coordinator in each network and Readjustment Counseling Service region. These coordinators would comprise a Continuity Committee capable of working with VHA's Seamless Transition Task Force to assure and further integrate the DoD/VA continuum of care. This objective would be enhanced with information management tools that track veterans through each care setting.

The Special Committee on PTSD also recommended establishing a PTSD Clinical Team at each VA medical center and assigning a family therapist to each vet center. Finally, to continue to educate its workforce, the Committee has recommended that VA form and convene a National Steering Committee on PTSD education. This seems particularly critical as VA attempts to address the needs of a new generation of veterans and attempts to successfully disseminate its new clinical practice guidelines. It also offers another opportunity partnership between VA and DoD aimed at establishing and sharing best PTSD practices.

While your comments on most of the recommendations of your Special Committee were generally supportive, you also expressed the view that networks must embrace their own funding priorities within limited resources and must acquiesce to performance goals that reflect these priorities. Unfortunately, this appears to be leading to significant inequities in access to specialized PTSD care across the system. Nationally, too, VA must make the commitment to continually revitalizing and updating the clinical skills of specialized program staff. This is where I believe VA would be well-served in convening a National PTSD Steering Committee.

I would appreciate learning of any plans you have to deal with these issues which could potentially affect so many of our returning service members. In that regard please inform me of plans you may have for 1. correcting internal inconsistencies between the data reported to Congress on the capacity of specialized PTSD treatment programs as identified by VA's Office of Inspector General; 2. coordinating with the Department of Defense (DOD) to identify a plan for transferring data from post-deployment assessments on an aggregate basis to ensure VA can adequately plan for providing services to veterans returning from the global war on terrorism; 3. ensuring transfer of individual pre- and post-deployment health assessments from DOD immediately upon a service member's discharge; 4. establishing a means of ensuring and assessing networks' effectiveness in implementing new clinical practice guidelines for PTSD; 5. developing informatics capable of tracking veterans throughout VA's medical system; and 6. expanding access to specialized treatment in VA and vet centers vis-à-vis recommendations made by your Special Committee on PTSD. Because of the urgency of this matter, I appreciate these plans at your earliest convenience, but no later than March 15, 2004.

Sincerely,

LANE EVANS
Democratic Ranking Member

cc:// Chairmen of Under Secretary's Committee on Care for Veterans with Serious Mental Illness and Under Secretary's Special Committee on Post-Traumatic Stress Disorder

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

MAR 1 0 2004

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, DC 20515

In Reply Refer To:

Dear Congressman Evans:

Thank you for your recent letter conveying your support for the Department of Veterans Affairs (VA) actions to serve the troops fighting the global war on terrorism: men and women who will, one day, become veterans. I also appreciate the extension of the congressionally mandated life of the Special Committee on Post-Traumatic Stress Disorder (PTSD) and the new date for its annual reports through May 1, 2008.

Your letter outlined several areas of concern related to services provided by VA to veterans suffering from mental disorders, especially PTSD. Enclosed are responses to each of the six topics noted in the last paragraph of your letter. VA mental health care incorporates state-of-the art psychopharmacology, psychotherapy and communications technology to provide the best quality care in the most accessible, and efficient manner for the patient. VA mental health care is oriented towards rehabilitation and recovery for veterans with mental disorders consistent with the Goals of the President's New Freedom Commission on Mental Health. While your letter emphasized issues related to mental disorders, it is important to recognize that VA's ability to provide comprehensive health care services for veterans also allows VA to address the medical and surgical, as well as the mental disorders of the veterans who come to us for care, and their adjustment to the injuries and illnesses they have sustained in the service of their country. VA's ability to provide comprehensive physical, emotional and social support benefits for veterans and their families, affords veterans the opportunity to return to optimal functioning in society.

If you have questions about any of the programs or plans described in this response, please have a member of your staff contact Dr. Larry Lehmann, Chief Consultant, Mental Health Strategic Health Care Group, at (202) 273-8434. Your interest in the well being of veterans is appreciated.

Sincerely yours,

Robert H. Roswell, M.D.
Under Secretary for Health

Enclosures

Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)
Responses to Questions from
The Honorable Lane Evans

Question: What are the plans for correcting internal inconsistencies between the data reported to Congress on the capacity of specialized PTSD treatment programs as identified by VA's Office of Inspector General (OIG)?

Response: The Capacity Report has depended upon data generated by the Cost Distribution Report (CDR), a system with limitations that was not intended to provide the level of detail now required. A replacement report (Monthly Program Cost Report (MPCR)) is being developed to address this issue. Prior to full implementation of the MPCR, the Allocation Resource Center (ARC) and the Decision Support System (DSS) designed an interim CDR-type reporting tool that utilizes existing DSS data to capture the required information. The first MPCR report, with data from all VHA sites, has been completed and is currently under review.

The ARC, in coordination with the Office of Patient Care Services, will soon convene a special work group, composed of appropriate representatives from those offices, as well as from the DSS Support Office and the Office of the Deputy Under Secretary for Health for Operations and Management. This work group will assess the validity of the generated data throughout the collection phase for the FY 2003 Capacity report with emphasis on the use of this data for the detailed mental health information. The group will also monitor and assess pilot testing of the advanced CDR replacement during FY 2004, and recommend corrections as necessary, and make a recommendation to the National Leadership Board regarding discontinuance of the CDR. Selected field staff will also participate.

We are confident that reporting capabilities of the MPCR will better match the data requirements for future capacity reports, including the mental health designations. VA sees the development of accurate and reliable data systems as a priority and is working diligently to ensure that such data systems are in place in order to produce a more accurate Capacity Report.

Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)
Responses to Questions from
The Honorable Lane Evans

Question: What are the plans for coordinating with the Department of Defense (DoD) to identify a plan for transferring data from post-deployment assessments on an aggregate basis to ensure VA can adequately plan for providing services to veterans returning from the global war on terrorism; and ensuring transfer of individual pre- and post-deployment health assessments from DoD immediately upon a service member's discharge?

Response: Through the VA/DoD Executive Council structure, the VA Seamless Transition Task Force, and the DoD Deployment Health Task Force, VA and DoD have been working to enhance the flow of information between VA and DoD to improve the coordination of medical care for deploying and redeploying service members. Members of these groups have been tasked to identify data requirements needed by VA; appropriate DoD sources for the data; potential statutory, regulatory or policy barriers to information transfer; electronic capture of key data; and establishment of linkages with existing medical care data bases. While a system for transferring DoD's pre/post deployment health assessment data to VA has not yet been developed, we anticipate the receipt of specific recommendations this spring. Additionally, we are pleased to report that we have been receiving regular updates of rosters of separated military personnel.

As noted in the incoming letter, these data from the pre- and post-deployment assessments would be helpful in the diagnosis and treatment of PTSD. These data would also be useful in the diagnosis and treatment of other psychological conditions, like depression, which increase in frequency after traumatic wartime experiences. Moreover, this type of baseline health data would be very useful for long-term clinical care and disability determination during the lifetime of these new war veterans.

We believe the ideal solution to this issue would be for DoD to share the computer file of this health information with VA, as is done with other electronic health data maintained initially by DoD. This health dataset could then be incorporated into the "Health Data Repository" or into VA's "Clinical Patient Record System" (CPRS), where it would be readily accessible by VA health care providers and by the Veterans Benefits Administration (VBA) for the lifetime of these war veterans. These are two standard approaches to health data sharing between DoD and VA, and they ensure both confidentiality of patient information and compliance with HIPAA regulations. As such, we were pleased by the charge from the Assistant Secretary of Defense for Health Affairs to establish the DoD Deployment Health Task Force with a specific requirement to develop recommendations to electronically capture pre- and post-deployment health

assessments on all deploying service members and establish linkages with the VA health record system.

Successful implementation of this charge will allow VA to develop and maintain a master file, avoiding a situation in which each pre/post deployment health record will have to be asked for individually, thus slowing down critical processes, such as diagnosing delayed psychological problems, like PTSD, and adjudicating disability claims. Furthermore, with this information VA will have a good overall understanding of pre-deployment health problems and trends in post-deployment health, thus making program planning to meet veterans' needs less difficult.

Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)
Responses to Questions from
The Honorable Lane Evans

Question: What are the plans for establishing a means of ensuring and assessing Networks' effectiveness in implementing the new Clinical Practice Guidelines (CPG) for PTSD?

Response: VA's plan for the implementation of the new PTSD CPG involves several steps.

1. The completed guideline has been posted on the Office of Quality & Performance (OQP)/DoD website at www.oqp.med.va.gov/cpg/cpg.htm. Educational programs on management of PTSD highlighting the CPG will be carried out over the next several months.

2. The guideline, which describes a full range of information regarding diagnosis and treatment of Acute and Post Traumatic Stress Disorder, will be accompanied by provider tools including a Guideline Summary, Pocket Card and key Point Cards pertaining to: a.) Acute Stress Reaction in a Civilian Population; b.) Combat and Operation Stress Reaction During Ongoing Military Operations; c.) Assessment & Management of Acute Stress Disorder and Post Traumatic Stress Disorder in Primary Care; d.) Assessment & Management in Mental Health; and e.) Pharmacotherapy Interventions.

3. Data collection to determine if patients have been screened for PTSD has already commenced through the Office of Quality Performance's External Peer Review Program (EPRP).

4. Development of appropriate indicators for assessing implementation of the PTSD guideline by the Mental Health Strategic Healthcare Group in collaboration with the Offices of Quality and Performance and the Deputy Under Secretary for Health for Operations and Management has been initiated.

The new PTSD Clinical Practice Guidelines will be fully implemented this Fiscal Year and their impact on patient care will be tracked.

Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)
Responses to Questions from
The Honorable Lane Evans

Question: What are the plans for addressing the development of informatics capable of tracking veterans throughout VA's medical system?

Response: VA's Veterans Health Administration (VHA) is a world-class leader in the use of an electronic health record system to manage patient information. The Veterans Information Systems and Technology Architecture (VistA) is a rich and fully automated environment that supports day-to-day operations at all local VA medical centers. The Computerized Patient Record System (CPRS), the provider interface for VistA, supports Provider Order Entry, Imaging and Clinical Decision Support. CPRS also contains "Remote Data Views" of veteran health data from all VHA locations. Using CPRS, VA clinicians can access veteran data from across all medical center locations, thus allowing VA to track veterans throughout the entire medical system. Essentially, any authorized provider treating a veteran at any VA facility can access that veteran's data in any VA health system.

VHA also has developed the HealtheVet Strategy that will transform VistA from a collection of health data from local hospital-based information systems into a single Health Data Repository (HDR). The HDR will support the health of veterans across the continuum of care. HealtheVet VistA invokes a new architecture in which "common services" become the intermediary between the Database and User. One of the new common services is the development of rules-based inferencing engines. These inferencing engines will provide the knowledge-based artificial intelligence to allow large scale clinical decision support on all veterans at all times, regardless of whether the data originates from the HDR or the Clinical Data Repository (CDR) from DoD.

In 2002, VA and DoD developed the Federal Health Information Exchange (FHIE) (formerly known as the Government Computer-based Patient Record, GCPR) to provide VA clinicians select DoD health information from veterans who were discharged from military service. DoD now transmits all electronically available health data from its Composite Health Care System (CHCS) to a secure FHIE repository where it is stored until requested by a VA clinician treating a veteran. Using the Remote Data View capability, the VA clinician can now access portions of the veteran's military health record prior to discharge from military service. As a result of a joint effort between VA and DoD, the HDR will interface with the DoD CDR to support the bi-directional exchange of computable data. This interface, known as Clinical/Health Data Repository (C/HDR), will provide VHA access and use of discrete DoD clinical data for automated clinical decision support algorithms. Such capability will allow VA clinicians to more rapidly evaluate and address veteran health concerns, such as PTSD in returning

service members. The C/HDR project is entering the prototype phase; prototype interoperable data repositories are scheduled for comp etion in October 2004.

VHA also is developing prototype Home Telehealth applications to further support the ability to provide continuous care to veterans wherever they are located, including the home setting. Telehealth systems permit the transfer of clinical measures, vital signs and certain lab tests. Telehealth systems also support the assessment of activities of daily living (ADL) and mental health status.

The HealtheVet-VistA strategy and the development of informatics to track veterans throughout VA medical centers are consistent with the long-range strategy for the Electronic Health Records Plan – HealthePeople (Federal). This Plan provides the roadmap for VA and DoD to achieve interoperability between the two health information systems by 2005. The Plan provides for the exchange of health data by the Departments and development of a health information infrastructure and architecture supported by common data, communications, security and software standards and high performance health information systems. HealthePeople (Federal) is a long-term strategy to achieve full interoperability among Federal health information systems starting with the ability to provide a two-way exchange of health related information between VA and DoD. The implications of this Plan are as follows:

- Improved sharing of information;
- Common standards for architecture, security, communications, data, technology, and software;
- Joint procurements and/or building of applications where appropriate;
- Increased opportunities for sharing existing systems and technology;
- Converged and/or collaborative VA and DoD health information technology applications where feasible and within mission requirements; and
- Interoperable health records and data repositories.

Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)
Responses to Questions from
The Honorable Lane Evans

Question: What are the plans for expanding access to specialized treatment in VA and Vet Centers vis-à-vis recommendations made by the Under Secretary for Health's Special Committee on PTSD?

Response: The Special Committee made several recommendations related to clinical services that are specifically cited in the incoming letter. Establishing a PTSD Clinical Team (PCT) in every VA medical center may not be needed in terms of workload at a given facility. Public Law 108-170 authorizes an additional $5 million to establish new PTSD clinical programs, and it is likely that some additional PCTs will be established. It must be noted; however, that there are other, highly effective ways to enhance access to specialty PTSD care in sites, including CBOCs, that may not have a PCT. These include having PTSD specialists onsite (i.e., one or two clinicians who are skilled in PTSD care, but not the three staff required for a PCT). In FY 2002, 13,428 individuals received care from a PTSD specialist in a site that did not have a PCT. In addition, telemental health can be used to bring specialty PTSD care to smaller sites where there is no PCT or PTSD specialist. Mental health PTSD Veterans Integrated Service Network (VISN) leads are being identified across the system. A PTSD Education Steering Committee is engaged in planning new PTSD educational programs for FY 2004.

The PTSD Committee also recommended, and the Under Secretary for Health agreed in principle, that a family therapist be located within each Vet Center. The Secretary approved the Vet Centers to extend readjustment-counseling services to all veterans returning from the Global War on Terrorism (GWOT) in Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) in Iraq. To date, the Vet Centers have served over 4,600 GWOT veterans. Since the onset of Operation Iraqi Freedom in March 2003, the Vet Centers have also been actively pursuing the program's community-based service mission by way of conducting systematic outreach to military installations targeted to receive returning troops from Afghanistan and Iraq, with particular attention to National Guard and Reserve personnel returning to their home communities following their deployment. Vet Center staff visits to military installations, and National Guard and Reserve components, promote coordination with DoD family assistance centers to provide a continuum of care for separating service men and women. Within the context of the Vet Center program's outreach activities, family members of service men and women deployed to the Global War on Terrorism may be provided with educational information, case management and referral services by Vet Center staff.

The Secretary also approved of VA's recommendation for the Vet Centers 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 Iraq.

In addition, the Under Secretary for Health recently approved an initiative to augment the Vet Center program's capacity to provide outreach to veterans returning from the GWOT in the theaters of combat operations in Afghanistan and Iraq. Specifically, the initiative is for Full-Time Employee Equivalents (FTEE) and associated salary dollars to hire approximately 50 temporary outreach workers for up to a three-year period at targeted Vet Centers. Based upon the model of a similar initiative implemented in the wake of the Gulf War in 1991, the plan is to hire recently separated GWOT veterans into these temporary outreach positions. Augmented Vet Center outreach will be 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 will be located on or near active military out-processing stations, as well as National Guard and Reserve facilities. Veteran temporary hires will augment Vet Center services in providing briefing services to transitioning servicemen/women regarding military-related readjustment needs, as well as the complete spectrum of VA services and benefits available to them and their family members. The new hires will also organize local community activities to provide information and education about VA, DoD, and other community support services available to veterans and family members.

In fact, VA has been engaged in planning for support of returning troops from the Iraq War in close collaboration with DoD since the spring of 2003. VA and DoD collaborated on the "Treating War Wounded" satellite series and subsequent web-based and print Veterans Health Initiative module of the same name. This training tool was first broadcast in April 2003. VA collaborated with DoD in the creation of the DoD Post-Deployment Questionnaire, which includes screening questions for PTSD, depression and substance abuse as well as questions about physical injuries and exposures and family stressors. VA has created an automatic screening tool that is incorporated into the electronic health record for all returning Iraq veterans, which includes questions on PTSD, depression and substance abuse. In June 2003, VA's National Center for PTSD released a CD ROM distributed to all VA facilities entitled the "Iraq War Guide" which makes recommendations for the assessment and treatment of returning veterans.

Social workers have been identified as Points of Contact in key DoD installations (e.g., Walter Reed Army Medical Center) and in all VA medical centers to assist returning veterans. The VA Seamless Transition Task Force has added a direct link from the VA Internet web page for Operations Iraqi Freedom and Enduring Freedom to help regular active duty, Reservists and members of the National Guard called to active duty, veterans and family members access information. Specialized PTSD services in VA are expanding to meet increasing veterans' needs.

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Statement of
Dr. Thomas Horvath, Chief of Staff
Houston 'Michael E. DeBakey' VAMC
Before the
Subcommittee on Health
Committee on Veterans' Affairs

March 11, 2004

Mr. Chairman,

Thank you for inviting me to address the Committee on the topic of Post Traumatic Stress disorder in the context of the overall availability of mental health services in the Veterans Health Administration, with special attention to the needs of our newest groups of veterans from the battlefields of Afghanistan and Iraq.

I am a physician with internal medicine and neurology training from Australia and psychiatric training from this country. Since my arrival to the U.S. 30 years ago, I have served veterans in the VA in every capacity from resident, to staff psychiatrist, to section and service chief, to Chief of Staff, and as the director of mental health in VACO for six years. I am currently the Chief of Staff of one of the largest VA Medical Centers, now named after the legendary cardiac surgeon and WWII veteran, Michael DeBakey. Here, I am responsible for all the clinical activities of a primary and tertiary care, medical, surgical, psychiatric, acute and rehabilitative hospital, which now services over 70,000 veterans in East Texas. I am a professor in the Menninger Department of Psychiatry, named after another famous veteran, in the Baylor School of Medicine in Houston. I have traveled very widely and site-visited most VAMCs. I have gained first-hand familiarity with the mental health scene in the VA by working closely with the Committee for the Seriously Mentally Ill Veteran since it's conception, by Congress in 1994 to advise the USH on all aspects of mental health, including PTSD, and to evaluate VHA's efforts in this regard and then inform to Congress. Our Annual Reports have been constructive, but outspoken, and have pointed to many areas necessary for the improvement in the delivery of critical mental health services.

This has never ceased to amaze me, as I grew up in a Europe caught between Fascism and Communism, where free speech was a rare commodity and a dangerous practice. I grew up in a Europe that sent it's sons to war and slaughter in profligate numbers, and then abandoned them to their fate or even persecuted them for their political beliefs or even for being conscripted for the wrong side. You see, I am the son and grandson of combat veterans. As my father lay dying in 1991, his delirious mind took him back to his field hospital where his soldiers were dying for lack of supplies. My grandfather's four-year service in the trenches left him with a stutter, shellshock, and several wounds. (My other grandfather died as a POW.) Thus for me, PTSD is a family experience and vivid reality, not a textbook abstraction. It is not a personal experience, as my ten-year service in the US Army Reserve taught me the Combat Stress Doctrine, but did not

expose me to it. My periods of mortal danger during the 1956 Hungarian Revolution against communism were too brief, too exhilarating; Patton's 3rd Army brought our incarceration by the Nazi's in 1945 to a happy ending. Still, having seen the ravages of war in my country of birth and in my family; having seen the delayed effect of Changi Prison, the Burma railroad and the New Guinea Campaign in my Australian patients, I expected to learn a lot more when I came to the wealthy United States. Imagine my disappointment when in a three year residency training(1973 – 1976), at the Palo Alto VA, I had no instruction what-so-ever in military medicine, post deployment psychiatry, or even participated in an honest discussion of the pain of returning Viet Nam veterans. None of my twelve classmates have served in the military (although the impact of witnessing the shattered lives of veterans was such that, two of us joined the VA and a third went into the Navy). What we learned, we learned from veterans. Later, I learned a lot from Dr. Larry Kolb, WWII Navy veteran, eminent psychiatrist, and one of the people who shamed and scientifically convinced the APA to develop a formal definition for PTSD for it's Diagnostic and Statistical Manual, which the VA eventually followed. So this very real condition, affecting hundreds of thousands of veterans of all wars, finally received a name and a grudging recognition in 1979-1980. To this day however, some ill informed people fail to distinguish between a politically and culturally defined set of attitudes and complaints, the so-called "post-Vietnam syndrome" and a clinically coherent, statistically valid, formal diagnostic entity (DSMIV, APA, 309.81, 308.3).

One of my current patients exemplifies the distinction. He fought with the Marines who lifted the siege of Khe Sanh, endured fear, saw mutilated bodies, escaped close calls. Yet, he says today, " I don't deserve to be in the VA, other people suffered more, done more in combat." He does not draw a pension, has been a self-supporting small businessman. He believes the war had a purpose, and most American fought for a just cause and fought well. He never abused his family, though both his marriages ended due to the severity of his symptoms. These he controlled in Vietnam, not wanting to appear a coward, and suppressed by heavy social drinking afterwards. However, he had three hospitalizations in the last 15 years and has walked around with a loaded gun for weeks. He still has startle reactions; he can't watch Viet Nam theme movies, avoids other veterans. He has nightmares and frequent awakenings. He is withdrawn, has few social contacts, and his business failed due to his increasing isolation (and the loss of money in Enron shares). He has neuropsychologically proven memory and concentration defects. He meets all the necessary criteria for PTSD (309.81), but he does not have the Post Vietnam Syndrome.

Yet, many people to this day regard what I just described as a weakness, a yellow streak and not the red badge of courage. These beliefs die hard, even though well replicated brain scan studies of veterans with PTSD have shown physical shrinking of a part of the brain which controls emotion and memory, called the hippocampus. This atrophy correlates closely with the intensity of combat experienced decades ago. Scientists in the VA and affiliated eminent universities have also shown biochemical changes persisting for these decades that eventually result in higher rates of cardiovascular disease and possibly cancer (This was shown for WWII combat veterans and POWs.) So PTSD is not a little old "adjustment disorder" which is "all in the

veteran's head" it is not a hyped-up myth; it is a persistent, dangerous biological condition that maims the body as well as the mind, the brain as well as social relationships. It strikes the brave: the more combat you see, the more intense is your PTSD. (Yet some people are resistant to it to some extent) But it also strikes the lonely; unit cohesion provides a buffer, and a warm homecoming greeting and social support tends to prevent it – but the absence of these provides a multiplier, the beginning of a vicious cycle.

