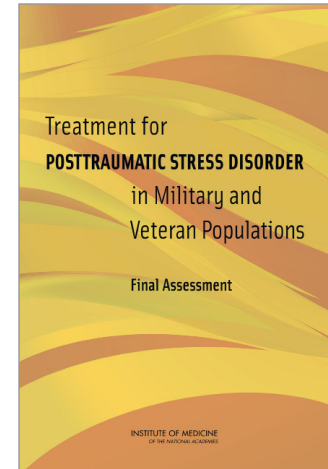


Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations

Final Assessment



Posttraumatic stress disorder (PTSD) is one of the signature injuries of the U.S. conflicts in Afghanistan and Iraq. An estimated 8 percent of current and former service members who were deployed to these areas have a PTSD diagnosis. For these men and women, readjustment from combat zone deployments and reintegration into families and communities may be significantly hampered by chronic distress and disability in physical, psychological, social, and occupational functioning.

In response to the growing PTSD burden among service members and veterans, a provision of the National Defense Authorization Act for 2010 required the Secretary of the Department of Defense (DoD), in consultation with the Secretary of the Department of Veterans Affairs (VA), to commission an Institute of Medicine (IOM) study to assess PTSD treatment programs and services in DoD and VA. The study was conducted in two phases; the final report, *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations*, contains the IOM committee's comprehensive assessment of DoD and VA efforts to prevent and treat PTSD in service members and veterans.

The U.S. conflicts in Afghanistan and Iraq are associated with a notable increase in PTSD prevalence. Between 2004 and 2012, the percentage of all active-duty service members with a diagnosis of PTSD increased from 1 to 5 percent.

PTSD Symptoms and Prevalence

PTSD is characterized by a combination of mental health symptoms—such as reliving a traumatic event, avoiding trauma-associated stimuli, and experiencing mood swings and hyperarousal—that persist for at least 1 month and impair normal functioning. Symptoms may occur soon after exposure to a traumatic event or may be delayed, sometimes for years. Increased exposure to combat-related trauma is associated with increased risk for developing PTSD.

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percent. In 2012, 13.5 percent of U.S. Army service members had PTSD, as did 10 percent of Marines, 4.5 percent of Navy personnel, and 4 percent of Air Force personnel. The same year, more than half a million veterans of all eras sought care for PTSD through VA health care services—making up 9.2 percent of all VA users. Almost 24 percent of these veterans (119,500) had served in the Afghanistan and Iraq conflicts.

PTSD Programs and Services at DoD and VA

Both DoD and VA have comprehensive health care systems that include numerous programs and services designed to prevent, screen for, diagnose, and treat PTSD, and to rehabilitate service members and veterans who have or are at risk

for PTSD. Many of the programs and services are under different commands and authorities, which makes it difficult to identify and evaluate them. This is particularly true for DoD, where various mental health programs are under the authority of the DoD central office and others are dispersed across the service branches, installation commands, and medical commands. In VA, policy and oversight for PTSD programs are managed from the central office, but regional and local health care directors have responsibility for day-to-day operations and program or service innovations.

Performance Measurement

Neither DoD nor VA has a mechanism for the systematic collection, analysis, and dissemination of data for assessing the quality of PTSD care.

Overview of IOM Committee Recommendations

- DoD and VA should develop an integrated, coordinated, and comprehensive PTSD management strategy that plans for the growing burden of PTSD for service members, veterans, and their families, including female veterans and minority group members.
- DoD and VA leaders should communicate a clear mandate through their chain of command that PTSD management, using best practices, has high priority.
- DoD and VA should develop, coordinate, and implement a measurement-based PTSD management system that documents patients' progress over the course of treatment and long-term follow-up with standardized and validated instruments.
- DoD and VA should have available an adequate workforce of mental health care providers—both direct care and purchased care—ancillary staff, and resources to meet the growing demand for PTSD services. This includes clear training standards, referral procedures, and patient monitoring and reporting requirements for all their mental health care providers.
- Both departments should use evidence-based treatments as the treatment of choice for PTSD, and these treatments should be delivered with fidelity to their established protocols. Any new programs and services should be piloted and include an evaluation process to establish the evidence base on their efficacy and effectiveness.
- DoD and VA should establish a central database or other directory for programs and services that are available to service members and veterans who have PTSD.
- DoD and VA should increase engagement of family members in the PTSD management process for service members and veterans.
- PTSD research priorities in DoD and VA should reflect the current and future needs of service members, veterans, and their families. Both departments should continue to develop and implement a comprehensive plan to promote a collaborative, prospective PTSD research agenda.

DoD and VA's significant financial investment in PTSD care—and trends that suggest that demand for such care will remain high in coming years—make it imperative that the departments improve measurement of outcomes and costs to determine the most high-value treatments for service members and veterans.

The IOM committee finds that metrics for program effectiveness, quality of care, program awareness, and availability and acceptance of PTSD services are needed. Clinicians cannot adequately track a patient's PTSD treatments (other than medications) or any patient outcomes in the electronic health record. Therefore, it is difficult to determine whether the therapies being used to treat PTSD are evidence-based or applied as intended.

Delivering High-Value Care

To deliver high-value health care, an organization must be able to determine patient outcomes and costs of treatment. However, neither DoD nor VA is in a position to do that, primarily because of the lack of outcome data, but also due to the absence of cost information for certain treatments. In addition, both departments increasingly rely on purchased care from outside providers to fill gaps in their own systems—and even less is known about the value of care delivered in such settings.

Total costs of PTSD care are high in both departments. In 2012, DoD spent about \$294 million and VA spent about \$3 billion on PTSD care for service members and veterans, respectively. DoD and VA's significant financial investment in PTSD care—and trends that suggest that demand for such care will remain high in coming years—make it imperative that the departments improve measurement of outcomes and costs to determine the most high-value treatments for service members and veterans.

Training the Workforce

DoD and VA have expanded their workforce in response to the growing need for PTSD programs and services, including an increased use of purchased care providers. Although this effort to increase access to care is an important first step, the IOM committee finds that the referral process to purchased care providers appears to be ad hoc rather than thoughtful clinical decision making. Questions remain about providers' adherence to the *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, adequacy of training in evidence-based treatments (such as prolonged exposure therapy and cognitive processing therapy) for both direct care and purchased care providers, and ability of providers to deliver that treatment. Both departments are exploring the use of new delivery methods for evidence-based treatments and provider training, such as telehealth and virtual reality, which may increase access to treatment, particularly for service members and veterans in underserved areas, and help providers learn PTSD treatment skills by interacting with patient avatars. More research is needed to determine the effectiveness of such delivery approaches.

Conclusion

Demands for PTSD services among current and former service members are at unprecedented levels and continue to grow. The IOM committee finds that both departments have made a



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sustained commitment to PTSD management and invested substantial financial and programmatic resources to provide care to service members and veterans, including the development of new and specialized programs for PTSD management.

However, a lack of standards, reporting, and evaluation significantly compromises DoD and VA efforts. The departments often do not know what treatments patients receive or whether treatments are evidence-based, delivered by trained providers, cost-effective, or successful in improving PTSD symptoms. The departments also collect little information about the effectiveness of their programs in the short or long terms. The IOM report offers recommendations and guidance for improving processes and infrastructure to allow DoD and VA to respond more strategically and effectively to the growing PTSD burden among U.S. service members and veterans. 

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