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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
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My name is Matthew J. Friedman, MD, PhD. Since 1989 I have been Executive Director of the VA's National Center for Post-Traumatic Stress Disorder (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.