Unit cohesion fell apart in many outfits in Viet Nam as the American part of the war was winding down. And warm homecomings were often missing – and I am sorry to say, the VA often was not a welcoming place either for Viet Nam veterans. I have served ten years in the Bronx VA and when I arrived, the conditions in some areas were as appalling as described by Ron Kovic and portrayed in the Film *Born on the 4th of July*. It should come as little surprise that the fifteen-year-old Research Triangle study has shown persistently high rates of untreated PTSD among Viet Nam combat veterans. However, it took our committee members and others almost eight years of arguments to have VHA commit to a follow-up repetition of that study, this time looking at the physical complications of PTSD, of enormous importance you would think. Dr. Keane is very familiar with the frustrating process of having to make our own VA face-up to it's own needs for data relevant for planning for what should be, but rarely is, the central mission of the VA; to bind the wounds of war. We are grateful however, to the USH who finally cut through the bureaucratic wrangling, and as we speak, a contract is being set. We are also grateful to some of his predecessors who supported the establishment of the National Center for PTSD, the finest research and education institute of its kind in the world, and for developing specialized treatment programs for PTSD. We are grateful that a previous USH finally listened to the repeated urgings of Congress, and established the first MIRECC six years ago. We now have eight of these centers and our USH has authorized the release of an RFP for the next two. He was perceptive enough to appreciate their success; the first three MIRECCs have brought in $ 33 M research income last year in return for a core funding of $ 5.4 M; over the past five years published 1,165 articles of veteran relevant research in the literature, educated thousands of providers, and brought forth new discoveries like the orphan drug Prazosin that so successfully treats combat related nightmares, that not only VA doctors, but Army physicians at Madigan are using it with OIF veterans.

I emphasize these positive developments because VHA has improved its services for some specialized mental health services. Twenty-five years ago, we had no PTSD services, no Vet Centers, no homeless services; now we do! The growth of PTSD services especially have been very gratifying; yet, it has not kept up with the demand.

Personal communication with staff deployed to and returning from the combat and communication zones reveal that servicemen and women are still reluctant to reveal their symptoms or their level of stress. Thus any superficial counts of overt clinical presentations may underestimate the real extent of the disorder. We should painfully remember the laudatory articles in the military psychiatric literature of the late 60's, that bragged that R&R and individual rotations virtually eliminated combat stress disorders in

Viet Nam (for an excellent analysis, see several chapters in War Psychiatry, Volume of Textbook of Military Medicine, OSG, USA, 1995). Combat stress continues to cause casualties, even as the application of CSC principles prevent or delay some; thus the need for VHA/MH services continues. But remember, while the consequences of stress certainly include PTSD as the lead element, combat stress is associated also with suicide, unexplained physical illness, depression and even the precipitation of schizophrenia and bipolar affective disorders. Thus, we must be able to provide not only our outstanding, drop-in, frequently veteran-run, Re-adjustment Counseling (Vet Center) Services that we can be very proud of, but also be able to provide a wide range of acute and rehabilitative mental health services. These must be relevant to the age, sex and ethnic composition of today's military, yet we must continue to honor our commitment to veterans of previous conflicts.

Yet, here the news is not good enough. The SMI Committee has repeatedly observed that VHA needs to increase capacity for specialized services for the mentally ill. This is pronouncedly so for substance abuse services that saw a decreasing number of veterans treated and a decreased amount of real dollars, due to the precipitous closing of a whole range of services six years ago. If we look at the inflation-adjusted dollar; VHA took 25% inflation adjusted dollars and 23% of staff from mental health services and transferred it to primary care or medical/surgical services. These latter have shown significant dollar growth over the past six years, while mental health suffered a relative decline. Now this was not the result of a single executive decision, but was the unintended consequence of hundreds of individual, probably well-meaning decisions to force setting up primary care, improve access to ever-larger numbers of veterans, and to enhance our preventative medicine standards. These were laudable goals, and we proudly achieved them, but at the expense of some of the mentally ill.

It is also entirely clear, however, that with appropriate network level leadership, good local planning and attention, this salutary increase in access to primary care did not have to come at the expense of the mentally ill. Some networks did an entirely fine job in maintaining capacity for the treatment of mental illness. Others did a terrible job. The somewhat unsatisfactory national average hides some truly bad scenarios and fails to reward some excellent performers.

Before my arrival in Houston 5 years ago, the Medical Center already reduced the average length of stay in psychiatry to 7-10 days, had closed beds and units, but had wisely retained the savings to beef up outpatient services. They actually increased the number of patients treated with no detectable loss of quality. They completely closed inpatient substance abuse, but were able to refer needy patients to community beds. Despite their best efforts, the number of substance abuse patients treated as outpatients declined, but some of the missing patients were probably picked up in our Homeless Program. Fortunately, the latter was well funded, both by VACO and the VAMC, and is one of the best in the country. Yet, even our Homeless Program could not prosper without collaboration from the non-profit U.S. Vets and the AmeriCorps programs and the City of Houston (and the cooperation of veterans who often use their own funds to pay for community rehabilitation beds). We have developed a well

regarded, well staffed Trauma Recovery Program and has engaged in funded PTSD research and training. Our people have studied the Iraqi War Veteran Clinician Guide; the PTSD Compensation and Pension Exam Guide; we have an OIF Clinical Coordinator and plans for the special treatment of younger soldiers away from older, chronic veterans. As we are not in a big military town, as a lot of the wounded seem to be heading to Tricare and not the VA, and as many transitioning new veterans have yet to discover the VA, we have not had a major influx yet. We are conscious of the concerns of soldiers about being labeled and stigmatized. We have mental health clinicians "embedded" in our primary care clinics and our two satellite country clinics and we work closely with our two urban Vet Centers.

We continue our investment in mental health just as much as in primary care. In fact, we refurbished our 6th floor mental health area the same time as we expanded our 1st floor primary care facilities. We also invest in science; have a MIRECC, a PADRECC, an HSRD Center of Excellence, all working at least in part on mental illness.

To illustrate our dilemma, let me tell you an incident from my Beaumont Clinic, which is experiencing a 20% growth annually. One of my excellent internists told me of two new patients he saw back-to-back. One, was a well-dressed cold war era CONUS served veteran, with diamond rings, who heard about VA's prescription medication benefit while playing poker, and who clearly asked for a set of expensive cholesterol lowering and BP maintaining medications (no, he did not ask for Viagra, but many do). The other was a young woman injured in the service who also experienced military sexual trauma. Fortunately this country clinic of ours does have a psychiatrist, but many CBOCs still have no mental health services despite years of warning by our Committee. (I understand, however, that our USH may have some late-breaking news in this regard.) So we did end up providing services to both veterans but how long can we do so and whom do we prioritize? Let me be clear: I not only applaud the extension of primary care services and preventive medicine, but I personally contributed to their development in Northport twelve years ago, and in Houston over the past five years. But in neither case did I take it out of the hide of services for the mentally ill. We competed for extra funds dedicated for the mentally ill when they were available. These were useful as seed money, but did not comprise our core funding. We simply managed our core allocations fairly and with stewardship and with an understanding that mental illness was real and combat PTSD and its complications were at the heart of what the VA was established for.

I regret to report that there are stigmas in the VA about the mentally ill. In this, we may be no worse than the rest of healthcare, as the President's New Freedom Commission identified stigma as a major obstacle to the freedom of the mentally ill; and the Surgeon General said in 1999, "For our Nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needed knowledge about the brain, mind, and behavior, stigma must not longer be tolerated". VA needs to do better, because much of the mental illness among veterans is the direct result of their faithful military service and combat experience (look at our service connection rates and the overseas

experiences of more than half of our patients, not just those with PTSD, but those with bipolar, addictive, schizophrenic disorders).

I am pleased that VA has established an action agenda to respond to the President's New Freedom Commission report and is developing a strategic plan for mental health programs to be released later this year.

United States House of Representatives
House Veterans Affairs Committee
Subcommittee on Health
Status of Veterans with PTSD
March 11, 2004

Testimony of Terence M. Keane, Ph.D.
Director, Behavioral Sciences Division
National Center for PTSD
VA Boston Healthcare System
&
Professor of Psychiatry, Psychology, & Behavioral Neuroscience
Boston University School of Medicine

INTRODUCTION:

My name is Terence M. Keane, Ph.D. For more than twenty-five years I've been actively involved in providing psychological care for veterans with war-related posttraumatic stress disorder (PTSD). With colleagues we established the first outpatient treatment program for PTSD in a VA Medical Center at the Sonny Montgomery VA in Jackson, Mississippi in the late 1970's. In 1989 I was named Director of the Behavioral Sciences Division of the National Center for PTSD with responsibilities spanning epidemiological studies, the development and refinement of assessment and diagnostic instruments, and the promotion of evidence based psychological treatment methods for PTSD.

For three years I served on the inaugural Special Committee on PTSD (1984-87); since 1986 I've had oversight responsibility for the National Vietnam Veterans Readjustment Study; and I've received twenty-four consecutive years of competitive funding from VA, the National Institutes of Health, Substance Abuse Mental Health Services Administration (SAMHSA), and a variety of foundations in order to support our research program on PTSD.

In 1980 I was named Chief of Psychology in Jackson and then in 1985 I became Chief in Boston. Currently, I have administrative and clinical responsibility there for all mental health services at the Boston outpatient clinics. As well, I have overall responsibility for the educational and training programs in psychology. These are some of the largest training programs in the country and include the only NIMH funded postdoctoral training program for PTSD in VA. Due to the quality of the clinical, teaching, and research programming on PTSD, VA Boston was designated as a VA Clinical Center of Excellence in PTSD for the past four years, one of only two such centers in all of VA.

In the wake of the terrorist attacks on New York City and the Pentagon I became actively involved in several panels assembled by multiple federal agencies, including VA, NIMH, and DOD. These panels were charged with identifying best practices for the early

intervention for people exposed to massive trauma. As well, I've participated in separate policy conferences for the psychological care of war veterans in many different countries including the United Kingdom, Australia, Canada, Kuwait, and Croatia to name a few.

As a function of these various roles and responsibilities I would like to present my perspective on clinical, research, and educational status of VA in its efforts to manage the large cohort of veterans with PTSD from prior eras as new cases of PTSD emerge from our military engagements in Iraq, Afghanistan, Bosnia, and our peacekeeping efforts in various parts of the world including Africa and the Caribbean.

STATUS OF CLINICAL PROGRAMS:

Data from the Northeast Program Evaluation Center (www.nepec.org) indicate that in FY 2002: a) there were more than 180,000 veterans service connected for PTSD, sixty percent of whom received mental health care from VA; b) there was a 15% increase in the number of veterans treated for PTSD system wide from FY2001-02; and c) there was a concomitant five percent decrease during the same period in the number of inpatient discharges for PTSD consistent with the refocusing of mental health care to outpatient care. Presently, VA provides psychological treatment to approximately 87,000 veterans with PTSD annually with costs estimated at $250 million. With the increase in enrollment of veterans seeking PTSD services, VA is attempting to meet the challenge of providing care for PTSD veterans.

In the last eight years VA has emphasized the transition of care from an inpatient to an outpatient locus to enhance patient access and satisfaction with care. This transition was premised in the reduction of costly inpatient care and the reengineering of resources to the provision of less costly outpatient care. These are laudable goals. In some instances many of these resources were reallocated to outpatient mental health care; and in other cases few if any were reallocated, thus placing increased pressure on the system to care for a growing number of eligible veterans. Many facilities do not offer individualized psychological care, emphasizing the more efficient group models of care. Unfortunately, group therapies for PTSD have little evidence to support their effectiveness.

VA is the international leader in the psychological care of its military veterans. This is, to a large extent, due to the proliferation of programs in the 1980's and early 1990's. As well, this is due to the outstanding research and education programs that are a part of VA's mission. These research and educational programs remain intact largely due to the support of VA's Medical Research Service and Academic Affairs who continue to provide support for the next generation of researchers and clinicians in PTSD. In addition, continuing education programs sponsored by VA Learning University frequently address the problems of men and women with military related PTSD. The effect of this is that VA has a well-trained workforce for managing chronic PTSD.

A focus of VA needs to be the continued training in the management of acute cases of PTSD and in the provision of early interventions for those at greatest risk for the development of chronic course of PTSD. VA responded to the terrorist attacks on the US

through the National Center for PTSD, utilizing its nationally recognized website (www.ncptsd.org), and assuming a leadership role for VA in educating clinicians in the system about the acute needs of service men and women returning from the war on terror. These efforts were timely, but there needs to be a more focused and continuous effort to train the workforce in the treatment of acute stress disorder and acute PTSD using contemporary methods.

VA's international leadership in the problems of psychological trauma is a function of the many specialized programs for PTSD nationwide (including Readjustment Counseling), the research and educational programs that VA supports, the outstanding Mental Illness Research, Education, and Clinical Centers that are funded by VA, and also the consistent productivity of the National Center for PTSD under the leadership of Matthew Friedman, M.D., Ph.D. These resources provide the foundation for continued excellence in the area of PTSD and should be supported and perhaps even enhanced in this time of war.

Needed in VA at this time is a specific focus on acute cases of PTSD. In particular we have a need to capitalize on the growth in knowledge internationally on methods and models to prevent the development of chronic PTSD among those at greatest risk. In the past ten years members of the scientific community have worked to identify the key risk factors that lead to the development of PTSD among those exposed to war-zone stressors.

Recent clinical trials provided new scientific information on the success of early psychological interventions after trauma exposure. Bringing this new information into the field should be a priority. We have the technology and the knowledge to begin the process of introducing these new treatments to the field. Evaluating its impact and measuring the process of treatments delivered by alternative new technologies is important for the United States to remain the international leader in the psychological trauma field.

How can this be achieved? Possibly VA could create centers of excellence in early interventions for war trauma, centers that would provide the leadership in this emerging field of care. Implicit in the focus of these centers of excellence would be the innovative delivery of care to those people at greatest risk for developing PTSD; one particular focus would be the integration of physical and mental health services acutely to those who've sustained significant injuries. A second focus would be on those who require long-term rehabilitation for war injuries. Another component of such centers would be the use of the Internet and telecommunications for the rapid and convenient delivery of care for people exposed to undue war-zone stress. Making these services available, evaluating and improving them with empirical methods, and serving as a standard for the delivery of care in creative new ways will be a few of the objectives for such centers. In the very near future it may well be possible to provide effective psychological and psychopharmacological treatments for people soon after exposure to traumatic events. Centers for Early Interventions for Trauma would insure that VA would be the national leader in this arena. These Centers would be resources for VA, DOD, and for the public health system of the United States more broadly.

Academic Affairs in VA is one major resource for training the future workforce of VA. It is remarkably effective. At Boston University, VA rotations are decidedly the most popular and the most frequently sought rotations in our psychiatry and psychology training programs. We have trainees in medical school and in graduate school in clinical psychology, on internship and residency, and we have postdoctoral fellowships for psychologists and psychiatrists specifically in the area of PTSD. Often these candidates would prefer to stay within VA, but are taking positions in the private sector because of our inability to hire.

STATUS OF EPIDEMIOLOGICAL RESEARCH STUDY:

The National Vietnam Veterans Readjustment Study was a landmark achievement for the Department of Veterans Affairs. Completed in 1988 at a cost of nearly $10 million, this unprecedented and award winning study represented the first time that a country sought to effectively understand and measure the psychological impact of a war on the men and women sent to fight it. The NVVRS became the benchmark for methodological rigor for psychiatric epidemiological studies throughout the next decade. In addition, its influence on public policy was impressive. VA responded to the findings by establishing a wide range of treatment programs across the country, programs that are largely still functioning today in some fashion. These programs treat the 87,000 veterans with PTSD from all eras who come to VA today.

In FY 2002, Congress mandated a systematic follow up of the veterans cohorts to determine the long-term course of PTSD and to study the physical health consequences of contracting this condition. The NVVRS veterans are the only representative sample of veterans from that era and so findings from the cohort will be generalizable to the entire population of male and female Vietnam Theater Veterans. The findings of this study would assist VA in planning for mental and physical health services among this cohort. With $5 million allocated to plan the study, VA let a sole source contract to the Research Triangle Institute in North Carolina.

Extensive planning was initiated in October of 2002 with a Scientific Advisory Board consisting of outstanding epidemiological experts. This study was an unusually complex one in that it was the first time that excellent psychiatric measurement was to be employed in conjunction with state of the art physical health measurement. Expectedly, the estimated costs of this study began to rise. In November 2003, we in VA decided to place the study out to bid in order to insure that the price of this study was the best possible and that we received the optimal study for the cost. As a result of this decision, the results of the study will be delayed for an indeterminate period of time. The delivery date for this report was originally scheduled to be September 30, 2004. We will have a better estimate of the delivery date once the new contract is initiated.

SUMMARY OF POINTS:

- VA is unquestionably the international leader in treatment, education, and research on war zone related PTSD.

- With the existing demand for services high and the possibility for increased demand from new veterans, there is a need for creativity in the development and delivery of effective interventions. Redirected resources, or greater use of the resources saved by re-engineering inpatient to outpatient care, should be considered.
- PTSD treatment programs for women veterans exist to some extent in Vet Centers with far fewer specialized resources in VA medical facilities. The needs 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.
- VA is presented with an opportunity to take the national lead in the development and evaluation of the effectiveness of early psychological and psychopharmacological interventions for promoting resilience and preventing adverse outcomes following exposure to traumatic events. Consideration for sponsoring Centers for Early Interventions for Trauma is one way to assert this leadership in a pressing national issue.
- Use of telecommunications, especially the world-wide web, for surveillance, treatment, and evaluation of early interventions will be one efficient approach for managing these complex problems in cost effective ways. They may prove to be indispensable for the Seamless Transition implemented between VA and DOD for care of injured Americans.
- 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.
- Filling vacancies in high priority areas such as combat related PTSD treatment should be a priority.
- Critical information on the longitudinal course of PTSD and its health consequences will be derived from the follow up study of the National Vietnam Veterans Readjustment Study. These data will provide valuable information for setting future healthcare priorities for this generation of veterans. This Congressionally mandated study, due to Congress on September 30, 2004, will be delayed due to its complexity and the related costs.

Thank you for this opportunity to present to you this morning.

Statement of
Harold Kudler, MD
Co-Chair, VA Under Secretary for Health's Special Committee on PTSD
Department of Veterans Affairs
Before the
Committee on Veterans' Affairs
Subcommittee on Health
March 11, 2004

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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.

Testimony of

Sally Satel MD

Resident Scholar

American Enterprise Institute

Before a hearing of the

Subcommittee on Health of the House Veterans Affairs Committee

on

Posttraumatic Stress Disorder in Operation Iraqi Freedom Veterans

on Thursday, March 11, 2004

in Room 334 Cannon House Office Building, at 9:30 AM

Mr. Chairman and members of the committee, thank you for inviting me here today. Let me begin by saying that posttraumatic stress disorder is real and painful condition. Undoubtedly, it will afflict some men and women returning from Iraq. A humane and grateful country must treat them. But how many will be afflicted is difficult to know at this time.

It is generally put forth as an established truth — that roughly one-third of returnees from Vietnam suffered PTSD. This is at best debatable, given that fifteen percent were assigned to combat units. As we try to help the soldiers of Operation Iraqi Freedom meld back into society, it would be a mistake to rely too heavily on the conventional wisdom about Vietnam.

I will first discuss the questions raised by the government-mandated study on war stress among Vietnam veterans. Second, I will put forth some clinical and social principles for responding to the soldiers who are now rotating home.

The National Vietnam Veterans Readjustment Study: The Research Triangle Institute (under contract from the Veterans Affairs Administration) released the study in 1990. It concentrated on post-traumatic stress disorder, a psychiatric condition marked by disabling painful memories, anxiety and phobias after a traumatic event like combat, rape or other extreme threat.

The NVVRS found that 31 percent of soldiers who went to Vietnam, or almost one million troops, succumbed to PTSD after their return. The count climbed to fully half if one included those given the diagnosis of "partial" post-traumatic stress disorder.

On closer inspection, however, these figures are shaky. As I mentioned, only 15 percent of troops in Vietnam were assigned to combat units, so it is odd that 50 percent suffered symptoms of war trauma. True, non-combat jobs like driving trucks put men at risk for deadly ambush, but Army studies on psychiatric casualties during the war found the vast majority of cases referred to field hospitals did not have combat-related stress at all. Rather, most were sent for psychiatric attention because of substance abuse and behavioral problems unrelated to battle.

Moreover, during the years of the most intense fighting in Vietnam, 1968-69, psychiatrists reported that psychiatric casualties numbered between 12 and 15 soldiers per thousand, or a little more than 1 percent. If the 1990 readjustment study is correct, the number afflicted with diagnosable war stress multiplied vastly in the years after the war. Again, it does not add up.

How to explain the postwar explosion in Vietnam cases? The frequently proffered answer is that the start of the disorder can be **delayed** for months or years. This belief, however, has no support in epidemiological studies. And consider the striking absence of delayed cases in long-range studies like that of people affected by the Oklahoma City bombing.

Such studies have found that symptoms almost always develop within days of the traumatic event and, in about two-thirds of sufferers, fade within a year.

It is worth noting that the concept of delayed post-traumatic stress was introduced in the early 1970's by a group of psychiatrists led by Robert Jay Lifton, an outspoken opponent of the war. They decided that many former soldiers suffered what was called post-Vietnam syndrome — marked by "alienation, depression, an inability to concentrate, insomnia, nightmares, restlessness, uprootedness and impatience with almost any job or course of study" — and that this distinguished veterans of Vietnam from those of any other war.

(It took years for a critical mass of scholarship to accumulate showing that Vietnam veterans were comparable to both Vietnam era veterans and non-veterans in terms of employment, income, level of education, divorce rate, suicide, homelessness.[1])

While there were little data to back up the existence of this delayed syndrome, the image of the veteran as a walking time bomb was a boon to the antiwar movement, which used it as proof that military aggression destroys minds and annihilates souls. Yes, some veterans suffered the crippling anxiety of chronic post-traumatic stress disorder. But the broad-brush diagnosis of post-Vietnam syndrome also served political ends.

There are a couple of other reasons to be skeptical. A well-advertised syndrome like PTSD could have provided a **medicalized explanation** for many unhappy, but not necessarily traumatized, veterans who had been trying to make sense of their experience. This seems particularly relevant to NVVRS subjects who seldom sought care or compensation. Such "effort at meaning" is a deeply human – and well-documented phenomenon.

In addition, the NVVRS researchers **did not measure degree of impairment** in the subjects interviewed. Nor were frequency of symptoms recorded. There is an active debate in the psychiatric literature about over-diagnosis (of many conditions, not just PTSD) prompted by the fact that clinicians or epidemiologists do not always take into account the degree of impairment associated with symptoms. After all, it is not uncommon for some people to have symptoms (e.g., nightmares, painful memories) but to function at a very high level and neither they nor those around them consider them sick. Having too low a threshold for diagnosing pathology was not uncommon at the VA where I worked. I saw, for example, a number of a troubled middle-aged veterans who had only minor complaints of nightmares or occasional disturbing thoughts of Vietnam find themselves misdiagnosed with PTSD. The most recent edition of the Diagnostic and Statistical Manual requires presence of impairment or great suffering. It is very possible that the NVVRS had **too low a threshold for diagnosing PTSD**.

Also, the NVVRS relied heavily on self-report. Psychological studies, however, have shown how **fallible memory** can be. For example, people tend to reconstruct the past in terms of the present--they often exaggerate the degree of earlier misfortune if they are feeling bad, or minimize old troubles if they are feeling good. A 1997 report in the

American Journal of Psychiatry by West Haven VA psychiatrists Steven Southwick, Dennis Charney and C. Andrew Morgan ("Consistency of memory for combat-related traumatic events in veterans of Operation Desert Storm," volume154: 173-7) examined Desert Storm veterans at one month and two years after their return to the U.S.

In the group, memory for traumatic events changed from first to second assessment for 88 percent of them (70 percent recalled a traumatic event at two years that they did not mention at the first month evaluation; 46 percent mentioned a traumatic event at one month but not at two years). Veterans with the most PTSD symptoms, the authors wrote, "tend to amplify their memory for traumatic events over time" though are probably unaware how those memories had changed. In other words, individuals with more severe symptoms of anxiety and depression remember a traumatic event as being worse when they are asked about it a second time than when asked about it earlier. Those with fewer symptoms, however, tended to recall the event as less harrowing than they had previously described it. This observation —from other studies of car accident victims, witnesses to a school shooting, international peacekeepers—are remarkably consistent.

