Treatment for Posttraumatic Stress Disorder in Military and Veterans Populations
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Statement of

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Good morning Mr. Chairman, Ranking Member Burr, and members of the committee. Thanks to Senator Sanders, Senator Burr, and members of the Committee on Veterans' Affairs, for your concern about veteran's health.

My name is Elspeth Cameron Ritchie. I am a long-time Army psychiatrist now serving as the chief clinical officer for the District of Columbia's Department of Mental Health. Before retiring from the Army in 2010, I spent the last five of my 24 years in uniform as the top advocate for mental health inside of the Office of the Army Surgeon General. Before that, I served in other leadership roles including the psychiatry consultant to the Army Surgeon General at the Department of Defense Health Affairs. I trained at Harvard, George Washington University, Walter Reed, and the Uniformed Services University of the Health Sciences. I am a professor of psychiatry at the Uniformed Services University of the Health Sciences - the U.S. military's medical school -- in Bethesda, Md.; I am also a clinical professor of psychiatry at Georgetown University. I am here before you today because of my experience as a volunteer serving on the Institute of Medicine (IOM)[1] Committee on the Assessment of Ongoing Efforts in the Treatment of Posttraumatic Stress Disorder. I will address the issues on posttraumatic stress disorder as revealed by the IOM committee, however, any remarks I make regarding suicide will be my personal opinion as the committee did not address issues of suicide in its study.

Posttraumatic stress disorder (PTSD) is one of the signature injuries of the U.S. conflicts in Afghanistan and Iraq, but it affects veterans of all eras. It is estimated that 7 to 20% of service members and veterans who served in Operation Enduring Freedom

[1] The National Academy of Sciences, National Academy of Engineering, and the Institute of Medicine of The National Academies were chartered by Congress in 1863 to advise the government on matters of science and technology.

(OEF) and Operation Iraqi Freedom (OIF) may have the disorder. PTSD is characterized by a combination of mental health symptoms—re-experiencing of a traumatic event, avoidance of trauma-associated stimuli, adverse alterations in thoughts and mood, and hyperarousal—that last at least a month and impair functioning.

PTSD can be lifelong and pervade all aspects of a service member's or veteran's life, including mental and physical health, family and social relationships, and employment. It is often concurrent with other health problems, such as depression, traumatic brain injury (TBI), chronic pain, substance abuse disorder, and intimate partner violence. The Department of Defense (DoD) and the Department of Veterans Affairs (VA) provide a spectrum of programs and services to screen, diagnose, treat, and rehabilitate service members and veterans who have or are at risk for PTSD.

The 2010 National Defense Authorization Act tasked the IOM with assessing those PTSD programs and services. The IOM conducted the study in two phases; the committee members directed the literature searches, requested data from the DoD and the VA, and visited nine military medical facilities and six VA medical facilities. I will discuss the committee's findings.

PTSD Management Strategies

PTSD management in DoD appears to be local, ad hoc, incremental, and crisis-driven with little planning devoted to the development of a long-range, population-based approach for the disorder by either the Office of the Assistant Secretary of Defense for Health Affairs or any of the service branches. Each service branch has established its own prevention programs, trains its own mental health staff, and has its own programs and services for PTSD treatment.

VA has a more unified organizational structure than DoD and is able to ensure a more consistent approach to the management of PTSD in its medical facilities. However, there are few data to indicate that PTSD-related performance measures are being met, although improving mental health care is one of VA's major initiatives in its strategic plan.

Although the DoD and VA are coordinating strategic efforts such as the *DoD/VA Integrated Mental Health Strategy* and the *National Research Action Plan for Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*, those activities have not proven to be sufficient to determine whether PTSD management is improving or whether a population-based approach is being used to reach and treat all service members and veterans in need of care for PTSD. Furthermore, current DoD and VA strategic efforts do not necessarily encourage the use of best practices for preventing, screening for, diagnosing, and treating for PTSD and its comorbidities, and do not extend to ensuring continuity of care as service members transition from active duty to veteran status.

