STATEMENT OF
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TO THE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE ACTIONS CONCERNING POST TRAUMATIC STRESS DISORDER TREATMENT, OUTREACH AND INTERVENTION TO DEPLOYED SERVICE MEMBERS

JULY 27, 2005

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to comment on the Department of Defense (DoD) and Department of Veterans Affairs (VA) actions to address outreach, intervention, availability of services and appropriateness of resources regarding the demand for Post Traumatic Stress Disorder (PTSD) and other mental health services for deployed service members, including Reserve and National Guard members.

As the Global War on Terror continues, casualties are mounting and the ability of the nation to take care of those who have fought bravely continues to be tested. We must not fail. History has shown that the cost of war does not end on the battlefield.

Service members do not all suffer from obvious wounds such as amputations, traumatic brain injury (TBI) and other severely disabling conditions. Mental health experts estimate as high as 30 percent of those serving in Operations Enduring Freedom (OEF) and Iraqi Freedom will suffer the hidden wounds of traumatic stress due to combat exposure and the rigors of the battlefield.

The American Legion/Columbia University PTSD Study

OIF/OEF veterans should fare much better than their Vietnam veteran counterparts with regard to treatment of PTSD. Much more is now known about the factors that predispose an individual to chronic PTSD, the qualities of the stressors that may lead to PTSD and the factors in the post-trauma life course that may exacerbate or ameliorate PTSD symptoms. Contributing to this knowledge base, a study conducted by The American Legion and Columbia University was published in the *Journal of Consulting and Clinical Psychology*, Vol. 71, No. 6 (December 2003). The study was begun in 1984. In 1998 we had the opportunity to re-survey the population of Legionnaires we had studied in 1984, making this the first longitudinal study to examine risk factors related to the course of PTSD in a random sample of American Legionnaire Vietnam veterans. We now have a sample of 1,377 Legionnaires who served in Vietnam, completed the

survey in 1984 and again in 1998. We also have surveys from 1,941 veterans who served in other areas of the world during the Vietnam War and who responded both times.

The study showed that the strongest predictor for having PTSD at follow-up in 1998 was having had PTSD in 1984. Veterans who had PTSD in 1984 were 14 times more likely to have PTSD in 1998. Nearly 12 percent of the population met the criteria for a diagnosis of PTSD in 1998, which is a similar percentage to that observed by other researchers. Thus, large numbers of veterans are at high risk for continuing to suffer from PTSD. Combat exposure is the traumatic event most highly associated with PTSD in these veterans and we have observed a dose-response relationship: the higher the levels of combat exposure, the more likely the development of PTSD. We also observed a heterogeneous course for PTSD over the life span, that is, only 5.3 percent of the population met the criteria at both times. This implies a steady prevalence of about 12 to 15 percent. This is consistent with reports of World War II veterans. Today more than 123,000 veterans are service connected for PTSD, most as a direct result of combat exposure.

The study also identified other risk factors for a negative PTSD course: minority status, elevated depression and anger and the extent of perceived social support.

- We found that minority status along with perceived community negative attitudes at homecoming and lack of community involvement were risk factors for the course of PTSD. This suggests that social stigma or exclusion from the community plays a large role in the persistence of the disorder. Other studies have shown that lower socioeconomic status and educational strata factors may predispose PTSD. Minorities also appear to have the poorest prognosis for recovery from PTSD. The well-known negative attitudes of the public toward returning Vietnam veterans contributed mightily to the chronicity of PTSD in later life; attitudes which our currently returning veterans will not have to suffer. The higher educational levels of the present day all-volunteer force and the hero status being afforded our newly minted combat veterans, along with proactive prevention and treatment methods by both DoD and VA may well contribute to a lower incidence of PTSD in new this new cohort of veterans.

- Our study found that depression and anger were also risk factors for PTSD. Possible explanations for this finding is that that elevated depression and anger may be markers for PTSD severity and persistence and may interfere with the confrontation with and processing of traumatic memories that appear to be necessary for recovery from the disorder. Patient characteristics that predict negative treatment response such as a high level of anger at the beginning of the prolonged combat exposure may also be associated with more chronic PTSD in later life. Recent reports of higher than usual suicide rates among troops in Iraq should raise red flags for both VA and DoD**.**