Thus it is vital that researchers try to **corroborate the battlefield events** that veterans cite as causes of their post-traumatic stress. Researchers on the NVVRS did not even attempt this. "Unless we avail ourselves of the historical archival material to verify self-reported traumatic events, will never know how much memory distortion has infected the data base on post-traumatic stress disorder," cautions psychologist Richard McNally of Harvard University, author of *Remembering Trauma* (Harvard University Press, 2003.)

Some may believe that military personnel files are woefully unreliable. There is by no means consensus on that contention. True, no data source is perfect, but taking into account the information on personnel files is surely better than relying solely on memories that are over ten years old, often decades old. While no perfect document exists, the best estimate could be derived from triangulating various sources of information, memory included. It is simply hard to believe that there were no other independent sources that could verify, at minimum, whether a soldier was within 100 miles of a combat zone.

Records aside, the NVVRS findings remain problematic for the reasons discussed above. Furthermore, a study conducted by the Centers for Disease Control published in 1988 found that only fifteen percent of veterans ever suffered PTSD and that two percent met criteria at the time of the interview. (The Centers for Disease Control Vietnam Experience Study, " Health status of Vietnam veterans: I. Psychosocial characteristics," *Journal of the American Medical Association* 259: 2701-2707)

"As psychiatrists we are urged to learn the lessons of Vietnam, but no one is sure what those lessons are," says psychiatrist and trauma expert Simon Wessely of King's College London. "Do the explanations for allegedly high rates lie in the jungles of Vietnam," Wessely asks, "in America's struggle to come to terms with the war, or with symptoms manufactured to fit a cultural narrative and expectation of what kinds of mental stress these veterans would experience?"

Relevance to today? Keep in mind that subjects were interviewed for the NVVRS at *least a decade* after return from Vietnam. Its questionable findings notwithstanding, the study bears little on immediately returning veterans because it measured symptoms present in veterans when they were a decade or more, not weeks, away from being overseas.

A study by Jonathan Borus, a research psychiatrist at the Walter Reed Army Research Institute in the early 70's (now at Harvard) may shed some light here. In 1974 Borus reported data comparing the emotional and behavioral readjustment of almost 600 Vietnam veterans, most of them assigned to combat units, and about 200 non-combat counterparts who served elsewhere overseas or in the U.S. Borus found no difference between the two cohorts of veterans (*Archives of General Psychiatry* vol. 30: 554-7). "From a review of public and professional reports," he wrote, "it seems to me that some mental health professionals have ...overstepped their data to support their politics." Not only was Borus' sample twice as large as the NVVRS (which had 300 theater vets), most of them were assigned to combat units and his analysis took place months not decade(s) after the war.

But the most informative glimpse at what is happening now come from a report released just two days ago. The VHA Office of Public Health and Environmental Hazards, Report #4, (March 9, 2004) states **that 436 soldiers out of 107,540** separated from active duty in Iraq **have thus far been diagnosed with PTSD**. This is about .4% of veterans who returned. According to adherents of the NVVRS, we can expect to see a seventy-fold increase in PTSD over the next decade? This is an astounding (and unrealistic) amplification.

Lessons:

1. *interpreting psychological states*: Will many men and women may feel dislocated, sad, bitter? Of course. They may have trouble sleeping and be distractible, even hostile. Is this psychopathology? Depending on how dysfunctional the person is and degree of persistence, it could indeed be.

2. *promoting protective factors*: important to enumerate the factors known to protect against post-traumatic stress symptoms and PTSD. These include the benefits of a smooth reintegration of the veteran into family and community, society's appreciation for his sacrifice, minimal economic hardship, engagement in purposeful work and the ability to derive reward, or at least, meaning from the war experience, as horrible as it might have been at times. The Veterans Administration may have a role in fostering some of these factors.

3. *formal vs. informal care*: Many of the returning young men and women will find comfort and support in the embrace of their families, friends, communities, and houses of worship. Those who are too anxious or depressed to function or who have started

drinking or using drugs heavily should get professional help. Informal discussion groups may be an option.

What is crucial is that the help we give vets does not transform acute problems and into chronic ones. The VA itself has doubtless learned some of those lessons from its treatment of Vietnam veterans.

4. *practical treatment focus*: Group or individual treatment should be focused on solving practical problems and rehabilitation and putting traumatic experiences in perspective. It should not entail repeated telling of terrifying or demoralizing stories and encourage the client to assume the identity of the psychologically crippled veteran. Inpatient treatment should be reserved for those who cannot function. Specialized inpatient PTSD units have been problematic; they seemed to facilitate regression rather than readjustment.

5. *beware of the disability trap*: Also, therapists should not be predicting mental disability or pushing veterans quickly toward obtaining service connected disability payments. Not surprising, disability payments provide an economic incentive to maintain dysfunction. A veteran deemed to be fully disabled by post-traumatic stress disorder can collect $2,000 to $3,000 a month, tax free. If work is often the best therapy (it structures one's life, gives a sense of purpose and productivity, provides important social opportunities and a healthy way to get one's mind to stop ruminating about problems), then ongoing disability payments can be the route to further disability and isolation.

Once a patient gets permanent disability payment, motivation to ever hold a job declines, the patient assumes – often incorrectly -- that he can no longer work, and the longer he is unemployed, the more his confidence in his ability for future work erodes and his skills atrophy. He is trapped into remaining "disabled" by the fact that he was once very ill but by no means eternally dysfunctional. (If disability benefits are unequivocally indicated, lump sum payments with or without a financial guardian might make better sense than monthly installments.)

6. *enlightened skepticism is in order*: Some veterans who did enter the VA medical/disability system, as Paul McHugh M.D., former chairman of psychiatry at Johns Hopkins University, observed, settled easily into the status of PTSD vet. The diagnosis "conferred a status preferable to such alternatives as personality disorder, alcoholism, or adjustment disorder." Veterans would have been better served by a skeptical stance on the part of their therapists. Loren Pankratz, a psychologist retired from a Veterans Administration Medical Center in Oregon, has written extensively about patients who distort their history and make false attributions about the cause of their symptoms. During his 25 years as a VA psychologist, Pankratz regularly dug into the military records of World War II and Vietnam veterans who told him about especially daring or improbable exploits. Pankratz was not interested in exposing or embarrassing these men, and because he was usually able to redirect them into proper treatment, he had no need to tell them he knew their stories were dramatically embellished. Gradually, Pankratz realized that many failed to improve because they were being treated for the wrong problem. Checking records helped guide Pankratz to more appropriate therapy.

7. *don't suggest pathological interpretations to fragile people*: People who are feeling fragile can be very susceptible to suggestion. From the World War I on, psychiatrists have warned about the power of morbid expectations on soldiers and advocated that clinicians raise expectations of recovery, not disability, in those with acute psychological problems. We know, for example, that debriefing after a crisis – counselor-led groups in which victims are urged to rehash the vivid and terrifying aspects of an event – can actually impede the resolution of stress symptoms. Many times acute symptoms will be a normal and temporary, and yes, very painful, part of the readjustment phenomenon. Predicting that vast numbers of Iraq vets have a future of dysfunction ahead of them, is demoralizing and risks fulfilling the prophesy.

Some soldiers will return from Iraq and Afghanistan with severe psychological problems, and we must do everything in our power to help them. The vast majority, however, will be able to adjust --and imposing on them the questionable legacy of Vietnam will not do them any service. As the British psychiatrist Simon Wessely has put it: "Generals are justly criticized for fighting the last war, not the present one. Psychiatrists should be aware of the same mistake."

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[1] The Centers for Disease Control Vietnam Experience Study. Post-Service Mortality among Vietnam Veterans. *JAMA* 257(1987) 790-795; The Centers for Disease Control Vietnam Experience Study: Psychosocial Characteristics JAMA 259 (1988):2701-7; D.A. Pollack, Rhodes P., Boyle, C.A., et al., Estimating the Number of Suicides Among Vietnam Veterans. *Am J Psychiatry* 147 (1990):772-6; news release. Bureau of Labor Statistics, U.S. Department of Labor, Washington, D.C. Oct. 21, 1994 (cited in Burkett and Whitley 1998, p. 317)

Statement of
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Under Secretary for Health
Department of Veterans Affairs
Before the
Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives

March 11, 2004

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Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear before you today to discuss the programs of the Department of Veterans Affairs (VA) for the care of veterans who may be suffering from posttraumatic stress disorder (PTSD) as a consequence of their exposure to the hardships of deployment and the rigors of combat.

Mr. Chairman, as you are no doubt aware PTSD is not a new condition. There are written accounts of similar symptoms that go back to ancient times, and there is suggestive evidence in the historical combat medical literature starting with the Civil War. PTSD has been observed in all veteran populations that have been studied, including World War II, Korean conflict, and Persian Gulf populations, and in United Nations peacekeeping forces deployed to other war zones around the world.

Careful research and documentation of PTSD began in earnest after the Vietnam War. The National Vietnam Veterans Readjustment Study estimated in 1988 that the prevalence of PTSD in that group was 15.2 percent at that time, and that 30 percent had experienced the disorder at some point since returning from Vietnam. PTSD has also been detected among veterans of the Gulf War, with some estimates running as high as eight percent. Therefore, it would be imprudent to underestimate the potential for appearance on PTSD in veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), particularly since the onset of PTSD symptoms may be

delayed for months or even years following the associated stressful event. I believe that VA has the programs in place and is well prepared to meet the challenges this poses.

Mr. Chairman, on the basis of lists of separated OIF and OEF veterans received from DoD, we currently estimate that 13,580 OIF veterans and 1,798 OEF veterans have received health care from VA for a wide variety of health problems. Thus far, their health problems have been similar to those found in other young military populations seeking health care. Among OIF veterans, 1,927 have been seen for mental disorders, and among OEF veterans, 262 have been seen for mental disorders. For combined OIF/ OEF cohort of patients, 456 have been diagnosed with PTSD, 57 have received a diagnosis of acute stress disorder and 552 have been diagnosed as having depressive disorder. The Vet Centers have thus far served over 4,600 OIF and OEF veterans.

For returning service members who are experiencing emotional and behavioral problems, VA has mental health programs including the Readjustment Counseling program specifically developed to assess and address emotional and behavioral problems associated with the military experience. Within these mental health programs, VA operates a continuum of clinical care for posttraumatic stress disorder in its medical centers and clinics. This is accomplished both through general mental health clinics, through PTSD specialists in general mental health programs and through specialized PTSD programs. VA is recognized world wide as a leader in the treatment of PTSD.

VA medical centers provide a network of more than 100 specialized inpatient and outpatient programs for veterans with PTSD. Each specialized program offers veterans education, evaluation, and treatment conducted by mental-health professionals from a variety of disciplines, such as psychiatry, psychology, social work, counseling, and nursing. I am also pleased that Congress mandated additional funding of $25 million for mental health programs including PTSD programs in P. L. 108-170. We will allocate this funding this year to augment mental health and PTSD program capacity.

On February 3, 2004, the Vet Center program was funded to hire an additional 50 employees for a period of three years with the specific purpose of outreaching OEF, OIF and Global War on Terrorism (GWOT) veterans. Based upon the model of a similar initiative implemented in the wake of the Gulf War in 1991, the plan is to hire recently separated GWOT veterans into these temporary outreach positions. With this additional

staff, Vet Center outreach will focus on 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 will be located on or near active military out-processing stations, as well as National Guard and Reserve facilities. Veteran temporary hires will augment Vet Center services in providing briefing services to transitioning servicemen/women regarding military-related readjustment needs, as well as the complete spectrum of VA services and benefits available to them and their family members. The briefings will outline the entire spectrum of VA services and will encourage these veterans to utilize their local Vet Center as the point of entry into VA. The new hires will also organize local community activities to provide information and education about VA, DOD, and other community support services available to veterans and family members.

A screening instrument in the form of a clinical reminder triggered by the veteran's separation date is being implemented for returning OIF and OEF veterans who come to VA for health care. This assessment tool will prompt the provider with specific screening requirements to assure that veterans are evaluated for medical and psychological conditions that may be related to recent combat deployment.

VA has developed clinical practice guidelines (CPGs) for treating veterans following deployment. These CPGs give health care providers the needed structure, clinical tools, and educational resources that allow them to diagnose and manage patients with deployment-related health concerns. Two post-deployment CPGs have been developed in collaboration with DoD, a general purpose post-deployment CPG and a CPG for unexplained fatigue and pain. On February 27, 2004, VA and DoD released a new CPG on the management of traumatic stress. This guideline pools DoD and VA expertise to help build a joint assessment and treatment infrastructure between the two systems in order to coordinate primary care and mental health care for the purpose of managing, and, if possible, preventing acute and chronic PTSD.

The Veterans Health Initiative (VHI) is a program designed to increase recognition of the connection between military service and certain health effects; better document veterans' military and exposure histories; improve patient care; and establish a database for further study. The education component of VHI prepares VA healthcare

providers to better serve their patients. The VHI program includes a module on PTSD in Primary Care, is designed to increase recognition of PTSD in medical primary care settings. A module was created on "Treating War Wounded," adapted from VHA satellite broadcasts in April 2003 and designed to assist VA clinicians in managing the clinical needs of returning wounded from the war in Iraq. Modules on spinal cord injury, cold injury, traumatic amputation, Agent Orange, the Gulf War, PTSD, POW, blindness/visual impairment and hearing loss, and radiation are also available. Training modules on infectious disease risks in Southwest Asia and on Weapons of Mass Destruction were released in January 2004. We are developing additional modules on military sexual trauma, traumatic brain injury, and pulmonary diseases of military occupational significance.

VA has developed training programs and clinical tools to ensure that our clinicians will be better able to identify and treat problems presented by the newest generation of combat veterans. To further aid VA employees in their efforts to assist OIF/OEF veterans, we have recently distributed a video entitled "Our Turn to Serve" to all VHA and VBA field facilities. The video helps VA staff better understand the experiences of military personnel serving in Operations Iraqi Freedom and Enduring Freedom and explains how they can provide the best possible service to these newest combat veterans. We have also provided copies of this video to Military Treatment Facilities. Additionally, we have created a web page for VA employees on the activities of the VA Seamless Transition Task Force. Included are lists of points of contact for all VHA health care facilities and VBA regional offices, copies of all applicable directives and policies, press releases, brochures, posters, Task Force minutes, and resource information.

VA's National Center for PTSD, created in 1989 in response to a Congressional mandate to address the needs of veterans with service-connected PTSD, has also developed an Iraq War Clinician's Guide. A website version, which can be found at WWW.NCPTSD.ORG, contains the latest fact sheets and available medical literature and is updated regularly. The first version of the Iraq War Guide was published in June 2003. It is now being revised in collaboration with DoD based on our experience with returning casualties. These important tools are integrated with other VA educational

efforts to enable VA practitioners to arrive at a diagnosis more quickly and accurately and to provide more effective treatment.

Readjustment Counseling

VA's Readjustment Counseling program plays a significant role complementing VA health care services with unique service functions not available elsewhere in VA. Our mental health clinical activities and Vet Centers are linked to assure coordination of services to our patients.

Readjustment counseling is provided through a national system of 206 community-based Vet Centers. The Vet Center program service mission features a holistic mix of direct counseling and multiple community-access functions: psychological counseling for veterans exposed to war trauma to include post-traumatic stress disorder, and/or who were sexually assaulted during military service, family counseling when needed for the veteran's readjustment, community outreach and education, and extensive case management and referral activities. The latter activities include a full range of supportive social services designed to assist veterans improve general levels of post-military social and economic functioning. Vet Centers also prioritize care to high-risk groups such as minorities, women, disabled, high combat exposed, rural and homeless veterans.

On April 1, 2003 the Secretary of Veterans Affairs extended eligibility for Vet Center services to veterans of Operation Enduring Freedom. On June 25, 2003 Vet Center eligibility was extended to veterans of Operation Iraqi Freedom and subsequent operations within the Global War on Terrorism. To date the Vet Centers have provided transition services to 4,690 GWOT veterans and their family members. Over 60% (2,731) of these veterans sought care in the first five months of fiscal year 2004 clearly demonstrating the increasing utilization of readjustment services from GWOT veterans and family members.

Since the onset of Operation Iraqi Freedom in March 2003, the Vet Centers have also been conducting systematic outreach to military installations targeted to receive returning troops from Afghanistan and Iraq, with particular attention to National Guard and Reserve personnel returning to their home communities following their deployment.

Vet Center staff visits to military installations and national guard and reserve components promote coordination with DoD family assistance centers to provide a continuum of care for separating service men and women. Within the context of the Vet Center program's outreach activities, family members of service men and women deployed to the Global War on Terrorism are provided with educational information, case management and referral services by Vet Center staff.

On August 5, 2003, the Secretary also authorized Vet Centers 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 Iraq.

Seamless Transition

Mr. Chairman, VA has been working hard, both internally and with DoD, to identify the men and women returning from combat theaters and to provide them the best possible VA service. These efforts have been discussed in previous hearings before the Veterans' Affairs Committee, but bear repeating, since these efforts also focus on providing a seamless transition for veterans who have readjustment or mental health problems. Through the efforts of VA Taskforce for the Seamless Transition of Returning Service Members and the VA-DoD Executive Council structure, VA has put into place a number of strategies, policies, and procedures to reduce red tape and streamline access to all VA benefits. VA's efforts in this regard ensure that veterans' mental health is part of their overall health care, consistent with the goals of the President's New Freedom Commission Report on Mental Health.

Under the guidance of the VA Taskforce for the Seamless Transition of Returning Service Members each VA Medical facility and each VA regional office has identified a point of contact to coordinate activities locally and to assure that the needs of returning service members and veterans are met and that additional contact is made should the veteran relocate. VA has distributed guidance on case management services to Veterans Health Administration and VBA field staff to ensure proper coordination processes and that our expectations are communicated and followed. The guidance

also addresses the roles and functions of the points of contact and case managers. VHA has recently revised its guidance to reflect recent experiences at field stations. The revised guidance will be distributed this month.

Working in collaboration with the military Surgeons General, the Veterans Benefits Administration has detailed two full-time Veterans Service Representatives and VHA has detailed two full-time social workers to the Walter Reed Army Medical Center, the military treatment facility (MTF) receiving the largest numbers of casualties. Beginning in late August 2003, full-time and part-time VHA social workers and VBA Veterans Service Representatives have also been assigned as VA/DoD liaisons to the Brooke, Eisenhower, and Madigan Army Medical Centers, Darnall Army Community Hospital at Fort Hood, and the National Naval Medical Center in Bethesda. They work closely with military medical providers and DoD social workers to assure that returning service members receive information and counseling about VA benefits and programs, as well as assistance in filing benefit claims. They also coordinate the transfer of active duty service members and recently discharged veterans to appropriate VA health care facilities. Through this collaboration, we have improved our ability to identify and serve returning service members that sustained serious injuries or illnesses while serving our country. Over 1,100 hospitalized soldiers have received assistance from VA social workers.

Summary

A service member separating from military service and seeking health care through VA today will have the benefit of VA's decades long experience treating Vietnam and Gulf war veterans. We have been working hard to inform and encourage returning service members to seek available VA services. We have undertaken significant educational efforts and provided clinical tools to prepare our staff to serve these new veterans and we have allocated additional funding for our mental health and Readjustment Counseling programs to assure that we meet the needs of returning OIF and OEF veterans.

This concludes my statement. My colleagues and I will be happy to respond to any questions that you or other members of the Subcommittee might have.

STATEMENT BY

LIEUTENANT COLONEL-PROMOTABLE KENNETH N. BROWN
CHAPLAIN, UNITED STATES ARMY
STUDENT, ARMY WAR COLLEGE
CARLISLE, PA

BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 108TH CONGRESS

Positive Healing Aspects Of Applied Chaplain Pastoral Care To Post-Traumatic-Stress-Disorder (PTSD) Victims: Pre-Combat, Combat, And Post-Combat

11 MARCH 2004

Congressman Simmons, it is a privilege to appear before you to discuss Army Chaplain's provision of combat pastoral care for our soldiers who experienced post-traumatic stress disorder (PTSD).

As Division Chaplain for the 101st Airborne Division (Air Assault) during combat operations in Afghanistan and later in Iraq I saw first hand the effects of PTSD on our fighting force. The beginning of this story though has its roots prior to the entry of soldiers into the combat arena. Pastoral ministry provided to our soldiers and families by U.S. Army Chaplains' begin post-combat, continuing throughout pre-deployment, deployment, reception/staging/onward-movement/integration (RSOI), combat operations, Phase IV SASO, redeployment, and reunion.

Chaplains of the 101st Airborne Division trained in accordance with the core principle of the U.S. Army Chaplain Corps as the centerpiece of preparation for combat. The core principles of the Corps are: "nurture the living, care for the wounded, and honor the dead." This framework for providing pastoral ministry/care enabled the 46 Chaplain's that went into combat in Iraq to focus on taking care of soldiers.

Chaplain's provided comprehensive pastoral care across the full spectrum of operations through out each phase and pushed forward with their assault units

in combat operations just as they had trained. Providing nurture, care, and honor in the face of enemy fire, traumatic wounds, battlefield-chaos, death, and fear. The Army Chaplain's unique positioning at the battalion level enabled chaplains to go forward with infantry and other maneuver units to provide first-line care in helping soldiers deal with immediate trauma producing events. Chaplains were trained to accomplish on-scene defusing which occurred within a few hours of the critical causation event, followed by a more formal debrief during breaks in the action, soldiers were recorded, and follow-up took place later, some during post-combat phase IV operations.

The Critical Incident Stress Management (CISD) framework that chaplains of the 101st Airborne Division (AASLT) trained to standard on proved to be and important tool in preventing some PTSD complications and certainly decreased the effects of PTSD in those who were identified and were cared for within a short period of the trauma.

An integral part of the chaplains success directly correlate to their well-developed spiritual preparedness and their certainty of their "calling" to provide this ministry to soldiers. Furthermore, the majority of the chaplains theologically integrated combat into that sense of call and as a result did not compartmentalize combat as an aberration from pastoral ministry, but saw combat as a (albeit traumatic) though key element of their calling to the military chaplaincy and their responsibility and privilege as a soldier-minister.

Probably the most critical role of the chaplain in providing pastoral care in a combat situation is the sense of bringing with them the presence of God into

the most horrific situations, reviving hope in the face of unspeakable horrors, sights, sounds, and smells; the intangibles become reality in the presence of such courage and fortitude. U.S. Army Chaplains wrote another storied page of selfless service, courage, and honor "For God and Country." They did this alongside thousands of courageous soldiers who faced the uncertainty of combat, the specter of death, and wounds comforted by the steadfast presence of "their chaplain."

The chaplains provided sustainment, encouragement, and spiritual strength during operations involving enemy body recovery and burial and hereto were critical in keeping the fighting strength of our force emotionally, mentally, and spiritually healthy. PTSD is a pernicious depression that is both acute and chronic. The intentional presence and battlefield circulation of the chaplain is critical for infusing hope, encouragement, and counsel for the victims of this scourge.

The unearthing of mass grave sites and the prayers and pastoral care given to the mass grave site teams was another area where the presence of chaplains was indispensable in providing immediate defusing and pastoral sensitivity,

Mass casualty incidents occurred where there were many wounded, some traumatic wounding, and death – chaplains were on-hand or arrived within minutes because of their strategic positioning on the battlefield and proximity to the event. Again, they provided the utmost care, professionalism, empathy, situational awareness, and appropriate counsel to soldiers and leaders alike.

Due to the close relationships that chaplains fostered with their soldiers before combat and building on those relationships during the hardships of deployment and hostilities enabled chaplains to be a unique "go-to" person for soldiers who were experiencing PTSD or other problematic dysfunctions. As well this close bond helped the chaplain identify quickly those who were experiencing the lingering effects of PTSD and provide them personal immediate counsel and assistance.

As part of the their overall mission chaplains continued to provide suicide intervention and prevention training, family and marital issues counsel, personal problems intervention, screenings of home-ward bound soldiers, and PTSD follow up of chronic occurrence or "flare-ups" as always chaplains referred soldiers assessed at risk to appropriate health care professionals.