Leadership and Communication

DoD leaders at all levels of the chain of command are not consistently held accountable for implementing policies and programs to manage PTSD effectively. In each service branch, there is no overarching authority to establish and enforce policies for the entire spectrum of PTSD management activities. A lack of communication among mental health leaders and clinicians in DoD can lead to the use of redundant, expensive, and perhaps ineffective programs and services while other programs, known to be effective, languish or disappear.

VA leadership engagement in PTSD management among sites varies resulting in different types and quality of PTSD programs and services. Although the VA central office has established policies on minimum care requirements and guidance on PTSD treatment, it is unclear whether VA leaders adhere to the policies or encourage staff to follow the guidance.

Performance Measurement

DoD and VA do not collect data to identify best practices throughout the spectrum of their PTSD programs and services, although there are some initiatives to do so. Given that DoD and VA are responsible for serving millions of service members, families, and veterans, it is surprising that no PTSD outcome measures of any type for psychotherapy or pharmacotherapy are consistently used or tracked in the short or long term (with the exception of the VA Specialized Intensive PTSD Programs). Without tracking outcomes neither department knows whether it is providing effective, appropriate, or adequate care for PTSD. Reliable and valid self-report measures are available and could be used to monitor progress, provide real-time response information to providers and patients, and guide modifications of individual treatment plans. VA is in the process of expanding its electronic health record to capture the types of psychotherapy that patients are receiving, but the revised record still will not include regularly administered outcome measures. Most veterans who have PTSD do not receive care in VA specialized PTSD programs, so their treatments and outcomes are unknown.

Workforce and Access to Care

DoD and VA have substantially increased their mental health staffing—both direct care and purchased care. However, staffing increases do not appear to have kept pace with the demand for PTSD services. Staffing shortages can result in clinicians not having sufficient time to provide evidence-based psychotherapies readily and with fidelity. The lack of time to deliver psychotherapy with fidelity is reflected in the fact that in 2013 only 53% of OEF and OIF veterans who had a primary diagnosis of PTSD and sought care in the VA received the recommended eight sessions within 14 weeks. Provision of evidence-based treatments also implies refraining from providing services or programs that lack an evidence base or whose evidence base has been deemed ineffective by recent research. The size of the VA and DoD workforces will be influenced by how efficiently and effectively staff use their time to deliver the most effective assessments and treatments in a patient-centered approach. Although expanding the number of staff to meet needs may be necessary, it may also be possible to achieve equal or better results with more efficient use of existing staff and by having existing staff use the most effective programs and services.

Neither department appears to have formal procedures for evaluating the qualifications of purchased providers, mechanisms to determine the best purchased care provider for an individual patient, or a requirement that those providers give referring providers updates on patients' progress. Having standards, procedures, and requirements for direct care and purchased care providers will help to ensure that they are trained in evidence-based treatments that are consistent with *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, understand military context and culture,

measure the progress of patients in treatment on a continuing basis, and, in the case of purchased care providers, coordinate with patients' DoD or VA referring providers regularly. DoD and VA have expanded training in evidence-based psychotherapies for all mental health staff. However, the training is not required for purchased care providers in either department.

Evidence-Based Treatment

DoD and VA have expended considerable effort to develop, update, and disseminate the *VA/DoD Clinical Practice Guideline for Management of Post-traumatic Stress.* The guideline provides algorithms for choosing an evidence-based treatment for PTSD, addresses comorbidities, describes approaches for engaging patients in treatment, and discusses the evidence on first-line and other psychosocial therapies and pharmacotherapies.

However, mental health care providers in both departments do not consistently provide evidence-based treatment in spite of policies that require that all service members and veterans who have PTSD receive first-line treatments, such as cognitive processing therapy and prolonged exposure therapy. It is unclear what PTSD therapies most service members or veterans receive in any treatment setting and whether their symptoms improve as a result. DoD and VA are also integrating complementary and alternative therapies into some of their specialized PTSD programs, but the interventions need to be studied to establish their evidence base and to ensure that their use does not deter patients from receiving first-line, evidence-based treatments.

