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Statement of
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Thank you, Mr. Chairman and members of the Committee. I wish to applaud the efforts by members of the Congress and the Department of Veterans Affairs (VA) to address the healthcare needs of those service members currently engaged in combat operations. Moreover, recent legislation to support additional mental health care programs throughout VA demonstrates leadership's support for quality care for the men and women who bravely serve in the United States military.

Thank you for the opportunity to appear before you today to discuss the role of the Department of Veterans Affairs and the National Center for Post-traumatic Stress Disorder (NCPTSD) in meeting the mental health care needs of veterans and service members returning from Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF). VA has performed a tremendous service to our country's soldiers and veterans through outreach programs designed to provide unprecedented access to care for those who have served.

My testimony today will focus on a number of topics, including 1) comparisons between veterans from previous combat and peacekeeping missions and the current cohort of OIF/OEF veterans; 2) lessons learned from working with veterans from these previous combat and peacekeeping missions; 3) an overview of collaborative educational and clinical initiatives between NCPTSD and DoD to support OIF/OEF service members, veterans and their families; and efforts to provide education and training to the mental health community located on the Hawaiian Islands concerning stress, violence and traumatic stress. 4) anticipation of educational and clinical training needs to augment VA/DOD seamless transition process.

I. Comparisons between Vietnam veterans and OIF/OEF veterans
During the last 30 plus years, VA and the National Center for PTSD have performed an outstanding service to this country's veterans by developing the best possible assessment and treatment protocols for combat related Post-traumatic Stress Disorder (PTSD). VA has provided outstanding and quality healthcare to thousands of veterans who bravely served their country in

overseas wars for their emotional and psychological difficulties. As a result of this long standing commitment, accurate assessment tools and evidenced-based guidelines are now readily available for VA and DoD providers. As we move forward in this tradition to provide quality healthcare to our nation's service members and veterans, we need to recognize the importance to update and refine VA's models of care in order to best serve the next generation of American Veterans.

Most of what we know about the effects of traumatic stress, we learned from veterans from previous wars and peacekeeping missions (e.g., Vietnam, Somalia). We now face both a great challenge and opportunity as we translate our knowledge and clinical expertise, learned over the past 30 years, into evidenced based treatment for this current cohort of OIF/OEF veterans. We must appreciate both the differences and similarities between the previous generations of warriors with those serving in today's military.

Past Perspectives: The Veterans of the Vietnam War
Veterans of the Vietnam era cohort were a relatively homogeneous group: largely young males between the ages of 18-22 years old, single, drafted-active duty, and therefore in the relatively early stages of life development, and education, work, and career goals. Typically, they served a single 12-13 month deployment in country. Unlike those veterans of prior wars, those who returned from Vietnam faced a divided, and at times, hostile public. Unlike the experience of veterans of prior wars, few large scale homecoming ceremonies were offered to show support. In fact, veterans were often publicly scorned and society's negative stereotyping/ stigmatizing often foretold a difficult and problematic readjustment/reintegration into society.

At first, a small percentage of Vietnam veterans accessed VA care. This may have been due, in part, to the lack of knowledge about the effects of combat stress on psychological adjustment following military service. Also, these veterans returned to a hostile and divided US public who cast blame on the veterans as well as the government for the war. At that time, veterans may have avoided VA due to a fear of being labeled ?crazy? or ?mentally imbalanced.?

Current perspectives: Veterans/Returnees of the Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF)
Veterans and returnees of OIF/OEF and the Global War on Terror (GWOT) often return to supportive communities who express appreciation for their sacrifices---despite political divisions in our country about the meaning and purpose of these wars. The age range of these combatants is 18-60 years. Many service members are married with children. Most of the Reserve and National Guard have jobs and careers at home. Currently, women constitute a significant segment of the combined forces approximately 10%, many of whom serve in leadership roles. Unlike those who served in previous combat theaters, those deployed in OIF/OEF are likely to have experienced deployments lasting longer than 12-13 months and significant numbers may have experienced repeated deployments.

In terms of assessment, diagnosis, and treatment, the field of PTSD is no longer in its infancy. We now have a body of knowledge that is replete with a variety of theories, assessment measures, treatment models, practical interventions, educational tools, and research findings in physiological, medical, psychological, and behavioral domains. Studies suggest that the great

majority of current returnees, like those veterans of prior wars, experience the normal range of post-deployment adjustment reactions. Similarly, a smaller percentage develops PTSD as a result of their combat experiences. A recent study (Hoge, et al., 2004) in a sample of Army and Marines (n= 3,671) who served in Iraq and Afghanistan, indicates that post-deployment, approximately 12% met criteria for PTSD. Pre-deployment assessment found the rates for PTSD were very similar to those of the general population: 5% and 3-4% respectively. Collectively, 17% met criteria for PTSD, Depression, or Generalized Anxiety Disorder (GAD). Of those whose responses were positive for a mental disorder, 38-45% were actually interested in receiving help and 23-40% actually received help.