My personal experience and observation during OIF leads me to unequivocally state that the Army chaplain remains a constant force of good on the battlefield, one who brings a dynamic healing, comfort, and care to soldiers and leaders they cannot get from any other. The 46 chaplains of the 101st Airborne Division (AASLT) during OIF remained steadfast in providing nurture, care, and honor they never wavered. The 101st Airborne Division (AASLT) ultimately lost more soldiers to death than any other combat unit in Iraq. The specter of death cuts a huge wound across the hearts of fellow comrades, these scars will forever remain, but the soothing of the wounds can be rejuvenating and the healing process can bring a real sense of new life to the survivors and instills in many a renewed desire to live lives that honor the sacrifice of their friends.

Chaplains' are the catalyst, beginning with their thorough pastoral relationship establishment with their soldiers, right up to the moment of their initial defusing intervention. The pastoral care chaplains render, not the least of which is their significant pastoral role in the corporate healing process that begins with the memorial services, and concomitantly post-wound ministry, funerals, family care, grief processing assistance, and sustained pastoral ministry that continues long after return to home station.

There is a Latin axiom; "*nemo dat quod non habet*," that is, you cannot give what you do not have. The chaplains of the 101st Airborne Division (AASLT) were prepared and they gave of themselves in such a way that many soldiers benefited tremendously because their chaplain was there and was prepared.

The critical combat pastoral care provided by chaplains to soldiers decreased acute PTSD significantly. The follow on care effectively reduced chronic episodes of PTSD. Once soldiers return to home station the post-combat relationship between chaplain and unit soldiers continues to be pastoral, a pastor is a shepherd, the shepherd takes care of the sheep, those that are well, and those that are wounded – the healing continues, no soldier or family member is left to struggle with PTSD alone. An integral network of support organizations, family care groups, chapel communities, and a host of other service agencies welcome back and reintegrate their soldiers.

It's imperative that the lessons learned about PTSD during this conflict are correctly understood, tem plated, and applied so as to improve on early intervention techniques and prevention of chronic PTSD, the best hope for

accomplishing this objective in my opinion is exemplified in the first-line defender in this battle – the well-trained, uniquely "called," and fully prepared battalion chaplain.

The health and welfare of the soldier is safeguarded by the presence of a well-trained and equipped chaplain who is deployed to the battlefield. The training of chaplains to this level of expertise happens in the training base environment and cannot be accomplished post-deployment. Similarly, chaplains returning from the battlefield must be recipients of post-combat support the same as other returning combat soldiers. This underscores the absolute need for a strong base ops environment of experienced green suited chaplains who understand the military. Pro Deo Et Patria.

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE
ON VETERANS' AFFAIRS

STATEMENT OF

LIEUTENANT CHARLES E. HODGES

UNITED STATES NAVAL RESERVE

CHAPLAIN CORPS

MARINE CORPS RECRUIT DEPOT

PARRIS ISLAND SOUTH CAROLINA

BEFORE THE

SUBCOMMITTEE ON HEALTH

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

POST TRAUMATIC STRESS DISOSRDER AND OTHER MENTAL HEALTH PROBLEMS FROM THE RIGOR OF A COMABT OR HARDSHIP DEPLOYMENT

ON

MARCH 11, 2004

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE
ON VETERANS' AFFAIRS

LT Charles E. Hodges, CHC, USNR

Chaplain Hodges was raised in Ohio and Florida. He earned a BA in Political Science from University of Florida, Gainesville Florida, and a Master of Divinity from Lutheran Theological Southern Seminary (with a focus on pastoral care and counseling). He was commissioned a Lieutenant, Chaplain Corps, USNR in August 1998 and attended Chaplain School, NETC, Newport, RI from 5 October through 24 November 1998. His first assignment after graduation was as Command Chaplain in USS SEATTLE (AOE 3) from December 1998 through December 2000. USS SEATTLE deployed to the Persian Gulf in support of Operation Southern Watch in September 1999.

Chaplain Hodges was then assigned to 2d Marine Division in January 2001. He served with 3d Battalion, 6th Marines (3/6) from March 2001 through January 2003. 3/6 was attached to the 26th Marine Expeditionary Unit (Special Operations Capable) as Battalion Landing Team 3/6. BLT 3/6 was one of the first units to enter Afghanistan in December 2001. Chaplain Hodges' second assignment within 2MarDiv was from 3 February through 3 September 2003 with 2d Assault Amphibian Battalion (2dAABN), which supported 1st Marine Division (1MarDiv) in operation Iraqi Freedom from February through June 2003.

Chaplain Hodges is presently assigned to 2d Recruit Training Battalion at Marine Corps Recruit Depot, Parris Island, SC. He is married to Kristin Henderson.

Chairman Simmons, Representative Rodriguez, and distinguished Members of the Subcommittee:

This statement will focus on the need for military chaplains to be involved in pastoral counseling of veterans returning from combat. A recent professional experience will help introduce the issue. After this anecdote, the logic for chaplain presence and involvement will be presented. It will be followed by a discussion of issues encountered in a battle field setting; examples of the aftermath of a deployment in which the stress of deployment problems were not addressed contrasted against a deployment in which the stress of deployment was addressed; and finally, possible strategies for the ways chaplain involvement can improve the readiness of service members.

Several Marines and Sailors returning from Operation Iraqi Freedom have received new orders to Marine Corps Recruit Depot Parris Island. Each of these people had different experiences in Iraq, saw different aspects of the war, and reacted to it in different ways. One Marine who was part of the push north to Baghdad in western Iraq, returned home and began to experience nightmares, cold sweats, emotional (although not hallucinatory) mood flashbacks, and a feeling of distance from his family. The chaplain of his battalion, aware of my experiences in Afghanistan and Iraq, and my training and professional experience with pastoral counseling issues referred the Marine to me for counseling.

Pastoral communication between military chaplains and eligible employees of the Department of Defense is considered privileged; however, he gave me permission to share his story if I ever found it useful in the Core Value classes I teach to Marine recruits, or in other appropriate settings. He only asked that I not reveal his name or rank.

In counseling situations such as the one with this Marine, I usually allow the individual to guide the conversation. But in the course of the conversation, I am sometimes able to identify and point out possible issues of which the Marine or Sailor may not be totally aware, but which may be contributing to their problems. In this case, the Marine had been reluctant to talk in depth to anyone about the things he saw and experienced in the push north to Baghdad. He felt ashamed because he believed his issues were the result of some personal deficiency. I am not certain when the issues first appeared, but I had the impression from our conversation that he was immediately bothered by his experiences, carried that burden with him throughout the war, and suffered from increased difficulties when he was reunited with his family.

I told the Marine about some of the stress related issues I sometimes deal with in my own life after serving in Afghanistan and Iraq. These include an increased startle reflex, and a strong reaction to weapons fire on the rifle range – when I hear a sudden volley of rifle fire, I jump and sometimes find myself looking at the ground to check for tire tracks or foot prints to indicate those areas where I can walk without fear of stepping on a land mine.

Suddenly the Marine seemed engaged. He told me how one of his recent responsibilities had also taken him out to the rifle range, and after arriving on the range, the first volley made him jump, and for a split second, he thought he was back in Iraq and needed to find a secure place in which to take cover. From there, he started opening up and sharing things with me that he had not told to anyone else.

His first disturbing experience was when he saw the body of a dead enemy combatant. Based on the condition of the corpse, it was obvious that the person had been dead for several days.

This prompted me to share a similar experience of some of the Marines in Afghanistan. In the Khost region of northern Afghanistan, they had discovered fresh graves that had been disturbed and opened. Investigation revealed that the graves contained the bodies of children who appeared to have died from natural causes. The images of these innocent children were haunting several of the Marines and they needed someone to talk to in order to process the event.

I explained to the Marine in the office that he and other Marines in Afghanistan had all been suddenly confronted with their own mortality when they encountered the bodies of other people. By sharing my experiences, the death and the horror I saw, and the death and the horror that other Marines and Sailors experienced, I was able to gain the trust of the Marine in my office that day. I was able to assure him that what he was going through was normal. I offered him techniques that would help reduce some stressors in his life and perhaps diminish others. I also offered suggestions on how he could help his wife better support him as he continued to cope with his experiences in Iraq.

About five weeks later, after the holiday season, we met again. He was feeling closer to his family and was able to enjoy the holiday season with them. Now that he was happier, his wife seemed happier.

This story illustrates how shame, uncertainty, and a feeling of unique isolation can aggravate stress issues associated with combat experience. Seeking out a chaplain can often be a first step towards recovery. Because military law considers conversation with a chaplain to be privileged, service members see chaplains as a safe resource for help. The chaplain can serve as a reality check and a source of unbiased information. The chaplain can either offer initial help in overcoming stress or if the problems persist, recognize the need for referral to qualified medical professionals for specific treatment.

In addition, service members suffering from stress issues associated with combat may seek out their unit chaplain because they have already developed a relationship of trust, borne out of the shared discomfort, misery, boredom and terror of deployment. The chaplain was there with them as they risked their lives in dangerous situations. The chaplain's unique position of trust, confidentiality, and accessibility helps ensure that feelings of shame or fear of exposure will not cause the service member to delay seeking help. Now, more than ever in the history of warfare, the presence of a chaplain is critical to the emotional and spiritual health of service members in deployment situations.

Some writers have suggested that warfare today has become a twenty-four-hour-a-day, seven-day-a-week activity. During the Civil War, combat ceased at sundown when soldiers returned to their camps and sat around the fire to recall the day's events with each other. But with the advent of advanced weaponry, combat can now be conducted at any time and any place. In the past, the threat came primarily from explosives hurling lead, iron, and steel. Today, the stressors are more difficult to identify as combatants deal with the threat of unseen biological, and chemical, and radiological (CBR) weapons, protective head-to-toe suits necessary to defend oneself from bio-chemical attack, suicide bombers, dirty bombs, and asymmetrical warfare on a scale never before seen in history. While past generations dealt with longer separations from home in difficult conditions, the total stress is greater today when one takes into consideration all the strange and terrifying unknowns. And because the stress is constant, there is insufficient time to process it as combatants did in past generations. To help our service members deal with combat related stress, several tools are available.

Strenuous physical activity can help deal with stress. By simply working out, service members can mitigate some of the stress of the day. Another important tool offered by

Chaplains is Critical Event Debriefing (CED) within small groups of trusted peers, guided by a trusted leader, following a format that is proven to diminish the effects of the trauma of combat or disaster situations. This setting is similar to the civil war campfires around which soldiers processed the day's events. Today, one trusted leader, due to the nature of the office, is the military chaplain who serves with the combatants on deployment and is with them in combat.

Comparing my return from Afghanistan with Battalion Landing Team 3/6 (BLT 3/6) to my return from Iraq with 2d Assault Amphibian Battalion (2dAABN) will help illustrate how effective CED with chaplains and other mental health professionals in the field can help reduce stress in combat veterans.

Due to limited transportation assets, BLT 3/6 returned from Afghanistan to their ships in the Indian Ocean over a period of about two weeks. For several weeks the ships of the amphibious readiness group remained in the area in the event they were needed for further operations. When we received the order to return to the United States, circumstances prevented us from arriving home until three months after our retrograde from Afghanistan.

In Iraq, after 2dAABN, in support of 1st Marine Division, reached Baghdad, we were soon ordered to move south to a city closer to the Kuwaiti border. We remained at that city for several weeks, waiting for our turn to move to Kuwait for one of the limited flights out of the area. Marines and Sailors were free to move about when they were not on duty. Although they were restricted from going beyond a certain distance or into areas suspected to be unsafe, they were not as confined as they would have been aboard a ship. They were also free to relax whenever they had completed their appointed duties. Since the area was considered safe and the threat of CBR attack highly improbable, the greatest stress was waiting for the next mail

shipment. Marines and Sailors had time to share their experiences when they were comfortable doing so.

When we received word that we would soon be moving south to Kuwait for flights home to the United States, I began developing a stress control class to be presented to all hands before we left our last position in Iraq. Over a three-day period, all Marines and Sailors received basic guidelines on how they and their fellow Marines could practice CED, focusing on the main points necessary to reduce stress in their lives as part of our combat and operational stress control efforts.

Despite the fact that 2dAABN was flown from Kuwait to the United States in less than twenty-four hours, and before that endured worse conditions than BLT 3/6 in Afghanistan, I ministered to fewer post deployment issues than I did after Afghanistan. While this is non-scientific, anecdotal evidence, and other variables were undoubtedly at work, it does suggest that the presence of a trusted chaplain helps with prevention of stress related problems after deployment.

In my present assignment at Parris Island, I have come to believe that if time and resources permit, effective prevention of stress related issues should begin in basic training. They would also be given the tools they will need to mitigate the effects of the emotional trauma and stress that comes with war. Helping recruits recognize that life includes death, and that everyone eventually dies, may help recruits with the day they are finally confronted with their own mortality, and help them work through the trauma of violent death, whether it occurs on the battlefield or due to accidents or disasters.

The military chaplain, especially one who was with the unit as they went into battle, is viewed as a trusted, confidential, and accessible resource. His office, in garrison, or under a tree

or shelter-half in the field, is considered a sanctuary for military personnel. The chaplain can be a safe resource and asset in helping the troubled service member. And if the chaplain recognizes that the service member needs professional help beyond the skill level of the chaplain, the service member's trust in the chaplain will help overcome the denial, resistance, and shame that might otherwise prevent the service member from seeking necessary assistance.

You cannot put a price on emotional and spiritual well-being. Sea Service Chaplaincy is a critical dimension in fostering the holistic well being of Sear Service personnel. The U.S. Navy Chaplain Corps seal says it best, - Vocati ad Servitium - We are called to serve.

Written Presentation

By CDR Mark A. Jumper, CHC, USN
Project Officer, USMC Warrior Transition Program
Provided for the U.S. House Committee on Veterans' Affairs, Subcommittee on Health
334 Cannon House Office Building
0930, Thursday, 11 March 2004

1) Background

It is clear, from research and experience, that certain dynamics occur in the lives of military personnel exposed to the trauma of combat and hostile environments. Post-Traumatic Stress Disorder (PTSD) is a familiar result. These dynamics are common to these veterans from all times and cultures. Dr. Jonathan Shay's landmark book, Achilles in Vietnam: Combat Trauma and the Undoing of Character, dramatically demonstrates this commonality between the experiences of ancient warriors, as illustrated by Homer in the Iliad and the Odyssey, and modern warriors, such as the Vietnam veterans seen by Dr. Shay in his practice.

The U.S. Marine Corps, recognizing this reality, implemented in June 2000 a very fine program and policy to deal with combat stress in the field, found in Marine Corps Reference Publication (MCRP) 6-11C, *Combat Stress*. This manual deals with prevention, identification, and care of combat stress casualties, provided by interdisciplinary teams including medical and chaplain personnel.

The U.S. Coast Guard, in the meantime, makes extensive use of the Critical Incident Stress Management (CISM) program in order to assist personnel following their frequent encounters with death and trauma in operations. During my service with the Coast Guard in Miami, I became aware that all personnel, not just those displaying symptoms, can benefit from programs that help them cope with their experiences. A person who deals with several traumas, without apparent ill effect, may cross a threshold of saturation when the next trauma is encountered, causing symptoms to emerge. The Coast Guard, using its program of post-trauma debriefs, endeavors to detoxify its personnel in order to keep them from reaching that saturation threshold. This is done for all personnel that encounter trauma incidents, whether they display symptoms or not.

The U.S. Navy Chaplain Corps, which provides ministry to all the sea services—Navy, Marine Corps, Coast Guard, and Merchant Marine—first trained all its chaplains to serve as CISM team members in FY1998. This training was supplemented with an additional module entitled, "Warrior Transformation," which dealt specifically with combat stress and its aftermath. One of the principles of such programs is to provide them in the field, soon after personnel complete their operations.

2) Program History

The Chaplain of the Marine Corps, Rear Admiral Louis Iasiello, now Chief of Navy Chaplains, assigned me in February 2002 to design and implement a warrior transition program

for Marines deployed to Afghanistan and Pakistan as part of Operation Enduring Freedom (OEF). Chaplains assigned to CREDO units would provide this program. CREDO is a retreat and seminar program, founded in 1971 to serve returning Vietnam veterans. There are now ten CREDO units in the Department of the Navy worldwide. CREDO chaplains are especially trained and experienced to deal with deep personal issues, the emotional aspect of those issues, and helping personnel find profound healing. The Commandant of the Marine Corps approved the pilot program design and provided complete funding for several team deployments, along with a climate of strong support.

Our original plan was to provide this Warrior Transition program near the field of OEF operations. However the Marines rapidly completed their OEF mission and were relieved by Army units. Our CREDO team therefore provided the pilot program at Camp Pendleton for 500 OEF veterans, in April 2002. These Marines gave the program very positive reviews, but recommended that it be provided on their way home.

Our next deployment, in November 2002, featured a CREDO team providing the Warrior Transition program for over 1,500 Marines of the 11th Marine Expeditionary Unit as they returned from a Middle East deployment that was frustratingly routine, except for the death of two Marines at the hands of terrorists in Kuwait. With essential support provided by the Commanding General, Marine Forces Pacific, we were able to meet the Marines in Australia, and provide the program as they sailed homeward. Over 94% of participants stated that they would recommend the program to another Marine.

CREDO chaplains then provided Warrior Transition for homeward-bound Marines on the Atlantic side, and for Reserve Marines completing their one-year call-ups at Camp Lejeune.

I consider it Providentially fortuitous that the three CREDO directors most directly involved with the Warrior Transition Program—CDR Dan Stephens at Camp Pendleton, LCDR Ron Ringo at Camp Lejeune, and myself—had all come directly from Coast Guard billets in which we were thoroughly experienced in response to real-world operational trauma, and the use of CISM programs. While Warrior Transition is not a CISM program, it does use some insights, wisdom, and practices of the CISM community.

Following Operation Iraqi Freedom (OIF), the Commandant of the Marine Corps issued a directive (ALMAR 032/03, signed 05/18/2003) that every Marine returning from OEF and OIF receive the Warrior Transition program, in-theater, before returning home. A CREDO chaplain team (active and Reserve) from Camp Pendleton then deployed to Kuwait and Iraq. We provided the program directly for thousands of Marines, Sailors and Soldiers assigned to the I Marine Expeditionary Force. We also trained dozens of chaplains to provide the program for those personnel assigned to their units. Marine commands, in accordance with the Commandant's guidance, were impressively thorough to insure that no personnel left the theater without receiving the Warrior Transition program. Surveys of participants continued to be strongly positive regarding their views of the program's usefulness.

The Warrior Transition program is now being institutionalized in the Marine Corps. Homeward-bound Marines receive the program from teams composed of deployed CREDO

chaplains, and their own unit chaplains. CREDO Pendleton provided the program, just last month, deploying to join the latest returning Marine Expeditionary Unit at Guam.

The Navy has also begun to use a similar program, provided by Mobile CREDO teams. Initial field tests with Sailors, even using Marine-oriented programs, brought highly positive responses. CDR Rick Silvieira, CREDO San Diego director, pioneered a program design specifically oriented toward Naval units. A Navy program was first offered in January 2004 for the USS ENTERPRISE battle group, deployed in the Persian Gulf, by a team led by CDR Bob Pipkin, CREDO Norfolk director.

CDR (Select) Dale White, directly supervising the CREDO program at the Office of the Chief of Chaplains, oversaw the formation and operation of the Warrior Transition program. His vision and wise supervision have been essential to getting the program up and running so successfully.

3) Program Sources

Warrior Transition is a chaplain-based spiritual ministry, using insights and principles found in the works of several authors and researchers in the field of military operations. These include:

Grossman. Dave (LTC, USA (Ret.), former professor at U.S. Military Academy, West Point, NY). *On Killing: The Psychological Cost of Learning to Kill in War and Society.* Back Bay Books, 1996.

International Critical Incident Stress Foundation, Inc., Ellicott City, MD.

Hanson, Victor Davis. *Carnage and Culture: Landmark Battles in the Rise to Western Power.* Doubleday, 2001.

Keegan, John. *The Face of Battle.* Viking Press, reprint 1995.

Shay, Jonathan. *Achilles in Vietnam: Combat Trauma and the Undoing of Character.* Scribner, 1995.

_____. *Odysseus in America: Combat Trauma and the Trials of Homecoming.* Scribner, 2003.

The following were also used as consultants and trainers for the Warrior Transition program:

Peter Bauer, LCSW, LMFT. Clinical Social Worker, Mental Health Clinic, VAMC Kerrville, TX.

Jonathan Shay, M.D., Ph.D. Psychiatrist, Veterans Administration, Boston, MA.

Carl Washburn, M.D. Psychiatrist, Hartford, CT; former Recon Staff Sergeant, USMC.

In addition, an effort was made to coordinate with the interdisciplinary Operational Stress Control And Readiness (OSCAR) program, led by psychiatrists, sponsored by Headquarters Marine Corps and piloted at Camp Lejeune. This thorough program, including all phases of deployment from preparation forward, was still in the pilot phase during OEF and OIF. MARADMIN 428/03, signed 09/15/2003, guides the expansion of OSCAR to all three Marine divisions for a two-year evaluation period. OSCAR offers great potential for chaplains, mental health professionals and experienced Staff Non-Commissioned Officers (SNCOs), working together, to provide a most impressive program.

When it comes to working in areas of mutual concern with other helping professionals, we chaplains strive for teamwork as colleagues, not competitors!

4) Program Goals

The goals of the Warrior Transition Program include:

Recognize warriors for their service and sacrifice, and thank them for their contributions.

Unlike classic Return & Reunion programs that focus primarily on homecoming and readjustment to society, to focus on the warrior's own soul and personhood, as it has developed particularly in response to combat and hostile environments. Those personnel who have prepared for months for combat, even if they do not encounter it, will experience certain dynamics in connection with their preparation, and their transition back to normal society.

Help the warrior recognize, evaluate and manage experiences that have been encountered, and changes that have occurred within. We call this a mental and spiritual washdown.

Model for the warrior the positive role of debriefings as an opportunity to honor and process one's experiences in positive ways. Debriefings may beneficially occur, both informally among unit members (Ref. Grossman, "group absolution"), and formally in programs such as ours.

Give the warrior essential information and training regarding the dynamics of combat preparation, combat experience, and trauma, introducing the warrior to these helpful concepts.

Help the warrior avoid and/or repair highly toxic thoughts and behaviors, such as violations of what's right (especially committed by one's own side), and dehumanization of the enemy.

Encourage the warrior to intentionally seek an integrated balance in life of positive physical, mental, and spiritual practices.

Prepare the warrior for readjustment to society in terms of those dynamics and experiences related above. Encourage the warrior to assertively reintegrate into society, and to share experiences (AS APPROPRIATE) for the benefit of self and of society.

5) Some Recommendations

Personnel that experience Acute Stress Disorder (ASD), due to multiple strong stressors and traumas, can best be helped during a four-week window from the onset of such stimuli. Such intervention, during that time, can delay or prevent the onset of PTSD.

Personnel should be kept together with their units during the post-combat or post-trauma period, and if possible, return together. The separation of unit members from each other, prior to the unit's return home as a whole, can be devastatingly unhealthy.

Personnel leaving combat and hostile environments are best served by a slow, deliberate return to society. "A slow boat home" is the best possible transition. Should air travel be used, personnel should have a deliberate transition time at some intermediate point prior to return.

Continued mutual check-ups among unit members, frequent self-checks, and continued command monitoring of personnel, are highly desirable following return.

Personnel who are empowered to understand what they've gone through, and know what steps they can take in response, are best equipped to proceed in life free of debilitating, destructive disorders.