- Intense exposure to combat was a major risk factor for Vietnam veterans and is no less so for veterans of the Afghanistan and Iraq wars. These conflicts entail stereotypical exposure to warfare experiences such as firing weapons at human beings, being fired upon by the enemy or in friendly-fire incidents, witnessing injury and death, going on special missions and patrols, handling remains of civilians, enemy forces and U.S. and allied personnel. In Vietnam, little was known of the effects of months of unabated

combat duty on troops. Save for the occasional in-country rest and relaxation (R&R) and a one-week R&R out-of-country, service personnel were more or less in combat for the full tour of duty. There were no "lines" to fall behind for relative safety. Troops in Afghanistan and Iraq are now facing the same type of insurgency environment where anything can and does happen without notice, leading to high anticipatory anxiety. Enlisted soldiers, non-commissioned officers and officers are now trained to identify the signs of normal "battle fatigue" as well as the signs of severe, incapacitating stress-reactions. Post-battle debriefings are now routinely used to allow soldiers to vent and share their emotional reactions. Troops who exhibit severe war-zone stress reactions are treated humanely and receive special care. The guiding principle is known as Proximity-Immediacy-Expectancy-Simplicity (PIES). Early and simple interventions are provided close to the soldiers unit and the soldier is told his or her reactions are normal and that he or she can expect to return to their unit shortly.

Outreach

The all-volunteer operations in Iraq and Afghanistan differ from previous conflicts in that the Reserve and National Guard make-up a higher percentage of those deployed, more women are deployed and experiencing combat conditions and more troops are married. These differences present problems that heretofore were not addressed on the scale they present today. Reserve and National Guard return home and try to reintegrate into their communities leaving the military support system that they have relied on for many months. The American Legion is concerned with the unique stressors faced by the Reserve and National Guard that are presented with repeated deployments. Not only do America's servicemembers experience the horrible images of war, issues at home can also weigh heavily on their minds. Will they have a job when they return? Will they be able to keep their home? The unique experiences of military combat can create anxiety about their own situations at home and make them more susceptible to stress reactions.

In 2003, almost 17 percent of veterans used specialized mental health services provided by the Veterans Health Administration (VHA), and 22 to 29 percent of veterans are estimated to suffer from substance use disorders. A study in the New England Journal of Medicine of U.S. combat infantry troops returning from operations in Iraq and Afghanistan found that 15 to 17 percent screened positive for major depression, generalized anxiety disorder or PTSD after deployment. However, for those who screened positive only 23 to 40 percent actually sought care. The study concluded that while returning troops are at significant risk of stress-related mental health problems, "subjects reported important barriers to receiving mental health service." The biggest concern voiced was about the stigma attached to mental health services. Indeed at the Joint Department of Defense (DoD)/ VA Conference on Post Deployment Mental Health held in March 2005 stigma was thought to be the major barrier to getting help.

Effective outreach is critical to ensuring needed mental health services are accessed in a timely manner. Outreach conducted by VA and DoD has improved considerably over the last few years. Outreach activities include:

- Transition Assistance Programs and Military Briefings (TAP);
- Reserve and Guard Briefings at the Unit level;
- Veterans Assistance at Discharge (VADS);
- Letters to service members by the Secretary of VA;
- Letters to Adjutant General by Secretary of VA;
- Remote areas services and outreach;
- Mental Health Screening at the Unit level.

Vet Centers

Vet Centers are invaluable resources to veterans and VA. Given the protracted nature of current combat operations, repeated deployments and the importance of retaining experienced combat service men and women in an all volunteer military, it is essential to promote the readjustment of service men and women and their families. The mission of the Vet Centers is to serve veterans and their families with professional readjustment counseling, community education, outreach to special populations, work with community organizations. Vet Centers are key links between veterans and other services available within VA. Vet Centers are located in the community and there are 207 of them throughout the country. Approximately 65 percent of the staff are veterans and of those over 40 percent are combat veterans.

On April 1, 2003 the Secretary of VA extended Vet Center eligibility to veterans of OEF and later that same year extended eligibility to veterans of OIF. On February 3, 2004 the VA Under Secretary for Health authorized the Vet Center program to hire 50 OEF/OIF veterans to conduct outreach to their comrades from the War on Terrorism. These outreach counselors were placed in 34 states and the District of Columbia. In addition, on August 5, 2003 Vet Centers were authorized to furnish bereavement counseling services to surviving parents, spouses, children and siblings of service members who die while on active duty, to include federally activated Reserve and National Guard personnel.

Vet Center staff reach out to thousands of veterans and family members at demobilization sites and TAP briefings. The American Legion continues to be an unwavering advocate for Vet Centers and their most important mission. We believe Vet Centers are central to the mission of VA and that they truly strive to fulfill their statement of purpose:

> "We are the people in VA who welcome home war veterans with honor by providing quality readjustment counseling in a caring manner. Vet Centers understand and appreciate veterans' war experiences while assisting them and their family members toward a successful post-war adjustment in or near their community."