Central Database of Programs and Services

DoD does not have a central database of PTSD programs and services that are available throughout the service branches. Without such a database, it is impossible to compare programs and services, to identify the ones that are effective and use best practices, and to recognize the ones that need improvement or should be eliminated. Most of the specialized PTSD programs in the service branches were developed and implemented locally. As a result, clinicians and other mental health care providers have no resource that provides information on programs (for example, type, location, admission criteria, and treatment modalities) to which they might refer service members who need specialized PTSD care, or that might serve as models for new programs at their facility.

Although the VA prepares an annual report on its specialized PTSD programs, that report does not include all PTSD treatment settings, such as general mental health clinics and women's health clinics. Furthermore, the report does not contain any descriptive information on program elements and does not appear to be widely used.

All stakeholders, including families and direct and purchased care providers, would benefit from ready access to a routinely updated database in which programs are described and evaluated according to standardized measures. Existing resources, such as the National Center for PTSD, could be leveraged to develop more comprehensive information about VA-wide PTSD programs and services (not just specialized ones) and, in a collaborative effort, include those of DoD.

Family Involvement

DoD has a variety of resources to assist service members and their families and others in learning about PTSD, its diagnosis and treatment, and its impact on family and friends. Many support services are available to service members and their family members in military installations and personnel in those programs and services are trained to recognize early symptoms of PTSD, provide nonclinical supportive care, and refer service members and their families to appropriate professional care.

VA also has resources for families of veterans who have PTSD, such as the National Center for PTSD. Some veterans have expressed their interest in and preference for having their partners involved in their PTSD treatment and the need for support groups for those partners. However, there is no formal VA-wide program for engaging family members in the veterans' treatments, for providing psychoeducation in a facility, or for establishing support groups for family members. In several VA mental health programs, veterans who have PTSD and their partners and children receive couple or family therapy from professional clinicians. VA, including Vet Centers, provides peer counselors and peer support groups that help to engage veterans in treatment, reduce stigma, and promote empathy, but data on the number of veterans who seek treatment as a result of peer counseling or who participate in support groups are not available. Vet Centers also provide counseling services for family members.

Research Priorities

There can be substantial barriers to conducting PTSD research within and between the departments and in collaboration with academic, government organizations,

and private partners. To date, there does not appear to have been a systematic effort by either department to identify those barriers and mechanisms to overcome them. Nevertheless, DoD and VA are funding broad PTSD research portfolios and are working collaboratively with the National Institutes of Health and other organizations to fill research gaps (for example, developing the joint *National Research Action Plan for Improving Access to Mental Health Services for Veterans, Service Members, and Military Families* for improving access to mental-health services), but much work remains to be done.

DoD and VA are spending substantial time, money, and effort on the management of PTSD in service members and veterans. Those efforts have resulted in a variety of programs and services for the prevention and diagnosis of, treatment for, rehabilitation of, and research on PTSD and its comorbidities. Nevertheless, neither department knows with certainty whether those many programs and services are actually successful in reducing the prevalence of PTSD in service members or veterans and in improving their lives.

Suicide

As previously mentioned, I am here today in several capacities: as a former IOM Committee member on PTSD, and as a retired career Army psychiatrist and subject matter expert on military suicide. This part of the testimony is from my professional experience in military and veteran mental health and suicide issues and does not reflect the collective opinion of the IOM.

The military has made a comprehensive effort to understand the dynamics of those who kill themselves while on active duty. That information is obtained in a variety

of ways including suicide event reports, which help to inform suicide prevention efforts. The suicide numbers are still stubbornly hard to reduce, but the rate among active duty troops is beginning to flatten.

Far less is known about the reasons for suicide in reserve troops who kill themselves while not on active duty or on suicides in veterans. The numbers of Guard and reservists, including IAs or individual augmentees, who are killing themselves is still unacceptably high, and moreover we do not know why they are doing it.

For example, it's important that we also focus on the needs of our "Non Traditional Deployers". Members who deploy in support of missions like Detainee Operations have often been forgotten. This includes a large contingent of Navy Sailors who deployed to GITMO, Iraq Theater Interment Facilities and Afghanistan Interment Facilities. They received very little training in the jobs they were asked to preform, and came back to even less demobilization support.