6) What Chaplains Offer

Chaplains offer an integrated, whole-person understanding that actively includes physical, mental, and spiritual factors. It is this combination of all three factors that offers the best hope of quality living for those who have experienced combat and trauma. The spiritual ministry of chaplains, taking into account many physical and mental insights, and often offered in conjunction with social work, medical and mental health colleagues, provides a resource found nowhere else.

Those exposed to combat and trauma have experienced, in the most profound and searing ways possible, ultimate questions of life, death, fate, purpose, and meaning. While physical and mental treatments can be of great help in dealing with such experiences, it is essential to include chaplains, specializing in exactly those ultimate questions, in the treatment team and plan. Only such quality, professional spiritual service, in conjunction with every other resource we can offer, holds hope to help our veterans find those answers, and that positive future, that they have earned so dearly.

A Christian Scripture, speaking from its particular perspective, speaks well to these universal issues: "Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies and God of all comfort, who comforts us in all our tribulation, that we may be able to comfort those who are in any trouble, with the comfort with which we ourselves are comforted by God.

For as the sufferings of Christ abound in us, so our consolation also abounds through Christ. Now if we are afflicted, it is for your consolation and salvation, which is effective for enduring the same sufferings which we also suffer. Or if we are comforted, it is for your consolation and salvation. And our hope for you is steadfast, because we know that as you are partakers of the sufferings, so also you will partake of the consolation." (2 Corinthians 1:3-7)

7) Conclusion

We in the Warrior Transition program are deeply grateful, and feel particularly privileged, to have been entrusted with the hearts and minds of our deserving veterans. Our program is rather modest in scope. We may not work wonders in a sixty- to ninety-minute program (though God may!). But we can accomplish some valuable things to help our veterans. We do it from a powerful perspective of Divine belief, and spiritual reality, that we wish to make available to every veteran. We are trained to make such an offer in such a way as to completely respect each veteran's own beliefs. This offer, we believe, will be found beneficial by many. Such is our hope; such is our prayer; and such is our plan, with God's help.

Thank you, from the heart, for this opportunity to share our story. May God bless you in your mission. And may God bless America, and those who serve her together, one nation, under God!

Statement
of
Chaplain Robert W. Mikol
Department of Veterans Affairs
VA New Jersey Health Care System
on
Role of Department of Veterans Affairs (VA) Chaplains for Veterans
Suffering from Post-Traumatic Stress Disorder (PTSD)
before the
Subcommittee on Health
of the
Committee on Veterans' Affairs
U.S. House of Representatives

March 11, 2004

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Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear before you today to discuss the role of Department of Veterans Affairs (VA) Chaplains in providing pastoral care for veterans who suffer Post-Traumatic Stress Disorder (PTSD) and other mental health problems from the rigor of a combat or hardship deployment.

Post-Traumatic Stress Disorder Psychiatric Residental Rehabilitation Treatment Program (PRRTP)

The VA New Jersey Health Care System provides the outpatient PRRTP at the Department of Veterans' Affairs Medical Center, East Orange, New Jersey, and the inpatient PRRTP at the Department of Veterans' Affairs Medical Center, Lyons, New Jersey. Both medical centers share the responsibility for extended outpatient care to veterans of all conflicts. I am Primary Chaplain to the PRRTP on the Lyons Campus. The Lyons PRRTP is a 45-day, 24-hour inpatient program. The model for treatment is an inclusive multi-disciplinary team approach of psychiatric, medical, psychological, social, spiritual/religious* and support staff. The focus of the therapeutic model is

intense group and individual counseling settings by the mental health and social services staff members. Our unit has a 25-bed maximum capacity.

As one of two assigned Chaplains to the PRRTP at Lyons, I have the honor and privilege of recognition as a member of the healthcare team. I participate in team reviews and have conferred with clinical members regarding veterans' spiritual/religious issues as presented in this therapeutic treatment. I accept and receive referrals and consults from clinical staff to enhance the progress of the clinical rehabilitation of the veteran. Veterans are encouraged and invited to establish private appointments with the Chaplains and most accept this invitation to do so. The clinical team is aware of the significance of spiritual/religious/moral/ethical values and beliefs in the lives of combat veterans. Hardship or combat tours may have PTSD spiritual/religious influences; this lasting impact may occur during combat or well after repatriation. PTSD Chaplains are uniquely trained and familiar with combat related spiritual/religious issues either by personal experience with these issues or through the wisdom of years in ministry with combat veterans. Chaplains also document in veterans' charts relating opportunities used by veterans for counsel or instruction. Issues with direct clinical relevance are cited in the interdisciplinary notes as well as formal spiritual assessment for each veteran.

Confidentiality provides the veteran the freedom to share openly and honestly his/her feelings and difficulties with beliefs, values, morality, and ethical questions related to their declared God/Higher Power, themselves, their significant others, families, and their military experiences. Chaplains are available 24 hours/day for pastoral care to all veterans. Crisis care is provided in the case of immediate need during a veterans' program tour such as death in the immediate family or other critical event. Chaplains also provide unit didactic group settings in the program such as Feelings Group and Survivors' Guilt Group for inpatient and outpatient veterans. Chaplains will assist veterans with Twelve-Step Programs in alcohol and drug abuse rehabilitation when requested by the staff or veterans.

A vital event of the Lyons PRRTP is a visit to the National Vietnam Memorial in Washington, D.C., every six weeks. This is a mandatory field trip for all inpatient veterans. The visit begins in the early morning and ends in the evening with return to the hospital. I accompany staff and veterans as their Chaplain to assist with grief and separation when confronting the names of lost and missing comrades. A significant obligation and responsibility of the Primary Chaplain for PRRTP is to invite veterans to share with each other the names and memories of lost or missing friends who are inscribed on "The Wall." Warmly named "The Gathering," this experience provides veterans opportunities to commit their friends to "The Books of Heroes." This experience enhances grieving, sharing, and bonding among veterans as well as closure. Chaplain Service has been awarded national "Best Practice" recognition for this event.

The PRRTP invites veterans to an annual PRRTP Reunion each year on the campus. Veterans who have completed the 45-day tour are invited to fellowship with their significant others and veterans of earlier and later unit groups. Food and entertainment are provided for families and close friends.

The Chaplains are available and regularly present information to the staff and veterans regularly on and off the unit. The acceptance and welcome of Chaplains is a valued enhancement to the mission of the PRRTP.

Spiritual Issues and Injuries of Combat Veterans

I have served our veterans as a full-time Clinical-Pastoral Chaplain for over 15 years within the PRRTP at the Lyons Campus of the VA New Jersey Health Care System. Pastoral responsibilities are vastly different with veterans diagnosed with mental health and PTSD from the rigors of combat and/or hardship deployments. Training for Chaplains in PTSD is adequate but not specific to the ministry of Chaplaincy. Chaplains participate in all disciplinary, mental health, and PTSD training offered throughout VA as well as the Department of Defense and private sector settings. However, most of the

experiences and wisdom is acquired through close dialogue with clinicians and other mental health Chaplains especially those who have experience with PTSD combat veterans. Simply stated, Chaplains learn by experience the critical issues of combat-related trauma and its impact upon the spiritual/religious/moral/ethical dimension of a person. I will list here the spiritual issues and injuries that I have confronted in my years as Clinical-Pastoral Chaplain in the PRRTP at Lyons.

1. Lack of meaning and/or purpose in life
2. Hopelessness in personal efforts to return to God, family, and self
3. Inability to control emotions, passions, and behavior
4. Rage
5. Fear
6. Revenge against members of the cultures/nationalities of "the enemy"
7. Distrust of government systems and some political principals
8. Isolation from family, friends, and society
9. Lack of empathy or sympathy for others and systems
10. Diminished trust in spiritual/religious beliefs, values, denominations, and clergy
11. Guilt regarding responsibility for death or injury to fellow combat veterans and the perceived responsibility for their capture or death
12. Loneliness due to the feeling that "intimacy is painful"; separation, injury, or death of loved ones reflects upon responsibility to protect and to serve others
13. Grief over the loss of innocence, morality, faith values and beliefs, commitments, and the loss of fellow combat veterans and friends
14. Survivors' Guilt is the perceived responsibility of expectations not fulfilled to prevent injury and/or death or to survive while others did not survive
15. Depression
16. Dysfunctional relationships in marriage, family, employment, and with systems such as communities of faith and government agencies

17. Battered self-esteem, self-worth which discounts positive feelings of duty, honor, sacrifice, and bravery

This listing is as inclusive as possible. Degrees of intensity and depth are not expressed here due to the inability to address the pain, brokenness, and desperation of combat veterans to their military experiences. Many veterans revisit and reprise their trauma during the calendar year, especially when the months reflect the period of the year the initial trauma occurred for them. This reprising of the "anniversary" adds more stress to Clinical and Chaplain personnel and resources.

Model of Ministry to Combat Veterans of PRRTP

I will outline the result of years of experience with our combat veterans on and outside the PRRTP from my tour of duty of over 15 years at the Lyons Campus, veterans outreach centers, and community-based outpatient clinics of the VA New Jersey Health Care System.

Veterans teach Chaplains about their pain and brokenness. Chaplains must actively listen, actively observe, discern, and learn from veterans before he/she can effectively minister, shepherd, and understand their lives. This is my "prime directive" of ministry to combat veterans diagnosed with PTSD and mental health disorders.

I must accept the individual veteran as he/she presents him/herself to the team and to the Chaplains. Projecting or transferring from the Chaplains' experience or life events diminishes ministry and pastoral care.

Chaplains must not be judgmental or convicting of the integrity of the veteran. Combat veterans have convicted and condemned themselves over years of regret, guilt, and shame. A Chaplain must acknowledge and validate this in the veteran and begin to rebuild and resurrect the spiritual core of the veteran in understanding the context of

war, conflict, and the role of the warrior. This requires humility and strength in the Chaplain and in the veteran.

The Chaplain reflects to the staff and veterans a Power Greater Than All of Us. This Power is identified by many names and understood in many interpretations. Rage against the Chaplain may not be personal but in many instances against whom the Chaplain represents to the veteran. The God/Higher Power who is condemning will solicit rage from the veteran as the God/Higher Power who is forgiving and compassionate will solicit surrender from the veteran. A Chaplain must discern this and begin pastoral care from that point in the veteran's experience.

A Chaplain must be supportive and empathetic to the pain, suffering, and brokenness of the veteran and his/her family. This would allow opportunities to invite spouses, children and significant others into counseling and pastoral care. This is by invitation not by demand, as the veteran will not allow control of the family beyond his/her influence at times.

Chaplains by role and representation challenge the veteran and his/her present life values and behavior, positive or negative. Chaplains celebrate the accomplishments and challenge patiently to evaluate alternatives to failures. This is an exciting and fulfilling dimension to ministry with combat veterans.

A mode of operation I believe in ministry to combat veterans that has been learned by trial and error over the years is not to be political about foreign national policies with combat veterans. This encourages diversion from the more critical spiritual/religious issues of trauma, combat, and repatriation. I express to the veteran when conversations evolve into the political justifications or assumptions of war that the issues are more profound in him/her than political policy judgements. In group settings, I encourage spirituality issues rather than religious issues. Our veteran population on the unit is diverse in faith expressions from orthodox to unaffiliated to any belief system. These consults are delegated to private counseling sessions other than group settings.

A Chaplain is a person who has the competence, ability, skill, talent, and mission to partner with veterans to reestablish belief and faith. The resources are varied and many in ministry to accomplish this in Chaplaincy. Chaplains enrich understanding through teaching, counseling, and advising in supportive ways the latent spirituality of the veterans. The uniqueness of Chaplains within VA and the Department of Defense is the ability to integrate the healing into a life filled with pain and distrust. The former complements the latter. The mercy and healing grace of God will restore the deficits and guilt/shame of decisions and actions of the past and present. This I call "conversion of the spirit."

In conclusion, I would summarize the Chaplain ministry to combat veterans diagnosed with PTSD and mental health disorders as walking with a veteran from the "valley of the shadow of death" to the light of the honor of warrior as understood in the ancient codes of valor. In other words, each day of Chaplaincy I repeat to myself, "Today I must walk with each of them from the place of victim to the place of survivor...victorious, honorable and on the way to peace and integrity."

Resources of Ministry

Scriptural and ancient teachings of the Bible, Torah, Koran, Gita etc;
Cultural, literary and the fine arts;
Meditation, prayer, rituals and rites;
Faith Group Chaplains, community clergy;
Interdisciplinary clinical professionals, journals, and papers;
Dr. Elisabeth Kubler-Ross: Death and Dying; Grief;
Eric Erickson: Personality Development;
Twelve-Step Programs for Alcohol, Drug Addiction, and PTSD;

* "spiritual/religious" is defined as follows: "...spiritual" qualities of the heart, mind, and soul of a person; that is emotional, rational, and intangible qualities (love, hate, sadness, joy, peace, hope, courage, etc.) unknown to others and core to a person's beliefs and values; "...religious" is acting out, living, and manifestation of values, beliefs; sharing and teaching others those qualities that each possesses within themselves.

Statement of
Father Philip G. Salois, M.S.
VISN 1 Chaplain Program Manager and Chief, Chaplain Service – VA Boston Healthcare System
Before the
Subcommittee on Health
Committee on Veterans' Affairs

March 11, 2004

Thank you, Mr. Chairman and Committee Members, for the unique opportunity to be here to address all of you on an important subject very near and dear to my heart -- the psycho-spiritual effects on men and women who have participated in and witnessed first-hand the horrors of war on the battlefield.

Let me first of all preface my remarks by giving you a small picture of what qualifies me to speak to the subject. At the age of 20, I was drafted into the United States Army and served as a combat infantryman from 1969-1970. As a result of leading a rescue mission on March 1, 1970, I was awarded the Silver Star. I also served 12 years in the United States Army Reserves as a Chaplain in hospital units; my last assignment was with the 883rd Medical Company (Combat Stress Control). In addition, I have worked for the last 15 years as a Chaplain in the VA Boston Healthcare System with a special focus on PTSD and spiritual healing.

Having gone through an extensive journey of healing myself, and the journey is not over, I can speak as a witness to the fact that when one has been exposed to war up close and personal, that person is forever changed, scarred and spiritually wounded. Even with the best of foreknowledge and training available, there is absolutely nothing that can prepare a young man or woman for the horrors that war will embed in one's mind, heart and soul. That being said, it is important to learn from lessons from the past, particularly the war in Vietnam and the devastating effects it has had on thousands of men and women. We share the experiences and the wisdom we have gained for our young men and women returning from Iraq and Afghanistan.

The February 15th issue of the New York Times Magazine featured a lengthy article entitled "The Permanent Scars of Iraq" by Sara Corbett. It relates the story of a

few returning soldiers from the 101st Airborne Division who were wounded both physically and psychologically. Reading this article transported me back some 30-plus years as something that could have been written in the 70's – only the characters and geography have changed. Sleepless nights…nightmares….flashbacks….self-medicating with alcohol and drugs…..not communicating with the spouse…..thousand yard stare, and the saga rages on. The psychosocial-spiritual effects of war are universal as I learned when I met war veterans from all over the world at the First International Conference of Psycho-Social Consequences of War in Dubrovnik, Croatia in April 1998. There is a common denominator among persons who have engaged in hostile fire in time of war, and that common denominator is deep-seated wounds at every human level. The memory is forever branded into the fabric of one's life.

How do we meet the challenge of reaching out to our brother and sister veterans who have been to hell and come back to talk about it? It is often said in the circle of ministers I associate with that, "*Religion is for those afraid of hell…and spirituality is for those who have been there and don't want to go back!*"

Veterans Affairs Chaplains are certified and clinically trained to serve the spiritual needs of the returning veterans from Iraq and Afghanistan. It is of paramount importance that VA Chaplains play in integral role on the mental health inter-disciplinary teams in our medical facilities. They continue to provide excellent one-on-one spiritual and pastoral counseling to our veteran patients. They also facilitate spirituality groups for those suffering from PTSD and substance abuse. In fact, there are two 12-step models that have been drafted with a special focus on PTSD modeled after the 12 steps of Alcoholics Anonymous.

In 1989, I founded the National Conference of Viet Nam Veteran Ministers, an organization comprised of people like myself who served in Vietnam as enlisted men and women and later answered the call to ordained ministry. We also invited Vietnam Chaplains to join. The purpose was to share our trauma stories with one another on the level of faith and spirituality so that we could receive affirmation and healing of our souls. It truly was and still is a clinic for wounded PTSD-ridden ministers. As an outgrowth of this organization, which is better referred to as a community, we began to explore ways of sharing our stories with combat veterans. Combat veterans, by the very

nature of their exposure to battle, i.e. killing and witnessing death, develop a poisonous world-view causing a wounded "Imago Dei." This phrase, "Imago Dei", or Image of God refers to the belief that all persons are created in God's image. That wounded "Imago Dei" is characterized by secret-keeping, loss of voice and self-enforced separation. Secret-keeping – how can I ever talk about what I witnessed and participated in on the battlefield to my spouse, my children, my friends? As a result this causes us to lose our voice. If we are keeping secrets, then we stop communicating, which then forces the third factor – self-enforced separation, isolation or more commonly referred to as *"bunkering in."* Our combat veterans experience deep guilt, which comes in many forms: guilt from killing or maiming civilians, children who may be booby-trapped or enemies disguised as friendlies. It could be guilt over a mistake, which caused the mutilation or death of a comrade. It could be guilt over being a survivor when buddies were killed. The list goes on.

One way the National Conference of Viet Nam Veteran Ministers found to be helpful was to develop a Spiritual Healing Weekend Retreat Program for combat veterans and their spouses or significant others. In the past seven years we have offered 15 of these retreats throughout the country. Although it is a mere drop in the bucket, veterans and their families have been greatly comforted and assisted spiritually in these retreats. Many couples have come back to these retreats and brought other couples with them. We felt it was important to try to get the veteran to bring their spouse or significant other to these retreats, because our goal was to help heal the family and not just the veteran – to re-open those doors of communication, the lack of which can destroy a relationship.

The main point I want to make before this committee is the importance of making the combat veteran, particularly those who are now coming home from overseas deployment, begin the process of telling their story to someone who can encourage them and guide them in a healing, loving and accepting manner. They may feel they are "damaged goods." The role of the Chaplain is to help them recognize that their experience offers them a unique perspective on the meaning of life and that their suffering is not meaningless but can be redemptive. The Chaplain can help the veteran learn what it means to be a *"wounded healer"* – which the veteran in his or her woundedness can help heal another wounded veteran. That is the gift of life one person

can give to another. The theory of the Sacred Story we teach them is the use of their personal story as a vehicle of healing. The development of one's unique story through eyes of faith and ultimately the redemptive value of their Sacred Story can move them from a state of being "scared," recognizing that they are "scarred," and ultimately seeing themselves as "sacred." It is a far greater task for the minister to guide the veteran in this direction than moving letters around in a word-play but it gets the point across. We tell our veterans that there is no one else on earth like them, just as there are not two fingerprints the same, neither is their story. It is a true gift of love when they can speak the story with all the trauma, pain, suffering, tears and emotions, and share that story with another human being who is hurting.

Over the years, I cannot count how many Vietnam veterans and veterans from World War II and Korea I have counseled but the end result of war and its impact on our psyche is the same. I, along with my colleagues, welcome the opportunity to reach out to the returning soldiers, marines, sailors and airmen and women to begin that healing process so that it does not begin to fester and grow like a cancer that eats away at the core of their being. If we knew back in the 70's and 80's what we know today, how many lives could have been saved? How many marriages could have been saved? Who knows?

Thank you once again for the opportunity to address this esteemed body.
Father Philip G. Salois, M.S.

United States House of Representatives
House Veterans Affairs Committee
Subcommittee on Health
Status of Veterans with PTSD who may be suffering from post-traumatic stress disorder as a consequence of their exposure to the rigors of combat and hardship deployments
March 11, 2004

Testimony of Matthew J. Friedman M.D., Ph.D
Executive Director
National Center for PTSD
VAM&ROC White River Junction, VT
&
Professor of Psychiatry and Pharmacology
Dartmouth Medical School

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 (PTSD). 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 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: to provide treatment for veterans with PTSD; to support research on scientific questions concerning the etiology, clinical course and treatment of PTSD; to provide education and training to VA professionals in order to improve their clinical skills regarding PTSD-related problems; and to provide appropriate adjudication of PTSD disability claims in a timely manner.

During my five-year term (from 1984-1989) as Chairman, the Special Committee submitted annual reports to Congress concerning the status of VA PTSD programmatic capacity. As a result, I acquired a national perspective on VA clinical, research and educational programs and I will draw on that experience in my subsequent remarks. My focus since 1989, when I was appointed Executive Director of the National Center for PTSD, has primarily been on research and education. I have remained informed about VA's clinical capability, however, as an ex-officio member of the Under Secretary for Health's Special Committee on PTSD currently chaired by Harold Kudler, MD, who will be providing his own testimony at this hearing.

In short, I have been treating veterans with PTSD for over thirty years, since 1973, and I have had a national perspective on VA's PTSD programs for twenty years, since 1984.

From these perspectives, there is much to be optimistic about regarding VA's capacity to meet the growing mental health demand that is being created by military returnees from Iraq and Afghanistan. Unfortunately, there are also major areas of concern.

From the late 1980's to mid-1990's VA had dramatically increased its inpatient, outpatient (PTSD Clinical Teams, PCTs) and Vet Center capacity to meet the growing clinical demand by veterans with PTSD. This growth in available services was greatly enhanced by new dollars created by congressional actions. Along with expanded resources came a growing sophistication by VA clinicians who collectively constitute the most skilled and experienced group of PTSD practitioners in the world.

In recent years, however, budgetary pressures have affected this capacity in three ways. In some VISNs, PCTs have been functionally dismantled and merged with institutional Mental Hygiene Clinics. In other VISNs, PCT staffing has been eroded compromising institutional capacity to meet veteran demand for PTSD treatment. Elsewhere, PCTs have remained intact but tasked to provide additional clinical services despite reduced or flat line funding and staffing.

In short, even before the war in Afghanistan, VA PTSD treatment capacity had been overtaxed. The extent of these problems varied by facility and by VISN. Even in facilities that continued to back up their institutional commitment to PTSD treatment with adequate resources, PCTs were over-extended and straining to meet clinical demand from veterans. Unless this trend can be reversed by raising the priority and by providing adequate resources for PTSD services, it is unrealistic to expect that VA will be able to provide enough additional services to new warzone veterans from Iraq and Afghanistan.

A second concern has to do with the different demands that will be placed on VA programs as these new veterans enter the system. VA treatment, for the most part, has been for veterans with chronic PTSD. This is understandable when you consider that most veterans currently enrolled in VA programs served in the military many years ago (eg World War II, Korea or Vietnam). Although some VA clinicians have recently had experience with acutely traumatized individuals (most notably in Oklahoma City after the bombing of the Federal Building, in the New York metropolitan area after the September 11th attacks, and elsewhere to provide treatment for veterans recently returned from a variety of United Nations and NATO deployments), most VA clinicians are not currently prepared to provide the best care for recently traumatized individuals. I am actually less worried about this issue than about the lack of resources for PTSD programs, mentioned above, because there are now numerous examples in which VA hospital-based and Vet Center clinicians have demonstrated their capacity to meet the clinical needs of recently traumatized veterans when given adequate training. In other words, I believe that a large-scale system-wide training program is needed to prepare VA clinicians to meet this new challenge.