II. Lessons learned from research and treatment of previous veterans

Important lessons from clinical research and treatment interventions to thousands of veterans in the past thirty years provide us with a solid foundation of treatment experience that should enable us to respond appropriately and effectively to the needs of veterans and service members from OIF/OEF. Through our work with active duty, National Guard and military reserve units, we have learned to integrate such experience with recent scientific and clinical advances in the field. The following are lessons learned to be considered for OIF/OEF service members and veterans:

1. Greater implementation of early intervention strategies for service members recently exposed to highly stressful events provides an opportunity to apply primary prevention to offset the psychological trauma of combat operations. The importance of early intervention strategies, such as psycho-education to service members, veterans, and families, can not be over-emphasized. Early intervention may provide the best opportunity to prevent more chronic forms of PTSD in the months and years following combat operations.

2. Associated with early intervention strategies is the concept of ?stage of transition.? We now recognize that many individuals who experience traumatic stress go through a normal transitional period which may be marked by mild clinical features (e.g., insomnia, sadness). However, it is important to recognize that this phase is an absolutely normal response to loss or stress. We encourage providers not to immediately label these responses with psychiatric labels. In addition, we recommend to providers to watch for potential ?red flags? such as substance abuse, anger, concentration deficits, which may be signs that the individual requires additional professional interventions.

3. Further, we have been promoting a population-based approach to screening for combat stress within the military and VA. Both agencies are now routinely using the NCPTSD Primary Care PTSD Screen. This screen is a brief, four-item tool that can accurately and efficiently identify individuals who warrant further assessment for possible PTSD. In addition, NCPTSD has produced many gold-standard assessment instruments, such as the Clinicians Administered PTSD Scale (CAPS).

4. We have learned that in addition to addressing issues of traumatic stress, that it is important to address resilience and growth. Instead of a narrow focus on PTSD symptoms and related difficulties, we have promoted resilience, or ?psychological armor? to both active duty and

veterans from OIF/OEF. This approach has the effect of increasing positive, active coping and maintaining one's life goals and plans both during and after military experience.

5. Veterans and service members do not always seek out behavioral health care, even when they suffer from combat stress/PTSD or other psychiatric conditions. For example, many veterans will seek mental healthcare from their primary care providers. In response, we now provide greater education to primary care providers about the effects of combat stress on the physical and psychological status of their patients. Further, we now provide more on-site mental health staff in primary care settings in order to address these psychological issues, such as combat stress/PTSD, within the medical setting and during the primary care appointment.

6. Veterans from each combat era develop a unique lexicon, or language to describe their own unique combat experiences. In addition to appreciating the unique aspects of their war zone experiences, it is also important that clinicians learn the lexicon that veterans speak to describe these experiences. By having a shared language, clinicians can deliver treatment interventions that more accurately capture the veterans' experience.

7. Polytrauma and blast related injuries are complex medical conditions that require focused, coordinated and comprehensive medical interventions. These conditions may consist of trauma to the head, eyes, ears, and spinal cord, as well as multiple injuries to internal organs, musculoskeletal and connective tissue systems. Closely related to the physical injuries are potential mental health conditions, such as posttraumatic stress disorder (PTSD), major depression, and anxiety disorders, which may interact with the physical injury to decrease overall health status and adherence to medical regimens. Such complex medical injuries require coordination with mental health to treat the psychological wounds associated with these physical injuries.

III. Overview of collaborative educational and clinical research initiatives between NCPTSD and DoD

The National Center for PTSD is a consortium composed of the following seven divisions: Executive, Women's Health Sciences, Behavioral Science, Clinical Neurosciences, Evaluation, Education, and Pacific Islands. Our world renowned website is www.ncptsd.va.gov. I would like to highlight some of the National Center's recent educational and clinical research initiatives. For clarity of discussion, I have divided these into two main groups: (i) those that are primarily the purview of personnel of the NCPTSD Education, VA Palo Alto Healthcare System and the Pacific Islands Divisions (VAPIHCS), and (ii) those related to the entire NCPTSD consortium.

NCPTSD Education and the Pacific Islands Divisions:
NCPTSD personnel have been engaged in multiple collaborative educational and clinical research activities with the Department of Defense.

