

**United States House of Representatives
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Status of Veterans with PTSD
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**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.