Although I take these aforementioned concerns very seriously, I also believe, from my 30-year perspective, that there have been many positive developments that should be emphasized. As a result, I believe that given adequate institutional, programmatic and monetary support as well as sufficient training for clinicians, the VA could rapidly mobilize its potential and provide needed services to new veterans of the War on Terrorism. Let me list the reasons why I believe current realities differ significantly from the situation that we faced in the post-Vietnam era:

1. PTSD has matured as a field. We now have state-of-the-art assessment and diagnostic capability. We are also in a position to offer excellent treatments, including two FDA approved medications as well as proven psychosocial approaches such as cognitive-behavior-therapy (CBT).
2. VA practitioners are sophisticated and highly motivated to continually improve their skills regarding PTSD treatment.
3. VA educational and training programs, made available by the Employee Education System, National Center for PTSD, Mental Illness Research and Education Centers (MIRECCs) and Readjustment Counseling Service, are available to clinicians in a variety of formats.
4. Collaborations with mental health colleagues in the Department of Defense (DoD) are at an all time high. Indeed we at the National Center as well as many VA mental health professionals from other facilities are currently involved in many collaborative, consultative, educational and research initiatives with DoD colleagues. "The Iraq War Clinicians Guide" currently available as a compact disc or on the National Center's website, www.ncptsd.org is undergoing a second revision in collaboration with military mental health specialists at Walter Reed Army Medical Center. Furthermore, a recent joint application from the National Center and the Uniformed Services University of Health Sciences (USUHS), if funded, would provide education, training and VA consultation to DoD mental health practitioners on the ground in Afghanistan and Iraq, at DoD mobilization/demobilization centers, and at VA facilities.
5. A joint VA/DoD effort has produced a recently approved set of clinical practice guidelines for Acute Stress Reaction, Acute Stress Disorder and PTSD. It provides state-of-the-art guidance concerning appropriate interventions for any active duty or veteran individual requiring professional attention in the acute warzone setting, the primary care arena, or the mental health setting. Since the VA and DoD professionals who collaborated to create these practice guidelines have thought through, collectively, many of the fundamental challenges to providing optimal treatment, it might be useful to reconvene this group so that they might contribute to a strategic planning process through which to provide appropriate care to returnees from Iraq and Afghanistan in need of treatment. Furthermore, a joint VA/DoD training for all VA mental health, vet center, and primary care clinicians built around these practice guidelines would directly address any skill deficits regarding treatment of recently traumatized veterans and thereby enhance VA's capacity to meet the needs of new veterans.
6. A number of VA/DoD collaborations are already up and running. In some cases, VA clinicians travel to nearby military bases to assist DoD colleagues in

screening, assessment and treatment of recent returnees from Iraq and Afghanistan. Otherwise, VA professionals are providing direct consultation to DoD colleagues on a number of clinical, educational and research issues that are pertinent to meeting the clinical needs of recent returnees from the warzone. Such activities should be encouraged and enhanced, whenever and wherever possible.

In summary, I believe that many of the necessary components are already available with which to build a seamless spectrum of care embracing DoD and VA practitioners. What is needed is a coherent strategic plan, adequate resources, a national training initiative, appropriate surveillance and clear accountability to insure that men and women returning from Iraq and Afghanistan receive whatever care they may need and deserve.

House of Representatives VA Health Subcommittee: Hearing on PTSD
Ronald J. Zaczek

I'm Ron Zaczek, a former Marine, UH-1E Crewchief who flew 393 combat missions in Vietnam during 1967. By 1981, I was married with two children, had a fine home and was a successful engineer. Nevertheless, my life was coming apart. I was filled with anger and was emotionally abusive to my family. I was frequently hostile in the workplace and one particularly bad day, I started to plan suicide. When I realized what I was doing, I did what every man does when he comes apart – I called my wife and asked her to 'tell me what to do!' I drove to the Vet Center in Elkton Maryland and began six years of ultimately successful therapy for PTSD.

During therapy, I began writing about the events that were at the heart of my PTSD, put into the context of how my counselor and I worked through them. I did this as an explanation and apology to my family, and also to help other veterans. The result, *Farewell, Darkness*, is now used as an aid to therapy in the VA's Outreach Program. Vietnam vets and family members write and call to tell me how the book has improved their lives. Veterans of Desert Storm and Somalia tell me that my story resonates with them as well. *Farewell, Darkness* may also help vets of Iraq and Afghanistan. I'm providing copies to Ms. Kathleen Greve, for review as the Committee deems appropriate.

I'm seriously concerned about our responsibility as a nation to educate veterans of Iraq and Afghanistan, and their families, about acute and chronic PTSD. The differences and similarities between the nature of combat in Vietnam and the war in the Middle East, and the validity of using treatment modes developed for Vietnam vets with vets of the wars against terrorism are a matter of current debate. I wish to address a different issue that relates importantly to PTSD - the difference in perspective that Vietnam vets and the general public had regarding combat-related trauma at the time PTSD was catalogued 30 years ago, and the perspective the public and veterans have of PTSD today. The difference is significant. It permits and requires an approach to educating vets of Iraq and Afghanistan about PTSD that builds upon the tragic experience of Vietnam, *as well as* 30 years of society's growing awareness and understanding of the long term consequences that trauma can have in our lives.

It's important to recall that the term 'PTSD' didn't exist during or before Vietnam. The disorder wasn't officially defined until after that war. In WWII the terms were "Nervous Disability" or "Combat Fatigue," and I'm told were considered signs of weakness or poor character. A veteran of Okinawa told me that it was known as "having shit in your blood" despite the fact that over 30% of battlefield evacuations on Okinawa were due to nervous disability. I'm unaware of any battlefield evacuations due to battle fatigue in Vietnam, though I know enough about the disorder today to say that I and many of my fellow Marines were displaying acute symptoms of PTSD while In Country. Had the thought of battle fatigue even occurred to me as a combat Crewchief, I would have dismissed it as "unMarine-like." When PTSD entered the lexicon around 1980 I saw it as a character flaw – an excuse the weak and lazy used to justify their failure in society. I was a decorated Marine and, yeah, I had some tough times, but PTSD didn't apply to me.

Since Vietnam there's been a sea change in how PTSD is viewed and accepted by society. PTSD has come out of the closet. Having PTSD is respectable in a tragic sort of way. We hear about PTSD on NYPD Blue, and know that it can develop as a result of rape, urban violence or an act of God. The increase in public awareness of PTSD is a good thing; vets returning from the Middle East will likely not be labeled as 'ticking time bombs,' and shunned as were the vets of Vietnam. Still, there's a problem: PTSD has not only become acceptable; it seems to be an almost inevitable outcome of any traumatic experience. Increased awareness of PTSD without adequate education about the disorder is a sword that cuts both ways. If something is 'inevitable' it can't or at least shouldn't be ignored. But 'inevitability' can lead to the false deduction, "I was in combat, so I must have PTSD." Without adequate education, some vets will assume the worst, creating unnecessary problems for themselves, their families, and an increasingly cash-strapped federal treatment system.

The dilemma is when and how education should start. Today we know that rapid intervention is essential to avoid or reduce the impact a traumatic event has in later life. In combat, there's no time for intervention. You have to shut down your feelings as you move from action to action. What would

happen if someone were to sit down with an American fighting in Iraq or Afghanistan and have a conversation something like this?

"We need to work on this PTSD thing. We need to make sure it isn't going to happen to you like it did to the Vietnam guys. If we don't work this now, here's what will happen. In 10 years, you'll have been divorced several times and moved aimlessly from job to job. You won't have any friends that you haven't made before today. You'll be an addict, alcoholic or workaholic and your kids and wife will be afraid of you. You'll sit with your back to a wall but you won't know why, and you'll feel naked without a gun or a knife. When you're not having nightmares, you'll still wake up every two hours, and check doors and windows to make certain the perimeter of your house is secure. Oh, you'll play 'chicken' with cars and trains just to get the kind of rush you had in combat. But it won't work. Every time you survive, you'll still feel like you lost."

Obviously, you can't have this kind of demoralizing conversation with a man or woman on the line of battle. The harsh fact is that preserving battlefield effectiveness is more important than dealing with the possibility of delayed stress disorder later in life. This is a choice between evils, and the greater evil must be served. But unlike Vietnam, where we enjoyed the luxury of ignorance, commanders and troops in Iraq and Afghanistan know that PTSD exists. The nation has a moral obligation to do whatever we can *now,* so that vets and their families can avoid the life I've portrayed in my "conversation." Public awareness has made the disorder understandable, anticipated and even expected. As a combat veteran, with fair to middling coping skills for my own PTSD, I maintain that this is *precisely* the conversation that needs to take place, more or less as I've written above.

When and where is the optimum time to have that tough conversation? It's a difficult question. There is no "good" time. Taking into account obvious logistical problems, the most *effective* time is during the final days of deployment, as a transition before returning to the U.S. The military may understandably chafe at this, but the troops will be most attentive, feel more comfortable talking, even if they joke about it, in the presence of their friends, still in desert camouflage. At the latest, the conversation must take place as soon as the vet returns home. This will be far less effective since the vets will see the obligatory "PTSD talk" only as delaying their return to life and their loved ones, waiting just outside the base gate. A different conversation with the family needs to happen *before* their loved one returns. *Farewell, Darkness,* possibly revised to speak more directly to current vets and families can educate them about the symptoms of PTSD and avenues for treatment. Most importantly, it can reassure them that if PTSD surfaces, there is hope.

To summarize, the Department of Defense and the Veterans Administration face two challenges. The agencies need to seamlessly

- Begin educating vets about PTSD before they come home in order to reduce the likelihood of troops' developing chronic PTSD. This can be done in a rear area without diminishing combat readiness and the skills essential to survive each day.
- Educate veterans returned from combat, and loved ones, about PTSD without turning the development of chronic PTSD into a self-fulfilling prophecy.
- Provide early recognition and adequate treatment for vets who do develop PTSD.

I have no doubt that the VA, through the community Vet Centers and Veterans Hospitals can deliver the necessary assistance vets of Iraq and Afghanistan require if given the necessary budget and staff. They've been saving lives for a long time. I also believe that the VA is but one part of the solution. The Department of Defense and the VA should be chartered by the Congress to jointly plan and coordinate PTSD education for troops before leaving the battle area as well as the delivery of services to vets and their families at home. This is especially critical for returning Reservists and National Guard who may not have ready access to military or veterans' facilities. The veterans of our latest war deserve nothing less.

Ronald Zaczek
230 Rhett Lane
Elkton MD 21921

Statement of Richard ''Rick'' Jones, AMVETS National Legislative Director, on Post Traumatic Stress Disorder

Chairman Simmons, Ranking Member Rodriguez, and Members of the Subcommittee:

On behalf of AMVETS National Commander S. John Sisler and the nationwide membership of AMVETS, I am pleased to offer our views to the Subcommittee on Health regarding the state of veterans who may be suffering from post traumatic stress disorder, a psychiatric condition caused by traumatic experience, such as combat.

AMVETS has been a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces. Today, our organization continues its proud tradition, providing, not only support for veterans and the active military in procuring their earned entitlements, but also an array of community services that enhance the quality of life for this nation's citizens.

For the record, AMVETS has not received any federal grants or contracts during the current fiscal year or during the previous two years in relation to any of the subjects discussed today.

Mr. Chairman, AMVETS is concerned about the prospect of budget-driven compromises that may adversely affect the potential of the Department of Veterans Affairs (VA) to deliver quality, timely access and appropriate care to veterans facing the debilitating condition of Post Traumatic Stress Disorder (PTSD).

While there are multiple areas within the VA healthcare system that raise our interest, the debate on the level of preparedness for specialized care commensurate with veterans need is one we welcome. We trust this hearing will help bring light to an area that desperately needs to be a high priority

for VA.

VA is recognized worldwide as a true leader in the area of PTSD research. As a leader, they bring scholarship and dedication to this vaguely understood condition. In the area of research, it is important that Congress and the administration provide adequate funding for clinical research in areas that will lead to high quality service with efficient and effective treatment programs in the VA system.

PTSD is the most common psychiatric disorder arising from combat. People with PTSD symptoms experience a variety of different emotions. They may have difficulty sleeping and feel detached or apart from those closest to them. They may express strong emotions of anger or take up alcohol or drugs to numb themselves from their distress. As well, they may experience memory problems, depression, thoughts of suicide and violent behavior.

As we reach out to offer rehabilitative treatment to veterans suffering from PTSD resulting from their wartime service, it is important that we, as a nation, do not lose the necessary focus and commitment to programs that can make a difference in the lives of veterans struggling to recuperate from their wounds of war.

For years, AMVETS has consistently reported that resource shortfalls have placed in jeopardy the level of services of the PTSD and substance abuse service programs. With resources short, what money is available goes elsewhere to other priorities within the system. PTSD and mental health programs are funding with whatever remains. The result of these adverse funding decisions leads to staff reductions and insufficient, failing service.

Without adequate funding, AMVETS must ask whether the dedicated staff professionals who work to sustain these programs can possibly continue to bring compassion and healing to veterans experiencing PTSD.

Many will associate PTSD with the Vietnam War. As we have discovered, however, veterans with this type of special need are not solely associated with that war.

PTSD may have been called by a different name – shell shock, battle fatigue, soldier's heart or some related designation, but post traumatic stress disorder is part of every war. The condition may carry a different term of reference, but the outcome is the same. It's a special need that requires specialized treatment.

While every war is unique, the Iraq-Afghanistan wars are the most violent encounters since Vietnam. And it should be recognized that as this current generation of soldiers leave the battlefield for home, they too will be left to deal with their past exposure to combat. How severe and widespread the psychological wounds will be is yet to be totally understood.

AMVETS is not aware of a current full national assessment, however, it is reported that the Pentagon is finding that 10 percent of troops evacuated from the war zone to Germany were being treated for PTSD reasons. A report from southeastern Wisconsin indicates that nearly twenty-five percent of the roughly 90 troops returning from Iraq are being seen for mental health concerns.

Also, questions have begun to be asked about the suicide rate among returning troops. The Department of Defense has implemented health

screening for all returning veterans. And the VA has activated a system wide mental health screening procedure similar to DoD's targeting at-risk veterans. But there is a clear indication that those coming home will carry many of the images of violence and war.

AMVETS clearly sees a need for increasing the number of mental health workers and enhancing their training. Providing the best possible health care to our Nation's veterans remains a difficult task, however, given the fact that VA already struggles with an inadequate budget.

VA health care delivery faces a moment of decision. Without reinforcing and strengthening the capacity of the VA system to treat veterans suffering from PTSD, VA will have to make difficult choices regarding the number of professionals whose work and lives touch those veterans in the PTSD programs. The legacy of the program and its potential to compassionately care for service-connected veterans is at stake.

It is clear that chronic resource shortfalls are building into a structural delivery deficit. VA healthcare treatment provided to veterans suffering from PTSD faces a stress of its own. In too many cases, competing pressures on hospital administrators and the lack of adequate funding are beginning to show stiffer challenges, resulting too often in deficient services.

While treatment to veterans in mental health programs requires a strong commitment, VA field personal are growing less and less able to maintain the programs that make a difference in veterans lives. There are reports, for example, that veterans are waiting an average of five and a half months to enter post traumatic stress disorder programs.

In addition, current VA policy presents a heavier burden on veterans with PTSD. In January 2003, VA decided to terminate future access to over 200,000 veterans. Under this circumstance, VA may never see many veterans with PTSD symptoms. Should this policy continue, these veterans will likely remain undiagnosed. They will carry out their lives, retreating into a variety of different manners, without ever being seen by VA or understanding that there's treatment available.

Though these veterans have earned medical care. And it was promised. It will not be delivered, because Congress and the administration cannot cooperatively find the will to fund what everyone declares as one of the nation's top priorities – veterans health care.

[It's interesting to note that despite carrying more than 600 million congressionally appropriated fiscal year 2003 dollars into fiscal year 2004, VA banned access to the VA healthcare system for Priority 8 veterans based on a lack of funding. The current administration budget suggests not spending $800 million in fiscal 2004 and pushing those "budgeted" funds into fiscal year 2005.]

In a recently reported PTSD case, it took three decades to discover a case of PTSD that had previously fallen through the cracks. Abe Garcia of Oakland, California, was lucky when after recovering from an auto accident; he entered a residential treatment program at the National Center for PTSD in Menlo Park. He was diagnosed with PTSD developed in 1969 at the age of 21 when he served in Vietnam.

According to the Oakland Tribune, Abe Garcia indicated that his PTSD began at a time his airbase was under continual sniper fire. "The scary part is we

didn't know our enemy. We would get mortared and rocketed." He said it sounds a lot like the situation in Iraq, "I'm sure a lot of them are doing what we did – becoming numb to survive."

While the lessons learned in cases like Garcia's will help the newest veterans overcome their experiences, some cases of the notorious symptoms may not appear for several years after VA's two-year timeline disappears for returning warriors.

If we continue to deny access for an entire group of veterans, do we begin another cycle of servicemembers falling through the cracks of a system that may offer only two years of veterans health services to those who do not have obvious combat wounds. Some will say that these individuals will be served. After all, they have service connected injuries, so they will certainly have access to the VA healthcare system. The situation, however, presents a "Catch-22." If their PTSD doesn't reveal itself early enough and they no longer have access to the VA system, how does VA determine the hidden wounds of post traumatic stress disorder.

AMVETS believes it is imperative that chronic shortfalls in VA healthcare funding be corrected. It cannot continue without a rising potential for serious adverse affect on those who defended our freedoms.

Our veterans experiencing PTSD deserve treatment. They need to know that the symptoms they face, including panic attacks and flashbacks, can be treated. They need to know that they are not alone in the symptoms they face. And they need to know that VA will be there when they need care.

Mr. Chairman, recovery programs offer the best hope of beating the

symptoms of PTSD. Unfortunately, too many servicemembers stress disorders may go undiagnosed. VA counseling can help, but only if the symptoms of restlessness, trouble sleeping, nightmares, and related things that happen to those who experience the trauma are detected and connected to their PTSD.

As our servicemembers return from overseas deployment, counseling teams are urgently needed to ask the right questions and prepare the right course to deal with everyone's exposure to the conditions of combat. And the system needs to remain accessible to all veterans.

We trust that Congress will understand the need to ensure adequate funding is in place to deal with the physical and psychological health of returning troops. And we trust Congress and the administration have learned that the mental health concerns associated with post traumatic stress disorder often can be delayed from a month to years.

As we watch this year's appropriations process our concerns rise knowing that too many sick and disabled veterans may have to continue their wait. It is important, nonetheless, that we do our honest best to meet our promise to provide quality health care in return for military service in defense of this country.

Mr. Chairman, in closing, AMVETS looks forward to working with you and others in Congress to find the best ways to strengthened and improved health care to all of America's veterans. As we find ourselves in times that threaten our very freedom, our nation must never forget those who ensure our freedom endures. AMVETS thanks the panel for the opportunity to address this matter.

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STATEMENT OF
ADRIAN M. ATIZADO
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 11, 2004

Mr. Chairman and Members of the Subcommittee:

I am pleased to provide this Subcommittee with the views of the Disabled American Veterans (DAV), an organization of more than one million wartime disabled veterans, on the state of veterans who may be suffering from post-traumatic stress disorder (PTSD) as a consequence of their exposure to the rigors of combat and hardship deployments.

In 1980, the American Psychiatric Association added PTSD to the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Although a controversial diagnosis when first introduced, PTSD has filled an important gap in psychiatric theory and practice. From an historical perspective, the significant change ushered in by the PTSD concept was the stipulation that the etiological agent was outside the individual. The key to understanding the scientific basis and clinical expression of PTSD is the concept of "trauma."

In its initial DSM-III formulation, a traumatic event was conceptualized as a catastrophic stressor that was outside the range of usual human experience. The framers of the original PTSD diagnosis considered traumatic events as clearly different from the very painful stressors that constitute the normal unpredictable changes of life. By this logic, adverse psychological responses to such "ordinary stressors" would be characterized as Adjustment Disorders, rather than PTSD in DSM-III and DSM-IV terms. This distinction between traumatic and other stressors was based on the assumption that although most individuals have the ability to cope with ordinary stress, their adaptive capacities are likely to be overwhelmed when confronted by a traumatic stressor. Because of individual differences in this appraisal process, different people appear to have different trauma thresholds, some more protected and some more vulnerable to developing clinical symptoms after exposure to extremely stressful situations.

PTSD is unique among other psychiatric diagnoses because of the importance placed upon the etiological agent, the traumatic stressor. In fact, one cannot make a PTSD diagnosis unless the patient has actually met the "stressor criterion," meaning that he or she has been exposed to an historical event that is considered traumatic. Clinical experience with the PTSD diagnosis has shown, however, that there are individual differences regarding the capacity to cope with catastrophic stress so that, while some people exposed to traumatic events do not develop PTSD, others go on to develop the complete syndrome.

In a recent New York Times article titled "The Permanent Scars of War," a recurring theme emerges among servicemembers who have paid the price to survive war, in that they are anxious to go home, but are simply not quite ready to talk about it. Yet, however far into the future they become ready, all constituencies must be assured that the Department of Veterans Affairs (VA) will have a full continuum of health care services available to these future veterans. It is VA's commitment to the preservation of its core missions that must be brought to bear in order to fulfill our nation's moral obligation to the men and women who have sacrificed so much defending our nation.

Although maintaining the Veterans Health Administration's (VHA's) capacity of specialized services is statutorily required, VA medical facilities have failed to maintain the capacity for the treatment and care of veterans with severe mental illness and PTSD. VA's move towards providing care in an outpatient setting produced extensive closures of specialized inpatient mental health programs. Additionally, VA's failure in many locations to ensure replacement of those services with PTSD Clinical Teams and community-based programs such as mental health providers in community-based outpatient clinics (CBOCs), effectively denies many veterans access to needed care.

It is essential for VHA to maintain equal access to a full continuum of mental health services across the Veterans Integrated Service Networks for veterans suffering from PTSD. Intensive case management is often necessary to successfully manage patients with severe mental illness on an outpatient basis. Additionally, many veterans dealing with substance abuse disorders and PTSD need a structured support system with routine monitoring by mental health care professionals. Without access to appropriate VA mental health care services, these male and female patients may experience serious setbacks, homelessness or other related problems, and have to rely on other community resources for assistance.

Through the VA, many women veterans seek counseling and treatment for PTSD, and need inpatient mental health services for psychiatric conditions that developed as a result of sexual assault that occurred during military service. The January 25, 2004, article in the Denver Post, which describes at least 37 female servicemembers sought sexual-trauma counseling and other assistance after returning from war duty in Iraq, Kuwait and other overseas stations, serves as a reminder that the increase in the number of women serving in the military will significantly impact the services provided by VA. Currently, women make up 15 percent of the active military force, serve in all branches of the military, and are eligible for assignment in most military occupational specialties. Projections show that by the year 2010, women will comprise well over 10 percent of the veteran population.

Women veterans continue to express concern about privacy and safety issues at some VA facilities. Every VA facility should consistently and strictly adhere to privacy and safety protocols for women veterans. Male and female veterans suffering from PTSD may have very different core issues surrounding their traumatic event, such as combat-related vs. sexual abuse or trauma. It is not uncommon during an inpatient hospitalization or domiciliary stay, for a single woman veteran to be placed in a ward with 30 men. It is understandable in this situation that a woman might feel threatened or that her safety might be endangered. Individual women veterans undergoing treatment programs for PTSD frequently report they are the only female in

the group and often feel too intimidated to discuss gender-specific issues. This could potentially lead to complications for the clinician trying to provide group therapy.

Some VA facilities have closed their women veterans' inpatient psychiatric units citing low utilization rates, which do not make them cost effective. There are now only a few VA facilities with inpatient psychiatric units specifically designed to meet the special needs of women veterans. Consequently, women veterans may be further disadvantaged in terms of access to and the quality of care for PTSD symptoms in women who have experienced sexual trauma. It is in this instance that we suggest VA facilities secure contracted care at a nearby facility where numbers of women are too low to be cost effective to maintain an inpatient psychiatric unit or provide appropriate care.