In January 2005, the Navy Bureau of Medicine (BUMED) asked NCPTSD/VAPAHCS staff to coordinate a leadership summit of Navy, Marine and VA leadership in Southern California. The summit was attended by military and VA mental health, medicine, and chaplains, and line

officers from Marine Corp Headquarters, BUMED, Camp Pendleton, Camp Lejuene, San Diego Naval Hospital, National Center for PTSD, and VA Central Office. The focus of the meeting was coordination between services, across hospital settings, and transition to VA treatment facilities. In May, 2005, the NCPTSD organized a two day combat stress clinical training program for Navy and Marine mental health and primary care military staff located throughout the western states (i.e., Camp Pendleton, Naval Hospital San Diego, Miramar Air Station, Twenty-nine Palms).

In June 2005, based on trainings provided to staff at Camp Pendleton, Marine Corp Headquarters requested that NCPTSD/VAPAHCS staff provide clinical training related to identification and interventions for combat related stress to all Marine Corp Community Services (MCCS) staff at major Marine Corp bases in the US.

NCPTSD/VAPAHCS has created an internet web-based clinical training curriculum entitled PTSD 101. The goal is to provide enhanced training for all VA and DoD field clinicians who provide services to veterans, reservists, and active duty returnees with PTSD, adjustment disorders, or other combat stress reactions. This web-based curriculum of over 20 courses provides practitioners with a convenient, practical, and user-friendly means to access a range of continuing education materials that focus on the diagnosis, assessment, and treatment for PTSD and other combat stress reactions. This new web-based curriculum will allow practitioners to access training materials 24-hours a day/ 7 days a week, from any computer terminal.

Since the Congressional mandate for VA/NCPTSD includes developing and providing education and trainings about cultural issues affecting the Pacific Islands, I sought out partnerships with leadership from community mental health agencies and DoD. Further, VA/NCPTSD reached out to partner with local, state, and private agencies to provide educational and clinical trainings about combat stress/PTSD.

One outcome of partnering with the larger communities on the islands has been the establishment of what will become an annual conference entitled "Stress, Violence, and Trauma: Promoting Hawaii's Resilience." This conference is organized by a planning committee comprised of a consortium of multiple federal, state and local governmental and non-profit agencies. Also, after Senator Akaka's staff learned about the conference, they expressed enthusiastic support and joined the planning efforts. Our first conference was held in April, 2005 and was attended by a very receptive audience of over 250 people. Our next conference is being held January 11 and 12, 2006 at the Hale Koa Hotel. (A description of the conference, at which the Undersecretary for Veterans Health Administration, Dr. Jonathon Perlin, will be presenting, is located at our website at (http://stressconference.com/). This educational event has increased the visibility for the Pacific Island Division. This collaboration has already had many positive outcomes as we have provided important clinical trainings for both Army and Marines in Hawaii who have been deployed and redeployed from Iraq and Afghanistan. We want to take the opportunity to thank Senator Akaka and his staff for their support to make this annual conference a success.

Staff from NCPTSD's Pacific Island Division (VAPIHCS) collaborates closely with the Army personnel stationed at Schofield Barracks' Soldier Assistance Center and the Family Assistance Center. NCPTSD staff consult the Directors of the Solider Assistance Center and the Director of

the Family Assistance Center who oversee the collection of needs assessment/clinical intake data for soldiers who screen positive for combat-related stress. In 2004, we provided a series of monthly trainings to DoD mental health providers at the Soldier Assistance Center on treatment for OIF/OEF returnees suffering from combat stress. Since that time, we have continued to provide ongoing trainings for newly hired therapists and residents on evidenced based treatment guidelines for the treatment of PTSD, assessment of combat stress-related disorders, early intervention for combat stress, intervention for sexual assault, and alcohol abuse treatment. Additionally, NCPTSD staff members co-lead group educational interventions with military personnel at the Soldier Assistance Center for returnees and their spouses.

In February 2005, members of the NCPTSD Educational and Clinical Laboratory (VAPAHCS) and Pacific Island Divisions (VAPIHCS) provided a five-day conference at Tripler Army Medical Center and Schofield Barracks titled ?War-Zone Related Issues for Active Duty Personnel: Pre-, Post-, and Redeployment.? Audience members were over 100 Tri-service mental health professionals, including Family Service Workers, Social Workers, Psychiatrists, Psychologists, Chaplains, and Primary Care Providers. Members of the NCPTSD/VAPIHCS and US Army, Schofield Barracks also developed a ?Building Resilience Coping Skills Group,? with a manual and workbook that address post-deployment stressors uniquely reported by OIF/OEF returnees. Tri-service military providers were trained in implementing the group intervention, and several groups have been successfully conducted at Schofield Barracks and at Pearl Harbor.