Now would be the time to identify these members and study them, so we can identify what the training they went through was like, how they were treated in theater, and how they were received once they returned home. It would be good to compare these service members with service members who have been trained in the Military Correction Officer programs, and see how they favor during the same deployment environments.

The suicide rates among these sailors have continued to increase since 2010, and it is my thought that these rates may rise over the coming year with the IA's going away with the ending of the war. These sailors have been able to suppress their mental injuries by continuing to deploy and with that no longer being an option, it is likely that psychological symptoms will start to set in, and send most of them into a shock.

The numbers of veteran suicides are widely cited as 22 per day. However, as compared with suicides among active duty military, almost nothing is known about what precipitates self-injury among veterans. Anecdotally, I think that younger veterans are killing themselves in a pattern similar to that of active duty members, in other words over relationship and occupational difficulties. The pattern in older veterans appears to be more similar to the civilian population, with depression and substance abuse as key culprits.

To the best of my knowledge, the VA's suicide epidemiological office has two people. Thus the first of my recommendations is to better resource the efforts to understand who is killing themselves and why so that the risk of this tragedy can be reduced.

A second recommendation is to better screen veterans for exposures to a number of potentially toxic agents, including Mefloquine (an antimalarial), which has been associated with psychiatric symptoms and suicide. Fifty years after the beginning of the Vietnam War, and twenty-three years after the first Gulf War and the so-called Gulf War illness, the military has dramatically stepped up their screening as troops re-deploy home. But this is not yet uniformly done in the VA.

I turn now to the direction of research into PTSD treatment and suicide prevention. The VA has certainly been a leader in the former area. I would like to see them continue in that capacity, with a focus on expanding the evidence-base for the so-called cadre of complementary and alternative medicines (CAM) or integrative therapies. These CAM treatments include medical acupuncture, yoga, mindfulness, stellate ganglion block, and canine and equine therapy. For many of these CAM therapies, the evidence-

base is promising but insufficient to guide changes in standard clinical treatment paradigms for PTSD. Given the well-documented low rate of effectiveness in existing evidence-base therapies (less than 30% overall) and the epidemic of PTSD in our military and veteran populations, it is an imperative that VA and DOD invest in research for new and innovative therapies with preliminary data showing favorable outcomes in PTSD symptom reduction.

It is important to keep in mind that many patients are already using these CAM strategies, some through established medical clinics and others through the internet or other non-traditional means. Based on preliminary published data as well as anecdotal patient testimonials, we know that some patients benefit greatly from these CAM therapies, but we do not yet know who which types of patients benefit most or why. DoD has begun doing some research on these innovative approaches, but it does not have the sophisticated ability to conduct clinical trials with the same capacity as VA does.

Finally, I would like to close with a concept that is important for all listening to understand: "moral injury". "Moral injury" is not a psychiatric disorder but a condition imposed by war, often related to the act of killing or of seeing others die. Service members who have served in prisons, such as Guantanamo Bay and Abu Ghraib may be at highest risk. As a psychiatrist who has treated countless patients with PTSD, I believe that the related shame and guilt contribute to substance abuse, divorce, and suicide, but again there is not yet adequate research. I would encourage the VA—as well as the military and civilian community—to acknowledge and discuss these almost existential concepts with patients.

In closing, I would like to thank you for inviting me to testify before this committee. I appreciate the work of the Senate Committee on Veterans Affairs. On behalf of the IOM PTSD committee members, I thank you for your trust in our ability to assist you with this important work for our nation's veterans. I know from my service on the IOM committee that the nation's scientists are happy to serve, and look to you for guidance on how we can be of most assistance to you and the VA and the DoD in addressing this difficult issue. I look forward to answering any questions you might have regarding the IOM's PTSD report. Attached to my testimony are the IOM committee's recommendations. Any questions you might have regarding suicide will be my opinion as the committee did not address that issue as it was not part of their statement of task as outlined in the legislation.