VHA is a recognized leading authority in research on and treatment of PTSD. The National Center for PTSD was created in 1989 within the VA in response to a Congressional mandate to address the needs of veterans with military-related PTSD. From the Center's internet website at www.ncptsd.org, a number of fact sheets, articles, and clinical newsletters about PTSD may be accessed, such as "PTSD and Problems with Alcohol Use." The fact sheet states: "Women exposed to trauma show an increased risk for an alcohol use disorder even if they are not experiencing PTSD. Women with problematic alcohol use are more likely than other women to have been sexually abused at some point in their lives." As numerous studies about the relationship between psychiatric disorders, particularly PTSD, and alcohol abuse have been conducted, and VA's own National Center for PTSD recognizes the relationship, legislation to eliminate compensation for the effects of service-connected alcohol and drug abuse continuous to be proposed.

Such legislation ignores the distinction between alcohol abuse arising from the use of alcohol to enjoy its intoxicating effects and alcohol abuse that results from a service-connected disability. Alcohol use is particularly more prevalent among veterans who suffer from the disordered thinking of serious mental conditions or who suffer from the disturbing symptoms of PTSD caused by severe psychological trauma such as the death and destruction of combat. When our fighting men and women leave the battlefield only to fight another war raging from within, it is unconscionable to create a bar to benefits designed to restore, to the extent possible, the veteran to the position he or she would have enjoyed had he or she not incurred the disability.

Except where secondary to another service-connected disability, the law already prohibits compensation for disability from alcohol or drug abuse. For several years, through an erroneous interpretation of law and one that was inconsistent with another interpretation within VA itself, VA denied compensation for disability from alcohol or drug abuse although the effects of another service-connected mental or physical disability caused the abuse. Congress intended to prohibit compensation for alcohol and drug abuse as primary conditions, but did not intend to deny compensation when a veteran's service-connected mental or physical disability induced use of alcohol or drugs to escape mental or physical pain. In *Allen v. Principi*, 237 F.3d 1368 (Fed. Cir. 2001), the court agreed with DAV's argument that the law does not bar compensation for disability from alcohol abuse when caused by a service-connected disability.

It is obvious that to prohibit compensation for alcohol abuse in this instance does not recognize medical principles and fair and equitable treatment of veterans, nor does it recognize the real nature of the effects of severe trauma and severe disability upon young men and women who bear these extraordinary burdens and suffer these extremely traumatic experiences. We oppose such an unwarranted and inequitable change in the strongest possible terms.

DAV recognizes that VA has made an effort to address problems associated with capacity of its specialized programs designed to enhance the state of veterans who may be suffering from PTSD as a consequence of their exposure to the rigors of combat and hardship deployments. But clearly, more needs to be done. VA must honestly assess and request accurate funding levels needed to fulfill its mission of providing quality and timely specialized health care services to our Nation's most vulnerable veterans.

STATEMENT OF

PAUL A. HAYDEN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

SUBMITTED TO THE

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

WITH RESPECT TO

STATUS OF DEPARTMENT OF VETERANS AFFAIRS' POST-TRAUMATIC STRESS DISORDER PROGRAMS

WASHINGTON, D.C. MARCH 11, 2004

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.6 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I appreciate the opportunity to present our views regarding the Department of Veterans Affairs' (VA) programs for the care of veterans suffering from post-traumatic stress disorder (PTSD) as a consequence of their exposure to the rigors of combat and hardship deployments. We thank the subcommittee for holding a hearing on this most important and timely subject.

As veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) return home – transitioning from the DoD health care system to the VA-- VFW believes it is critical that VA place an increased emphasis on mental health services. An ever-growing demand for these specialized services, which started even before the War on Terrorism, has saturated the VA system.

According to the 2003 report of the Special Commission on Post-Traumatic Stress Disorder, released before the invasion of Iraq, fifty percent of all veterans who were service connected for PTSD became service connected within the last five years, and the population served by VA's specialized PTSD outpatient programs grew 86 percent between 1995 and 2001. Other data compiled by the Veterans Health Administration (VHA) reported that among the 107,540 veterans who have recently separated from active duty military (data compiled combined various separation files from September 2003, November 2003, December 2003, and February 2004), 1,927 or 14% were diagnosed with a mental health problem. Of those 1,927, more than 450 were diagnosed with PTSD.

Despite the substantial evidence of the need to increase VA mental health services, recent years have seen erosion in VA mental care capacity. Virtually every entity that monitors VA mental health care programs, including Congress, the Government Accounting Office, VA's Committee on Care of Veterans with Serious Mental Illness and the *Independent Budget* (IB), which VFW co-authors, have documented extensive closures of specialized inpatient mental health programs and VA's failure in many locations to replace those services with community-based programs.

Currently, VA operates a network of more than 140 specialized programs for the treatment of PTSD through its medical centers and community based out-patient clinics (CBOCs), but one third of the CBOCs do not provide even basic mental health services. Further, a report by the VA Office of the Inspector General found that 39 of the outpatient PTSD programs said to exist have no specialized staff assigned to them, which would indicate a far more widespread problem. Given the recent inadequate VA appropriations, individual mental health care commitments among various VA networks are challenged to maintain the real dollar

level needed to serve veterans. Across the board, VA's mental health-care spending has declined by 8% over the past 7 years and by 25% percent when adjusted for inflation.

Other VA programs providing mental health services include 206 community–based Vet Centers located in all 50 states, Puerto Rico, the Virgin Islands, the District of Columbia and Guam. Vet Centers provide a variety of readjustment services including psychological counseling for veterans exposed to combat and/or sexual trauma, family counseling, community outreach, employment services and extensive information about benefit services. Vet Center staff often consists of a psychiatrist, psychologist, clinical social worker, psychiatric nurse or other mental health professionals. Sixty percent of the Centers are staffed by veterans, many of whom served in a combat zone. The holistic, non-threatening environment provided by the Vet Centers has earned a 99% percent satisfactory rating from veterans using the services -- the highest level of satisfaction recorded for any VA program. VFW feels that this highly successful program should be the model for PTSD treatment, and we would like to see more Centers outside the larger medical facilities and increased staff added throughout VA.

With such wide-spread disparity in the availability of needed services across the VHA system, VFW continues to find that veterans with mental illness can have no assurance that any given facility, or network of facilities will meet their mental health needs. We believe that the development of these programs must be approached with deliberation and care and with proper funding.

We stand by IB recommendations that Congress must incrementally augment funding for specialized treatment and support of veterans, to include the influx of returning troops who have mental illness, PTSD or substance-use disorders by $500 million each year from fiscal year 2005 through fiscal year 2009. VHA must invest these resources in programs to develop a continuum of care that includes effective screening, intensive care management, psychological

rehabilitation, peer support, integrated treatment of mental illness, PTSD, substance-use disorder and other support services for veterans with serious mental illness.

We also believe that in order to effectively care for our veterans with specialized mental health needs, more effort must be made to provide a seamless transition between VA and DoD for those men and women returning from combat. Much has been said about VA and DoD's ability to provide an invisible line between separating servicemember and the veteran. VFW has testified that a key component to any servicemember's transition from active duty to veteran has to be timeliness and accuracy of information in order to facilitate quick and accurate enrollment into the VA health care system. Unfortunately, the current VA/DoD process for sharing information remains far from seamless.

We believe that the two Departments should use standardized information nationwide. An institutional environment should be created in which information flows easily across all components of care and benefits, across geographic sites, and across discrete patient-care, compensation and other benefit incidents, while protecting privacy and confidentiality. This would go along way in helping those returning from war to get the help they need without any lapse in time and ensuring continuity of treatment

Indicators suggest thousands of OIF soldiers could be suffering from the burden of war. To date, the Army reports 23 OIF soldiers killed themselves in Iraq and Kuwait in 2003, well above normal Army rates. Six others committed suicide upon returning home to the United States, with the most recent taking place in Monument, Colorado the weekend of March 13, 2004.

PTSD by definition is capable of manifesting itself over months, years and even decades after the horrors of war are over. For some, the counseling and treatment options VA provides gives them the solutions they need to confront these after-effects of conflict.

We have an obligation to care for those veterans who served their country honorably and have come home with invisible scars of war. They should be provided full access to VA's comprehensive continuum of specialized care. Only then can we begin the healing process for those lives that have been seriously impacted by the debilitating effects of mental illness.

Mr. Chairman that concludes my statement for the record. Again, thank you for allowing the VFW to present its views on this subject. We look forward to working with the Committee to improve VA's mental health programs.

Questions for the Record
Honorable Rob Simmons
House Committee on Veteran Affairs
Subcommittee on Health
March 11, 2004

Hearing on the Status of Department of Veterans Affairs' Post-Traumatic Stress Disorder (PTSD) Programs

Question 1: Given the obvious importance of PTSD, please provide an explanation why so few of the Special Advisory Committee's recommendations have been acted on by the Department.

Response: The third annual report of the Under Secretary for Health's Special Committee on PTSD listed a total of 34 recommendations. At that time, nine were considered met, and an additional ten recommendations were partially met. Since then, VHA actions have addressed and resolved twelve of the partially met and unmet recommendations, including those on best practices (R.13-16) through publication of the new VA! DoD PTSD Clinical Practice Guidelines in Feb. 2004; those on national coordination of PTSD research (R. 31- 32); and the recommendation of addition of new MIRECCs (R. 30), which is currently underway. We are currently working through the remaining issues.

Question 2: How often do you meet with the Special Advisory Committee and what is the purpose of those meetings? Please provide the Committee the minutes of the last meeting you held with this advisory committee.

Response: The Under Secretary for Health's (USH) Special Committee on PTSD meets annually in Washington, DC to assess the past year's progress and to plan future initiatives to be addressed in the next year's annual report to Congress. At that time, the Committee meets with the USH to identify concerns of the Committee and also to learn the interests and recommendations of the USH. Meetings with the USH and Committee leadership may take place at other times, such as the meeting in March 2004 at which the USH met with leadership of the PTSD Committee and the USH Committee on Care of Seriously Mentally Ill Veterans to focus on plans to assist returning Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans.

Formal minutes of these meetings are not taken. Rather the Committee Chairs take notes that are then used to develop the next annual report.

Question 3: Do you believe that VHA is optimally prepared to deal with the mental health needs of returning veterans from Iraq and Afghanistan, given the tremendous demand you face from veterans of prior wars for VA's limited health care resources?

Response: VA's preparations to meet the needs of returning Global War on Terrorism (GWOT) veterans from Afghanistan and Iraq are active and ongoing. VA's mission in this regard is to identify existing problems in a timely manner and provide the services required to efficiently address such problems. In recognition of the existing workload pressures faced by VA clinicians, special resource allocations have been made to help in meeting the needs of the current veteran population. These include the hiring of fifty GWOT veterans to join the ranks of VA's readjustment counselors specific ally to provide outreach to returning GWOT veterans and their family members. In addition, the $25 million authorized by Public law 108-170 to enhance mental health services, will enhance services for Iraq and Afghanistan veterans. Of the $25 million, $5 million

will go to enhance PTSD programs, and $5 million for substance abuse services. Ten million dollars will be allocated to clinical programs jointly identified by Mental Health Strategic Healthcare Group (MHSHG) and Under Secretary for Health's Committee on Care of Veterans with Serious Mental Illness. An additional $5 million will be allocated to other mental health programs identified by MHSHG, with a particular focus on supporting returning OEF/OIF veterans. VISNs and facilities located near large numbers of returning OEF/OIF veterans, especially those from Reserve and National Guard units will be assessed for additional staffing to assist in the transition of these veterans back into the community and meeting their psychosocial needs.

Question 4: Do veterans from the two most recent wars in Central Asia join existing waiting lines for VA health services, or do they receive higher-level access to VA health care? What is VA's basis for this decision?

Response: Veterans who have served in QEF and OIF, and are requesting treatment for a service-connected disability, such as PTSD, are moved to the head of any waiting list. Those who do not qualify for higher enrollment status based upon service-connection or other eligibility factors, are enrolled in priority category 6 and are eligible to receive needed hospital care, medical services, and nursing home care for a 2-year period following their discharge or release from military service for any disability that may be related to their combat service in these operations. As a result, we may be able to identify and treat their problems, including psychosocial stressors, early before they develop into chronic and disabling disorders.

Question 5: On October 16, 2003, Chairman Smith held a Full Committee hearing to consider testimony from you and Dr. Winkenwerder on efforts to coordinate a smoother transition between DoD and VA concerning the needs of war veterans of Iraq and Afghanistan. Problems were noted and we took testimony on those. You and Dr. Winkenwerder committed to making progress on those problems. What is the status now of those unresolved matters of coordination and transition that were discussed at the October hearing?

Response: In October 2003, VHA and VBA issued joint guidance to help VHA and VBA staff had better understand their responsibilities for providing services to returning combat veterans. The VHA guidance document provided information on the roles and functions of staff serving as liaisons to DoD medical facilities, points of contact at VHA medical facilities, and case managers at VHA medical facilities. Full and part time social workers were assigned as VHA liaisons to the major DoD medical facilities (National Naval Medical Center at Bethesda and the Brooke, Eisenhower, Madigan and Walter Reed Army Medical Centers) to help facilitate transfer of care from the DoD medical facility to a VHA medical facility. Each VHA facility identified a point of contact for arranging for inpatient or outpatient care for transitioning returning combat veterans. Each VHA facility also assured that a nurse or social worker case manager was assigned to combat veterans transferred to that VHA facility. Since these roles were new, the VHA guidance document served as a means of orientation and training.

Over the three-month period since the guidance was initially published, VHA staff identified additional roles and functions that needed to be added to the guidance. We also sent the original VHA guidance document to VHA liaisons, points of contact, case managers, and senior leaders and requested their input for any needed revisions to the document. In March 2004, all of the recommended changes were incorporated into a new guidance document, and it was released to all VHA medical facilities.

VHA staff, who serve on the VA Seamless Transition Task Force, are now working on a

"Frequently Asked Questions" document to provide additional guidance to the liaisons, points of contact and case managers. The staffs at VHA medical facilities have provided questions. Other questions have been compiled from e-mail and telephone requests for information or clarification that have come to VA Central Office. The Frequently Asked Questions document is currently being finalized for publication.

The Departments also chartered a joint integrated project team to manage the second-phase of the Plan, achieving interoperability through database repositories, the DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR). The CDR/HDR effort, known as CHOR, is on target to demonstrate bi-directional interoperability and movement of pharmacy and demographic data in a prototype during 2004. Database interoperability, will support full interoperability of health information applications between the Departments by 2005.

In March 2004, VA and DOD awarded a contract to a vendor to develop a bidirectional pharmacy solution that will demonstrate interoperability in a prototype environment. VA and DOD are on track to complete the prototype by October
2004.

A Memorandum of Agreement (MOA) to formalize the transfer of information on the service members entering the Physical Examination Board process has been drafted and signed by VA's Under Secretaries for Health and Benefits. The purpose of the MOA is to better prepare VA for the "handoff" of each returning service member. The MOA was sent during the week of March 29th to DoD for review and to secure the appropriate signatures at DoD. The document has been shared informally and discussed at the Joint Executive Council.

VA continues to improve outreach to Guard and Reserve. Since October, the following activities have been completed, are continuing, or have started:

- Benefit Briefings: Coordination activities between VBA and Counseling Re-Adjustment Services personnel for Briefings on Pre-Deployment Information! Benefits and De-briefings at Post- Deployment phases at Reserve Units,
- Video: Development of an "in-flight" video that describes benefits to returning troops from DoD and VA: *"We are by Your Side",*
- Brochure/Wallet Card: Development of a wallet card and Brochure with basic information and key web links for benefits and services available. Brochures have been distributed to all mobilization sites. Wallet cards will be distributed to all outreach personnel to give to troops and family members,
- CD-ROM with the *"We are By Your Side"* video and additional web links from DoD and VA on all services available to take home and play again for family and relatives,
- Coordination efforts between Army National Guard Case Managers and POCs at Counseling Readjustment Centers and VHA facilities for referrals and seamless transition of troops from the mobilization station to VHA,
- Bereavement Counseling: Counseling and Readjustment Service provides bereavement counseling to family members who have lost a loved one in OIF/OEF,
- Establish Timelines for Outreach: Timeline established for interventions to troops by VHA and Vet Center Staff at intervals of 2 weeks, 3 months, 6 months, 12 months, 18 months, and 24 months post-deployment. VAMC facilities are encouraged to have "Town Hall "meetings and welcome home sessions to provide brochures and handouts to returning troops and families,

- Family Readiness Conferences: VHA, VBA and Vet Center staffs are available to

participate in poster displays and presentations to reserve groups and reserve senior leadership such as the recent family readiness conference in St. Louis. Other recent events in which we participated include an Omaha VHA conference and table display on seamless transition, with representatives from VHA (VISN and facility), Vet Center, and VBA (Regional Office) to answer questions of conference attendees and collaborate among the displayer personnel, and a VA/DoD Sharing Conference with table display, presentations, and a video. In May, the Vocational Rehab and Employment (VR&E) held a conference with a panel for Seamless Transition and table display of accomplishments, a video, and brochures. In June, an email was sent to all Army National Guard Adjutant Generals requesting a visit of VA personnel to talk to troops and Headquarters staff on role of VA and the services available for returning troops. Work has begun on the development of a satellite broadcast to better coordinate points of contact in VHA, VBA, VR&E, and Vet Center, with a satellite broadcast scheduled in July.

- Public Service Announcements: Hometown America and small cities where troops have been deployed will be receiving PSA's to highlight the role of VA in providing benefits and services to returning troops,
- Partnership with VBA and VHA at mobilization stations: VA POC's have collaborated to provide information and services to troops entering the mobilization station,
- Developed a video: *"Our Turn to Serve"* was developed to educate VA and DoD employees on the benefits to returning Guard/Reserve personnel seeking healthcare and follow-up for service connected injuries and the purpose/goals of seamless transition,
- WEB Page development: Using the icon for OIF/OEF, returning reservists can use this site as a portal for an array of services and benefits. This is also discussed on the CD-ROM with links to many sites and benefits,
- Communication Distribution Plan: Developed a distribution plan for brochures, booklets, CD-ROM to reach Guard/Reserve personnel at home or at their reserve units, and
- Educational Outreach to VA and DoD Professionals: There are several initiatives that have been developed to educate all healthcare providers regarding health hazards and risks for troops serving overseas: Clinical Practice Guidelines, Newsletters, Veterans' Health Initiative, Broadcasts on Care for the War Wounded" and also sharing of other broadcasts with DoD medical personnel.

The following is an update on the Patient Treatment File Recommendations for Returning Service Members:

PTF Recommendation 3.5. *VA and DOD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events.*

The VA/DoD Health Executive Council (HEC) has established a Deployment Health Work Group, which is aggressively addressing these issues. Goal 2 (High Quality Health Care), Objective 2.1, of the Joint Strategic Plan addresses the issues described in this recommendation. DoD is also establishing an office to be the one point of entry for all VA data requests, including stressor and chemical biological, radiological, nuclear, and environmental (CBRNE) exposure information.

PTF Recommendation 3.6. *By fiscal year 2004, VA and DOD should initiate a process for routine sharing of each service member's assignment history, location, occupational exposure, and injuries information.*

Goal 2 (Quality Health Care) and Goal 4 (Integrated Information Sharing) of the Joint Strategic Plan include objectives designed to accomplish this recommendation. Both the HEC (through the Deployment Health Work Group) and the Benefits Executive Council (BEC) are currently developing and implementing processes to address these items. Examples of these processes are as follows.

- The Departments initiated joint implementation of Phase I of the Federal Health Information Exchange (FHIE) in June 2002 with the release of the Near Term Solution (NTS) for all VA medical centers. FHIE NTS contained outpatient pharmacy, laboratory, and radiology report data.

- Subsequent enhancements have been made to FHIE to improve sharing of health information:
    - Version 3 containing discharge summary and admission, discharge, transfer (ADT) data were made available in February 2003
    - The Departments released an early Version 4 in June 2003 containing allergy data; the next release of Version 4 contained consult data by September 2003;
    - Version 5 containing DoD Pharmacy Data Transaction Service (PDTS) data (retail pharmacy) was made available in December 2003.
    - Version 5.1 containing DoD Standard Ambulatory Data Record (SADR) data was made available in March 2004;
    - The FHIE interface with the VBA Compensation and Pension Records Interchange (CAPRI) system was completed in November 2003. This interface permits FHIE data on separated service members to be made available and used by claims processors within the Veterans Benefit Administration to assist with the timely processing of compensation and pension (disability) claims; and
    - The Veterans Benefit Administration is developing two additional interfaces that have been added to the FHIE (Pharmacy data transition service and DoD standard ambulatory data record).

To date, DoD has transferred records for 1.9 million unique service members into the EHIE repository for use by VA clinicians. Having completed all scheduled development and enhancements, the Departments placed FHIE into sustainment mode. EHIE will continue to support the transfer of select DoD data to VA clinicians in support of health care and determination of benefits.

The use of the DoD's Defense Enrollment Eligibility Registration System as the basis for integrated information sharing for VA eligibility determination and enrollment is being reassessed. Progress for this effort is dependent on successful requirements analysis following current baseline analysis. The Registration Eligibility & Contact Management contract awarded in August 2003 was cancelled to re-baseline the effort and to conduct the requirements analysis necessary to be successful in this effort. New milestones and timelines will be incorporated into the revised joint strategic plan.

VA currently receives thirty-one separate data feeds from DoD Defense Manpower Data Center (DMDC); there are an additional eleven data feeds from VA to DoD/DMDC. VA's partial analysis of these data, to date, indicates that these feeds are not redundant, but largely represent different events in the Veteran's military history (such as enlistment, separation, or retirement).

The immediate action underway is to perform a detailed analysis of DMDC data, and to enhance one of the existing data feeds to support the needs of Operation Seamless Transition, as soon as possible. The agencies are implementing processes to ensure the privacy and security of shared data.

PTF Recommendation 3.7. *The Departments should: 1) add an ex officio member from VA to the Armed Forces Epidemiological Board and to the DOD Safety and Occupational Health Committee; 2) implement continuous health surveillance and research programs to identify the long-term health* consequences of military service in high-risk occupations, settings, or events; and 3) jointly issue an annual report on Force Health Protection, and make it available to the public.

The HEC has established 11 Work Groups comprised of representatives from both VA and DoD, to address specific issues of common interest to VA and Military Health Care System. These groups are developing and implementing processes addressing most of the issues listed in this recommendation. Objectives within Goal 2 (Quality Health Care) and Goal 6 (Joint Contingency/Readiness Planning) of the Joint Strategic Plan also address these recommendations. A representative from VA now serves on the Armed Forces Epidemiological Board. At this point, there is no plan to publish a joint report on Force Health Protection, since that is DoD's primary mission.

The following is an update on relevant Joint Executive Council Activities:

Goal 2 (Quality Health Care) of the VA/DoD Joint Strategic Plan addresses deployment health issues in goal 2.1.2.

2.1.2 Identify and foster opportunities for sharing information and resources between VA and DoD in the areas of deployment health surveillance, assessment, follow-up care, and health risk communication to include Pre-deployment health assessments, medical environmental and chemical, biological, radiological, nuclear and explosives (CBRNE) surveillance during deployments, individual assignments and unit location during deployments, post-deployment health assessments and clinical practice guideline data, and post-deployment briefings on VA benefits and services, particularly for those who served in a combat zone.

In responding to this element, the HEC established the Deployment Health Working Group (DHWG) in September of 2002. Dr. Susan Mather, VA's Chief Officer for Public Health and Environmental Medicine, and Dr. Michael Kilpatrick, DoD Deputy Director, Deployment Health Support Directorate, chair the work group. The DHWG has published Post-Deployment Clinical Practice Guidelines; developed and published learning modules on post deployment health issues; coordinated the exchange of clinical information on individual service members, including pre- and post-deployment health assessments; developed and distributed information brochure on VA benefits and services for those veterans who served in a combat zone; and established a subcommittee to recommend new directions for pre- and post-deployment health research initiatives.

Question 6: In response to the Chairman's question, you stated VA is involved in the DoD study of suicides by active duty service members in the two current war zones. What is VA's particular role in that review and how do you intend to use the results in assisting veterans who seek VA care?