Personnel from the NCPTSD (VAPAHCS/VAPIHCS) were requested to provide a series of outreach and educational trainings to the 3,000 deploying members of the Hawaii's 29th Infantry Brigade (National Guard) and their families in March 2005. We conducted lectures addressing the impact of deployment stress upon families, and provided educational materials, created by the NCPTSD, that were specifically geared to their needs. The National Guard has requested that VA/NCPTSD provide follow-up educational trainings to families prior to their spouses return and again upon the service member's return in March 2006.

Similarly, the Marine Corps requested ongoing educational trainings to spouses of the 800 returning Marines at Kaneohe Marine Base. Members of the VA/NCPTSD are also conducting presentations that address deployment and post-deployment stress on families and provide accompanying VA/NCPTSD educational materials specifically geared to families.

VA/DoD Education and the NCPTSD Consortium

Due to the successful collaboration to create an Army version of the Iraq War Clinician's Guide, a Marine Corps version is also currently being created. The Marine Corps version is a collaboration between USMC/VAPAHCS/VAPIHCS and will provide the most current relevant clinical information about combat stress and PTSD for both military and VA personnel.

Returning from the War Zone: A Guide for Military Personnel: This pamphlet was created to assist active duty, National Guard, military reserve, and veteran military service members to positively cope with adjustment during their transition back to civilian life. Returning from the War Zone: A Guide for Families of Military Personnel: This pamphlet was created to help military families understand and assist their loved ones following a homecoming.

IV. Recommendations for educational and clinical training needs to augment VA/DOD healthcare

In the months and years ahead, VA nationwide and VA/NCPTSD will continue to serve as a tremendous resource for service members and veterans. VA's task is to continually refine and improve the processes of care in order to apply evidenced-based treatment models for those service members injured or psychologically affected during combat operations. Further, the collective goal of the VA and DoD healthcare is to support and facilitate the seamless transition and reintegration of the veteran into his or her family, work, and community settings. VA/NCPTSD is well positioned to support this mission.

Here are four suggested recommendations for continued enhancements to quality care within VA system:

Implementation of Innovative Treatment Delivery Systems
Compared to the Vietnam era veterans, the current cohort of veterans display a wider diversity in age, racial, cultural, and educational backgrounds. They tend to be more comfortable using advanced technology. Many in the current generation of warriors have grown up with instant access technology, such as the internet, digital imagery and communication and other electronically advanced public and military technologies. These service members and veterans may be more comfortable with technology than any other previous generation of warriors and veterans. Thus developing innovative treatment delivery systems employing technology based systems (internet-based, virtual reality) may provide a relevant platform that suits these individuals' preferences for treatment. VA/NCPTSD's Pacific Islands Division continues to promote PTSD telemental health as a way of providing specialty PTSD services to veterans residing in remote locations. In addition, NCPTSD provides ongoing education and supervision to national programs interested in developing PTSD telemental health for current veterans and returning OIF/OEF veterans.

Continued Education and Clinical Training for VA Providers
Many treatment providers in VA have tremendous expertise working with older generations of veterans. According to VA estimates, 40% of these providers will be nearing retirement age in the next five years. We can expect a new influx of younger treatment providers to enter VA's workforce during this time as well. These younger treatment providers will not share the first hand knowledge of lessons learned from the work over the past 30 years.

For these reasons, education and clinical training have become the primary foundation to support the mission and goals of VA and DoD health care. In order to best serve the unique health care needs of the OIF/OEF veterans, a wide educational net must be cast to clinical service providers, including mental health and primary care providers. In addition, veterans will seek out health care from spiritual leaders or others in the community. Education and clinical training will play an integral role in determining whether a veteran's combat stress reactions resolve early, or develop into a more chronic form of PTSD.

In summary, continued education and training are important foundations as VA continues to provide quality care to veterans from OIF/OEF, as well as previous wars. Further, it is imperative that the VA continues to develop innovative strategies to disseminate education not only to the

veterans who come to VA but also the veterans who will access other community based healthcare. VA's NCPTSD is uniquely positioned, as VA's leader in the field of combat-related stress, to support VA to meet this objective. The VA/NCPTSD is staffed with highly talented clinicians, researchers, and educators who are devoted to development and dissemination of empirically based treatment protocols, assessment instruments, and guidelines for addressing combat stress and PTSD.