Post Deployment Health Reassessment

DoD has created a post-deployment health reassessment to be implemented 3-6 months upon the service members' return from areas of combat. This new assessment will focus on the adverse health effects —especially mental health difficulties like PTSD, and social readjustment issues—

that the service members experience after attempting to resume their lives. It addresses the observation that many of these health effects may not manifest immediately. Some problems are not evident for months after the service member returns from combat duty.

The health information obtained from these reassessments is supposed to be used to improve communication between the health care provider and the service member and to help in assessing the service member's health. This program will be available to active duty, reserve and guard members through VA and TRICARE by the end of September 2005. All the services have submitted their respective implementation plans. The plan is to have a phased approach with adjustments made as needed.

The 1st Marine Expedition Force at Camp Pendleton, California was the first to test the program using an Internet–based version. However, technical problems with the electronic version subsequently led to the need to test a paper version that also ran into some difficulties. The program has also been tested by a group of reservists in the Midwest with feedback expected in September 2005.

Coordinated efforts between DoD and VA are essential in ensuring the mental health and well being of all returning service members. Implementation is always the most difficult part of the process. It takes time, funding, and most of all, cooperative leadership to ensure service members reap the benefits of a good solid program.

Early Intervention

Early screening, triage, and intervention may help to prevent the development of chronic post deployment mental health problems. However, due to the stigma associated with the admission that one may have mental health issues, it is thought that many service members do not truthfully answer the PTSD screening questions on the DD–2796 Post-Deployment Health Assessment.

One of the findings at the Joint DoD/VA Conference on Post Deployment Mental Health maintained that prevention and intervention should start as a squad-level responsibility. If those service members under the leadership of their first line supervisor were led through discussions on normal reactions to stressful events the service members may be capable of better self care and more supportive of their peers experiencing these reactions. The British Royal Marines have already proven this to be successful through their TRIM Program.

Combat Stress Control In–Theater

Combat stress control teams are stationed throughout Iraq to provide mental healthcare to service members who begin experiencing combat and operational stress reactions, and to help prevent others from developing them. Behavioral health teams are incorporated in some units in Iraq as well as Afghanistan. These teams serve to educate service members and their chains of command about symptoms of combat and operational stress reactions, teach self-help techniques and exercises that can be used to combat these reactions, and inform service members of the professional services available to assist them. Those who request it or appear to need extra help are typically referred for "restorative care," offered at fixed locations, generally limited to 72

hours. It includes more intensive stress and anger management, relaxation training and individual and group counseling.

While these stress teams are valuable and certainly a step forward, they are limited in staffing and only reach a fraction of the service members that need them.

Combat Stress Programs

Many programs and policies have been established to identify and mitigate the effects of combat stress on the lives of service members who served in areas of conflict. Returning service members are required to complete a post-deployment health assessment, a post-deployment health re-assessment 3 to 6 months after return and attend a risk communication and benefits briefing. Returning service members are also supposed to undergo deployment cycle support, unit reintegration, and family reintegration.

Some of the programs available include: Military One Source, an Internet and telephone-based counseling program that allows service members to discuss anything that causes them stress; the Specialized Care Program (SCP) that addresses therapeutic and relaxation methods to cope with pain and stress; and case management that tracks people as they go through the health care system.

The Combat Stress and Deployment Mental Health (OSDMH) working group has been established to address problem solving for combat-related stress. The working group, a joint DoD/VA entity, will re-examine and rewrite combat stress control regulations and guidance so that it will reflect new information and be interoperable for use among all the DoD services and VA.

Project DE-STRESS

Project Delivery of Self Training and Education for Stressful Situations (DE-STRESS), a pilot study funded by the National Institute of Mental Health in collaboration with Boston University School of Medicine and Boston Department of Veteran Affairs Medical Center is designed to test methods for reducing PTSD symptoms for those exposed to military-related trauma. The study uses Internet-based interventions to determine which one effectively helps the participant control his or her symptoms. Stress Inoculation Training (SIT) seeks to instill stress management strategies, teaching the participant that stress is inevitable.

This two year study will consist of in-depth assessments, intensive stress management training sessions and daily, self-paced, Internet-based follow up participation with 24/7 trainer monitoring and guidance. Each group will have 50 participants recruited primarily from Walter Reed Army Medical Center's health care system. The principle investigators are officers from Walter Reed Army Medical Center, staff from the Boston VA Medical Center and staff from the University of New South Wales.