Response: While VA did not participate in the DoD review of active duty suicides, the results of the DoD Report will be analyzed by VA to reinforce our ability to prevent suicides to the greatest degree possible. It is important to recognize that VA will be assessing the full range of psychological, social, and biological issues that may impinge on the health of returning veterans as they reintegrate into the community. VA will specifically screen for depression, substance abuse, as well as PTSD, which are most frequently associated with suicidal behaviors. Initial assessments of veterans' social, family, and economic situations will assist in providing support and correction of problems in these particular areas. Initial reports of the DoD study reinforce the validity of this approach. VA has, in fact been engaged for the past several years in a series of suicide prevention educational programs, clinical assessments and program planning activities, linked to a significant degree to initiatives such as the Surgeon General's National Strategy for Suicide Prevention (2001), the Institute of Medicine Report, Reducing Suicide (2002), and most recently the President's New Freedom Commission on Mental Health.

Question 7: VA has shifted to primary care with less reliance on inpatient programs to deal with mental illness, drug, and alcohol disorders. However, VA's 2002 data show that veterans in PTSD outpatient programs did not significantly reduce their alcohol or drug use. On the other hand, VA's reported results in providing inpatient and residential care for veterans with PTSD showed significant improvement -- 20% reduction in drug use and 9% reduction in alcohol use. Given these reported outcome differences, should VA be turning to more inpatient and residential treatment options for veterans with PTSD who also exhibit substance use disorders?

Response: Inpatient residential services are important for crisis stabilization and to establish improved coping with emotional problems for that subset of patients who need more structure and support in order to successfully enter outpatient care in the community. It should be recognized that most patients seeking PTSD or substance abuse care, including those who use inpatient residential services, would primarily require ongoing outpatient care for these chronic, recurring disorders. Funding from the Veterans Millennium Health Care and Benefits Act was used to enhance both PTSD and substance abuse treatment programs, including both inpatient residential services as well as outpatient care. VA will use the additional funding identified by the Veterans Health Care Capital Health Care, Capital Asset, and Business Improvement Act of 2003, in part to establish new PTSD and substance abuse programs.

Question 8: The press is reporting Walter Reed's use of the latest technologies in its efforts to help amputees of the current wars. Many Members of this Committee have visited the amputees at Walter Reed Army Medical Center and have been inspired by their courage and amazed at what is being done for them with these new technologies. These prosthetic devices are highly sophisticated machines, and some even use artificial intelligence to aid a veteran in regaining the ability to walk, grasp objects, and perform other tasks. VA's prosthetics and sensory aids program will be inheriting some of these veterans in future years, for re-fitment, repair, adjustment, and replacement of high-level prosthetic devices.

Given the nature of the advanced technologies being used at Walter Reed, is VHA prepared for this new generation of prosthetic devices? Also, are veterans now under VA care, those from prior wars with old injuries, being afforded some of this emerging technology from the Army?

Response: Yes, VHA provides new and emerging technology as it becomes available in the marketplace. VHA is able to respond to changing technology, and we support the introduction of new technology. We refit, repair, adjust, and replace this technology as the veteran progresses through life-changing conditions into old age. We provide this technology through a system of

over 500 private contractors who are part of the VA Amputee Clinic Teams at the medical facility. This method of care is the same one used at Walter Reed.

VHA has been and will continue to be prepared to receive our war injured and treat them with the latest in new artificial limb technology. It is important to point out that VA's policy of providing high tech extends to all the special disabled categories of patients such as spinal cord injured, blind, traumatic brain injury, and hearing impaired. Examples of items provided to them are computers for the blind that have speech output, lightweight titanium wheelchairs, power assist and high-end power wheelchairs, digital hearing aids, and voice activated environmental control units for high-level spinal cord injured.

Moreover, the VA engages with the developers of new technologies in academia, at other government agencies, and among the private sector to identify emerging technologies that might enhance the lives of disabled veterans and to communicate the diverse needs and requirements of this community. One mechanism by which such engagement occurs is through workshops, such as the one that is being co-sponsored by the White House and the VA on *"Emerging Technologies in Support of the New Freedom Initiative: Promoting Opportunities for People with Disabilities."* The conference, which is to be held October 13-14 in Washington D.C., will bring together expert representatives from the research, industry, government, policymaking, and disabled communities.

Question 9: Congress authorized a new PTSD longitudinal study in Public Law 106-117 and expanded its purposes to include a review of the overall health status of veterans with chronic PTSD. The law requires the report of that study by the end of September 2004. I understand the report will be delayed. Please explain why the study is delayed, what VA is doing to get the report completed and provide the Committee a projection on when the report will be completed. How much has the PTSD study cost to date, and what is your estimate of the total cost of the study?

Response: It should be noted that, while VA had a sense of the plans and costs proposed by the original contractor, a formal study protocol for the National Vietnam Veterans Longitudinal Study (NVVLS) was never actually submitted to VA. The terms of the original contract allowed VA to decide whether to exercise its option to proceed with subsequent phases of the study; VA chose not to exercise its option with the original contractor for reasons other than projected costs. The contractor proposed three options that were reviewed by the project Scientific Advisory Board (SAB) and presented for the project Executive Committee. Each involved higher costs than the original costs estimated by VA, but the SAB and Executive Committee identified the middle cost option, an increase of $12M over the original estimate, as the best option, and it was planned to submit a request for additional funds. The contractor did not provide detailed documentation of their project plan until mid 2003, and at that time, their proposed cost had increased to $17M. The contractor created a set of survey and interview questions that could be used wholly or in part by an organization completing the NVVLS.

The management and oversight of the NVVLS is being revised. A new scope of work is been developed. A new Contracting Officer and Contracting Officer's Technical Representative (COTR) will be designated. The contract will require monthly progress and cost reports from the contractor. There will be a higher level of scrutiny by VA contracting staff to ensure that products are received on a regular basis, stay within available resources, and will serve to measure the progress of the project. It is believed that these actions will ensure satisfactory completion of the project. It is anticipated that the new contract will be awarded in late FY 2005 and a report prepared for Congress in FY 2006.

Question 10: The CARES Commission report, released on February 13, 2004, stated that currently, one-third of your community based outpatient clinics have no available mental health services. Two years ago, it was reported to us that about four in ten CBOCs had mental health services available. Please provide a report of the degree to which mental health services are being made available at this time in CBOCs, along with your plan to expand that availability.

Response: Veterans with a primary psychiatric diagnosis are currently receiving treatment for that disorder in all CBOCs by either primary care physicians or mental health specialists. Under the Mental Health Strategic Plan now under development, we are studying the most effective way to require access to specialty mental health services in all CBOCs. Plans under consideration to extend specialty mental health services to those CBOCs that do not now provide them and to expand services to those that provide insufficient services include the following:

- expand health services provided through VA's telehealth programs beyond the 48 CBOCs now receiving such services;
- contract with mental health providers in the local community;
- initiate a new performance measure, updated monthly, that reveals the percent of CBOCs in each VISN that have at least 10% of visits to a mental health professional, with an acceptable level of 85 percent.
- develop new outcome measures that the Under Secretary's Action Agenda Steering Committee will monitor regarding the status of the program expansion.

Question 11: In her testimony Dr. Sally Satel expressed the view that the current PTSD disability rating system uses a low threshold to compensate for PTSD and creates a disincentive for veterans to seek employment, thus setting a trap" that keeps these veterans "disabled for life". Do you agree or disagree with Dr. Satel?

Response: A VA diagnosis of PTSD is based upon the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, of the American Psychiatric Association (DSM-IV). DSM-IV is the basis for diagnosing and classifying mental disorders in the United States. As such, the VA standard for diagnosing and evaluating PTSD is the same as the American Psychiatric Association standard.

The Schedule for Rating Disabilities provides percentage evaluations based on the average impairment of earning capacity in civil occupations resulting from a service-connected disability. When evaluating a mental disorder, the evaluation is assigned based on occupational and social impairment. The frequency, severity, and duration of the psychiatric symptoms are considered in evaluating occupational and social impairment. When psychiatric symptoms in available medical evidence meet a particular percentage evaluation by regulation, VA grants the benefit at that percentage.

VA also provides Vocational Rehabilitation and Employment Services for eligible veterans to help them prepare for, find, and keep suitable employment. A veteran is eligible for Vocational Rehabilitation and Employment if he or she has a VA established service-connected disability rated at least ten percent disabling with a serious employment handicap, or at least 20 percent disabling with an employment handicap.

Given the programs available to these veterans through the Vocational Rehabilitation and Employment Program, we believe that VA vigorously supports and encourages employability for all qualifying disabled veterans.

Question 12: Does VA's model of disability compensation for veterans with chronic PTSD and other mental health diagnoses contravene or support the goals of clinical rehabilitation of veterans with mental illnesses? Is there another way to proceed that you would recommend to Congress that could be simultaneously compensatory and conducive to rehabilitation? If so, please describe any such reform.

Response: VA's compensation system supports the goal of rehabilitation of veterans, which is to allow the veteran to function in society to the optimal degree possible for them. The fact that a minority of veterans who are service-connected for mental disorders are 100 percent service connected attests to that. Without compensation, many disabled veterans would fall into homelessness. The added stress and risks of homelessness would in all likelihood lead to further deterioration of their condition, and therefore be directly harmful to their wellbeing. Our Nation's veterans deserve better than that, and the compensation system assures they receive what they truly deserve. It is VA's policy to promote the rehabilitation and recovery of veterans with mental and physical disorders to the greatest degree possible. Projects studying approaches to enhance employment opportunities for veterans have been and continue to be developed. To date, however, there is no evidence that alternative approaches to the current compensation system can be applied successfully. However, as directed by PL 108-136, the Veterans' Disability Benefits Commission will examine the Disability Compensation program and the appropriateness of a schedule for rating disabilities based on average impairment of earning capacity.

Question 13: Would it be fair for Congress to compensate veterans for mental disabilities on a basis that is different from the manner of compensation for physical disabilities?

Response: Mental disabilities are evaluated differently than physical disabilities, as the criteria for rating mental disabilities is specific to those disabilities.

By statutory authority, the Secretary of Veterans Affairs applies a schedule of ratings based on the average reduction in earning capacity in civil occupations due to service-connected injuries or diseases.

VA's evaluation criteria for rating mental disabilities adequately address a veteran's impairment of earning capacity, and there is no need to address mental disorders differently. However, as directed by PL 108-136, the Veterans' Disability Benefits Commission will examine the Disability Compensation program and the appropriateness of a schedule for rating disabilities based on average impairment of earning capacity.

Question 14: Dr. Satel also testified that VA needs to further explore veterans' military records in examining their claims concerning PTSD. Time did not permit a more thoroughgoing discussion of this issue. Could you respond to that concern in the context of current VA policy?

Response: By regulation, service connection for PTSD is established if there is medical evidence diagnosing the condition; a link established by medical evidence between current symptoms and an in-service stressor; and credible evidence that the claimed in-service stressor occurred.

VA examines a veteran's military and medical records when verifying a claimed in-service stressor in evaluating a claim for service connection for PTSD. Uncorroborated reports regarding stressful events are not accepted. VA has extensive procedures in place to ensure full development of evidence for claimed in-service stressors. This usually involves the assistance of the National Personnel Records Center, the U.S. Armed Services Center for Unit Records Research, and other Federal agencies, as appropriate.

Having a medical diagnosis of PTSD based upon a verified stressor is as important as the confirmation of that claimed stressor. Part of VA's duty to assist veterans is to provide a VA examination to obtain a medical diagnosis of PTSD based upon a verified stressor, if this is not already part of the veteran's record. At the examination, the veteran's military records are reviewed. Service connection and disability payments will only be granted based upon the three criteria above.

In the context of verifying a reported stressor upon which a medical diagnosis of PTSD is based, which is required for service connection, the veteran's military record is fully investigated.

Questions for the Record
Honorable Lane Evans
House Committee on Veterans Affairs
Subcommittee on Health
Committee on Veterans Affairs'
March 11, 2004

Hearing on the status of the Veterans Affairs' Post Traumatic Stress

Question 1: We were recently warned that VA would be late in delivering the National Vietnam Veterans Longitudinal Study to the Committee. After two years, VA's first contractor produced a study protocol that VA believed was too expensive. In addition, both parties agreed the study would not be timely. Rather than trying to negotiate with the contractor, VA has now sent out an entirely new request for information to a new group of potential contractors. What will VA do to ensure that the next contract it lets does not result in the same problems?

Response: It should be noted that, while VA had a sense of the plans and costs proposed by the original contractor, a formal study protocol for the National Vietnam Veterans Longitudinal Study (NVVLS) was never actually submitted to VA. The terms of the original contract allowed VA to decide whether to exercise its option to proceed with subsequent phases of the study; VA chose not to exercise its option with the original contractor for reasons other than projected costs.

The management and oversight of the NVVLS is being revised. VA is competitively rebidding the contract to obtain additional proposals. A new scope of work has been developed. A new Contracting Officer and Contracting Officer's Technical Representative (COTR) have been designated. The contract will require monthly progress and cost reports from the contractor. The COTR will provide monthly briefings to the Under Secretary for Health (USH) on the progress of the contractor relative to the scope of work. It is believed that these actions will ensure satisfactory completion of the project.

Question 2: Dr. Roswell, are you confident you have adequate information from DOD to plan for the resources VA will need to meet the needs returning troops will have for PTSD and other services?

Response: At approximately six-week intervals, VA has been receiving an updated roster from the Department of Defense (DoD) of separated military personnel who served in Iraq and Afghanistan. With this roster, VA has been able to assess health care visits of these veterans to the VA utilizing computerized inpatient and outpatient records. Because of improvements in VA's health information technology since the Gulf War in 1991, VA is now able to track the health care utilization and diagnoses of all Iraqi Operation Freedom

(OIF) and Operation Enduring Freedom (OEF) veterans every time they receive health care from the VA. This information has been valuable in resource planning by allowing us to determine the level of health care needed by recent war veterans and their most common health problems.

It would also be helpful if VA had the following additional information:

1. Information on the physical and stress-related exposures of troops during deployment. This type of information would actually be more useful in projecting the needs of returning veterans than the information we currently have on their VA health care usage after their return to the United States.

2. Post-deployment health screening data available in a computerized format. Such information would be helpful for the purposes of patient care because DoD's post-deployment health assessment elicits information on health status just after deployment and asks about risk factors for both physical and psychological health problems.

3. Information from the DD 214 in a completely computerized format (as opposed to simply a scanned image of the document). Information from the DD 214 would enhance the process by which we identify veterans who served in combat and who are eligible for care under the special treatment authority in 38 U.S.C. section 1710(e)(1)(D). This, in turn, would expedite VA's ability to furnish needed care to those veterans.

Question 3: In your 3/10/04 response to Congressman Evans' letter regarding preparing for new post-traumatic stress disorder workload, VA indicated that it continues to work with DOD to develop systems for sharing information. Does VA expect to routinely collect some sorts of information, such as the post-deployment assessments VA has stated would be useful for its purposes, in the near future or is this exchange years' away?

Response: There are a number of technical alternatives, e.g. leveraging work accomplished through Federal Health Information Exchange (FHIE), and planned through the joint VA/DoD Clinical/Health Data Repository (CHDR) projects, to provide access to the data. VA and DoD meet regularly as part of the Deployment Health Working Group to discuss issues that include the development of systems for sharing information. However, a specific timetable and technical approach cannot be provided until the users in both departments agree upon the requirements. We do not believe an agreement between the departments will be resolved in 2004.

Question 4: Family support is so critical in helping veterans make the transition from being a "warrior" to a "citizen" once again. VA is authorized to provide care to family members, incidental to the care it provides veterans (CFR Sect. 17.38). It is also authorized to provide bereavement counseling in some circumstances

(38 CFR Sect. 17.98). Does VA require any additional authority to provide the types of supportive services required by families of veterans from the GWOT either through vet centers or through the VA medical centers? Does it have the resources to deliver needed services?

Response: VA concurs that family counseling is an essential component for serving homecoming veterans. For some war-traumatized veterans family counseling is an important addition to individual and/or group post-war trauma counseling. Family counseling can help ease the tensions of homecoming for all veterans and help war-traumatized veterans manage the possibly adverse affects of their psychological trauma on other family members. The provision of family counseling has been an integral part of the Vet Center program s service mission since the program's beginning in 1979. The law authorizing VA to provide readjustment counseling, 38 U.S.C., section 1712A, includes authority for the Vet Centers to provide family counseling when determined to be essential to the veteran's readjustment. In August 2003, the Secretary granted approval for the Vet Centers to provide bereavement counseling to surviving family members of Armed Forces personnel who died while on active duty in service to their country. Now, in addition to serving the family members of veterans, the Vet Centers are also actively providing bereavement counseling to military family members who have lost loved ones in the battlefields of Afghanistan or Iraq. The Under Secretary for Health's Special Committee on PTSD and the Secretary's Advisory Committee on the Readjustment of Veterans recommended increasing the Vet Center program's capacity to provide family counseling by adding trained family therapists at existing Vet Centers. VA is currently developing a proposal for action for implementation.

Question 5: Can you provide the Committee with a detailed plan for spending the $25 million the Congress included for enhancing VA mental health programs, including PTSD?

Response: P.L.108-170 provides $5 million for enhancing PTSD programs, and $5 million for substance abuse services. A review committee with both VACO and field representation is evaluating the current array of PTSD and substance abuse specialized treatment programs. Networks with significant deficits in programming will be identified and contacted to determine their interest in enhancing these services. Programs focusing on co-occurring substance abuse other mental disorders, as well as opiate substitution programs will be among the types of services assessed for development along with residential and outpatient PTSD and substance abuse care programs. Subsequent to this analysis, s~ec1~d II be invited to submit written proposals. These proposals will be reviewed and funding recommendations will be made based upon veteran need and quality of submissions. This process is expected to be completed by June 2004.

Ten million dollars will be allocated to clinical programs jointly identified by the Mental Health Strategic Healthcare Group (MHSHG) and Under Secretary for Health's Committee on Care of Veterans with Serious Mental Illness. These programs will have a special focus on rehabilitation and recovery of patients with all types of serious mental disorders. The development of these programs will further the goals of the Action Agenda for Transforming VA Mental Health Care, designed to implement the recommendations of the President's New Freedom Commission on Mental Health in the VA.

An additional $5 million will be allocated to other mental health programs identified by MHSHG, with a particular focus on supporting returning OEF/OIF veterans. VISNs and facilities located near large numbers of returning OEF/OIF veterans, especially those from Reserve and National Guard units will be assessed for additional staffing to assist in the transition of these veterans back into the community and meeting their psychosocial needs.

Question 6: Dr. Roswell, you responded to a question from Rep. Strickland that indicated VA would seek authority to extend its military sexual trauma program. Is it time to make this a permanent program? Why or why not?

Response: The Advisory Committee on Women Veterans has recommended (this in their 2000, 2002, and 2004 bi-annual reports to Congress. A 2002 DoD survey showed that the problem may be less than it once was in the military, and however, there is still a significant amount of sexual harassment (45% for women and *31%* for men), sexual coercion (8% and 1%), and sexual assault (3% and 1%.) Furthermore, victims do not always realize the full impact or seek treatment until many years afterwards. The need, therefore, will continue for many years, and VA must be positioned to provide veterans with sexual trauma services and related health care indefinitely.

A legislative proposal to make permanent our authority to operate program of counseling and treatment for sexual trauma is currently being finalized within the Department. We hope to be able to submit it to Congress sometime this spring.

Question 7: Both the Under Secretary for Health's Special Committee on PTSD and the Committee on Care for Seriously Mentally Ill Veterans have recommended some approaches to identifying acute cases of PTSD among our newest veterans—providing education to identified VA points-of-contact, for example, and conducting small group information sessions immediately before the National Guardsmen and reservists are demobilized. How does VA plan to respond to these recommended initiatives?

Response: A number of educational products have been provided to the field in support of care for veterans returning from OEF and OIF. A list of these products, prepared by the Office of Environmental Hazards, is in the attached document entitled, "Providing Health Care and Benefits for a New Generation of

Combat Veterans. Additional educational programs are currently being planned for VA clinicians who will be serving as points of contact for returning veterans.

Assessing and meeting the needs of returning veterans includes providing treatment for their mental and physical disorders associated with deployment to Afghanistan and Iraq as well as their readjustment to the community and civilian life. Both face-to-face and media supported training initiatives (e.g. written materials and web-based Veterans Health Initiatives) are planned for the coming months. Revised with DoD collaboration, we are also updating the National Center for PTSD's Iraq War Guide based on recent experiences of returning OEF/OIF veterans is also being completed.

Question 8: Do you think a National Educational Forum on PTSD would be appropriate to disseminate and highlight all of the new information, including the clinical practice guidelines, VA has brought to the Subcommittee's attention?

Response: Such a forum is one of the approaches planned as part of the educational initiatives noted in the response to question 7, above. In addition, there will be a special emphasis on issues of returning OEF/OIF veterans at the Readjustment Counseling Service National Training program in November 2004. A list of projects already planned for FY 2004 involving PTSD has been provided by EES and is attached.

Question 9: Dr. Batres, vet centers have seen 4600 veterans from the GWOT. Does recruitment account for the difference in the numbers vet centers have seen and the number of new patients (about 500) VA PTSD programs have seen? Do the vet centers have additional capacity?

Response: The Vet Center program provides a unique outreach service within the Veterans Health Administration. By design, the Vet Centers systematically provide these services to returning Global War on Terrorism (GWOT) veterans and their families. The fact that Vet Centers are community-based, community integrated, streamlined, efficient and veteran friendly contributes greatly to their ability to be flexible and effective. To a great degree, the Vet Center program structure allows them the flexibility and mobility to address these outreach missions. In this regard, the Vet Centers were cited by The Presidential Advisory Committee On Gulf War Veterans' Illnesses for providing exemplary outreach services to contact and inform Gulf War veterans. The Committee further recommended that other VHA services and programs adopt Vet Center strategies for conducting outreach to improve services to Gulf War veterans.

On April 1, 2003, Secretary Principi authorized extending eligibility for Vet Center services to veterans of OEF. On June 25, 2003, eligibility for VA readjustment counseling services was extended to veterans of OIF and subsequent operations within the GWOT. To date the Vet Centers have provided transition services to over 5,200 GWOT veterans and their family members. Since the onset of OIF in

March 2003, the Vet Centers have also been actively pursuing the program's community-based service mission by conducting systematic outreach to military installations targeted to receive returning troops from Afghanistan and Iraq, with particular attention to National Guard and Reserve personnel returning home following their deployment. Vet Center staff visits to military installations, and to National Guard and Reserve components, promote coordination with DoD Family Assistance Centers to provide a continuum of care for separating service men and women. Within the context of the Vet Center program's outreach activities, family members of service men and women deployed to the GWOT are provided with educational information, and case management by Vet Center staff.

In addition, the Under Secretary for Health recently approved an initiative to augment the Vet Center program's capacity to provide outreach to veterans returning from the GWOT in the theaters of combat operations in Afghanistan and Iraq. Specifically, the initiative is to hire approximately 50 temporary outreach workers for up to a three-year period at targeted Vet Centers. Based upon the model of a similar initiative implemented in the wake of the Gulf War in 1991, the plan is to hire recently separated GWOT veterans into these temporary outreach positions. This augmented outreach effort will serve to facilitate the early provision of VA services to returning veterans and their family members immediately upon the service members' separation from the military. These positions will be located on or near active military out-processing stations, as well as National Guard and Reserve facilities. These temporary veteran-hires will significantly add to the Vet Centers' ability to get the word out to transitioning servicemen/women about their expected military-related readjustment needs and the complete spectrum of VA benefits available to them and their family members. These new hires will also organize local community activities to provide information and education about VA, DoD, and other community support services available to veterans and family members.