Availability of Mental Health Services

VA leads the world in the treatment of PTSD and US veterans from all conflicts seek treatment from VA for mental health issues. The availability of mental health services in VA varies considerably from one Veterans Integrated Services Network (VISN) to the next. The reason for this is usually because the VISNs do not consider mental health a priority and do not spend the money to institute programs. While Community Based Outpatient Clinics (CBOCs) are supposed to be providing outpatient mental health services, not all of them do.

Capital Asset Realignment for Enhanced Services (CARES)

The CARES decision published in May 2004, called for the closing of Highland Drive VA Medical Center in Pittsburgh, PA; VAMC Brecksville, OH; and VAMC Gulfport, MS. All three of these facilities provide a broad range of mental health services, substance abuse treatment, PTSD treatment and outreach and referral services. Indeed, Highland Drive has also opened a complete Adult Day Health Care Program, and is home to the OEF/OIF Primary Care Clinic serving active duty and veterans of these two conflicts.

Access to and the provision of adequate mental health services to our nation's veterans was a provision left out of the most comprehensive evaluation and retooling of the largest health care system in the nation, VA. Because VA provides services that are not comparable to the private sector, it was difficult to devise an accurate model that could project mental health needs into the future. However, the CARES process proceeded forward with promises that mental health needs would be "folded in" to the overall strategic plan that also includes the implementation of CARES.

To VA's credit a Mental Health Strategic Health Care Group, made up of dedicated hard working individuals, developed a mental health strategic plan for the entire system. While the plan has been tentatively concurred with and partially released, implementation and integration of the plan will take years.

The American Legion has strenuously objected to the fact that mental health services were left out of the CARES process and we will continue to ensure that veterans services are not shut down before new facilities are completely functional.

Operation Enduring Freedom/Operation Iraqi Freedom

Implementation has not always been VA's strong suit. The VA's Special Committee on PTSD was established 20 years ago to aid Vietnam-era veterans diagnosed with PTSD. Since its establishment, the Special Committee has made many recommendations to VA on ways to improve PTSD services. A Government Accountability Office (GAO) report from February 2005 pointed out that VA delayed fully implementing the recommendations of the Special Committee, giving rise to questions regarding VA's capacity to treat veterans returning from military combat who may be at risk for developing PTSD while maintaining PTSD services for veterans currently receiving them. In September 2004 GAO also reported that officials at six of seven VA medical facilities stated that they might not be able to meet an increase in demand for

PTSD services. Additionally, the Special Committee reported in its 2004 report that sufficient capacity is not available within the VA system to meet the demand of new combat veterans and still provide services to other veterans.

Over the past three years The American Legion's System Worth Saving Task Force has completed site visits to every VAMC. We looked at mental health services provided and at the capacity of the facilities to handle the recent returnees. Like the GAO report, we found that many facilities were increasingly concerned with their ability to handle an increasing workload.

Resources

It has been estimated that nearly 30 percent of those returning veterans from OIF/OEF, both men and women, will be diagnosed with some type of stress disorder that will require treatment. The importance of VA to maintain capacity in the mental health area cannot be overstated. Recognized as a national leader in the treatment of mental illness, most notably PTSD, success in treatment protocols, recruiting and retaining capable mental health experts and implementing new and innovative initiatives is critical.

Our site visits revealed a critical shortage in the funding of VA health care. A great majority of the facilities reported having to convert capital improvement dollars to health care dollars in order to meet the service demands of the current veteran patient population. The result of this is not having enough money to make needed repairs on infrastructure needs, resulting in huge maintenance backlogs at facilities.

The House passed version of the fiscal year 2006 Military Quality of Life and Veterans Affairs Appropriations bill now pending in this Congress "fences off" $2 billion for specialty mental health treatment. The American Legion appreciates Congress' recognition of the need for resources in this area; however, we believe that this will force VHA to further ration care in other areas. Shuffling funds within a weak budget is no way to run a health care system designed to take care of the soldiers wounded both in body and psyche while defending our freedoms. Congress should appropriate a supplemental $2 billion in fiscal year 2006 to cover this critical need.

Conclusion

While much progress has been made in the efforts to identify and treat servicemembers suffering from the effects of PTSD, The American Legion urges this Committee to provide VA with the resources necessary to not only meet the current demand for mental health care, but also, the future needs of the young men and women returning home from the current conflicts in Iraq and Afghanistan.

The American Legion continues to support the efforts of VA and DoD and we look forward to working with Congress to ensure VA is capable of fulfilling its mission of providing the best treatment and care possible to this nation's veterans.